

**Healthcare-Associated Infections Advisory Committee**

March 23, 2016

**APPOINTED MEMBERS PRESENT:** Laurie Murray-Snyder (phone)  
Pat Preston, MS (phone)  
Mary Shanks, RN, MSN, CIC  
Dee Dee Vallier (phone)  
Diane Waldo, MBA, BSN, RN, CPHQ, CPHRM, LNCC  
Bethany Walmsley, CPHQ, CPPS

**NOMINATED MEMBERS PRESENT:** Beth DePew (phone)  
Debra Hurst, RN, BSN, CIC  
Ruby Jason, MSN, RN, NEA-BC  
Akiko Saito  
Teresa Shepherd (phone)

**APPOINTED MEMBERS EXCUSED:** Paul Cieslak, MD  
Kelli Coelho, RN, CNOR  
Jon Furuno, PhD  
Jamie Grebosky, MD  
Joan Maca, RN  
Nancy O'Connor, RN, BSN, MBA, CIC  
Rachel Plotinsky, MD  
Dana Selover, MD, MPH

**NOMINATED MEMBERS EXCUSED:** Deborah Cateora  
Larlene Dunsmuir, DNP, FNP, ANP-C

**ADJUNCT MEMBERS PRESENT:** Mary Post, RN, MS, CNS, CIC

**OHA STAFF PRESENT:** Zintars Beldavs, MS, HAI Program Manager/ACDP Section Manager  
Genevieve Buser, MD, HAI Public Health Physician  
Kate Ellingson, PhD, HAI Reporting Epidemiologist  
Alexia Zhang, MPH, HAI Epidemiologist

**ISSUES HEARD:**

- Call to Order and Roll Call
- Approval of December 2015 HAIAC Meeting Minutes
- OAR Language Updates
- NHSN 2015 Data Update
- Outbreaks 2016
- Findings from On-site Facility IP Assessments (2015-2016)

- Promoting Injection Safety and Understanding Risks
- Surgical Site Infection Webinars for Prevention
- CAUTI Prevention in Long-Term Care
- Public Comment
- Discussion: Themes & Topics for Future 2016 Meetings
- Adjourn

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.

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## **Call to Order and Roll Call**

Chair Mary Shanks

1pm. Quorum present.

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## **Approval of December 2015 HAIAC Meeting Minutes**

All Committee Members

Minutes were unanimously approved as written.

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## **OAR Language Updates**

All Committee Members

### **Discussion**

Clarification requested on location information:

- Question: Are patients receiving specialty care integrated into medical, surgical, and medical/surgical units?
- Answer: No, Oregon rules align with CMS, which requires reporting from units specifically defined as medical, surgical, or medical/surgical units. In NHSN mapping documentation ([http://www.cdc.gov/nhsn/PDFs/pscManual/15LocationsDescriptions\\_current.pdf](http://www.cdc.gov/nhsn/PDFs/pscManual/15LocationsDescriptions_current.pdf)), wards must be defined as “mixed acuity” if they house beds for both medical and specialty care.
- Member Comment: It is likely that HAIs are occurring in these units even though there are lots of underlying infections. Even if surveillance is not perfect, you should be able to track change over time.

- Chair Comment: Many hospitals do track infections in these units, even if they are not reportable.
- OHA Response: OHA can only “see” infections that are reportable by law. We would encourage hospitals to conduct surveillance in specialty units for quality improvement and prevention. When considering which HAIs should be made publically reportable by law, we have to consider issues like risk adjustment, additional burden borne by hospitals, and validity of surveillance in these units.
- OHA comment: Based on member concern about clarity of unit definitions, we will not vote on passage of the OHA updates today.

### **Action Items**

- Kate Ellingson to review location specification in OARs.
  - UPDATE: location information currently exists under 333-018-0100, “Definitions.” This section updated to include wards that were integrated into the Oregon’s mandatory reporting program in January, 2015.
- Revised OARs, including the updated “Definitions” section, will be sent to HAIAC by email on 4/13/2016.
- OAR updates will be voted on at Rules Advisory Committee (RAC) on 4/20/16.
- All HAIAC members will be invited to the RAC.

### **NHSN Update – 2015 Preliminary Data (*see slides for details*)**

Kate Ellingson, Oregon Public Health Division

Preliminary data for 2015 presented for HAIs reportable by hospitals.

- Majority of CLABSI infections reported from wards, not ICUs
- CAUTI definition changed in 2015, so SIRs unreliable for comparison
- HHS targets will be reestablished for 2020 based on 2015 data
- C. difficile increased in 2015; Oregon did not meet 2013 HHS target
- Next Steps:
  - Validate all data with facilities by 5/15/16
  - Create PDFs of aggregate data for printing
    - Provider and Consumer versions
    - No facility-specific data, but aggregate by state, region, county
  - Post all facility-specific data online:
    - Data.oregon.gov: excel spreadsheets and trends
    - HAI & HCW influenza vaccination interactive map

### **Discussion**

- Question: Will there be a printable option for the online portion of the report?

- OHA Response: Online maps might be tricky to print, but we can work on options for printing out of [data.oregon.gov](http://data.oregon.gov); the ultimate goal, if we can find the resources, is a report card for each facility, and potentially each infection that makes meaningful comparisons.
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## **Outbreak Update – 2016 Review (*see slides for details*)**

Alexia Zhang, Oregon Public Health Division

Outbreak Snapshot for 1/1/16 – 3/18/16

- HAI outbreaks account for > 50% of all outbreaks reported to OHA
- GI outbreaks responsible for >75% of all healthcare-related outbreaks
  - GII norovirus sub-type appears to be spreading
  - Several sapovirus infections confirmed in assisted-living
- Outbreak reporting criteria reviewed; clarified in new OARs and on poster
- SSI cluster among orthopedic patients
- Zika virus outbreak: 6 Oregon cases; information for healthcare providers at [bitly.com/zikaoregon](http://bitly.com/zikaoregon)

### **Discussion**

- Question: what's the pathogen for the SSI outbreak?
  - OHA response: it's mixed organism for both hip and knee replacements, including different GI and GU organisms, but not staphylococcus.
  - OHA comment: one reason for the number of healthcare-associated influenza and GI outbreaks in LTCFs is that OHA has been proactive about encouraging LTCFs to report outbreaks; reporting is not punitive, rather a mechanism for understanding the epidemiology of these pathogens and instituting control measures.
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## **Infection Control Assessment and Response (ICAR) Update (*see slides for details*)**

Mary Post, Oregon Patient Safety Commission

- As part of CDC/Ebola funding, OHA funds on-site infection prevention consultations
  - 25 facilities offered consultations in 1<sup>st</sup> year; 35 minimum for subsequent years
  - Visits involve using a standardized CDC assessment tool
  - OPSC/OHA lead, local health department, and local APIC member on-site
  - Facilities selected based on NHSN data, outbreak data, CMS nursing home compare, HCW influenza vaccination rates, other recommendations
  - Settings: hospitals, ASC, LTCFs, dialysis, and clinics
  - Visit entails opening meeting, staff interviews, observations, and audits
  - Information from visit summarized from facility, then aggregated and sent (de-identified) to CDC
- Key findings from first 19 assessments

- Injection safety lapses: multidose vials in immediate care areas, labeling
- Incomplete implementation of mandatory interfacility communication requirement
- Antibiotic stewardship implemented in hospitals but little support for activities in other settings
- Instrument sterilization and high-level disinfection practices can be improved
- Training programs for environmental services teams need to be developed
- Next Steps
  - Finalize first year (baseline) results
  - Plan mitigation strategies
  - Hold regional meetings to improve collective infection prevention and communication across sites sharing patients and healthcare infrastructure
  - Identify facilities who may benefit from IP consultation in Year 2

### **Discussion**

- Member Comment: A medical or nursing license is a social contract with the people of Oregon, and our job is public safety, so I wonder who in the leadership is supposed to formulate plans?
- Ebola grant part B overview: provided facilities with baseline consultation and follow-up a few months later. Initially had trouble getting in the door, but word has spread and it's much easier this year.

### **Action Item**

OHA will send out a summary of Mary's observations. Charge of committee is to figure out how to prioritize infection control gaps and how to use data to inform outbreak investigations.

## **Promoting Injection Safety and Understanding Risks (*see slides for details*)**

Kate Ellingson, Oregon Public Health Division

Oregon involvement in One and Only Campaign

- Official member state
- Goals to raise awareness among provider communities and public health
- Small grant targeting providers in rural areas
- Infections can occur when:
  - Syringes are reused
  - Single-dose vials are used for >1 patient
  - Multi-dose vials are misused
  - Glucometers are used for >1 patient and not properly disinfected
  - Healthcare workers divert controlled substances by injecting themselves and contaminating vials or syringes subsequently used for patients
- Resources available here: <http://www.oneandonlycampaign.org/>

## Discussion

- Member comment: there are many issues related to opioid use and prescribing. We had a complaint brought to the nursing board from a patient who said their pain was not adequately managed because a nurse was trying to taper a patient off per guidelines. Providers are acutely aware of opioid issues; patients will ER shop.
  - OHA Response: OHA is conducting surveys of hospitals, ASCs, and SNFs about infection prevention practices. There are questions on that survey about injection safety competency and training. Results to be presented at the June meeting and we can continue to discuss this issue and the HAIAC's role in guiding the program.
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## **Surgical Site Infection Webinars for Prevention**

Mary Shanks, Kaiser Westside Medical Center

Diane Waldo, Oregon Association of Hospitals and Healthcare Systems

- Two webinars have been held so far to encourage sharing of practices and improvement processes with the goal of providing resources/education to other IPs or Quality professionals working on improving surgical outcomes.
- Focus on reportable procedures: Total Joint procedures, Colon surgery and laminectomy.
- Webinar #1 Hips and Knees 2/23/16
  - Kaiser Permanente, Legacy Good Sam, Providence St Vincent, Salem
  - Reviewed pre-admit, pre-op, intra-op, post-op practices
  - Included pre-op bathing with CHG cloths or Hibiclens, use of mupirocin vs iodine, surgical prep, traffic control, attire
  - Differences noted in: screening- MRSA/MSSA, decolonization, dressings, glucose management, involvement of the surgical team as well as leadership
- Webinar #2 Colon SSI 3/17/16
  - Kaiser Permanente, OHSU, MultiCare Tacoma
  - KP- pathway to zero
  - OHSU- standardized bowel prep- abx
  - Ertapenem
  - Dedicated closure tray
  - MultiCare- Clean fascia closure-anastamotic time out- change gloves/gown/hand hygiene, PICO dressings, use of wound protector, standardized post op-wound care instructions
- Third webinar scheduled for 4/19- Laminectomy
- OAHHS records all webinars working to promote slides to others

## Discussion

- Member comment: what about other types of surgeries in other types of settings?
- OHA response: we are focusing now on currently reportable surgeries, but certainly there are concerns about standardization of practices in other settings. This could be a topic of discussion for a future date (how to address major surgeries or risky procedures performed in ambulatory settings).

