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Unannounced CMS infection control inspections go nationwide in 2012

“We are asking the question: What is the hospital doing to prevent these infections?”

By **Gary Evans**, Executive Editor



Russ Olmsted

An unannounced inspector from the Centers for Medicare and Medicaid Services (CMS) walks into the hospital and summons the infection preventionist. Looking down at a clipboard, he asks: “What were the last two hospital acquired infections that were serious preventable adverse events in the hospital, [meaning they caused] patient harm or death following development of the infection? What was done about each?”

Prepare now, because this is coming.

Those questions and a slew of others are contained in a CMS draft document called “Acute Care Hospital Infection Control Tool for Surveyors” obtained by *Hospital Infection Control & Prevention*. (See the CMS questions, related stories, p.135-138) As we previously reported in our July issue, the largest payer of health care in the country is rapidly developing a national inspection program for infection control in hospitals.

There are the inevitable concerns and caveats, as hard-pressed IPs face increasing scrutiny from yet another regulatory agency. No stranger to these real-world concerns, a veteran IP nevertheless made the big-picture point that puts the flurry of CMS initiatives in hospitals and — most recently — dialysis centers in perspective.

“It certainly is good for patients,” says **Russ Olmsted**, MPH, CIC, an infection preventionist at St. Joseph Mercy Health System in Ann Arbor, MI.

The draft survey for CMS inspectors is being trialed in 10

In This Issue

- Involuntary guidelines?** CMS essentially turning some CDC recommendations into regs. cover
- Twenty IC questions:** Know the answers to these to prepare for CMS visit 135
- Survey snapshot:** Key elements and expectations in the CMS draft survey of hospital infection prevention programs 137
- Two hats:** For IPs covering occupational health, here are the CMS questions for infection control related to employee health 138
- CMS targets dialysis:** Facilities must report infections, antibiotic use data to CDC to receive full reimbursement 139
- Politically incorrect:** OSHA infectious disease reg stalled along with the rest of its agenda in an anti-regulatory season 140
- Clean spaces, healthy patients:** With a new appreciation for risk of the healthcare environment, housekeepers are on the front lines of infection prevention 141



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states, Washington D.C. and Puerto Rico. The tool will be refined as warranted based on the evaluation, with the final product expected to debut in all 50 states in October 2012. The CMS has created a survey tool for a sweeping assessment of infection prevention, using a patient tracer approach similar to the Joint Commission to follow key issues through the care process. The pressure is on, but infection preventionists who pivot toward this initiative by reviewing the CMS expectations — and making hospital senior administration well aware of them — are poised for empowerment.

“It certainly has the potential for that,” says Olmsted, the 2011 president of the Association for Professionals in Infection Control and Epidemiology. “The good news is that it’s consistent with Joint Commission requirements, but also it will be highlighting infection prevention practices in the acute care setting. It’s certainly very detailed. I was really impressed with the scope of this.”

Despite the breadth of the assessment, all the measures and expectations fall under CMS authority in its standard: 42 CFR 482.42 Condition of Participation (CoP): Infection Control.

“It’s built on the CoP for acute care hospitals

— the foundation for it is already well established,” he says. “It looks at a number of key areas that include safe injection practices and hand hygiene. It includes quite a bit of detail on the prevention practices pulled from CDC guidelines. It’s pretty good in that sense. I will say it looks like it is moving along that similar trajectory [as other CMS initiatives]. CMS really is adopting CDC guidelines in terms of infection prevention.”

The long arm of the law?

Indeed, though CMS officials seem somewhat reluctant to say it quite directly, the agency is essentially codifying the voluntary infection control guidelines by the Centers for Disease and Prevention. The agency was involved in creating the CMS survey questions and the draft document is under review by the CDC’s Healthcare Infection Control Practices Advisory Committee (HICPAC). Though the CMS may be wary of being perceived as the “infection control police,” there is growing national impatience with the status quo of strictly voluntary guidelines in a new era of patient advocacy and healthcare reform.

“The questions from the tool were primarily chosen from the CDC guidelines as well as

continued on p. 136

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Editorial Questions

For questions or comments, call **Gary Evans** at (706) 310-1727.

CMS plays 20 questions: Know these answers

A draft hospital inspection tool developed by the Centers for Medicare and Medicaid Services (CMS) instructs surveyors to ask infection preventionists the following questions. The objective of the survey is to "broadly assess the infection control program and systems in the facility; evaluate communications structure(s), program processes, supporting systems, and the integration between the Infection Prevention and Control program and other key hospital programs."

