Interfacility Transfer Communication & Injection Safety

Oregon Public Health Division
Healthcare-Associated Infections HAI Program

Oregon Health Authority

Objectives

- Interfacility transfer communication
  - Overview of law
  - Implementation to date
  - Resources
- Injection safety in healthcare
  - Background: outbreaks & core principles
  - Oregon-specific concerns and initiatives
  - Resources

INTERFACILITY TRANSFER COMMUNICATION (IFT)

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Background: IFT law

- Effective January 2014, OAR 333-019-0052
- "Communication During Patient Transfer of Multidrug-Resistant Organisms" (MDROs)
- Includes acute, ambulatory, and long-term care facilities (LTCFs)
- Report to receiving facility any disease requiring transmission-based precautions
- Written notification must be in transfer documents and readily accessible

IFT rule implementation

- 2015 OR surveys: 60 hospitals & 140 skilled nursing facilities (SNFs)
- Reported compliance with IFT Law
  - Hospitals: 83%
  - SNFs: 73%
- “We notify receiving facilities of MDROs at discharge”
  - 92% hospitals Agree or Strongly Agree
  - 92% SNFs Agree or Strongly Agree
- “Transferring facilities notify us of MDROs”
  - 38% hospitals Agree or Strongly Agree
  - 53% SNFs Agree or Strongly Agree

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Healthcare-Associated Infections (HAI)

- Learn about HAIs
- For Health Care Facilities
- For Health Professionals
- For the Public
- HAI Reporting
- HAI Surveillance
- HAI Validation
- HAI Prevention
- HAI Publications and Maps
- Infection Control Resources

Public Health > Diseases and Conditions > Communicable Disease > Healthcare-Associated Infections (HAI) > HAI Prevention > Interfacility Transfer Communication

Interfacility Transfer Communication

Communication During Patient Transfer of Multidrug-Resistant Organisms (MDRO)

As part of best practice during patient transfers, information about a patient's medical status, including colonization or infection with a multidrug-resistant organism, should travel with a patient and be readily available to medical providers.

On this page:

- What does Oregon law require?

Related Resources

- Diseases A-Z
- Emerging Infections
- CDC's HAI website
- National Healthcare Safety Network (NHSN)
- HAI Definitions (pdf)

https://public.health.oregon.gov/DiseasesConditions/CommunicableDisease/HAI/Prevention/Pages/Interfacility-Communication.aspx

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Template form

Facility Logo

Inter-facility Infection Control Transfer Form

SENDING FACILITY TO COMPLETE FORM and COMMUNICATE TO ACCEPTING FACILITY
Please attach copies of latest culture reports with susceptibilities, if available

Patient/Resident Last Name	First Name	Date of Birth
Print or place Patient Label		

Sending Facility Name	Sending Facility Unit	Sending Facility Phone #

Is the patient/resident currently on antibiotics? □ **NO** □ **YES** **DX:** ______________________

Does the patient/resident have pending cultures? □ **NO** □ **YES**

Is the patient/resident currently on precautions? □ **NO** □ **YES**

Type of Precautions (check all that apply) □ **Contact** □ **Droplet** □ **Airborne** □ **Other:**___________

Does patient currently have an infection, colonization OR a history of a multidrug-resistant organism (MDRO)?	**Colonization or history** *Check if YES*	**Active infection on treatment** *Check if YES*
MRSA (methicillin-resistant *Staphylococcus aureus*)	☐	☐
VRE (Vancomycin-resistant *Enterococcus*)	☐	☐
C. diff (*Clostridium difficile, CDI*)	☐	☐
***Acinetobacter* spp.,** multidrug-resistant	☐	☐
Gram-negative organism resistant to multiple antibiotics* (e.g., *E. coli, Klebsiella, Proteus* spp.)	☐	☐
CRE (carbapenem-resistant *Enterobacteriaceae*)	☐	☐
Other:**	☐	☐

*Culture report with multiple antibiotics marked resistant (R); send copy of report with susceptibilities.
**Other: lice, scabies, shingles, norovirus, influenza, tuberculosis, etc.

