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AHC Media

CMS Regulation taps IPs for Key Stewardship Role

Proposed rule calls for antibiotic stewardship in all hospitals

By Gary Evans, AHC Media Senior Staff Writer

Infection preventionists have drawn key supporting roles in a proposed rule by CMS requiring antibiotic stewardship programs in hospitals to rein in drug-resistant bacteria and stop the rise of *Clostridium difficile*.

CMS directly linked infection preventionists to antibiotic stewardship, but called for program leadership at a level comparable with a physician/pharmacist. How big a priority has antibiotic stewardship become? CMS is incorporating the term into its current “infection control” Conditions of Participation (CoP) 482.42. CMS proposes a change to the title of this CoP to “Infection Prevention and Control and Antibiotic Stewardship Programs.”¹

“The beauty of that is the incorporation of antimicrobial stewardship and changing the wording to infection ‘prevention’ and control,”

says **Sue Dolan**, RN, MS, CIC, president of the Association for Professionals in Infection Control and Epidemiology (APIC). “They are not mutually exclusive and they shouldn’t be working in silos. They are integral to one another — it’s truly a two-way street. This overall arching theme of having them together and working in sync makes a lot of sense.”

The proposed rule is open for comment until Aug. 15, 2016. (*See editor’s note at the end of this story.*) As a first step toward regulation requiring antibiotic stewardship, earlier this year

“THE BEAUTY OF THAT IS THE INCORPORATION OF ANTIMICROBIAL STEWARDSHIP AND CHANGING THE WORDING TO INFECTION ‘PREVENTION’ AND CONTROL.” - DOLAN

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CMS sent out a proposed rule calling for hospitals to send their drug utilization and resistance data to the CDC's National Healthcare Safety Network (NHSN) Antimicrobial Use module.

(<https://federalregister.gov/a/2016-09120>) CMS will then include the data on its Hospital Inpatient Quality Reporting (IQR) Program.

In addition, the proposed antibiotic stewardship rule would require that the hospital governing body ensure that systems are in place and are operational for the tracking of all infection surveillance, prevention and control, and antibiotic use activities. Moreover, problems identified by the respective programs must be addressed. This section of the rule speaks to the need for resources to fulfill the requirements, meaning antibiotic stewardship should not fall into the dreaded "unfunded mandate" category.

"The APIC public policy committee will be taking a more critical look at the document and providing comments," Dolan says. "So it is hard for me to predict [APIC's formal response], but certainly, I can see that there would be a trend toward [program] support for a lot of the recommended changes. We have been working with policy makers to educate them and support funding resources to help with the implementation of such programs, especially those in the NHSN. We need that system so we can have reporting to the antibiotic utilization module and the antibiotic resistance module. These efforts are going to continue on the advocacy side of APIC."

In addition to antibiotic stewardship, the CMS proposed rule revised and reiterated some of the general requirements for infec-

tion control — raising questions by some IPs about whether their duties were being expanded. For example, CMS proposes that the infection preventionists "be responsible for preventing and controlling healthcare-associated infections (HAIs), including auditing of adherence to infection prevention and control policies and procedures by hospital personnel."

In an early comment to the CMS proposed rule docket, an unidentified IP in Indiana objected to this seemingly perfunctory description to IP duties.

"I don't think the infection preventionists should be responsible for control and preventing HAIs," the IP told CMS. "My rationale is that while my title includes the words 'control' and 'prevention,' I do not work at the patient bedside. It is the healthcare workers who are directly at the bedside that control and prevent infections by their actions. I can create/recommend policies and protocols based on evidence-based practice and I can audit adherence to the policies. The verbiage should be the 'infection preventionist is responsible for implementing evidenced-based policies and procedures to prevent and control infections, including auditing adherence to the policies and providing feedback to hospital leadership and personnel.'"

Another unidentified IP from Alabama expressed a similar concern in comments submitted on the proposed rule.

"As a busy, dedicated infection preventionist in a large medical center, it is unrealistic to make already overwhelmed IPs responsible for auditing adherence to IP & C policies and procedures by hospital personnel," the IP wrote in comments to CMS. "We do audits, provide

guidance, tools, corrective actions, and standards but ultimately leadership of the multitude of areas should have responsibility auditing adherence. IP & C has a role but should not have primary responsibility since it has no line authority to ensure compliance. The proposed rule refers several times to leadership involvement and responsibility.”

However, an unidentified IP from California, who was among the early commenters on the rule, took the view that CMS was empowering infection prevention programs.