Questions

1. Please tell me about the IC program from a process perspective i.e. how do you learn about specific cases of hospital associated infections, patients needing isolation precautions, unsanitary conditions etc., and what processes do you follow to track and address these concerns?
2. Please tell me about the Infection Prevention and Control program structure.
3. How is your (IC) time organized in a typical workweek?
4. Tell me about the process for development of the infection control plan including when and how often is it developed, is it based on a risk analysis, who participates in its development, who approves the plan, when is each plan effective?
5. Tell me about ongoing infection control activities that you monitor that are not linked to the QAPI program.
6. Who participates in the development of infection control program related policies and procedures and who approves new policies or updates?
7. How do you ensure that the hospital environment is sanitary?
8. What systems and processes does the hospital use to ensure each of the following:
 - Prevention of infections and communicable diseases
 - Investigation of infections and communicable diseases
 - Control of infections and communicable diseases.
9. Tell me about the infection control log, i.e. what goes into the log and how is it utilized within infection control program activities?
10. Tell me about the following systems dealing with infections and communicable diseases (whether hospital acquired or not):
 - Systems for identifying infections and communicable diseases?
 - Systems for reporting infections and communicable diseases?
 - Systems for investigating infections and communicable diseases?
 - Systems for containing and controlling infections and communicable diseases?
 - What is the screening process for patients presenting in the ED and for new admissions
 - What is the bed management process for patients placed on an isolation status?
 - What is the hand-off process to communicate isolation status and is that hand-off process consistent throughout the hospital?
11. How are healthcare personnel (HCP) trained in infection control systems, processes, practices, strategies? —How often —Competency assessments? —Documentation?
12. Tell me about the communications systems between the infection control program and QAPI?
13. Looking at the facility layout, which areas are not included in Quality Assessment and Performance Improvement (QAPI) activities related to infection prevention and control? Ask as open ended first, and then ask about specific areas.
14. What are the infection control related QAPI indicators for select units and service areas? (Include outpatient services and contract services)
15. Is the hospital tracking the infection prevention/control quality indicators in contract areas (if applicable)?
16. Tell me about infection prevention/control patient safety activities.
17. What were the last two hospital acquired infections that were serious preventable adverse events in the hospital (i.e. patient harm or death following development of the infection).
18. What was done about each of the last two serious hospital acquired infections?
19. Describe the antibiotic stewardship program, if one exists, and efforts to prevent MDROs.
20. Tell me about infection prevention/control training process for non-paid staff, environmental staff, and clinical staff i.e. how often, how much is covered, and are competencies assessed and documented in personnel files or elsewhere? ■



other nationally recognized guidelines such as the AORN," explains **Karen Hoffmann**, RN, MS, CIC, infection prevention specialist at the CMS and one of the principals behind the survey program. "These guidelines of course are generally recognized as standards of practice. They

won't be any big surprise to the infection preventionists. We created this set of questions and tools to reflect all areas of the hospital."

Asked if there were nevertheless some elements of a dreaded "unfunded mandate" in all this, Hoffman emphasized that the CMS expects administrative support for the IPs facing the inspectors and their questions.

"Hospital administration plays an important role in infection control with administrative support and financial resources to make infection control an institutional priority [and] really to see that the measures on this tool are actually in place and implemented," she tells *HIC*. "I don't think that this is going to create a burden or a problem. In actuality, it is going to be a real asset to them — used as a self-assessment tool. It represents the minimal standards of infection control practice."

Still, the process outlined in the CMS survey is anything but cursory, calling for two surveyors to do a thorough review that is expected to take two days. Moreover, the draft survey instructions encourage inspectors to "drill down" on identified problems and look for deficiency patterns across units and practices.

"This might include widening [inspection] scope, conducting additional staff or patient interviews, making additional observations, and/or reviewing policies, procedures, addi-

tional records or other pertinent documentation," the CMS survey advises inspectors. "For example, hand hygiene concerns noted while observing patient treatment or health care worker activities should prompt the team to widen the scope of review related to hand hygiene. Is this a concern on other units? Are competencies related to infection control practice documented and up to date in personnel files? Do hospital policies and procedures reflect current practice in the hospital, i.e. is the hand hygiene concern limited to one practitioner or broadly to hospital infection control processes and systems? Surveyors are not limited to the use of the tool and are encouraged to use their judgment and survey expertise in assessing infection control compliance."

