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In this issue: JCAHO Update for Infection Control

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# New standards, surprise inspections demonstrate JCAHO's emphasis on IC

*2005 draft standards return to 'prescriptive' approach*

The Joint Commission on Accreditation of Healthcare Organizations has raised the ante again on infection control professionals, drafting prescriptive new standards for 2005 and putting the field at the top of the list for surprise inspections next year.

"With the whole new accreditation process — Shared Visions / New Pathways — we are trying to focus on the most important issues related to quality and safety of care," says **Carol Gilhooley**, director of accreditation process improvement at the Joint Commission. "Infection control has risen to the forefront."

The Joint Commission has targeted infection control as a "critical focus area" for 2004 random, unannounced surveys. **(See related story, p. 99.)** The latest developments continue its unprecedented focus on infection control, including formation of a special committee of epidemiologists last year after ICPs protested a proposal to consolidate and reduce the number of infection control standards in 2004. **(See *Hospital Infection Control*, December 2002, under archives at *www.HIConline.com*.)**

The 2004 standards now are largely unchanged from this year **(see supplement, p. 103)**, but the standards proposed for 2005 are much more specific regarding program description and documentation. **(See draft standards, p. 100.)**

The requirements include a written plan "that identifies priorities, focuses the activities, and evaluates the efficacy of the program based on identified risks and risk-reduction strategies."

In issuing the proposed 2005 standards, the Joint Commission cited Centers for Disease Control and Prevention (CDC) estimates that there are approximately 90,000 nosocomial infection-related deaths in the United States each year. "The importance of infection prevention and control to the safety, as well as the quality, of patient care suggested the need for a complete review of the Joint Commission's current infection control standards," **Dennis O'Leary**, MD, Joint Commission president said in a statement.

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"In many instances, the standards would retain their current focus but become more prescriptive in nature. The overall intent of these standards revisions is to place greater emphasis on infection control problem identification and active intervention," he added.

With input from the expert panel, the Joint Commission identified the following six critical infection control areas:

- staffing and personnel issues;
- adherence to national guidelines;
- employee health;
- data collection and analysis;
- the environment of care;
- infection control program evaluation.

### *Too much busy work?*

The new prescriptive approach and focus on documentation has not been well received by some ICPs.

"Every minute spent writing policies and procedures and disseminating information on written paper is that much time taken away from real work, [such as] surveillance and education," says **Helen Litvack**, RN, MSN, CIC, nurse epidemiologist at Vassar Brothers Medical Center in Poughkeepsie, NY. "To sit and write all of that stuff is a full-time job and does not ensure quality. I mean, every day we are dealing with a new disease — real problems that show up in the emergency room. It's ridiculous."

But others in the field note that ICPs can't have it both ways, protesting when the Joint Commission standards appear either to be shrinking or expanding. Joint Commission requirements, as many have long observed, are probably the only reason infection control has survived as a profession.

"Let's face it, [ICPs] got real concerned when the infection control standards started getting too thin and too vague," says **Ona Montgomery**, RN, MSHA, CIC, infection control coordinator at the Department of Veterans Affairs Medical Center in Amarillo, TX. "Infection control programs didn't get much support until the Joint Commission started requiring them in their standards."

That said, it has always been difficult to measure and demonstrate an infection prevention's program efficacy, she concedes.

"[The standards] are more prescriptive, but I like the fact that they have specifically required a written, prioritized program plan," Montgomery says. "Over the years, it has sort of been assumed that's what you would have, but it really hasn't been written in the standards in a long time."

One of the recurrent areas of emphasis is that the infection control program must be collaborative, applying to "all programs, services, and settings" within a hospital.

"What we are trying to do is to get people to look at systems and processes in an integrated fashion," Gilhooley explains. "

So when they are looking at infection control, they are looking at organizationwide communication, staffing, and all of the things that impact infection control. Not just a policy or procedure

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that they have in a book," she points out.

The proposed standards emphasize that the nature of infection control places responsibility for prevention activities among "all departments and individuals" in an institution.

"People tend to think that the infection control program belongs to them, and if there is a problem it is their fault or responsibility," says **Ruth Carrico**, RN, MA, CIC, director of infection control at the University of Louisville (KY) Hospital. "To me, the way the Joint Commission is leaning is continuing to stress the infection control program goes across all hospital functions. It takes the 'I' out of infection."

The Joint Commission proposed standards also emphasize that the written plan has to be readily accessible to staff, which could be a key step in broadening infection control responsibilities hospitalwide, Montgomery notes.

"[If] the infection control responsibilities reside throughout the organization, then everybody should be able to see how they fit in," she said. "That is something that we have probably not done well in all of our programs. I don't know that just making it accessible to staff does it, but I think the intent is that more of the rank and file know where they fit into the infection control program."

On the other hand, Montgomery questions why so many elements of employee health fall under the responsibility of infection control in the proposed standards.

"I am struck by how much employee health information and content is in this standard, and yet there is no occupational health standard per se within the Joint Commission system," she adds. "Although they talk repeatedly about the elements of employee health that impact on infection prevention, they don't address the infrastructure for employee health."

In addition, the standards only generally refer to the need for "effective" infection control staffing, leaving institutions to be the arbiters of that effectiveness.

"I was hoping there would be a little bit more content on how to assess appropriate staffing,"

*(Continued on page 101)*

## A few ICPs will receive a JCAHO surprise party

*Infection control targeted for random inspection*

The Joint Commission on Accreditation of Healthcare Organizations' move to target infection control in surprise inspections next year could actually help ICPs in programs that lack administrative support, observers note.

"An organization that has not been supportive of infection control is going to have to really reevaluate that because certainly it is being recognized as an important aspect of patient outcomes," says **Susan Kraska**, RN, CIC, an ICP at Memorial Hospital of South Bend, IN.

In that regard, struggling ICPs should make their organization aware that infection control is moving front and center on the Joint Commission radar. "Absolutely, I would be cutting out every article and sending e-mails to the front office if that was my situation," she says.

The Joint Commission has deemed infection control a "critical focus area" for 2004 random, unannounced surveys. While only a random 5% sample of accredited organizations are subject to the surprise inspections, infection control also will face scrutiny during regularly scheduled surveys.