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**Public Comment & Topics for Future 2016 Meetings (*see slides for details*)**  
Kate Ellingson, Oregon Public Health Division

- Public comment read from a member of a residential care facility (independent living) concerned about influenza vaccination among healthcare workers
  - Concerned that reporting of rates for SNFs only, not assisted or independent living settings with vulnerable patients
  - Recommended consideration of legislation as other states have to require influenza vaccination of all healthcare workers and volunteers
- Possible future meeting topics (*See slides for details*)
  - Continued data updates (NHSN, outbreaks, site visits)
  - HCW influenza vaccination
  - Update on Ebola-funded center of excellence hospitals
  - Focus on long-term care issues

**Discussion**

- Members discussed pursuing legislation that would require healthcare workers to receive flu vaccinations
  - Uphill battle due to union resistance.
  - Oregon has a law that prohibits forcing vaccinations on workers
  - Possible to at least extend reporting of HCW vaccinations beyond SNFs to residential care facilities
- Request for a longer meeting so that more issues can be covered in depth

**Action Steps**

- OHA will confer with the Office of Licensing and Regulatory Oversight (OLRO) on the issue of extending healthcare worker influenza vaccination requirements in residential settings.
- OHA will look into lengthening the meetings to 3 hours starting in December.

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**Minutes Written by:**

Kate Ellingson

**Exhibit Summary**

A – Agenda

B – December 16, 2015 Minutes

C – Oregon Administrative Rules - Oregon Health Authority, Public Health Division, Chapter 333

D – Oregon Public Health Division Reporting for Healthcare-Associated Infections Poster

**E – NHSN Update: 2015 Preliminary Data**

**F – Outbreak Update**

**G – Healthcare-Associated Infections Advisory Committee: Ebola Grant Overview Part B**

**H – Prevention Focus: Making Every Injection Safe**

**I – Healthcare-Associated Infections Advisory Committee: CAUTI Prevention in Long-Term Care**

**J – Topics for Future Meetings**

**Healthcare-Associated Infections Advisory Committee**

June 22, 2016

**APPOINTED MEMBERS PRESENT:** Paul Cieslak, MD  
Jon Furuno, PhD  
Laurie Murray-Snyder  
Pat Preston, MS (phone)  
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**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

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## 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.

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## 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.

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## 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.
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## NHSN 2015 Annual Report Update

Kate Ellingson, OHA

- OHA is encouraging the use of the portal: [data.oregon.gov](http://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.
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## **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.

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### **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.
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## 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.

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### **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.

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**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**

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# **Ebola Assessment Hospitals and ICAR Centers of Excellence**

*September 2016  
HAIAC Fall Update*

Judy Guzman-Cottrill, DO  
Medical Lead, Ebola & Emerging Pathogen Preparedness

The logo for the Oregon Health Authority, featuring the word "Oregon" in a small serif font above the word "Health" in a large serif font, with the word "Authority" in a smaller serif font below "Health".

Oregon  
Health  
Authority

# Ebola Assessment Hospitals

- Asante Ashland Community Hospital
- Kaiser Westside Hospital
- Legacy Good Samaritan Hospital
- Providence Milwaukie Hospital
- Samaritan Lebanon Community Hospital
- (St. Charles Redmond Medical Center)

# Reminder: No More PUMs!

- No entry screening for returning travelers
- Continued triage screening will be crucial for rapid identification → isolation → notification
  - Acute illness+ recent international travel
- Ebola Assessment Hospital Designation continues
  - How do we continue collaboration & improvement?

# Oregon ICAR Centers of Excellence

## Infection Control Assessment and Response

The screenshot shows the CDC website interface. At the top, it says "CDC Home" and "Centers for Disease Control and Prevention" with the tagline "CDC 24/7: Saving Lives. Protecting People.™". There is a search bar and a navigation menu with letters A-Z. The main content area is titled "State-based HAI prevention" and "Infection Control Assessment and Response (ICAR) Program". A sidebar on the left lists various topics under "Healthcare-associated Infections". The main content area includes a list of states and territories under "On this Page".

**Healthcare-associated Infections**

- Map: HAI Prevention Activities
- Infection Control Assessment and Response (ICAR) Program**
- HAI Prevention Projects
- Tracking
- Investments
- State Success
- Resources for States

**On this Page**

- Alabama
- Alaska
- American Samoa
- Arkansas
- California
- Chicago
- Colorado
- Connecticut
- Delaware
- District of Columbia
- Federated States of Micronesia
- Florida
- Georgia
- Guam
- Hawaii
- Mississippi
- Missouri
- Montana
- Nebraska
- Nevada
- New Hampshire
- New Jersey
- New Mexico
- New York City
- New York
- North Carolina
- North Dakota
- Ohio
- Oregon
- Pennsylvania

# What is an ICAR Center of Excellence?

- Initial collaboration with self-identified Ebola Assessment Hospitals
- Continued active engagement with OHA to strengthen infection prevention
  - Each hospital's work & priorities will vary
  - Periodic updates (6 and 12 month FU visit)
  - Continued collaboration via telephone, email, webinar, etc.

# “Repurposing” CDC’s Assessment Hospital Document

- These should not be considered “expectations”
- Summarizes a hospital’s overall readiness for preventing the transmission of highly contagious pathogens, and commitment to strengthening Oregon’s infection prevention infrastructure

# Facility Infrastructure

- Review of Hand Hygiene product placement
- Review of PPE placement throughout hospitals
- AIIR capacity
  - Within each hospital, and across entire hospital system
  - Ensure safety checks are in place

# Patient Transportation

- Inter-Facility
  - Continued partnerships with EMS partners (mostly through Ebola work):
    - Transport plans
    - Annual training of EMS partners (PPE, safe transport)
  - Notification of MDROs and isolation recommendations prior to accepting or transfer to another facility

# Laboratory

- Maintaining POC or central lab area for necessary diagnostics (based on differential diagnosis)
- Continued collaboration to improve lab personnel competencies and education
- Designated primary lab partner with OSPHL to serve as clinical liaison

# Staffing

- Detailed, scalable staffing plans to support 96 hours of care

# Worker Safety

- Compliance with OSHA Respiratory Protection Program and Bloodborne Pathogen and Needlestick Prevention
- Plans for employee exposures (TB, measles, varicella, blood and body fluids)
- Immunization promotion, monitor rates immunized (flu, MMR, VZV, Tdap)
- Ill provider policy

# Clinical planning

- Hospital has patient (and visitor) post-exposure management and prophylaxis plans in place
  - Influenza, measles, varicella, pertussis, blood or body fluids

# ICAR Centers of Excellence

- Comments, suggestions, or questions?

# 2015 HAI REPORT FINDINGS

>> Health Care-Associated  
Infections: 2015 Oregon  
Annual Report



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Authority  
PUBLIC HEALTH DIVISION

Oregon  
Health  
Authority

# Oregon HAI Report

## Outcome measures:

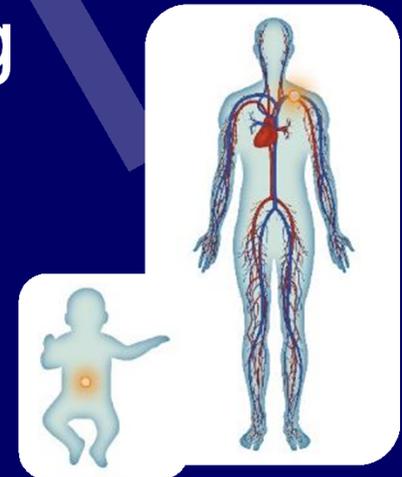
- CLABSI – adult & pediatric ICUs and wards, neonatal ICUs
- CAUTI – adult & pediatric ICUs and wards
- SSI – CBGB, COLO, HPRO, HYST, KPRO, LAM
- *C. difficile* LabID events
- MRSA BSI LabID events
- Dialysis events – BSI & BSIs related to vascular access

## Benchmarks:

- 2013 HHS Targets
- Percentile on 2014 National SIR Distribution

# Central Line-Associated Bloodstream Infection (CLABSI)

- 52 acute care hospitals reporting
- 161,715 central line days
- 118 infections
- SIR: 0.43 (0.36-0.52)
- 57% fewer infections than predicted
- 2013 HHS Target=50% reduction



# Central Line-Associated Bloodstream Infection (CLABSI)

- SIR in adult and pediatric ICUs: 0.35 (0.26-0.46) ✓
- SIR in adult and pediatric wards: 0.53 (0.41-0.67) ✗
- SIR in neonatal ICUs: 0.75 (0.41-1.27) ✗

Figure 4. Oregon CLABSI standardized infection ratios (SIR) in adult and pediatric ICUs: 2009–2015

