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TABLE OF CONTENTS

LITERATURE REVIEW

HEALTH CARE–ACQUIRED INFECTIONS

8 IPs’ Detective Work Stops a CRAB Outbreak
By Tori L. Whitacre Martonicz

COVID-19

10 Vaccines Protect Pregnant Women and Positive Fetal Outcomes
By Tori L. Whitacre Martonicz

LONG-TERM CARE

11 CMS’ Proposed Minimum Staffing Requirements Could Cost $10 Billion Annually
By Infection Control Today® Editorial Staff

IN ADDITION

6 Publisher’s Note

HAND HYGIENE

7 Bug of the Month
By Tori L. Whitacre Martonicz

12 In the News

17 Interactive News

33 Product Locator

FEATURES

ENVIRONMENTAL SERVICES

18 Investment in Environmental Services Saves Money and Lives, Boosts Morale: An Example From Geneva
By Alexandra Peters, PhD, and Didiee Pittar, MD, MS, CBE

HAND HYGIENE

21 How to Obtain Better Hand Hygiene Adherence: Ideas From Health Care Workers on the Floor
By Tori L. Whitacre Martonicz

PREVENTION

28 The 3 C’s, Part 2: Communication
By Heather Saunders, MPH, RN, CIC

HEALTH CARE–ACQUIRED INFECTIONS

30 Inpatient and Outpatient Clinics Must Monitor Fomites as Part of IPC Protocols
By Henry G. Spratt Jr, PhD, David Levine, PhD, DPT; Susan McDonald, EdD, OTR/L; and Meredith Rippy, BS

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October is Breast Cancer Awareness Month & Healthmark is all about Pink

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Another school year has begun and with it comes seasonal influenza and COVID-19 concerns. This year, however, we are in a much better position to fight a winter surge thanks to pediatric COVID-19 vaccines.

Our cover story for this issue of *Infection Control Today* examines prevention strategies for seasonal influenza in the health care setting. Author Jan Dyer spoke with William Schaffner, MD, medical director of the National Foundation for Infectious Diseases, who cautions us on page 24 not to let our guard down when it comes to the flu.

To coincide with this month’s Association for the Health Care Environment Exchange conference, held October 3 to 5, 2022, in Orlando, Florida, the feature on page 18 explores how environmental hygiene practices are implemented on an international level. Follow along with us at infectioncontroltoday.com for coverage from that meeting.

Turn to page 28 for the next article in the series by Heather Saunders, MPH, RN, CIC, director of infection control for the Office of Population Health at Johns Hopkins Medicine, on how to revolutionize the field of infection prevention and control. This one centers on one of the most important factors: communication.

Henry G. Spratt Jr, PhD, a senior microbiologist in the Department of Biology, Geology, and Environmental Science at the University of Tennessee at Chattanooga, and colleagues make a compelling argument for regular monitoring of patient fomites within inpatient and outpatient clinics. “Of course, the usual suspects as fomites include doorknobs and light switches but should not be limited to those common items,” Spratt writes on page 30.

We round out the October issue with some ideas from infection preventionists on the front lines on how to increase adherence to hand hygiene best practices on page 21. Feel free to send your ideas to editor Tori Whitacre Martonicz (tmartonicz@mjhlifesciences.com).

Thank you for reading,

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President and CEO
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**Full Steam Ahead for Fall: Flu Season, COVID-19 Vaccines, and More**
Watch Your Cat for Me!

BY TORI WHITACRE MARTONICZ

I am one of the world’s most common parasites, and I may infect more than 40 million individuals in the United States, even if they don’t know it. I am a single-celled parasite found throughout the world. Although the carrier often doesn’t know I am in their body, I can persist for long periods of time in humans (and other animals), possibly even for a lifetime.

Very few individuals infected with me have symptoms because a healthy person’s immune system usually keeps me from causing illness. However, in pregnant and immunocompromised individuals, the infection I cause could lead to severe health problems, even death. When an individual becomes infected with me, I form cysts that can affect almost any part of the body, most often the brain and the muscle tissue of different organs, including the heart.

I am only excreted in cat feces—because wild and domestic cats are my ultimate host—so I am found in food, water, and dirt contaminated with cat excrement. I do not become infectious until 1 to 5 days after being shed in cat feces, and I may remain infectious for months or years. Cats become infected with me from other cats or by eating the flesh of infected birds or mammals. Even pet cats should not be fed raw meat and should not hunt outside.

To prevent me from infecting the individuals in your house, dispose of cat feces and litter daily before I have a chance to become infectious. Flush feces down the toilet or deeply bury them, seal litter in a plastic bag to avoid dispersing litter dust into the air, and disinfect litter pans daily with boiling water.

You can also become infected with me by ingesting raw or undercooked contaminated meat (especially pork, lamb, and venison) or shellfish (oysters, clams, or mussels) and by eating food contaminated by knives, other utensils, cutting boards, and other foods that have had contact with something contaminated with me.

I am not passed from person to person, except in rare instances of organ transplants or blood transfusions and through mother-to-child (congenital) transmission during pregnancy. I cannot be absorbed through intact skin.

Some of the symptoms I cause include muscle pain, fever, and headache, sometimes lasting for weeks. Other symptoms (similar to the flu) include body aches, fatigue, and swollen lymph nodes. My presence is often difficult to diagnose without specific screening.

Individuals with weakened immune systems should avoid getting me altogether. Use preventive medications if you have been receiving chemotherapy or have recently had an organ transplant. Also, if an individual has been infected with me in the past, I may reactivate if the individual becomes immunocompromised. Some symptoms of a more severe infection include headache, confusion, poor coordination, seizures, lung issues, and blurred vision caused by severe inflammation of the retina.

If a pregnant individual is infected with me early on, the pregnancy will end in stillbirth or miscarriage. Babies who survive being infected with me are likely to be born with serious problems, including seizures, an enlarged liver and spleen, jaundice, and severe eye infections.

Most states don’t screen infants for the infection I create, and only a few babies infected with me show signs of the disease at birth. In fact, infants who are infected often don’t develop signs until their teenaged years or later.

Most healthy individuals don’t require treatment for me. However, if you’re otherwise healthy but have signs and symptoms of the acute infection of me, your physician may prescribe the folic acid antagonist pyrimethamine (Daraprim), typically used for malaria, and sulfadiazine, an antibiotic used with pyrimethamine to treat toxoplasmosis.

Who am I?

To discover who I am, visit InfectionControlToday.com/view/oct-2022-bug-month
Detective work and teamwork halted a potentially deadly outbreak in a Louisiana hospital. The infection preventionists (IPs) in the hospital reached out to the state Department of Health, and the two teams coordinated and addressed the situation before it grew worse. A report describing this situation was published in the *American Journal of Infection Control* and was originally presented as a poster at the Association for Professionals in Infection Control and Epidemiology (APIC) 2022 Annual Conference, held June 13 to 15, 2022, in Indianapolis, Indiana. The lead investigator, Erica Washington, MPH, CPH, CIC, CPHQ, FAPIC, who is also the health care–associated infection and antibiotic resistance program coordinator for the Louisiana Department of Health, spoke to *Infection Control Today*® (*ICT*®) about how the situation was resolved.

**ICT**®: Please give a summary of the key findings and why they are important.

**EW:** This study surrounded an investigation of carbapenem-resistant *Acinetobacter baumannii* that was identified in a cluster of patients who were admitted to an acute care hospital. The IPs at the hospital noticed that they were being admitted from the same ventilator skilled nursing facility (VSNF). So they alerted my team at the Louisiana Department of Health. We activated an investigation, first doing chart abstractions of the patients from the records at the acute care hospital and then working with the VSNF to do first an infection control assessment in person, then colonization screenings to identify additional cases and make sure that transmission was not ongoing of this potentially deadly bug. The colonization screenings were done in coordination with the Centers for Disease Control and Prevention (CDC) [antimicrobial] resistance laboratory networks. The key findings were that one patient was admitted to the same room that a previous patient was discharged from. That situation led to some of our recommendations surrounding environmental cleaning, hand hygiene, and additional infection control inclusive efforts with environmental services and reupping on infection control competencies within that setting.

**ICT**®: What do you consider the practical application of the key findings for IPs?

**EW:** Practically, even beyond looking at the infection control recommendations, I think we can look a bit upstream. The IPs at the acute care hospital were skilled at cluster detection. I think that detection was commendable. All [the IPs] were certified. Their director of infection prevention [was] touting the fact that they all got certified in infection control… and they quickly coordinated with public health. And although we do receive reports of these infections, their detection was swift and very timely; that activated a quick and coordinated approach.

The second thing would be communications. [The IPs] communicated with us and then subsequently within...
the facility itself, so communications between infection control departments at an acute care hospital and a long-term care setting then became strengthened as well. We’re always promoting the ability of patients to move between facilities in different setting types, [and IPs] need to understand how to handle patients upon discharge or admission. I think that was a good outcome [of this study] as well. Then, also, understanding the fact that identifying additional cases through colonization screening can inform infection control, and whether the facilities need to promote or strengthen infection control efforts within a facility.

**ICT**: What results from the study surprised you?

**EW**: [When] we looked at the chart abstractions, the first thing I clued into was the resistance patterns among the isolates. For cases 1 and 3, [they] were the same. So I had a bit of information that those cases had some crossover on some level. It turns out that [the patient in] case 3 was admitted to the same room as [the patient in] case 1 after [the patient was discharged]. [This was discovered during] rounding, so I can’t underestimate or speak more highly of doing infection control rounding during infection control assessments. Because when looking at the layout of the ventilator unit, I saw that the rooms were laid out right across from each other as well. So that also led to some recommendations around potentially [increasing] hand hygiene, aside from environmental cleaning, as well. I recommended that the facility have a policy against gel and acrylic nails because I did observe some personnel having gel and acrylic nails. After CDC did their work-up for the isolates, they saw that those isolates for cases 1 and 3, were pan[drug] resistant and carbapenemase producing. I think that we get a lot of information out of contributing to the body of knowledge around resistance patterns in our own populations and how the resistance patterns are changing, as well. And just informing and making sure that the facilities understand colonization vs infection as well. So making sure that antibiotic stewardship is working in concert with the colonization screenings, so that we’re not inappropriately treating individuals who don’t necessarily have an infection. But I think that we had suspicions around cases 1 and 3, [which were] then confirmed on rounding when looking at the room layouts [and by] the confirmatory testing from CDC.