“As an infection preventionist for the past 10 years and certified by CBIC, I have read the proposed rule [and] support it to its fullest,” the IP wrote to CMS. “IPs are constantly requested to provide evidence of rules and regulations when attempting to make a positive impact on preventing HAIs. With antiquated verbiage and lack of regulatory processes it has been a hardship to get the ‘buy-in’ from leadership within the hospitals. This is definitely a great step in the right direction.”

In more specific comment on hand hygiene, an unidentified IP from Kansas said CMS could help IPs and protect patients by specifically banning artificial nails, which can harbor bacteria.

“As an infection preventionist, I know that hand hygiene is the best preventive method to reduce or prevent healthcare-associated infections,” the IP says to CMS. “Unfortunately, the statement that, ‘Hospitals must follow hand hygiene guidance as suggested by the CDC or WHO’ does not help healthcare facilities to enforce [bans of] artificial, gel, acrylic nails or nail polish as the CDC and WHO guidelines are very open to interpretation and outdated. ... I feel that it would benefit every patient

in the United States and reduce the cost of healthcare if the statement was concrete and stated: ‘Healthcare workers shall not wear artificial, gel, or acrylic fingernails while having direct contact with patients in the healthcare setting.’”

By adding the word “prevention” to the CoP name, CMS is promoting larger, cultural changes in hospitals so “that prevention initiatives are recognized on balance with their current, traditional control efforts,” the agency states. Adding “antibiotic stewardship” to the title emphasizes the important role that hospitals should play in combating antimicrobial resistance with implementation of a robust stewardship program that follows nationally recognized guidelines for appropriate antibiotic use, CMS explained.

According to CMS, the rule “would require a hospital to develop and maintain an antibiotic stewardship program as an effective means to improve hospital antibiotic-prescribing, [and] curb ... potentially life-threatening, antibiotic-resistant infections.” This would promote better alignment of hospital infection control and antibiotic stewardship efforts with nationally recognized guidelines and “heighten the role and accountability of a hospital’s governing body in program implementation and oversight,” CMS states.

As outlined by CMS, the following goals for an antibiotic stewardship program would have to be met:

- Demonstrate coordination among all components of the hospital responsible for antibiotic use and factors that lead to antimicrobial resistance, including, but not limited to, the infection prevention and control program, the Quality Assurance & Performance Improvement (QAPI)

program, the medical staff, nursing services, and pharmacy services.

- Document the evidence-based use of antibiotics in all departments and services of the hospital.
- Demonstrate improvements, including sustained improvements, in proper antibiotic use, such as through reductions in *C. diff* and antibiotic resistance in all departments and services of the hospital.

As proposed in the new CMS rule, IPs would be responsible for the development and implementation of hospitalwide infection surveillance, prevention, and control policies and procedures that adhere to nationally recognized guidelines.

IPs would also “be responsible for communication and collaboration with the antibiotic stewardship program,” CMS states. “Based on the evidence provided by CDC, IDSA, SHEA, and others, we believe that collaboration between the hospital’s infection prevention and control and antibiotic stewardship programs will provide the optimal approach to reducing HAIs and antibiotic resistance.”

The CMS proposed requirement for leadership responsibilities of a stewardship program calls for “the hospital, with the recommendations of the medical staff leadership and pharmacy leadership, to designate an individual, who is qualified through education, training, or experience in infectious diseases and/or antibiotic stewardship ... who would serve as the counterpart to his or her colleague(s) leading the hospital’s overall infection prevention and control program.”

There was some concern expressed during past discussions of antibiotic stewardship that infection preventionists would be given responsibility beyond their authority, as only physicians can

prescribe antibiotics. CMS acknowledges this issue and draws a clear line between infection control and antibiotic stewardship.

“The skills needed to lead each program are different,” CMS states. “Infection prevention programs are often led by nursing staff who do not prescribe antibiotics. Antibiotic stewardship programs are led by physicians and pharmacists who have direct knowledge and experience with antibiotic prescribing.”

The programs have the shared goal of preventing both infections and antibiotic resistance, so “close collaboration” is essential even though each has its own distinct structure and leadership responsibilities, CMS notes. After the rule is finalized, CMS will develop interpretive guidelines to instruct surveyors how to determine hospital compliance.