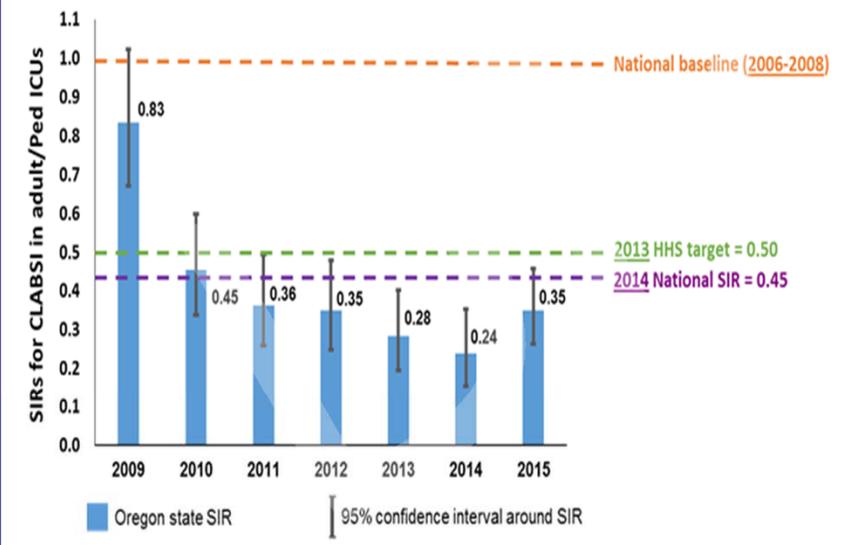
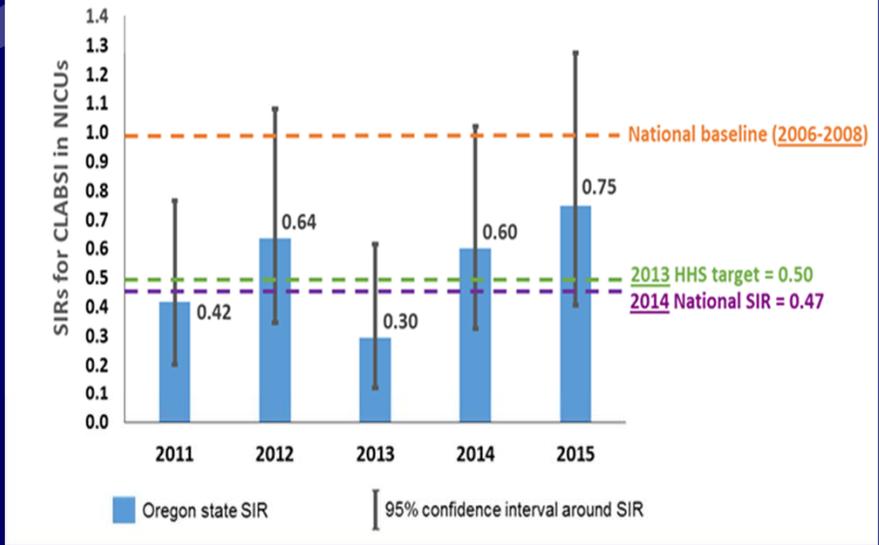
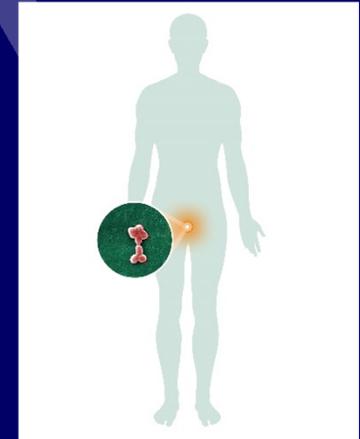


Figure 5. Oregon CLABSI standardized infection ratios (SIR) in neonatal ICUs: 2011–2015



# Catheter-associated Urinary Tract Infection (CAUTI)

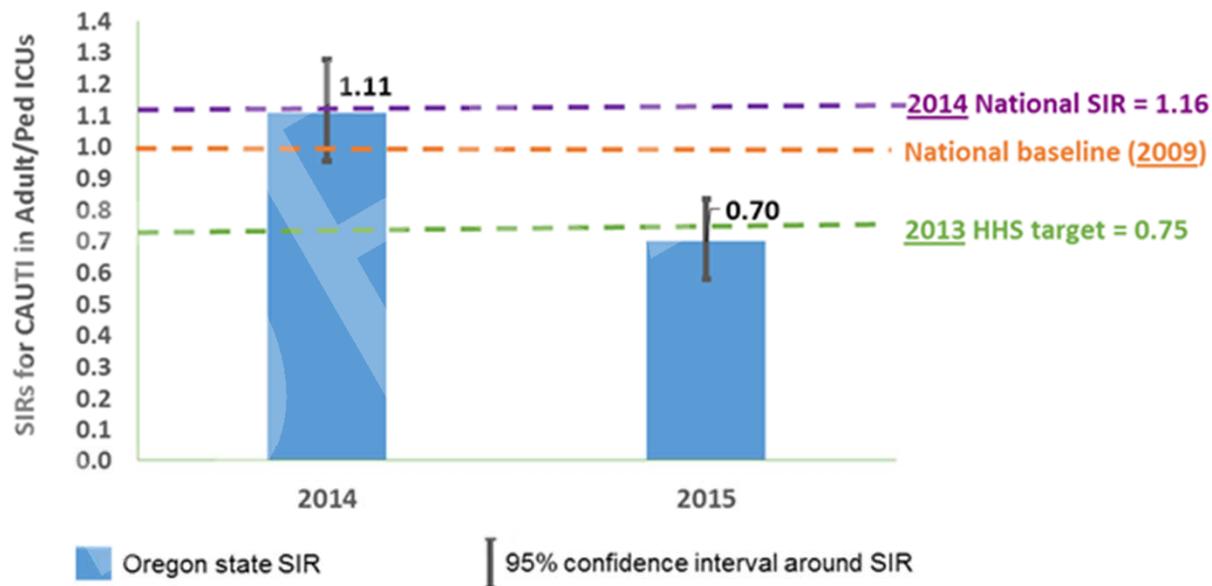
- 57 acute care hospitals reporting
- 191,494 catheter days
- 188 infections
- SIR 0.54 (0.47-0.63)
- 46% fewer infections than predicted
- 2013 HHS Target=25% reduction ✓



# Catheter-associated Urinary Tract Infection (CAUTI)

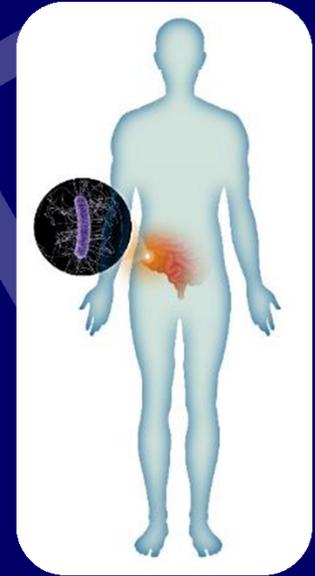
- SIR in adult and pediatric ICUs: 0.70 (0.58-0.84) ✓
- SIR in adult and pediatric wards: 0.40 (0.31-0.50) ✓

Figure 6. Oregon CAUTI standardized infection ratios (SIR) in adult and pediatric ICUs: 2014–2015



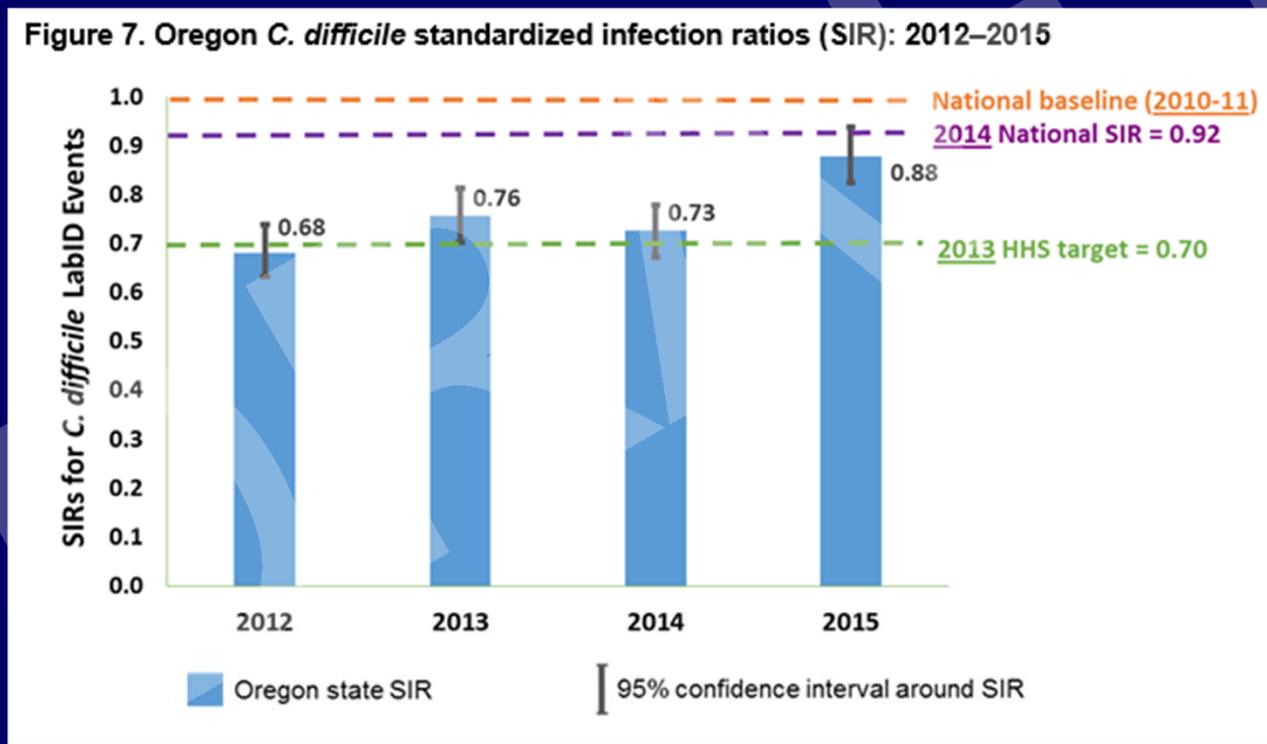
## ***C. difficile* LabID Reporting**

- 61 acute care hospitals reporting
- 1,395,478 patient days
- 909 hospital-onset infections
- SIR: 0.88 (0.82-0.94)
- 12% fewer infections than expected
- 2013 HHS Target: 30% reduction



