



# Hospital Employee Health®



## CDC isolation guideline sparks new debate on respiratory protection

*Is CDC providing enough HCW protection?*

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— *The Joint Commission Update for Infection Control*

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Updated guidelines designed to prevent nosocomial transmission of diseases inject some new uncertainties in the efforts to protect health care workers.

For years, hospitals have relied on the "3-foot rule" — the concept that caregivers need to use droplet precautions if they are within 3 feet of a patient. That has given way to a 6-foot recommendation and an acknowledgement that little is known about the range of infectivity.

The *Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007*, a set of influential recommendations issued by the Centers for Disease Control and Prevention, also recognizes that some "opportunistic" infectious agents that are not typically airborne may be transmitted via aerosolized particles.

But the passages that are causing concern for some health care worker advocates involve the use of masks and respirators for protection of health care workers. For example, one passage seems to imply that annual fit-testing may not be necessary: "The optimal frequency of fit-testing has not

### OSHA can enforce annual fit-testing rule

*'Wicker Amendment' defeated in Congress*

Annual fit-testing is once again the unqualified rule for tuberculosis. A Congressional caveat that prohibited the U.S. Occupational Safety and Administration from using federal funds to enforce the annual fit-testing rule for TB has been defeated in the House of Representatives.

Defeating that provision, which had been in place since 2003, was a major goal of health care worker unions and some professional organizations, such as the American Industrial Hygiene Association.

*(See OSHA, page 100)*

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been determined; retesting may be indicated if there is a change in facial features of the wearer, onset of a medical condition that would affect respiratory function in the wearer, or a change in the model or size of the initially assigned respirator."

The guideline does not specify that the U.S. Occupational Safety and Health Administration requires annual fit-testing of filtering face-piece respirators, such as N95s. In fact, in July, Congress let the so-called Wicker Amendment expire. Proposed by Rep. Roger Wicker (D-MS), it prohibited OSHA from using federal funds to enforce the annual fit-testing rule for tuberculosis. (See

related story, cover.)

"It's an incredibly equivocal document," says **Bill Borwegen**, MPH, occupational safety and health director of the Service Employees International Union (SEIU). "It seems only natural that you should err on the side of caution and the precautionary principle and not err on the side of danger."

Yet **Michael Bell**, MD, associate director for infection control at CDC's Division of Healthcare Quality Promotion (DHQP), insists that the agency incorporated occupational health input and sought to bridge the difference of opinion between infection control professionals and industrial hygienists as it drafted the isolation guideline.

"We agree completely with the precautionary principle," which states that in the absence of scientific data, facilities should err on the side of protections for health care workers, says Bell. "The dichotomy is a little bit outdated. We're finding that industrial hygiene and infection control are overlapping increasingly these days."

Bell noted that DHQP has hired its first industrial hygienist, a prior employee of the National Institute of Occupational Safety and Health, to provide that in-house perspective.

"The isolation guideline agrees with NIOSH recommendations," says Bell. "It recommends that for respiratory protection, we require a fit-tested N95 respirator certified by NIOSH, a program for respiratory health training and instruction in self-fit-check."

## ***NIOSH supports annual fit-test***

When the isolation guidelines were released, the SEIU and the AFL-CIO sent a joint letter to NIOSH director **John Howard**, MD, MPH, JD, LLM, asking for NIOSH's position on the scientific evidence supporting annual fit-testing and the distinction, if any, between airborne infectious diseases and other airborne particles.

In an 11-page letter, Howard responded: "NIOSH supports the current legal requirement that follow-up respirator fit testing be performed annually for employers covered by OSHA's Respiratory Protection Standard and believes that OSHA has shown that the current best scientific, and practical, evidence supports an annualized periodicity for follow-up respirator fit-testing across all covered industries."

Howard noted that NIOSH is conducting research on the changes in fit over time that might have implications for fit-testing. That data collection

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## What's new in the isolation precautions?

Here are some highlights from the *Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007*:

- **Respiratory hygiene/cough etiquette:** The severe acute respiratory syndrome (SARS) epidemic pointed out the need for better source control among patients, visitors and health care workers with respiratory infections. Patients should be asked to "cover their cough" with a tissue or, if possible, coughing patients should be masked. Health care workers with respiratory infections should avoid direct patient contact or should wear a mask. Hand hygiene should occur after contact with respiratory secretions.

- **Droplet spread:** The SARS outbreak demonstrated that droplets could travel 6 feet or more from the source patient. Droplet spread depends on such factors as the velocity and method they are propelled (coughing vs. talking, for example), humidity, and infectivity of the organism. "It may be prudent to don a mask when within 6 to 10 feet of the patient or upon entry into the patient's room, especially when exposure to emerging or highly virulent pathogens is likely."

- **Multiple means of spread:** While some organisms are primarily spread through direct contact with mucous secretions, the guidelines note that some, such as *Staphylococcus aureus* and noroviruses, may become aerosolized and could be spread over short distances.

- **A new way to label transmission:** Aerosol transmission could be considered: 1) obligate: under natural conditions, disease occurs following transmission of the agent only through inhalation of small-particle aerosols (e.g., tuberculosis); 2) preferential: natural infection results from transmission through multiple routes, but small-particle aerosols are the predominant route (e.g. measles, varicella); and 3) opportunistic:

agents that naturally cause disease through other routes, but under special circumstances may be transmitted via fine particle aerosols.

- **SARS, avian and pandemic influenza:** The guidelines refer health care personnel to the CDC web site for current recommendations. However, they note that CDC currently recommends the use of N95 respirators when caring for patients with SARS, and the use of respiratory protection during aerosol-generating procedures such as intubation, bronchoscopy, and suctioning of patients with SARS, avian or pandemic influenza.

- **Safety culture:** A commitment to a culture of safety leads to greater adherence to hand hygiene and other infection control measures. A culture of safety occurs through 1) the actions management takes to improve patient and worker safety; 2) worker participation in safety planning; 3) the availability of appropriate protective equipment; 4) influence of group norms regarding acceptable safety practices; and 5) the organization's socialization process for new personnel.