The responsibilities listed for antibiotic stewardship leadership — and presumably some of these tasks could be done in collaboration with IPs depending on the hospital — include the following

- the development and implementation of a hospitalwide antibiotic stewardship program, based on nationally recognized guidelines, to monitor and improve the use of antibiotics.
- all documentation, written or electronic, of antibiotic stewardship program activities,
- communication and collaboration with medical staff, nursing, and pharmacy leadership, as well as the hospital’s infection prevention and control and Quality Assurance Performance Improvement (QAPI) programs, on antibiotic use issues, and
- the competency-based training and education of hospital personnel and staff, including medi-

cal staff, and, as applicable, personnel providing contracted services in the hospital, on the practical applications of antibiotic stewardship guidelines, policies, and procedures.

Barbarians at the Gates

The CMS move to enforce antibiotic stewardship was inevitable given an executive order to do so from the White House last year, which followed the CDC’s increasingly urgent warnings about the looming prospect of untreatable infections. The most recent example came in a CDC alert about a multidrug-resistant fungal infection with high mortality emerging on four continents.² (See related story in this issue.)

“[CMS IS] PROPOSING REVISIONS THAT WOULD REQUIRE A HOSPITAL TO DEVELOP AND MAINTAIN AN ANTIBIOTIC STEWARDSHIP PROGRAM AS AN EFFECTIVE MEANS TO IMPROVE HOSPITAL ANTIBIOTIC-PRESCRIBING PRACTICES... .”

That comes on the heels of the first U.S. case of horizontal genetic transfer of a novel plasmid *mcr-1*, which confers resistance to the last-line drug colistin in

Escherichia coli. Unnecessary and indiscriminate use of antibiotics selects out such strains, a pattern that has been recurring since bacteria resistant to penicillin appeared more than a half-century ago.

“[CMS is] proposing revisions that would require a hospital to develop and maintain an antibiotic stewardship program as an effective means to improve hospital antibiotic-prescribing practices and curb patient risk for possibly deadly *C. diff* infections, as well as other future, and potentially life-threatening, antibiotic-resistant infections,” the proposed rule states. “We would promote better alignment of a hospital’s infection control and antibiotic stewardship efforts with nationally recognized guidelines and heighten the role and accountability of a hospital’s governing body in program implementation and oversight.”

As part of the antibiotic stewardship program, hospitals would be required to improve their internal coordination among all components responsible for antibiotic use and reducing the development of resistance, including, but not limited to, the infection prevention and control program, the QAPI program, the medical staff, nursing services, and pharmacy services, CMS states.

The C-Suite

CMS aims in the new rule to “enhance the accountability” of hospital leadership for the infection prevention and control and antibiotic stewardship programs. This accountability would extend all the way to the governing body level of the institution. “We wish to promote a hospitalwide culture of safety and quality, and we are

proposing these regulatory changes to introduce a catalyst at the leadership level,” CMS states in the rule.

For example, CMS endorsed an Executive Walk Rounds program developed at Brigham & Women’s Hospital in Boston. The goals of the rounds are to ensure safety is a high priority for senior leadership and get information from staff about safety issues.

“In addition to consultation with nursing leadership, we would also require hospital governing body consultation with medical staff, pharmacy leadership, the infection preventionist(s), and the leader of the antibiotic stewardship program,” the CMS rule reads. “We believe these changes would provide hospitals with greater flexibility and open up the process and expand accountability and involvement at all levels.”

In general, infection preventionists and healthcare epidemiologists can provide support and guidance to antibiotic stewardship programs through surveillance for syndromes of interest, implementing interventions to guide the delivery of evidence-based practices, and translating data and infection rates to healthcare workers, nursing units, and administrators, says Dolan, hospital epidemiologist at Children’s Hospital in Aurora, CO.

Frontline interventions can quickly identify multidrug-resistant organisms, but the rigor needed for all steps of the process is immediately underscored.

“Yes, we can provide early identification of organisms, but even before that we need to make sure our staff knows how to get the right specimen and do it properly,” she tells *Hospital Infection Control & Prevention*. “That’s a huge piece and we can really impact there.”

IP involvement will be critical to get patients into the appropriate level of isolation while drug susceptibilities and resistance factors are determined. Compliance with precautions and core measures like hand hygiene are then important to protect other patients from cross transmission, she notes. IPs could also be involved in using electronic surveillance data to inform risk assessment and action plans, development and implementation of clinical algorithms for treating infections, creation of evidence-based bundles, checklists, and real-time electronic reminders on antibiotic ordering for providers, Dolan explains.

“EDUCATION IS ANOTHER OBVIOUS ROLE FOR IPS, AS THEY CAN UNDERSCORE PRUDENT AND APPROPRIATE USE OF ANTIBIOTICS FOR PROVIDERS AND EXPLAIN TO CONSUMERS AND PATIENTS WHEN ANTIBIOTICS ARE NOT NEEDED.”