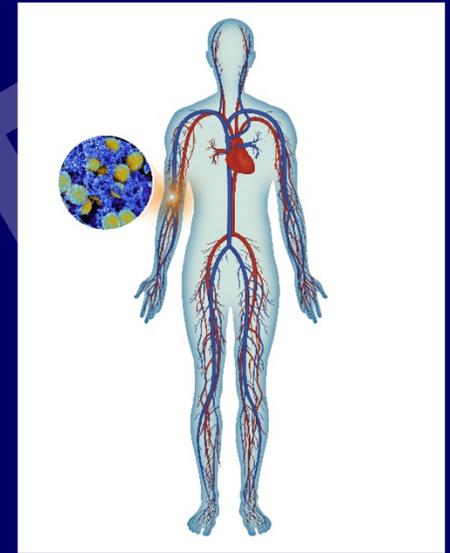
# C. difficile LabID Reporting

- 2015 SIR is the highest ever reported in the state



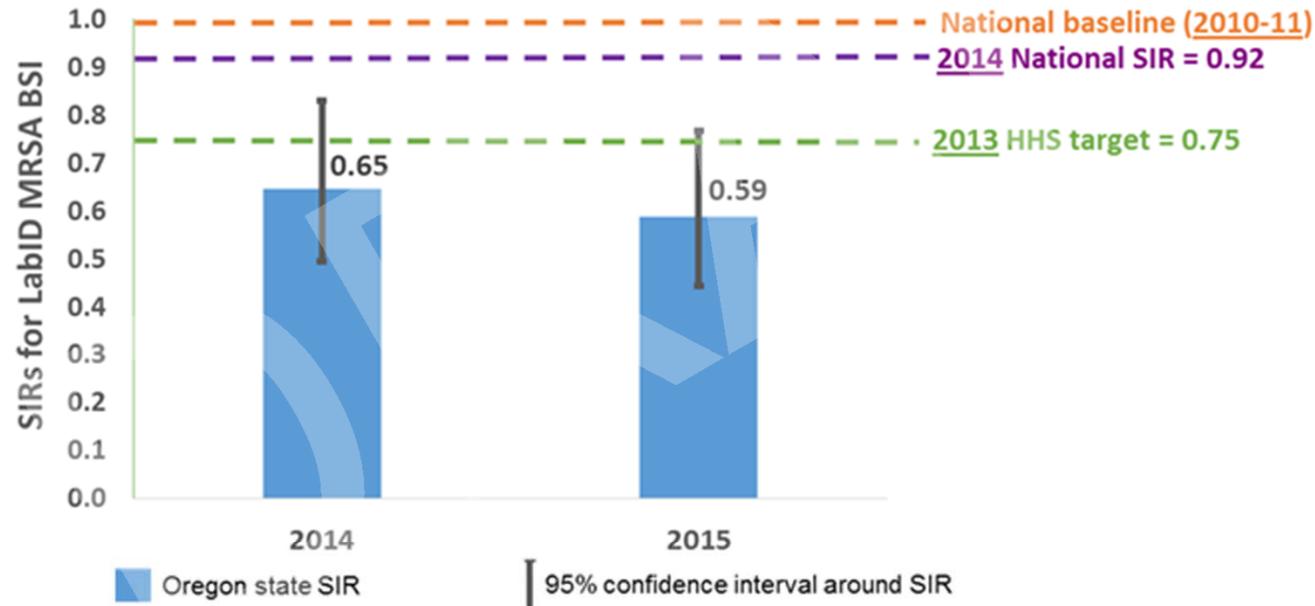
# MRSA Bacteremia LabID Reporting

- 61 acute care hospitals reporting
- 1,498,541 patient days
- 51 hospital-onset infections
- SIR: 0.59 (0.44-0.77)
- 41% fewer infections than expected
- 2013 HHS Target=25% reduction



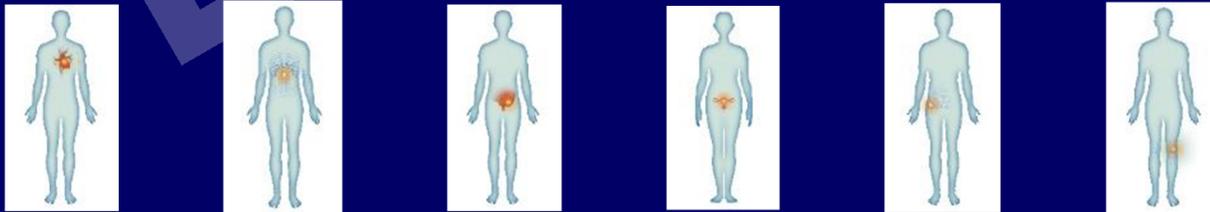
# MRSA Bacteremia LabID Reporting

Figure 8. Oregon MRSA BSI standardized infection ratios (SIR): 2014–2015



# Surgical Site Infection (SSI): Complex Deep/Organ Space

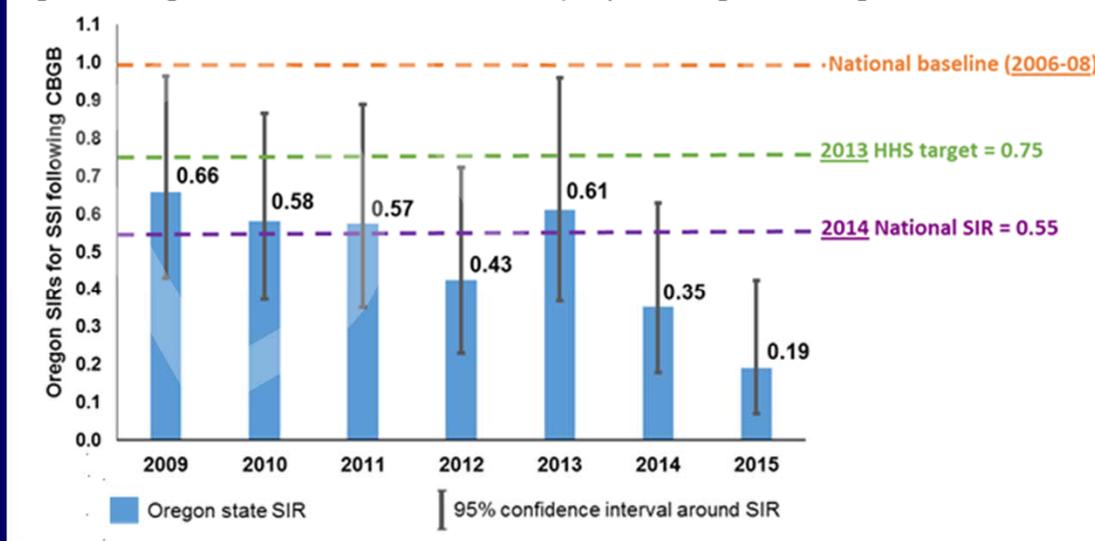
- 36,178 procedures reported
- 216 complex SSIs
- SIR: 0.62 (0.54-0.71)
- 38% fewer than predicted
- 2013 HHS target=25% reduction ✓



# Surgical Site Infection: CBGB

- 2,207 procedures reported
- 5 complex SSIs
- SIR: 0.19 (0.07-0.42)
- 2013 HHS Target=25% reduction ✓

Figure 9. Oregon standardized infection ratios (SIR) following CBGB surgeries: 2009–2015

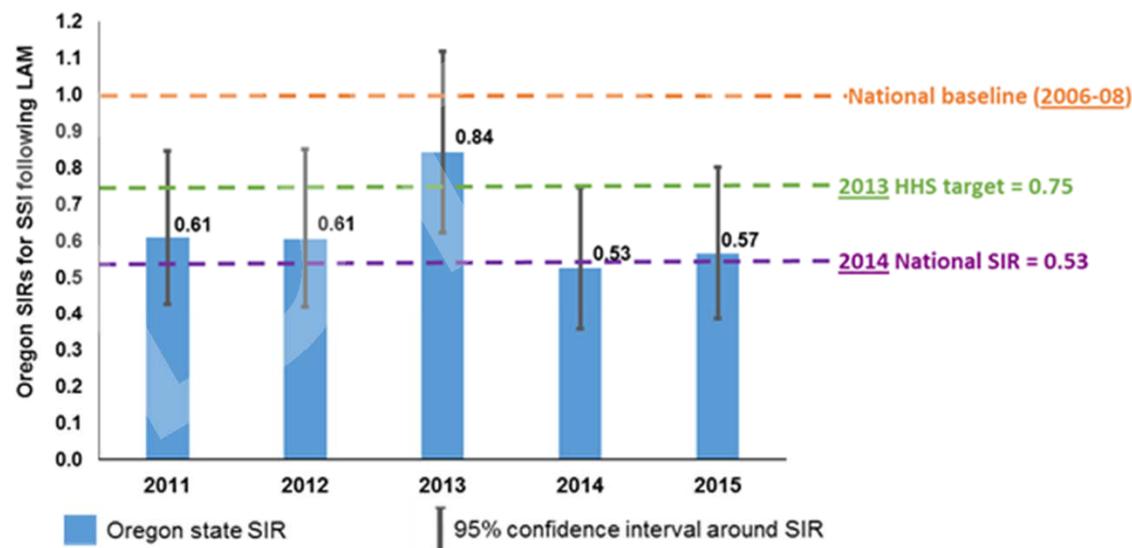


# Surgical Site Infection: LAM

- 8,447 procedures reported
- 29 complex SSIs
- SIR: 0.57 (0.39-0.80)
- 2013 HHS Target=25% reduction



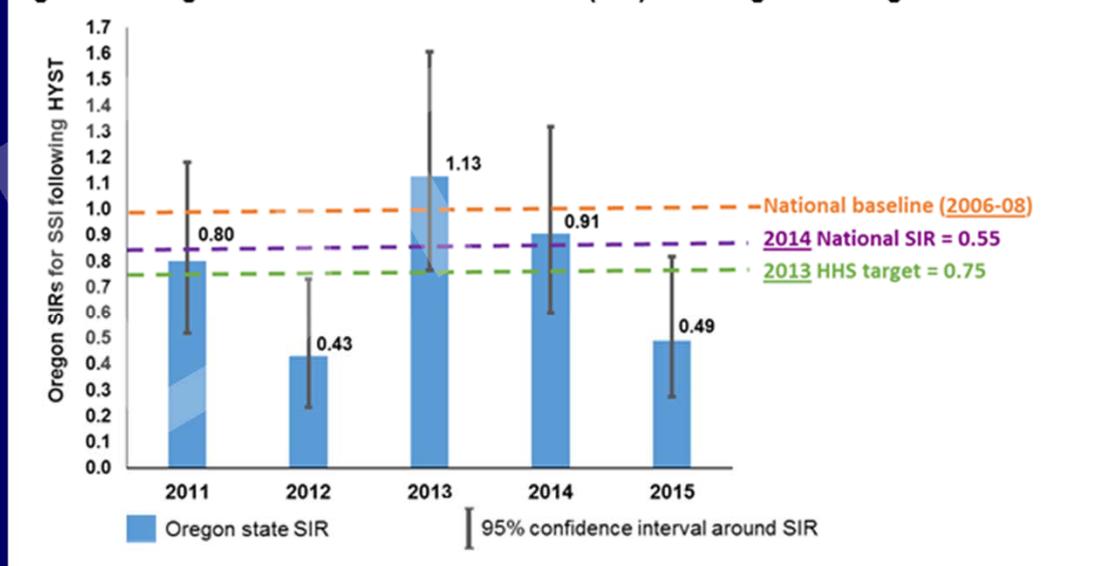
Figure 10. Oregon standardized infection ratios (SIR) following LAM surgeries: 2011–2015



# Surgical Site Infection: HYST

- 3,143 procedures reported
- 13 complex SSIs
- SIR: 0.49 (0.27-0.82)
- 2013 HHS Target=25% reduction ✓

Figure 11. Oregon standardized infection ratios (SIR) following HYST surgeries: 2011–2015

