Interfacility Transfer Communication & Injection Safety

Oregon Public Health Division
Healthcare-Associated Infections HAI Program
Objectives

• Interfacility transfer communication
  – Overview of law
  – Implementation to date
  – Resources

• Injection safety in healthcare
  – Background: outbreaks & core principles
  – Oregon-specific concerns and initiatives
  – Resources
INTERFACILITY TRANSFER COMMUNICATION (IFT)
Background: IFT law

• Effective January 2014, OAR 333-019-0052

• “Communication During Patient Transfer of Multidrug-Resistant Organisms” (MDROs)

• Includes acute, ambulatory, and long-term care facilities (LTCFs)

• Report to receiving facility any disease requiring transmission-based precautions

• Written notification must be in transfer documents and readily accessible

http://tinyurl.com/oregonift
IFT rule implementation

- 2015 OR surveys: 60 hospitals & 140 skilled nursing facilities (SNFs)

- Reported compliance with IFT Law
  - Hospitals: 83%
  - SNFs: 73%

- “We notify receiving facilities of MDROs at discharge”
  - 92% hospitals Agree or Strongly Agree
  - 92% SNFs Agree or Strongly Agree

- “Transferring facilities notify us of MDROs”
  - 38% hospitals Agree or Strongly Agree
  - 53% SNFs Agree or Strongly Agree
More information

https://public.health.oregon.gov/DiseasesConditions/CommunicableDisease/HAI/Prevention/Pages/Interfacility-Communication.aspx
## Inter-facility Infection Control Transfer Form

**SENDING FACILITY TO COMPLETE FORM and COMMUNICATE TO ACCEPTING FACILITY**

*Please attach copies of latest culture reports with susceptibilities, if available*

<table>
<thead>
<tr>
<th>Patient/Resident Last Name</th>
<th>First Name</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

*Print or place Patient Label*

<table>
<thead>
<tr>
<th>Sending Facility Name</th>
<th>Sending Facility Unit</th>
<th>Sending Facility Phone #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

**Is the patient/resident currently on antibiotics?**
- [ ] NO
- [ ] YES

DX: ________________

**Does the patient/resident have pending cultures?**
- [ ] NO
- [ ] YES

**Is the patient/resident currently on precautions?**
- [ ] NO
- [ ] YES

**Type of Precautions (check all that apply)**
- [ ] Contact
- [ ] Droplet
- [ ] Airborne
- [ ] Other: ________________

**Does patient currently have an infection, colonization or a history of a multireistant organism (MDRO)?**

<table>
<thead>
<tr>
<th></th>
<th>Colonization or history</th>
<th>Active infection on treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MRSA</strong> (methicillin-resistant <em>Staphylococcus aureus</em>)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td><strong>VRE</strong> (Vancomycin-resistant <em>Enterococcus</em>)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td><strong>C. diff</strong> (<em>Clostridium difficile, CDI</em>)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td><strong>Acinetobacter spp., multireistant</strong></td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td><strong>Gram-negative organism resistant to multiple antibiotics</strong> <em>(e.g., E. coli, Klebsiella, Proteus spp.)</em></td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td><strong>CRE</strong> (carbapenem-resistant <em>Enterobacteriaceae)</em></td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td><strong>Other</strong>:</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

*Culture report with multiple antibiotics marked resistant (R); send copy of report with susceptibilities.

**Other**: lice, scabies, shingles, norovirus, influenza, tuberculosis, etc.
INJECTION SAFETY

ONLY ONCE.
Safe injection practices are a set of measures to perform injections in an optimally safe manner for patients, healthcare providers and others. Learn about Safe Injection Practices >
Unsafe Injections: A National Issue

- Over 50 US outbreaks (1998-2014) due to unsafe injections
- >700 patients infected
- >150,000 patients notified of potential exposure
- Syringe reuse
- Improper use of single-use/multi-dose vials
- Improper arterial blood gas measurement
- Drug diversion

http://www.oneandonlycampaign.org/
Core principles of injection safety

- Foundational principles that guide prevention efforts across settings
- Underpin the CDC’s One and Only Campaign
- Incorporated into Infection Control Assessment and Response (ICAR) tools