- **Masks:** Recommends masks and goggles or the use of face shields to protect health care workers from splashes and sprays of respiratory secretions as a part of Standard Precautions.

- **Respiratory protection:** The guidelines state that "The subject of respiratory protection as it applies to preventing transmission of airborne infectious agents, including the need for and frequency of fit-testing is under scientific review . . ." Respirators may be reused by the same health care worker for tuberculosis "providing the respirator is not damaged or soiled, the fit is not compromised by change in shape, and the respirator has not been contaminated with blood or body fluids. There are no data on which to base a recommendation for the length of time a respirator may be reused."

- **Sharps safety:** The prevention of sharps injuries is an "essential element" of Standard Precautions. ■

will end in 2010.

NIOSH also is developing new criteria for respirators which will improve their overall fit characteristics. However, Howard noted that the fit criteria will not alter the need for individual fit-testing to ensure that the respirator fits the user.

As for the behavior of aerosolized infectious particles, Howard said, "NIOSH also believes that particles of the same size, regardless of whether the particle is infectious or not infectious, will exhibit the same aerodynamic behavior and should be treated in the same manner with regard to respiratory protection and fit testing."

In other words, the same rules that apply to

industrial respiratory protection are pertinent for health care.

Bell insists that CDC has accepted basic aerodynamic principles, and that the isolation guideline reflects that. For example, in contrast to previous definitions of infectious droplets, the guideline states, "Observations of particle dynamics have demonstrated that a range of droplet sizes, including those with diameters of 30µm or greater, can remain suspended in the air."

Yet aerosolized particles do not necessarily remain infectious, and therein lies the difference between infectious agents and an industrial hazard, such as coal dust, says Bell. "There are many

reasons why these particles change over time and lose their infectivity," he says.

DHQP is not in conflict with NIOSH, he says. "Our relationship with NIOSH has been very good for the last couple of years," Bell says. "The irony is that both groups have the same goal. They just use different words. Some of the philosophical issues might seem different. When you parse it down to actual intent and practices, they end up being very similar."

When there is a question about transmission patterns of a particular disease, such as SARS or pandemic influenza, the guideline recommends using an N95, he notes. It also recommends an N95 for aerosolizing procedures, such as intubation or bronchoscopy.

That guidance is not strong enough to reassure health care workers that they will be protected an emerging infectious disease, Borwegen charges. "The bottom line, at the end of the day, is that because of this kind of lack of protection, if we have a pandemic situation, workers are not going to go to work because they're going to be scared," he says. "I don't know what purpose this serves

to not practice the precautionary principle and not to protect people from these particles."

(Editor's note: The isolation precautions are available on CDC's web site at [www.cdc.gov/ncidod/dhqp/pdf/guidelines/Isolation2007.pdf](http://www.cdc.gov/ncidod/dhqp/pdf/guidelines/Isolation2007.pdf).) ■

## Evaluate risk before choosing respirators

*Hospital chooses PAPRs to raise protection*

Choosing a respirator is partly a matter of numbers. Each one has a rating for its filtration and seal, which reveals how much of the contaminated ambient air would still reach the lungs.

But assessing the risk in health care is more complicated than a single calculation — and so is selecting the proper respirator.

"Each individual institution must make a decision about risk: What risk is acceptable for your institution?" says **John Schaefer**, CIH, HEM,

### OSHA

*(Continued from cover)*

"Science will trump ideology," said **Bill Borwegen**, MPH, safety and health director of the Service Employees International Union (SEIU). "Evidence-based research will trump ideology. There have been enough studies to show the value of annual fit-testing. Until there's research to show otherwise, this is the prudent approach that we should be taking."

The vote came in the wake of concern about extensively drug-resistant (XDR) TB and the well-publicized case of Andrew Speaker, who traveled internationally while the Centers for Disease Control and Prevention sought his quarantine. Rep. Roger Wicker, R-MS, who sponsored the amendment to the appropriations bill, argued that annual fit-testing was onerous but not protective.

Some hospitals had continued their annual fit-testing programs despite the Wicker Amendment, but many employee health professionals now face the prospect of ramping up their fit-testing programs to comply. "Our members are concerned about doing this on annual basis," says **Denise Knoblauch**, RN, BSN, COHN-S/CM, executive president of the Association of Occupational Health Professionals in Healthcare and clinical case manager at the OSF SFMC Center for Occupational Health at Saint Francis Medical Center in East Peoria, IL.

Some feel that too much emphasis has been

placed on the annual repetition of the fit-tests. "Those organizations that are saying it's going to improve the safety of health care workers I think are giving their members a false sense of security," says **Pat Sullivan**, MSN, RN, employee health coordinator at Vassar Brothers Medical Center in Poughkeepsie, NY.

Such questions about respirator fit-testing are reflected in the recently released *Guideline for Isolation Precautions*. (See related article on p. 99.)

In a debate before the House Appropriations Committee, Wicker argued that the prohibition had saved millions of dollars in health care costs but not led to a single known case of tuberculosis infection among health care workers. Yet other members of Congress countered that the decision should be left up to occupational health experts — and both OSHA and the National Institute for Occupational Safety and Health maintain that annual fit-testing is necessary to ensure that the respirators are not leaking.

In fact, the annual fit-testing rule remained in effect for other diseases requiring respiratory protection, such as SARS and pandemic influenza. In the event of a pandemic, the American Nurses Association will tell members to insist on having a fit-tested respirator, says **Erin McKeon**, ANA's associate director of governmental affairs.

"Our advice would be that if you have not been provided a fit-tested respirator or you have not been fit-tested in the last year, do not treat those patients," she says. ■

CPEA, associate director of health safety and environment at Johns Hopkins University and Medical Institutions in Baltimore. Schaefer presented a model for respiratory selection at the recent annual conference of the American Industrial Hygiene Association.