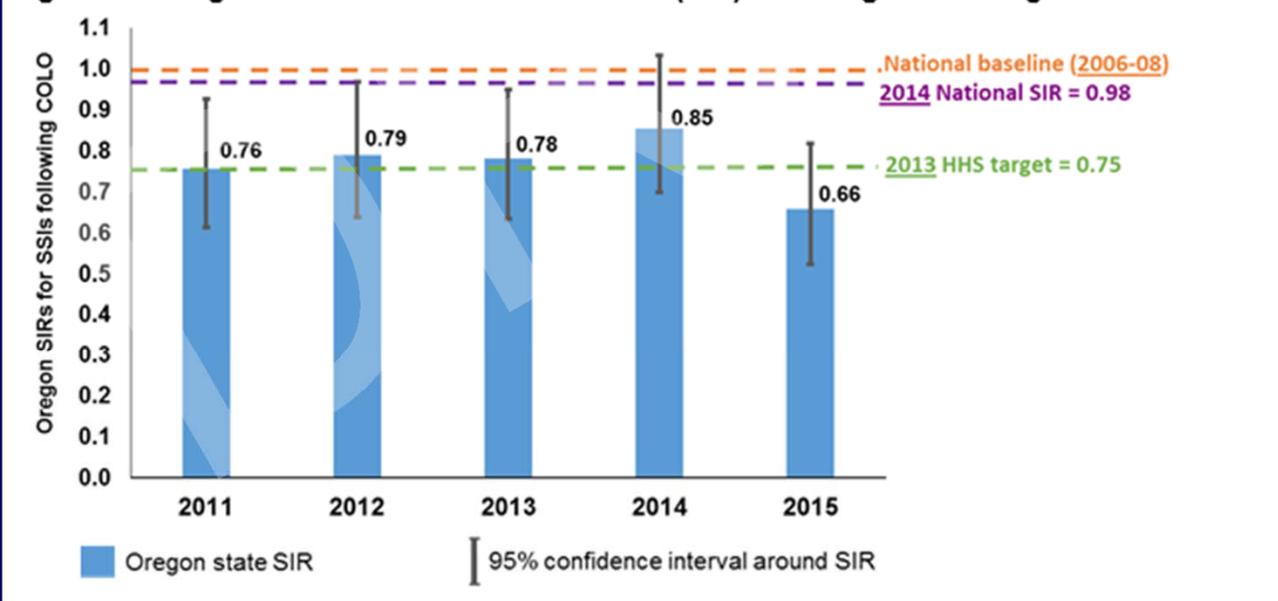


# Surgical Site Infection: COLO

- 3,870 procedures reported
- 77 complex SSIs
- SIR: 0.66 (0.52-0.82)
- 2013 HHS Target=25% reduction



Figure 12. Oregon standardized infection ratios (SIR) following COLO surgeries: 2011–2015

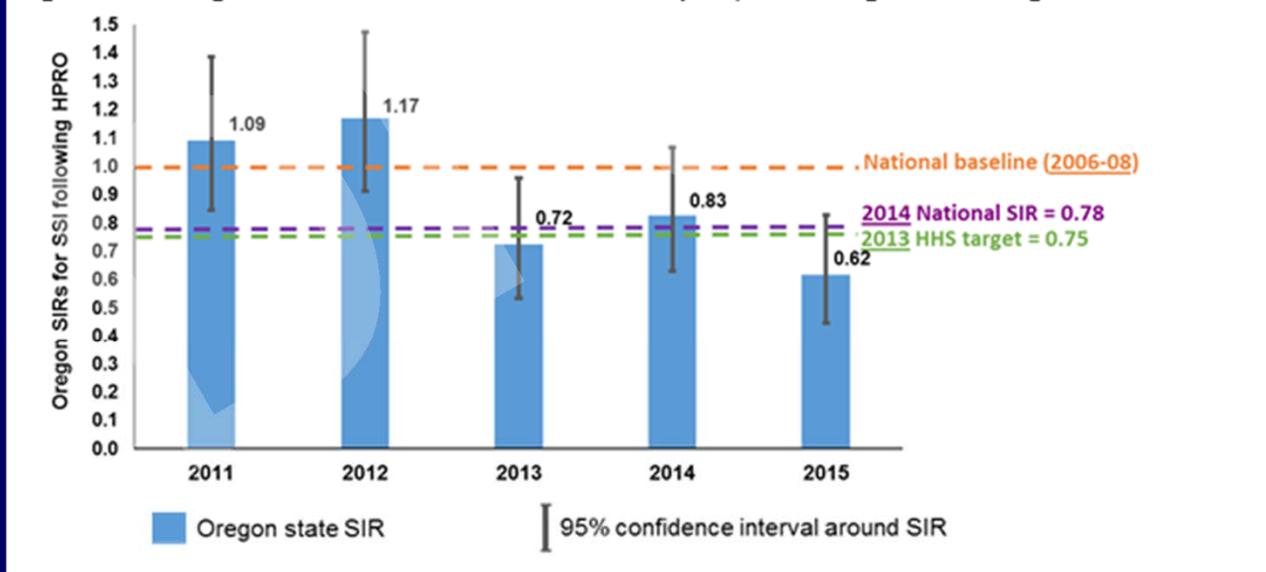


# Surgical Site Infection: HPRO

- 8,224 procedures performed
- 41 complex SSIs
- SIR: 0.62 (0.45-0.83)
- 2013 HHS Target=25% reduction



Figure 13. Oregon standardized infection ratios (SIR) following HPRO surgeries: 2011–2015

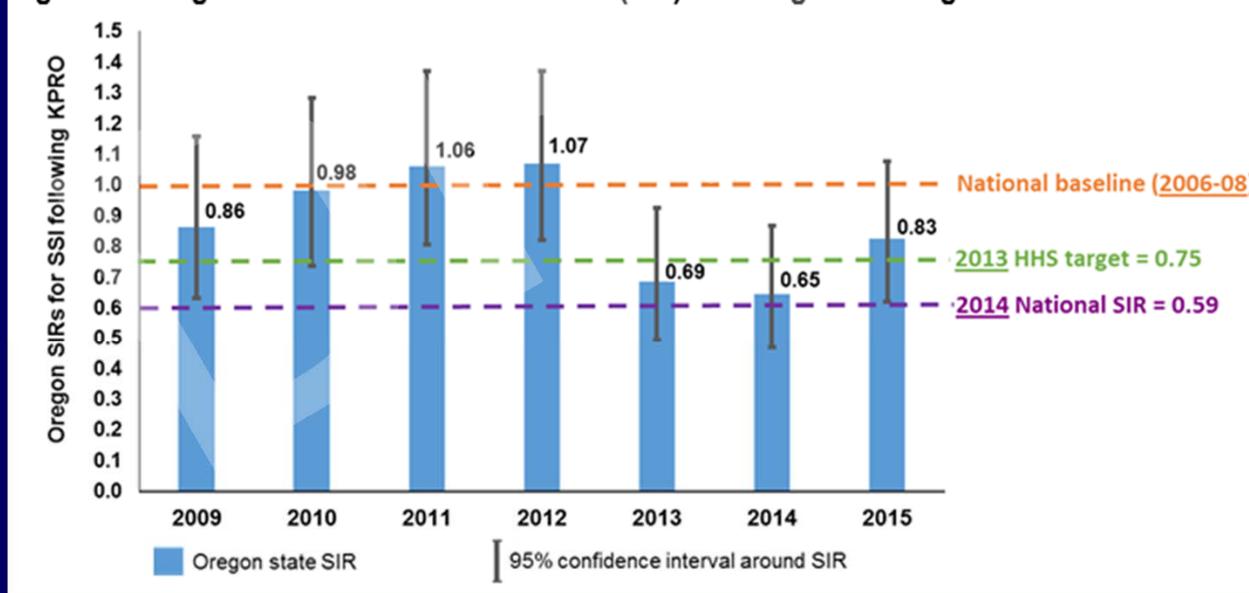


# Surgical Site Infection: KPRO

- 10,287 procedures reported
- 51 complex SSIs
- SIR: 0.83 (0.62-1.08)
- 2013 HHS Target=25% reduction



Figure 14. Oregon standardized infection ratios (SIR) following KPRO surgeries: 2009–2015



# Dialysis Facilities

- Bloodstream Infections
  - 0.43 bloodstream infections per 100 patient-months
  - 60% fewer than the national average
- Access-related Bloodstream Infections
  - 0.30 access-related bloodstream infections per 100 patient-months
  - 58% fewer than the national average

# Data.Oregon.gov

- Facility-specific tables for each HAI

**Figure 2. Example of an online facility-specific table with national benchmarks included**

Patient Days Observed	Predicted	2015 SIR	SIR 95% CI	SIR Icon	SIR Interpretation (2010-11)	2013 HHS Targets	Percentile on 2014 National SIR Distribut	
2,646	1	1.66	0.602	0.030, 2.968	▼	Fewer infections	SIR Target (<0.7) Met	36-40%
825	0	0.37	*	*		#s too small to calculate	ZERO Infections	
3,721	1	2.13	0.47	0.024, 2.317	▼	Fewer infections	SIR Target (<0.7) Met	26-30%
155,993	198	111.54	1.775	1.540, 2.036	▲	Statistically more infections	Target Not Met	96-100%
6,846	3	3.45	0.87	0.221, 2.367	▼	Fewer infections	Target Not Met	56-60%
28,485	18	18.26	0.986	0.603, 1.528	▼	Fewer infections	Target Not Met	66-70%
24,672	9	13.71	0.656	0.320, 1.204	▼	Fewer infections	SIR Target (<0.7) Met	36-40%
503	0	0.23	*	*		#s too small to calculate	ZERO Infections	
24,199	7	14.33	0.488	0.214, 0.966	▼	Statistically fewer infections	SIR Target (<0.7) Met	26-30%
30,907	10	19.88	0.503	0.256, 0.897	▼	Statistically fewer infections	SIR Target (<0.7) Met	26-30%
41,865	16	29.48	0.543	0.321, 0.863	▼	Statistically fewer infections	SIR Target (<0.7) Met	31-35%