**ICT**: Do you have any plans for further observations to gather more information?

**EW**: So the way that colonization screenings work is that we ensure that transmission is stopped by asking facilities to do 2 rounds of screenings. And if 2 rounds occur where no additional cases are identified, then we can be confident that transmission [has been] stopped. So that’s the prospective way that we can ensure patient safety. And then we do the surveillance statewide, as well, as far as ensuring the quality side of best practices for infection control in this setting. We certainly confirm recommendations to the facility regarding environmental cleaning, hand hygiene, and the like, in education. But, [those recommendations are] something that [requires] ongoing training. Those are also some things that our health department is working with APIC to do. We have in the past, I believe in 2018, contracted APIC to do long-term care trainings in Louisiana. And we’re working, hopefully, in the next 6 to 12 months to contract them to do additional trainings in our state around long-term care–focused trainings and infection control.

**ICT**: Is there anything else you would like to add?

**EW**: Considering [that] your audience consists of IPs across the provider spectrum, I want them to know that all health departments, or all state health departments and some local and city health departments, are staffed with health care–associated infection coordinators like myself who work with the CDC on activities just like this. So working with the [antimicrobial] resistance laboratory networks, [I want to tell them] to make sure that we are detecting and containing and responding to antibiotic resistance threats. If we reach out to you for your help with colonization screenings, understand that the materials, supplies, and shipping are free of cost. We know that the personnel time is not free, but this goes far [toward] contributing to the body of knowledge about changing resistance. [I also wish to stress] understanding how you can be informed about transmission-based precautions and protecting patient safety and the health of your patients within health care states.

*This interview has been edited for length and clarity.*

**REFERENCE AVAILABLE AT**

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**A carbapenem-resistant Acinetobacter baumannii cluster was identified and stopped because of due diligence of the infection preventionists at an acute care facility in Louisiana.**
COVID-19 Vaccines Protect Pregnant Individuals and Positive Fetal Outcomes

BY TORI L. WHITACRE MARTONICZ

COVID-19 vaccination in pregnant individuals prevents infection effectively and has no adverse outcomes, according to a recently published pooled analysis. Regardless of the COVID-19 vaccine type or the trimester in which the pregnant individual received the vaccination, the study showed a lack of significant adverse pregnancy, fetal, or neonatal outcomes. The authors also emphasized the decreases in COVID-19 infection rates and COVID-19–related hospitalizations in vaccinated pregnant individuals.

“There is a gap between the current rate of vaccination and the desired rate, owing to doubts regarding the safety of the available vaccines,” the investigators wrote in a recent report published in the American Journal of Infection Control, titled “Is it Safe and Effective to Administer COVID-19 Vaccines During Pregnancy? A Systematic Review and Meta-analysis.” They continued, “Our meta-analysis reinforced the lack of adverse outcomes in association with COVID-19 vaccination during and after pregnancy for females and neonates and reiterated the effectiveness of the former as well.”

Investigators reviewed 10 observational studies analyzing a total of 326,499 pregnant women. Their results demonstrated that COVID-19 vaccination effectively prevented infection (odds ratio [OR], 0.56; 95% CI, 0.47-0.67; P < .00001) and related hospitalizations (OR, 0.50; 95% CI, 0.31-0.82; P = .006). The results showed that vaccination did not alter the rate of adverse outcomes in pregnancy, including, spontaneous abortion, preeclampsia or eclampsia, stroke (occurring within 4 weeks of delivery), meconium-stained amniotic fluid, spontaneous vaginal delivery, operative vaginal delivery, cesarean delivery, postpartum hemorrhage, and blood transfusions. The COVID-19 vaccine also was observed to shield against neonatal intensive care unit admissions for COVID-19 (OR, 0.85; 95% CI, 0.81-0.90; P < .00001).

The study showed “no adverse pregnancy outcomes in vaccinated females in comparison with the unvaccinated. Current guidelines being followed regarding vaccination of pregnant females enforce the administration of the inactivated influenza vaccine and the inactivated tetanus, diphtheria, [and] pertussis vaccine, with live vaccines such as the measles, mumps, rubella vaccine and the varicella vaccine being contraindicated in pregnancy,” the investigators wrote. “The type of vaccine plays a major role in its respective safety profile, with live vaccines being contraindicated due to the increased risk of perinatal infection and congenital birth defects—while inactivated vaccines do not pose such risks to the mother or fetus.”

In a subgroup analysis of fetal outcomes based on location, a reduction in preterm births after vaccination was observed in Israel (OR, 0.87; 95% CI, 0.76-0.99; P = .03) and Norway (OR, 0.81; 95% CI, 0.71-0.92; P = .001); however, the United States and Sweden showed no difference. The incidence of stillbirth decreased in Norway (OR, 0.42; 95% CI, 0.20-0.91; P = .03) and Sweden (OR, 0.71; 95% CI, 0.52-0.99; P = .04), with no change in the other locations.

“The Royal College of Obstetricians and Gynaecologists [has] suggested that pregnant women should preferably take their COVID-19 vaccine after the first trimester, provided they are not at an increased risk for infection with the virus due to the fetus being more susceptible to the development of adverse outcomes during that window,” the investigators noted. “Nevertheless, several studies including ours have not shown a significant change in neonatal adverse outcomes, post vaccination in the first trimester.” However, the investigators acknowledged that large-scale, randomized trials are needed to confirm the results of this study.

Additionally, “clear guidelines are needed to help health care professionals in advising and implementing the vaccination of pregnant females against COVID-19. Pregnant patients also require the assurance needed to readily take the vaccine. Our meta-analysis can act as a reference for health care professionals and policy makers, for the prompt and much-needed vaccination of pregnant females against the SARS-CoV-2 virus,” the investigators noted.

REFERENCE AVAILABLE AT INFECTIONCONTROLTODAY.COM
CMS’ Proposed Minimum Staffing Requirements Could Cost $10 Billion Annually

BY INFECTION CONTROL TODAY® EDITORIAL STAFF

Nursing homes and long-term care (LTC) facilities need to increase staffing minimums across the United States. That expansion could cost US $10 billion annually, according to the American Health Care Association and National Center for Assisted Living (AHCA/NCAL). The AHCA/NCAL published a new report titled “Staffing Mandate Analysis In-depth Analysis on Minimum Nurse Staffing Levels and Local Impact” released from the accounting and consulting firm CliftonLarsonAllen LLP. The report was in response to a Centers for Medicare and Medicaid Services (CMS) report released in April 2022, which proposed a changed rule for the per diem prospective payment system for skilled nursing facilities, with payment updates for federal fiscal year 2023. As part of the proposed rule, CMS is requesting input regarding the establishment of a minimum staffing requirement for LTC facilities.

The AHCA/NCAL report notes that the funds related to the payment system the CMS report mentions would support the hiring of 187,000 nurses and nurse aides, at 4.1 hours per resident day in 94% of LTC facilities, to comply with the requirement for the need to care for more than 900,000 residents.

However, if facilities are required to meet this increased hiring standard and are unable to comply, 205,000 residents (or 18%) could be displaced. The facilities would have to decide how to reduce their census to meet the staffing minimums.

The press release states that “this analysis covers RNs [registered nurses], LPNs [licensed practical nurse], and CNAs [certified nursing assistant]. RNs include directors of nursing and RNs with administrative duties; RN/LPNs include LPNs with administrative duties; and LPN/nurse aides include CNAs, aides in training, and medication aides/technicians.”

The situation is not new, but it is becoming worse because the work required of the staff has doubled since the start of the pandemic. Currently, more than half of all LTC providers said that their overall workforce conditions have deteriorated since January 2022, according to a NCAL survey published in June 2022. The proposed increased staffing requirement will exacerbate the situation. However, according to the same NCAL survey, LTC staff agreed that their residents deserved the best care, and the increased staff would provide that support.

Results of studies show that with increased staff, residents have better outcomes and more fulfilling lives, but the pay for LTC workers is far lower than at hospitals or other facilities, and hiring and retaining workers is a challenge.

“Every nursing home wants to hire and develop more caregivers, but they can’t do it alone. An enforcement approach will not solve this long-term care labor crisis,” Holly Harmon, RN, AHCA’s senior vice president of quality, regulatory, and clinical services said in the press release. “We urge the administration and Congress to put forth meaningful aid and policies that will help us recruit and retain the dedicated caregivers our nation’s seniors deserve.”

Mark Parkinson, president and CEO of AHCA, concurred with Harmon, as noted in the press release. “This report makes it crystal clear that increasing staffing standards in nursing homes requires substantial and consistent government resources. Even then, nursing homes would have the impossible task of finding another 187,000 nurses at a time when vacant positions sit open without applicants for months on end. The unintended consequences of this sort of unfunded mandate would be devastating to hundreds of thousands of vulnerable residents who could be forced out of their nursing home.”

Even before the COVID-19 pandemic, the LTC industry was facing an unprecedented staffing crisis because of the nationwide nursing shortage. Nursing homes have lost over 200,000 workers during the pandemic, a higher number than any other health care segment. Further, more than 450,000 workers are expected to be needed by 2025, which is unlikely to be achievable. The proposed staffing requirement may represent a nearly impossible demand on an already overburdened system.

REFERENCES AVAILABLE AT INFECTIONCONTROLTODAY.COM
CDC Radically Cuts COVID-19 Guidelines Right as School Year Begins: Not All Experts Approve

BY INFECTION CONTROL TODAY® EDITORIAL STAFF

Centers for Disease Control and Prevention (CDC) announced recently that it no longer recommends that someone quarantine if they come into close contact with an infected individual. The CDC also announced individuals no longer need to stay at least 6 feet away from others in public spaces.

Although these changes are significant with the school year getting underway, one other change affects schools even more meaningfully. In the statement, CDC shelves the recommendation that schools do routine daily testing, unless, in certain situations, the testing is needed, such as during a surge in infections, officials said.

