

# Hospital Infection Control & PREVENTION

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September 2010

Volume 37, No. 9

(Pages 97-108)

## Health care unions call for OSHA standard on infectious diseases

*SEIU, ANA cite need for infection control enforcement*

By **Gary Evans**, Senior Managing Editor

Squaring off with the nation's leading infection prevention groups, health care worker unions and associations are urging the Occupational Safety and Health Administration (OSHA) to develop an infectious disease standard that would essentially regulate and enforce infection control programs in hospitals.



Susan Dolan, RN, and APIC oppose OSHA regulation

The Service Employees International Union, (SEIU), which counts some 1 million health care workers among its members, strongly encouraged OSHA to promulgate an Infectious Disease Standard.

"We believe that the most effective approach for OSHA to assure compliance with infection control measures to protect workers from these diseases is through a comprehensive enforceable standard," the SEIU stated in comments to OSHA. "[We need a standard] that covers a wide range of infectious agents and protects

healthcare workers from dangerous and potentially deadly diseases so they can provide their patients with the quality care they need and deserve without jeopardizing their own health and safety."

OSHA set the stage for regulatory action on occupational infection prevention in hospitals and other health care settings with a recent

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**Financial Disclosure:**  
Editor Gary Evans, Associate Publisher Coles McKagen, Consulting Editor Patrick Joseph, MD, and Katherine West, Nurse Planner, report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

request for information on the need for an infectious disease standard.<sup>1</sup> The comment period is closed, but the docket submissions by key stakeholders suggest a tumultuous debate is only just beginning. Noting that infection prevention programs are largely "voluntary," the agency went beyond its longstanding interest in airborne infections to include a request for comment on those transmitted via droplet and contact. As a result, OSHA is essentially considering regulating the full gamut of health care infection prevention.

The Association for Professionals in Infection Control and Epidemiology (APIC) argues that an OSHA standard on infectious diseases would unnecessarily duplicate existing guidelines, standards and regulations such as those already in respective effect by the Centers for Disease Control and Prevention, the Joint Commission and the Center for Medicare and Medicaid Services (CMS).

"We are currently following national guidelines by CDC and other entities such as the Joint Commission. We feel that there are agencies like CMS that are enforcing those guidelines," says **Susan Dolan**, RN, MS, CIC, APIC public policy chair. "If they identify problem areas, that may be something we can take a look at, but until that time I don't think we can pinpoint something they have identified as an issue. We may learn things that we didn't realize were there, but our sense from what we

are hearing from members is that they don't seem to understand why this is needed."

The SEIU said it was "a false perception that the industry is self-regulated. "The Joint Commission, which accredits hospitals with a primary focus on patient care, conducts pre-announced inspections of most hospitals every 3 years," the union argued. "[There has been an] historic lack of attention by governmental agencies responsible for health and safety. Only relatively recently has OSHA begun to issue standards and guidance for hazards that cause injuries and illnesses to health care workers."

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### ***ANA says expand California reg***

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A lack of enforcement of infection control recommendations was also cited as an issue by the American Nurses Association (ANA), a group with considerable political clout that represents some 3 million registered nurses.

"Much of the evidence on infection transmission and prevention is not new information, however the shortcoming lies in the capacity to enforce programs," the ANA said in comments to OSHA. "Healthcare employers are responsible to provide an aggressive infection control program. The California-OSHA Aerosol Transmissible Diseases standard may be a model for future OSHA standard which could incorporate contact transmission as well."

**Hospital Infection Control & Prevention**<sup>®</sup>, including **Infection Control Consultant**<sup>™</sup> and **Healthcare Infection Prevention**<sup>™</sup> (ISSN 0098-180X), is published monthly by AHC Media LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

**POSTMASTER:** Send address changes to **Hospital Infection Control & Prevention**<sup>®</sup>, P.O. Box 740059, Atlanta, GA 30374.

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This activity is effective for 36 months from the date of publication.

Target audience: Infection control practitioners and infectious disease physicians.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

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Indeed, many observers think the Cal-OSHA airborne standard is the most likely template for a national standard, though OSHA is now talking about going beyond its traditional respiratory infection focus to include other modes of transmission. (See *related story*, p. 100.) In that regard, the ANA cited the need for clarity around disease transmission by contact, droplet and airborne transmission in the wake of the pandemic.

"The 2009 H1N1 pandemic resulted in much uncertainty and mixed messages that caused confusion around transmission even when more information became known about the H1N1 virus," the ANA told OSHA. "The highest level of respiratory protection must occur to provide healthcare workers with appropriate protection. ANA supports the development of a more protective respirator which is user-friendly and ideally does not require fit testing so nurses and other healthcare workers experience an optimal level of respiratory protection when exposed to airborne or droplet infectious agents. In the interim, there is a strong need to enforce the annual fit testing requirement in order for healthcare workers to be prepared to achieve the highest level of respiratory protection."

Quantifiable knowledge of occupationally acquired infections of healthcare workers is hampered by a lack of systematic tracking and reporting, the ANA noted. "ANA recommends that an improved reporting and tracking methodology be developed and utilized to expand the knowledge of the prevalence of infectious disease exposure and incidence of healthcare workers to benefit both the healthcare worker and the patients who they serve," the nurses group stated. "This will allow data for infection control planning and prevention."

