ACIPC Victorian SIG March 2017 - Meeting notes

Presentation of survey responses

Louise Hobbs presented data from the small survey conducted approx. 1-2 weeks prior to the Vic SIG. The aim of the survey was to gauge if there are differences between healthcare facilities in the application of transmission based precautions (TBP), particularly for contact transmission. (See PowerPoint presentation for all data.)

Please note that this survey was only conducted as a "quick-and-dirty" look at some infection control practice differences between Victorian healthcare facilities; used only as the starting point for the generation of discussion. It should not be viewed as scientific data and should not be quoted outside the context of the Vic SIG meeting.

There were a total of 33 respondents to the survey; although not all questions were answered by each respondent (some questions may not have been applicable). Below are some of the main points shown by the data.

Bare-below-the-elbows (BBE)

- The majority (87%) of respondents indicated that their facility has a (BBE) policy.
- Louise Hobbs noted that Melbourne Health was one of the (very few) organisations that hadn't gone to a BBE policy.

Use of TBP in acute care

- When there are Victorian DHHS guidelines with infection control guidance (e.g. CPE or gastroenteritis), most facilities used TBPs for those organisms/diseases.
- A risk assessment for need for isolation is undertaken for many multi-drug resistant organisms (MDRO).
- vanA VRE is isolated more frequently than vanB VRE.
- Nearly 40% still always isolate MRSA in a single room.

Use of TBP in sub-acute care & residential care

- Once again where there are guidelines, TBP are used for those organisms/diseases.
- Increased risk assessment for need for isolation

TBP audits

- 22% respondents do not undertake TBP audits.
- 78% respondents do undertake TBP audits with varying frequency (monthly, quarterly, targeted)

Visitors and PPE use

- Approx 60% of respondents indicated that they require visitors to wear PPE when visiting patients in contact, droplet and airborne precautions.
- Comments received:
    - Following education
    - Depends on level of interaction

- Only when visiting more than one patient

Clinical waste from patients in TBPs

- Approx 53% respondents indicated that only blood stained waste is put into clinical waste, ie, not from patients in isolation rooms in TBPs.

Questions discussed in further detail following the survey responses

1. Review the Victorian MRO guidelines to include level of PPE guidelines for particular organisms?

- Should there be clearer guidance in guidelines re the level of PPE required in different healthcare facilities (HCF)?
- Most attendees had heard of the *Patient-centred risk management strategy for multi-resistant organisms* (2011). (Link here: https://www2.health.vic.gov.au/public-health/infectious-diseases/infection-control-guidelines/patient-centered-management-multi-resistant).
- The very old DHHS VRE guideline has now been completed removed from the DHHS website and is replaced by the *Patient-centred risk management strategy for multi-resistant organisms*.
- Victorian CPE guideline for health services (and long-term residential care facilities) supersedes infection control guidance within the above guideline with respect to CPE.
- There are differing practices by HCFs with respect to when TBPs are implemented (primarily for MDROs).
- Sue Gonelli from Peninsula Health (PH) discussed the risk assessment tool used in their HCF to prioritise isolation rooms with respect to MDROs. It is called the Risk of Infectious Organisms Transmission (RIOT) scale. Some other organisations do risk assess for placement but don't use such a formalised tool. PH are happy to share the tool. (The tool will be circulated with these meeting notes.)
- Many organisations have different MRO screening strategies as well.
- Austin Health have three different types of contact precautions:
    - Routine: plastic apron & no gloves; for MDROs such as VRE & MRSA
    - Enhanced: plastic apron and gloves; for gastroenteritis & C. difficile
    - Intensive: long-sleeved gown & gloves; for CPE and highly resistant MDROs
    - Risk assess (have algorithm for VRE but otherwise no formal tool) for vanB VRE & MRSA. vanA VRE always intensive contact precautions. Have helped to successfully decrease incidence on new vanA VRE acquisitions following outbreak approx 2 years ago.
    - Staff appear to have adapted to the differing levels of contact precautions well.
- May be confusing for patients when this changes between HCFs, more so when in acute care setting. Also confusing for staff going between different HCFs.
- Each HCF has differing facilities; room availability, configurations etc so may be too difficult to be more prescriptive or standardised.