Many experts approve of the change, including Monica Gandhi, MD, MPH, director of UCSF—Bay Area Center for AIDS Research (CFAR), professor of medicine and associate chief of the Division of HIV, Infectious Diseases, and Global Medicine, and medical director of the Ward 86 HIV Clinic, Zuckerberg San Francisco General Hospital, and a member of the Infection Control Today® (ICT®) Editorial Board.

“I applaud the revised CDC guidelines, which embrace that our advances in vaccines and treatment have significantly lowered the risk of severe disease, hospitalization, and death,” Gandhi told ICT®. “The guidelines still recommend isolation and masking after a positive test but, otherwise, acknowledges advances in our COVID-19 tools in mid-2022, as well as balances other needs of society including that of keeping children in school.”

Two and a half years after the beginning of the pandemic, an estimated 95% of Americans 16 years and older have acquired some level of immunity, either from being vaccinated or infected, agency officials said, and that is the basis for the change.

However, not all experts agree with the CDC’s guideline changes. Ambassador Deborah Birx, MD, who once served as the director of CDC’s Division of Global HIV/AIDS, part of the agency’s Center for Global Health, says the CDC’s guideline changes are too soon.

“Saying you are following the science and data requires agencies to collect population-based science and data and transparently provide that data to support guidance to the American people,” Birx said told ICT®. “I remain disappointed that CDC continues to provide guidance without full population data in support of the changes. Mitigation practices should absolutely evolve with additional tools to combat the virus from vaccination to antivirals and long-acting monoclonals. But without treating every COVID-19 severe disease that results in hospitalization and death as a failure of programming, we will continue to have an unacceptable rate of fatalities compared to all other high-income countries.”

The guidelines are only a part of the whole issue with mitigating the effects of COVID-19. Birx also said, “We are not addressing the critical gaps in access to primary health care in rural America and among our tribal nations. We need to understand and address these gaps at the community level to move this virus to an endemic status for all Americans. We must acknowledge the limitations in science and data in our understanding of long COVID-19 as well as persistent severe disease among specific Americans.”

CDC’s announcement on the COVID-19 guidelines is not enough explanation to the American public, Birx explained. “CDC must show the data supporting their shifts both in increasing and decreasing mitigation so every American can be empowered to make the decisions for themselves and their family so every American can not only survive but thrive despite persistent COVID-19 infections.”

One point from CDC stayed the same: The responsibility to stay safe remains on the individual. “To prevent medically significant COVID-19 illness and death, persons must understand their risk, take steps to protect themselves and others with vaccines, therapeutics, and nonpharmaceutical interventions when needed, receive testing and wear masks when exposed, receive testing if symptomatic, and isolate for equal to or more than 5 days if infected,” the announcement said.

REFERENCE AVAILABLE AT INFECTIONCONTROLTODAY.COM
Langya Virus, a Novel Virus, Is Identified in China

BY NINA COSDON

Identified in at least 35 individuals in eastern China, a new type of henipavirus, Langya virus, is suspected to have infected shrews before jumping to humans.

A t least 35 patients across 2 Chinese provinces have been infected with the phylogenetically distinct Langya henipavirus (LayV), according to an August report in the New England Journal of Medicine.

The investigators reported that they could not find evidence that the virus transmitted between individuals, suggesting it is spreading zoonotically. Though the sample size is small, they suspect Langya virus was hosted by shrews before infecting humans.

During routine surveillance of patients with fever in eastern China with a recent history of animal exposure, a team of investigators isolated acute LayV infection after metagenomic analysis of 1 patient’s throat swab sample.

Subsequently, 35 patients with LayV infection were identified in the Shandong and Henan provinces of China, 26 of whom were infected with LayV alone, meaning no other pathogens were present.

Of these 26 patients, 100% presented with fever, 54% with fatigue, 50% with cough, 50% with anorexia, 46% with myalgia, 38% with nausea, 35% with headache, and 35% with vomiting. Additionally, 35% had abnormalities of thrombocytopenia, 54% had leukopenia, 35% had impaired liver function, and 8% had impaired kidney function. The investigators noted that none of the patients with LayV have died of the infection.

A serosurvey of domesticated animals revealed LayV seropositivity in 2% of goats (3 of 168) and 5% of dogs (4 of 79). The investigators also surveyed 25 species of small wild animals, finding LayV RNA in 27% of shrews (71 of 262), suggesting shrews may be a natural reservoir of Langya henipavirus.

The Langya virus comprises of 18,402 nucleotides (nt) with genomic organization identical to other henipaviruses. LayV was first detected in 2018 via a sample from a farmer living in the Shandong province who presented with fever. Over the next 2 years, 34 other individuals, most of them farmers, were infected with the virus in the Shandong and Henan provinces.

Langya henipavirus belongs to the genus Henipavirus and family Paramyxoviridae, home to the Hendra and Nipah viruses, which are known to infect and cause fatal disease in humans. LayV is most closely phylogenetically related to Mojiang henipavirus, a virus with a genome length of 18,404 nt originally discovered in southern China.

Zoonotic virus spillover is nothing new and not necessarily cause for concern, but the COVID-19 pandemic, which was likely caused by zoonotic viral transfer at a market in Wuhan, China, has escalated the level of concern associated with zoonotic events.

Contact tracing of 9 infected patients with 15 close-contact family members revealed no transmission of LayV. The investigators reiterated the limitations of the small sample size, but hypothesized that unlike COVID-19, human-to-human transfer of Langya henipavirus is fairly unlikely: “There was no close contact or common exposure history among the patients, which suggests that the infection in the human population may be sporadic.”

REFERENCES AVAILABLE AT INFECTIONCONTROLTODAY.COM
Monkeypox: Birx Says We Are Not Ready for a New Pandemic

By TORI L. WHITACRE MARTONICZ

What did the United States learn from the COVID-19 pandemic and its ensuing response, and are we prepared for new diseases to arrive? According to infectious disease expert and former White House Coronavirus Response Coordinator, Ambassador Deborah Birx, MD, we have the tools but are not fully equipped to tackle another pandemic.

Birx recently spoke with Infection Control Today® (ICT®) in an exclusive interview on some of the new threats, including Langya virus, monkeypox, and polio.

ICT®: Are we prepared for a new pandemic?

Ambassador Deborah Birx, MD: We are definitely not prepared because you can see it in the mistakes made with monkeypox. It was very frustrating to me. In fact, it’s why I came back from Africa on March 2, 2020, as I couldn’t…follow and just watch from afar the mistakes we were making domestically [with COVID-19], and we made the same mistakes 2 and a half years later with monkeypox: undercommunication, underraising of the alert, undertesting, undervaccinating. And this time we had a vaccine, but underpreparation, [and] you could see monkeypox coming.

Every infectious disease that has caused an issue in Europe has come to the United States within the past 3 years. It doesn’t matter whether they are new variants of COVID-19 or monkeypox; we can see these infections coming. And we could, because we have the tools, prepare better for their arrival and use data, and empower the communities at risk.

On May 8, 2022, a note should have gone out through our LGBT community that said, “This is what’s happening. This is how transmission occurs.” That’s a community that’s extraordinarily responsive, that understands infectious diseases so well, and they’re educated. We had a ready community that could have been alerted, that could have been vaccinated. Instead of having what I believe to be 10,000 to 20,000 cases, right now, most of them nondiagnosed, we wouldn’t have had them because we would have [vaccinated] in those high-risk communities. Instead, we didn’t do any of that. We waited. We had magical and mystical thinking that we would be [doing] better. And that’s very frustrating to me.

Infectious diseases do not care about your income status or where you live. They move through a population through the way that they spread. Every mistake that we made with COVID-19 in January and February of 2020 was repeated in real time with monkeypox. So that tells me we haven’t learned our lessons. We’re not [working] in a proactive way. We wait till we get into a crisis, and then we respond. That’s what resolving in the high fatality rates from COVID-19. That’s still our position persistent to today. And it’s what’s resolving in monkeypox spread because we’re not utilizing [the lessons we have learned]. It’s not a monkeypox vaccine. It’s a smallpox vaccine, a vaccine, but highly effective.

I don’t know whether we think we’re exceptional when it comes to infectious disease, but we are not. We’ve had higher fatalities—about 60% more fatalities—in this country than the United Kingdom over the past 18 months because we didn’t use the tools that we had for COVID-19. I see how the UK expanded testing and expanded knowledge and got tests even into small communities, educating the public and saying, “If you test before you see your older grandparents or your sick aunt, you’ll prevent most of the spread of this virus.” We didn’t do that. The UK did, and their fatalities through Delta and Omicron [variants] are 60% less. So there are tools out there, and there is knowledge, and we know exactly what’s happening. But we’re not using any of those things to combat the diseases that we’re seeing.

ICT®: We’re not using those tools. They’re sitting there. The COVID-19 tests are sent out by the US Postal Service, but we’re still not using them.

DB: That gets into a significant problem because are those tests going to the right place? When this gets down to implementation, if you’re tracking the data and utilizing data, you see that the primary group that is still being hospitalized and still dying are individuals over 70 years old. We know where every single individual over 70 years old lives in this country. There are 35 million of them. Fewer than 1.2 million live in nursing homes. We know where everybody else lives because most of them receive Social Security checks, so tomorrow, we could send 10 tests to every single person over 65. And say, “When you have an alert that there is COVID-19 in your community, please test twice a week as soon as you’re positive. This is your telehealth number. Call it, and we will immediately get you a prescription or overnight Paxlovid to you. That’s how you empower people. Don’t empower people by saying, “Go to a website:
try to order [the tests] online. You’ll get 4 tests.” You really need 10, but we’re going to give you 4? It’s so inadequate, yet, somehow, I guess it makes us feel good. Or we say things like, “Test and treat,” and we put out these slogans. And yet there’s no way to test and treat if you live in rural Oklahoma, northern Mississippi, northern Alabama, the small towns....There is no ability to see a physician or a primary care physician or a nurse practitioner and get Paxlovid.

We’re not addressing the barriers to access, and that is very frustrating to me because that is how you combat infectious diseases. You look at who is not being reached, and you fix those structural barriers. There are simple solutions, and we have them. Frankly, it would be cheaper. We have enough money; it’s how we’re utilizing the money. We went from 7 million people on [medical] treatment with our current budget in 2014 to 20 million people on treatment by 2021. How did we do that? We did that by utilizing dollars effectively and addressing what the real needs were rather than what we perceive the needs to be. I think today...80% of the workforce at the Centers for Disease Control and Prevention should be out in the states, living there and understanding how health care and public health is delivered, and being there on the front lines as part of the response and part of the implementation. Stop sitting at the computer and watching the horror of this unfold and get out there and make it different.