"It's not just unannounced; it's the full survey as well," says **Carol Gilhooley**, director of accreditation process improvement at the Joint Commission. "We will look at things like surveillance, prevention and control. We will actually talk to individual patients, employees, and physicians, even contract service workers and volunteers. We want to see a systemwide, integrated process. The organization has to collect data, analyze it, and do something about it — not just leave it out there hanging."

The inspections will be based on the 2004 standards **(see supplement, p. 103)**, not the recently drafted 2005 standards. The dizzying pace of activity is part of a series of sweeping standards revisions and survey process improvements known as the Shared Visions-New Pathways initiative. In addition to infection control, staffing and medication management were cited as critical areas for unannounced inspections in 2004.

Random unannounced surveys will end in January 2006 when JCAHO begins conducting all regular accreditation surveys on an unannounced basis. Many ICPs welcome the fact that infection control is now among the most critical aspects of accreditation.

"I am all for this," says **Ruth Carrico**, RN, MA, CIC, director of infection control at the University of Louisville (KY) Hospital. "The whole idea of a survey is to determine your current level of practice. We all should be practicing as if we were having a survey tomorrow. Tell them the things you do well. This is your opportunity to toot your horn." ■

# Draft standards detail policy demands for ICPs

*The nuts and bolts of a more prescriptive approach*

The Oakbrook Terrace-based Joint Commission on Accreditation of Healthcare Organizations' proposed infection control standards for 2005 include a more prescriptive approach that already is proving controversial.

Many of the requirements are detailed in the new standard IC.2.10, which outlines expectations for documentation and written policies. According to the Joint Commission draft, the written plan should be "a succinct, useful document, formulated beforehand, that identifies needs, lists strategies to meet those needs, and sets goals and objectives. The format of the plan may include narratives, policies and procedures, protocols, practice guidelines, clinical paths, care maps, or a combination of these."

For the complete infection control draft standards for 2005, go to http://www.jcaho.org/. Select "Accredited Organizations." Under "What's New for Accredited Organizations," select "Hospitals," and then select "2005 Proposed Standards."

The standard rationale and elements of performance include the following:

**Standard IC.2.10**
The organization has an organizationwide, written infection prevention and control plan.

**Rationale**
A written plan identifies priorities, focuses the activities of the program, and structures evaluation of the efficacy of the program based on identified risks and risk reduction strategies.

**Elements of Performance for IC.2.10**

1. The organization's infection prevention and control plan is in writing and is easily accessible to licensed independent practitioners (LIPs), staff, students/trainees, and volunteers.

2. The organization's infection prevention and control plan includes:
   A. A description of the responsibilities of each department/service/program/unit that has a part in the infection prevention and control program
   B. A description of the scope of the surveillance activities, which include:
      - the focus of surveillance with a description of the rationale for the focus
      - the methods of surveillance
      - tracking incidence and prevalence rates of infections
      - investigations of outbreaks of infectious diseases within the organization
      - role (if any) in community/public health surveillance
   C. Individuals (by position or name) responsible for approving actions to prevent or control the transmission of infections
   D. Systems for reporting information:
      - within the organization to the appropriate staff
      - to federal, state, and local public health authorities in accordance with law and regulation
   E. Activities for LIPs', patient staff's, students' /trainees', and volunteers' health including processes for:
      - the appropriate use of standard precautions and other applicable precautions to reduce the transmission of infectious agents between and among LIPs, patients, staff, visitors, student/trainees, and volunteers
      - an organizationwide program to address hand hygiene among LIPs, staff, students/ trainees and volunteers.
      - screening for exposures and/or immunity to infectious diseases based on demographics of the population served and/or the geographic location of the organization
      - minimizing risks associated with medical devices
      - immunization programs (if offered)
      - LIPs, staff, student/trainees, and volunteers diagnosed with an infectious disease that may put the population they serve at risk
      - LIPs, staff, student/trainees, and volunteers who have been occupationally exposed
      - the availability and use of personal protective equipment and/or clothing
      - strategies for reducing risks for infections related to the use of devices and procedures required for patient care
   F. Systems for communicating with LIPs, staff, students/trainees, and volunteers about infection prevention and control issues
   G. Processes for equipment management including:
      - appropriate cleaning, disinfection, and/or sterilization of supplies and equipment
      - the reuse of equipment designated by the manufacturer as disposable, consistent with regulatory and professional standards
      - storage

3. Infection prevention and control policies, procedures, and activities are based on guidelines and successful practices. ■

Montgomery says. "We know that there can't be an easy formula for determining staffing ratios, but you might expect somewhere it would specify that there is evidence that leadership had evaluated the appropriateness of staffing."

Given the use of more descriptive statements in the draft standards, it is somewhat surprising that the Joint Commission did not trumpet infection control as a patient safety program, she adds.

There are references to continuous quality improvement approaches but few nods to the more recent nomenclature of the patient safety movement.

"In a lot of Joint Commission publications, they are talking about that critical link between infection control and patient safety," Montgomery explains. "I didn't see that patient safety wording come out in the standards very strongly. I'm really surprised there wasn't some additional wording in the standards that emphasized that link."

Also conspicuous in its absence — not that anyone is necessarily complaining — is mention of the Joint Commission's request for reports of fatal or debilitating nosocomial infections.

The Joint Commission previously issued a *Sentinel Event Alert* instructing ICPs to "manage as sentinel events all identified cases of death and major permanent loss of function attributed to a nosocomial infection [i.e., except for the infection, the patient would probably not have died or suffered loss of function]." The move was prompted in part by press criticism that many nosocomial-related deaths occur, yet few reports are in the Joint Commission database.

"Nosocomial infections have been underreported to us," Gilhooley says. "Maybe, with this [recent] emphasis, people might start to make the connection that nosocomial infections that lead to death or serious impairment are sentinel events and, hopefully, increase reporting."

However, the request for data has been controversial, and some ICPs warned early on that the epidemiologic soundness of the request was questionable.

"I think of all things that is the most difficult to assess — whether a nosocomial infection was the proximal cause of death or permanent disability," Montgomery adds. "[But] it really surprised me that there is no real mention in these standards of infection-related sentinel events."