INJECTION SAFETY

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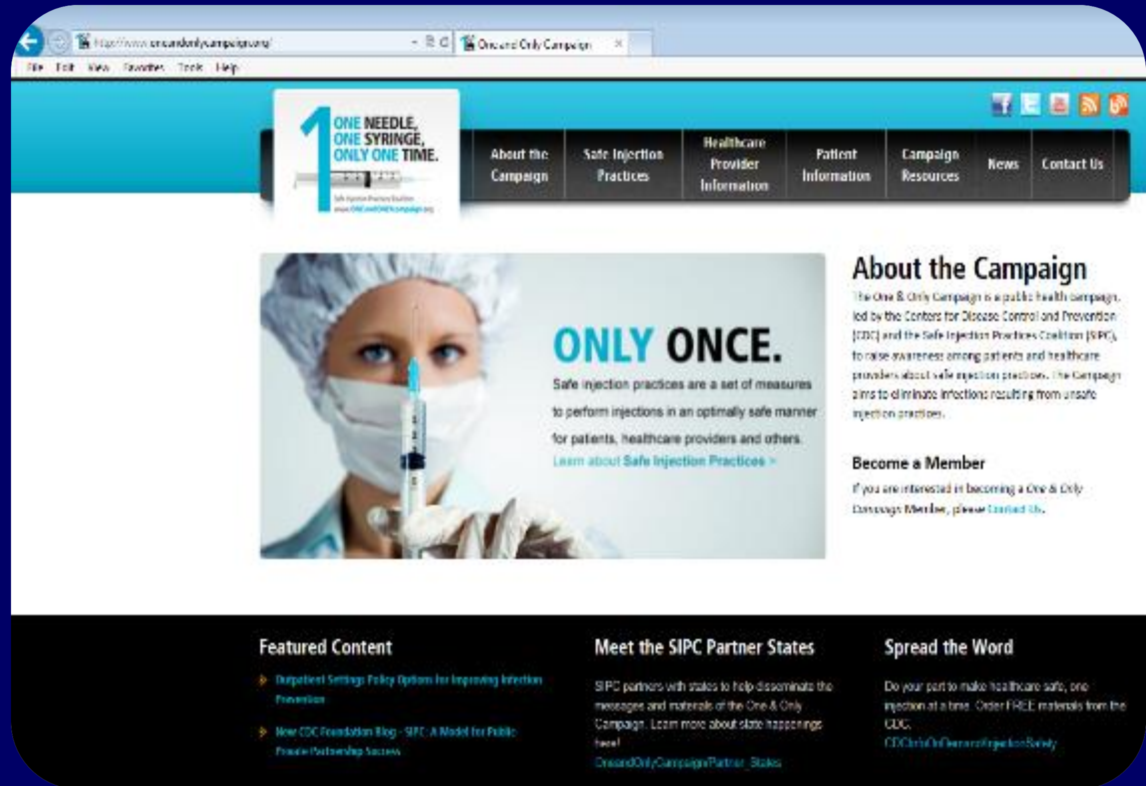
Unsafe Injections: A National Issue

- Over 50 US outbreaks (1998-2014) due to unsafe injections
- >700 patients infected
- >150,000 patients notified of potential exposure
- Syringe reuse
- Improper use of single-use/multi-dose vials
- Improper arterial blood gas measurement
- Drug diversion