**Figure 3. Interactive filter capability by county and health preparedness program region:**

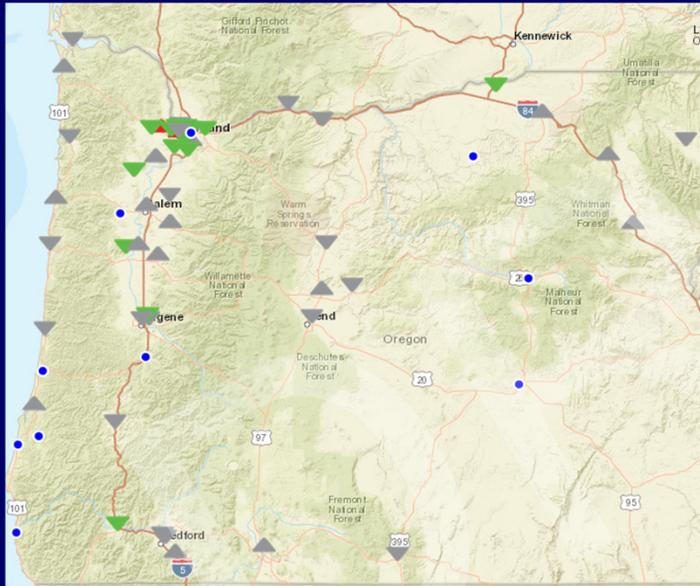
SIR Icon	SIR Interpretation (2010-11 US baseline)	2013 HHS Targets	Percentile on 2014 National SIR Distribution	County	HPP Region	(non)	Filter
▲	More infections	Target Not Met	71-75%	CLACKAMAS	Region1	(45.4	Conditional Formatting
▼	Statistically fewer infections	SIR Target (<0.7) Met	26-30%	CLACKAMAS	Region1	(45.5	Sort & Roll-Up
▼	Statistically fewer infections	SIR Target (<0.7) Met	16-20%	CLACKAMAS	Region1	(45.4	Filter
▼	Statistically fewer infections	SIR Target (<0.7) Met	11-15%	CLACKAMAS	Region1	(45.5	Filter this dataset based on con

County - is -

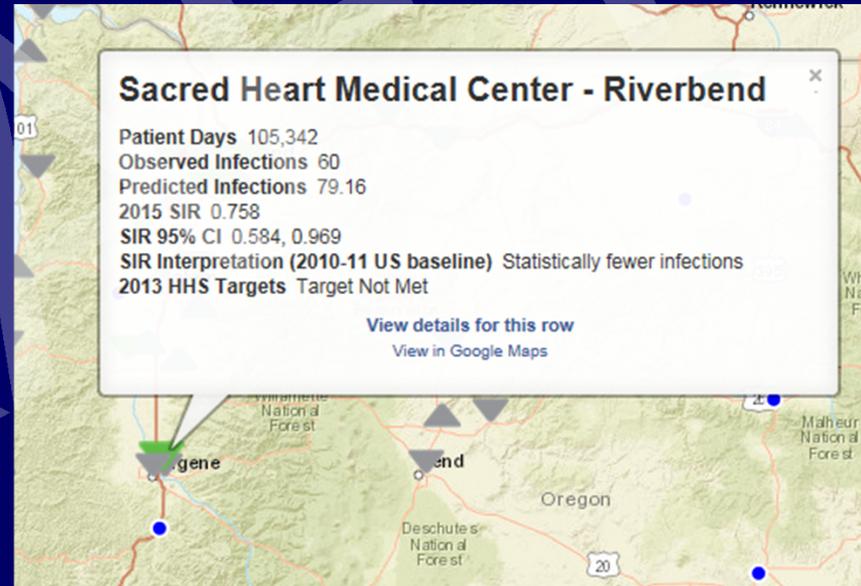
CLACKAMAS

# Facility-specific Datasets: Data.Oregon.gov

- Facility-specific maps for each HAI



Map of hospital performance on hospital-onset *C. difficile*



Example of facility-specific detail on CDI enumerated by clicking on facility

# Data.Oregon.gov Features

- Easy to access and use
- Customizable
- Visualize data in different formats
- Ideally, faster to publish information

# Planned Timeline

- 9/26 – Email sent to healthcare facilities to preview their data
- 10/3 – Summary report and facility-specific tables and maps will be available on the Oregon HAI Publications and Maps website ([healthoregon.org/hai-reports](http://healthoregon.org/hai-reports))

**WHAT'S NEXT?**



# NHSN Re-baseline

- Data reported to NHSN for 2015 will be used as the new baseline for SIRs
- Scheduled release: December 2016
- New SIRs available for 2015 data and forward
- Upcoming NHSN Re-baseline webinar
  - Wednesday, October 5, 2016 11:00AM-12:30PM PST
  - <https://cc.readytalk.com/r/bukusltexl4t&eom>

# HHS 2020 Targets (DRAFT)

- CLABSIs: 50% reduction from 2015 baseline
- CAUTIs: 25% reduction from 2015 baseline
- MRSA BSI: 50% reduction from 2015 baseline
- CDI: 30% reduction from 2015 baseline
- SSIs: 30% reduction from 2015 baseline

# Questions?

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# HAIAC

Alexia Zhang, MPH

Healthcare-Associated Infections Epidemiologist  
Acute and Communicable Disease Prevention Program

Wednesday, September 28<sup>th</sup>, 2016

The logo for the Oregon Health Authority, featuring the word "Oregon" in a small serif font above the word "Health" in a large serif font, with the word "Authority" in a smaller serif font below "Health".

Oregon  
Health  
Authority

# Outbreaks since 6/1/2016

Etiology	Count	Setting
<b>Norovirus</b>	28	<b>LTCF (21), hospital (1), school (1), restaurant (2) other* (4)</b>
<b>Gastroenteritis</b>		
<i>Salmonella</i>	3	foodborne (2), multistate (1)
<i>E. coli</i> O157	2	fair (1), foodborne? (1)
astrovirus	1	DCC
Cryptosporidium	1	club pool
Hepatitis A	1	foodborne
Vibrio parahaemolyticus	1	foodborne
unknown	17	<b>LTCF (11), school (2), hospital (1), DCC (1), other (2)</b>
<b>Respiratory</b>		
Pertussis	3	DCC (1), school (1), community (1)
Parainfluenza 3	1	<b>LTCF</b>
Unknown	1	<b>LTCF</b>
<b>Rash</b>	2	<b>LTCF (1), DCC (1)</b>
<b>Other</b>	1	<b>hospital</b>
<b>Total</b>	62	

## Healthcare associated outbreaks, June 1-Sept 22<sup>nd</sup> 2016

- Healthcare associated infections account for 60% (n=37) of all outbreaks from September to December

Facility type	Norovirus	Parainfluenza	unknown-GI	unknown-respiratory	Other
Memory Care	2	0	1	0	1
Assisted Living Facility	12	0	7	0	0
Skilled Nursing Facility	6	1	2	1	0
Adult foster home	1	0	0	0	0
Hospital	1	0	1	0	1
<b>Total</b>	<b>22</b>	<b>1</b>	<b>11</b>	<b>1</b>	<b>2</b>

Interesting outbreaks (and others) this summer

- *E. coli* O157 associated with fair
  - 3 cases all attended fair
  - 2/3 HUS
  - Narrowed down exposure to sheep/goat exhibits at the fair
  - Common pattern linked to petting zoo and raw milk exposure
- *Salmonella* Newport associated with a restaurant
  - 13 cases of *Salmonella* Newport that match by pulse field gel electrophoresis
  - 9 cases ate at the same restaurant over the span of 25 days
  - Specific vehicle could not be implicated
  - Contamination likely occurred at this restaurant given the epidemiological evidence

# *Mycobacteria chimaera*

- Mycobacteria chimera reported in Oregon

The screenshot shows the CDC Emerging Infectious Diseases (EID) journal website. The page title is "Transmission of *Mycobacterium chimaera* from Heater-Cooler Units during Cardiac Surgery despite an Ultraclean Air Ventilation System". The authors listed are Rami Sommerstein, Christian Rüegg, Philipp Kohler, Guido V. Bloemberg, Stefan P. Kuster, and Hugo Sax. The article is from Volume 22, Number 6, June 2016. The journal is published by the Centers for Disease Control and Prevention (CDC).

- Heater-cooler units during cardiac surgery have been linked to *Mycobacterium chimaera* infections
  - Position unit away from surgical field

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# Thank You

<http://public.health.oregon.gov>

alexia.y.zhang@state.or.us

The logo for the Oregon Health Authority is centered in a light blue, curved banner at the bottom of the slide. It features the word "Oregon" in a small, white, serif font above the word "Health" in a large, white, serif font. Below "Health" is the word "Authority" in a smaller, white, serif font.

Oregon  
Health  
Authority

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# **HEALTHCARE-ASSOCIATED INFECTIONS ADVISORY COMMITTEE: EBOLA GRANT PART B CONSULTATIONS**

September 28, 2016

Mary T. Post, RN, MS, CNS, CIC

Director, Infection Prevention

Oregon Patient Safety Commission

# Centers for Disease Control (CDC) Ebola Grant

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**Focus:** build statewide infection prevention infrastructure, capacity and education

- Conduct Ebola readiness consultations of Oregon Ebola Tier 2 Assessment Hospitals
- Develop statewide infection control capacity to prevent healthcare-associated infections
- Expand biosafety capacity at the Public Health Laboratory

