

Physician's Risk Advisory



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The Solution is Right at the Tips of our Fingers.

With all of the focus on new initiatives aimed at preventing health care-related infections, and with the understanding of the extraordinary impact these infections have on both public health and the cost of healthcare, a noteworthy study appears to have confirmed that basic hand hygiene - in the form of rigorously enforced hand washing by staff before patient encounters - directly contributed to an almost 90% decrease in the infection rate of an OB unit at a major urban teaching hospital. Although the findings were initially challenged, continued observation of the protocol sustained the reduction in infection and reinforced the importance of hand washing as a highly effective infection control technique.

What's most interesting about this study was that it was performed in 1847, 20 years before Lister's first published article and about 30 years before the publication of both Koch's Postulates and Pasteur's work on germ theory; all of whom whose work later confirmed the underlying premise of the study's findings. Accordingly, if we can agree that an association between hand hygiene and the reduction of infection rates has been well-established for over 160 years, why is this most fundamental of antiseptic techniques still so often ignored?

Over the years, health care organizations and government agencies have developed many successful strategies to battle health care acquired infections (HAIs). However, chief among the impediments to attaining successful infection control is simply a wide-spread lack of compliance with these proven guidelines – such as hand washing as promoted by Dr. Semmelweis on that OB unit so long ago.

In a study published in the June 2008 *Infection Control & Hospital Epidemiology*, observers documented the hand hygiene behavior of staff at the University of Toledo Medical Center. Over a five month period, nurses were observed to

comply with hand washing approximately 91% of the time while physicians registered in at 72%, the lowest compliance rate among all groups studied. Why did the doctors rank so low? Too busy? Too indifferent? Whatever the reasons, in the final analysis, are any of them truly valid given what we know about how pathogens are transmitted? What needs to happen to get our full attention? In the case of Dr. Semmelweis, it was the death of one of his closest colleagues from a hospital acquired infection that helped urge him on in his efforts.

According to a study released by the Leapfrog Group in 2007, only 35% of the of 1,256 hospitals participating in their Hospital Quality and Safety Survey were fully compliant with hand hygiene practices and 87% didn't consistently follow established infection-control guidelines. As Dr. Patrick J. Brennan, Chairman of the CDC's Healthcare Infection Control and Prevention Advisory Committee (HICPAC) noted, "Too often where we fail is not in the knowledge but in the execution."

Hand hygiene can involve more than the usual washing with soap and water. Alcohol-based hand rubs are also effective when used correctly. However, alcohol-based hand rubs are no silver bullet and they don't work on all pathogens. For example, *C. difficile*, one of the most common types of healthcare associated infections in the US, is often better managed by soap and water hand hygiene than alcohol-based hand rubs. In addition to hand hygiene, gloves should be worn whenever treating patients with infectious diseases. Likewise, equipment, counter tops, fixtures, etc. must be cleaned and disinfected thoroughly on a regular basis.

With this understanding, how compliant is the staff in *your* office or clinic with basic infection control techniques – including hand washing? For that matter, how compliant are you? Are you sure

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that your colleagues and support staff always wash their hands or use hand rubs between every patient encounter? Or have some (or many) become so complacent that even this simple, proven infection control technique has taken a back seat to the many demands of a busy practice? Who in your practice is paying attention? The California Department of Health Services estimates that as many as 9,600

Californians die each year from hospital acquired infections with many, many more that suffer needlessly and require extra care and longer hospital stays. In addition, it's been estimated that health care-related infections add \$3 billion to California's annual health care costs. The bottom line is that we simply cannot afford to disregard the value of basic hand hygiene. There simply is far too much at stake.

Legislative Updates 2008 – Infection Control.

SB 1058: Hospital-acquired infection reporting and control.

This new law establishes the **Medical Facility Infection Control and Prevention Act** that requires health care facilities to implement screening, prevention, and reporting of specified health-care-associated infections to the state Department of Public Health (CDPH).

Effective January 1, 2009, every inpatient *who meets any of the following criteria*, must be tested for MRSA *within 24 hours of admission*;

- 1) Scheduled for surgery and has a documented medical condition making him or her susceptible to infection,
- 2) Discharged from a general acute care hospital *within 30 days* prior to the current hospital admission.
- 3) Will be admitted to an intensive care unit or burn unit of the hospital.
- 4) Receives inpatient dialysis treatment.
- 5) Transferred from a skilled nursing facility.

If the patient tests positive for MRSA, the attending physician must inform the patient or the patient's representative immediately or as soon as practically possible. A patient who tests positive for MRSA infection must be provided, prior to discharge, oral *and* written instructions regarding aftercare and precautions to prevent the spread of the infection.

Effective January 1, 2011, a patient who shows evidence of increased risk of invasive MRSA must again be tested for MRSA immediately *prior* to discharge, unless he or she had tested positive for MRSA infection or colonization when admitted.

By January 1, 2011 the California Department of Public Health (CDPH) must post on its web site *hospital-specific* data regarding the incidence rate of health-care-associated MRSA bloodstream infections, *C.diff* infections, and

healthcare associated vancomycin-resistant enterococcal bloodstream infections. Central line infections will be posted effective January 1, 2011 and starting on January 1, 2012, the CDPH will begin to post incidence rates of deep or organ space surgical site infections and orthopedic, cardiac and gastrointestinal surgical procedures designated as clean and clean-contaminated.

SB 158: Hospital Acquired Infection Mitigation

This new law also addresses the control of hospital-acquired infections and represents another far-ranging effort by the state legislature to address this critical issue by expanding the role and responsibility of acute care hospitals, and the CDPH. Specific provisions include; 1) establishing an infection surveillance, prevention, and control program within the CDPH to provide oversight of hospital prevention and reporting of hospital-associated infections through the National Healthcare Safety Network (NHSN) of the CDC and 2) expanding the responsibilities of the CDPH's Healthcare Associated Infection Advisory Committee (HAIAC) to provide oversight and direction of related activities. Significantly, among it's many, many other provisions, this law requires acute care hospitals, acute psychiatric hospitals and skilled nursing facilities to implement a facility-wide hand hygiene program. In this regards, it's an interesting comment on the times that the state legislature feels compelled to mandate health care professionals to engage in the most basic of patient safety behaviors.

In the final analysis, it appears that a review of old Dr. Semmelweis' findings may again be in order. Performing hand hygiene before and after seeing patients is far more than just a good idea – it can be a life saver.

NOTE: For copies of the complete Legislative Updates on the two new laws noted above, contact your Risk Manager or Sutter Health Risk Services.