Education is another obvious role for IPs, as they can underscore prudent and appropriate use of antibiotics for providers and explain to consumers and patients when antibiotics are not needed. Though CMS involvement may raise compliance issues and attendant anxieties for IPs, regulations

rooted in financial incentives and penalties could also empower infection control to reduce more patient infections and preserve the efficacy of antibiotics. A speaker at the recent APIC conference in Charlotte, NC, observed that IPs were perfectly positioned to join the fight to stave off a post-antibiotic era.

“You appreciate the importance of antibiotic resistance,” says **Rita Olans**, DNP, RN, CPNP, APRN-BC, assistant professor at the MGH Institute of Health Professions in Boston. “You are used to working the systems using the multidisciplinary linkages that you have created in your hospitals. You know your hospitals. You’re everywhere. You are experienced at operationalizing critical interventions. When do they call you — when there’s a critical need, right?”

Editor’s note: To comment on the CMS proposed rule, refer to file code CMS-3295-P. To submit electronic comments on the CMS regulation, visit <http://www.regulations.gov>. Follow the “Submit a comment” instructions. Alternatively, you can mail written comments to the following address: entries for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-3295-P, P.O. Box 8010, Baltimore, MD 21244. Comments must be received no later than 5 p.m. on August 15, 2016. ■

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CMS: Extends IC Across Continuum

Dropping 'officer' moniker for IP, ICP

A proposed rule on antibiotic stewardship by the CMS would broaden the scope of infection control beyond the hospital.¹

“Given the number of facilities through which a patient might travel, [the CMS] proposes to increase the involvement of hospital infection prevention and control programs [to] facilitate communication across settings,” the agency states in the proposed rule.¹

With this requirement, the CMS is addressing a longstanding issue across the healthcare continuum. There have been frequent communication breakdowns between hospitals, nursing homes, and other facilities as patients with multidrug resistant pathogens or some other infectious condition move to various points of care. Thus better “communication across settings” is needed to avoid situations like failure to isolate an infected patient, potentially triggering an outbreak in the receiving facility.

The CMS goes further in this provision in calling for IPs to “address infection control issues identified by public health authorities,” which typically would be related to an investigation of an outbreak in the community.

In a more nebulous application of this concept, the CMS proposes language at 482.42(a)(2) that would “adjust the scope of the hospitals’ prevention and control programs from its current focus on the

transmission of infections between patients and personnel.” The CMS calls for IPs to focus on infections in a broader sense, including visitors, the hospital environment and again transitions of care between facilities.

“GIVEN THE NUMBER OF FACILITIES THROUGH WHICH A PATIENT MIGHT TRAVEL, [THE CMS] PROPOSES TO INCREASE THE INVOLVEMENT OF HOSPITAL INFECTION PREVENTION AND CONTROL PROGRAMS [TO] FACILITATE COMMUNICATION ACROSS SETTINGS.” - CMS

In other proposed revision, the CMS is dropping the antiquated term “infection control officer” in favor of infection preventionists or the previous name of choice, “infection control professional.” In a nod to professionalism that APIC has long been pushing for, the CMS called for hospitals to “ensure that the individuals so

designated are qualified through education, training, experience, or certification - such as that offered by the Certification Board of Infection Control and Epidemiology Inc. (CBIC).” The CMS also said IPs continue training and ongoing education.

In another move that elevates the profession, the CMS proposed rule calls for consulting with physician and nursing leadership in hiring an IP.

“The proposed requirement would be a subtle, but important, departure from the current requirement 482.42(a), which simply requires that an officer or officers be designated to implement and develop the program,” the CMS said in the rule.

The idea is in part to get clinical leadership involved in infection control and more invested in promoting a culture of safety.

In terms of basic duties, the IPs would be responsible for “all documentation, written or electronic, of the prevention and control program, and its surveillance, prevention, and control activities,” the CMS states. Similarly, IPs are responsible for training staff on infection control measures and policies.

“[CMS] believes that this proposed revision is more specific and more in keeping with current standards of practice in hospitals than the current provision ... that requires a hospital to ensure that its

training programs address problems identified by the infection control officer,” the agency explained in the rule. ■

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To Promote Innovation, Flexibility, and Improvement in Patient Care. Proposed Rule. Fed Reg June 16, 2016: <http://1.usa.gov/291Ftlc>

Common CMS Infection Control Citations

Surprise inspections begin with a ‘walk-through’

Even as CMS makes a bold push into regulating antibiotic stewardship programs, the agency is inspecting hospitals and finding common, recurrent problems.

