

Healthcare-Associated Infections Advisory Committee

June 22, 2016

APPOINTED MEMBERS PRESENT: Paul Cieslak, MD
Jon Furuno, PhD
Laurie Murray-Snyder
Pat Preston, MS (phone)
Mary Shanks, RN, MSN, CIC
Diane Waldo, MBA, BSN, RN, CPHQ, CPHRM, LNCC

NOMINATED MEMBERS PRESENT: Deborah Coteora (phone)
Debra Hurst (phone)
Ruby Jason (phone)
Teresa Shepherd

APPOINTED MEMBERS EXCUSED: Kelli Coelho, RN CNOR
Gwen Cox, RN, BS
Jamie Grebosky, MD
Joan Maca, RN
Nancy O'Connor, RN, BSN, MBA, CIC
Rachel Plotinsky, MD
Dana Selover, MD, MPH
Dee Dee Vallier

NOMINATED MEMBERS EXCUSED: Beth DePew
Larlene Dunsmuir
Akiko Saito

ADJUNCT MEMBERS PRESENT: Mary Post, RN

OHA STAFF PRESENT: Kate Ellingson, PhD, HAI Reporting Epidemiologist
Monika Samper, RN, HAI Reporting Coordinator

ISSUES HEARD:

- Call to Order and Roll Call
- OAR Updates: FluVax Survey
- NHSN 2015 Annual Report Update
- Sterilization and disinfection overview and hot topics
- Findings from on-site facility IP assessments in ambulatory settings
- Outbreaks Update 2016
- Healthcare Worker Influenza Vaccination Legislative Update
- Public Comment / Adjourn
- Discussion: themes and topics for future meetings

These minutes are in compliance with Legislative Rules. Only text enclosed in italicized quotation marks reports a speaker's exact words. For complete contents, please refer to the recordings.

Call to Order and Roll Call

Chair Mary Shanks

The meeting was called to order at approximately 1:00 pm. There was not a quorum.

Approval of March 2016 HAIAC Meeting Minutes

All Committee Members

Minutes for March 23, 2016 meeting were not voted on due to the lack of a quorum.

OAR Updates: HAI and Flu Vax

Monika Samper, OHA

- OARs language has been modified for clarity and to better align with CMS mandates.
 - Last year, the HAI and flu vaccination reports were combined, but this year, healthcare worker influenza vaccination data will be published in a separate report as a result of feedback from the committee.
 - OHA is about a month past the report due date and only about 50% of the data has been collected because, for the first time, the data includes dialysis centers. NHSN has been having a lot of compliancy issues so the data collected so far is not an accurate reflection of the dialysis centers.
-

NHSN 2015 Annual Report Update

Kate Ellingson, OHA

- OHA is encouraging the use of the portal: data.oregon.gov
 - It is an open data portal that a lot of different states are using, each with their own portal
 - Oregon Health Authority is encouraging various divisions to use this portal to publish data
 - The portal, which is very easy to utilize, permits users to view maps and download data.
- Executive Summary in progress
 - Data will remain on one page but the graphic is going to be split into two pages to improve readability and accommodate the addition of medical, surgical, and medical/surgical wards.
 - Device-associated infections and LabID events will be on the front and SSIs on the back.
 - The first graph will have *C. diff* and CAUTI
 - The second graph will have MRSA and CLABSI
 - Page 2 will have all of the SSIs
- You can get to this table by using the web link and you can filter by location types, which gives the user a lot of flexibility to view data the way that they want to and there are no restrictions on the length of the page.

- This allows the state to be a little more descriptive about what the data means, better summarizes the data for other programs to use, and can be exported to an Excel sheet.
 - The state met the 2013 HHS target of 50% reduction in CLABSIs with an SIR of 0.43.
 - This is the last year that we will be using the 2013 targets. Next January, we will be benchmarking against 2020 HHS targets, so the risk adjustment will be much better moving forward.
 - There were 41% fewer SSIs than predicted, based on the old HHS targets: the fewest infections observed were for CABGs and the most for KPRO procedures. The SSI is 0.59, so we're moving in the right direction.
-

