Preventing the flu is up to you

Strategies to prevent the spread of influenza in patients and healthcare providers in ambulatory care

By Sue Barnes, RN, CIC
National Leader, Infection Prevention and Control, Quality and Safety Department, Program Office, Kaiser Permanente

The benefit of reducing the risk of influenza for our patients is indisputable, though the road to that goal is not clear cut. Infection preventionists (IPs) continue to support not only covering coughs or respiratory etiquette and hand hygiene, but also instituting mandatory flu vaccination for healthcare personnel (HCP) in order to optimize risk reduction.

Flu transmission

Influenza viruses spread from person to person primarily through large-particle respiratory droplet transmission (e.g., when an infected person coughs or sneezes near a susceptible person). Transmission via large-particle droplets requires close contact between source and recipient persons, because droplets generally travel only short distances (approximately 6 feet or less) through the air. Indirect contact transmission via hand transfer of influenza virus from virus-contaminated surfaces or objects to mucosal surfaces of the face (e.g., nose, mouth) may also occur. Adults shed influenza virus from the day before symptoms begin.

Preventing the flu, continued on page 3
Welcome to the fall 2012 edition of Preventing Infection in Ambulatory Care, APIC’s quarterly e-newsletter providing ambulatory infection preventionists (IPs) with valuable, up-to-date information to aid in preventing infection.

It’s that time of the year again—flu season. Are you being proactive in encouraging healthcare personnel to get vaccinated? Are you prepared for a potential outbreak in your facility? In the lead story titled “Preventing the flu is up to you,” Sue Barnes, RN, CIC, provides important information about flu vaccinations, respiratory etiquette, hand hygiene, outbreak investigation, and more to help you stay on top of your game this flu season.

Inpatient settings monitor and manage isolation procedures, but isolation can also be a challenge for outpatient settings. The fall issue features a fascinating case study on the successful implementation of outpatient isolation from MD Anderson Cancer Center. Read about their collaborative strategy to develop and implement a successful outpatient isolation program to reduce exposure to multidrug-resistant organisms and improve patient safety.

“Knowing the requirements for proper cleaning, disinfection, and sterilization of instruments and ensuring staff are following them will provide a safe environment for ambulatory surgery patients, reduce the risks of infection, and lead to great patient outcomes,” writes Marcia Patrick, MSN, RN, CIC. Patrick provides readers with eight essential steps to ensuring that your disinfection and sterilization procedures are up to par.

Nancy Hailpern, APIC director of Regulatory Affairs, and Lisa Tomlinson, APIC senior director of Government Affairs, provide readers with details on a recent GAO report on unsafe injection practices in ambulatory care settings. The hope is that a thoughtful and coordinated response to this GAO report could improve patient safety by reducing bloodborne pathogen outbreaks in ambulatory care settings.

Additionally, we provide readers with a summary of state legislation that affects ambulatory care and surgical centers.

We hope you’ll find these articles informative and useful for your practice. As always, we welcome your comments and encourage you to write to editor@apic.org telling us what you want to read and need to know.

Regards,

Preventing Infection in Ambulatory Care Editors
Preventing the flu, continued from page 1

Young children also might shed virus several days before illness onset, and children can be infectious for 10 or more days after onset of symptoms. Severely immunocompromised persons can shed the virus for weeks or months. Persons treated with influenza antiviral medications continue to shed influenza virus while on treatment. This means that it is not possible to prevent transmission of flu with respiratory etiquette alone.

Flu vaccination

Everyone 6 months of age and older should get a flu vaccine each year (this Centers for Disease Control and Prevention recommendation started with the 2010-2011 influenza season). This includes HCP.Achieving high influenza vaccination rates of HCP and patients is a critical step in preventing transmission of influenza.

There are two types of influenza vaccine:

1. Inactivated trivalent vaccine (TIV) - a vaccine containing killed virus that is given with a needle, usually in the arm. There are three different kinds of TIV on the market in the U.S. now.
   - The regular trivalent inactivated vaccine is given intramuscularly and is approved for people 6 months of age and older, including healthy people, those with chronic medical conditions, and pregnant women.
   - A “high dose” trivalent inactivated vaccine is also given intramuscularly and contains four times the amount of antigen as the regular TIV. It is approved for use in people 65 years of age and older and was introduced in 2009-2010.
   - An intradermal trivalent inactivated vaccine is administered into the dermal layer of the skin via a single-dose, prefilled microinjection syringe and contains less...
antigen than the intramuscular TIV formulations. The intradermal vaccine was approved for use in people 18 through 64 years of age in 2011.