In particular, hospital infection control programs are not always following the manufacturer’s instructions for the use and cleaning of devices and they are often not in compliance with their own written policies, says **Karen Hoffmann**, RN, MS, CIC, FSHEA, infection prevention consultant at the CMS.

Hoffmann updated the inspection findings recently in Charlotte, NC, at the APIC annual meeting.

“Again, all of the manufacturer’s instructions have to be followed,” she says. “No matter what you say, [unless] you have something from the manufacturer that gives you a personal waiver from following the instructions.”

CMS and its state inspectors will first verify if you have an active and effective surveillance program in place, and evaluate if the program is meeting the needs of patients and staff throughout the complex

“That should be a question they are asking,” she says. “How are you doing that?”

State agencies and other deemed authorities inspecting for CMS typically arrive unannounced and immediately begin an impromptu tour with a critical eye.

“State agencies will often do a walkthrough immediately upon

arrival, and what they are looking for is a sanitary environment,” Hoffmann says. “That’s just the way they do their survey process. They are looking for those ‘oops’ things going on before you can put out a warning that a state agency is in your facility. If they see some practice that looks out of whack, that’s when they will want to see your policy. They will interview the staff and they might interview patients or residents. They will really look hard at issues of isolation precautions, injection safety, and the cleaning [of the] environment.”

“STATE AGENCIES WILL OFTEN DO A WALKTHROUGH IMMEDIATELY UPON ARRIVAL, AND WHAT THEY ARE LOOKING FOR IS A SANITARY ENVIRONMENT.”
- HOFFMANN

It wasn’t always this way. CMS is continuing a startling transformation from benign payer to infection prevention enforcer. The flashpoint for this metamorphosis came in 2008, when CMS inspectors visited a Las Vegas endoscopy clinic but failed to notice the flagrant reuse of single-dose vials

and other needle safety violations. After tens of thousands of patients had to be tested for bloodborne pathogens and lawsuits and criminal proceedings made the national news, CMS made a fateful culture change that continues today.

“They really have a mandate to provide good care,” Hoffmann told APIC attendees.

A former IP working in hospitals and public health, Hoffmann says CMS has undergone a culture change that aligns its mission more directly with IPs in terms of patient safety.

“One of the things I’ve been very impressed with is that [many employees] came from the provider side before they started at CMS, so they do — believe it or not — have a sensitivity to this,” she says. “It’s just getting everybody [together] on the latest, evidence-based guidance. That is really what we have been trying to do there the last five years. What I hear them say when there is a decision to be made is, ‘Are the [CMS] recipients at risk of care?’ They are really focused on that and it is really a quality and safety direction they have gone in.”

In doing so, CMS is bound by regulation to enforce its Conditions of Participation, meaning inspections that are currently being conducted to oversee basic aspects of infection control will soon be established for antibiotic stewardship.

Among the most frequent

hospital citations currently are some aspect of a “dirty environment,” she says.

“It doesn’t say in the interpretative guidance if you have layers of dust, tape, and mold you will get a citation, but I guarantee you that is considered an unsanitary environment,” Hoffmann says.

Also commonly cited are leaking washers and sinks, holes in walls, and missing floor or ceiling tiles.

“These are not new, but they keep citing them so they must be out there,” she says. “So you need to [look for] those places.”

Reflecting lapses in clinical areas, hospitals are being cited for placing clean endoscopes in dirty bins or hanging them in a way that invites contamination. “Not within a cabinet — they are actually touching the floor,” she says. “I’ve actually seen that.”

Another frequent hospital citation is untrained staff, and inspectors still report health-care workers using unsafe injection practices or using cleaning products inappropriately.

“They will grab the bottle and ask a housekeeper what is the contact time for this,” Hoffmann says. “How much of an area to you cover using that wipe? Those kind of ‘in-use’ questions are practical.”

Other common violations include patient care staff not abiding by basic infection control practices — “everything from hand hygiene to isolation,” she says.

Healthcare workers so frequently misuse patient exam gloves, it is one of the most commonly cited deficiencies in inspections. According to Hoffmann, the most frequent CMS citations involving gloves include the following:

- thinking double-gloving protects against puncture injury,

- not having gloves accessible in locations where they are needed/used,
- failure to clean hands after removing gloves,
- moving from patient to patient without cleaning hands and changing gloves, and
- using alcohol hand rubs to “wash” gloves rather than changing them.