Attacking a longstanding problem

The onsite, random survey follows a flurry of other CMS reporting and pay-for-performance initiatives aimed squarely at the longstanding

problem of health care associated infections (HAIs). For example, in order to receive full CMS Medicare payments in 2012 dialysis facilities must submit three months of data on infec-

"These guidelines of course are generally recognized as standards of practice. They won't be any big surprise to the infection preventionists. We created this set of questions and tools to reflect all areas of the hospital."

Karen Hoffman, RN, MS, CIC

tions and antibiotic use to the CDC's National Healthcare Safety Network. (*See related story, p. 139.*) The aggressive CMS agenda is part of broader federal public health efforts including the Department of Health and Human Services (HHS) national "Action Plan to Prevent Healthcare-Associated Infections." In addition, the recently formed broad collaborative dubbed the Partnership for Patients has the stated goal of decreasing healthcare acquired conditions by 40% in the next two years. With HAIs comprising a major portion of those events, the CMS seeks a dynamic new approach to infection prevention.

continued on p. 138

A snapshot of the CMS inspection program

A draft inspection tool for hospital infection control developed by the Centers for Medicare and Medicaid Services (CMS) includes the following key elements.

42 CFR 482.42 Condition of Participation (CoP): Infection control: The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases.

(a) Standard: Organization and policies. A person or persons must be designated as infection control officer or officers to develop and implement policies governing control of infections and communicable diseases.

(1) The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel.

(2) The infection control officer or officers must maintain a log of incidents related to infections and communicable diseases.

(b) Standard: Responsibilities of chief executive officer, medical staff, and director of nursing services. The chief executive officer, the medical staff, and the director of nursing services must—

(1) Ensure that the hospital-wide quality assurance program and training programs address problems identified by the infection control officer or officers; and

(2) Be responsible for the implementation of successful corrective action plans in affected problem areas.

The survey: This Infection Control Tool provides a new survey structure for assessing hospital compliance with the Infection Control CoP. Use of the tool should not replace the important critical thinking skills that surveyors use in the full and comprehensive evaluation of each hospital's infection control program, and is not intended to limit survey process. If surveyor's observations raise concerns, they can widen scope, review medical records, review policies and procedures, and/or conduct additional interviews to deepen their level of inquiry in order to assess potential infection control deficiencies.

Use of the tool can improve the CMS survey process by standardizing the approach, providing a consistent, evidence-based framework for focused surveyor observations, and standardizing and simplifying important survey documentation. The pre-test period is intended to evaluate the efficacy and ease of use of the tool, use surveyor feedback and input to improve the tool, and determine its impact on the hospital's infection control efforts. Your participation

in the pretest involves change that can be difficult and a new survey process that is structured. It does, however, provide an opportunity for you to give your opinion on how to make this tool a welcomed addition for your colleagues when it is finalized.

Modules and sections: The questions are organized into sections (e.g. hand hygiene) and the sections are organized into Modules (e.g. Critical Care Module). The modules and sections are designed and organized to assist surveyors in the assessment of compliance with the CMS infection prevention and control requirements. Some sections that are labeled "tracers" are meant to highlight specific procedures or activities that can cause infections.

These "tracers" include questions concerning hospital prevention activities for CAUTI (catheter associated urinary tract infection), SSI (surgical site infection), CLABSI (central line associated blood stream infection), and VAP (ventilator associated pneumonia). This is not an exclusive list of HAIs that hospitals should address in their programs. Hospital infection prevention and control programs must also include provisions to address other infectious disease such as MRSA, *Clostridium difficile*, hepatitis, TB, and influenza.

Five Modules:

- 1: Program Scope and Design
- 2: General Location
- 3: Critical Care
- 4: Invasive Procedures
- 5: Environmental Services and Sterile Reprocessing

• Note that Modules 2, 3, and 4 include the same initial nine sections (hand hygiene, injection practices and sharps safety, environmental cleaning, personal protective equipment, point of care devices, noncritical device reprocessing, single use device reprocessing, urinary catheter tracer, and central line tracer).

Survey Process: After the entrance conference and hospital tour, one surveyor begins the interview process using Module 1 (suggested "open ended" questions) and the other begins to complete Modules 2-5. With guidance provided in Module 1 of the tool, surveyors evaluate the infection prevention and control program (based primarily on interview and review of documentation) including:

- Infection control/prevention program and resources
- Systems to identify, report, investigate, and control communicable disease and infection
- Systems to control transmission of MDROs, promote antibiotic stewardship, and surveillance
- Personnel education system/infection control training

CMS questions for employee health

For the infection preventionist who also covers occupational health, the draft hospital inspection guideline by the Centers for the Medicare and Medicaid Services (CMS) includes an evaluation of employee health programs. The CMS survey tool lists these discussion points and questions to ask employee health professionals and education directors:

- Tell me how health care workers are trained in infection control systems, processes, practices, and strategies? (How often; Competency assessments; Documentation)
- Tell me about the hospital system for identifying and addressing employee exposure events including blood-borne pathogen exposure events, needle-sticks, and other sharps incidents.
- Tell me about the hospital system for addressing employee post exposure evaluation and follow up.
- Tell me about the hospital system for tracking and trending health care worker infection exposure events.
- Tell me about the system in place for providing Hepatitis B vaccine to health care workers? What personnel are excluded? Are non paid personnel screened?
- Tell me about the system in place for screening and addressing tuberculosis.
- Tell me about the system in place for respirator fit testing and storage/availability of respirator equipment.
- Are HCP offered annual influenza vaccine and does the hospital track success rates for HCP who get the vaccine?
- Tell me about the system in place for respirator fit testing and storage/availability of respirator equipment.
- Are HCP offered annual influenza vaccine and does the hospital track success rates for HCP who get the vaccine?
- Tell me about infection prevention/control training process for non-paid staff, environmental staff, and clinical staff i.e. how often, how much is covered, and are competencies assessed and documented in personnel files or elsewhere?

continued from p. 136

“We want to focus more on the bedside — on the patients and procedures — than has been done in the past,” says **Daniel Schwartz**, MD, MBA, chief medical officer of the CMS Survey and Certification Group. “We don’t want the surveyors sitting in a room scouring through policies and procedures for four to six hours.”

In that regard, the CMS instructs surveyors to trace and observe patient care during an entire episode of care.

“Those patient tracers are meant to emphasize some of the HAIs that are mentioned in the HHS action plan — MRSA, C. diff and surgical site infections,” he tells HIC. “We want the surveyors out looking at how the hospital is trying to prevent those infections from being transmitted. That’s kind of the change here. We are asking the question: What is the hospi-

tal doing to prevent these infections?”

The survey tool describes the patient tracing component as follows:

“During a surgical procedure or endoscopy, the surveyor should follow the patient through the pre-procedure holding area, into the operating room or endoscopy suite, and then into the post-procedure holding area,” the document reads. “For a radiology test, such as a CT scan, the surveyor should be present at the patient’s room when the patient is transported to the radiology department and then remain with the patient as they are returned to their room. If a patient on contact precautions must have a test done in a location other than their room, the surveyor should be present as the patient is taken for the test and as they are returned to their room. This allows the surveyor to assess infection control and prevention of infection transmission in all locations

and by all healthcare personnel involved in that episode of care.”

In addition, the CMS is distributing the survey tool to the Joint Commission and other accrediting organizations, meaning the same approach and similar questions may be asked during an accreditation survey typically done every few years to deem CMS condition of participation status.

“They are certainly welcome to use the tool although there is no requirement that they do so,” Schwartz says. “The [CMS inspections] are unannounced.”

At least at this juncture, the program is more of a consultation and no penalties or citations are expected to be levied. “The only things that we would cite them for is if ‘immediate [patient] jeopardy’ is seen,” he says. “We certainly couldn’t ignore that.”

Again, all aspects of the survey and inspection process reflect requirements and expectations already in place in the CMS conditions of participation, he emphasizes.

“The health and safety standards have not changed so this really should not be a burden on the hospitals,” he says. “The expectation here is that they are paying attention to infection control and infection prevention in their facilities. This is just a way for the surveyors to best assess that condition of participation.”

After the testing phase and survey revisions, CMS surveyors will begin training in earnest before flanking out to the nation’s hospital infection prevention programs. “We’re planning in-person training in Baltimore probably in the March [2012] timeframe,” Schwartz says. “After the training this [will expand to] all 50 states. We are going to ask each state to use each tool at least once by the end of the fiscal year 2012.” ■

CMS and CDC target infections in dialysis

Reimbursements linked to surveillance

In the latest in a remarkable surge of infection prevention initiatives, the Centers for Medicare and Medicaid Services (CMS)

is partnering with the Centers for Disease Control and Prevention to prevent health-care associated infections in dialysis facilities.

The initiative includes a new CMS requirement for dialysis facilities to submit three months of 2012 infection and antibiotic use data to CDC’s National Healthcare Safety Network (NHSN) in order to receive full Medicare payment. This is the first CMS/CDC data collaboration related to dialysis settings. However, the two agencies have been aligning patient safety efforts on multiple hospital quality measures.