2. Live, attenuated intranasal influenza vaccine (LAIV) is given as a nasal spray and can be used in healthy people 2-49 years of age who are not pregnant.

Arguments in favor of mandatory flu vaccination include:

- Each year, 5 to 20 percent of U.S. residents acquire an influenza virus infection, and many will seek medical care.
- More than 200,000 persons, on average, are hospitalized each year for flu-related complications.

Respiratory etiquette and hand hygiene

In addition to vaccination, the key methods for preventing transmission of the flu are covering coughs and sneezes, frequent hand hygiene with alcohol-based hand rub or soap/water, and social distancing of 3 to 6 feet during flu season.

Outbreak investigation

In the event of a suspected influenza outbreak, the following are commonly recommended steps to guide the investigation. For more information, please see Outbreak investigation, prevention and control in healthcare settings by Kathleen Arias.

1. Initiate the outbreak by determining:
   - Location/setting of outbreak
   - Number of ill cases and susceptible cases (if known)
   - Infectious disease etiology suspected
   - Date the outbreak was reported to the local health department
   - Investigator’s contact information

2. Case definition
   - While the outbreak control measures for many respiratory diseases are similar, it can be helpful to know the etiology of the outbreak in order to apply disease-specific control measures.
   - The definition of an outbreak of acute febrile respiratory illness, influenza-like illness, or influenza varies somewhat by setting. The local health department may always choose to consider additional scenarios as outbreaks, based on their own judgment of the situation.

- 4 to 11 percent of children hospitalized with laboratory-confirmed influenza require treatment in the intensive care unit.
- Among 1,308 hospitalized children in one study, 80 percent were aged <5 years.
- From 1979 through 2001, the estimated annual overall number of influenza-associated hospitalizations in the United States ranged from approximately 55,000 to 431,000 per annual epidemic (mean: 226,000).
- Adults shed influenza virus from the day before symptoms begin. Young children also might shed virus several days before illness onset, and children can be infectious for 10 or more days after onset of symptoms. Severely immunocompromised persons can shed virus for weeks or months. Persons treated with influenza antiviral medications continue to shed influenza virus while on treatment.
3. Create a line list of cases

4. Specimen collection and laboratory testing
   - Employ control measures for outbreaks of influenza-like illness.
   - Promote and administer the current season's influenza vaccine to patients and HCP, following current vaccination recommendations for the use of nasal and intramuscular influenza vaccines.
   - Minimize potential exposures in waiting areas and other parts of the facility. Promote good hand and respiratory hygiene and provide the necessary supplies.
   - Monitor and manage ill HCP. Ensure that HCP who develop fever and respiratory symptoms are excluded from work until at least 24 hours after fever has resolved (without the use of fever-reducing medicines such as acetaminophen or ibuprofen).
   - Adhere to standard precautions for all patients and implement droplet precautions for all patients with suspected or confirmed influenza.
   - Use respiratory protection (e.g., N-95 mask) when performing aerosol-generating procedures.
   - Manage visitor access and movement within the facility, with consideration for protection of both patients and visitors.
   - Monitor influenza activity in the community and in the facility. Work with local and state health authorities if an outbreak is detected in the facility.
   - Implement environmental and engineering controls to eliminate or reduce exposures to influenza. Examples include standard cleaning and disinfection procedures and the installation of partitions or curtains in shared areas.
   - Train and educate HCP on preventing transmission of infectious agents.
   - Administer influenza antiviral chemoprophylaxis and treatment to patients and HCP according to current recommendations, when appropriate.

5. Monitoring and wrap-up
   - Identify whether there are new cases or continuing transmission.
   - Maintain a line list.
   - Implement additional control measures as needed.
   - Submit additional specimens to public health department (PHD) for untreated cases with new onset, if outbreak etiology has not yet been confirmed.
   - Identify when two incubations have passed since the last suspected exposure. At this point, consider the outbreak closed, though advise the facility to alert the PHD if additional cases are discovered.
   - Continue to update the PHD about the outbreak status throughout the course of the outbreak, and advise when the outbreak is closed.
   - Create and present some type of outbreak summary within 30 days after outbreak closure (e.g., share with local infection prevention committee, PHD).