When that last one drew a surprised reaction from the APIC audience, Hoffmann said, “It still happens.” In other citation trends, if your records show evidence of a “cluster investigation” or something suggestive of an outbreak, CMS inspectors will want to know how the issue was resolved.

“If you recognize a problem but can’t show documentation of a conclusion to that [discovery], that can be problematic,” Hoffmann says.

“ANOTHER FREQUENT HOSPITAL CITATION IS UNTRAINED STAFF, AND INSPECTORS STILL REPORT HEALTHCARE WORKERS USING UNSAFE INJECTION PRACTICES OR USING CLEANING PRODUCTS INAPPROPRIATELY.”

With CMS and its deemed authority accreditors like The Joint Commission being more transparent about citations and deficiencies, IPs should be well aware of the expectations, says **Susan Dolan**,

RN, MS, CIC, president of APIC.

“I think as IPs, we are fairly aware of the issues they are seeing in other hospitals; it gives us a heads-up,” she tells *Hospital Infection Control & Prevention*. “I think the one area that is a common problem is disinfection and cleaning of equipment. Every individual facility should be following the manufacturer’s recommendations and your own written policies and procedures. Make sure they are evidence-based and you are following national guidelines.”

IPs can help by doing observational rounds and meeting with staff who are doing cleaning and disinfection.

“Our challenge is to make sure we have the correct policies and procedures in place, the proper training and the proper auditing and inspections,” Dolan says.

There continues to be confusion about “immediate use” steam sterilization, formerly called “flash sterilization,” Hoffman notes.

“The bottom line is that you only can use immediate-use steam sterilization for urgent needs — [for example], you drop an instrument and you don’t have a replacement,” she says. “It can’t be done routinely.”

Other common problems are not verifying the efficacy of a high-level disinfection solution before use, and not following the manufacturer’s instruction for pre-cleaning of scopes.

CMS are particularly focusing on proper cleaning and disinfection of duodenoscopes, which have been linked to outbreaks of carbapenem-resistant Enterobacteriaceae (CRE).

“[Inspectors] will ask for the manufacturer’s instructions as well those for the automated endoscopy reproprocessors,” Hoffmann

says. “Then they will observe the duodenoscopes being reprocessed

and ask the responsible staff to demonstrate how they are adher-

ing to manufacturer’s instructions and any new guidance.” ■

CDC Issues Alert On Emerging Yeast Infections

Candida auris can cause severe infections in vulnerable patients

Another emerging infection is on the radar.

The latest threat to patient safety comes in the form of a heretofore obscure yeast *Candida auris*, which has emerged in a multidrug resistant strains in nine countries worldwide, the CDC reports.¹

First reported in 2009 in Japan, *C. auris* has now been identified in other parts of Asia, Africa, South America and the United Kingdom. The pathogen was previously detected in the U.S. in 2013, so there is concern that it will become recurrent given its global presence.

“It is unknown why *C. auris* has recently emerged in so many different locations,” the CDC states. “Molecular typing of strains performed by CDC suggests isolates are highly related within a country or region but highly distinct between continents. Although the causes for such emergence are unknown, they may include new or increasing antifungal selection pressures in humans, animals, or the environment.”

In some healthcare outbreaks it has caused infections with high mortality in vulnerable patient populations, so infection preventionists should heighten vigilance and cast a wide net in surveillance of suspect organisms.

The pathogen is emerging as a healthcare associated infection in some countries, causing bloodstream infections, and wound

infections in patients with underlying conditions like diabetes and the presence of central venous catheters, the CDC reports.

The problem is *C. auris* can be challenging to identify in the lab or may be confused with other yeast varieties using standard lab methods.

“Commercially available biochemical-based tests, including API strips and VITEK-2, used in many U.S. laboratories to identify fungi, cannot differentiate *C. auris* from related species,” the CDC states. “Clinical, state, and public health laboratories should be aware of this organism and of the limitations in its identification.”

The news is no better on the antibiotic resistance front, as some strains of *C. auris* are resistant of as many as three major classes of antifungals drugs. With treatment options limited, infection control basics are a high priority.

“Until further information is available, healthcare facilities should place patients with *C. auris* colonization or infection in single rooms and health-care personnel should use standard and contact precautions,” the CDC recommends. “In addition, state or local health authorities and CDC should be consulted about the need for additional interventions to prevent transmission.”

Back to Basics

In a nutshell, *C. auris* is another reason to strive for high compliance with hand hygiene and proper glove use, particularly since the hospitalized patient, at least initially, may not be diagnosed with the infection.