Risk is clearly related to the type of infectious disease your health care workers will encounter. XDR-TB, or extensively drug-resistant tuberculosis, would be of even greater concern than drug-susceptible TB. Pandemic influenza will, at least initially, call for higher levels of precautions than seasonal influenza.

The respiratory risk of infection for the health care worker is influenced by the time exposed and the ventilation of the room. For example, 12 air exchanges per hour will create a lower-risk environment than six air exchanges per hour, the minimum required by the Centers for Disease Control and Prevention for airborne isolation rooms.

Chemical hazards have a designated exposure limit, but infectious organisms are not that clear-cut. Infectivity of organisms differs — and may vary even among patients. Some patients may release a high concentration of organisms in coughing or even breathing. During SARS, for example, some patients were dubbed “superspreaders” because of their heightened infectivity. Aerosol-generating procedures, such as bronchoscopy or intubation, clearly also increase risk.

For many diseases, infectivity isn’t well understood. It is theoretically possible for someone to become infected from a single infectious particle. But hospitals can use data from measles and tuberculosis — two airborne diseases — to gauge the potential effectiveness of respirator types for viruses and bacteria, says Schaefer.

### ***Risk data on measles, TB***

One study of airborne spread of measles in an elementary school produced some quantifiable data on infectivity. The index case produced 93 quanta of airborne infection per minute. The probability of infection from an hour of exposure without respiratory protection was 29%, or one in 3.5.<sup>1</sup>

Wearing a fit-tested N95 would have reduced that probability to 7%, or one in 24, calculated Schaefer. By using a powered air-purifying respirator (PAPR), the probability would have been 1% or less, depending on the fit factor of the model.

A 1982 study of nosocomial tuberculosis found that a patient in an isolation room with six air

exchanges per hour released 60 quanta of infectious particles.<sup>2</sup> That amounted to a 19% probability of infection after an hour of exposure without a respirator, or a risk of one in five. With an N95, the risk would drop to 5%, or one in 20, and would be less than 1% with a PAPR, Schaefer says.

“From an industry hygienist point of view, for someone to become ill or die due to workplace exposure is unthinkable,” says Schaefer. Infection control, however, seeks to minimize transmission but accepts some level of risk.

Ultimately, hospital administrators must consider factors that include cost, employee comfort and preference, and regulatory issues, he notes. “This is just another way of adding a factor for risk of infection,” he says.

### ***Selecting reusable respirators***

Johns Hopkins has chosen to maximize protection — but also to benefit from respirators that can be reused. For example, the hospital’s emergency department recently decided to stock elastomeric half-face respirators for pandemic influenza preparedness.

If a pandemic lasted a month, N95s would cost about \$40 a person, assuming that health care workers used two masks a day for 20 days, says Schaefer. An elastomeric respirator with a cartridge that can be cleaned with bleach or alcohol costs \$20, he says. The hospital also would not need to worry about lack of supplies or unavailability of the fit-tested models.

Meanwhile, the hospital purchased about 200 PAPRs, which are available on every floor and don’t need to be fit-tested.

Yet some health care workers prefer the N95, and Johns Hopkins still provides those. The hospital convened a committee that included front-line health care workers and selected models based on comfort and ease of use. Employees who are assigned N95s receive annual fit-tests.

Johns Hopkins is now evaluating its respiratory protection for pandemic influenza preparedness. Schaefer and his colleagues are reviewing departments and job descriptions to determine which employees would be at the greatest risk during a pandemic. The respiratory protection will differ based on that risk assessment, he says.

“We’re going to inform people of the potential risk they have and what type of device they will be using to protect themselves,” he says.

Ultimately, Schaefer hopes that employees will feel confident in the protection the hospital is

providing — and will be more likely to report for work in the case of a pandemic.

## References

1. Riley EC, Murphy G, and Riley RL. Airborne spread of measles in a suburban elementary school. *Am J Epidemiol* 1978; 107: 421-432.
2. Cantanzaro A. Nosocomial tuberculosis. *Am Rev Respir Dis* 1982; 125:559-562. ■

# CDC: Use declination statements on flu vaccine

*Pressure grows to document why HCWs decline*

Hospitals are feeling even greater pressure to ask health care workers to sign declination statements if they don't receive the influenza vaccine.

In its 2007-2008 guidelines for seasonal influenza, the Advisory Committee on Immunization Practices called on hospitals to "obtain signed declinations from personnel who decline influenza

vaccination for reasons other than medical contraindications." The expert panel develops recommendations that are adopted by the Centers for Disease Control and Prevention. **(For a full excerpt from the guidelines, see below.)**

Some states are mandating the reporting of influenza immunization rates of health care workers and are strongly recommending the use of declination statements. For example, the Minnesota Department of Health is promoting the use of declination statements and may make use of the statements a quality goal by 2010.

"There's definitely pressure to move in this direction," says **William Buchta**, MD, MPH, medical director of the Employee Occupational Health Service at the Mayo Clinic in Rochester, MN, and co-author of a position statement by the American College of Occupational and Environmental Medicine opposing declination statements.

Buchta conducted a small pilot study of declination statements at Mayo and found that they did not influence health care workers to receive the vaccine. Mayo already vaccinates about 75% of its health care workers. **(For more information, see *Hospital Employee Health*, June 2007, p. 66.)**

## CDC: Vaccinate all health care workers

**T***his is an excerpt from the Prevention and Control of Influenza: Recommendations of the Advisory Committee on Immunization Practices (ACIP), 2007. The recommendations are available at [www.cdc.gov/mmwr/preview/mmwrhtml/rr5606a1.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5606a1.htm).*

All health care personnel (HCP), as well as those in training for health care professions, should be vaccinated annually against influenza. Persons working in health care settings who should be vaccinated include physicians, nurses, and other workers in both hospital and outpatient care settings, medical emergency response workers (e.g., paramedics and emergency medical technicians), employees of nursing home and chronic care facilities who have contact with patients or residents, and students in these professions who will have contact with patients.