ICT*: What advice do you have for those health care workers who are out on the front line, who are facing this, who are out there in the trenches?

DB: First, thank you. I saw you. I heard you. I got to see the frontline workers in Billings, Montana, at the 2 major hospitals there. In these hospitals, there may only be 1 infectious disease expert, and just a couple who we call intensivists. I watched them create 30-plus intensive care unit beds out of a capacity of 20.

There was a lot of innovation that hasn’t been captured, that could make us all stronger if we would listen to them and what they did. It was part of the reason why I went out to the states and the communities; I wanted to see what was working, and take that back and make sure our federal response was supporting what was working. That’s what we should be asking every day of every hospital and clinic—“Are we helping you? What do you really need?”—and not assume what they need, but get out there and find out what they need. Then figure out how we’re going to expand peer community outreach. I think it’s possible.

I saw great programs being executed in the United States, and [the] historically Black colleges and universities program that brought community health workers training into the 11th and 12th grades. So these young women could leave high school with already an incredibly valuable skill that could be utilized immediately within the community.

We have to make sure that we change how funding is provided. So right now, we should be saying to National Institutes of Health [NIH], 20% of Americans live in rural America, [and] 20% of the NIH research dollars need to support research at the local level in rural areas. The same way with Health Resources and Services Administration; 20% of their clinical dollars that they’re utilizing for these federally qualified health clinics need to go to places like...small town, Ohio, so that people have access. It was shocking to me to watch federal officials say, “Talk to your primary care physician about getting vaccinated and boosted” knowing—or not knowing—that 20% or more of Americans have never had a primary care physician [and] need this the most. It’s a complete [disconnect] between the perception of health care delivery in America and what’s truly happening. If they would talk to health care workers, they would understand what they need, what is happening, and what kind of additional support needs to be made in order to ensure people can not only survive in these times of the pandemics, but we all can thrive.

ICT*: And we’re not thriving right now.

DB: No, and it’s not about lockdowns. People are always saying, “Oh, well, you wanted to do mandates and lockdowns.” The only time you do that is when you have nothing, which is where we were in March or April of 2020. But after that, we never suggested at the federal level that anyone lock down. In fact, I did the opposite; [I] tried to get more schools open, and [I] went to 30 universities to try to make sure they stayed open and to learn from them, and then take that to other universities so that they could stay open. And the same way with schools. This was about being safe, yet open. We had the tools to do that. It runs through definitive use of testing during surges, access to Paxlovid, access to monoclonal antibodies that are still effective in some cases, access to vaccine and boosting and knowing who’s still susceptible to severe disease despite vaccinating and boosting because we know who those people are. We can see it in the data, but we’re not doing anything to stop it again. We’re watching and hoping things get better rather than seeing and doing. I think we’re going to still be behind if we don’t use data for action.

This article has been edited for length and clarity.

Scan the QR code to watch ICT’s video interview with Ambassador Birx.
Health care jobs largely have rebounded to prepandemic levels, although COVID-19 will affect health care and the entire US job market for years to come.

The Peterson Center on Healthcare and Kaiser Family Foundation’s Health System Tracker compiled and analyzed employment figures from the US Bureau of Labor Statistics’ Current Employment Survey and the Job Openings and Labor Turnover Survey. Although the pandemic recession may be over, “recovery is incomplete,” said the report. “What impact has the coronavirus pandemic had on health employment?”

July 2022 was the first month since the pandemic that nonhealth-sector jobs rose above February 2020 levels, the report said. Even with gains, health care sector employment was 0.5% lower than in February 2020.

Health care employment has “been relatively recession-proof,” nudging upward even during the Great Recession of December 2007 to June 2009. It tanked with the rest of the economy in spring 2020, falling from total health employment of 16.5 million individuals in February 2020 to 14.9 million 2 months later.

Measuring year on year, that was not as bad as the rest of the job market. Health employment fell 8.3% from April 2019 to April 2020, while nonhealth-care-related employment dropped 13%, the report said.

Within health care, physicians’ offices had a drop in workers of about 11% in April 2020, but has rebounded most strongly, reaching prepandemic levels in about April 2021 and now showing about 4% growth.

Every area within the health care sector, except for nursing care facilities, was growing steadily before March 2020. But even with recent gains, no areas of the health care sector have reached levels of job gains that were projected before COVID-19, based on prepandemic rates.

For example, in-home health jobs grew by 0.28% per month from 2017 to early 2020. Had that continued, home health service workers would number 1.68 million in July 2022, instead of 1.57 million, the report said.

That effect was smallest for physicians’ offices, where the July 2022 employment was just 0.8% below projected growth levels from before the pandemic. The difference was most pronounced for nursing care facilities (12%) and community care facilities for older individuals (13.5%), according to the report.

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Priya entered the room. ‘All right, everyone, the [Joint Commission] surveyors will be starting their day in the emergency department. Let’s all go down there, do spot checks, and support the nurses as a team.’ To my surprise, that moment was when the magic of infection prevention and control happened.
Few jobs are as important and often as thankless as environmental services (EVS). These teams are key players in ensuring patient satisfaction and combating health care–associated infections (HAIs), but many of them are virtually invisible, without professional job titles or presence in the hospital organizational chart. Many health care facilities around the world employ (or outsource) relatively untrained cleaners for low wages. They then demand EVS staff work long hours in relatively demanding conditions and often in contact with dangerous chemicals and fail to recognize the importance of these jobs or understand how this work can disrupt the chain of transmission. As a growing body of evidence demonstrates, the hygienic health care environment is important for patient safety.1-3 Yet, many institutions still do not consider health care environmental hygiene (HEH) “health care.” However, there needs to be a shift in how facilities view HEH. The focus of this shift must center on EVS teams.

At the Geneva University Hospitals (HUG) in Switzerland, environmental hygiene holds special importance. Prior to becoming the director of World Health Organization Collaborating Center on Infection Prevention & Control and Antimicrobial Resistance, Didier Pittet, MD, MS, CBE, led the Infection Prevention and Control (IPC) Department in restructuring the way cleaning was performed at the hospital, including the practice of hand hygiene. These changes were organized into what would become the WHO multimodal hand hygiene improvement strategy, which includes 5 elements: system change, training and education, monitoring and feedback, workplace reminders, and institutional safety climate.4 Ultimately, many of these changes directly affected the EVS teams, reducing cost and staff turnover and improving quality. Although this restructuring was radical at the time, its continued success may provide some guidance for improving HEH programs, especially the challenges facing EVS teams. At HUG, EVS staff have living wages and opportunities for career advancement and remain employed at the hospital for an average of 22 years.

To initiate these changes and avoid the increasingly common outsourcing of EVS staff to an external service provider, HUG redeveloped the training system, educating staff not only on cleaning procedures but also on the transmission of pathogens and the importance of cleaning itself. Because EVS staff often come from a lower-income demographic, HUG and regional authorities developed national part-time certification programs of 2 to 3 years. Any staff member who desires to improve their knowledge may do so for free. The courses not only cover EVS management but also reading, writing, and other subjects. Individuals participating in the program can attend these courses during their work time; HUG pays for the courses, the hours staff members spend...
in them, and the cost of additional staffing when individuals are in class. All EVS team managers are hired directly out of the pool of graduates of the certification program. This formula not only motivates the team but also lends legitimacy to the management, as they have firsthand knowledge of what the job entails.

Because HUG is a public institution, EVS teams have job security once they pass their trial period and can be terminated only for a major transgression or instance of misconduct. EVS staff have the option of joining the union, and the union meets regularly with hospital management.

After initial training, staff continue to receive additional training on specific environments and procedures and may receive individualized training if needed. Managers are always onsite, although EVS staff mostly clean alone. They have pre-treated flat mops and cloths for every room and a detailed checklist for procedures on their cart. Tasks are clearly divided between the EVS staff and nursing staff so that no areas are unassigned and left uncleaned.

Monitoring of staff performance is conducted twice a year for each individual and consists of visual and adenosine triphosphate (ATP) tests. Both tests are designed to verify the process; the goal is not to trap someone who missed a spot but to ask an individual to clean a surface to be evaluated and examine the process with the manager if the surface does not pass the ATP test. If needed, monitors will reexamine the cleaning procedure in a pedagogic setting, identify and address the issue causing the lapse in quality, and retest the procedure. If performance is consistently good, staff members may train to become increasingly specialized, such as working exclusively in operating theaters.

Employees can be taught to wipe a surface correctly, whether they are directly employed or outsourced by the hospital. The problem does not lie with outsourcing itself but that institutions usually get what they pay for. It is common practice for health care facilities to cut funding for their HEH programs when budgets are tight, and those cuts affect the EVS teams directly. It is easy to see why EVS workers may receive a lower-income, relatively uneducated demographic and the skills required of the position rarely lend themselves to specialization. But failure to invest in employees has a detrimental effect on staff morale, retention, and quality of work.

To perform at their best, EVS teams need all 5 components of the WHO multimodal strategy: necessary cleaning products and equipment, continuing training and education, regular monitoring and feedback that is constructive and includes individualized plans for improving performance, reminders that include HEH safety posters and tasks to be performed, and other elements that are more difficult to quantify but build a strong institutional safety climate. This last component is the most difficult to achieve because it requires ownership of the work and mutual respect and benevolence among EVS teams, medical and nursing staff, and management. It is therefore crucial for the HEH program that EVS management work closely with the institution's IPC department.