In outbreaks in other countries, the pathogen appears to be able to transmit from environmental surfaces so the CDC is recommending an EPA-registered anti-fungal cleaning agent if *C. auris* is suspected.

There have clonal outbreaks of as many as 30 patients in some overseas outbreaks, suggesting transmission from patient to patient from transient colonization on the hands of healthcare workers and/or environment surfaces and fomites.

“The precise mode of transmission within the healthcare facility is not known,” the CDC states.

Healthcare facilities with a suspect or confirmed case of *C. auris* infection should contact state/local public health authorities and CDC at candidauris@cdc.gov. ■

REFERENCE

1. Centers for Disease Control and Prevention. Global Emergence of Invasive Infections Caused by the Multidrug-Resistant Yeast *Candida auris*. June 24, 2016: <http://www.cdc.gov/fungal/diseases/candidiasis/candida-auris-alert.html>

HCWs Don Gloves – And Not Taking Them Off

UK researcher says 60% wear gloves when not warranted

While medical examination gloves are a bedrock protective measure for patients and healthcare workers, some of the latter may be guilty of overkill – i.e., wearing gloves when they are not called for and infrequently changing them.

Jennie Wilson, PhD, MSc, RGN, HonMFPH, an associate professor in the Infection Prevention Society in Brentford, UK, delved into some of the emotional and psychological aspects of glove use recently in Charlotte at the annual meeting of the Association for Professionals in Infection Control and Epidemiology (APIC).

“We defined as appropriate glove use [when healthcare workers] were doing a procedure with their gloves on that involved direct contact with blood and body fluid, mucous membranes, or that involved a patient under contact precautions,” she says. “If they were weren’t doing any of those things, we considered the glove uses inappropriate. Almost 60% of the [observed] episodes where gloves were used there wasn’t an indication to use them. This tells us that people are widely using gloves when they don’t need to use gloves for infection control.”

In a study that included interviews with healthcare workers, Wilson found workers wearing gloves for routine tasks like making a bed. Others had “no particular reason” to be wearing gloves, but nevertheless were doing so.

“I asked the auditors, what were these people doing?” Wilson says. “We don’t know really, they were just wandering around with a pair of gloves on – sometimes for about 20 minutes.”

Of course, wearing gloves routinely – apparently for the worker’s protection – translates to contamination via

other environmental surfaces, equipment and the like before the worker approaches the patient bedside.

“When you have a nice pair of blue gloves on you’re very hygienic,” she says. “Not necessarily - because you have probably touched hundreds of things before you get to the patient. But the impression given is you are very hygienic because you have gloves on”

Same Patient, Same Gloves

Even some workers who changed their gloves appropriately to begin care made the mistake of leaving them on for more than one task with the same patient.

“They may empty a catheter bag, give the patient mouth care, check the patient’s blood sugar – all with the same pair of gloves on,” she said.

Wilson and colleagues interviewed some 50 healthcare workers in two hospitals to better understand their rationale for such ubiquitous glove use. Here are some of the comments they received from healthcare workers explaining why they wear gloves.

- “Some older men or women can’t always wash their own clothes and things. They cannot always be as clean as they might have been when they were younger”
- “When patients have skin conditions, even when you know that it’s not anything which is contagious and catching...it looks horrible.”
- “I find that when I have gloves on I’m less OCD about needing to wash my hands”
- “I was told in induction that we don’t need gloves for washing patients ...but, for me, I don’t feel com-

fortable not wearing gloves. I feel a lot safer and I feel a lot more relaxed.”

- “[Gloves] make me feel safer, more relaxed, more comfortable, and more confident”
- “If I wasn’t wearing gloves [for washing a patient] I think I’d feel kind of awkward.”
- “Obviously, if it’s quite personal areas you’re definitely going to wear your gloves....”
- “I’d take a judgment from the patient I think because sometimes they might be more uncomfortable if you didn’t wear gloves, whereas if you’ve got your gloves on it’s a bit more clinical so they feel a more dissociated from it.”

Ultimately, glove use is highly influenced by personal decisions and healthcare workers may feel they have the right to wear them for their own peace of mind.

“That’s really critical because if we are going to change behavior we have to recognize that that’s how people feel about it,” Wilson says. “They don’t think anybody else has the right to tell them when they should or should not wear gloves.”

Workers observed erred on the side of wearing gloves, in part because they don’t know if the patient may be infectious.

“To me, that sounds like a conflation of standard precautions - treat everybody the same - and contact precautions - you wear gloves for everything,” Wilson says. “They’ve merged the two things, and said that means you wear gloves with everybody because that’s what we do when we know somebody has an infection.” ■

Zika Transmitted By Needlestick To Lab Worker

First documented occupational Zika infection

The question of whether Zika virus can be transmitted via needlestick is no longer hypothetical.