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### ***Sinking in a sea of data***

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More data collection is not exactly music to the ears of an infection preventionist. APIC expressed concern about any "increased burden of reporting infectious agents (e.g., MRSA) when it is very difficult to distinguish occupational versus community acquisition." Instead of adding additional reporting requirements, the focus within facilities should be on timely post-exposure prophylaxis for targeted diseases to protect the health of employees, APIC argued.

"There are already a lot of requirements for documentation and data collection," Dolan says. "Having another agency coming in requiring

different documentation, a different method of submission, and being subject to more surveys seems like a duplication to us. It would be an added burden that would take us away [from key duties]. We encouraged our members to submit [comments] to show all of the things that they are currently doing."

In its submitted comments to OSHA, APIC said it "does not see any additional gain from a highly redundant standard and the burden of documenting elements of infection prevention efforts for yet another government agency." APIC also rejected OSHA's contention that infection prevention programs are voluntary efforts designed primarily to protect patients.

"We believe that OSHA has mischaracterized IPC programs as "voluntary," APIC stated. "Hospitals, ambulatory care centers, other care-delivery sites and related entities understand that in order to receive Medicare and Medicaid funds, these programs are mandated by CMS and any agency which has received deemed status from CMS. Beyond reducing reimbursement, CMS hospitals not complying with its standards risk loss of certification or even their license if CMS determines the facility has unsafe conditions related to life safety codes and infection control standards. Therefore CMS and other accrediting agencies' enforcement affect both patients and health care workers."

In addition, infection prevention programs are designed to protect both patients and workers APIC emphasized. "Hospitals are concerned about the health and safety of all occupants, whether patients, health care workers, or visitors," APIC stated. "Therefore elements of the infection prevention programs must include airborne, droplet and contact assessments, as well as attention to environmental/engineering controls for the environment affecting ALL occupants."

APIC reminded OSHA that programs typically develop a risk assessment for the specific population served and for the types of communicable diseases likely to be seen in the specific facility. For this purpose, hospitals and other settings use reportable communicable disease entries published weekly from local and state and federal agencies, APIC explained.

"Therefore, specific issues may vary by locale," APIC said. "The best example is TB, for which CDC guidelines indicate that some areas may have minimal risk and need not carry out TB testing nor develop respiratory protection programs."

# Will Cal-OSHA airborne standard go national?

*State plan may be expanded by national office*

With the Occupational Safety and Health Administration (OSHA) opening preliminary rule-making on a national infectious disease standard, infection preventionists pondering the end result of the effort may follow the old admonition, "look to California."

Just as it did with the first versions of the blood-borne pathogen standard years ago, Cal-OSHA enacted an Aerosol Transmissible Diseases standard that became effective in August 2009. With health care worker unions already expressing support for a national version of the standard, it appears OSHA may use the regulation as a template.

Cal-OSHA was able to achieve support for the standard from both the California Hospital Association and labor unions representing health care workers. While it requires fit-tested N95 respirators (or greater protection) for health care workers caring for patients infected with a novel pathogen, it also temporarily allows fit-testing to occur biannually rather than every year. That provision was based on the premise that future research will clarify fit-testing issues and it automatically expires in 2014.

However, some IPs in California ran into problems trying to comply with the standard during the H1N1 pandemic, when fit-testing and respirator supply issues were an overwhelming problem.

"The standard didn't allow for any flexibility in the event of a lack of supplies, such as during a pandemic," says **Susan Dolan**, RN, MS, CIC, public policy chair of the Association for Professionals in Infection Control and Epidemiology (APIC).

"[Infection preventionists] found that very challenging in addition to the cost issues. Anecdotally, our members were just really concerned that there wasn't enough evidence or justification for having such a standard. That was the piece that seemed to be a disconnect for our members."

In that regard, APIC is not likely to support a national version of a standard it resisted at the state level. "We did not understand the need or justification for California's aerosol transmissible disease standard, given the studies that were examined by OSHA and stakeholders that did not demonstrate that the TB rate in HCWs was any higher than the general population," APIC stated

in its comments submitted to OSHA.

California's airborne standard covers a range of issues, including the minimum air exchanges per hour in negative pressure rooms (12, although they can be six if HEPA filtration is used), vaccinations and fit-testing. The standard also calls for employers to:

- implement "source control measures" such as a respiratory hygiene/cough etiquette program, as recommended by the Centers for Disease Control and Prevention.
- identify patients needing airborne infection isolation in a timely manner. If the facility doesn't treat patients with airborne infectious diseases, it must transfer the patient within five hours (or by 11 a.m., if the initial patient encounter occurs after 3:30 p.m.). Exceptions are provided when rooms are not available, and when a transfer is medically contraindicated.
- maintain an exposure control plan that outlines the job classifications that may involve aerosol transmissible disease exposure, high-hazard procedures, tasks requiring respiratory protection, and the control measures. The plan also must address medical surveillance, reporting of exposures, and evaluation of exposure incidents. It must be reviewed annually, and employees must be involved in that review.
- have a system of communicating the infectious disease status of patients to which employees may be exposed that complies with medical confidentiality requirements. If employees are not sick but must be removed from their normal assignment because an evaluating physician determines they have been exposed or may be infectious, they must be provided with an appropriate alternate assignment or be paid if they are furloughed. This "precautionary removal" period ends when either the person has passed the incubation period or if the employee gets sick or is otherwise unable to work.
- provide annual training to employees with potential exposure to patients with aerosol-transmissible diseases.
- have adequate supplies of personal protective equipment.
- provide vaccines for susceptible health care workers with the potential for exposure. Employees who decline a recommended vaccine must sign a declination statement.
- conduct TB tests at least annually for employees with occupational exposure (or perform annual symptoms screens for employees who are baseline positive for latent tuberculosis infection). ■

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## ***TB battle resonates***

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The OSHA initiative could reopen some old wounds from the protracted debate between infection control and occupational health over a national tuberculosis standard. Indeed, some commentators recalled that specific situation, reminding OSHA that its contention that health care workers were at greater risk of TB was never borne out in data.