http://www.oneandonlycampaign.org/

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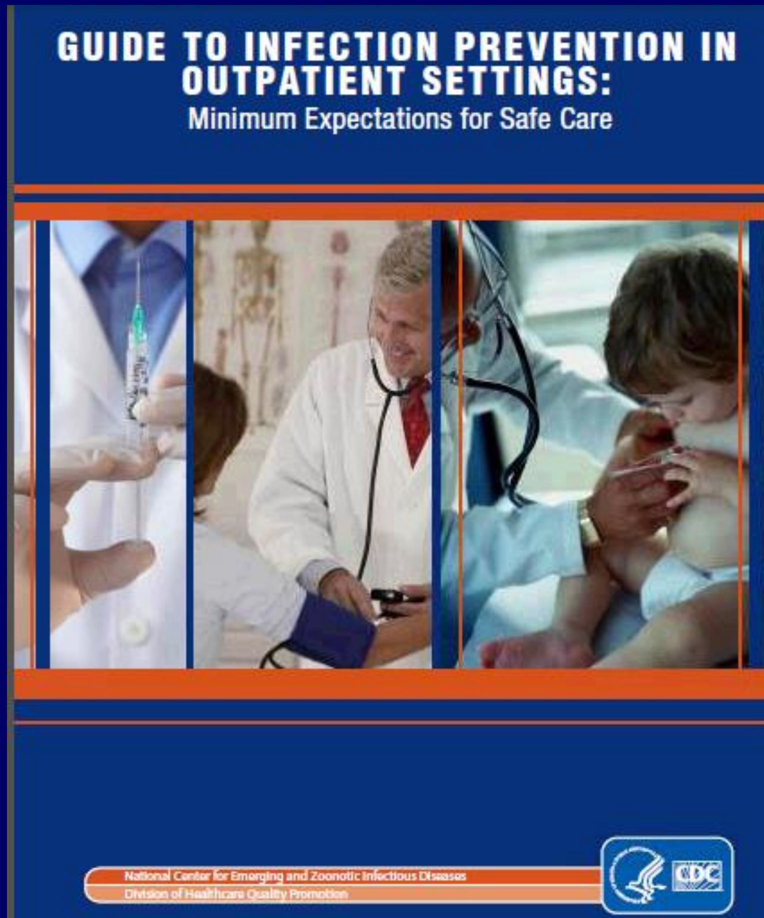
www.healthoregon.org/hai
www.oneandonlycampaign.org

Core principles of injection safety



- Foundational principles that guide prevention efforts across settings
- Underpin the CDC's One and Only Campaign
- Incorporated into Infection Control Assessment and Response (ICAR) tools

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http://www.cdc.gov/HAI/settings/outpatient/outpatient-care-guidelines.html

Key elements of injection safety

1. Use aseptic technique when preparing medications

2. Cleanse the access diaphragms of medication vials with 70% alcohol before inserting a device into the vial

3. Never administer medications from the same syringe to multiple patients, even if the needle is changed or injection administered through intravenous tubing

4. Do not reuse a syringe to enter a medication vial or solution

http://www.cdc.gov/HAI/settings/outpatient/outpatient-care-guidelines.html

Key elements of injection safety

5. Do not administer medications from single-use vials, ampoules, or bags or bottles of intravenous solution to more than one patient
6. Do not use fluid infusion or administration sets (e.g., intravenous tubing) for more than one patient
7. Dedicate multidose vials to a single patient whenever possible
   - If multidose vials will be used for more than one patient, they should be restricted to a centralized medication area
   - Should not enter the immediate patient treatment area

http://www.cdc.gov/HAI/settings/outpatient/outpatient-care-guidelines.html

Key elements of injection safety

8. Dispose of used syringes and needles at the point of use in a sharps container that is closable, puncture-resistant, and
9. Adhere to federal and state requirements for protection of HCP from exposure to bloodborne pathogens.

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HCV morbidity & mortality in Oregon

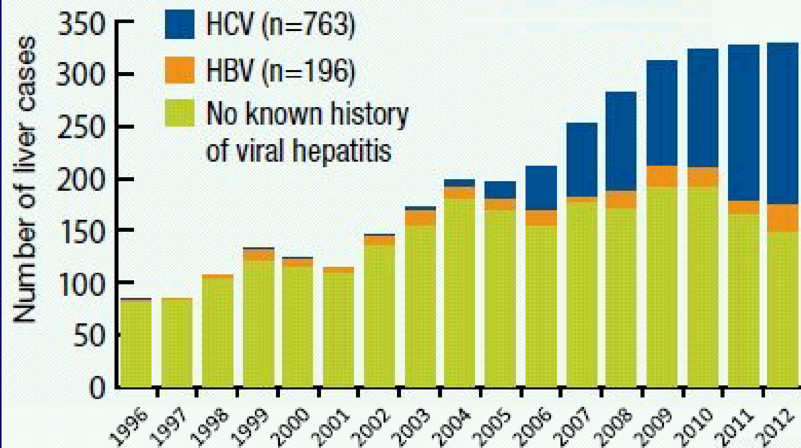
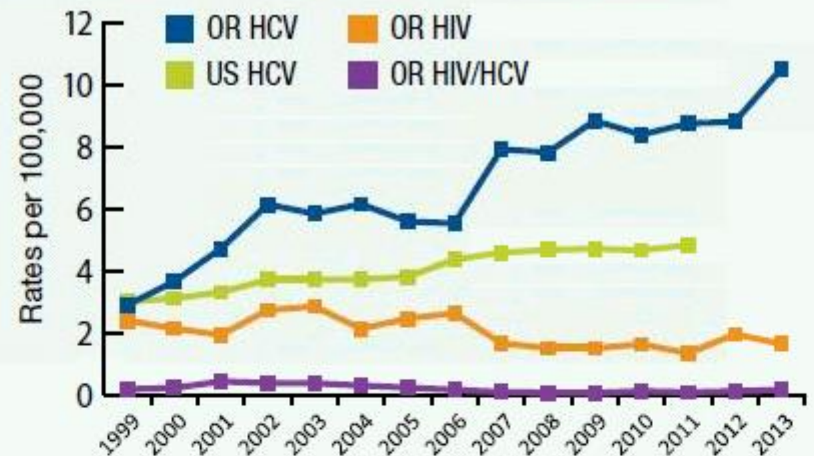