As feared, the virus can indeed transmit to a healthcare worker who suffers a percutaneous injury, but a Pittsburgh lab worker who was occupationally infected is recovering nicely, the Allegheny County Health Department (ACHD) reports.

The case appears to be the first documented instance of Zika transmission via needlestick, though public health and hospital officials have warned since the epidemic be-

gan that it was certainly possible. It underscores that healthcare workers must be vigilant with infection control precautions and needle safety to protect themselves from Zika and a host of other bloodborne pathogens.

The woman “contracted the virus from a needlestick while working with the Zika on an experiment in a laboratory. Her symptoms have resolved and she is doing well,” Allegheny health officials reported. The needlestick reportedly occurred on May 23 at a University of Pittsburgh lab, with the worker becoming symptomatic about a week

later and then fully recovering.

The most common symptoms of Zika are fever, rash, joint pain, and conjunctivitis. While now a confirmed occupational threat to healthcare and lab workers, Zika is primarily spread by *Aedes* mosquitoes and can be transmitted sexually.

The worker was reportedly advised to cover up when outside and use insect repellent to reduce the chances of spreading the virus to others via a mosquito bite. ■

Cleaning Agent Leads to Asthma-Like Symptoms

*Balance need to kill *C. diff* with worker protection*

Nobody wants to eradicate *Clostridium difficile* more than infection preventionists, but they must balance patient safety with the respiratory health of workers using powerful cleaners to eradicate resilient *C. diff* spores.

“There really has to be a balance between patient safety and worker safety,” says **Megan Casey**, RN, MPH, a nurse epidemiologist with the National Institute for Occupational Safety and Health (NIOSH). “We need to make sure that worker safety is not compromised as we continue this battle against healthcare-associated infections.”

Preliminary results of an ongoing public health investigation indicate that a powerful sporicidal cleaning agent used in some 500 hospitals is being linked to wheezing, watery eyes and asthma-like symptoms in healthcare workers, NIOSH reports.¹

The product contains acetic acid, peroxyacetic acid, and hydrogen peroxide. A branch of the CDC, NIOSH recently published a summary of the findings that included the following key points:

- Researchers interviewed 79 (78%) of 101 current environmental services staff about their health.
- Among the 68 employees who worked with the product, the most commonly reported health outcomes were watery eyes (46%), nasal problems (41%), asthma-like symptoms (28%), use of allergy medicine (16%), and shortness of breath (16%).
- A total of 30 (44%) reported at least one work-related health outcome. Most commonly reported work-related symptoms were watery eyes (29%) and nasal problems (22%).

Among the recommendations² by

NIOSH is to implement a reporting system that would permit employees to report work-related symptoms, with the option for employees who do not wish to be identified to remain anonymous. If environmental services staff do report respiratory, skin, and/or eye symptoms, a combination of engineering and administrative controls might be needed to reduce employee exposures. ■

REFERENCES

1. CDC/NIOSH. Notes from the Field: Respiratory Symptoms and Skin Irritation Among Hospital Workers Using a New Disinfection Product — Pennsylvania, 2015. *MMWR* 2016;65(15):400–401.
2. Hawley, BM. Are Hospital Cleaning Staff at Risk When Using a One-step Cleaner? NIOSH Science Blog. April 29th, 2016: <http://bit.ly/29vFOUQ>



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CME/CE QUESTIONS

1. CMS proposes a change to the title of its current infection control Conditions of Participation to "Infection Prevention and Control and Antibiotic Stewardship Programs."

- a. True
- b. False

2. According Karen Hoffman, RN, MS, CIC, how do state inspectors for CMS typically begin an unannounced visit to a hospital?

- a. Approach the main desk and ask to see the infection preventionist
- b. Go straight to central services and assess disinfection and sterilization
- c. Do a walkthrough inspection of the facility
- d. Ask if duodendoscopes are used in the facility

3. A powerful cleaning agents linked to asthma-like reactions in healthcare workers contains which of the following ingredients?

- a. Acetic acid
- b. Peroxyacetic acid
- c. Hydrogen peroxide
- d. All of the above

4. International healthcare facilities are reporting an emerging multidrug-resistant yeast called:

- a. *Candida auris*
- b. *Candida stellatoidea*
- c. *Oidium albicans*
- d. *Aspergillus fumigatus*

COMING IN FUTURE MONTHS

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