For a list of flu prevention resources, see page 20 (click here)
Monitoring and managing isolation have routinely been practiced in the inpatient setting at MD Anderson Cancer Center, but not consistently in the outpatient centers. With the increasing number of patients visiting outpatient centers, appropriate monitoring and management of isolation patients has become very important. When patients are not monitored, proper isolation precautions may not be taken, increasing the risk of patient and staff exposure to multidrug-resistant organisms (MDROs) and other organisms of concern. Likewise, failure to remove patients from isolation in a timely manner results in unnecessary increases in staff time and personal protective equipment use, along with decreased patient satisfaction.

With more than 1.2 million outpatient visits per year at MD Anderson Cancer Center, monitoring and managing isolation patients in the outpatient setting is a huge undertaking. As of November 2008, only seven of the 22 outpatient centers at our institution participated in removal of patients from isolation. At that time, more than 2,000 patients were on isolation. A standard method for checking the isolation status of outpatients was not in place. This resulted in both the failure to use appropriate precautions, and the lack of patient assessment to determine

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Isolation Patient Follow-up Algorithm

FIGURE 1: Patient Isolation Status Algorithm

Exclusions from Follow-Up Cultures:
- Satellites
- Diagnostic Imaging
- Diagnostic Centers
- Radiation Oncology

Polly Williams
Infection Control Practitioner
February 16, 2009
the follow-up required to remove patients from isolation.

To assure patient safety in the outpatient centers and to further address the use of isolation precautions and timely removal of patients from isolation, it was time for a change. The Infection Control department convened the Outpatient Isolation Solution Session in November 2008, under executive sponsorship. The Infection Control, Performance Improvement, and Outpatient Nursing Leadership departments facilitated a brainstorming session with representatives from all of the outpatient centers and enterprise applications. We constructed a fishbone diagram to identify issues contributing to the problem and identified opportunities for improvement. Five different workgroups were formed. In addition, the group created the Patient Isolation Status Algorithm (see Figure 1) to assist in solving the problem along with an action plan and a timeline to monitor the progress of our short-term and long-term goals.

Within five months, many short-term solutions were in place. A daily list of scheduled isolation patients was emailed directly to the manager and...
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Instrument reprocessing is an area fraught with risks to patients. This is a complex process, made even more difficult by the inherent complicated design of some instruments that make them very hard to clean and disinfect or sterilize. A recently published investigation of surgical site infections related to bone shavers concluded that even when cleaned per manufacturer’s recommendations, they remained contaminated with tissue and other debris, including bristles from the cleaning brush.¹

1. Cleaning always comes first.

This brings up the first “rule” for cleaning, disinfection and sterilization. You must physically clean before an instrument can be disinfected or sterilized. There is no magic in either high-level disinfectant solution or the autoclave. If you fail to clean, the disinfection and sterilization processes will also fail.

It is important to have the manufacturer’s directions for cleaning, disinfecting, or sterilizing each instrument you have in your inventory and these directions must be readily available to the staff performing these functions. They also must follow them. For complex devices such as endoscopes, it can be helpful to post the cleaning instructions on the outside of cabinet doors above the cleaning area so all can see and follow them. Manufacturers often have these available for free or they can be downloaded and printed. In addition to the instructions for the device, the instructions for use of the high-level disinfectant and/or autoclave must be available. Perform adequate training and competency review to ensure everyone is following the procedures correctly and to reduce inconsistencies among different staff members.²

2. Don’t forget staff safety.

Personal protective equipment appropriate to the exposure potential is required, not optional. Heavy duty gloves, a water-resistant gown, mask, and eye protection (e.g., goggles, glasses with solid side shields or a chin-length face shield) are required. These items must be removed and hands cleaned before leaving the soiled utility room or area and before moving from cleaning instruments to removing soaked scopes or packages from the autoclave.³
3. Assure accuracy.

High-level disinfectant solution must be tested for potency before each use and the results logged. Test strips are brand-specific; one cannot use brand “A” test strips with brand “B” high-level disinfectant. Test strip bottles should be dated when opened and discarded per manufacturer’s instructions. The strips should be quality control tested each time a new bottle is opened and per manufacturer’s instructions. This assures that the results of the dipstick testing will be accurate.

4. Take the time to do it the right way.

It always makes me nervous when a staff member says, “Oh, we love it when Stanley is back there processing scopes. He can turn them around in under 10 minutes!” A look at the label on the high-level disinfectant shows a 12 minute soak time. That’s a problem. If volumes are so high that shortcuts must be taken to meet demand, the better choice is to obtain additional scopes.