Facilities that employ HCP should provide vaccine to workers by using approaches that have been demonstrated to be effective in increasing vaccination coverage. Health care administrators should consider the level of vaccination coverage among HCP to be one measure of a patient safety quality program and obtain signed declinations from personnel who decline influenza vaccination for reasons other than

medical contraindications. Influenza vaccination rates among HCP within facilities should be regularly measured and reported, and ward-, unit-, and specialty-specific coverage rates should be provided to staff and administration). Studies have demonstrated that organized campaigns can attain higher rates of vaccination among HCP with moderate effort and using strategies that increase vaccine acceptance.

Efforts to increase vaccination coverage among HCP are supported by various national accrediting and professional organizations and in certain states by statute. The Joint Commission has approved an infection control standard that requires accredited organizations to offer influenza vaccinations to staff, including volunteers and licensed independent practitioners with close patient contact. The standard became an accreditation requirement beginning Jan. 1, 2007. In addition, the Infectious Diseases Society of America recently recommended mandatory vaccination for HCP, with a provision for declination of vaccination based on religious or medical reasons. Fifteen states have regulations regarding vaccination of HCP in long-term care facilities, three states require that health care facilities offer influenza vaccination to HCP, and three states require that HCP either receive influenza vaccination or indicate a religious, medical, or philosophical reason for not being vaccinated. ■

The declination statements are just one tool to improve health care worker influenza immunization rates, says **Anthony Fiore**, MD, MPH, medical epidemiologist at CDC and an author of the ACIP recommendations.

The National Health Interview Survey indicates that only 34% of health care workers received the flu vaccine in 2005. The vaccine shortage clearly affected immunization rates that year, but Fiore notes the need to attain much higher vaccination coverage.

The advisory panel chose to highlight the importance of health care worker immunization in this year's recommendations, he says. "We wanted to bring it to the forefront and say this is a problem," he says.

### **Putting patients at risk?**

In a declination statement, health care workers acknowledge that they have been offered the vaccine. They may be asked to indicate their reason for declining. But sometimes the sharp wording of statements requires them to acknowledge that they are knowingly putting their patients at risk. For example, the sample form provided by the Minnesota Department of Health states: "I am eligible for the flu shot but do not wish to have the influenza vaccine given to me. I understand that my refusal of it may put patients, visitors, and family, with whom I have contact, at risk should I contract the flu."

Before adopting that language, Buchta advises, hospitals should seek legal and risk management advice.

Not everyone views declination statements as a critical strategy. The Joint Commission requires hospitals to monitor their health care worker influenza immunization rates and take steps toward improved coverage. But the accreditation body doesn't specifically require declination statements.

The Council on State Governments' Health States Initiative recently released a briefing document for state legislators on influenza immunization of health care workers. It recommends legislative action to ensure free access to vaccines and education of health care workers and to require health care facilities to report influenza vaccination rates. It does not mention declination statements.

"It is the employees' right to weigh the risks and benefits and decide whether this is right for them," says Buchta. "Most people will make the right decision." ■

## **'Get to zero': Pittsburgh VA vows to stamp out MRSA**

*Culture change boosts hand hygiene*

**M**ultidrug-resistant *Staphylococcus aureus* (MRSA) is reaching alarming levels around the country, but at the VA Medical Center in Pittsburgh, MRSA rates have dropped by 60% in the past five years. The key: Health care workers are team players in a comprehensive approach to halting MRSA.

Patients are tested on admission and discharge in a system of active surveillance, but the success story goes far beyond that. The hospital was committed to making a "cultural transformation" that gives health care workers a voice in decision making and problem-solving.

Meanwhile, at every entrance, in every room, in the lobby and outside the elevators, the medical center installed alcohol gel dispensers. It's impossible to avoid hand hygiene. Patients, visitors, and employees alike are urged to pay attention to it.

This multipronged approach to reducing infections has spread to VA hospitals across the country and serves as a model for other hospitals as well.

"It is a significant change in the way we've operated [in the past]," says **Rajiv Jain**, MD, FACP, chief of staff at the VA Pittsburgh Health Care System and project director for the national VA initiative. "But if we involve more and more people than just the infection control and employee health staff, it becomes easier and the success comes more quickly."

A recent survey of hospitals by the Association for Professionals in Infection Control and Epidemiology in Washington, DC, underscored the importance of combating MRSA. Hospital inpatients are infected at a rate of 46.3 per 1,000, which is eight to 10 times higher than previous estimates, the survey found. (See related article on p. 104.)

"That's a landmark study," says Jain. "I think it should be a wake-up call to all of us that the problem of drug-resistant organisms is a significant one. We all need to be vigilant and do our part to prevent the spread of infections as much as we can."

### **A slogan and surveillance**

The MRSA eradication program began in 2001 with the slogan, "Getting to Zero." The goal: No more MRSA.

“We probably won’t ever get to zero because of the community-acquired MRSA that exists,” concedes **LaToya Miller**, MPH, MRSA program manager, “but we definitely want to strive for that and get as close as possible.”

Patients receive a nares swab on admission, discharge, and transfer between units. “The transfer swabs are important because they allow us to track which units the infections are occurring on, if they are occurring,” she says.

Employees are not routinely swabbed, says Jain. “Even if [someone] were to become colonized, it’s hard to know what that information means,” he says. “The majority of the time, the employees are transient carriers. They just carry the organism for a very short time and then they lose it, so they’re not carriers anymore.”

Treating carriers also might backfire by creating greater antibiotic resistance, he says. However, employees should be educated about MRSA so they can be tested if they are going to have a high-risk procedure, such as heart surgery or a joint procedure, he says.

Education of employees is an important component of the MRSA eradication program, Miller notes.

### **Making a cultural change**

Eradicating MRSA and other multidrug-resistant organisms requires more than traditional infection control tools. It calls for nothing less than a cultural transformation, say Jain and Miller.

“It’s basically changing the paradigm of how we view infection control,” says Miller. “It needs to be every employee’s responsibility. We have found that from infection control down to environmental management, we all have a role in making sure our hospitals are safe and that veterans are not getting hospital-acquired infections.”