All these measures, from decent wages and benefits to onsite management and certification programs, incur a significant cost to the institution. So how can such measures be justified? To do so, one must look at the cost in context. According to the WHO report on HAI, the pooled HAI prevalence in high-income countries was approximately 7.6%. The annual estimates of the financial cost of such infections are approximately $6.5 billion for the United States and $7 billion for Europe. For improved hand hygiene practices (estimated to cause between 50% to 70% of HAIs), some studies estimate between a 35- and 92-fold return on investment. Even if only 15% to 20% of HAIs are spread through the environment, they remain a huge financial burden. The Centers for Disease Control and Prevention estimates that of the $45 billion cost of HAIs, $25 billion to $31.5 billion could be saved with better IPC programs. In short, although limited data exist about HEH on its own, infection prevention has a higher return on investment than nearly any other cost-reducing medical intervention. The issue with HEH is that indirect costs of HAI are often not calculated in the same budget, making the connection more difficult to quantify.

Because HEH practices are generally heterogeneous and not usually based on best practices or evidence, there is much room for improvement. Nevertheless, the HUG model for environmental hygiene is not universally applicable in its current state. Most health care facilities around the world do not have access to the same level of resources or institutional support. The IPC research team at HUG is working on creating a transposable model of its HEH program so elements from their experience can be adapted and adopted to enhance all levels of resources and cultural contexts.

Additional information about work on this subject:

- Results of an international pilot survey on health care environmental hygiene at the facility level
  www.ajicjournal.org/article/S0196-6553(22)00133-X/fulltext
- Systematic review on the ability of health care environmental hygiene to reduce health care-associated infections
- Adapt to Adopt—Didier Pittet TEDx Talk. PittetTEDxPlaceDesNations www.youtube.com/watch?v=5tgH0uTqQcE
- Clean Hospitals Network www.cleanhospitals.com
Global improvement will require a major cultural shift in how hospitals see HEH programs as a whole, starting with the realization that EVS teams are an integral part of infection prevention and as deserving of support and respect as any other staff. Simple, low-cost interventions can make a real difference. Better training, clearer instructions, and more respect and communication in the workplace will have a positive effect on the health care facility’s budget, EVS teams, and patients.

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DIDIER PITTET, MD, MS, CBE, is the hospital epidemiologist and director of the Infection Control Programme & World Health Organization Collaborating Centre on Infection Prevention and Control and Antimicrobial Resistance, University of Geneva Hospitals and Faculty of Medicine, Switzerland.

He is the author and coauthor of more than 500 publications in scientific journals and editor of the first textbook on hand hygiene for medical professionals, Hand Hygiene – A Handbook for Medical Professionals (Pittet, Boyce, Allegranzi, edition Wiley-Blackwell, 2017). Pittet is also the recipient of several national and international honors including a CBE (Commander of the British Empire) awarded by Her Majesty Queen Elizabeth II for services to the prevention of health care-associated infection in the UK (2007).

Since 2005, Pittet has been working closely with the WHO as the lead adviser of the First Global Patient Safety Challenge, whose Clean Care Is Safer Care program is active in hospitals in 189 of the 195 United Nations member states. Pittet is also credited with revolutionizing patient care processes in hospitals by replacing hand washing with soap and water with the systematic use of alcohol-based handrubs and spreading this change in practice to health care centers around the world.

In June 2020, Pittet was appointed by the President of the French Republic, Emmanuel Macron, as president of an independent mission created to assess the management of the COVID-19 crisis and to better address the risks posed by the pandemic and delivered the report of this commission in May 2021. The mission’s primary objective was to assess the relevance, speed, and proportionality of the French response in the management of the health, social, and economic crises, in particular in comparison to other countries’ responses.

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~1/3 of positive blood cultures are FALSE positives.
How to Obtain Better Hand Hygiene Adherence: Ideas From Health Care Workers on the Floor

BY TORI L. WHITACRE MARTONICZ

Every medical professional knows the importance of hand hygiene (HH). It is the first and most critical defense against the chain of infection. So why is HH adherence so difficult to maintain in health care facilities? Countless methods have been devised to encourage and require adherence: apps on cell phones, video cameras, computer programs, stickers, and other small tokens of positive feedback, and most often, infection preventionists (IPs) among health care workers (HCWs) noting who followed required HH guidance and who did not.

But why do HCWs, knowing how important it is, not perform the appropriate HH procedures every single time it is endorsed or required by their facilities? Infection Control Today® (ICT®) went to IPs and asked, “What keeps you from performing HH, and what do you think keeps other HCWs from consistently adhering to HH requirements?”

Why Hand Hygiene Is Important

Leslie Bozigian Curtin, RN, CMIP, former assistant director of nursing and infection preventionist at Sumter East Health and Rehabilitation Center, has been in the health care field for 40 years. “To break the chain of infection, you have to have an infective agent, a method of transmission, and a susceptible host. Then you must have [a] method of getting the agent to the susceptible host. So anytime you can break any one of those links in the chain, you will break the infection process. The easiest way to do that is HH,” she said.

Curtin tells her HCWs to perform HH in the following situations:
1. When you put your purse away
2. When you put your coat away
3. Before you go into any other room on the unit
4. If you go into someone’s room and deliver a tray
5. In between providing care for patients
6. Before providing any patient care
7. Before and after you go to the restroom
8. Before and after you eat a meal or snack
9. After providing care requiring gloves, you must take your gloves off and wash your hands again.

Why Isn’t Hand Hygiene Consistently Performed?

Tracy M. Field, RN, WCC, LALD, corporate infection preventionist for Ecumen, a long-term care (LTC) organization, told ICT® she sees HH not performed, especially in LTC facilities, despite technological advances. “Things have come a long, long way. In the 30 years I’ve been in health care, one of the biggest things that has developed is the placement of hand sanitizer. They have those wall units right at the patient rooms. They have these strategic placings of solution everywhere. But even though those are there, I still see [HCWs] walk by them,” she said.

The first barrier to HH adherence is familiarity with the patient, Field told ICT®. “We live and work with these [patients] whom we love very much. We’re their family, and they’re our family. When you feel like you love this [patient], you take care of them every day; you don’t look at them as infectious. You might skip [HH] because it’s not like the...
hospital…and this [patient] in front of you is not super sick. It’s a different situation. In senior care, HH is just as important: all we can do for infection prevention. But there is this sweetness about the care we give [due to familiarity]. I see that as a big barrier,” she said.

Field also explained the second barrier: complacency. In an LTC facility, an HCW may think, “I took care of this person every single day [in the past] week; I know they’re not sick.” The HCW comes back 2 days later, [and the patient has] COVID-19 or norovirus. And the HCW was already exposed. There’s this kind of complacency where the HCW thinks, ‘Oh, I take care of these [patients] all the time. They’re not sick.’ I see that thought as a barrier for senior care,” she said.

Other reasons for improper HH that came up in the discussions with IPs were staffing challenges and lack of time. In these situations, the HCW tries to get everything done, and HH is the easiest and first guideline to be overlooked. “Staff shortages are so overwhelming that you’re frazzled and frustrated,” Field said.

However, Field explained these feelings are no excuse. “[HCWs] complain they don’t have time to wash their hands or...use hand sanitizer.”

—Tracy M. Field, RN, WCC, LALD

HCWs tell ICT® why they do not always adhere to hand hygiene (HH) guidance

- Placement of hand sanitizer dispensers (they should be outside every room)
- Type of HH product (ie, hand sanitizer or soap; it may be sticky and smell bad)
- Limited access to hand sanitizer, requiring use of pocket or clip-on sanitizer
- Lack of quality hand sanitizer. Leaves film on hands
- Lack of sinks in hallways
- No soap, paper towels, and/or hot water
- Familiarity and complacency with patient
- Lack of time and/or feelings of being overwhelmed
- Belief that wearing gloves eliminates the need for HH
- Fatigue at following HH guidance
- Belief that HH damages acrylic nails

However, Field explained these feelings are no excuse. “[HCWs] complain they don’t have time. I don’t think [HCWs] can argue they don’t have time to wash their hands or...use hand sanitizer...It is not that we don’t have time. Our mind has gotten so loaded with wearing the mask, wearing eye protection, putting on a gown, and so on for these rooms. It’s an overload of intense situations that is bogging HCWs down. We lose that laser focus, and you fall back and miss some steps,” she said.

ICT® also asked Laura Miller, MD, MPH, FAAFP, the main reason she sometimes finds herself not following HH procedures. Miller is an assistant professor in the Department of Family Medicine and Community Health at the University of Minnesota in Minneapolis. “I think No. 1 is time and so many different things in our cognitive spaces. We’re in and out of different locations with patients and care teams. There are many things going on [and] many moving parts happening,” Miller said.

Miller said another reason for poor HH adherence is lack of access to hand sanitizer. It may not be refilled or in the right place. “That’s a big gap I have noticed, and it is certainly something that could be actionable. We have come a long way now that we are in the era of hand sanitizer solutions readily available. We’ve transitioned to having [hand sanitizer] alongside hand washing stations. It is handier and more useful to have hand sanitizer solution available instead of hand washing [stations] because it takes so much more time and space to [wash].”

Additionally, according to Miller, simply remembering to do HH may be difficult “especially in more emergent and urgent situations, when you’re trying to get in the emergency department [because] your patient is not doing well in the hospital.” She went on to say, “When you’re in obstetrics, and you’re having a crunch in your time, it’s hard in the moment to stop when you have something more urgent in front of you.”

Miller echoed other HCWs who spoke to ICT® about sticky and/or smelly hand sanitizer or soap. “There have been times when a refill pack or something is different...so I’m going to avoid that one.” She also mentioned allergies or dermatologic effects from hand sanitizer solution. Being alcohol based, it is a drying agent that may cause severe and chronic skin issues.

However, Curtin said there is no excuse for lack of HH adherence; even children know to wash their hands well and often. No matter their reason for improper HH, her admonition to HCWs is always the same: “You can’t wash your hands or use hand sanitizer too many times.”
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Preventing INFLUENZA in the Health Care Setting

BY JAN DYER
Since COVID-19 is here to stay, are health care workers apathetic to the effects of influenza? The last 2 flu seasons were “rather aberrant,” says William Schaffner, MD, medical director of the National Foundation for Infectious Diseases, said in an interview with *Infection Control Today*® (ICT®). “Two years ago, there was no flu. Well, that was because we were all locked up. Children are the great spreaders of the influenza virus in our population, and they were all at home.”

Schaffner continued, “Last year, we had an influenza season that started up in December and [went] into early January as though it were going to be a moderately severe season. And then the bottom fell out! Influenza just plummeted and then, surprisingly, it lingered for a long time, and we were getting cases of flu beyond April and into May. So we’ve had 2 aberrant seasons, both of them less impactful than usual.”