5. The cleaning equipment matters.

The cleaning equipment must be available and in good repair. Brushes must be able to clean all the surfaces. Like worn out toothbrushes, old or heavily used brushes won’t do the job. For scopes, each scope has specific cleaning requirements. Failure to have the correct brushes can result in debris being left in channels and ports on a scope. If it isn’t physically clean, you cannot high-level disinfect or sterilize it.

6. Immediate-use sterilization isn’t always the answer.

Similarly, what is being “flashed” in your autoclave? All the accrediting agencies say flashing, now called “immediate-use sterilization,” is never a replacement for proper inventory. Keep a list of what is being processed for immediate-use. It will tell you where additional instruments are needed. Surveyors are looking carefully for this.

Immediate-use is only for critical instruments that are dropped and should not be used for routine reprocessing of sets or trays of instruments. When you do use immediate-use sterilization, be sure the correct cycle is run, as cycles vary. If using instrument caskets, be sure the casket is labeled for an immediate-use cycle. Always be sure the wrapper or pouch you are using is the correct one for the cycle you are running. There are specific products for specific types of loads.

7. Ensure parameters are met.

Autoclaves must have a printable “receipt” for your load log, showing that the time, temperature and pressure parameters were met. Without a printout, someone would have to stand by the autoclave and ensure that these parameters were met (i.e., the autoclave reached the correct temperature and pressure for
the correct amount of time). If yours doesn’t have a printout, it’s time to replace the autoclave.

Sterile packages should be labeled with the date processed and the load number. Internal and external indicators must be included in each pack. Biological testing must be performed at least weekly and with each implant load (and the implant quarantined until the rapid readout biological is negative). Many facilities run a biological daily; it helps to more quickly identify problems with the autoclave. Facilities using their autoclave less than weekly should run a biological with each load.


Be sure you have documentation of routine and any special maintenance for each autoclave. The type and frequency of service is found in the autoclave manual. The service must be provided by a knowledgeable technician. Follow the manufacturer’s instructions for cleaning the autoclave. For desktop machines, this generally includes weekly and monthly tasks that may include removing all the racks, cleaning the interior, checking the gasket, and draining and replacing distilled water. It’s obvious when the racks haven’t been removed in a long time; they’re really hard to get out.2

Knowing the requirements for proper cleaning, disinfection and sterilization of instruments and ensuring staff are following them will provide a safe environment for ambulatory surgery patients, reduce the risks of infection, and lead to great patient outcomes.

References:

1. http://www.fda.gov/MedicalDevices/Safety/AlertsandNotices/ucm170639.htm
Between 2001 and 2011, the U.S. Centers for Disease Control and Prevention (CDC) identified 18 bloodborne pathogen outbreaks in ambulatory care settings, and the agency believes this underestimates the full extent of such outbreaks. In his capacity as the Ranking Member of the U.S. House of Representatives Subcommitteee on Health, and because one such outbreak in his Congressional district impacted more than 4,000 of his constituents, Representative Frank Pallone (NJ) asked the U.S. Government Accountability Office (GAO) to study outbreaks related to unsafe injection practices. The GAO report, released in July, noted that both the CDC, through evidence-based guidelines, and the Centers for Medicare & Medicaid Services (CMS), through ambulatory surgical center (ASC) Conditions of Participation in Medicare, provide federal oversight to ensure compliance with infection control standards. The report also noted, however, that more action is needed to protect patients from infection due to unsafe injection practices.

Outbreaks are difficult to track for a variety of reasons. For example, not all care settings fall within CMS oversight; there is no requirement that facilities report outbreaks to the CDC; patients who develop infections may seek treatment at a different facility rather than the one at which the original procedure was performed; or people infected with viral hepatitis resulting from unsafe injection practices may not display symptoms for years after the procedure. In fact, a recent study by the Institute of Medicine reported that up to 75 percent of people infected with hepatitis may be unaware of the infection.

In conducting the study, GAO interviewed representatives of several agencies within the U.S. Department of Health and Human Services (HHS) that have a role in injection safety issues, including the CDC, CMS, the Agency for Healthcare Research and Quality (AHRQ) and the Food and

As a result of its study, GAO recommended three areas in which HHS could strengthen its efforts in injection safety

By Nancy Hailpern and Lisa Tomlinson
APIC Director of Regulatory Affairs APIC Senior Director of Government Affairs
Drug Administration (FDA). GAO also interviewed representatives of organizations and companies that focus on patient safety and medical devices, including representatives from APIC.