In 2008 data, hemodialysis patients acquired some 37,000 central-line associated bloodstream infections (CLABSIs), the CDC reports. In addition, within the last decade there have been more than 30 outbreaks of hepatitis B and hepatitis C in non-hospital healthcare settings that include dialysis centers. The CDC is providing several new resources to dialysis facilities and patients to ensure smooth NHSN enrollment and improved quality care. These include a new dialysis safety web site including infection prevention recommendations, as well as step-by-step NHSN enrollment and training materials. (*See editor’s note, p. 140.*)

There are thousands of free standing dialysis centers in the U.S., owned primarily by the major corporate chains in the field. To a lesser degree, dialysis services are offered by or affiliated with hospitals. Hospital based IPs that fall in this category should prepare to begin reporting data, while the regulation for freestanding clinics would seem to provide a new opportunity for IP consultants.

“We have a dedicated dialysis unit so we are already looking at this new pay for reporting initiative as something we are clearly planning to comply with,” says **Russ Olmsted**, MPH, CIC, an infection preventionist at St. Joseph Mercy Health System in Ann Arbor, MI. “We actually already have our dialysis unit enrolled in NHSN and they are reporting.”

The substantial number of CLABSIs among hemodialysis patients is also a problem for hospitals, as the infections are a

major cause of admissions and readmissions. A primary prevention measure is the avoidance of central lines in favor of arteriovenous fistulas for dialysis patients.

"If a [dialysis] patient develops a bloodstream infection, inevitably they are going to be admitted to a nearby hospital," Olmsted says. "The way I interpret this updated pay for reporting rule, if you didn't have a dedicated dialysis unit in your hospital it should have minimal impact in terms of needing to report this. But certainly if you have a dialysis facility within your scope of service then there is a pretty significant incentive to go ahead and begin reporting this data if you are not already."

Infection prevention measures

CDC recommendations to prevent infections in hemodialysis include the following:

Surveillance and feedback using

NHSN: Conduct monthly surveillance for BSIs and other dialysis events and enter events into CDC's NHSN. Calculate facility rates and compare to rates in other facilities using NHSN. Actively share results with front-line clinical staff.

Hand hygiene surveillance: Perform monthly hand hygiene audits with feedback of results to clinical staff.

Catheter care/ vascular access observations: Perform quarterly audits of vascular access care and catheter accessing to ensure adherence to recommended procedures. This includes aseptic technique while connecting and disconnecting catheters and during dressing changes. Share results with front-line clinical staff.

Patient education/engagement: Provide standardized education to all patients on infection prevention topics including vascular access care, hand hygiene, risks related to catheter use, recognizing signs of infection, and instructions for access management when away from the dialysis unit.

Staff education and competency: Provide regular training of staff on infection control topics, including access care and aseptic technique. Perform compe-

tency evaluation for skills such as catheter care and accessing at least every 6-12 months and upon hire.

Catheter reduction: Incorporate efforts (e.g., through patient education, vascular access coordinator) to reduce catheters by identifying barriers to permanent vascular access placement and catheter removal.

Chlorhexidine for skin antisepsis: Use an alcohol-based chlorhexidine (>0.5%) solution as the first line agent for skin antisepsis, particularly for central line insertion and during dressing changes. Povidone-iodine, preferably with alcohol, or 70% alcohol are alternatives.

Catheter hub cleansing: Cleanse catheter hubs with an appropriate antiseptic after the cap is removed and before accessing.

Antimicrobial ointment or chlorhexidine-impregnated sponge dressing: Apply bacitracin/gramicidin/polymixin B ointment or povidone-iodine ointment to catheter exit sites during dressing change OR use a chlorhexidine-impregnated sponge dressing.

[Editor's note: The CMS rule is available at <http://bit.ly/sdENgT>

To enroll a dialysis facility in NHSN, visit <http://1.usa.gov/s4rRBX>

To view new CDC dialysis safety website, visit <http://1.usa.gov/rCyyXe> ■

Politically incorrect: OSHA ID reg stalled

Economy, politics blunts reg agenda

Growing anti-regulatory pressure in a down economy — to say nothing of presidential politics as an election year looms — are making it exceedingly difficult for the Occupational Safety and Health Administration (OSHA) to advance its controversial proposed infectious disease standard to protect health care workers.

As we previously reported in *Hospital Infection Control & Prevention*, OSHA is strongly considering a proposed rule that

would address airborne, droplet and contact transmission in health care settings. Occupational infections during the SARS epidemic and the H1N1 pandemic spurred the agency interest, though many infection preventionists immediately came out against the idea.