Two milder-than-usual flu seasons, plus a population worn out with relentless worries about COVID-19, may have created an apathetic attitude about flu for some individuals. “Recent memory on the part of the general public is a little bit dim on influenza now,” Schaffner said. “We’re going to have to remind them that this is also an illness that we have to take seriously.”

The public may not be the only ones who need a refresher course. Although health care workers seem to be more aware of the importance of influenza prevention thanks to the COVID-19 pandemic, “they have expressed high levels of frustration, burnout, and fatigue with interventions which can lead to subsequent challenges with implementation,” Kate Grusich, a public affairs specialist for the Centers for Disease Control and Prevention (CDC), said in an interview with ICT®.

However, she added, “The pandemic has highlighted the role of core infection prevention and control (IPC) practices like hand hygiene and environmental disinfection and led to renewed efforts to improve these practices.” The past few years have been extremely instructive. “Lessons learned about the importance of ‘source control’ is one specific example that will likely continue to pay dividends for prevention efforts for other respiratory viruses, including influenza viruses,” she said.

Influenza in a medical institution “has a different epidemiology and effects compared to influenza in the community,” causing more complications and mortality, warn investigators for the Transgovernmental Enterprise for Pandemic Influenza in Korea, who published a guideline on flu prevention and control in health care settings.1

Roughly 0.3 to 0.8 cases of flu occur per 100 hospitalized patients, the researchers say. When an outbreak happens in a health care institution, the attack rate increases to 0.7% to 20%, and can rise to more than 30% in the ward where the outbreak began. In a long-term care facility with many older patients, they add, the attack rate can leap to 70%. The risk gets higher for the staff, too, of course, with an attack rate of 11% to 59%.1

However, the study authors cite research that found when “aggressive” infection control measures were used, such as vaccination, reporting and monitoring respiratory symptoms, and “exclusion from work” for the symptomatic, the attack rate for health care workers was maintained at less than 2%.1

The key is to cast a wide protective net. Preventing the spread of pathogens, like influenza viruses, in health care settings depends on implementing sets of interventions to “build redundancy” and improve effectiveness, Grusich says. Interventions like early recognition of patients with acute respiratory illness who might have influenza and the use of recommended personal protective equipment are important. She says the use of facemasks by symptomatic patients for source control, although recommended as part of standard precautions for individuals with respiratory symptoms for years, is also an important intervention that has been used for COVID-19 patients in health care settings, and should be applied to all patients with respiratory symptoms in health care settings.

The Occupational Safety and Health Administration (OSHA) recommends, among other things, encouraging sick workers to stay home; using airborne infection isolation rooms; making sure HVAC systems in patient rooms, procedure rooms, and examination rooms are functioning properly; and limiting the transport of infectious patients throughout the facility (instead, conduct exams and procedures at the bedside). However, OSHA warns, pandemic flu is always a concern for health care employers, and advises that a pandemic flu plan “should be based on a ‘worst-case’ scenario.”2

As Grusich indicates, it’s not a matter of simply covering bases but covering them using redundant measures. The
“cornerstone of influenza prevention,” she said, is annual vaccination. Here again, COVID-19 has stolen nearly all attention. That’s one reason Schaffner is concerned. “[In] the fall of 2021, as we were starting to vaccinate for influenza, there had been so much attention [given] to [the] COVID-19 vaccine that I had to reintroduce the notion of influenza to [individuals] and remind them [it] was another nasty respiratory virus [for] which we have vaccine. And I felt I was starting from scratch,” he said.

Certainly, the steps people took to prevent COVID also helped prevent flu. Grusich noted only slight reductions exist in the estimated percentages of children and adults who received the influenza vaccine this past season compared with the 2020-2021 season. “However, the estimated percentage of pregnant [individuals] who received [an] influenza vaccine during this past season was substantially lower than [in] the [previous] 2 seasons,” she said, adding the reasons for lower influenza vaccination coverage in children, pregnant individuals, and nonpregnant adults are unknown.

“Despite best efforts, flu vaccination in the US has remained under 50% for most seasons; although, it has slowly been rising.”3 Schaffner said a myth he’d like to dispel is the idea “that because we do not have a perfect match between the vaccine and the circulating virus, the influenza vaccine’s not good. ‘We don’t need to get it.’ That’s a very dangerous concept. Even [if] there’s not a good match, there’s often sufficient protection so the recipient is protected against the most serious aspects of influenza.” These aspects include hospitalization, intensive care unit admission, and death.

For healthcare workers specifically, he said, “by getting the vaccine, we are not only protecting ourselves—it’s a patient safety issue. We don’t want to give our infection to our patients! It’s important
that we do everything as a professional and ethical responsibility to prevent the transmission of our virus to our patients."

According to results of a CDC survey of 2391 health care personnel, 76% of health care workers reported getting flu shots in the 2020-2021 season. That was fewer than the previous season (81%), although not statistically significant. Vaccine coverage was highest among those working in hospitals (92%) and lowest among workers in long-term care facilities (66%).

"One of the things that accelerated change in hospitals and large health care systems was the vaccine became mandatory," Schaffner said. "And that concept has not been embraced in the long-term care industry. I think because there’s so much turnover in personnel, industry leaders are concerned [whether] they’ll have enough [staff] working if they insist on vaccination. That’s what I keep hearing."

The CDC survey results showed physicians, nurses, and pharmacists had the highest coverage (91.3%, 90.3%, and 90.3%, respectively). Interestingly, receipt of a COVID-19 vaccine was the second strongest factor correlated with higher influenza vaccination coverage. Also interesting is that 10.5% of respondents said they got vaccinated “to reduce flu’s impact on the health care system during the COVID-19 pandemic.”

Vaccination coverage was lowest among health care workers whose employers neither required nor recommended vaccination. “Before mandates, there were clear distinctions among [individuals] depending upon their professional background. Pharmacists were the best vaccinated. Over time, the doctors [were] second, but the nurses were always in third place. The literature is full of this. Nurses express more concern for one reason or another about vaccination, which is a matter of double concern because our nurses have the most contact with patients. You would want them to be vaccine advocates rather than vaccine cautious,” Schaffner said.

The main reasons health care workers gave for not getting a flu shot were “I do not need the vaccination” (17%), “I might experience adverse effects or get sick from the vaccine” (12%), and “I don’t think the vaccination is effective in preventing flu” (12%).

“Some health care providers don’t like needles. Some are concerned the vaccine isn’t good. They’re concerned about—and this is not trivial—side effects. Well, [most individuals] who get [the] influenza vaccine may have a sore arm for a few hours or a day, but it’s unusual. And [if] we look at experience, we don’t have a big spike in absenteeism for reasons of side effects when we get these vaccines,” Schaffner said.

But physical adverse effects are not the only thing worrying health care workers. Schaffner said they may be concerned about “adverse effects in the sense that if they’re not working, they won’t get paid. There are lots of single health care workers out there, and [for] single moms, that’s a real threat to their home economics. And there [are], among younger women who are health care providers, lingering concerns about reproductive issues. Of course, influenza vaccine is recommended for [anyone] who’s pregnant.”

Research has shown workplace vaccination promotions such as onsite clinics can boost vaccination numbers. Convenience can be one of the best-selling points for flu vaccination, because economic concerns include not wanting to come in on an unpaid day to get the vaccine. “You can’t penalize people for getting vaccinated,” Schaffner says. “You have to provide the vaccine during work time.” That means also for the individuals who work at night or on weekends. “You may actually have to, in certain circumstances, bring the vaccine to them.”

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What’s next?
In the CDC survey, most of the respondents (up to 87%) agreed or strongly agreed with statements such as “Flu vaccine is safe” and “If I get a flu vaccine, people around me would be protected.” Positive attitudes toward the safety and effectiveness of the vaccine were strongly associated with higher vaccination coverage. On the other hand, approximately half of health care workers disagreed with the statement that “flu is a serious threat to their health.”

The flu virus is notoriously mutable, providing new challenges every year. Can we know—or guess—what this coming flu season will be like? “The CDC long ago discovered that predicting flu was a very [iffy] business, Schaffner says. “So I won’t predict that but I will tell you that in Australia, they’ve had a fairly brisk influenza season. It doesn’t always predict what will happen during our winter but it is a cautionary note. So if we needed another reason to be vaccinated, there it is. We don’t know what comes, so we hope for the better and prepare for the worst. And preparing for the worst is, ‘Let’s all get vaccinated.’”

JAN DYER is a writer and editor specializing in clinical topics. She lives in Suffern, New York.

REFERENCES AVAILABLE AT INFECTIONCONTROLTODAY.COM
The word OK is my least favorite word in the English language. I have been guilty of obsessing over the word more than once in my lifetime. However, this obsession only takes place when it’s delivered in written form. In response to the word, my internal conversation usually sounds something like this: “Are they OK, or are they just saying they’re OK? Maybe I should ask whether they’re really OK or whether they’re only saying they’re OK, expecting me to know they’re not actually OK.”

Renowned for his work in nonverbal communication, Albert Mehrabian, PhD, a professor of psychology at the University of California, Los Angeles, combined 2 studies in 1971 to come up with the now-famous observation that only 7% of communication is verbal—7%!—which means 93% of all communication is nonverbal. This nonverbal communication consists of 55% body language and 38% tone of voice. This is why I am prone to obsessing over the meaning of OK when I see it in written form.

Today, communication is frequently exchanged through email, texts, and social media. More and more individuals are using these forms of communication to communicate sensitive information. Texting is now the most common form of communication for adults under the age of 50. I’d guess they also obsess over the word OK when they receive it as a reply. The shift in communication method has significantly challenged our understanding of one another, and misunderstandings resulting from written communication are just as present in the workplace.

In my previous article, I introduced you to the concept of the 3 C’s: connection, communication, and collaboration. In the work we do as infection preventionists, the 3 C’s ensure our words are not only heard but listened to and acted upon. If you haven’t read the first article in the 3 C’s series, I’d encourage you to pause your reading of this one and read about the first of the 3 C’s: connection.