As a result of its study, GAO recommended three areas in which HHS could strengthen its efforts in injection safety:

**Education:** In collaboration with the Safe Injection Practices Coalition (of which APIC is a member), the CDC developed the One and Only Campaign to raise awareness among patients and healthcare providers about safe injection practices. The campaign provides materials and other resources to educate clinicians on injection safety. GAO recommended that the CDC strengthen its targeting of the campaign to healthcare settings that may not be overseen by CMS, such as physicians’ offices.

**Data collection:** Although CMS substantially expanded its oversight of infection control practices in ASCs for fiscal years (FY) 2010 and 2011 and directed ASC surveyors to use the CMS Infection Control Surveyor Worksheet in conjunction with direct patient observation, CMS decided to stop collecting data directly from the worksheets after FY 2011. GAO recommended that CMS and CDC work together to resume collecting data related to injection safety from the worksheet or any other source of comparable data that will allow for continued monitoring of unsafe injection practices.

**Monitoring compliance:** CMS’s decision to stop collecting surveyor worksheet data prevents the CDC from using these data to analyze the extent of outbreaks due to unsafe injection practices over time. GAO recommended that CMS and the CDC use surveyor data to continue monitoring compliance with infection control standards at ASCs and that the CDC continue monitoring trends related to compliance.

HHS concurred with all of the GAO recommendations. In its response to the GAO report, the agency reported that CMS plans to resume surveys via the Infection Control Surveyor Worksheet for a state-stratified random sample of ASCs beginning in FY 2013 and repeated approximately every three years, and that this data will enable CMS and the CDC to aggregate data in order to assess injection safety trends over time. The response also noted that the CDC supports targeting the outreach of the One and Only Campaign to specific provider groups and care settings.