The general concern is that flexible and evolving Centers for Disease Control and Prevention guidelines are better designed to address a moving target like infectious diseases than rigid OSHA standards. The issue is reminiscent of OSHA's previous failed attempt to create a standard to protect health care workers from tuberculosis.

"While the agency learned a great deal from the previously proposed tuberculosis rule, the agency is considering the current infectious disease activity in the larger context of standard and transmission-based precautions rather than on a disease-by-disease basis," OSHA stated.

While the infectious disease proposed rule is in its early stages, OSHA initiatives that were much closer to finalization have also been stalled out by the current economic and political climate. For example, a record-keeping rule that would add a column to the OSHA 300 log for musculoskeletal disorders (MSDs) seemed on a fast-track in 2010, with implementation scheduled for 2011. However, it became mired in an unusually lengthy review in the Office of Management and Budget, and OSHA withdrew the rule. The agency gathered more comments and was expected to reissue it in time for the rule to become effective in 2012. It remains in limbo.

"I've been amazed at the extent to which OSHA's agenda has been affected," says **Brad Hammock**, an attorney with Jackson Lewis in Reston, VA, who specializes in occupational health law and was counsel for safety standards at OSHA from 2005 to 2008. "There's never one thing that causes a delay in a regulatory initiative by OSHA. There are things that go on behind the scenes that have nothing to do with politics. It could be something as simple as difficult technical issues with a rule. But I suspect it's

a combination of a lot of things [including politics]," he says.

Republicans have put OSHA in their sights as they criticize "job-killing" regulations.

"We're coming up to an election year. Jobs are the top issue in the upcoming election and a dominant theme has been government creating an atmosphere where jobs can be created. OSHA has been an easy whipping boy, like the EPA [Environmental Protection Agency], for that theme," says **Eric J. Conn**, an attorney who heads the OSHA group at Epstein Becker and Green in Washington, DC. ■

New spotless spotlight shines on EVS workers

Housekeepers are part of 'medical team'

Cleaning patient's rooms may not seem like the most important job in the hospital. But environmental service workers save lives in their own way — by preventing the spread of infections. A new spotlight on their role may boost the resources, communication and training focused on this group of workers.

Environmental service workers save lives in their own way — by preventing the spread of infections.

"Clean Spaces, Healthy Patients," a national initiative of the Association for Professionals in Infection Control and Epidemiology (APIC) and the Association for the Healthcare Environment (AHE), stresses the links between infection control professionals and environmental services.

Within hospitals, the departments are becoming aligned. Although employee health isn't a formal part of the APIC/AHE initiative, EH professionals are often part of the dialogue, as well.

"Historically, we have been two of the departments in health care that have been

under-resourced," says **Marita Nash**, MBA, CHESP, director of Environmental Services and Linen at Hunterdon Medical Center in Flemington, NJ, and a member of the Clean Spaces advisory panel. "Together, we solicit the resources to address that need."

Meanwhile, the Service Employees International Union (SEIU), which represents more than 1 million health care workers, has been training hospital-based environmental services workers in green practices — and in some basics about the difference between cleaning and disinfection and the problem of healthcare-acquired infections.

"We're giving them a fundamental understanding of the importance of their role," says **Bill Borwegen**, MPH, health and safety director of SEIU in Washington, DC.

Microbes on mouses

The surfaces in a patient room and the nurses' station are prime culprits for fomite spread of infectious diseases, and research has increasingly found microbes on common items: stethoscopes, bed rails, computer keyboards, telephones. Studies have even found bacteria on doctors' neck ties¹ and doctors' coats and nurses' uniforms.²

Better training of housekeepers can reduce the contamination. A study at Rush Medical Center in Chicago found that training and monitoring of housekeepers improved the cleaning of surfaces in patients' rooms — and reduced the transmission of vancomycin-resistant enterococci (VRE).³

At Hunterdon Medical Center, the training includes sessions on communication among professionals and non-professionals — an effort to break down the hierarchical barriers. Environmental service workers are part of the "medical team" on a unit, says Nash.

That integration should occur even if a hospital uses a contractor for environmental services, says Nash. Those workers still have a commitment to doing the job correctly, she says. And the hospital still has a manager who oversees environmental services and can work closely with infection control and

employee health, she says.

Green means less risk

Environmental services workers also must learn how to protect themselves from the chemicals they use to decontaminate the rooms. For example, Hunterdon has eliminated most trigger spray bottles, which can aerosolize the cleaning solutions. If a spray bottle is used, the workers spray it onto a rag rather than on the surface, Nash says.