The culture change begins at the top, as “leadership” takes on a new meaning. No longer do mistakes come from administration such as orders to an army of employees. Instead, leadership seeks solutions from those on the front lines, says Jain.

“The leadership provides the policy guidance, but the staff [members] are the experts,” he says. “They’re the ones involved in the day-to-day patient management.”

To facilitate that dramatic change, VA Pittsburgh held “discovery action dialogues,” or action-oriented focus groups, with staff. Administrators attended unit briefings once a week to share data and get feedback from the

## **APIC: MRSA widespread throughout U.S. hospitals**

*Prevalence higher than previous estimates*

**A**bout 46 out of every 1,000 inpatients are infected or colonized with multidrug-resistant *Staphylococcus aureus* (MRSA), a rate that is eight to 10 times higher than previous estimates, according to findings from the Association for Professionals in Infection Control and Epidemiology.

In the most comprehensive study of its kind, the Washington, DC-based organization surveyed 1,237 health care facilities, which encompassed 21% of the nation’s hospitals. Infection control professionals were asked to report infection rates on specific dates to gather a “snapshot.” The responses included hospitals of all sizes from all 50 states.

The prevalence of MRSA has been troubling. In 1972, only 2% of health care-associated *S. aureus* infections were MRSA. Today, MRSA is the most common pathogen-causing health care-associated infection in the United States.

According to APIC, the survey found that:

- 81% of patients were detected by clinical cultures;
- 19% were detected by active surveillance cultures;
- 77% were detected less than 48 hours within admission, which indicates that they either acquired it in the community or during a previous hospital admission;
- 37% had skin and soft-tissue infections only (which are generally a sign of community-acquired MRSA);
- 63% had infections at sites other than skin or soft tissue, such as blood or urinary tract infections or pneumonia.

About 28% of hospitals conduct active surveillance to determine if patients are colonized. The active surveillance typically targeted patients transferred from long-term care facilities or other health care facilities or patients in high-risk areas, such as the intensive care unit or dialysis unit. ■

employees.

The health system also launched a “positive deviance initiative,” which focuses on finding the solutions to problems within a community rather than turning to outside experts. (More information on positive deviance and the VA Pittsburgh Health System is available at [www.positivedeviance.org/projects/pittmrsa/VAPHS\\_Singhal\\_Greiner.pdf](http://www.positivedeviance.org/projects/pittmrsa/VAPHS_Singhal_Greiner.pdf).)

An example: Nurses complained that there

were not enough beds for patients with community-acquired MRSA who needed to be in isolation. Environmental services responded to the problem by deciding to do a “terminal clean,” or more intense cleaning, on all rooms rather than just a select few. The health system now has more flexibility when placing a patient with MRSA.

The initiative makes the VA “a place where everyone feels comfortable in bringing forth their ideas,” says Miller.

### ***Enlist the help of patients***

Employees aren’t the only ones who have been involved in Getting to Zero campaign. Patients have a role in making sure that health care workers comply with hand hygiene.

In one VA hospital, patients receive cards when they’re admitted. When a clinician comes into their room to provide care, they hold up a green card to acknowledge that they’ve seen the clinician perform hand hygiene. They hold up a pink card to say, “Please stop and wash your hands.”

## **Want to prove your value? Audit it!**

*An audit tool verifies performance*

**H**ow do you prove the value created by the employee health service? Perhaps you can show a reduction in injury rates or workers comp claims. Or you report the number of TB screens performed and immunizations delivered. Or you demonstrate broader impact from a wellness initiative.

One systematic way to demonstrate your results is through an internal audit. You can check your services against compliance and performance goals and compare your policies with your actions.

**Mary Asherbranner**, RN, BSN, MSHA, COHN-S, director of client operations at CHD Meridian Health Care in Nashville, TN, a provider of contractual employee health services, conducts a comprehensive audit every two years and “mini-audits” once a quarter.

Audits are an effective way to validate what you are doing — and to uncover weaknesses that you need to correct, says Asherbranner. “We can show that we’re providing the best care and that we’re using not only industry standards, but best practices,” she says.

“It’s hard for veterans to say, ‘Dr. So and So, please stop and wash your hands.’ So this is a nonverbal way to tell the provider they need to do hand hygiene,” says Miller.

The MRSA program leaves it up to individual hospitals to determine how to boost hand hygiene. Some use an interdisciplinary team to conduct observations — sort of a “secret shopper” in health care. One hospital gives stickers to patients and providers. Patients can give stickers if they observe hand hygiene or take them away if they don’t.

The providers and veterans with the most sticker receive rewards.

To sustain a program, you need to be creative and continue to motivate people, says Jain. It needs buy-in beyond infection control and employee health, he says.

“Make it fun,” he says. “Celebrate your successes. Reward people when you see good behavior. Make sure you listen to staff and remove barriers. The staff will see this is a real change and they will get excited and help you move forward.” ■

For example, to check compliance with chemical safety, an audit would prompt you to verify the Material Safety Data Sheets for all chemicals. “When new chemicals or new products are introduced into the hospital, do they go to a safety group for approval?” says Asherbranner. “That would be one process that I would expect should happen automatically.”

That review of the MSDS system would not just be a paperwork function. You would also make sure that employees have easy access to the information — for example, online — and that they know how and when to refer to the MSDS. The audit would verify that employees know how to respond to a spill and which chemicals they work with require special handling.

### ***Identify risk potential***

Here are some steps to take when setting up an audit:

- **Identify areas of the greatest potential risk.** You can’t include everything on a single audit, nor should you try. You want to have the greatest possible impact. Work with your risk managers to identify areas of potential liability for the hospital and review your injury data for risk of injury to employees.