The GAO is a nonpartisan, independent, investigative agency that works for Congress. In 2008, the GAO released a series of reports on healthcare-associated infections in hospitals and ASCs in the U.S., which included a recommendation for broader leadership from HHS to coordinate and prioritize infection control practices. The HHS response to these reports led to establishment of an interagency steering committee that developed the National Action Plan to Prevent Healthcare-Associated Infections. Patient safety advocates are hopeful that a similarly thoughtful and coordinated response to this GAO report could improve patient safety by reducing bloodborne pathogen outbreaks in ambulatory care settings.
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As public policy efforts at all levels of government continue to focus on improving healthcare quality in all care settings, APIC continues to monitor infection-related legislation. This table focuses on state legislation impacting ambulatory surgical centers (ASCs). In many states, legislative sessions last for two years, and legislation that has not been enacted carries over from the first to the second year of the session. As such, the 2012 state legislation table includes some bills that were introduced in 2011 and are either still pending or saw action in 2012. Bills that have been introduced or have had a change in status since the last issue of Preventing Infection in Ambulatory Care are shaded in blue. For more information on legislation impacting ASCs, or other legislation affecting your state, please contact Nancy Hailpern, director of Regulatory Affairs, at 202-454-2643 or nhailpern@apic.org, or visit the legislative map on the APIC website at www.apic.org/Advocacy/Legislative-Map.
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<th>Introduces ASC reporting of HAIs</th>
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<tr>
<td>Delaware</td>
<td><strong>HB 403</strong>&lt;br&gt;(Introduced 6/16/2012) Bill would expand the existing HAI reporting law to include certain non-hospital facilities, including freestanding surgical centers, and would require a practitioner who treats an HAI related to a clinical procedure to report the HAI back to the facility where the procedure was performed.</td>
<td>No</td>
<td><a href="http://www.legis.delaware.gov/LIS/lis146.nsf/vwLegislation/HB+403/$file/legis.html?open">http://www.legis.delaware.gov/LIS/lis146.nsf/vwLegislation/HB+403/$file/legis.html?open</a></td>
<td>Bill enacted on July 20, 2012</td>
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<td>Hawaii</td>
<td><strong>HB 2172</strong>&lt;br&gt;(Introduced 1/20/2012) Bill would require surgical outpatient facilities to follow U.S. Centers for Medicare &amp; Medicaid Services requirements pertaining to ASCs.</td>
<td>Yes</td>
<td><a href="http://www.capitol.hawaii.gov/session2012/bills/HB2172_.HTM">http://www.capitol.hawaii.gov/session2012/bills/HB2172_.HTM</a></td>
<td>Legislature adjourned without enacting legislation</td>
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<td>Kentucky</td>
<td><strong>HB 416</strong>&lt;br&gt;(Introduced 2/16/2012) Bill would require healthcare facilities, including ambulatory care centers, to implement infection prevention programs in high-risk areas, and report to the state health department all HAI and MDRO infections through CDC’s National Healthcare Safety Network (NHSN). The health department would be required to make the information publicly available in understandable language that allows for comparisons between facilities. A similar bill was introduced in 2011.</td>
<td>Yes</td>
<td><a href="http://www.lrc.ky.gov/record/12RS/HB416.htm">http://www.lrc.ky.gov/record/12RS/HB416.htm</a></td>
<td>Legislature adjourned without enacting legislation</td>
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<td>SB 42</td>
<td>(Introduced 1/3/2012) Bill would require the State Board of Medical Licensure to establish infection control requirements for pain management facilities.</td>
<td>No</td>
<td><a href="http://www.lrc.ky.gov/record/12RS/SB42.htm">http://www.lrc.ky.gov/record/12RS/SB42.htm</a></td>
<td>Legislature adjourned without enacting legislation</td>
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<td>Massachusetts</td>
<td><strong>HB 614</strong>&lt;br&gt;(Introduced 1/19/2011) Bill would require ASCs to develop model MDRO screening and precautionary procedures for high-risk patients.</td>
<td>No</td>
<td><a href="http://www.malegislature.gov/Bills/BillHtml/106867generalCourtId=1">http://www.malegislature.gov/Bills/BillHtml/106867generalCourtId=1</a></td>
<td>Bill was incorporated into HB 1519 and MDRO screening and precautionary provisions were removed</td>
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<td><strong>HB 1519</strong></td>
<td>Similar provisions in HB 4155, SB 2400</td>
<td>No</td>
<td><a href="http://www.malegislature.gov/Bills/BillHtml/106867generalCourtId=1">http://www.malegislature.gov/Bills/BillHtml/106867generalCourtId=1</a></td>
<td>Provisions involving checklists of care were passed as part of SB 2400 (see below for status of SB 2400)</td>
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<td>(Introduced 1/20/2011) Provisions of this bill would direct the public health department to develop checklists of care to prevent adverse events and reduce HAI rates, and encourage their implementation in ASCs.</td>
<td>No</td>
<td><a href="http://www.malegislature.gov/Bills/BillHtml/106867generalCourtId=1">http://www.malegislature.gov/Bills/BillHtml/106867generalCourtId=1</a></td>
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<td><strong>HB 4070</strong></td>
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<td>No</td>
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<td>Provision involving consumer website was passed as part of SB 2400 (see below for status of SB 2400)</td>
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<td>(Introduced 5/4/2012) Bill would require the state to establish a consumer health information website that displays data on HAIs and serious reportable events from ASCs.</td>
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<td>Provision involving consumer website was passed as part of SB 2400 (see below for status of SB 2400)</td>
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<td><strong>HB 4155</strong></td>
<td>Similar provisions in HB 1519, SB 2400</td>
<td>No</td>
<td><a href="http://www.mass.gov/legis/journal/desktop/Current%20Agenda%202011/H4155.pdf">http://www.mass.gov/legis/journal/desktop/Current%20Agenda%202011/H4155.pdf</a></td>
<td>Provisions involving checklists of care were passed as part of SB 2400 (see below for status of SB 2400)</td>
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<td>(Introduced 6/5/2012) Provisions of this bill would direct the public health department to develop checklists of care to prevent adverse events and reduce HAI rates, and encourage their implementation in ASCs.</td>