Though the comment period has closed, the guidelines still are subject to revision. The Joint Commission's expert infection control panel is slated to meet to discuss them in mid-August. ■

# Expert witness: Ready for a Perry Mason moment?

*Tips and tricks to know before taking the stand*

Infection control professionals considering the exciting trial by fire of being an expert witness should be ready to "think like a lawyer" and realize they are entering into a realm where there are more questions than answers, a former colleague turned attorney advised.

"When you're in infection control, you usually have answers," explained **Julie A. Savoy**, BSN, RN, JD. "You can tell them, 'This is contact isolation, or standard precautions is all you need.' Now I find that in this role, all I have are the questions. All I have are the issues. There aren't a lot of answers, and you have to become comfortable with that."

A veteran ICP who decided to make a career change and go to law school, Savoy described the role of the expert witness recently in San Antonio at the annual conference of the Association for Practitioners in Infection Control and Epidemiology (APIC).

"Being an expert witness is very exciting," she said. "It's worthwhile because you get the opportunity to really vindicate the rights of an injured individual or to be able to protect a health care provider in a meritless suit. But it's very difficult. You've got to have a good attorney team. You've got to have good preparation, and you yourself have got to be very solid to put yourself through that."

Attorneys may seek out ICP experts when a medical-related case hinges on an epidemiological issue.

"To be an expert witness, you're going to want to be the one who is up there on the stand providing that Perry Mason moment for the attorney who has employed you. They happen," added Savoy, a lawyer with the Gachassin Law Firm in Lafayette, LA.

## *The battle is joined*

But before one gets to that dramatic moment, there are legal details, gamesmanship, and the dreaded deposition. Once the legal battle is joined, there is a process called "discovery" when both sides review the facts and decide whether to negotiate a settlement or proceed to trial. Even at

this early point, ICPs may be contacted either as potential expert witnesses or as legal nurse consultants, she said. The roles are different, because the nurse consultant will not be taking the stand and providing expert testimony to the jury.

"A legal nurse consultant really works behind the scenes," she said. "Typically, they are employed on a contract basis or in some large firms on a full-time basis by the firm that does a lot of medical malpractice, defense, or plaintiff's work. They often act as kind of a paralegal."

The nurse consultant somewhat serves as a gatekeeper, considering the issues and weighing in on the legitimacy of the claim, she noted. In medical malpractice litigation, the question often is has there been a breach in the standard of care? That requires a precursor question: What is the standard of care?

"Typically, a lay jury or a judge is not expected to have that knowledge. They require the assistance of an expert to provide them with what the standard of care is and whether there was a breach in that said standard of care for a given case," Savoy said.

That's where the ICP as expert witness comes in. "Typically, if we're talking about infection control or employee health, you're going to need an expert in that area to explain to the jury what the standard is and what occurred in that particular case," she said.

The judge first will determine whether testimony of an expert to is testable, peer reviewed, and has widespread relevant scientific acceptance.

"This could be tailor-made for infection control science and epidemiology," she said. "Just about anything that you would end up being called to testify about in infection control or hospital epidemiology is going to meet these criteria. If it doesn't, you probably shouldn't be testifying."

By the same token, ICPs should not venture outside of their area of expertise when providing expert testimony. "If you're in a long-term care setting, I caution you against becoming employed as an expert in an acute case because that's a very weak spot in your translation of knowledge that the other side's going to attack," Savoy warned. "Even though you're certified and you have the basic knowledge, it's not where you practice every day."

Make sure you use relevant current, reputable references and that your opinion is based on an "objective" review of the facts. "Yes, you're being employed by them, whichever side that you choose to be employed by, but you've got to sleep at night," she said. "You have to make sure — because it's your knowledge that's going to be up there on the stand — that what you're testifying to is grounded in science."

### *The dreaded deposition*

The discovery phase of the case also includes the deposition, where the attorney from the other side asks you questions for the record. "Even this far down the road toward trial, there may be room for settlement negotiations at that point," she said. "They want to see what it is you have to say. In a deposition, they're really not going to be attacking you. They are more trying to be your buddy usually and kind of get all the information that they can out of you."

Typically, when attorneys depose expert witnesses, they will ask about qualifications, education, experience, and publications. "They want to know what expert opinions you have come to in your review of the case," she said. "They want to know what the basis of your opinions are. In other words, if you feel that there is no breach of the standard of care, what made you come to that conclusion?"

An attorney may try to determine if the witness made any assumptions in reaching an opinion because assumptions are subject to attack at trial. Depositions are difficult but not as demanding as the actual testimony and cross-examination that follows, she said.

"What we've seen from juries is that they expect the testimony that you're going to provide as an expert to be complicated. It's got to be complicated, or we wouldn't need an expert," she said.

The jury may have preconceived notions that you are going to be biased and condescending. "The best thing I can tell you is all of us in our roles every day teach and teach our co-workers and the providers that we work with," she told APIC attendees. "That's what you're going to get up there and do as an expert witness. You're going to teach the jury the science of the case and the facts, and a good attorney leads you through that process."

That is well and good, but next is cross-examination, when the opposing attorney may try to discredit you or your testimony. "Maintain your composure above all," she advised. "Do not become defensive. The jury is not stupid. They

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realize what that attorney is trying to do you. They realize [that person is] trying to confuse you. They realize [he or she] is putting things out of context. Be careful. Listen to the question. If you're working for a good attorney, you will have been well prepared at that point."

### *Don't overstate expertise*

Being ill prepared could lead to disaster, as in a case where an expert witness somewhat overstated her expertise in infection control, Savoy recalled.

"The woman was not certified; she was not a member of APIC," she said. "They're going to attack your credentials. Above all, maintain your credibility. There's nothing worse than someone who overinflates. So be very, very careful. If anything, be humble in your expertise; be confident in your knowledge, but be humble. And teach. As I said earlier, teach the jury."

Another typical strategy is to review the witness's prior positions in publications and testimony. "Have you ever testified before and said something differently than what you've said in this case?" she said. "Probably so, and maybe there was a reason for why things were different in that case. The facts were different. The hospital was different. The patient was different. But they're going to attempt to use it against [you]."