Good communication is such an important tool in the work we do as infection preventionists. But unless you’ve lived alone in the mountains for most of your life, you know good communication is essential for everything. If you can learn to communicate effectively, you can resolve a great deal of conflict before it arises. If you communicate poorly, your messages are never received, or worse, misinterpreted. Misinterpretation leads to problems in all areas of life.

In 2005, social psychologist Justin Kruger, PhD, a professor at New York University Stern School of Business, published research that concluded 50% of emails are misinterpreted by individuals receiving them. This statistic shouldn’t surprise us. When we communicate in written forms such as email, we’re missing tone of voice and body language to help us deliver messages clearly.

We’ve all received emails sent with good intention but whose meaning we question. I will receive an email that reads “Sure” and become concerned the recipient is angry at my request. However, a colleague will read the email and say, “No, I think he’s excited by the request! I don’t think he’s angry at all.” Neither of us can tell whether the recipient is upset or excited by the request because the response is delivered without any body language or tone of voice. Therefore, we read our own biases into the email. When so much of our communication is dependent on body language and tone of voice, it’s no wonder email and text messages are easily misinterpreted. We’re robbing ourselves of 93% of our normal communication methods.

Scan to read about the first of the C’s: Connection
As infection preventionists, we need individuals to not only hear our words but respond to them with action.

My grandmother had a pink rotary phone that hung on the wall in her kitchen for decades. She never used it. I thought it was broken for the longest time because when she wanted to talk to someone, she’d walk 10 blocks to their house and knock on their door instead of picking up the phone. Once I realized her phone worked fine, my millennial self thought this behavior was the strangest thing. Why not pick up the phone and call them? I think my grandmother understood and valued the importance of communicating in person when you’re able, especially when you have difficult messages that may not be well received. More recent generations (mine included) do not understand this point. We’re all arguing over texts and (mine included) do not understand this point. We’re all arguing over texts and social media.

If you want to be heard and understood, communicate in person. Don’t use written forms of communication when you can pick up the phone, and don’t use the phone when you can communicate in person. In-person communication should always be the gold standard. As an infection preventionist, you often have difficult messages to communicate, including ones your audience does not want to hear. Can you communicate them in person? Over the phone? Over the phone with video?

For example, you should avoid telling your surgeons via email you have ruled in a surgical site infection and believe poor sterile technique is contributing to high infection rates. That approach is wrong for so many reasons. Schedule a meeting and discuss those infections in person. Pick up the phone and call the important parties. And whatever you do, do not use social media.

However, sometimes the written word will be your only avenue for communication. It’s not practical to communicate 100% of the time in person or over the phone. I knew an employee who would walk all over the hospital to deliver simple messages, wasting a great deal of time in the process. Decide what communication should take place in person and what is safe to send by email or text. In many ways, digital methods can increase our productivity and improve our communication when done right.

With a few tips, you can become a savvy user of written words to communicate effectively. Email will continue to be a large part of the working world, and mastering email communication will help us become more successful in our careers and life. First, become a better writer. Your sentences and paragraphs should flow, and your formatting should help the reader digest your message. Two emails may say the exact same thing, but the reader will have an easier time digesting one message over another because of its formatting. I cringe when I receive an email that is 1-page-long paragraph written in cursive, light purple font.

Second, proofread your emails. For sensitive emails where communication cannot take place in person or over the phone, ask someone else to proofread the email if possible. Ask them whether any part of the email sounds negative and whether your main message is clear.

Last, use emojis and punctuation as communication tools. You read that correctly—use emojis. According to several surveys, emojis such as a simple smile are becoming more common in the workplace and are even viewed as professional. By carefully and strategically placing emojis, you can use them to approximate tone and body language. A well-placed emoji may help communicate difficult or more complex messages, meaning the reader is less likely to misinterpret the message. An OK sent with a simple smile emoji ensures the recipient isn’t left wondering about the meaning of the word.

As infection preventionists, we need individuals to not only hear our words but respond to them with action. However, in our digital age, effective communication can be challenging. When only 7% of communication is in the words we use, digital communication methods leave out nonverbal signals to convey our message. When communicating difficult messages, in-person communication is always best. If not possible, phone calls, preferably with video chat, can be a suitable alternative. However, we can use digital communication to our advantage, increasing our productivity. To do so, we must aim to become better writers, proofread our messages, and strategically employ emojis and punctuation to substitute for nonverbal communication methods. If we want individuals to listen and turn our words into action, we must communicate effectively. I look forward to our next article, where we’ll explore the last of the 3 C’s, collaboration.

Until next time.

Tips for effective written communication

1. Become a better writer.
2. Proofread your emails.
3. Use punctuation and emojis as communication tools.
Health care professionals know anything you touch can serve as a reservoir for pathogens. They also know you can transmit or contract a pathogen by coming in contact with a contaminated fomite (inanimate object). As part of our medical education, we were taught fomites can play important roles in the spread of infectious disease.1 Doorknobs and light switches are the usual suspects, but fomites also include countertops, handrails, mobile phones, and clothing.1 These items are present in most indoor environments. However, when considering health care facilities, the number and types of fomites increase dramatically, as does the presence of infectious pathogens present in those facilities.

Protocols for the proper disinfection of fomites have been in place for decades. Routine procedures for disinfecting surfaces in health care and other facilities were seriously tested when SARS-CoV-2 appeared in 2020. The spread of COVID-19 prompted questions about its mechanisms of transfer. What was more important to address: person-to-person contact, airborne transfer, or fomite transfer? Not knowing exactly how individuals became infected with COVID-19, early studies suggested the virus could survive on plastic or stainless steel for days, resulting in advice to disinfect everything.2,3 However, even though the COVID-19 virus can survive for days on surfaces, epidemiological data did not support contact with contaminated fomites as the greatest risk for spread of infection. Later studies on the importance of social distancing and mask wearing helped provide a better mechanism to avoid spread of the virus in indoor environments.4 Vaccination is now recognized as the best mechanism to avoid the spread of COVID-19. Airborne mechanisms are more responsible for the spread of COVID-19 than contact with contaminated fomites, evidence suggests. However, the automatic inflow of fresh air through mechanical ventilation systems may not completely eliminate the risk of airborne transmission in indoor environments such as health care settings.

Inpatient and Outpatient Clinics Must Monitor Fomites as Part of IPC Protocols

Thorough cleaning and disinfection reduce the role fomites play in the spread of disease.

BY HENRY G. SPRATT JR, PHD; DAVID LEVINE, PHD, DPT; SUSAN MCDONALD, EDD, OTR/L; AND MEREDITH RIPPY, BS

Table. Potential fomites in a neonatal intensive care unit of a children’s hospital inpatient clinic5

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<th>Individual baby isolettes</th>
<th>Communal equipment</th>
<th>Physical plant</th>
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<td>Stethoscopes</td>
<td>Bed scale keyboard</td>
<td>Return air duct (HVAC)</td>
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<td>Electronic thermometers</td>
<td>Breast milk refrigerator handle</td>
<td>Floors near sinks</td>
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<td>Isolette (bed) port handle</td>
<td>Breast milk freezer handle</td>
<td>Sink faucet handles</td>
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<td>Bath basins</td>
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<td>Pump controls</td>
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<td>Supply drawer handles</td>
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<td>Computer keyboard and mouse</td>
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<td>Nurse cell phones</td>
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<td>Cardiac monitor screens</td>
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reaction to disinfect surfaces opened up discussion on fomites as transmission vectors for infectious disease.

For a recent study of a neonatal intensive care unit (NICU) in a local children’s hospital, swab samples were taken from 20 sites in the unit by researchers from the University of Tennessee at Chattanooga’s Clinical Infectious Disease Control (CIDC) Research Unit (Table 5). Results of this study indicated that of the 20 NICU surfaces swabbed, 12 sites (60%) had viable staphylococci and 4 of those sites (20%) had methicillin-resistant Staphylococcus aureus (MRSA) (Figure 1). However, Centers for Disease Control and Prevention (CDC) guidelines on routine environmental sampling for pathogens in hospitals deemed swab sampling not cost-effective, discouraging its use unless certain criteria (eg, ongoing bacterial infections of unknown etiology) were met. As a result, surface contamination of MRSA within this NICU would have gone unnoticed without the work of the CIDC.

Many outpatient clinics also have surfaces that come in contact with patients and act as vectors for infection. The CIDC also conducted studies of selected fomites in a children’s outpatient clinic and physical therapy clinics and looked at devices linked to recovery for hip replacement surgery.

In the children’s outpatient clinic, 72 of 208 (35%) swabs taken over a 6-month period found viable MRSA on the floors and toys that patients played with in the waiting room. In general medicine and pulmonary unit rooms of this outpatient clinic, similar levels of contamination were found, with significantly higher levels of MRSA on the general medicine floors than on the pulmonary unit floors (P < .05). In both the inpatient and outpatient clinics, floors are generally not off limits to children sitting or playing. Additionally, any medical instrument in clinic rooms (eg, blood pressure cuff or pen/pencil) that falls to the floor may become contaminated with pathogens present on the floors. Clinics should consider implementing protocols about contact with floors and dropped items.

For outpatient health care workers, including physical therapists (PTs) and occupational therapists (OTs), specific instruments play a critical role in patient therapy. For example, a common therapy in PT clinics is therapeutic ultrasound. This therapy involves not only the ultrasound head but also a coupling gel (usually contained in a bottle) that enhances the efficacy of the ultrasound. In a 2014 study, viable MRSA was observed on nearly 4% of the tips of gel bottles sampled. Although viable MRSA was not found on the ultrasound heads, other species of bacteria were found on 35% of the ultrasound heads tested. When ultrasound heads were disinfected using an approved quaternary ammonium-type disinfectant for 30 seconds, only 1 ultrasound head had any living bacteria. One option to reduce potential contamination from ultrasound coupling gels would be to use sterilized, single-use packets of gel for each patient.

In a study of physical therapy clinics, 16 of 81 (20%) bottles of lotion and cream used in massage therapy (soft tissue mobilization) had viable bacteria including Staphylococcus aureus on the threads of previously opened bottles. New bottles of lotion and cream did not have viable bacterial contamination. If protocols are in place to properly disinfect these bottles, risk of infection will decrease.