Figure 6 (See Table 49 in the Appendix section for details.)



- The mortality rate in Oregon from HCV was nearly twice the national average in 2011.

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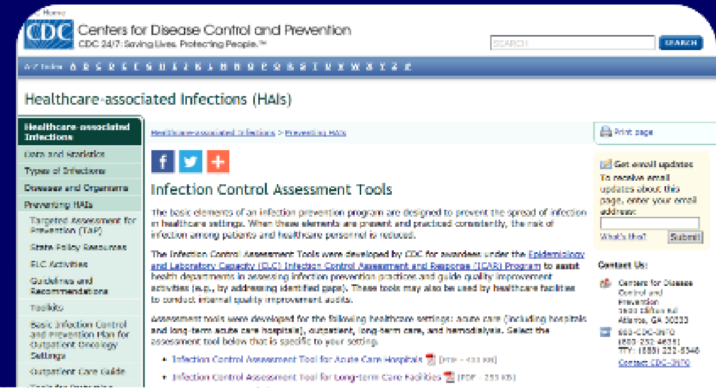
Ward JW. The hidden epidemic of hepatitis C virus infection in the United States: occult transmission and burden of disease. Topics in Antiviral Medicine 2013;21:15-9.

Injection safety practices in Oregon

- What do we know? Not much
- Current efforts:
  - Sporadic reports of breaches & investigations
  - CDC-funded Infection Control Assessments
  - Small grant to study & promote injection safety



II. Infection Control Training, Competency, and Implementation of Policies and Procedures

Elements to be assessed	Assessment
F. Injection Safety (This element does not include assessment of pharmacy practices)	
1. Hospital has a competency-based training program for preparation and administration of parenteral medications (e.g., SQ, IM, IV) outside of the pharmacy.	◯ Yes ◯ No
Verify the following:	
a. Training is provided to all personnel who prepare and/or administer injections and parenteral infusions.	a. ◯ Yes ◯ No
b. Training is provided upon hire, prior to being allowed to prepare and/or administer injections and parenteral infusions.	b. ◯ Yes ◯ No
c. Training is provided at least annually.	c. ◯ Yes ◯ No
d. Training is provided when new equipment or protocols are introduced.	d. ◯ Yes ◯ No

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http://www.cdc.gov/hai/prevent/infection-control-assessment-tools.html

Oregon surveillance & prevention efforts

- Small CDC grant to augment prevention
- Member state: One and Only Campaign
- Raise awareness
  - Public health professionals
  - Provider communities
- Focus on rural area
  - Survey of practices
  - Targeted interventions

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DON'T DO IT

Sharing Insulin Pens and Other Injection Equipment Harms Patients

In 2009, in response to reports of improper use of insulin pens in hospitals, the Food and Drug Administration issued an alert reminding healthcare providers that insulin pens are meant for use on a single person only and are not to be shared. Unfortunately, there have been continuing reports of patients placed at risk of bloodborne and bacterial pathogen transmission through sharing of insulin pens.

A SIMPLE RULE

Injection equipment (e.g., insulin pens, needles and syringes) should **never** be used for more than one person.