Looking for further inconsistency, the opposing attorney will compare and contrast your testimony with what was said in the deposition, she warned. "They love to throw those depositions in your face so you've got to be real familiar with your deposition testimony going in there," she added.

After cross-examination, the attorney that hired the witness has the opportunity to "redirect," essentially clarifying and restoring the proper context to the testimony. "A good attorney is going to prepare you ahead of time and pick you back up and recover you — rehabilitate the witness, so to speak — when the other side is finished with you," she said. ■

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# Scabies: A creepy bug strikes fear in workers

*Nosocomial mite outbreaks on the rise*

Forget antibiotic-resistant pathogens and even bloodborne infections. If you want to strike fear in the heart of health care workers, mention scabies.

Scabies is a transmissible infestation of the skin with a real bug, the burrowing microscopic mite *Sarcoptes scabiei.* Even after you kill them, they stay under your skin until it sloughs off.

"We have had employees take care of people with tuberculosis and meningitis, but you have something like this, and the panic was unbelievable," says **Alexis Raimondi**, RN, infection control practitioner at Beth Israel Medical Center in New York City. "They would be coming up to me, pulling up their sleeves and saying, 'Do you think this could be it?' I felt really bad for them. The itching, especially at night, is intense."

Raimondi relays a cautionary tale about a nosocomial problem that appears to be on the increase, although scabies is not a reportable condition.

According to information from the Centers for Disease Control and Prevention (CDC): "In recent years, there has been an increase in the occurrence of crusted scabies among immunocompromised patients, particularly persons with HIV, which has led to the transmission of scabies among personnel, patients, and their families."[1] **(See education handout, p. 108.)**

The first signs at Beth Israel were in a general warning from New York health officials that scabies outbreaks were occurring in long-term care. "Then it hit the hospitals," she says.

In October 2002, the hospital admitted two patients through the emergency department (ED) with skin rashes that were not initially recognized as scabies. The index case was an elderly, immune-compromised female nursing home resident who came in with what eventually would be diagnosed as Norwegian scabies, a particularly dastardly presentation of the mite.

"It has more flaking and scales and a very heavy mite infestation," Raimondi says.

"The problem was that it wasn't originally recognized as scabies. She was immunocompromised and had gone through various treatments. The elderly, because of their skin, can have other things going on, and they did not recognize it as scabies," she adds.

Unrecognized, the bug and its burrowing

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# Patient, Worker Handout for Scabies Education

Nosocomial outbreaks of scabies have occurred in a variety of health care settings, including intensive care units, rehabilitation centers, long-term care facilities, hospital wards, a dialysis unit, and a health care laundry, according to the Centers for Disease Control and Prevention (CDC).[1] The CDC cites the following Q&A information to assist with scabies education of patients and health care workers.

**Question:** What are the signs and symptoms of scabies infestation?
**Answer:** Symptoms and signs include:

- Pimplelike irritations, burrows, or rash of the skin, especially the webbing between the fingers; the skin folds on the wrist, elbow, or knee; the penis; breasts; or shoulder blades.
- Intense itching, especially at night and over most of the body.
- Sores on the body caused by scratching. These sores sometimes can become infected with bacteria.

**Question:** How did I get scabies?
**Answer:** By direct, prolonged, skin-to-skin contact with a person already infested with scabies. Contact must be prolonged (a quick handshake or hug will usually not spread infestation). Infestation is spread easily to sexual partners and household members. Infestation may also occur by sharing clothing, towels, and bedding.

**Question:** Who is at risk for severe infestation?
**Answer:** People with weakened immune systems and the elderly are at risk for a more severe form of scabies, called Norwegian or crusted scabies.

**Question:** How long will mites live?
**Answer:** Once away from the human body, mites do not survive more than 48-72 hours. When living on a person, an adult female mite can live up to a month.

**Question:** Did my pet spread scabies to me?
**Answer:** No. Pets become infested with a different kind of scabies mite. If your pet is infested with scabies (also called mange), and they have close contact with you, the mite can get under your skin and cause itching and skin irritation. However, the mite dies in a couple of days and does not reproduce. The mites may cause you to itch for several days, but you do not need to be treated with special medication to kill the mites. Until your pet is successfully treated, mites can continue to burrow into your skin and cause you to have symptoms.

**Question:** How soon after infestation will symptoms begin?
**Answer:** For a person who has never been infested with scabies, symptoms may take four to six weeks to begin. For a person who has had scabies, symptoms appear within several days. You do not become immune to an infestation.

**Question:** How is scabies infestation diagnosed?
**Answer:** Diagnosis is most commonly made by looking at the burrows or rash. A skin scraping may be taken to look for mites, eggs, or mite fecal matter to confirm the diagnosis. If a skin scraping or biopsy is taken and returns negative, it is possible that you still may be infested. Typically, there are fewer than 10 mites on the entire body of an infested person; this makes it easy for an infestation to be missed.

**Question:** Can scabies be treated?
**Answer:** Yes. Several lotions are available to treat scabies. Always follow the directions provided by your physician or the directions on the package insert. Apply lotion to a clean body from the neck down to the toes and left overnight (eight hours). After eight hours, take a bath or shower to wash off the lotion. Put on clean clothes. All clothes, bedding, and towels used by the infested person two days before treatment should be washed in hot water and dried in a hot dryer. A second treatment of the body with the same lotion may be necessary seven to 10 days later. Pregnant women and children often are treated with milder scabies medications.

**Question:** Who should be treated for scabies?
**Answer:** Anyone who is diagnosed with scabies, as well as his or her sexual partners and those who have close, prolonged contact to the infested person also should be treated. If your health care provider has instructed family members to be treated, everyone should receive treatment at the same time to prevent reinfestation.

**Question:** How soon after treatment will I feel better?
**Answer:** Itching may continue for two to three weeks, and does not mean that you still are infested. Your health care provider may prescribe additional medication to relieve itching if it is severe. No new burrows or rashes should appear 24-48 hours after effective treatment.

## *Reference*

1. Centers for Disease Control and Prevention. Guidelines for infection control in health care personnel, 1998. *Am J Infect Control* 1998; 26:289-354. ■

brethren found their way under the skin of 27 health care workers, including those in nursing, housekeeping, engineering, physical therapy, and physicians. "There was spread from various departments and to different areas of the hospital," she said.