SEIU is promoting the use of less toxic, "green" cleaners, which pose less health risk to the workers as well as others in the health care environment. But the environmental service workers need to understand how to properly use the products, such as how long they must stay on a surface before being wiped off, says Borwegen. "It's important that these workers be properly trained," he says.

Yet there are potential barriers. "These are some of the lowest paid workers in a health care facility," Borwegen says. "In many instances, they're contracted workers — they're not even employees of the hospital. They're predominantly an immigrant population. English may not be their first language."

It's important to use educational materials that have a lot of graphics and pictures, he says. Nash sometimes uses interpreter services, and she adjusts her training to accommodate those who have learning disabilities or literacy problems. For example, they may learn from observing and then demonstrate their competence, she says.

Monitoring quality of cleaning

At Hunterdon, there's an information loop from infection control to environmental services. In an environmental services audit, infection control swabs six surfaces in patient rooms to detect adenotriphosphate (ATP), an indicator of organic matter. They test different surfaces on different shifts in about 30 to 40 rooms a month.

"Right now, we are swabbing the overbed

table control knob, blood pressure cuff, the arms on the patient chair, telephone, toilet seat in the bathroom, and the light switch in the bathroom," says Nash.

The monitoring demonstrates the effectiveness of the environmental services staff. Infection control professionals often comment on the cleaning. "They'll stop and say, 'Thanks for doing such a great job.' That means more to my staff than anything in the world," says Nash.

And by teaming up, infection control and environmental services support each other. For example, Nash recently hired an employee for the night shift who cleans keyboards, computer mouses, telephones, medical record covers, and other such surfaces.

Of course, the users of those devices are expected to clean them regularly, as well, says Nash. The hospital provides germicidal wipes. "The culture [at our hospital] is that cleaning is everyone's responsibility," she says.

[Editor's note: More information about "Clean Spaces, Healthy Patients," including links to resources, is available at www.apic.org/cleanspaces.]

REFERENCES

1. Day, M. Doctors are told to ditch "disease spreading" neckties. *BMJ* 2006; 332: 442.
2. Wiener-Well Y, Galuty M, Rudensky B, et al. Nursing and physician attire as possible source of nosocomial infections. *AJIC* 2011; 39:555-559.
3. Hayden MK, Bonten MJ, Blom DW, et al. Reduction in acquisition of vancomycin-resistant enterococcus after enforcement of routine environmental cleaning measures. *Clin Infect Dis* 2006; 42:1552-1560. ■

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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. ■

COMING IN FUTURE MONTHS

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■ Reassessing liability issues after \$162 million ruling on HCV infections in Vegas

CNE/CME Questions

1. The Centers for Medicare and Medicaid Services (CMS) announced it will give hospitals a minimum of two-weeks notice before an inspection is conducted using its new infection control survey tool.
 - A. True
 - B. False
2. According to Daniel Schwartz, MD, MBA, chief medical officer of the CMS Survey and Certification Group, the survey program will not currently be used to cite hospitals unless surveyors determine patients are in:
 - A. unclean rooms
 - B. immediate jeopardy
 - C. isolation for no reason
 - D. all of the above
3. The CMS patient tracer component of its survey expressed particular interest in which infection?
 - A. catheter associated urinary tract infections
 - B. surgical site infections
 - C. central line associated blood stream infections
 - D. all of the above
4. New CMS requirements for dialysis facilities require submission of three months of infection data to the CDC's National Healthcare Safety Network in order to receive full Medicare payment.
 - A. True
 - B. False

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2011 Index

Abstract & Commentary

CDC guidelines for group B strep in neonates, FEB:22
Flawed data mar reports of CA-BSIs, JAN:10

APIC

CEO Katrina Crist Q&A: AUG:92
Cites ethical duty to mandate flu shots, MAR:43
Healthcare environment a top research target, AUG:88
Stresses link between IC and environmental services, DEC:141
Urges FDA to ban powdered gloves, JUN:70

Agency for Healthcare Research and Quality (AHRQ)

Casts wide net with \$34 million HAI initiative, MAR:27
Projects are part of HHS action plan; MAR:25

Blood glucose monitoring

CDC guidelines to prevent transmission during, OCT:113
CDC may urge HBV vaccination for diabetics, OCT:109.
Clinic contacts 2,345 patients after devices reused, OCT:116
IPs develop glucometer cleaning protocol, OCT:117
Q&A on finger stick devices, other issues, OCT:114

Central line associated bloodstream infections (CLABSIs)