"[We have] a concern that with this regulation, OSHA may be singling out healthcare workers (HCW) without good documentation that additional regulations will reduce the infection rate of HCW's exposed to infected patients, or patients to infected HCW's," commented **Bruce Cunha**, RN, MS, COHN-S, manager of employee health and safety at the Marshfield (WI) Clinic. "This is similar to what occurred with the tuberculosis standard that OSHA proposed back in 1997. We are not sure that OSHA is correctly identifying the potential for work exposure to infectious diseases. This is not restricted to just health care settings. The probability is that HCW's are actually better protected than workers in other industries in that they have had training and are more aware of signs and symptoms that may indicate a person has an infectious disease. The HCW is also educated and proficient in the use of personal protective equipment (PPE) and other IC measures such as hand washing."

On the contrary, the SEIU comments argued that health care workers face a host of occupational infectious disease risks not covered under the current OSHA bloodborne pathogen standard.

"Our healthcare members experience on a daily basis the inadequacy of existing OSHA requirements to protect them from non-blood borne infectious disease," the union comments continued. "While existing standards such as for respiratory protection are important, without a comprehensive standard healthcare workers work within a confusing system of mandatory requirements and voluntary guidelines. The confusion extends beyond just front-line workers to supervisors, upper management and local and state health departments which provide advice to most health care institutions. There is an important need for OSHA to provide clarity with a comprehensive standard to protect healthcare workers from exposure to and

risk of infectious disease."

In any case, regulations are a poor tool to address the unpredictable nature of infectious diseases, Cunha noted. "[E]xposure to most cases of infectious disease occur prior to the disease being diagnosed and protective measures being implemented," he told OSHA. "In this situation, additional regulations will not reduce the incidents of disease."

Still, the SEIU pointed to the success of OSHA's 1991 bloodborne pathogen standard in reducing the rate of occupationally acquired hepatitis B. "Later when the [bloodborne] standard was amended to require the use of safer needles, the number of accidental needlesticks were slashed as well," the SEIU told OSHA.

APIC cautiously conceded some positive aspects of that standard, but reiterated that more OSHA regulations are not needed.

"Although hospitals and other entities follow the OSHA bloodborne pathogen standard carefully, we believe the high level of efficacy of the HBV vaccine had an enormous impact on the reduction of HBV," APIC stated in its comments. "We acknowledge the impact of OSHA's standard but believe its impact was felt in many areas in which accessibility to HBV vaccination was less feasible. We also acknowledge the value of OSHA's attention to regular review of current safety devices, but also believe the current attention by CDC and CMS to increase focus on injection safety in all care settings is an important focus today."

An OSHA Infectious Disease Standard would result in "unnecessary increased costs that would take resources from other programs designed to protect workers and patients," APIC emphasized. "Because these efforts are already well-guided by other government agencies, they do not require additional monitoring by another government agency and represent a redundant and unnecessary cost burden for employers and taxpayers. APIC does not believe OSHA has demonstrated a specific problem that would permit development of a measure that would provide specific improvements over existing employee health and infection prevention programs."

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1. Department of Labor. Occupational Safety and Health Administration. *Infectious Diseases: Request for Information*. 75 Fed Reg 24,836- 24,844 (May 6, 2010). ■

# Juries may view CDC guidelines as mandates

*“These deadly infections are easily preventable – that’s their mindset.”*

In the increasingly litigious arena of infection prevention, juries are interpreting recommendations by the Centers for Disease Control and Prevention (CDC) as “mandated” standards of care.

As a result, infection preventionists may find their programs legally vulnerable if a decision not to follow an established guideline results in harm to a patient, a health care attorney said recently in New Orleans at the annual conference of the Association for Professionals in Infection Control and Epidemiology.

“These cases are coming directly into infection control departments,” said **Nicholas McConnell**, BA, JD, director of the health law practice group at Jackson & Campbell PC in Washington, DC. “I have worked with a number of infection control officers at hospitals — for days on end. There is so much paper in your institutions related to infection control that it is just food for feast by plaintiff lawyers.”

Among those papers, of course, are the CDC guidelines chapter and verse, which plaintiff attorneys are likely to seize on as an ironclad standard of care that should have been followed. IPs are well aware that the CDC can be somewhat equivocating in its voluntary recommendations, leaving enough “either/or” room to adopt one policy or another. However, the stronger the CDC’s stance on an issue, the greater the legal peril may be to the infection preventionist that ignores it.