Sterilization and Disinfection Overview and Hot Topics

Teresa Shepherd, VA, Portland

- The FDA-approved manufacturer's instructions are complex, often do not make sense, and are difficult to follow.
- Many of the medical devices that go down to the sterile processing department are very small, come with many parts, and have very detailed instructions for cleaning. Some of them have not been properly pre-cleaned so they are sometimes sent back, after being processed, with bone and flesh still imbedded in parts of the equipment.
- Sometimes even the vendors don't understand the proper procedures for cleaning the equipment, so they are not properly training hospital staff.
- This has a big risk factor, especially for hospital infection control and hospital acquired infections.
- This is a hot topic with The Joint Commission now.
- Dental is another huge area of concern.
- Sterilization and disinfection are important because it takes such a specialized set of skills and knowledge and not everyone will have them.
- There needs to be an initiative that is supported by leadership to better insure that things are being done correctly. This can be expensive because new equipment will have to be purchased and the amount of time required to properly process equipment may increase.
- In 2009, Joint Commission came out with new standards saying that sterile processing is important, people need to be trained, and there needs to be a competency assessment with performance feedback and audits.
- There is a big difference between disinfection and sterilization. Sterilization has a big safety net.
- There needs to be a subject matter expert on the infection control team that would focus on sterile processing so that the responsibility does not fall into the hands of the infection control staff. The subject matter expert could tie it all together.
- Oregon Patient Safety Commission has created and posted a toolkit for the ambulatory surgery centers on their website that has competencies for instrument repackaging and scope cleaning and reprocessing.
- There was also a suggestion to have a hands-on training course for instrument repackaging and scope cleaning and reprocessing.

- Some of the ASCs have offered the use of their sterile processing departments since they are often closed on the weekends.

Discussion

Committee members discussed options for learning environments for hands-on training for sterile processing and repackaging, such as a mobile truck that can move from site to site. This will take a lot of time, money, and planning but was suggested at an earlier meeting with CDC and was encouraged. There was talk of creating a subcommittee to set this idea in motion.

Findings from On-Site Facility IP Assessments in Ambulatory Settings

Mary Post, OHA/OPSC

- Mary Post discussed findings from assessments of ambulatory settings and dialysis facilities that are funded by the CDC through the Ebola grant. The goal is to work with local health departments and APIC members to build the infrastructure in the state.
 - Purpose is to work on building statewide infection prevention capacity.
 - The approach has been adapted at the regional level, Oregon is trying to build a partnership between the facilities across the continuum.
 - 25 facilities were offered consultations in the first year; the number will increase to a minimum of 35 facilities in subsequent years.
- There was a meeting last year to determine the selection of possible facilities for the assessment. Multiple approaches were looked at:
 - HAI NHSN data
 - Outbreak data
 - CMS Nursing Home Compare data
 - Influenza immunization rates
- We got some recommendations from various agencies and the biggest drivers were unusual pathogens or some kind of outbreak.
- One of the realizations was that specific hospital systems were not considered in the selection process, so some chains had several consultations and others didn't have any. Therefore, consultations will be spread out a little more in Year 2.
 - One of the big needs, especially for acute care facilities that have newer infection preventionists, is some additional support.
- CDC is using four different consult tools for these assessments based on each type of setting with different domains and requirements. Most of the data is now being collected out on the units or wards and are collected with audits, observations and staff interviews.
- Last year, 24 of the 25 assessments were done. This next year, 35 consults will be provided but we don't want to do this during the middle of a norovirus outbreak, for example, because they have other things to deal with.
 - After the dust has settled is a good time to go ahead because you're able to provide additional education and support for them.

- The tools are very heavily based on having competency-based training, performance feedback, and routine auditing of infection prevention practices, for example, sterile processing, as discussed earlier. This is something that's not in place in a lot of facilities; it's really based on going with what we've learned with contact precautions and a need to provide feedback such as people donning and doffing their PPE.
- It's really where the state of the art in best practices for infection prevention are moving.
- We mostly bumped up the long-term care facilities. We went from 10 to 15. We can shift as we see the need to move. Facilities are not performing well because of the lack of competency observations. There's a lot of zeros and this is not to infer that they're not quality organizations. It's really just measuring whether or not they have this new practice in place.
 - For ambulatory surgery centers and ambulatory clinics, one obviously needs to be doing a lot of SSI planning and training.
 - In terms of overall infection control program infrastructure:
 - Only one in five facilities met all requirements.
 - Three of the five had annually updated infection prevention policies and procedures.
 - Two had designated and trained infection preventionists. This does not mean certified infection preventionists but they at least have designated somebody and have documentation of additional training like our infection prevention fundamentals training course.
 - Three (60%) actually had a system for early detection and management of infectious individuals at point of entry to the facility.
 - In terms of competency-based education that provided job-specific training on infection prevention policies and procedures to healthcare personnel, no facility had this in place.
 - In terms of Healthcare Personnel Safety Domain:
 - One facility met all requirements.
 - 60% had exposure control plans for blood and bodily fluids.
 - 80% actually met all of the training requirements.
 - All provided post exposure follow-up, following a blood and bodily fluid exposure.
 - Only 40% actually tracked and trended and tried to decrease their actual exposures.
 - 40% had work exclusion policies that were specific about when ill employees should not report to work.
 - 40% encouraged prompt illness reporting to the supervisor
 - 60% had policies for not penalizing ill staff. Hopefully everybody is aware that Oregon now has new sick leave policies and individuals are entitled to 5 days of sick leave.
 - If you use sick time, then sometimes it comes out of PTO so people feel like that's penalizing them.