As the infected patients scratched their skin, flakes containing mites traveled and alighted on other surfaces. "Skin flakes can be on linen, clothing, floors, furniture," she says. "For example, the flakes might be in the linen and when you pull it off the bed, they go flying and land on the bedrail or on the furniture."

Rigid infection control measures were instituted, including contact isolation of known or suspected patients and education of health care workers.

"The first thing was education because the staff went into a total panic," Raimondi says. "Basically, you would think they were going to die. But it's kind of creepy. You read about it and think about it and want to start scratching."

Intensive skin assessments were done in the ED, looking for any other incoming cases. Patients who had been in contact with the index cases were treated empirically with permethrin.

No other patients developed infection, but workers were suffering as the wave of initial transmission — gradually emerging from an incubation period of up to six weeks — began to create pruritic rashes. In some cases, the mites found their way to uncovered skin between gloves and clothing.

"We noticed that right above the glove line between the sleeve of the scrubs you would actually see the demarcation of where the glove ended and the rash began," she says, adding that workers were advised to wear long-sleeved gowns with all suspect cases.

Health care workers were treated with permethrin, which was effective but did not immediately end the torment.

"It is a cream that is applied all over the body from the neck down," Raimondi says. "They keep it on over night and wash it off in the morning. It will kill the mites; but your skin has to keep sloughing off, so you still are itchy. The mites will be dead but they have burrowed under your skin."

Unfortunately, before the outbreak was contained, some workers spread scabies to family members, who also were treated to kill the bugs. The outbreak was disturbing and disruptive, with almost 240 health care workers being evaluated for possible infestation.

The medicine alone was $28 a tube. "It would have been a good time to buy stock it," she says.

"It was disruptive because the staff were very upset about it. There was a lot of anxiety about taking it home to their families. This went on for weeks. It started in October, and our last employee was diagnosed in December," Raimondi adds. ■

# Salmonella outbreak strikes children's hospital

*One hundred infected but source unclear*

A widespread salmonella outbreak that infected 101 health care workers, patients, and visitors at St. Louis Children's Hospital may be linked to an asymptomatic worker or a common contaminated food, investigators tell *Hospital Infection Control.*

The outbreak, which resulted in closure of the hospital cafeteria from June 6 to June 15, 2003, remains under investigation. "We cultured all of the food service workers, whether or not they were symptomatic," says **Alexis Elward**, MD, infectious disease physician at the facility. "We did find that there were some with positive cultures, including those who were asymptomatic."

Positive cafeteria workers were required to have two negative stool cultures before they could return to work.

"We cultured everybody [who worked in the cafeteria] and had them stay out of work until the final culture results were back," she says. "If their cultures were negative, they could come back to work. Of course, all of the usual criteria applied, like not working with a fever or diarrhea."

Overall, 70 health care workers, four patients, and 27 other visitors to the hospital were infected with the same strain of salmonella. There were no deaths.

"It's all the same strain of *Salmonella jadiama*," she says. "Almost all of the isolates are identical by pulse-field gel electrophoresis. At least one of the later cases has a little mutation, which is characteristic of secondary transmission in an outbreak. This strain of salmonella has been associated with outbreaks in the past. There is a handful of reports in the literature about it. Previous foods that have been implicated are tomatoes, cheese, chicken, and watermelon."

To try to determine the source, Elward is

conducting a case control study to identify risk factors for infection.

"We did a case control study with 105 controls and the 101 cases," she said. "We are still looking at the food to see if it was the source of the whole thing. I still don't have any definite conclusions about the source of the outbreak."

The hospital has taken samples from more than 400 people who visited the hospital or ate in the cafeteria since May 1. The cafeteria was subjected to disinfection and cleaning before it was reopened.

"We really have just tried to reinforce existing policies," she says. "We did extra education with nutrition workers right before we reopened the cafeteria about the proper ways to handle food and to disinfect equipment." ■

JOURNAL REVIEW

# Researchers find two distinct SARS strains

*Finding could foretell resurgence*

Tsui SKW, Chim SSC, Dennis Lo YM. **Correspondence: Coronavirus genomic-sequence variations and the epidemiology of the severe acute respiratory syndrome.** *N Engl J Med* 2003; 349:187-188.

In a finding that may foretell resurgence of severe acute respiratory syndrome (SARS), researchers in China have found that there may be two distinct strains behind the global SARS outbreak.

"These results emphasize the need for vigilance in order to prevent the resurgence of this disease," the authors warned.

Their teaching hospital was the site of a major outbreak of SARS. The researchers sequenced viral isolates cultured from clinical specimens from seven patients with SARS in the outbreak. They obtained the complete genomic sequence of the virus cultured from the mother of the index patient in the hospital outbreak.

The mother's symptoms began March 5, 2003; she died April 13, 2003. They also sequenced genes from viral isolates cultured from six contacts of the index patient, and all these sequences were identical. To investigate whether there were other strains of the SARS coronavirus in Hong Kong at the time of the outbreak, they sequenced the spike glycoprotein gene from isolates of virus cultured from four other patients with SARS who had had no contact with the index patient. Sequence variations were observed beyond what could be explained by culture-derived artifacts, leading them to conclude that two different SARS strains caused the infections.

"Our data show that since the first reports of SARS in November 2002 in Guangdong province, at least two strains of SARS coronavirus have emerged," the authors reported. "It is epidemiologically significant that even by mid-March 2003, these two strains of the SARS coronavirus had already been found in patients in Hong Kong. This observation means that there was more than one source of infection present at the beginning of the SARS epidemic in Hong Kong. Therefore, even if there had been no outbreak at the Metropole Hotel, SARS would probably have broken out eventually in Hong Kong." ■

ABSTRACT & COMMENTARY

# Depression and infection lead to a fatal interaction

*Linezolid for MRSA doesn't mix with an SSRI*

**Synopsis:** A patient receiving the selective serotonin reuptake inhibitor (SSRI) citalopram developed fatal serotonin syndrome after beginning therapy with linezolid for methicillin-resistant *Staphylococcus aureus* (MRSA) infection.