About the Safe Injection Practices Coalition

The Safe Injection Practices Coalition (SIPC) is a partnership of healthcare-related organizations led by the Centers for Disease Control and Prevention. The SIPC developed the *One & Only Campaign*—a public health effort to eliminate unsafe medical injections by raising awareness of safe injection practices.

For a list of SIPC partners, for more information about the campaign, and to view additional resources including videos and other materials, please visit:

OneandOnlyCampaign.org

For the latest news and updates, follow us on Twitter @injectionsafety and Facebook/OneandOnlyCampaign.

This material was developed by CDC. The *One & Only Campaign* is made possible by a partnership between the CDC Foundation and Lilly USA.

BE AWARE DON'T SHARE

ONE INSULIN PEN, ONLY ONE PERSON

What Every Healthcare Provider Needs To Know

60 second check

- 1 insulin pen =
  1 resident
- Label, check name
- Not damaged
- Expiration
- Recheck name
- Storage

COLORADO
Department of Public Health & Environment

Insulin Pen Safety
60 Second Check

Check the following 6 steps:

1. The pen is used for only one resident, even if the needle is changed between use. *Insulin pens should never be used for more than one person.*
2. Resident's full name is on the barrel of the insulin pen, not just the cap.
3. Pens with missing, detached, excessively soiled or damaged labels are immediately destroyed or returned to the pharmacy for disposal.
4. Medication is not expired.
5. Verify that you are delivering the right pen, to the right resident, at the right time.
6. •Medications should not be stored with disinfectants, insecticides, bleaches, household cleaning solutions, poisons, body fluids or food.
   •Medications should be stored in separate compartmentalized packages, containers or shelves to prevent intermingling of medications.

A simple 60 second safety check can prevent unintended errors which place residents at risk of acquiring bloodborne pathogen infections such as hepatitis B, hepatitis C, and HIV.

Please take time to check your steps.

For additional information please visit:

www.oneandonlycampaign.org/partner/Colorado

April Budorf,RN,BSN,MPH,CIC
Injection Safety Coordinator

303-692-3514
April.Burdorf@state.co.us

BE AWARE DON'T SHARE

ONE INSULIN PEN, ONLY ONE PERSON

2015 Assisted Living Resources

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Outbreak of *P. aeruginosa* and *K. pneumoniae*, outpatient chemotherapy center

- 14 (17%) bloodstream infections identified among 84 active clinic patients
- Unqualified/unlicensed providers delivering infusion services
- Cost-containment measures recently instituted
- Switched to common-source saline and heparin flush
- Bags used over several days for multiple patients
- Dedicated, single syringes per patient could be reused multiple times to access common saline bag
- Syringes for heparin flush shared among multiple patients (discarded only if visible blood)

Dobbs et al, AJIC (2014) 731-4

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WJTV

Basic Infection Control And Prevention Plan for

Outpatient Oncology Settings

National Center for Emerging and Zoonotic Infectious Diseases

Division of Healthcare Quality Promotion

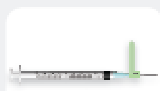
DO YOU PROVIDE TREATMENT FOR PATIENTS WITH CANCER?

PROTECT YOUR PATIENTS, YOURSELF, AND YOUR BUSINESS

Since 2002, at least nine serious infectious disease outbreaks have occurred in cancer clinics. These outbreaks involved unsafe injection practices, including the reuse of syringes. As a result, hundreds of patients became infected and thousands more required notification and testing for bloodborne pathogens.

REMEMBER! WHEN PREPARING MEDICATIONS AND INJECTIONS...

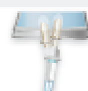
NEVER reuse these items:



Needles or syringes that have been used for any purpose

Vials with "single-dose vial" printed on the label

Saline bags

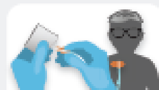


Intravenous tubing

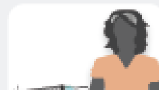
ALWAYS follow aseptic technique* when:

Preparing any medication

Disinfecting a vial's septum



Accessing a central line



Injecting any medications

*Aseptic technique is used by health care workers to prevent the contamination of clean areas, equipment, and sterile medications. This will help prevent the spread of infection. Please refer to CDC's Basic Infection Control and Prevention Plan for Outpatient Oncology Settings for more information.