CDC urges patients to ask about, MAR: 39
Checklists reduce mortality in elderly ICU patients, MAR:30
Gram-negative bugs elude CLABSI prevention, MAR: 40
Preventing in hospital wards and hemodialysis settings, APR:37
Unit drives CLABSIs to zero, JUL:78

Centers for Disease Control and Prevention

Addresses rising tide of gram negatives, SEP:102
Group B strep in neonates guidelines, FEB:22
Sets a new standard measure for HCW flu shots, SEP:106
Urges patients to ask about CLABSIs, MAR: 39
Vermont reports long-term care infections to, JUN:61

Centers for Medicare and Medicaid Services (CMS)

Planning unannounced infection control inspections, DEC:133
Hospital inspection survey questions: DEC:135
CMS going beyond ambulatory care survey: JUL:76
CMS pressure leads to prompt removal of catheters, SEP:97

Cuts motivate infection prevention, SEP:99
Employee health questions in hospital survey, DEC:138
Finalizing hospital infection control inspection plan, DEC:137
IPs can leverage CMS mandates:JUL:73
Promises “aggressive action” on HAIs, FEB:16
Snapshot of the hospital inspection program, DEC:137

Department of Health and Human Services (HHS)

AHRQ projects part of its HAI action plan; MAR:25
Long term care to be priority in HHS plan, MAY: 54

Emergency Department

Active screening for MRSA may not be effective, FEB:18

Endoscopy

New reprocessing guidelines reassure public about rare infections, JUL:82

Food and Drug Administration

Mulls glove ban powdered gloves, JUN:70

Flu shot mandates

Pressure builds for mandatory policies, FEB:19

CDC narrows egg allergy exception to flu shots, OCT:118

Gram negative infections

CDC Addresses rising tide of gram negatives, SEP:102
CDC recommendations to prevent carbapenem resistance infections, JAN: 4
Fatal NDM-1 infection, transfer of resistant plasmid, JAN: 5
Global problem of waning antibiotic efficacy, MAY:55
KPC becoming widespread, JAN:1
Maryland links long term care, hospitals to prevent, MAY: 52
Move between facilities on patient transfers, NOV:129
Persistent colonization in long term care residents, MAY:49
Rise related to drug prescribing practices, JAN: 7

H1N1 pandemic flu

HCWs infected often not wearing protective gear, FEB: 20

Hand Hygiene

Hospital issues \$1,000 fines for failure to wash hands, MAR: 45

Healthcare Associated Infections (HAIs)

IPs credited for dramatic drop in some HAIs, NOV:121
Reporting climbs, will prevention follow, SEP:100
Transition to an electronic record system spurs increase, NOV:130

Healthcare continuum

Gram negatives move between facilities via patients, residents, NOV:129

Infection control research expands out across, MAR:29
Maryland links long term care, hospitals to prevent infections, MAY: 52
UTIs kicked out of rehab, JUL:80

Hepatitis

CDC may urge HBV vaccination for diabetics, OCT:109.
CDC recommendations on HBV vaccination, OCT:111

Infection Preventionists

Bringing the IP to the bedside, AUG:85
Creative IPs use duct tape to save \$100,000, JUL:79
Credited for encouraging HAI reductions, NOV:121
Data collection demands hinder role in patient care, AUG:91
Develop glucometer cleaning protocol, OCT:117
IPs in long term lack training, part-time, JUN: 63
Raising the IP profile through educational campaign, AUG:87

Legionella

Controversial study suggests electronic faucets increase risk, MAY:57

Long term care

Many IPs in long term lack training, part-time, JUN: 63
Infection control woes linked to inadequate staffing: JUN:68
Isolation challenges with infected or colonized residents, JUN:67
States target infection control regs in nursing homes, JUN:64

Measles

Arizona hospital outbreak laborious and expensive, AUG:94

OSHA

Decides mandatory flu shots OK, with a caveat, MAR:44
Director says infectious disease standard needed to protect HCWs, JUN:72
Inspects outpatient centers for needle safety devices JUL:81
Moves forward with controversial infectious disease reg, SEP:104
Political climate, economy stall ID reg, DEC:140

Patient isolation

Confirming that MDRO patients are in isolation, NOV: 125
Keys to isolation compliance, NOV:126

Pediatric infection control

Presents unique challenges, FEB:13

Personal Protective equipment (PPE)

Many HCWs don't know the correct sequence to don, NOV: 128

Pertussis

CDC responds to outbreaks with new recommendations, MAY:58

Transplants

Rise of drug-resistant bugs threatens transplant patients, MAR:31

Ventilator Associated Pneumonia (VAP)

Intervention measures similar to CLABSI checklist reduce VAP, MAR:41