**Source:** Bernard L, et al. **Serotonin syndrome after concomitant treatment with linezolid and citalopram.** *Clin Infect Dis* 2003; 36:1,197.

**Abstract:** An 81-year-old man had been receiving citalopram 20 mg twice daily for three weeks prior to admission. He underwent debridement of chronic MRSA osteomyelitis of the ankle. Postoperatively he received linezolid 600 mg twice daily.

One week after starting linezolid therapy, he

developed mental status changes. At three weeks of therapy, he developed fever, hypertension, tachycardia, confusion, and tremors. A computed tomography scan of the head showed no abnormalities, and initial cardiac isoenzymes and troponin levels were not elevated.

During an attempted lumber puncture, he experienced cardiac arrest. He subsequently developed cardiac and hepatic dysfunction, as well as severe lactic acidosis.

He had multiple cardiac arrests and expired. An autopsy showed diffuse encephalopathy and an acute myocardial infarction.

**Commentary by Robert Muder, MD, hospital epidemiologist at VA Pittsburgh Healthcare System and associate professor of medicine at the University of Pittsburgh.**

Linezolid is a weak monoamine oxidase (MAO) inhibitor, and therefore, has the potential to interact with a variety of vasoactive amines and psychotropic drugs.

The serotonin syndrome is a potentially life-threatening illness that may occur with medication overdose or during the receipt of two or more drugs that enhance central nervous system

## CE/CME instructions

Physicians and nurses participate in this CE/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 **(at right)** to test their knowledge.

To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity in June 2003, you must complete the evaluation form that will be provided and return it in the reply envelope to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

## CE/CME *questions*

If you have any questions about the CE/CME testing method, please contact customer service at (800) 688-2421.

5. The Joint Commission's 2005 proposed standards for infection control require a written plan that:
   A. identifies priorities
   B. focuses activities
   C. evaluates the efficacy of the program
   D. all of the above

6. According to Susan Kraska, RN, CIC, the Joint Commission's move to target infection control in surprise inspections next year could actually help which kind of ICPs?
   A. those in programs that lack administrative support
   B. those in programs accredited by another agency
   C. those who work only part time
   D. all of the above

7. Julie A. Savoy, BSN, RN, JD, said infection control training meets and exceeds rigorous legal requirements for expert witnesses, so ICPs should not hesitate to testify outside of their area of expertise.
   A. true
   B. false

8. How long can the incubation period be before scabies symptoms start appearing after an exposure to the mite *Sarcoptes scabiei*?
   A. one week
   B. two weeks
   C. four weeks
   D. six weeks

**Answer Key:** 5. D; 6. A; 7. B; 8. D

## *COMING IN FUTURE MONTHS*

■ Efficacy affirmed: Alcohol rubs actually improve hand-hygiene compliance

■ Paws and claws: Hospital policies for pet therapy

■ *Bioterrorism Watch*: Flu as a weapon of terrorism

■ Protecting the extremely low-weight infant from infection

■ Full disclosure: Will your hospital's infection rates be in the local newspaper?

serotonin activity.[1] The symptoms include confusion, agitation, fever, diaphoresis, and abnormal neuromuscular activity such as hyperreflexia and myoclonus.

Treatment consists of withdrawal of the offending medications and supportive care. Serotonin blocking agents such as cyproheptadine may be beneficial in severe cases.

There are prior individual case reports of serotonin syndrome occurring with the SSRI paroxetine.[2] However, considering how widely SSRIs currently are being used, severe interactions between linezolid and SSRIs appear to be uncommon.

Nevertheless, these case reports underscore the potential for a life-threatening occurrence. It is of note that the patient reported by Bernard and colleagues continued to receive the combination of linezolid and citalopram for two weeks after mental status changes were first noted.

Could the outcome been different if the linezolid been discontinued earlier? The report also underscores the fact that serotonin syndrome is easily misdiagnosed at first presentation.

Patients being switched from an SSRI to a MAO inhibitor for treatment of refractory depression typically undergo a two-week drug-free washout period to reduce the likelihood of a serious drug interaction.

Bernard, et al, suggest that patients receiving an SSRI should likewise have that drug discontinued two weeks before initiation of linezolid. Considering that serotonin syndrome due to coadministration of linezolid and SSRIs appears to be uncommon, it's not clear that this should be a universal practice.

It would be quite reasonable to do so when treating chronic osteomyelitis, since a brief delay in antimicrobial therapy is unlikely to adversely affect outcome.

If, on the other hand, linezolid treatment is necessary for a potentially life-threatening infection (for example, sepsis caused by *Enterococcus* resistant to vancomycin and quinupristin / dalfopristin) in a patient receiving an SSRI, careful monitoring of mental status and autonomic function is warranted for the duration of therapy.

### *References*


1. Lane R, Baldwin D. Selective-serotonin reuptake inhibitor-induced serotonin syndrome: Review. *J Clin Psychopharmacol* 1997; 17:208-221.

2. Wigen CL, Goetz MB. Serotonin syndrome and linezolid. *Clin Infect Dis* 2002; 34:1,651-1,652. ■






## CE/CME objectives

After reading each issue of *Hospital Infection Control*, the infection control professional will be able to do the following:

- identify the particular clinical, legal, or educational issue related to epidemiology;
- describe how the issue affects nurses, hospitals, or the health care industry in general;
- cite solutions to the problems associated with those issues, based on guidelines from the federal Centers for Disease Control and Prevention or other authorities, and/or based on independent recommendations from clinicians at individual institutions. ■

JCAHO Update for Infection Control

*News you can use to stay in compliance*

# Joint Commission's request for fatal infection data may yield little meaningful prevention information

*Infection control breaches will not be easy to document*

Infection control professionals attempting to comply with accreditors and do a root-cause analysis of fatal nosocomial infections must set narrow patient definitions and work closely with their quality improvement colleagues if any meaningful prevention data are to come out of the controversial initiative, an ICP warned.

One problem is that even the most in-depth analysis of a patient's care may not reveal a minor breach in infection control, which is all it takes in some cases to reverse the course of recovery.

