



Thursday, May 4, 2017 1:00–2:45 p.m. ET; Webinar Q&A
Infection Control in Long-Term Care: An Overview
Presented by: Dr. Joseph Mylotte

Question	Answer
<p>Is there a form to use for infection control data collection by infection? I have not been able to locate one.</p>	<p>Yes. I mentioned a form I have developed that lists infections with symptoms that can be used for surveillance. This form (Appendix A) will be made available. There are also other similar forms that have been developed by the Minnesota Department of Health. There is also a form developed by the Agency for Healthcare Research and Quality (AHRQ). Please see the reference list for information about downloading these forms.</p>
<p>With the new updated Requirements of Participation from the Centers for Medicare & Medicaid Services (CMS), does the designated infection control practitioner have to have a "certification" from a recognized educational source (Society for Healthcare Epidemiology of America [SHEA], Association for Professionals in Infection Control and Epidemiology [APIC], etc.) or can continuing education units (CEUs) suffice?</p>	<p>CMS regulations do not specifically state that certification is required. However, certification by APIC or National Association of Directors of Nursing Administration (NADONA) would certainly be beneficial in terms of providing education as well as documentation of training. However, documentation of continuing education courses is also appropriate. Documentation of the number and types of courses completed would need to be available upon surveyor request. Documentation of certification by APIC or NADONA will suffice by itself.</p>
<p>Do you recommend any specific templates for nurses to utilize before notifying MD of suspected infection?</p>	<p>Yes, definitely. The AHRQ form mentioned in the first question is a form that can be used for that purpose. Also, there are the INTERACT tools which provide an excellent method for communicating a change in status. The INTERACT tools are copyrighted but free to download. However, the tools cannot be incorporated into an electronic record or other types of software without permission from Florida Atlantic University (please see the website http://interact2.net/index.aspx for further details on the copyright issues).</p>
<p>If patient is <i>Clostridium difficile</i> positive after 3–4 days of admission, would that not indicate a hospital-acquired infection?</p>	<p>I think the question that is being asked is: If a patient with diarrhea has a positive <i>C. difficile</i> stool test more than 3 days after admission to a hospital, is this considered a hospital-associated infection? Answer is YES; OR is the question: If a patient with diarrhea has a positive <i>C. difficile</i> stool test more than 3 days after admission to a nursing home, is this considered a hospital-associated infection? By the definition presently being used by the National Healthcare Safety Network (NHSN) for the <i>C. difficile</i> surveillance module, any patient admitted to a nursing home from another healthcare facility who</p>



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	<p>develops diarrhea and has a positive <i>C. difficile</i> stool test within 4 weeks of admission has what is called long-term facility onset, acute-care transfer <i>C. difficile</i>. This circumstance is not considered to represent nursing home-associated infection even though the episode occurred more than 3 days after admission to the facility. I hope this answers the question. If not, please clarify and send the question again.</p>
<p>Is the MDS useful in collecting infection data?</p>	<p>No; it is not an appropriate way to collect surveillance data for infection. This has been studied, for example, as a method of identifying urinary tract infections (UTIs) and was not found to be valid compared to standard surveillance methods.</p>
<p>When is it that the infections are hospital acquired less than 3 days after admission to the nursing home? If stopping antibiotics after 2–3 days, would that not increase antibiotic resistance?</p>	<p>I am not certain I understand the first question. The 3-day limit applies whether someone is admitted to the hospital from the community or from the hospital to the nursing home. The concept is that 3 days is too short a time for infection to be acquired or associated with hospitalization in those admitted from the community or in those admitted to the nursing home from the hospital. Infections that develop within 3 days of admission to a hospital or nursing home were most likely incubating and symptoms subsequently developed within the 3-day window. The idea is to avoid calling an infection facility-associated that is incubating at the time of admission to the facility. This 3-day limit has been in place for surveillance purposes for several decades.</p> <p>Stopping antibiotic therapy after 2–3 days of treatment is not associated with an increase in antibiotic resistance to the best of my knowledge. The concept is that the longer the therapy, the more likely resistance will develop. I cannot think of a reason why a short exposure with an antibiotic would increase the chance of resistance. Keep in mind, however, that the specific antibiotic prescribed may also be important in addition to the duration in the development of resistance.</p>