

Ideas Solicited for Advancing/Improving  
Healthcare-Associated Infection Prevention  
February 11, 2016

**Environmental Cleaning in Healthcare Subcommittee**

1. There should be a 1-day mini course for environmental services workers on infection prevention and the vital role that they play in it.
2. There should be a yearly 1-hour webinar for hospital administrators, CFOs on “Environmental Services as Infection Prevention”
3. With ASHRAE 188-2015 finally a standard, I would like to see a focus on water as a source of hospital-acquired infection discussed at these meetings. In particular pseudomonas, all gram-negative bacteria, parasites, fungi and NTM and not solely legionella. Many interventions are misused and others are not even known to exist by healthcare leadership.
4. Address non-acute care settings. Outpatient settings such as ambulatory surgery centers are doing more invasive procedures on increasingly high risk patients.

**Injection Safe Practices Subcommittee**

1. Address non-acute care settings. Outpatient settings such as ambulatory surgery centers are doing more invasive procedures on increasingly high risk patients.

**Public Reporting and Education**

1. I would like to see a newsletter style email sent to the committee members once a month, keeping us abreast of the HAI related activities of CDPH. i.e. symposia, new campaigns, additions to the website, staff changes, media issues, etc.
2. An asterisk \* needs to go on the administrative penalties page explaining sections 5328.15 of the Welfare and Institutions Code. Also next to each time it is cited as the reason a report is not published.
3. There should be a graphic icon link to the hospital infection map on the Health Facilities Information page.
4. There should be a pictorial icon of “My Hospital’s Infection Map” on the CDPH.gov homepage so it is easy for the public to find.
  - a. Like the one on the HAI Program Page
5. There should be a telephone number for/and an explanation of immediate jeopardy on the website pages for consumers to file a complaint against a facility or provider.
6. CDPH YouTube Channel video sample:
  - a. How to clean-up a dead mouse in a trap
  - b. Preventing worker drownings on golf courses
  - c. Preventing palm tree trimmer fatalities
    - i. No videos on patient safety
    - ii. No videos on hand hygiene
    - iii. No videos on infection control
    - iv. It’s time!

7. The Two-day infection prevention mini course should include nurses, residents and medical students as part of its target audience. The marketing should broaden from just IPs.
8. CDPH provides facilities with a “Frequently Asked Questions” document regarding the Patient Safety Licensing Survey process. I would like to see a FAQ for consumers filing a complaint outlining the process, what they can expect, the deadlines and how to follow-up a complaint.
9. The liaison infection Preventionists are assigned to approximately 45 hospitals each. They are tasked with monthly call to the hospitals and reporting updates to CDPH.
  - a. How is the effectiveness of this program measured? By calls, by actual visits? By infection rates at their assigned facilities? We need to look at this program closer
10. CDPH provides facilities with a “Frequently Asked Questions” document regarding the Patient Safety Licensing Survey process. I would like to see a FAQ for consumers filing a complaint outlining the process, what they can expect, the deadlines and how to follow-up a complaint.
11. The CDPH Tweets Food Recalls but no infection outbreaks.
12. There were 20 acute care hospitals and 5 NICU outbreaks. 15 skilled nursing facilities.
13. Consumers would like that information also.

### **Antimicrobial Stewardship**

1. Address non-acute care settings. Outpatient settings such as ambulatory surgery centers are doing more invasive procedures on increasingly high risk patients.
2. Develop an inter-facility transfer check list that provides information about potentially transmissible organisms e.g. C. difficile, CRE, MRSA, VRE, Tb, etc. The committee could decide which information needs to be included but perhaps not restrict the format so that different electronic health records systems could be utilized where possible to create these reports.

### **New Subcommittee**

1. Include discussion of HAIs other than the HAIs specified in legislation. For example CAUTI, legionella, etc
2. Prevent HA Pneumonia Prevention – Prevention Initiative
3. Antimicrobial Resistance CDC Comment
4. Automated Checklist for everything from basic patient care to O/R. Surgery. My husband died because (1.) an infection that showed up twice in his labs went to completely untreated for over a month during which he had 2 major surgeries. (2) Two external surgical drains were not cleaned, tended to or removed until 18 days after transplant surgery. They grew resistant bacteria which backed up into his newly transplanted liver and kill him. **He died because of overlooked basics.**