"A lot of infection control practices aren't charted in the [patient's] chart," said **Teresa Garrison**, RN, MSN, CIC, CNLCP, an ICP with BJC Healthcare System in St. Louis. "So you are not going to see charted [for example] that the patient's central line dressing change was loose, and instead of changing it the nurse just taped it up a little bit better. So all of the things that put patients at risk actually aren't in the chart. I am still not convinced that doing a root-cause analysis is going to yield us much information on infection prevention."

Earlier this year, the Joint Commission on Accreditation of Healthcare Organizations issued a *Sentinel Event Alert* stating: "Manage as sentinel events all identified cases of death and major permanent loss of function attributed to a nosocomial infection (i.e., except for the infection, the patient would probably not have died or suffered loss of function)."[1]

The Joint Commission cited the Centers for Disease Control and Prevention's (CDC) definition of a nosocomial infection as: "a localized or systemic condition: 1) that results from adverse reaction to the presence of an infectious agent(s) or its toxin(s), and 2) that was not present or incubating at the time of admission to the hospital." Infections that lead to patient deaths or permanent loss of function should be regarded as sentinel events and subjected to a root-cause analysis with the idea of preventing such infections in the future.

### Review 'unexpected' deaths

Although such reporting is voluntary, Joint Commission surveyors may ask ICPs whether they have done anything with regard to the *Sentinel Event Alert*, said Garrison, who spoke recently in San Antonio at the annual meeting of the Association for Professionals in Infection Control and Epidemiology (APIC). She described a possible approach to the Joint Commission's request that has been undertaken as a pilot program in one of the BJC hospitals. One of the first data elements ICPs looked at was "unexpected" patient deaths, which were already being tracked by hospital case managers.

"They already have a definition for unexpected deaths, and it is very, very narrow," she said. "I would suggest that when you look at this for your hospital, you create something just as narrow. So, for example, a patient coming in by ambulance that is a trauma, CPR in progress, doesn't make the definition. Any patient in the hospital who has had a change in his code status and is now a 'do not resuscitate' doesn't make the definition. What you are left with is truly fairly healthy people who

are coming in for something and then they really are dying."

From that group, ICPs may be able to find some patients who died as a result of a nosocomial infection, but conducting the root-cause analysis will not necessarily fully explain the event.

"We wrote into the plan that we would review patients with unexpected death, and if they had a nosocomial infection, we would collaborate with performance improvement and risk management to decide at that point whether we are going to do a root-cause analysis," she says. "We also put into the plan that we were going to review resources needed for all of these root-cause analyses and also look at the yield of information in terms of infection prevention."

## Tips on what surveyors are looking for

In a presentation titled "Tips From the Troops," Garrison told APIC attendees what fellow ICPs are actually reporting after their Joint Commission inspections. Thus, she was able to advise ICPs on many of the questions surveyors are asking about the 2003 standards, which will continue into 2004 with very little change **(See standards, p. 105.)**

"The Joint Commission has become much more sophisticated in the way they look at our data and the questions they are asking us," she said. "This year, I have heard a lot of focus on baseline. 'What is your historic baseline? What are you doing about it?' And then stability. They have really been asking, for the first time, 'Are you sustaining the gain?' They are excited when you are able to drop a rate and make an improvement, but what they really want from you now is that you sustain that improvement and keep it going over a long period of time."

In the same vein, stopping an outbreak will certainly be viewed favorably, but surveyors may go a step further and ask the ICP what was learned from the experience.

"Although they love how you found the outbreak, controlled it, and improved things over time, their main questions this year have been, 'What have you learned about the process that you used to complete the investigation?'" Garrison said. "So if you learned something from your process that you would do differently the next time you have an outbreak, be sure to be able to describe that. Also, the trick here is to make sure you have implemented that revision in your [program policies]."

Overall, the Joint Commission requires that infection control programs reduce the risk of acquiring and transmitting infections among and between patients, staff, and visitors. To find evidence that such efforts are in place, they will look for the ICP to use five active verbs: identifying, analyzing, preventing, controlling, and reporting. "They are going to look at those, not only in the document review that you provide and in your interview, but they also are going to look for evidence of those activities from other staff members at the hospital when they are touring patent care areas," Garrison said.

To begin with, have a written program description that includes the infection control goals you are working under for the current year, she advised.

"Your annual goals need to be measurable, realistic, and coordinated with the organization's performance improvement [plans]. The Joint Commission loves this closed feedback loop, so you need to be sure you can tie what you are doing back to the organization's overall performance improvement plan," Garrison said.

Indeed, the Joint Commission will be looking for evidence of communication and interaction with other programs as part of its emphasis on multidisciplinary care. "The Joint Commission wants a multidisciplinary approach, and I think it fits us very well," she said. "What is so great about infection control is that we are everywhere and we get to go everywhere. We are constantly working across departmental lines, so to be sure to include that in your surveillance plan."

## Show clear link to occupational health

ICPs should have a statement of program oversight that clarifies their supervisor and the link between the program and hospital administration.

"You also need a statement on infection control authority," she said. "Do you have the authority to close down a ward to new admissions if it is experiencing an outbreak? If you don't have that authority, who has it? Be sure to include that statement in your program description."

In outlining your program, be sure to show a clear link with occupational health, an area of increasing interest to the Joint Commission, she emphasized. "The Joint Commission is continuously looking for [infection control] collaboration with occupational health."

*(Continued on page 106)*

# JCAHO posts 2004 infection standards

*Editor's note: The Joint Commission has posted "pre-publication" infection control (IC) standards for 2004 on its web site. After much discussion, the standards appear largely unchanged from 2003. Highlights are summarized as follows:*

**Surveillance, Prevention, and Control of Infection**

**Overview:** The goal of the surveillance, prevention, and control of infection function is to identify and reduce risks of acquiring and transmitting infections among and between patients, staff, physicians and other licensed independent practitioners, contract service workers, volunteers, students, and visitors. Surveillance, prevention, and control of infection covers a broad range of processes and activities, both in direct patient care and in patient care support, that are coordinated and carried out by the hospital. This function links with external organization support systems to reduce the risk of infection from the environment, including food and water sources.

**Standards**

**IC.1.10** The organization uses a coordinated process to reduce the risks of nosocomial infections in patients and health care workers.