LEARN MORE ABOUT WAYS YOU CAN KEEP YOUR PATIENTS SAFE BY VISITING ONEANDONLYCAMPAIGN.ORG AND PREVENTCANCERINFECTIONS.ORG.

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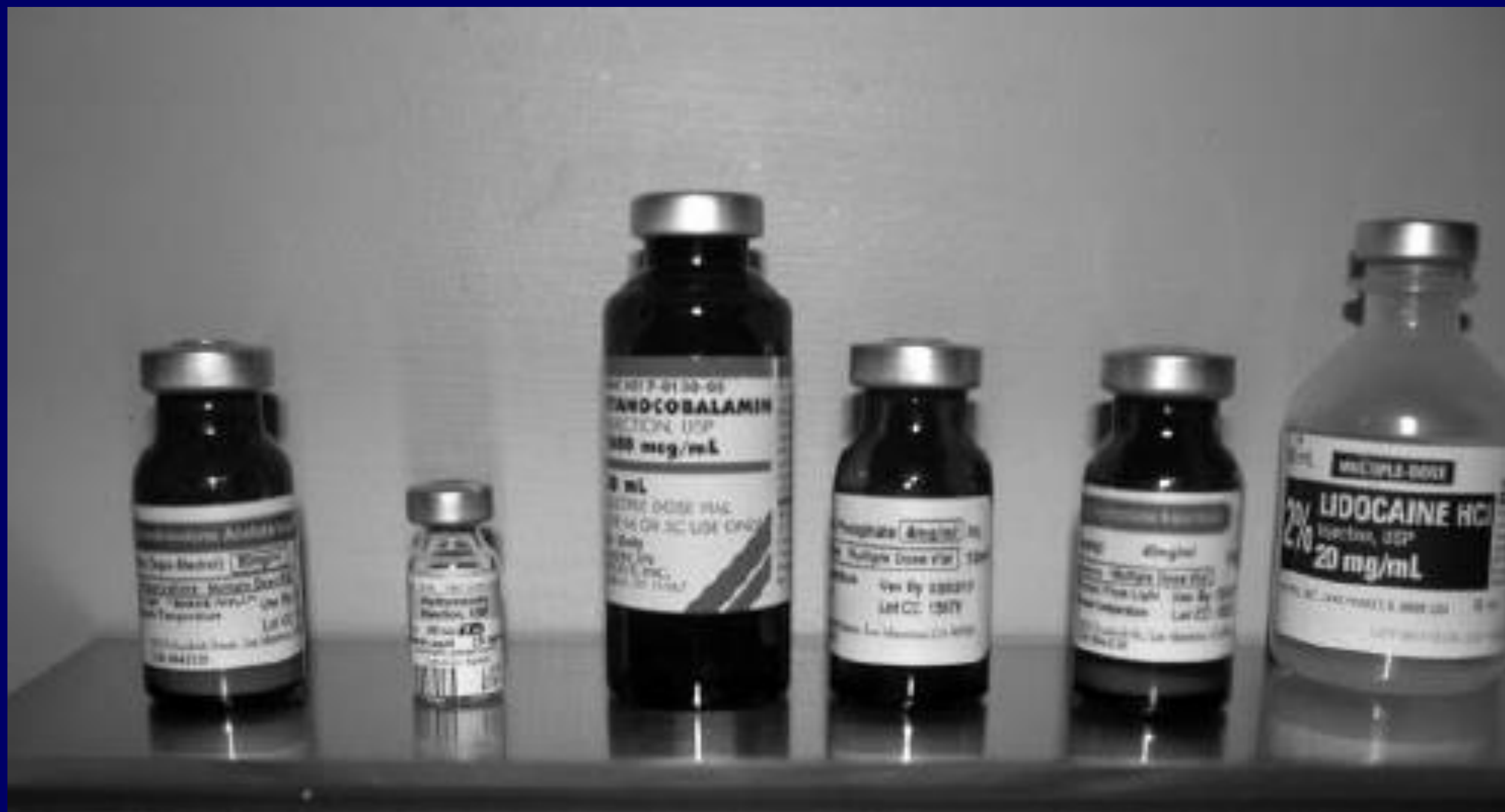
Methicillin-susceptible *Staphylococcus aureus* (MSSA) cluster in a rheumatology practice