# Part B. Targeted Infection Prevention Assessments

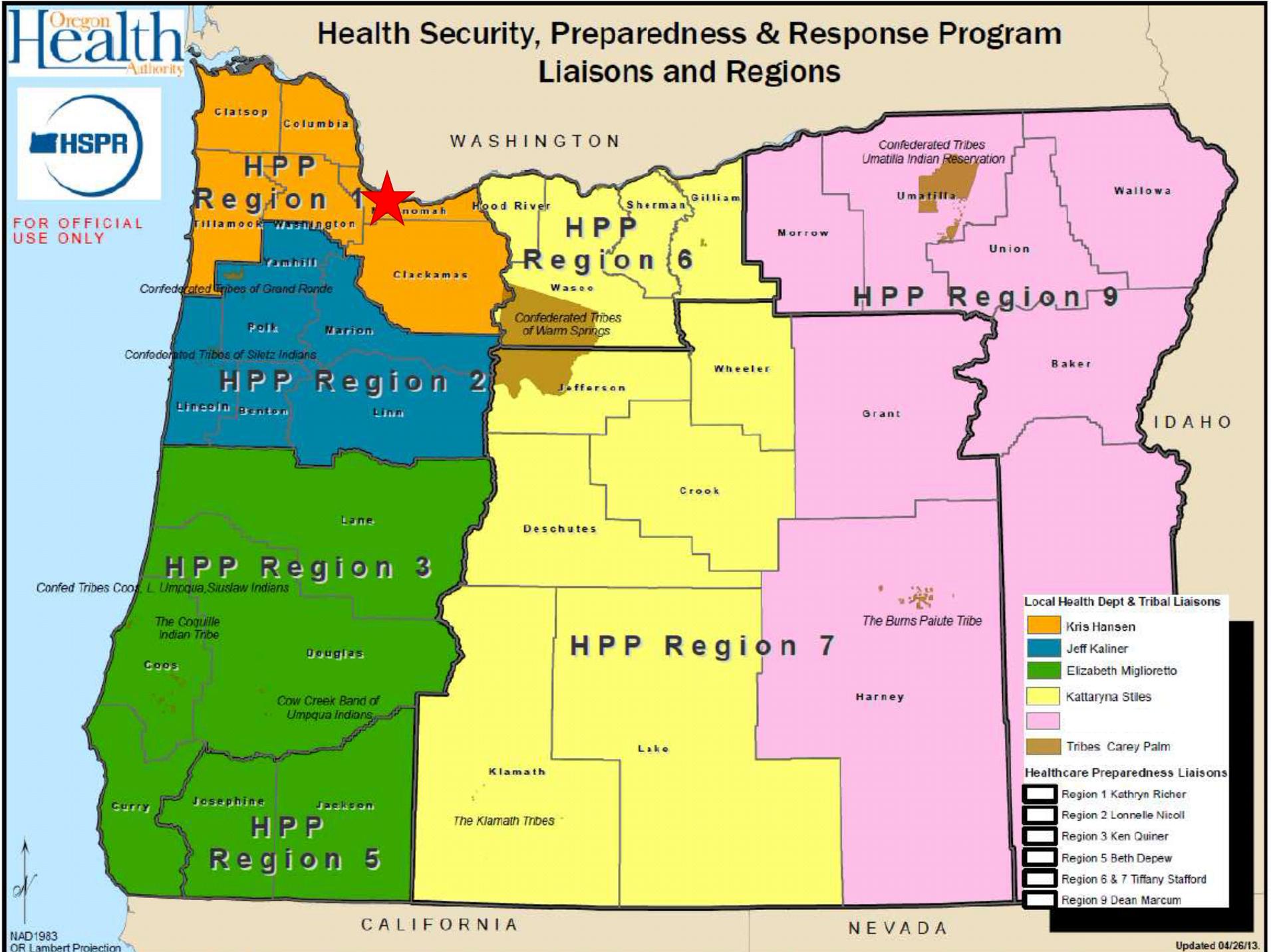
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- The CDC is funding on-site infection prevention assessments for facilities across the continuum of care
- Oregon is using a regional approach in facility selection with a goal to build partnerships between facilities in the same vicinity
- 25 facilities were offered the opportunity for consultations during the first year; numbers will now increase to a minimum of 35 in years 2 & 3
- Include Local Health Department, local APIC member on visits
  - Cross-pollination, practice ICAR tools

# Health Security, Preparedness & Response Program Liaisons and Regions



FOR OFFICIAL USE ONLY



**Local Health Dept & Tribal Liaisons**

- Kris Hansen
- Jeff Kaliner
- Elizabeth Miglioretto
- Kattaryna Stiles
- Tribes Carey Palm

**Healthcare Preparedness Liaisons**

- Region 1 Kathryn Richer
- Region 2 Lonelle Nicoll
- Region 3 Ken Quiner
- Region 5 Beth Depew
- Region 6 & 7 Tiffany Stafford
- Region 9 Dean Marcum

# Consultations

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- CDC has developed 4 different tools:
  - Acute Care, Long-term Care (LTC), Dialysis, and Ambulatory
- Each tool has different domains and requirements
- Template agendas have been created for each facility setting
- The majority of information to complete the tool is now obtained through observations, audits, and staff interviews in the clinical care areas

# Dialysis Assessment Domains

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- Infection control program and infrastructure
- Healthcare personnel safety
- Surveillance and disease reporting
- Hand hygiene
- Personal protective equipment
- Respiratory/cough etiquette
- Injection safety
- Environmental cleaning
- Dialyzer Reuse and Reprocessing (if applicable)
- Catheter and other Vascular Access Care
- Infection Control Training, Competency, and Audits

# A Caution Regarding the Findings

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- For most domains, the CDC Tools routinely ask about:
  - Observational competency training programs on hire, annually, and when equipment changes
  - Periodic audits (monitors and documents) with performance feedback to personnel
- The majority of facilities have zeros in most domains, with the exception being dialysis facilities
- This is not reflective of the quality of care provided nor a regulatory requirement; rather it is reflective of the processes the CDC and others would like to see facilities have in place in the future

## **DIALYSIS FACILITY FINDINGS**

# Infection Control Program Infrastructure

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- Three dialysis facilities have had consultations
- 66% had designated IP with special training
- 66% participated in network HAI QI Project
- 66% have contact precautions protocol
- All provide education to patients on access care, risks, signs of infection, and hand hygiene
- Space between dialysis stations and computers a concern
- All have HBV isolation room, none have isolation room for other conditions

# Infection Control Training, Competency, and Audits

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- All facilities provide job-specific training and observational competency to HCP on IP P & P on hire, and 66% annually
- All used standardized tools for education and practice assessments

# Healthcare Personnel Safety Domain

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- Two facilities (66%) met all domain requirements
- All provided post-exposure f/u, 66% tracked and tried to improve exposure rates
- All screen patients for HCV according to recommended interval
- All offered influenza vaccinations to staff
- All screened staff for TB
- All encouraged prompt illness reporting to supervisor, 66% had policies not penalizing ill

# Surveillance and Disease Reporting Domain

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- All entered bloodstream infection data into NHSN
- All had a list of reportable infections including hepatitis infections
- Only one facility had system in for interfacility transfer communication

# Respiratory/Cough Etiquette Domain

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- No facility met all elements of the domain
- 66% had signage posted at entrances
- All had required supplies located at entrances and common areas
- 33% provide designated space for sick individuals in waiting room
- 33% had ability to separate symptomatic patients by at least 6 feet from other patients during treatment

# Personal Protective Equipment(PPE) Domain

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All facilities met all domain requirements

# Environmental Cleaning Domain

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- One facility met all elements of the domain
- All facilities had policies that clearly define responsibilities for cleaning and disinfection of environmental surfaces and non-critical equipment
- 66% provided training on hire, annually, and when P & P changes
- 33% performed audits and provided feedback
- All had P & P for disinfection of glucometer , dialysis clamp, and conductivity/pH meters
- One facility performed dialyzer reuse- performed appropriately
- Observations: No facility meet all dialysis station disinfection requirements since process started prior to patient leaving chair



## **CDC Urging Dialysis Providers and Facilities to Assess and Improve Infection Control Practices to Stop Hepatitis C Virus Transmission in Patients Undergoing Hemodialysis**

The Centers for Disease Control and Prevention (CDC) has received an increased number of reports of newly acquired hepatitis C virus (HCV) infection among patients undergoing hemodialysis. Infection control lapses in dialysis care could expose patients to HCV. Any case of new HCV infection in a patient undergoing hemodialysis should prompt immediate action. CDC is urging dialysis providers and facilities to:

- 1) Assess current infection control practices and environmental cleaning and disinfection practices within the facility to ensure adherence to infection control standards;
- 2) Address any gaps identified by the assessments;
- 3) Screen patients for HCV, following CDC guidelines, to detect infections, determine treatment potential, and halt secondary transmission; and
- 4) Promptly report all acute HCV infections to the state or local health department.

# Hand Hygiene Domain

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- All facilities met all elements of the hand hygiene domain
- Hand hygiene rates ranged 85-95% due to ready access to sanitizers

# Injection Safety Domain

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- All had appropriate supplies and equipment to comply with safer sharps and injection devices
- 33% had a clean room physically separate from the treatment area for storage and preparation of injectable medications
- All facilities shared multi-dose vials in immediate treatment area
- All facilities had gaps identified when labeling immediate-use medications

# Summary of Findings Across the Continuum of Care

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- Most facilities do not have observational competency and audit requirements in place, so scoring poorly. Dialysis is an exception.
- Sharing of multi-dose vials in immediate care areas and labeling and use of immediate use medications remains an issue for dialysis facilities
- Gaps were commonly identified in the labeling and administration of immediate use medications
- Blood glucose devices not commonly used in the dialysis setting
- Implementation of Oregon inter-facility transfer written communication requirements is incomplete
- Hand hygiene practices were exceptional in most dialysis facilities.

# Summary of Findings (cont'd.)

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- Mixing and use of appropriate disinfectants for dialysis facilities were appropriate
- The Infrastructure of Infection Prevention programs is being improved, with many corporations now identifying onsite infection prevention staff with additional IP training
- Dialysis corporations have hired regional infection preventionists to assist with CMS required public reporting via NHSN

# Consultation Findings

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- Consultations have validated the reasons for ongoing competency-based training, performance feedback, and routine auditing of infection prevention practices
  - Hardwires training for new employees and new graduates
  - Rural areas often orienting staff who have no experience in their new positions so they need robust training programs
  - Practices “drift” unless reinforced
  - Individuals responsible for a process leave employment and no one is trained to continue the effort
  - Presence and feedback is an important component of infection prevention

# Infection Prevention Next Steps

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- Infection Prevention Fundamentals training course (Free)
  - November 1-3, 2016, Ambridge Center, Portland
- Training courses under development
  - Hands-on training for instrument reprocessing (the truck)
  - Healthcare facility Environmental Services managers/supervisors
  - Possible medical clinic toolkit and training workshop
  - Environmental Services room/bathroom cleaning video

# Next Steps

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- Plan mitigation consultations
- Incorporate findings into Infection Prevention Fundamentals Training Course and other educational offerings
- Hold regional meetings between healthcare facilities, local county health departments, and emergency preparedness representatives with state health department involvement
- Network and share resources with other states in Northwest Region

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# Healthcare Worker Influenza Vaccination in Oregon

Monika E. Samper, RN  
Healthcare-Associated Infections Program  
September 28, 2016

The logo for the Oregon Health Authority, featuring the word "Oregon" in a small serif font above the word "Health" in a large serif font, with the word "Authority" in a smaller serif font below "Health".