Consider near-misses. “If you don’t have a system in place to record a near-miss, you need one,”

## Excerpt: Occupational Health Audit Form

Policy No.	Section	Component	Expectation	Outcome: Pass/Fail
3.5	Staff	Areas/tasks requiring the use of respirators have been identified (29 CFR1910.134)		
3.5.1		Employees working in respirator-required areas receive an initial medical evaluation. Additional medical evaluations are done if the Respirator Questionnaire answers change or employee's medical or physical status change.		
3.5.2		Employees working in respirator-required areas receive annual training.		
3.5.6		Employees working in respirator-required areas receive annual fit-testing.		
3.5.7		Employees working in respirator-required areas complete the OSHA Respirator Questionnaire during their initial physical evaluation and before their fit-testing.		

*Source: Mary Asherbranner, RN, BSN, MSHA, COHN-S, CHD, Meridian Health Care, Nashville, TN.*

Asherbranner says.

Reducing injury and risk may go hand-in-hand with demonstrating compliance. For example, you may audit compliance with the sharps safety program. In addition to looking for compliance with the Bloodborne Pathogen Standard of the U.S. Occupational Safety and Health Administration, you also want to make sure employees are following the specific policies and procedures of your institution. Are they properly using the devices you've provided?

- **Break the audit into components.** Decide what specific items you need to verify. Set up a checklist on an Excel spreadsheet with each measure. When you conduct the audit, you may look at one area at a time, such as the respiratory protection program or management of the employee

health clinic. (See sample, above.)

- **Don't try to conduct the audit all at once.** "Look at it on a section-by-section basis," says Asherbranner. "That makes it more manageable."

Maintain a focus on the issues you've identified. It's easy to get sidetracked into other areas, but remember that you selected the items for their potential impact on your operations.

- **Validate your findings.** If you are auditing compliance with bloodborne pathogen policies, for example, you'll want to talk to nurses and make sure they can explain the policy. Do they know how to report an injury? Do they know where the exposure control plan is?

By auditing your program, you can make sure that competencies are maintained and that safety procedures are followed on an ongoing basis. ■

### COMING IN FUTURE MONTHS

■ Surgical residents fail to report needlesticks

■ OR sharps safety improves — but suture injuries remain

■ How to choose the best sling for lifting patients

■ Hospitals struggle to boost HCW influenza immunization

■ A new push for needle safety?

# NIOSH updates list of hazardous drugs

Comments accepted through Sept. 20

As many as 62 new drugs may be added to the list of potential workplace hazards by the National Institute for Occupational Safety and Health.

NIOSH first identified hazardous drugs in its 2004 in its alert titled *Preventing Occupational Exposures to Antineoplastic and Other Hazardous Drugs in Health Care Settings*. Since then, the Food and Drug Administration has approved about 70 new drugs and another 60 drugs have received warnings based on reports of adverse events among patients. The National Institutes of Health also has updated a hazardous drugs list.

NIOSH evaluated those drugs and compiled a list of 62 that potentially could present an occupational hazard to health care workers. NIOSH is accepting comments on the list, and some of the drugs may be removed if they are determined to present a minimal hazard.

The drugs are rated according to their toxicity and other characteristics. For example, cyclophosphamide, an antineoplastic drug, is often administered in a liquid form through an IV bag. The coated tablet may not be hazardous to health care workers, however, says **Thomas Connor**, PhD, a research biologist with NIOSH in Cincinnati who specializes in occupational hazards of hazardous drugs.

"Whether it's an occupational risk depends on how it's used and the dosage," he says.

NIOSH is soliciting comments on its list of hazardous drugs. It uses five criteria to define a drug as hazardous in the workplace: Carcinogenicity, teratogenicity or other developmental toxicity, reproductive toxicity, organ toxicity at low doses, genotoxicity, and structure and toxicity profiles of new drugs that mimic existing drugs determined hazardous by the above criteria.

"We want to make the process as visible as possible. That's why we're going through an extended review process," says Connor.

The revision of the list of hazardous drugs is just one step NIOSH has taken to increase safety in the workplace in this area. NIOSH has issued guidance on protecting health care workers and conducting medical surveillance. (See *Hospital Employee Health*, June 2004, p. 72, and July 2007, p. 79.)

## CNE questions

9. According to the new Guideline for Isolation Precautions issued by the Centers for Disease Control and Prevention, health care workers should wear a mask for droplet precautions if they are within \_\_\_\_\_ from a patient with a respiratory infection.
  - A. 3 feet
  - B. 4 feet
  - C. 6 feet
  - D. 8 feet
10. According to the CDC isolation guidelines, "opportunistic" organisms are:
  - A. agents that are more virulent than other diseases.
  - B. agents that are only infectious in patients who are coinfecting with other diseases.
  - C. agents that are usually not infectious.
  - D. agents that naturally cause disease through contact or droplet routes, but under special circumstances may be transmitted by fine particle aerosols.
11. According to the National Health Interview Survey, how many health care workers received an influenza vaccination in 2005?
  - A. 34%
  - B. 39%
  - C. 43%
  - D. 61%
12. Which of the following is an aspect of cultural change at the VA Pittsburgh Health System's MRSA eradication program?
  - A. Direct care providers must report results of patient safety measures.
  - B. Patients are given more input into their care decisions.
  - C. Leadership conducts "discovery action dialogues," or action-oriented focus groups, with staff.
  - D. Patient care providers work as a team.

Answer Key: 9. C; 10. D; 11. A; 12. C.

## CNE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **December** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

"We are raising awareness of this problem," says Connor, noting that NIOSH has been getting more inquiries about how to best protect health care workers from exposure to hazardous chemicals.