- Dec 2011: hospital IP notified health department
  - 4 patients admitted (length of stay 1-8 days) for surgical debridement of lab-confirmed MSSA infections
  - Health department identified 5th patient treated at different hospital's emergency department
- Cases all received joint injections at an independent outpatient rheumatology clinic on same afternoon
  - 3 exam rooms; poor records management
- Steroid from a compounding pharmacy labeled as a multi-dose vial (MDV) containing preservatives
- Opened MDVs and single-dose vials (SDVs) kept on top of towel dispenser

Drezner et al. *Infect Control Hosp Epidemiol* 2014;35(2):187-189

"Will the real multi-dose vial please stand up?"



Drezner et al. *Infect Control Hosp Epidemiol* 2014;35(2):187-189 [MSSA in Rheumatology Clinic]

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DRUG DIVERSION* SPREADS INFECTION FROM HEALTHCARE PROVIDERS TO PATIENTS

HEALTHCARE PROVIDER
with Hepatitis C or other bloodborne infection tampers with injectable drug

CONTAMINATED INJECTION EQUIPMENT AND SUPPLIES
present in the patient care environment

EXPOSURE OF PATIENT
results from use of contaminated drug or equipment for patient injection or infusion

*Drug diversion occurs when prescription medicines are obtained or used illegally by healthcare providers.

FOR MORE INFORMATION, VISIT CDC.GOV/INJECTIONSAFETY/DRUGDIVERSION

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Mechanisms of diversion

- False documentation (e.g., medication not administered to the patient or "wasted" and instead used by the HCW)
- Scavenging of wasted medication (e.g., removal of residual medication from trash or used syringes)
- Theft by tampering (e.g., removal of medication from a container or syringe and replaced with similarly appearing solution that may be administered to patients)

Multistate HCV outbreak, 2012

- 45 cases of HCV in New Hampshire, Kansas & Maryland associated with radiology technician
- HCW also diverted opiates in Michigan, Arizona, New York, and Pennsylvania
- Investigation reveals holes in licensure, certification, placement, hospital detection programs, and peer/supervisor reporting
- HCW sentenced to 39 years in prison

www.newsweek.com/2015/06/26/traveler-one-junkies-harrowing-journey-across-america-344125.html

Resource: CDC injection safety website

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http://www.cdc.gov/injectionsafety/drugdiversion/

Materials available for order free of charge

One & Only Campaign Materials For Order Via CDC-INFO

Safe Injection Practices DVD
Item 22-0087

Rx for Safe Injections Poster
Item 22-0696

It's Elementary Poster
Item 22-0697

Provider Brochure
Item 22-0702

Patient Brochure
Item 22-0701

Injection Safety Infographic
Item 22-1504

Single-Dose & Multi-Dose Vial Infographic
Item 22-1599

Injection Safety Pocket Card
Item 22-0713

Logo Poster for General Public
Item 22-0699

You Can Order 3 Ways

SCAN
Scan with your smartphone to access the ordering page

CALL
1-800-CDC-INFO

CLICK
wwwn.cdc.gov/pubs/CDCInfoOnDemand.aspx

Select Injection Safety–One & Only Campaign to order materials

Be Aware Don't Share Insulin Poster
Item 22-1503

Be Aware Don't Share Insulin Brochure
Item 22-1501

Injection Safety Dangerous Misperceptions Flyer
Item 22-1178

Injection Safety Healthcare Provider Checklist
Item 22-1176

The *One & Only Campaign* is made possible by a CDC Foundation partnership with Eli Lilly and Company

Injection Safety Fact Sheet
Item 22-1502

Injection Safety Healthcare Provider Toolkit
Item 22-1177

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Training video resources

Managing Patient Safety, One Injection at a Time

Managing Patient Safety, One Injection at a Time

EDUCATE YOUR TEAM

http://www.oneandonlycampaign.org/content/audio-video

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Thank you for your collaboration to improve care for Oregonians!

Acute & Communicable Disease Prevention Team
HAI Program
(971) 673-1111 (24/7)
Ohd.acdp@state.or.us

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Questions?
Follow up?

Healthcare Associated Infections (HAI) Program

Roza Tammer, MPH, CIC, HAI Reporting Epidemiologist

roza.p.tammer@dhsoha.state.or.us

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