Hospital Infection Control Requirements Upgraded

BY MARY ELLEN SCHNEIDER
New York Bureau

The Joint Commission has issued new requirements for hospitals in an effort to prevent infections from multidrug-resistant organisms, central line–associated bloodstream infections, and surgical site infections.

The requirements, which are part of the 2009 National Patient Safety Goals for hospitals, include a 1-year phase-in period with full implementation by Jan. 1, 2010.

It is critical for hospitals to begin addressing the issue of health care–associated infections and to try to keep the problem from worsening, said Dr. Peter Angood, vice president and chief patient safety officer for the Joint Commission. "We're in a bit of a tight spot and we need to work our way out of it," he said.

The new infection control requirements build on an existing National Patient Safety Goal on health care–associated infections that had previously included only requirements for compliance with hand hygiene guidelines and had called on hospitals to manage serious infections as sentinel events. Those requirements will remain in place along with the new elements of the goal. "Infection control is high on our priority list overall," Dr. Angood said.

Under the new 2009 requirements, hospitals are being asked to begin preparing to prevent infections resulting from multidrug-resistant organisms such as methicillin-resistant *Staphylococcus aureus*, *Clostridium difficile*, vancomycin-resistant enterococci, multidrug-resistant gram-negative bacteria, and other epidemiologically important organisms.

Starting in January 2010, hospitals will need to conduct periodic risk assessments for acquisition and transmission of multidrug-resistant organisms, and educate staff and independent providers about prevention strategies and their roles. Hospitals also will be required to provide education about infection control strategies to patients and families who are infected or colonized with multidrug-resistant organisms.

Hospitals will be required to have a surveillance program up and running by Jan. 1, 2010, that is based on the hospital's risk assessment. When indicated by the risk assessment, hospitals will need to implement a laboratory-based alert system to identify new patients with multidrug-resistant organisms, and an alert system to identify readmitted or transferred patients who have multidrug-resistant organisms.

Hospitalists, who are already on the payroll, are likely to be involved in implementing the new requirements.

DR. MICHOTA

The Joint Commission also has put new requirements in place to prevent central line–associated bloodstream infections and surgical site infections.

Related to the bloodstream infections, hospitals will be expected to use a catheter checklist and a standardized protocol for central venous catheter insertion and an all-inclusive standardized supply cart or kit for insertion of the catheters.

Also required is use of standardized protocols for maximum sterile barrier precautions during insertion of a central venous catheter and when disinfecting catheter hubs and injection ports before accessing the ports.

To prevent surgical site infections, the Joint Commission is requiring hospitals to conduct periodic risk assessments, select surgical site infection measures based on evidence, and evaluate the effectiveness of their prevention efforts. Also, hospital staff will need to measure infection rates for the first 30 days following most procedures and for the first year after procedures involving implantable devices.

The surgical site infection requirements were developed to be in line with well-established guidelines and should help organizations move toward compliance with those guidelines, Dr. Angood said.

All of the new requirements related to health care–associated infections include a 1-year phase-in period, with milestones for planning, development, and testing throughout 2009. Allowing organizations to phase in complex requirements over the course of a year helps them to perform better by achieving concrete goals before full compliance is expected, Dr. Angood said.

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Consider EBV in Patients With Genital Ulcers

BY SHARON WORCESTER
Southeast Bureau

DESTIN, FLA. — Since Epstein-Barr virus is known in rare cases to initially present as severe, painful genital ulcerations without other clinical or laboratory evidence of acute disease, this infection should be considered in the differential diagnosis of patients who present with such lesions.

"You won't see it presenting this way very often, but … if you have young patients presenting like this, remember to test for EBV," Dr. Bari Cunningham said at a meeting sponsored by the Alabama Dermatology Society.

Dr. Cunningham, of the University of California, San Diego, described the case of a 15-year-old girl who presented with extremely painful vaginal lesions.

"Of course, sexually transmitted diseases were first and foremost on everybody's mind," she said, noting that the patient, who was adamant that she was not sexually active, was traumatized by the constant questioning about her sexual history and by the fact that no one believed her.

When the cultures came back negative, the differential was broadened, and Behçet's syndrome, systemic lupus erythematosus, pyoderma gangrenosum, and inflammatory bowel disease were among the diagnoses considered. The girl's conditioned worsened. She became sicker and stopped eating, and more skin surfaces became involved. She was noted to have a swollen liver. All cultures up to that point were negative and a complete blood count was unremarkable; however, mild elevations on liver function tests, which developed during hospitalization, were noted, and the test for EBV immunoglobulin M came back positive.

Several cases of EBV presenting in this manner have been reported in the literature, she said, noting the lesions are extremely painful and there is typically a lack of evidence of acute EBV at presentation. ■

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Addressing health care–associated infections is a worthy goal, said Dr. Franklin Michota, director of academic affairs for the department of hospital medicine at the Cleveland Clinic. There is sufficient evidence to show a clinical benefit from implementing infection control strategies. "It's not an experiment to see if these things work," he said.

Hospitals are likely to face some upfront costs when implementing the new requirements, Dr. Michota said, especially if they need to put a new educational process in place to prepare staff. For that reason, hospitals may be looking to involve hospitalists, who are already on the payroll, in a variety of activities related to preventing health care–associated infections, he said.

Hospitalists may be involved in developing process improvement plans, tracking requirements, or tracking infections. Those who are not involved on the quality side may be asked to champion changes at the floor level by modeling appropriate hand hygiene or compliance with contact precautions.

"Shining additional light on [health care–associated infections] is good," said Dr. Patrick J. Cawley, president of the Society of Hospital Medicine and executive medical director at the Medical University of South Carolina, Charleston.

The requirements for central line–associated bloodstream infections, in particular, are a significant step forward, he said. There is clear evidence in the literature that compliance with central line placement protocols can significantly drive down infection rates, he said. "This is something we all should be doing anyway," Dr. Cawley said.

The Joint Commission also has added new requirements to the goal for medication reconciliation. Hospitals are advised to provide a complete and reconciled list of the patient's medications directly to the patient and explain the list at the time of discharge. In those settings where medications were used minimally or for a short duration, such as the emergency department, the hospital is required to perform a modified medication reconciliation process.

Also new in 2009 is a requirement to eliminate transfusion errors related to patient misidentification. Before beginning a blood or blood component transfusion, hospital staff must match the patient to the blood during a two-person bedside verification process. ■