For example, the CDC issued a fairly straightforward reminder earlier this year that anesthesiologists should wear a surgical face mask before administering epidurals or other spinal injections. The recommendation was the result of a fatal meningitis infection in a pregnant woman in Ohio being linked to this breach of infection prevention guidelines, the CDC reported.<sup>1</sup>

The publication of that report in the CDC’s *Morbidity and Mortality Weekly Report* effectively set a strong standard of care going forward, said McConnell, who was involved in a similar case in 2003. “A case involving a woman

who presented for a delivery back in 2003 is different from a patient who presents today in terms of the standard of care for masking of anesthesiologists in the performance of epidurals,” he said. “Information has moved.”

The findings in the meningitis case underscore the need to follow established infection control recommendations during spinal procedures, including use of a mask and adherence to aseptic technique, the CDC stated.

“In the literature you all live with you see all over the place this word ‘recommendations,’” McConnell said. “I can tell you in front of a jury, the word ‘recommendations’ is converted to ‘mandated.’ If there is a published recommendation, it will get into the hands of a lawyer who’s looking at what happened on behalf of an injured claimant and that word will become ‘mandated.’ In this day and age if there is a spinal procedure of any kind — spinal tap, epidural, whatever — and there is evidence that the anesthesiologist or other provider failed to mask, [if] there is a subsequent infection the case is indefensible.”

Health care lawyers like McConnell may be leery about taking cases to juries because nosocomial infections are now being widely characterized in the lay press as preventable events. Recent headlines include one from the *Washington Post* citing “deadly yet easily preventable infections,” he noted.

“If we don’t resolve cases, we are always aware that the jurors — ordinarily lay people out in the community — will decide what happens,” he said. “This is their understanding of what is going on in the infection world. These deadly infections are easily preventable — that’s their mindset. If you have a bad outcome it is hard to take away from them the knowledge that these things shouldn’t happen in a hospital or a surgical setting. They’re not supposed to happen.”

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## *The three legal questions*

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A legal case in the medical health care system raises three basic questions that every IP should know:

1. What is the standard of care? “What should you be doing — what should have been done?” McConnell said.

2. What is the standard of care applicable to the health care providers?

“Did any health care provider violate the

standard of care?" McConnell said. "Did they fail to do something that should have been done or do something they shouldn't have done."

3. If the answer is yes to question 2, was the violation a proximate cause of harm to the patient? "You can fail to give medication to a patient, but if it had no effect on the patient's course, no harm, no foul," he explained.

According to McConnell, typical legal language outlining the standard of care reads as follows:

"The physician or other health care provider — (And that can be the infection control officer in the hospital, he told attendees) — is required to have the same degree of skill, care, and knowledge of a reasonably prudent physician or other provider in his or her specialty acting under the same or similar circumstances."

It is important to note the emphasis on the phrase "the same degree," he said. "The law admires excellence, but it does not demand it. You are not required in your hospital to have the absolute best or latest technique or device. At some point a lot of this technology will become the standard of care and your institution will be required to have it."

By the same token, individual providers will vary by ability within the established standard of care.

"Not everybody can be the world's best neurosurgeon," McConnell said. "However, everybody who is trained in neurosurgery is expected to function in a reasonable prudent level of professional capacity similar to that of other neurosurgeons."

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## Reference

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1. Centers for Disease Control and Prevention. Bacterial Meningitis After Intrapartum Spinal Anesthesia — New York and Ohio, 2008-2009. *MMWR* 2010;59(03):65-69. ■

## HCW flu shot rates rise as mandates spread

*One in 10 HCWs must comply with flu vaccine*

More health care workers received the flu vaccine last season than ever before, but that has not eased the pressure to boost immunization rates. Health care workers who fail to get their flu vaccine increasingly face additional infection control burdens, possible termination

— or public rebuke.

Last spring, in an editorial titled "They Should Know Better," *The New York Times* took health care workers to task and advocated mandatory vaccination, saying: "We were disturbed to learn that health care workers shunned the swine flu vaccine in droves. Their training and skills will be essential if there is a dangerous flu outbreak. They, of all people, should know how important it is for them to get vaccinated — and that the risk of serious side effects is negligible."

The Immunization Action Coalition's "honor roll" now lists about 45 hospitals and health systems with mandatory programs. In a survey of about 1,500 health care workers sponsored by the Centers for Disease Control and Prevention, one in 10 reported that their employer required influenza vaccination.

"We can't simply rely on employee incentives to really get influenza coverage rates in the numbers that make a difference — above 90 percent," says Mary Quirk, a consultant to the coalition. "The data really demonstrate that requiring vaccination is a very important component."

Yet pushback against mandatory policies continues. Four HCA hospitals in California challenged a mandatory policy that required unvaccinated health care workers — including those with medical contraindications — to wear masks throughout their shifts and identifying marks on their badges. An arbitrator ruled that the hospitals could maintain the flu vaccination policy but must negotiate with the union about how to enforce it. The Service Employees International Union (SEIU) has won other battles against mandatory influenza policies, including one at the University of Iowa Hospitals and Clinics. The union's argument against mandatory policies was further fueled by a report by the Centers for Disease Control and Prevention that the H1N1 vaccine was 62% effective.

"If the vaccine was effective, you could maybe make the argument that [mandates] made sense," says **Bill Borwegen**, MPH, SEIU health and safety director. "To fire people for not getting a vaccine that's not all that effective, it's just massive overreach."