2. How are we managing CAR alerts?

- CARalert – Critical Antimicrobial Resistances
- The Australian Commission on Safety and Quality in Health Care established the National Alert System for Critical Antimicrobial Resistances (CARAlert) in March 2016 as part of the Antimicrobial Use and Resistance in Australia (AURA) Surveillance System.
- Any laboratory that identifies a possible CARalert organism must forward to one of 28 designated confirming laboratories (e.g. Microbiological Diagnostic Unit Public Health Laboratory (MDU PHL) in Melbourne).
- Only a few attendees had heard of the CARalert, possibly because laboratory generated data only, and as such are not informed when the lab has a CARalert organism.
- Link to CARalert website: https://www.safetyandquality.gov.au/antimicrobial-use-and-resistance-in-australia/what-is-aura/national-alert-system-for-critical-antimicrobial-resistances-caralert/
- See also the last CARalert report attached. Of particular interest are the CPE isolates by state and territory on pages 11-13.

3. Is it still justified to ask visitors to wear PPE?

- This question was included in the survey following discussion during the review of the Victorian CPE guideline for health services (in draft, due to be released April 2017). So primarily interested re contact precautions, particularly MDROs.
- The Society for Healthcare Epidemiology of America (SHEA) released guidance re PPE for visitors published [Isolation precautions for visitors (2015) *Infection Control & Hospital Epidemiology*, vol 36(7)]
    - link here to pocketbook summary): http://eguideline.guidelinecentral.com/i/517749-isolation-precautions-for-visitors-shea
    - Where MDROs like MRSA & VRE are endemic PPE for visitors not required
    - Contact precautions for visitors should be considered for extensively drug resistant Gram-negative organisms (e.g. CPE)
- What happens when patients go home and living with “visitors”; albeit not all hospital visitors are household contacts. They have probably already been exposed if a household contact. If you ask them to wear PPE in hospital then can be hard to explain why they don’t need to at home. Needs very good communication.
- Do visitors visit more than one patient? If so, should probably use PPE.
- Transplant patients and other ‘frequent-flyers’ often visit each other in hospital.
- At the Royal Children’s Hospital (RCH) visitors/parents may be in the child’s room without PPE but must not visit other communal areas (e.g. play room).

4. What are we auditing i.e. technique, stock, HH, etc

- Eastern Health undertake ward rounds each day; use the patient flow management database to determine which patients require what precautions and check that these are in place.
    - Also undertake a very simplified annual isolation room audit.
    - Use Audit Angel – collect data weekly and report quarterly.
- At Monash Health (MH) staff audit themselves. They observe staff donning & doffing PPE. Part of audit requirement for each ward/department for accreditation purposes.
    - Annually, MH IC staff review the audit results as part of the infection control audit for each ward/department.
- RCH undertake virtual wards rounds.

5. Do we need to revisit waste?

- This question was included following feedback provided for draft Victorian CPE guideline for long-term residential care facilities. The draft stated that PPE from residents could go into general waste.
- The Victorian Environmental Protection Authority (EPA) is responsible for regulating the storage, transport, treatment and disposal of clinical and related waste. The EPA has a *Clinical and related waste – operational guidance* document which is attached and can also be found at this link: http://www.epa.vic.gov.au/our-work/publications/publication/2009/september/iwrg612-1
- The EPA regulations definition of waste is largely based on the Waste Management Association of Australia's Industry code of practice for the management of biohazardous waste (including clinical and related wastes), 7th edition, July 2014. Link to the WMAA website where COP can be purchased: https://www.wmaa.asn.au/scripts/cgiip.exe/WService=WMAA/ccms.r?PageID=10345
- It was noted that the definition of clinical waste includes "*Waste from patients known to have, or suspected of having a communicable disease"*
- Much discussion ensued as to the definition of a communicable disease.
    - Does this include MDROs, which while transmissible may not be causing an infection at the time (i.e. colonised).
    - Not all patients with an MDRO will be in contact precautions and none of their waste will be put into clinical waste other than blood stained waste).
    - Some organisations place waste from patients with an MDRO into clinical waste and others don't. Not clear to many re this particular aspect of the definition of clinical waste.
    - Further clarification required from Vic EPA and WMAA as to what they would classify as a communicable disease.