- Needs to be clarified with the CDC tool.
 - 80% conduct appropriate TB screening and offer free hepatitis B and influenza vaccinations to their employees.
 - In terms of surveillance of disease reporting, everybody met all of the requirements for this domain.
 - They had lists of reportable infections
 - They educated patients on signs and symptoms of infections that they need to report.
 - For hand hygiene, unfortunately nobody met this domain.
 - 60% provided hand hygiene education on hire.
 - 40% offered hand hygiene training annually.
 - Nobody required observational competencies
 - Only one performed any type of periodic auditing for hand hygiene.
 - Only one facility had a policy that promoted preferential use of alcohol-based hand rubs.
 - 60% had supplies readily available.
 - In terms of actual auditing practices:
 - 20-40% compliancy rate
 - Most commonly it was observed that hand hygiene was not being performed after patient contact or after removing gloves.
 - In terms of personal protective equipment, again, nobody met all domains.
 - 80% do provide training on hire and annually.
 - Everybody had supplies available.
 - One of the gaps was 20% did not wear facial protection, as required.
 - In terms of injection safety:
 - 60% provide training on hire.
 - None provide annual training, observational competencies, audits, or feedback.
 - In terms of tracking controlled substances to prevent drug abuse and diversion:
 - Only 20% had a policy and procedure to track healthcare personnel access to controlled substances
 - All controlled substances were found locked and secured.
 - One the questions the tool does not ask ambulatory care facilities, but does ask in other domains: are they notifying infection prevention to help identify what's the real risk of blood born pathogen exposure and does the facility have a policy that actually indicates what should be done if drug diversion is found?
 - For respiratory cough etiquette domain:
 - 60% met all requirements of the domain.
 - All had signage posted at entrances.
 - All had required supplies available.
 - All but one facility had designated space for sick individuals.
 - All were educating families and visitors about appropriate precautions.
 - All but one facility actually educated staff on respiratory precautions, which is

very important during influenza season.

- In terms of point of care testing:
 - 80% trained on hire.
 - Only 20% trained annually.
 - 40% had competency-based training.
 - No facility was providing audits or feedback.
 - All used single-use lancets.
 - 40% did not adequately disinfect shared point-of-care devices according to manufacturer's instructions.
 - One facility was using a device that was not approved by manufacturer to be shared
 - One facility wasn't using the appropriate disinfectant for the appropriate contact time.
- In terms of environmental cleaning:
 - No facility met all of the elements of the domain.
 - It's really hard to perform well when there was a lack of policies clearly defining responsibilities for cleaning and disinfection.
 - Observational findings: staff were not able to consistently articulate dwell times for the disinfectants or explain directions for mixing solutions and testing concentrations.
- On surgical site infection prevention practices:
 - Only applied to two of the facilities that actually were doing surgical procedures.
 - Not monitoring adherence to preoperative surgical scrub application, use of surgical attire, drapes application, aseptic technique, ventilation requirement in surgical suites, OR work traffic, environmental cleaning during room turnover and terminal cleaning.
- Device reprocessing:
 - 40% had policies and procedures for cleaning and reprocessing devices
 - 60% received hands-on training on hire.
 - 20% receive training annually.
 - 20% had observational competencies.
 - Nobody was performing any type of audits or providing feedback.
 - One completed the whole process correctly.
 - 20% reused a single-use device, which should not happen.
 - 40% had appropriate workflow for soiled and clean work spaces.
- In terms of sterilization of reusable devices:
 - 60% used the enzymatic cleaners correctly. Most of the gaps were not measuring it appropriately.
 - 20% used brushes appropriately.
 - Only one was following all the wrapping and packaging instructions correctly.
 - 40% used biological indicators correctly.

- 40% labeled packs and pouches appropriately and appropriately maintained logs for each load.
 - In terms of high-level disinfection:
 - Two of the facilities performed high level disinfection.
 - One facility did everything correct.
 - The other facility had some issues in not using enzymatic cleaners appropriately and not handling the brushes correctly.
 - Both measured, mixed and did QC checks appropriately on the high level disinfection.
-