(Editor's note: The proposed list of hazardous chemicals is available at [www.cdc.gov/niosh/review/public/105/default.html](http://www.cdc.gov/niosh/review/public/105/default.html). NIOSH is accepting comments through Sept. 20 through an online form, [PublicReviewForm2006-05-01-07.xls](mailto:PublicReviewForm2006-05-01-07.xls), e-mail [niosh.docket@cdc.gov](mailto:niosh.docket@cdc.gov), fax (513) 533-8285, or written comments to NIOSH Mailstop: C-34, Robert A. Taft Lab, 4676 Columbia Parkway, Cincinnati, OH 45226.) ■

## CNE objectives

After reading each issue of *Hospital Employee Health*, the nurse will be able to do the following:

- **identify** particular clinical, administrative, or regulatory issues related to the care of hospital employees;
- **describe** how those issues affect health care workers, hospitals, or the health care industry in general;
- **cite** practical solutions to problems associated with the issue, based on overall expert guidelines from the Centers for Disease Control and Prevention, the National Institute for Occupational Safety and Health, the U.S. Occupational Safety and Health Administration, or other authorities, or based on independent recommendations from clinicians at individual institutions. ■

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# The Joint Commission Update for Infection Control

*News you can use to stay in compliance*

## **SHEA protests Joint Commission's proposed infection control standards**

*Revisions could dilute field, put ICPs back in silos*

The Joint Commission has proposed standards revisions that could weaken infection control programs “significantly at a time when health care associated infections (HAIs) are receiving increasing attention by legislators, payers, and consumers,” the Society for Healthcare Epidemiology of America (SHEA) warns.

In a letter submitted to the Joint Commission regarding its ongoing Standards Improvement Initiative (SII), SHEA protested a perceived dilution of infection control standards into the Leadership, Human Resources, and Emergency Management chapters.

“In addition, the standards as proposed do not speak to the integration of the infection control program into the organization’s quality improvement and patient safety initiatives as strongly indicated in the Centers for Medicare & Medicaid Services (CMS) Draft Infection Control Interpretive guidelines,” SHEA president **Victoria Fraser, MD**, stated in the letter. “This deficit coupled with the removal of programmatic resources, influx of communicable diseases, and staff competency and training to other chapters tends to ‘silo’ infection prevention and control activities.”

Asked to respond to the SHEA comments, **Robert Wise, MD**, vice president of standards and survey methods at The Joint Commission, says: “Soliciting feedback from the field and the public is a vital part of the SII project and all comments received are taken into consideration. At this time it would be premature to respond to SHEA’s concerns because modifications to the standards are still in process.”

Specifically, SHEA urged the elimination of

proposed standard IC.1.10 EP 2, which states: “When the individual(s) responsible for oversight does not have expertise in infection prevention and control, he or she consults someone with such expertise in order to make knowledgeable decisions.”

The proposed standard “appears to dilute the authority of the infection control professional and the physician/hospital epidemiologist by implying that the administrative position to which infection prevention experts report should consult external experts if they themselves have no training or experience in infection control,” SHEA argued. “We would propose that if trained and competent individuals are appointed to direct the infection prevention and control program, there is no need for the individual who had administrative oversight of the program to seek external consultation.”

### ***Changes would ‘fragment’ relationships***

If the ICPs need additional help or consultation, the more direct route would be for them to seek external consultation from experts as necessary, SHEA noted. “This should be supported by the administration. . . . The authority issue has been the backbone of successful IPC programs . . . It is more important to foster ongoing partnership and effective relationships between ICPs, health care epidemiologists and senior leadership and not to fragment those relationships.”

The Joint Commission drew a similar backlash in 2002 after ICPs successfully protested a proposal to consolidate and reduce the number of infection control standards. That flap was followed by press

criticisms that the Joint Commission was lax on infection control. As a result, the Joint Commission heavily emphasized infection control beginning with its 2004 patient safety goals and 2005 revised standards. Now, however, we seem to have come full circle, with SHEA warning that the currently proposed revisions will dilute and undermine infection control programs. Other specific points made by SHEA include key comments on the following proposed changes to existing standards:

- **Current Standard IC.6.10**

SHEA strongly disagrees with moving standards dealing with an influx of communicable disease patients to the Emergency Management Chapter. As indicated in this current standard and in current Environment of Care Standards, an integrated approach to emergency management, including involvement in local, state and national planning activities is key. Removal of this language from the Infection Control chapter dilutes the criticality of IC participation and fosters a silo approach. SHEA suggests instead a cross-reference here to leadership, medical staff, and environment of care standards as appropriate.

- **Current Standard IC.7.10 EP 2**

SHEA strongly disagrees with moving standards on qualifications of infection prevention professionals to the Human Resources chapter. Infection prevention and control specialists are unique in that literature shows education and specific training are necessary for reliable collection of data. This is especially necessary at a time when HAIs are receiving more and more public scrutiny, and mandatory reporting is required in at least 14 states. Having well trained and competent ICPs is integral to public reporting mandates whose goal is to provide comparative information on HAI that can be used by consumers to make healthcare choices. This standard should be retained with a cross-reference to Human Resources.

- **Current Standard IC.9.10**

SHEA strongly disagrees with moving the IPC program resource assessment and provision to the Leadership chapter. This dilutes the emphasis on IPC resources (IPC as nonrevenue-generator) at a time when HAI are receiving more public and payer scrutiny. This standard should be retained with a cross-reference to the Leadership chapter. SHEA agrees with the Joint Commission focus on risk assessment based on geographic considerations, patient and employee populations, services provided in order to inform surveillance activities and programmatic planning and prioritization. However, the focus on

written plans with written goals, objectives, and targets is too proscriptive and values form over substance. This focus may be especially problematic for smaller facilities with fewer resources secretarial resources. ■

## Flu shot standard stirs initial response

*Survey finds movement on longstanding problem*

The Joint Commission's new standard requiring hospitals to offer influenza vaccine to health care workers is showing some signs of initial impact, but the first real test will be the 2007-2008 flu season.

Effective Jan 1, 2007, the Joint Commission standard is aimed at improving poor immunization rates among health care workers, a historical problem that puts patients at risk of flu infections. In addition, last year the Centers for Disease Control and Prevention called for workers who decline seasonal flu shots to sign off on declination statements unless they have medical contraindications.<sup>1</sup> The Joint Commission's standard did not go that far, but may actually have a greater impact in the long run because hospitals do not want to run afoul of accreditation surveyors.