<td>No</td>
<td><a href="http://www.mass.gov/legis/journal/desktop/Current%20Agenda%202011/H4155.pdf">http://www.mass.gov/legis/journal/desktop/Current%20Agenda%202011/H4155.pdf</a></td>
<td>Provisions involving checklists of care were passed as part of SB 2400 (see below for status of SB 2400)</td>
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* Note: Shading indicates change in status from previous issue.
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<td>SB 2270</td>
<td>Bill would require the state to establish a consumer health information website that displays data on HAIs and serious reportable events from ASCs.</td>
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<td>Bill has been incorporated into SB 2400 (see below for status of SB 2400)</td>
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<td>SB 2400</td>
<td>Bill requires the state to establish a consumer health information website that displays data on HAIs and serious reportable events from ASCs. It also directs the public health department to develop checklists of care to prevent adverse events and reduce HAI rates, and encourage their implementation in ASCs.</td>
<td>No</td>
<td><a href="http://www.malegislature.gov/Bills/BillHtml/119663?generalCourtId=1">http://www.malegislature.gov/Bills/BillHtml/119663?generalCourtId=1</a></td>
<td>Bill enacted on August 6, 2012</td>
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<td>SB 281</td>
<td>Bill amends current emergency personnel notification law to require infection control officers in healthcare facilities, including ASCs, to inform state public health officials when an individual is transported to the facility who might expose workers to an infectious disease.</td>
<td>No</td>
<td><a href="http://www.gencourt.state.nh.us/legislation/2012/SB0281.html">http://www.gencourt.state.nh.us/legislation/2012/SB0281.html</a></td>
<td>Bill enacted on June 7, 2012</td>
</tr>
<tr>
<td>New Jersey</td>
<td>S 1203</td>
<td>No</td>
<td><a href="http://www.njleg.state.nj.us/2012/Bills/S1500/1203_I1.HTM">http://www.njleg.state.nj.us/2012/Bills/S1500/1203_I1.HTM</a></td>
<td>Pending in Senate Health, Human Services and Senior Citizens Committee</td>
</tr>
<tr>
<td>New York</td>
<td>AB 3963</td>
<td>No</td>
<td><a href="http://assembly.state.ny.us/leg/?default_fld=&amp;bn=+AB3963&amp;Text=Y">http://assembly.state.ny.us/leg/?default_fld=&amp;bn=+AB3963&amp;Text=Y</a></td>
<td>Pending in Assembly Health Committee</td>
</tr>
<tr>
<td></td>
<td>(Introduced 1/31/2011) Bill would require the state health department to develop an HAI prevention/reduction policy for healthcare facilities, including outpatient facilities.</td>
<td></td>
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<tr>
<td></td>
<td>AB 4969</td>
<td>No</td>
<td><a href="http://assembly.state.ny.us/leg/?default_fld=&amp;bn=+AB4969&amp;Text=Y">http://assembly.state.ny.us/leg/?default_fld=&amp;bn=+AB4969&amp;Text=Y</a></td>
<td>Pending in Assembly Health Committee</td>
</tr>
<tr>
<td></td>
<td>(Introduced 2/9/2011) Bill would prohibit healthcare coverage plans, including Medicaid, from reimbursing facilities for costs associated with treatment of HAIs that are deemed preventable by the state Health Commissioner.</td>
<td></td>
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<tr>
<td></td>
<td>AB 5576</td>
<td>No</td>
<td><a href="http://assembly.state.ny.us/leg/?default_fld=&amp;bn=+AB5576&amp;Text=Y">http://assembly.state.ny.us/leg/?default_fld=&amp;bn=+AB5576&amp;Text=Y</a></td>
<td>Pending in Assembly Codes Committee</td>
</tr>
<tr>
<td></td>
<td>(Introduced 2/23/2011) Bill would amend state law to make it a crime for a healthcare provider in any healthcare setting to reuse a syringe when the action results in the infection of a patient with a communicable disease.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note: Shading indicates change in status from previous issue.
<table>
<thead>
<tr>
<th>State</th>
<th>Bill</th>
<th>Description</th>
<th>Introduces ASC reporting of HAIs</th>
<th>Bill text</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oregon</td>
<td>SB 1503</td>
<td>Bill would require healthcare personnel to provide their employers with evidence of influenza vaccination or a written declination including the reason. Healthcare facilities would be required to report annually to the state health department on employee influenza vaccinations.</td>
<td>No</td>
<td><a href="http://www.leg.state.or.us/12reg/measpdf/sb1500_dir/sb1503.a.pdf">http://www.leg.state.or.us/12reg/measpdf/sb1500_dir/sb1503.a.pdf</a></td>
<td>Legislature adjourned without enacting legislation</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>HR 407</td>
<td>Resolution would call for a comprehensive budgetary analysis of the Pennsylvania Patient Safety Authority and recommend whether or not the authority’s existence should be discontinued. The authority is charged with promoting patient safety in ASCs. Resolutions do not have the force of law.</td>
<td>No</td>
<td><a href="http://www.legis.state.pa.us/cfdocs/legis/PN/Public/btCheck.cfm?txtType=HTM&amp;sessYr=2011&amp;sessInd=0&amp;billBody=H&amp;billTyp=R&amp;billNbr=0407&amp;pn=2411">http://www.legis.state.pa.us/cfdocs/legis/PN/Public/btCheck.cfm?txtType=HTM&amp;sessYr=2011&amp;sessInd=0&amp;billBody=H&amp;billTyp=R&amp;billNbr=0407&amp;pn=2411</a></td>
<td>Pending in House Human Services Committee</td>
</tr>
<tr>
<td>Utah</td>
<td>HB 55</td>
<td>Bill would require facilities, including ambulatory surgical facilities, to provide the state with the HAI data those facilities already submit to NHSN.</td>
<td>No</td>
<td><a href="http://le.utah.gov/~2012/bills/hbillenr/HB0055.htm">http://le.utah.gov/~2012/bills/hbillenr/HB0055.htm</a></td>
<td>Bill enacted on March 19, 2012</td>
</tr>
<tr>
<td>West Virginia</td>
<td>HB 4336</td>
<td>Bill would require the state health department to establish infection control requirements for pain management clinics.</td>
<td>No</td>
<td><a href="http://www.legis.state.wv.us/Bill_Status/bills_text.cfm?billdoc=b4336&amp;y2=2012&amp;sessid=1161&amp;sessTyp=RS&amp;i=4336">http://www.legis.state.wv.us/Bill_Status/bills_text.cfm?billdoc=b4336&amp;y2=2012&amp;sessid=1161&amp;sessTyp=RS&amp;i=4336</a></td>
<td>Senate companion bill, SB 437 enacted on March 29, 2012 (see below)</td>
</tr>
<tr>
<td></td>
<td>SB 437</td>
<td>Bill would require the state health department to establish infection control requirements for pain management clinics.</td>
<td>No</td>
<td><a href="http://www.legis.state.wv.us/Bill_Status/bills_text.cfm?billdoc=b437&amp;y2=2012&amp;sessid=1161&amp;sessTyp=RS&amp;i=437">http://www.legis.state.wv.us/Bill_Status/bills_text.cfm?billdoc=b437&amp;y2=2012&amp;sessid=1161&amp;sessTyp=RS&amp;i=437</a></td>
<td>Bill enacted on March 29, 2012</td>
</tr>
</tbody>
</table>