Outbreaks Update 2016

Kate Ellingson for Alexia Zhang, OHA

- Lexie Zhang provided a quarterly update on outbreaks between March 1 and June 14.
 - Thirty-six of the 101 outbreaks were gastroenteritis.
 - As usual, long term care facilities most frequently reported outbreaks.
 - We have an ongoing shigella outbreak in the MSM/homeless population. There's various GI and respiratory outbreaks in long-term care facilities and hospitals.
 - We had 15 influenza outbreaks and the majority of those were in long-term care or hospitals.
 - There's a cluster of surgical site infections in one hospital.
 - Many influenza outbreaks continued late into the season.
 - Healthcare-associated infections accounted for over half of all the outbreaks reported during this time period.
 - An expected bolus of the G.II 4 Sydney emerged along with some untypeable.
 - Here's our healthcare-associated outbreaks broken down by pathogens:
 - One case of *Exophiala dermatitidis* was discovered in an outpatient clinic where a man had been receiving corticosteroid, lidocaine, and Hylagan injections in his knee that resulted in a very rare black fungus infection. The pathogen likes hot, wet places.
 - OHA contacted CDC because it's a rare bug and was referred to the Mycotics Division. These experts did not suspect intrinsic contamination of the product. They had seen this pathogen in a clinic in another state and believed the infection was due to clinic practices.
 - We got Mary on the line to help consult based on her experience in the field. The pathogen along with fungal meningitis was associated in 2002 with the contamination of products at a compounding pharmacy. We determined that contamination was very unlikely because none of the drugs administered to the patient had been compounded.
 - We asked the facility about their practices. The medical assistant transports multi-dose vials in a cart from room to room where the physician draws up the

medicine. This is a no-no based on the One and Only Campaign web site.

- All medications should be drawn in a clean, medication prep area that's away from the patient care area.
- Multi-dose vials should be dedicated to a single patient whenever possible.
- The county communicable disease nurses, during an inspection of the facility, found the cart used to carry medications stored above a refrigerator that contained mold. The nurses are working with the facility on a remediation plan.

Discussion

The group talked about the outcome for the patient and which medications he was taking. Also, there was discussion about some of the other CDC practices around disinfection or sterilization of ultrasound probes.

Healthcare Worker Influenza Vaccination Legislative Update

Monika Samper, OHA

A legislative proposal to amend the OARs in regards to mandatory influenza vaccination for healthcare workers might also apply to other vaccines an employer could mandate for communicable diseases.

- There was support from the APIC chapter. The current president, Janet Sullivan, met with a legislative representative to talk about the process required to get an amendment passed.
 - First is to find a supporter, a champion, in either the House of Representatives or the Senate for the 2017 session.
 - There is a strong anti-vaccine coalition in the state that would really resist legislation. ONA has had some reservations, as well, regarding mandatory vaccine for nursing employees, so it would be a challenge to: 1) identify a legislative champion, and 2) get the legislation passed.
 - Janet sent out emails to every senator and representative in the state asking for support and did not get much of a response, so the committee might want to start talking more about the legislation as a group.
 - Vaccination requirements in OARs are limited to post exposure prophylaxis that require an employer to offer medication or a vaccine to the employee. The rules do not explicitly state that an employer can compel an employee to receive prophylaxis. This is why it is voluntary in Oregon and that's why there is a big push to increase the flu vaccination rates.
 - Some hospitals have higher vaccination rates due to mandatory masking during influenza season.
 - ONA's platform is that hospitals can't require vaccinations because it's a violation of someone's civil rights. Thus, conversations have steered toward

vaccinations being necessary for patient safety.

- There's a lot of legislative activity around this issue across the country, both supporting and opposing mandated vaccinations for healthcare workers.
- The last survey suggested that there is over a 67% vaccination rate in hospitals.

Discussion

This mandate is all about herd immunity and uniform vaccinations and whether it is actually worth the effort for only one pathogen. The discussion was also regarding the cost of vaccinations and the availability of them for non-healthcare workers, i.e., family members of the patients. Many hospitals provide them free of charge, but some long-term care facilities and ambulatory care centers do not and this could help with getting the vaccination rates increased.

Also, there was some discussion about the population of patients that are considered vulnerable and that they are affected by the healthcare workers being unvaccinated. A letter was mentioned that was written by a patient at an independent living facility that voiced some concerns about unvaccinated staff. This brought up other areas where the vulnerability of patients is often overlooked--foster care facilities, assisted living facilities, and independent living facilities. There is a great need to address these facilities, as well.

Action Items

Deborah is going to present to the committee about infection control priorities in the foster care and assisted living facilities for the counties.

Public Comment

Chair

No comments from public.

Discussion: Themes & Topics for Future Meetings

Chair

Kate mentioned that this is her last meeting and her position is open for rehire. The new person will be overseeing the reporting and helping to coordinate the future meetings. She expressed her appreciation to everyone and that it was a pleasure to have worked with this committee.

Minutes Written by:

Tina Meyer

Minutes Reviewed by:

Monika Samper

Diane Roy

Exhibit Summary

A – Agenda

B – March 23, 2016 Minutes

C – NHSN Update: 2015 Annual Report Data

D – Rigid Reusable & Single Use Sigmoidoscopes, Anoscopes, and Accessories; Cleaning, Disinfection, and Sterilization Instructions

E – Healthcare-Associated Infection Advisor Committee: Ebola Grant Part B Consultations

F – HAIAC Outbreak Update 2016