Key elements of injection safety

1. Use aseptic technique when preparing medications

2. Cleanse the access diaphragms of medication vials with 70% alcohol before inserting a device into the vial

3. Never administer medications from the same syringe to multiple patients, even if the needle is changed or injection administered through intravenous tubing

4. Do not reuse a syringe to enter a medication vial or solution

Key elements of injection safety

5. Do not administer medications from single-use vials, ampoules, or bags or bottles of intravenous solution to more than one patient

6. Do not use fluid infusion or administration sets (e.g., intravenous tubing) for more than one patient

7. Dedicate multidose vials to a single patient whenever possible
   - If multidose vials will be used for more than one patient, they should be restricted to a centralized medication area
   - Should not enter the immediate patient treatment area

Key elements of injection safety

8. Dispose of used syringes and needles at the point of use in a sharps container that is closable, puncture-resistant, and

9. Adhere to federal and state requirements for protection of HCP from exposure to bloodborne pathogens.

HCV morbidity & mortality in Oregon


- The mortality rate in Oregon from HCV was nearly twice the national average in 2011.
Injection safety practices in Oregon

• What do we know? Not much

• Current efforts:
  – Sporadic reports of breaches & investigations
  – CDC-funded Infection Control Assessments
  – Small grant to study & promote injection safety

Oregon surveillance & prevention efforts

• Small CDC grant to augment prevention

• Member state: One and Only Campaign

• Raise awareness
  – Public health professionals
  – Provider communities

• Focus on rural area
  – Survey of practices
  – Targeted interventions
DON'T DO IT
Sharing Insulin Pens and Other Injection Equipment Harms Patients

In 2009, in response to reports of improper use of insulin pens in hospitals, the Food and Drug Administration issued an alert reminding healthcare providers that insulin pens are meant for use on a single person only and are not to be shared. Unfortunately, there have been continuing reports of patients placed at risk of bloodborne and bacterial pathogen transmission through sharing of insulin pens.

A SIMPLE RULE
Injection equipment (e.g., insulin pens, needles and syringes) should never be used for more than one person.

ONE NEEDLE, ONE SYRINGE, ONLY ONE TIME.

About the Safe Injection Practices Coalition
The Safe Injection Practices Coalition (SIPC) is a partnership of healthcare-related organizations led by the Centers for Disease Control and Prevention. The SIPC developed the One & Only Campaign—a public health effort to eliminate unsafe medical injections by raising awareness of safe injection practices.

For a list of SIPC partners, for more information about the campaign, and to view additional resources including videos and other materials, please visit:

OneandOnlyCampaign.org

For the latest news and updates, follow us on Twitter @injectionsafety and Facebook/OneandOnlyCampaign.

What Every Healthcare Provider Needs To Know

Oregon Health Authority
60 second check

- 1 insulin pen = 1 resident
- Label, check name
- Not damaged
- Expiration
- Recheck name
- Storage
Outbreak of *P. aeruginosa* and *K. pneumoniae*, outpatient chemotherapy center

- 14 (17%) bloodstream infections identified among 84 active clinic patients
- Unqualified/unlicensed providers delivering infusion services
- Cost-containment measures recently instituted
- Switched to common-source saline and heparin flush
- Bags used over several days for multiple patients
- Dedicated, single syringes per patient could be reused multiple times to access common saline bag
- Syringes for heparin flush shared among multiple patients (discarded only if visible blood)

Dobbs et al, AJIC (2014) 731-4
DO YOU PROVIDE TREATMENT FOR PATIENTS WITH CANCER?

PROTECT YOUR PATIENTS, YOURSELF, AND YOUR BUSINESS
Since 2002, at least nine serious infectious disease outbreaks have occurred in cancer clinics. These outbreaks involved unsafe injection practices, including the reuse of syringes. As a result, hundreds of patients became infected and thousands more required notification and testing for bloodborne pathogens.