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staff of each outpatient center. We also made sure that the patient’s isolation status was made more visible in the electronic medical record. Furthermore, we developed audit tools to track the number of patients removed from isolation by area. We also focused on patient education by creating printed material for them. Staff were trained via “Train the trainer”, in-service, or computer-based modules. In addition, information was disseminated housewide through the Infection Control intranet site, closed circuit institutional TV, emails, forums, and meetings. (see figure 1)

To measure the success of the project, we looked at the baseline and 9 months post-intervention percentage of participating outpatient centers. Before the Outpatient Isolation Solution Session, only 32 percent of outpatient centers participated. Nine months post-solution, 93 percent of centers were participating. We also compared point prevalence of the patients on isolation at base line to those still on isolation 9 months later. Twenty-six percent of baseline patients were removed after implementation of this process. (see figure 2)

The program continues to be successful. An inpatient initiative took place in September 2010, which was basically the continuation of the outpatient initiative. Over the past 3 years, the number of patients removed from isolation has doubled. An average of 80 patients have been removed from isolation each month compared to the baseline of less than 40 per month. (see figure 3)

The project is sustained through 2012. It has been successful due to the multidisciplinary team approach, open communication, education, and support from the upper management, including our executive sponsors.

**Flu prevention resources**

- APIC position statement on HCP flu immunization
  [http://www.apic.org/Resource_/TinyMceFileManager/Advocacy-PDFs/APIC_Influenza_Immunization_of_HCP_I2711.PDF](http://www.apic.org/Resource_/TinyMceFileManager/Advocacy-PDFs/APIC_Influenza_Immunization_of_HCP_I2711.PDF)

- SHEA position statement

- Patient stories
  [http://shotbyshot.org/story-gallery/#Influenza](http://shotbyshot.org/story-gallery/#Influenza)

- Centers for Disease Control Flu Prevention

- Public Health Dept Flu Prevention

APIC gratefully acknowledges CareFusion, Signature Sponsor of *Preventing Infection in Ambulatory Care*, for its support in helping APIC launch its digitally-enhanced periodical to improve the reader experience.

**CareFusion**

*Makers of ChloroPrep*

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A message from signature sponsor, CareFusion:

As a leading provider of products, services and proven technologies supporting the healthcare industry, CareFusion is committed to improving the safety and cost of healthcare. We’re passionate about healthcare and helping those that deliver it. That’s why we’re proud to be an APIC Strategic Partner, and the Signature Sponsor of *Preventing Infection in Ambulatory Care*.