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## Hospital rate hits 74%

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In the 2009-2010 flu season, about 74% of hospital-based health care workers received either the seasonal or H1N1 flu vaccine (or

# It's official: You survived the pandemic

*WHO scales down response, advises vigilance*

Like a hurricane downgraded to a tropical depression, H1N1 influenza A has lost its pandemic status and is now just another troublesome flu bug as infection preventionists prepare for the annual outbreak season.

The World Health Organization recently made it official, basing its assessment on the global situation, as well as reports from several countries that are now experiencing influenza.

"As we enter the post-pandemic period, this does not mean that the H1N1 virus has gone away," says **Margaret Chan**, MD, director general of the WHO in Geneva. "Based on experience with past pandemics, we expect the H1N1 virus to take on the behavior of a seasonal influenza virus and continue to circulate for some years to come."

In the post-pandemic period, localized outbreaks of different magnitude may show significant levels of H1N1 transmission. "This is the situation we are observing right now in New Zealand, and may see elsewhere," she says. "In fact, the actions of health authorities in New Zealand, and also in India, in terms of vigilance, quick detection and treatment, and recommended vaccination, provide a model of how other countries may need to respond in the immediate post-pandemic period."

Globally, the levels and patterns of H1N1 transmission now being seen differ significantly from what was observed during the pandemic, Chan says. Out-of-season outbreaks are no

longer being reported in either the northern or southern hemisphere. Influenza outbreaks, including those primarily caused by the H1N1 virus, show an intensity similar to that seen during seasonal epidemics.

"During the pandemic, the H1N1 virus crowded out other influenza viruses to become the dominant virus," Chan says. "This is no longer the case. Many countries are reporting a mix of influenza viruses, again as is typically seen during seasonal epidemics."

Recently published studies indicate that 20–40% of populations in some areas have been infected by the H1N1 virus and thus have some level of protective immunity. Many countries report good vaccination coverage, especially in high-risk groups, and this coverage further increases community-wide immunity, Chan reported.

"Based on available evidence and experience from past pandemics, it is likely that the virus will continue to cause serious disease in younger age groups, at least in the immediate post-pandemic period," she warned. "Groups identified during the pandemic as at higher risk of severe or fatal illness will probably remain at heightened risk, though hopefully the number of such cases will diminish."

In addition, a small proportion of people infected during the pandemic, including young and healthy people, developed a severe form of primary viral pneumonia that is not typically seen during seasonal epidemics and is especially difficult and demanding to treat. It is not known whether this pattern will change during the post-pandemic period, further emphasizing the need for vigilance, Chan noted. ■

both), according to a survey commissioned by CDC. That is far higher than the 40% coverage rate that was previously cited for health care workers overall.

The vaccinations were highly sought after as the H1N1 pandemic struck last fall. But despite recommendations from CDC to continue vaccinations through the winter, few health care workers received vaccines after January, the survey showed.

Although the vaccine was considered to be an excellent match with the prevailing H1N1 virus, the vaccine effectiveness was lower than expected. That means a substantial number of health care workers still were susceptible

to H1N1 despite vaccination. And that is why some occupational health physicians have not supported mandatory policies that include punitive actions.

Employee health professionals need to "do everything we can to encourage people to get the flu vaccine," says **Mark Russi**, MD, chair of the Medical Center Occupational Health section of the American College of Occupational and Environmental Medicine (ACOEM) and director of occupational health at Yale-New Haven Hospital. "Most of us at ACOEM have stopped short of saying we should fire people who don't get the flu vaccine."

There's no question, however, that the man-

datory programs immediately increase flu vaccination rates. Among health care workers who reported employer mandates, 97% said they received the seasonal and H1N1 vaccines. If there was no mandate, 71% received the seasonal vaccine and 50% reported receiving the H1N1 vaccine. "Obviously mandates make a huge difference," says **Carla Black**, PhD, a CDC epidemiologist who helped coordinate the survey, which was conducted by the RAND Corp. of Santa Monica, CA.

The primary reason health care workers said they failed to get vaccinated was their belief that they didn't need the vaccine — "I never get sick."

"They don't realize they can be colonized and transmit the virus to patients and family members and not even know it," says **Gary Euler**, DrPH, a CDC epidemiologist with the Assessment Branch of the Immunization Services Division. "They need to be more altruistic in considering vaccination."

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### ***Asymptomatic disease a concern***

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Asymptomatic transmission of influenza is a concern for health care workers — including those who have been vaccinated but still contract the disease.

A seroprevalence study of 140 health care workers in Japan found that 28% had titers indicative of infection but only one reported having had influenza-like illness. These infections occurred despite the widespread use of masks or N95 respirators among the health care workers, the researchers said in their abstract, which was presented at the 2010 International Conference on Emerging Infectious Diseases in Atlanta in July.<sup>1</sup>

Although the influenza vaccine has gaps in its effectiveness, it remains the best tool to protect health care workers from influenza, says **William Schaffner**, MD, chairman of the Department of Preventive Medicine at Vanderbilt University in Nashville.

"I think we all have to remember that influenza has a very good vaccine but not a perfect vaccine," he says. "Even when you have a perfect match, as we did with H1N1 last year, you will not be able to protect everyone optimally. That's just a realization of the science of the influenza vaccine at this time. Sixty-two percent effective for \$15 [per dose] is about the best track record in preventive medicine today.