"I think it probably will [have more impact] because it is an accrediting agency," says **Tom Talbot**, MD, MPH, chief hospital epidemiologist at Vanderbilt University School of Medicine in Nashville. "The CDC has been saying for years that we've got to get our health care worker vaccination [rates] up. Some administrators in some hospitals will not move in that direction until someone kind of pushes them that way, whether it is through pay-for-performance or accreditation issues."

### ***No immediate expectations***

The Joint Commission has no immediate expectation for hospitals to meet some benchmark immunization rate, but does expect the standard to begin pushing national rates out of the abysmal 40% range. "I think the Joint Commission getting involved is a major step into hopefully making a difference into the pitifully low health care worker vaccination rates we

have," Talbot says.

Talbot was one of the lead researchers in a recent survey of members of both the Society for Healthcare Epidemiology of America (SHEA) and the Association for Professionals in Infection Control and Epidemiology (APIC). Respondents were surveyed to assess what actions they were taking in response to the standard. A surprisingly high 58% of respondents said they are using declination statements, even though the Joint Commission standard does not require the measure.

"The Joint Commission standard does not specifically require declination, but when they [drafted] it that is something that they did have proposed for comment," Talbot says. That and the CDC recommendations calling for declination no doubt had an impact, but ultimately the Joint Commission decided to drop declinations from the final standard. "It was probably because the opponents of it raised concerns," he says, "because the resources that are going to go into it are fairly significant. There are so many things ICPs and hospital epidemiologists are trying to tackle you have to make sure what you are diverting your resources towards will make a difference."

Indeed, declination statements shift some accountability to the worker declining flu vaccine, but critics charge they could lapse into a paperwork exercise.

"Even though we queried [on the survey], we don't know how the declination statements were promoted and enforced," he says. "They may be holding to the record-keeping policy and collecting the declination statements, but are they doing what they need to do to educate people. The burning question everybody wants to know is, 'If I am going to put all these resources into this and maybe reprimand them for not signing a paper is there going to be a benefit?'"

Conducted as a project of the SHEA/APIC Communication Network, the survey found that as 93.7% of respondents said, in the last three years, they have offered flu vaccine to employees, licensed independent practitioners and volunteers. Conducted between Dec. 21, 2006, and March 1 2007, the survey netted 650 responses from participants in 46 states. According to the survey, other methods ICPs will use to enhance immunization rates in light of the new Joint Commission standard include:

- providing more information in hospital employee newsletters or other communication devices (76%);
- offering more times when vaccination is

available (56%);

- tracking compliance by unit, and offer rewards for highest participation (41%);
- providing special influenza inservices to employees (39%).

The percentages of those responses will have to be pushed higher if the historic problem of low health care worker immunization rates is to be overcome, Talbot says. The SHEA/APIC network plans additional hospital surveys to assess the impact of the standard and other flu immunization initiatives. "We have real-world laboratories for the upcoming flu season to get us data to look at this," he says.

## Reference

1. Centers for Disease Control and Prevention. Influenza Vaccination of Health-Care Personnel Recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC) and the Advisory Committee on Immunization Practices (ACIP) *MMWR* 2006; 55:1-16. ■

## WHO hand hygiene text added to safety goals

*Can be used as an alternative to CDC*

The Joint Commission has added a new patient safety goal for 2008 that allows hospitals to comply with hand hygiene guidelines by the World Health Organization. Hospitals can either comply with the WHO guidance or the Centers for Disease Control and Prevention (CDC) hand hygiene guidelines, which have been listed as a patient safety goal since 2004.

"The Joint Commission recognizes that alternative guidelines exist for international health care with respect to hand hygiene and that the World Health Organization (WHO) guideline is contemporary in its approaches," says **Peter Angood**, MD, vice president and chief patient safety officer at The Joint Commission.

The CDC guidelines are widely considered the gold standard for hand hygiene, but the WHO guidelines are a good alternative, he says. "U.S.-based health care systems occasionally review international guidelines for incorporation into their practices," Angood says. "The Joint Commission has issued this modification to the National Patient Safety Goal in recognition and support of this specific hand hygiene

guideline approach.”

The other major patient safety goal related to infection control remains intact. It calls for hospitals to “manage as sentinel events all identified cases of unanticipated death or major permanent loss of function associated with a health care-associated infection.”

The WHO guidelines, which use the same ranking system as the CDC, include the following recommendations for health care workers:

A. Wash hands with soap and water when visibly dirty or contaminated with proteinaceous material, or visibly soiled with blood or other body fluids, or if exposure to potential spore-forming organisms is strongly suspected or proven (IB). (*Strongly recommended for implementation and supported by some experimental, clinical, or epidemiological studies and a strong theoretical rationale*); or after using the restroom (II). (*Suggested for implementation and supported by suggestive clinical or epidemiological studies or a theoretical rationale or a consensus by a panel of experts.*)

B. Preferably use an alcohol-based hand rub for routine hand antisepsis in all other clinical situations described in item C listed below if hands are not visibly soiled (IA). (*Strongly recommended for implementation and strongly supported*

*by well-designed experimental, clinical, or epidemiological studies.*) Alternatively, wash hands with soap and water (IB).

C. Perform hand hygiene:

- before and after having direct contact with patients (IB);
  - after removing gloves (IB);
  - before handling an invasive device (regardless of whether or not gloves are used) for patient care (IB);
  - after contact with body fluids or excretions, mucous membranes, nonintact skin, or wound dressings (IA);
  - if moving from a contaminated body site to a clean body site during patient care (IB);
  - after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient (IB);
  - wash hands with either plain or antimicrobial soap and water or rub hands with an alcohol-based formulation before handling medication and preparing food (IB);
  - when alcohol-based hand rub is already used, do not use antimicrobial soap concomitantly (II).
- (*Editor’s note: The WHO hand hygiene guidelines are on the web at: [www.who.int/patientsafety/events/05/HH\\_en.pdf](http://www.who.int/patientsafety/events/05/HH_en.pdf).)* ■

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