Oregon  
Health  
Authority

# HCW Flu Vaccination

Oregon Public Health

## >> Oregon Health Care Worker Influenza Vaccination Annual Report: 2014-2015

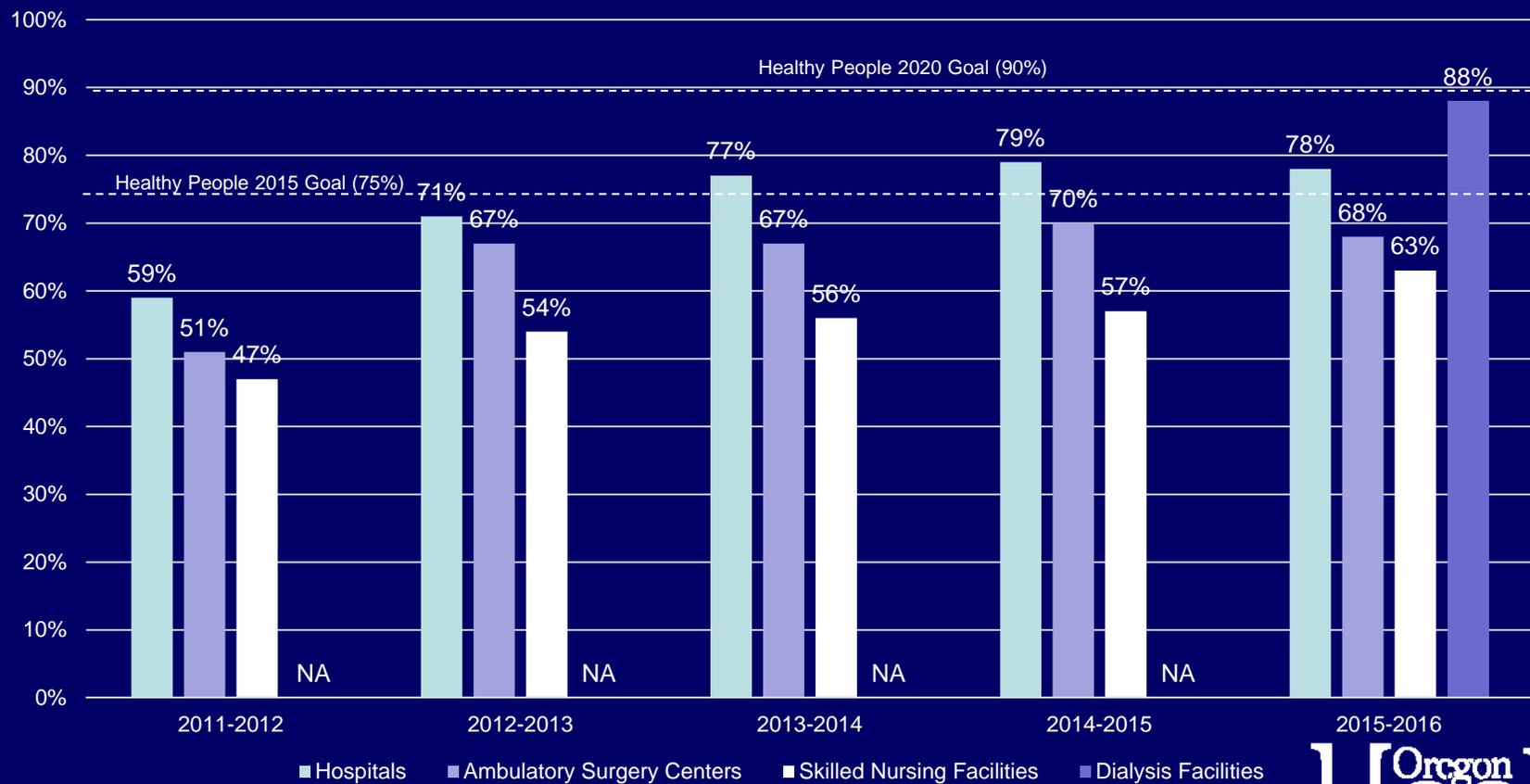


<https://public.health.oregon.gov/DiseasesConditions/CommunicableDisease/HAI/Pages/Reports-and-Data.aspx>

Oregon  
**Health**  
Authority

# HCW Influenza Vaccination

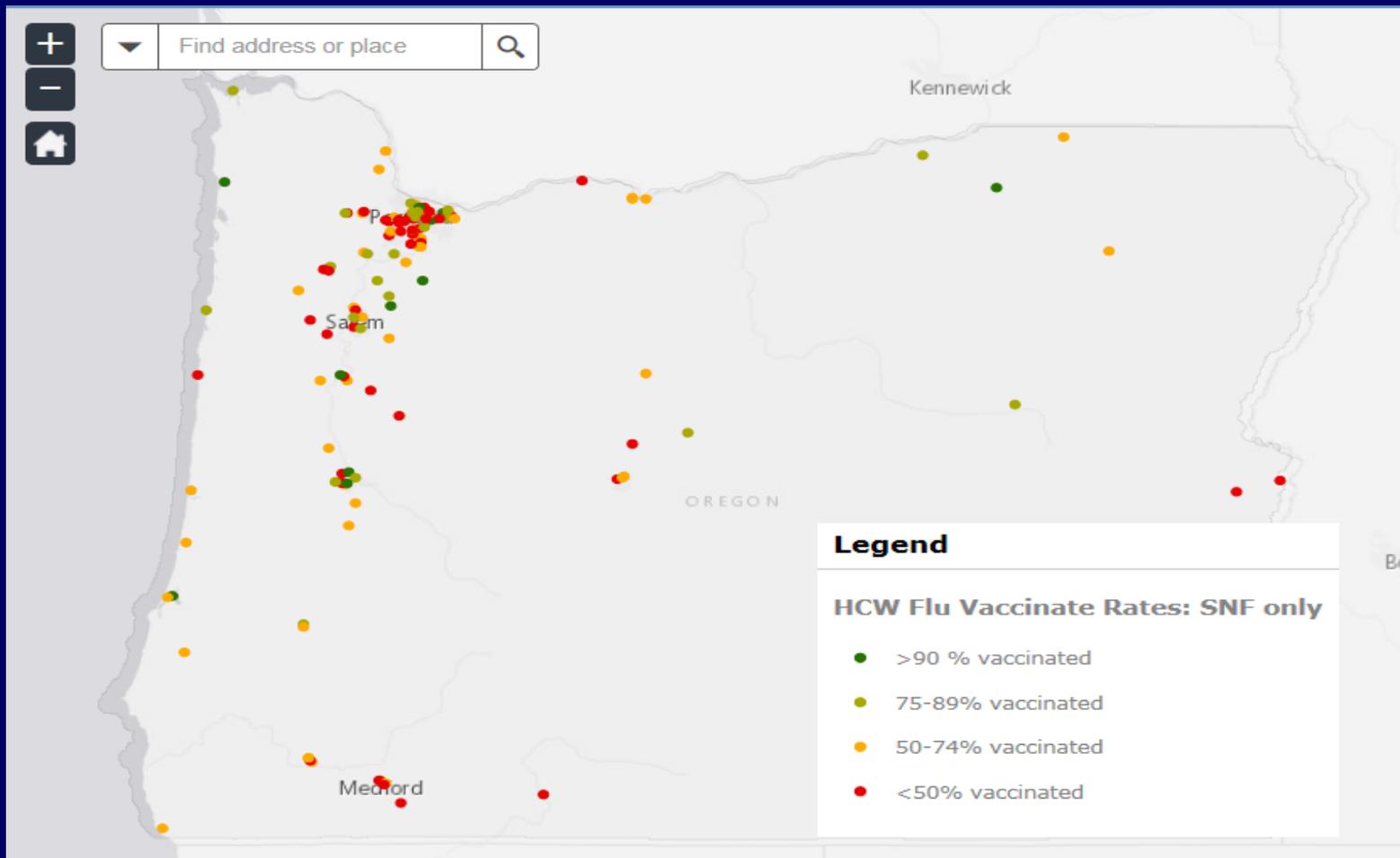
Figure 1. Healthcare personnel influenza vaccination rates for 2011-2012, 2012-2013, 2013-2014, 2014-2015, and 2015-2016 influenza seasons stratified by healthcare facility



# Facility-specific HCW Flu Vax: 2014 Provider Report

Facility name	# HCW eligible for influenza vaccine <sup>a</sup>	Rate of influenza vaccination for eligible HCW <sup>b</sup>	Rate of vaccine declination by eligible HCW	Rate of unknown vaccination status for eligible HCW	Change in vaccination rate since last season	Met HP2015 target (75%)	Met HP2020 target (90%)	Additional HCW needed to vaccinate to reach HP2020 <sup>c</sup>
Klamath Surgery Center	38	50%	11%	39%	-16%	X	X	15
Lane Surgery Center	32	75%	18%	18%	-14%	✓	X	5
Laser & Surgical Eye Center, LLC	42	45%	52%	2%	+11%	X	X	19
Lovejoy Surgicenter	27	30%	30%	41%	-18%	X	X	18
McKenzie Surgery Center	102	73%	19%	9%	-13%	X	X	18
Meridian Center for Surgical Excellence	20	100%	0%	0%	+8%	✓	✓	
Middle Fork Surgery Center	20	65%	15%	20%	-16%	X	X	5
Mt. Scott Surgery Center	108	52%	2%	46%	+89%	X	X	41
North Bend Medical Center	59	85%	12%	3%	+17%	✓	X	3
Northbank Surgical Center	153	55%	10%	35%	+14%	X	X	54
Northwest Ambulatory Surgery Center	95	74%	6%	20%	-16%	X	X	18
Northwest Center for Plastic Surgery, LLC	21	76%	10%	14%	-20%	✓	X	3
Northwest Gastroenterology Clinic	44	86%	0%	14%	-6%	✓	X	2
Northwest Spine and Laser Surgery Center	37	84%	16%	0%	+285%	✓	X	2
Ontario Surgery Center	21	67%	14%	19%	+4%	X	X	5
Oregon Ear, Nose, and Throat Surgery Center,	40	45%	10%	45%	-39%	X	X	18
Oregon Endoscopy Center, LLC	40	93%	8%	0%	+8%	✓	✓	
Oregon Eye Surgery Center, Inc.	49	61%	35%	4%	-5%	X	X	14
Oregon Outpatient Surgery Center	101	73%	21%	6%	+1%	X	X	17
Oregon Surgicenter	35	86%	14%	0%	+6%	✓	X	2
Pacific Cataract & Laser Institute	10	90%	10%	0%	+96%	✓	✓	
Pacific Cataract and Laser Institute	12	75%	25%	0%	-18%	✓	X	2
Pacific Digestive Endoscopy Center	8	38%	63%	0%	-20%	X	X	4
Pacific Surgery Center	24	75%	25%	0%	0%	✓	X	4
Pearl SurgiCenter	30	80%	20%	0%	+83%	✓	X	3
Petroff Center	17	41%	41%	18%	-31%	X	X	8

# Updated Interactive Map for Oregon: Benchmarking Healthy People Goals



## Oregon Update: 2015-2016 HCW Flu Vax

- Oregon HCW Influenza Vaccination Rates
  - Hospitals: 78%
  - ASCs: 68%
  - SNFs: 63%
  - Dialysis: 88%
- Healthy People Goals:
  - 2015 goal: 75%
  - 2020 goal: 90%



# Oregon: 2015-2016 HCW Flu Vax

Facility Type	# HCW	#HCW no-med exempt	Vax Rate (%)	Unknown Status (%)	Declined (%)
Hospital	100,155	99,157	78%	13%	9%
SNF	15,198	15,709	63%	18%	19%
ASC	5,403	5,333	68%	8%	22%
Dialysis	3,031	3,001	88%	5%	7%

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# Questions? Follow Up?

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