Our obligation is to protect our patients."

The 2010-2011 vaccine will include H1N1, but it also will contain H3N2 and influenza B antigens. For the first time, the CDC's Advisory Committee on Immunization Practices has recommended universal vaccination — flu vaccination of everyone six months old or older. Although this will increase demand for the flu vaccine, the CDC says it does not anticipate any supply problems this year.

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1. Suzuki A, et al. *Asymptomatic infection of Influenza A(H1N1) 2009 Pandemic Virus among Japanese health-care workers. 2010 International Conference on Emerging Infectious Diseases, July 11-14, 2010, Atlanta, GA.* ■

## **Isolation for life: The curse of 'Iraqibacter'**

*'If it gets a foothold it is very difficult.'*

Infection preventionists looking for guidance on discontinuing contact isolation for patients with multidrug-resistant *Acinetobacter baumannii* (MDR-Ab) remain in a quandary.

The latest recommendations by the Association for Professionals in Infection Control and Epidemiology (APIC) apparently will leave the situation unresolved, which is where it has been since so-called 'Iraqibacter' began its dramatic emergence in U.S. hospitals and nursing homes after initial cases were linked to soldiers returning from the Mideast wars.

The isolation issue came up in an exchange between audience members and a speaker previewing new APIC guidelines recently in New Orleans at the annual APIC educational conference. The APIC guidelines were slated to be released in the near future as this issue went to press. Speaking at the conference was **Patricia Rosenbaum** RN, CIC, an infection control consultant and a member of the taskforce that compiled the new APIC guidelines.

"Is there any indication in the new guidelines when you might be able to take [patients] out of isolation — is it indefinite?" asked an infection preventionist from Toledo, OH, in the question and answer period following Rosenbaum's presentation.

"I would not take them out of isolation, and

you want to flag them," Rosenbaum said.

"They are flagged, but we keep them in 'life-time' at the moment because there are no good criteria out there [on] when to take them out," the IP responded.

Another APIC audience member echoed the concern, saying her MDR-Ab patients were in isolation from "here to eternity."

"My feeling is that I would keep them on isolation precautions," Rosenbaum reiterated.

For its part, the Centers for Disease Control and Prevention has left the discontinuation of isolation for such patients an unresolved issue, citing "a paucity of information in the literature."<sup>1</sup> A policy on the website of Johns Hopkins Hospital in Baltimore, MD, (<http://www.hopkinsmedicine.org/heic/ID/mdr>) states that "at this time, there are no criteria for removing patients from isolation for MDR-Ab. Negative cultures do not indicate that the patient is free from colonization with the organism. This will be reconsidered as we acquire more data and experience controlling MDR-Ab."

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### ***Lives in the 'cracks and dust'***

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The excess of caution is due in large part to the harrowing task of trying to control outbreaks of MDR-Ab, which has the ability to persist in the environment and appears to transmit more readily than other resistant bugs.

"I can see where somebody would say, this is [another] multidrug resistant organism, so what's new?" Rosenbaum said. "What's different with this one is that it has a propensity for rapidly developing resistance to antibiotics. The other propensity — which is more alarming — is that if it gets a foothold in your facility it becomes very difficult to get rid of it. I think a lot of that is the environment. It lives in the cracks, in the dust, in machines. You must do very good environmental [cleaning]."

A recently published story found that gowns, gloves and the unwashed hands of health care workers were frequently contaminated with MDR-Ab, suggesting it is more easily transmitted than other resistant bacteria.<sup>2</sup>

"Their conclusion was that this organism was even more transmissible to gowns and gloves than MRSA and VRE," she said. "That's what they found, so it shows you how easily this could spread around a facility."

MDR-Ab is resistant to multiple drugs, and there are pan-resistant strains that are virtually

impervious to the full formulary.

"The appearance of a single case of MDR-Ab in an area with no previously identified cases should prompt an investigation and the timely implementation of selected control measures," she said. "They should go into contact precautions right away."

The patient population affected is typically the very seriously ill undergoing multiple courses of antibiotics, she noted.

"I don't know how many of you have treated [these patients] in your ICUs, but you can almost see the resistance build in very compromised patients that have been there an extended period of time," Rosenbaum said. "It seems like with each wave of antibiotics used, there is more and more resistance built until there is nothing left."

MDR-Ab transmission in healthcare settings has a strong environmental component, she said. "It has the ability to form a biofilm and this promotes its durability on surfaces and may contribute a great deal to the continuation of outbreaks," she said. "MDR-Ab can survive for days, weeks, months in the environment. It used to be thought of as a 'wet' organism, but now it is known to survive in dry environments."

In outbreak situations some IPs are having success with intensified cleaning regimens that include bleach solutions and the use of hydrogen peroxide vapor. "If transmission of the organism continues and the environment is suspect, the unit should be vacated and intensive cleaning performed," she said.

In any case, monitor environmental cleaning and make sure supplies like bleach wipes are being used properly, she emphasized.

"Remember it is one swipe with one wipe," she said. "If the cleaning person is using a wipe to go around the entire room they are portably taking it from place to place in the room."