REMEMBER! WHEN PREPARING MEDICATIONS AND INJECTIONS…

NEVER reuse these items:
- Needles or syringes that have been used for any purpose
- Vials with “single-dose-only” printed on the label
- Saline bags
- Intravenous tubing

ALWAYS follow aseptic technique* when:
- Preparing any medications
- Deseating a skin’s suture
- Administering a central line
- Injecting any medication

*Aseptic technique is used by health care workers to prevent the transmission of clean skin, equipment, and in the medication. This will help on how the spread of infections. Please visit the CDC Rapid Response Center and American Health Care Association for more information.

LEARN MORE ABOUT WAYS YOU CAN KEEP YOUR PATIENTS SAFE BY VISITING ONEANDONLYCAMPAIGN.ORG AND PREVENTCANCERINFECTIOS.ORG.

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For the latest news and updates, follow us on Twitter @OneAndOnlySafe and Facebook @OneAndOnlyCampaign.
Methicillin-susceptible *Staphylococcus aureus* (MSSA) cluster in a rheumatology practice

- Dec 2011: hospital IP notified health department
  - 4 patients admitted (length of stay 1-8 days) for surgical debridement of lab-confirmed MSSA infections
  - Health department identified 5th patient treated at different hospital’s emergency department

- Cases all received joint injections at an independent outpatient rheumatology clinic on same afternoon
  - 3 exam rooms; poor records management

- Steroid from a compounding pharmacy labeled as a multi-dose vial (MDV) containing preservatives

-Opened MDVs and single-dose vials (SDVs) kept on top of towel dispenser
“Will the real multi-dose vial please stand up?”

DRUG DIVERSION* SPREADS INFECTION FROM HEALTHCARE PROVIDERS TO PATIENTS

HEALTHCARE PROVIDER
with Hepatitis C or other bloodborne infection tampers with injectable drug

CONTAMINATED INJECTION EQUIPMENT AND SUPPLIES
present in the patient care environment

EXPOSURE OF PATIENT
results from use of contaminated drug or equipment for patient injection or infusion

*Drug diversion occurs when prescription medicines are obtained or used illegally by healthcare providers.

FOR MORE INFORMATION, VISIT CDC.GOV/INJECTIONSAFETY/DRUGDIVERSION

Oregon Health Authority
Mechanisms of diversion

- **False documentation** (e.g., medication not administered to the patient or “wasted” and instead used by the HCW)

- **Scavenging** of wasted medication (e.g., removal of residual medication from trash or used syringes)

- **Theft by tampering** (e.g., removal of medication from a container or syringe and replaced with similarly appearing solution that may be administered to patients)
Multistate HCV outbreak, 2012

- 45 cases of HCV in New Hampshire, Kansas & Maryland associated with radiology technician
- HCW also diverted opiates in Michigan, Arizona, New York, and Pennsylvania
- Investigation reveals holes in licensure, certification, placement, hospital detection programs, and peer/supervisor reporting
- HCW sentenced to 39 years in prison

Risk of Healthcare-associated Infections from Drug Diversion

When prescription medicines are obtained or used illegally, it is called drug diversion. Addiction to prescription narcotics called opioids has reached epidemic proportions and is a major driver of drug diversion. This webpage focuses on diversion involving healthcare providers who steal controlled substances such as opioids for their own use. This can result in several types of patient harm including:

- Substandard care delivered by an impaired healthcare provider,
- Denial of essential pain medication or therapy, or
- Risks of infection (e.g., with hepatitis C virus or bacterial pathogens) if a provider tampers with injectable drugs.

Outbreaks

CDC and state and local health departments have assisted in the investigation of infection outbreaks stemming from drug diversion activities that involved healthcare providers who tampered with injectable drugs. A summary of recent outbreaks is illustrated in the following timeline.

U.S. Outbreaks Associated with Drug Diversion by Healthcare Providers, 1983-2013
Materials available for order free of charge
Training video resources

http://www.oneandonlycampaign.org/content/audio-video
Thank you for your collaboration to improve care for Oregonians!

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Questions?
Follow up?

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