OTs must be careful with therapy devices that go home with patients, including those for patients recovering from hip replacement surgery. To limit the need for patients to bend over, reacher tools and sock aids help them pick up items from...
the floor or put their socks on. Both items, particularly during the training period in a clinic, may be shared with other patients.

Research emphasizes the potential role that fomites play in the spread of infectious disease in inpatient and outpatient clinical environments. This threat is not limited to hospitals; it also spreads via facility floors and any devices patients take home. We should not only ramp up cleaning and disinfection protocols in response to rapidly spreading pathogens such as the COVID-19 virus but also be proactive by minimizing the role fomites play in the spread of infectious diseases.

In a CIDC-sanctioned study of these OT devices, a different tack was taken. By adding living bacterial cultures (S aureus, Escherichia coli, and Bacillus cereus) in known quantities to surfaces of these 2 OT devices, the CIDC researchers determined potential survival of the bacteria. The reacher tool handles were made of metal, and the sock aids were made of nylon plastic.

Survival of these 3 bacterial species differed on each device. For the plastic sock aids, 7.5% of S aureus survived for 48 hours. For both E coli and B cereus, survival on sock aids was less than 1% after 48 hours. However, when looking at survival of these 3 bacterial species on the metal handle of the reacher tools, the highest percentage of survival at 48 hours was for B cereus (14%). S aureus also survived on the reacher tool handle (4%), but at a lower percentage than for the sock aids. Essentially no surviving E coli was found on the reacher tool after 30 minutes.

Interestingly, results of an earlier study of S aureus survival on therapeutic ultrasound sound heads found close to 25% survival of these cells after 72 hours on the metal surfaces. Whether therapeutic devices for PT or OT act as fomites in the spread of infectious disease hinges on disinfection techniques used by the therapists or other end users. Consideration of pathogenic bacteria survival on fomite surfaces should include knowledge of the materials used to make the devices.

We should not only ramp up cleaning and disinfection protocols in response to rapidly spreading pathogens such as the COVID-19 virus but also be proactive by minimizing the role fomites play in the spread of infectious diseases.

HENRY G. SPRATT JR, PHD, is a senior microbiologist and professor in the Department of Biology, Geology, and Environmental Science department at the University of Tennessee at Chattanooga. His research in microbial ecology, focusing on the presence of viable pathogens in clinical environments, has resulted in more than 25 publications and more than 110 conference presentations.

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SUSAN MCDONALD, EDD, OTR/L, is an associate professor and director of the occupational therapy program at the University of Tennessee at Chattanooga. Her research includes clinical infectious disease, Ehlers-Danlos syndrome, and educational research. She has more than 15 publications and has given more than 75 conference presentations.

MEREDITH RIPPY, BS, earned her degree in preprofessional biology at the University of Tennessee in Chattanooga in 2022. Her research involves surgical patient care, psychological variables associated with COVID-19 vaccination, and visibility of pathogens on occupational therapy instruments. Her research has resulted in 2 publications and 17 presentations.

References
Vitalacy Automated Hand Hygiene Monitoring Solution

The Vitalacy Automated Hand Hygiene Monitoring Solution delivers precise hand hygiene adherence to facilities struggling with the problem. The artificial intelligence of the system provides more comprehensive information than an infection preventionist standing over a health care worker with pen and paper. It provides 24/7 coverage for all shifts and staff, cutting the cost of extra staff. The system has been recognized by Newsweek’s Best Health Care series as one of the best hand hygiene monitoring products.

The Vitalacy Automated Hand Hygiene Monitoring Solution works with dispensers currently in facilities, contains visual and vibrational reminders, and features simple daily use with low information technology impact. It gives real-time coaching for frequency and duration. The system has 3 wearable forms: SmartBadge, SmartBand, and SmartClip. These forms use USB recharging, have water-resistant touch screen sensors, and come in several stylish colors. They are made of silicone band with an antimicrobial zinc coating.

The data gathered from the hygiene monitoring devices can be sorted to view reports on individual, unit, departmental, or total enterprise performance.

www.vitalacy.com

Belimed Ultrasonic Washers

Health care–associated infections and surgical site infections are expensive—physically, emotionally, and financially—for patients, health care workers, and facilities. One way to stop these infections is to verify instruments are disinfected and sterilized effectively. Ultrasonic cleaning prior to disinfection and sterilization is endorsed to assist in the process for complex and cannulated instrumentation.

Belimed Ultrasonic Washers will fill the need to eliminate all infections. Powerful cavitation breaks up gross soil and penetrates hard-to-reach areas in a way that brushes and sprayed water alone cannot. All Belimed units have clinician-friendly automatic tray lifts for reduced user strain, and a variety of Belimed’s ultrasonics offer wash, irrigation, and rinse options. Some units have advanced management information system and robotic processing features.

Interior tray clearance is 30 in wide, perfect for bariatric and robotic instruments. Some units have double- or triple-tray capacities with 70-lb maximum loads. They have a safety glass lid that allows users to verify instruments are submerged. Detergent dosing is accurate and repeatable with a flow meter. Accurate tank water temperature can be set from the display, and units have electronic water level sensors with 3 levels.

www.belimed.com/en-us

Honeywell Soft Comfort Nitrile Exam Glove Soft Blue

Health care workers are constantly looking for the perfect glove to wear while they work. They need flexibility and tactile sensitivity to do their jobs well. The Honeywell Soft Comfort Nitrile Exam Glove Soft Blue may be what they are looking for.

These natural rubber gloves are specifically designed for patient care. Lightweight, powder free, and latex free, these nitrile exam gloves are thin and silky, providing the perfect fit for finger and hand movement in a variety of health care settings. The fingertips are textured for a better grip, and the cuff is beaded for protection. These gloves are specifically designed for a wide variety of low-fluid exposure situations, are nonsterile, and are cleared for use with chemotherapy drugs. The standard length is 9.5 in, finger thickness is .09 mm, and palm thickness is .06 mm. They are also ASTM D6319 and D6978 compliant.

sps.honeywell.com/us/en
WikiPouch by Infection Prevention Products

WikiPouch was created by Meredith Lloyd, a single mother of 5 children, midwife assistant, and charge nurse in a skilled nursing facility. She developed the idea after realizing that plastic bags, when used to store reusable respiratory devices, are a significant cause of health care–acquired infections (HAIs). Plastic bags allow pathogens to live and create cross contamination.

WikiPouch is a breathable, moisture-wicking pouch and replacement technology that reduces HAIs with the use of nasal cannulas, handheld nebulizers, and other respiratory devices. WikiPouches are also available for other uses, including storage of electric and nonelectric toothbrushes, snore guards, night guards, hearing aids, eyeglasses, Foley catheter covers, stethoscopes, bag valve mask, blood pressure cuffs, and bedpans.

WikiPouches come in black, blue, white, and pink colors and may be written on with permanent marker to individualize. Some have Velcro straps, drawstrings, or peel-and-stick closures. They are more attractive than plastic bags and eliminate the condensation that forms in plastic bags. They are cheaper than plastic bags because they do not have to be consistently replaced. They are great for camping and travel as well. Infection Prevention Products has sold over 1 million pouches to long-term care facilities around the United States, and sales continue to increase.

www.wikipouch.com

Silentia Screens

Screens for patient privacy are used in many health care situations. Those screens are typically white or off-white cloth. What about a harder, smoother, and more substantial alternative? They would be easier and quicker to sanitize between patients without having to launder them, saving money. Silentia Screens fit those descriptions. Their folding privacy screens are flexible, easy to clean, and user friendly. The EasyCare and EasyClean functions create safe, mobile, and adaptable screens for increased hygiene.

The surfaces of Silentia Screens, including their joints, accessories, and trolleys, are easy to clean. They can be disinfected with cleansers normally found in health care settings and meet strict hygiene requirements. A single touch point handle minimizes the spread of pathogens, and the screens are easy to fold in and out. The wheels are encapsulated to block hair and dust from getting in and are easily removed to be cleaned in a shower or dishwasher.

Additionally, the screens can be attached, combined, and refigured easily for more privacy.

www.silentiascreen.com/us

Healthmark Humipaks

Study results show soiled surgical instruments should not be allowed to dry because gross soil will be easier to clean and disinfect. Point-of-use treatment should include keeping the instrument moist, if not removing all gross debris, because the chemistry changes and that may increase the cleaning challenge. Instrument manufacturers and associations like the Association for the Advancement of Medical Instrumentation and the Association of periOperative Registered Nurses recommend starting decontamination within 30 minutes. However, that is often not enough time.

Healthmark recognizes the struggle to clean and disinfect soiled instruments quickly and the need to keep them moist if they can’t be cleaned immediately. So Healthmark developed Humipak as a layer of highly absorbent material sandwiched between 2 layers of waterproof film.

The instruments or entire instrument tray are placed inside the clear Humipak. The specified amount of water is added to the absorbent layer, and the package is sealed by peeling away the adhesive strip. Within this atmosphere, the instruments stay moist up to 3 days, allowing more time to begin the decontamination process and staving off the change in debris chemistry. The delay in this change depends on the instrument type and the composition of the residue and gross debris. Humipaks come in various sizes, from 7.9 x 13.8 in to 30.3 x 25.5 in.

www.hmark.com

Looking Beyond the Surface

Illuvia® Sense is a surgical air decontamination system equipped with advanced internal sensing technologies to help organizations measure and proactively manage environmental quality.

The Illuvia® Sense not only inactivates more than 99.9% of harmful bacteria, viruses and spores;¹ it measures:

- Barometric pressure
- CO₂ Levels
- VOC Levels
- Airborne Contamination Levels
- Temperature
- Humidity

¹Evans, A. The efficiency of microorganism inactivation by the Aerobiotix air cleaner. (Research Triangle Institute, 2013).

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It’s time to take proven infection prevention further

Figures released from the CDC make stark reading for Infection Preventionists. An estimated 722,000 healthcare-associated infections occur annually, resulting in 75,000 deaths and billions in additional costs. More than half of these occurred outside of the intensive care unit.

To change these numbers, hospitals are adopting Hibiclens® for housewide daily patient bathing as an easy, valuable, infection prevention strategy.

For more information on how daily bathing with Hibiclens can help you in your infection prevention strategy visit www.hibiclens.com.


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