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### ***Transfer between facilities common***

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Your risk assessment for MDR-Ab should be informed by local public health data and an awareness that the pathogen moves between facilities via patients, Rosenbaum said.

"It is very persistent in a geographic area," she said, noting that in her consulting work she had a group of six to eight hospitals exchanging cases. "The IPs all got together so we all knew it was going from one place to another place to another. You should be aware of that."

In that regard, an immediate alert of MDR-Ab history is essential at time of admission and at the time of transfer to another patient unit, another service or a different healthcare setting, she stressed.

## CNE/CME Questions

9. Citing a lack of enforcement of infection control recommendations the American Nurses Association advised the Occupational Safety and Health Administration to consider adopting a nationwide standard based on an airborne regulation approved in what state?

- A. New York
- B. Florida
- C. California
- D. Illinois

10. The Association for Professionals in Infection Control and Epidemiology argued that an OSHA standard on infectious diseases would unnecessarily duplicate existing guidelines, standards and regulations such as those already in effect by the:

- A. Centers for Disease Control and Prevention
- B. Joint Commission
- C. Center for Medicare and Medicaid Services
- D. All of the above

11. In a recommendation that should now be considered the standard of care, the CDC said that anesthesiologists should do what before administering epidurals or other spinal injections?

- A. get immunized for meningitis
- B. don a surgical mask
- C. ask female patients if they are pregnant
- D. All of the above

12. A recently published story found that gowns, gloves and the unwashed hands of health care workers were frequently contaminated with this pathogen, suggesting it is more easily transmitted than other resistant bacteria.

- A. Multidrug-resistant *Acinetobacter baumannii*
- B. Methicillin-resistant *Staphylococcus aureus*
- C. Vancomycin-resistant enterococci
- D. Norovirus

"You want to make sure they know what they are getting," she said. "Your labs should have an alert notification system to let the IP department and the health care providers know when you are dealing with MDR-Ab."

In addition to hand hygiene and contact precautions, some facilities fighting outbreaks of MDR-Ab have tried a variety of enhanced precautions, she said.

"If you have a true outbreak, you'll begin to do anything to stop it," she said. "Some of the tactics and strategies that I have heard used in dealing with outbreaks include cohorting of staff and one-on-one nursing. Some hospitals have

## CNE/CME instructions

Physicians and nurses participate in this CNE/CME program by reading the issue, using the provided references for further research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to answer key to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing the semester's activity, you must complete the evaluation form that will be provided and return it in the reply envelope to receive a credit letter. ■

## CNE/CME objectives

Upon completion of this educational activity, participants should be able to:

- Identify the clinical, legal, or educational issues encountered by infection preventionists and epidemiologists;
- Describe the effect of infection control and prevention issues on nurses, hospitals, or the health care industry in general;
- Cite solutions to the problems encountered by infection preventionists based on guidelines from the relevant regulatory authorities, and/or independent recommendations from clinicians at individual institutions. ■

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such a large outbreak that they open a unit just for [MDR-Ab patients].”

In an outbreak, the aforementioned contact isolation measures become all the more stringent, with many facilities deciding to do any additional procedures like dialysis in the patient’s room.

“They don’t come out of the room for anything,” Rosenbaum said.

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1. Centers for Disease Control and Prevention. Siegal JD, Rhinehart E, Jackson L, et al. *The Healthcare Infection Control Practices Advisory Committee Management of Multidrug-Resistant Organisms in Healthcare Settings, 2006*. On the web at: [www.cdc.gov](http://www.cdc.gov).

2. Morgan DJ, Liang SY, Smith CL, et al. Frequent Multidrug Resistant *Acinetobacter baumannii* Contamination of Gloves, Gowns, and Hands of Healthcare Workers. *Infect Control Hosp Epidemiol*. 2010;31:716–721. ■

## CNE/CME answers

Answers: 9. C; 10. D; 11. B; 12. A

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## Environmental cleaning versus hand hygiene

*Is one more important than the other?*

By **Patti Grant**, RN, BSN, MS, CIC  
Infection Preventionist, Dallas, TX

Many will have an opinion, yet the question in the headline cannot be definitively answered. I will not attempt to solve the debate, but let me try to shed a little light on it.

Much of what we use in the delivery of health-care is so commonplace that bedside staff may not always think about these as potential infection risks: bedside carts for computerized charting, computer keyboards at the nurse station, and phones carried by staff provided by their facility, just to name a few. Absolutely, these items need to be routinely disinfected according to your policy as non-critical items. (As this topic is explored please note this column excludes items classified as "Critical" or "Semi-Critical" under the Spaulding Classification System.)

Healthcare is witnessing a potentially unprecedented emphasis on the 'timing issues' of disinfectant application to these surfaces. Placing most infection prevention eggs into this one basket can inadvertently provide a 'false sense of security' in bedside staff if emphasized as the most important factor in a safe infection prevention (IP) milieu on a daily basis.

Within the past two years I've noticed a subtle yet constant escalation in IP listserv chatter and informal conversations during routine networking that involves "how many minutes exactly for what germ, on what surface, wet time, dry time, etc." My informal opinion is that infection preventionists are discussing this ad nauseam in part because our litigious society keeps the interpretation of manufacturer's official directions and our scientific community recommendations at odds. As a result, the official time span for routine disinfection of non-critical items remains in a quandary.