**Elements of Performance**

1. The hospital's infection control process is based on sound epidemiologic principles and evidence-based information on reducing nosocomial infection.
2. The infection control program is appropriate to the following:
   - The hospital's geographic location
   - The volume of patient encounters
   - The patient populations served
   - The hospital's clinical focus
   - The number of staff.
3. The hospital's infection control program addresses issues defined by the hospital as epidemiologically important.
4. The hospital connects its infection control program with the local health department to ensure appropriate follow-up and control of infection.

**IC.1.20** The infection control process is managed by one or more qualified individuals.

**Elements of Performance**

1. One or more individuals qualified through education, training, experience, and certification or licensure oversee the infection control process.

**IC.2.10** Case findings and identification of demographically important nosocomial infections provide surveillance data.

**Elements of Performance**

1. Surveillance activities are appropriate to the organization's demographics and services.
2. Collection of surveillance data on nosocomial infections is ongoing.
3. Surveillance activities include data collected by staff health services.

**IC.3.10** When appropriate, the hospital reports information about infections both internally and to public health agencies.

**Elements of Performance**

The hospital reports information about infections both internally and to public health agencies as required by law and regulation and hospital policy.

**IC.4.10** The hospital takes action to prevent or reduce the risk of nosocomial infections in patients, staff, and visitors.

**Elements of Performance**

1. The organization implements strategies to reduce the risks and prevent transmission of nosocomial infections in patients, staff, and those who come into the organization.
2. The strategies are consistent with current scientific knowledge, accepted practice guidelines, and applicable law and regulation.
3. The mechanisms address the infection issues that are epidemiologically important to the hospital.

**IC.5.10** The hospital takes action to control outbreaks of nosocomial infections when they are identified.

**Elements of Performance**

The organization implements strategies to control outbreaks of nosocomial infections.

**IC.6.10** The hospital's infection control process is designed to lower the risks and to improve the rates or trends of epidemiologically significant infections.

**Elements of Performance**

1. The nosocomial infection risk-reduction process acts to lower the risks of and to improve the trends in or rates of epidemiologically significant infections.
2. The organization considers endemic rates (presence or occurrence of infections with geographic area) and epidemic rates (outbreak of infection in area or group) when analyzing data.
3. Infection control findings are used to inform organizationwide performance improvement processes.
4. Appropriate action is taken to decrease infection rates or trends.

**IC.6.20** Management systems support the infection control process.

**Elements of Performance for IC.6.20**

1. Management systems, including staff and data systems, support the hospital's IC objectives.
2. Data are used to improve IC processes.

**IC.6.30** The IC process includes at least one activity aimed at preventing transmission of epidemiologically significant infections between patients and staff.

**Element of Performance for IC.6.30**

At least one activity has been implemented to intervene in the potential transmission of infection between patients and staff.

By the same token, the Joint Commission is looking closely at hospital staffing patterns, and surveyors may want to know whether infection control has sufficient manpower. "You need to have some rationale for the staffing that you have in your department," Garrison said. "And you need to be able to explain the rationale for that. This can be controversial, especially in your interview when [the Joint Commission surveyor] is asking you about your staffing, and your CEO is sitting right there at the table with you."

If you are using a formula, like the CDC's national nosocomial infection surveillance system's 1.5 FTEs for the first 100 beds, explain that to the Joint Commission, she said.

"You need to have some statement about how you determine whether your staffing is adequate or not," she said. "Then have a staffing plan that addresses staffing variances. I doubt that many of us get any more ICPs when census goes up or when there is an outbreak. You need a statement that shows that these are fixed positions, but what are you going to do when you have an outbreak? How are you going to be able to handle the staffing and your daily workload?"

The Joint Commission requires that ICPs do case finding and identification of demographically important nosocomial infections via surveillance. "The tip here is to describe your surveillance," Garrison said.

"Is it targeted or total house?" she asked. "The Joint Commission does not ban total-house surveillance, so if you have a good rationale for that, they're not going to say you can't do it. But whatever your surveillance [approach], it needs to encompass the patient care that is provided in your facility and to cover occupational health services."

But creating a paper trail of surveillance data will not mean much if workers on the floor don't know which bugs are causing problems in the hospital.

"How have you acted on your surveillance findings?" Garrison said. "When they tour patient care areas, they are asking staff nurses, 'What kind of infections do you see on your unit? And what are you, the staff nurse, doing to reduce infections on your unit?'"

### Reference

1. Joint Commission on Accreditation of Healthcare Organizations. Infection control-related sentinel events. *Sentinel Event Alert* 2003:28. ■

# JCAHO urges passage of patient safety regs

*Law to ensure confidential reporting of errors*

National patient safety legislation that would encourage the confidential reporting of medical errors is critically needed in today's health care system, urged **Dennis O'Leary**, MD, president of the Joint Commission.

"Thousands and thousands of errors remain hidden today, and each of those is a lost opportunity for education and change," O'Leary said in recent testimony before Congress. "Federal confidentiality protections for reported adverse events, near misses, and their underlying causes are inextricably linked to the efforts to create cultures of safety inside health care organizations."

Such protective legislation would allow sharing of information and mutual problem-solving, he said.

The House recently passed H.R.663, the Patient Safety and Quality Improvement Act. The bill awaits consideration by the Senate.

"We are very hopeful that this is the year in which this critical piece of legislation will actually be enacted," O'Leary testified June 11, 2003, before the Senate Committee on Governmental Affairs.

If approved, the legislation will prevent subpoena of error-related information from health care organizations and practitioners, shielding providers from liability so medical errors can be analyzed and reduced throughout the medical system.

"[This bill] contains explicit language to clearly preserve that protection when the information is shared with an accrediting body for purposes of improving patient safety and health care quality," he said.

That could mean, for example, infection control professionals could report fatal or life-impairing nosocomial infections to the Joint Commission without fear of institutional liability. The Joint Commission makes considerable efforts to protect the confidentiality of its Sentinel Event Database, but many feel that only federal legislation can provide the protection to open up a national discussion of medical errors.

O'Leary also suggested that lawmakers establish performance incentives for achieving safety objectives through adoption of the Joint Commission's annual national patient safety goals. ■