In spite of this debate we know for sur-

vey purposes the official manufacturer's label takes precedence despite what our scientific guru's publish in the peer-reviewed literature. Regardless of the answer to this 'timing debate,' give your front-line staff the big picture and help them see, process, and practice the first (and last) line of IP defense.

With the current emphasis on "disinfecting everything" — including items that do not touch the patient — it is not surprising our bedside staff might be confused and stressed into possibly forgetting one of the most important aspects of safe bedside care. Yes, the environment needs to be clean, yet consistent compliance with good hand hygiene immediately before direct patient care reigns supreme. Those eggs also need to be prominent in the IP basket to secure consistent patient safety.

Bedside staff must be thinking clean hands before I touch my patient. This one thought in action is the beginning and end of most patient safety IP concepts. One way to help them live this habit is to teach the cleaning of hands upon entering a patient room. This action alone would go far in decreasing the transmission of organisms. The next step is cleaning of hands immediately before any invasive procedure such as starting or manipulating intravenous access, dressing changes, or emptying urine bags.

The staff must be able to speak to this truth when facing the proverbial survey question: "Who cleans that keyboard at the nurse desk, how often, with what disinfectant, and for how long does the product remain wet/dry?" Their response needs to reflect daily practice and include an emphasis on decreasing the risk of microorganism transmission as a legitimate stop-gap measure:

- We clean our hands before entering a patient room and before invasive procedures
- We clean our hands to break the chain of infection from any object we may have touched prior to entry into the patient room
- Since we know not all surfaces can be 100% germ free, even with proper adherence to routine disinfection policies, we must practice good hand hygiene
- Gloves alone cannot break the transmission of infection — We must clean our hands before patient care regardless of glove use or surface disinfection practices.

Having the perfect policy and staff correctly reciting what a surveyor perceives as most important, does not equal safe bedside IP care. Help them keep it real and protect their patients. ■



## Want to be a mentor? All you need is mentee

*'I am a mentor. You can be one too.'*

*Editor's note: This is part one of our coverage of a presentation on mentoring by **Carolyn E. Jackson, RN, MA, CIC**, infection preventionist at SHW Hadley Hospital and Skilled Nursing Facility in Washington, DC. Jackson spoke recently in New Orleans at the annual conference of the Association for Professionals in Infection Control and Epidemiology (APIC). For part two of this story, see the next installment of Wisdom Teachers.*

While the benefits of having a mentor may appear relatively straightforward, this vital professional relationship is not a one-way street. Experienced infection preventionists who mentor novice IPs — "mentees" — may find themselves challenged and changed by an experience that can be truly rewarding, Jackson says.

"It is a give and take relationship," she said. "You are also challenging yourself to higher achievement. Your mentees are going to challenge you [with questions]. That challenges you as a mentor to strengthen your knowledge base. And don't be afraid to say, 'I don't know.'"

As infection prevention continues to undergo demographic changes, taking an IP under an experienced wing is critical, whether the mentor is explaining the latest confusing array of acronyms and guidelines or serving as the calming voice in a crisis.

"You can hear the shaking voice of the person calling you at 3 o'clock on a Friday afternoon with a healthcare worker with chickenpox," Jackson said. "You can help build their self confidence because they will get through that. You did it, your colleagues did it, and the mentee also will get through it."

In a mentoring relationship, a more routine activity may be watching an educational webinar and then scheduling a discussion.

"You can discuss that and offer challenges as

you dissect some of the information conveyed in the webinar," Jackson said. "The mentor serves to help the mentee, but the mentee may pick up some issues that the mentor did not pickup."

Participation in a mentoring relationship increases the self-confidence of the rookie infection preventionist as she becomes familiar with a new role and different responsibilities, Jackson noted.

"It is so crucial to have an 'I can' attitude," she said.

OK, health care needs every good infection preventionist it can get, but what's really in it for the mentor? Plenty.

For example, mentoring creates opportunities for experienced professionals to strengthen their knowledge base and improve communication skills. Mentoring enhances your leadership, teaching, and coaching abilities, Jackson emphasized.

"You become a more effective practitioner when you do this," she said. "You begin to step out and you acknowledge the fact that 'Well, I do know a little bit about this.' Because if you are a sole practitioner sometimes you're challenged in your institution — sometimes you're not."

While gaining some personal growth by mentoring, experienced IPs will also open new channels, professional connections and networks as they help the mentee. "Issues such as improving your public speaking skills as you [help a mentee with this issue]," she said. "There are skills you will learn as a mentor that will help strengthen your role as an IP."

Beyond that you get that feel-good intrinsic satisfaction of helping an emerging professional develop to his potential.

APIC is trying to link up volunteer mentors with new practitioners, and the relationship need not be strictly local, she noted. (For more info go to [www.apic.org](http://www.apic.org)) "If it is your preference they will certainly try to match you with someone in your local area, but because of email and electronic communication it is a lot easier to keep in touch with people," she said.

Regardless of how you do it, mentoring means one day being that person that experienced IPs look back at and credits for their success. The skill sets of mentors will vary, of course, but that's part of the beauty of it.

"It's crucial that you do it, because no one else can do it like you can," Jackson said. "Our role, our responsibility in this area is great. We need to recognize the importance of giving back and the importance of trying to grow individuals into this profession. I am a mentor. You can be one too." ■