Public health response to reported infection control breaches in Pennsylvania

What can we do if there are no infections?

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Sharon Watkins, PhD

BUREAU OF EPIDEMIOLOGY
What is the health department’s role in responding to infection control breach investigations, if there aren’t any infections?
Department Mission

“to promote healthy lifestyles, prevent injury and disease, and to assure the safe delivery of quality health care for all Commonwealth citizens.”
Non-regulated facilities

- Dental practices
- Oral surgery
- Outpatient offices
  - Vaccines
  - Infusions
  - Cosmetic procedures
- Department of State
  - Licenses healthcare providers
Where does Epi come in?

• Typically
  - Investigate a cluster of illness to determine related exposures and risks

• IC Breaches
  - Investigate exposures and risks
    - Prevent future risk
    - Evaluate past risk
    - Look for a cluster of illness
Where does Epi come in?

- Faulty materials or inadequate practices
- Coordinate multiple sites
- Case finding
- Public awareness
  - E.g. patient notification; press release
- Provide expertise in infection control
  - Evaluate the risks

*Patel, Srinivasan, & Perz. (2008)*
Re: Infection Control Breach Investigation

To Whom It May Concern:

The Pennsylvania Department of Health (Department) is currently conducting a public health investigation following a report of infection control breaches in your facility. The Department is responsible for protecting the people of the Commonwealth in the most efficient and practical means for the prevention and suppression of disease. In this role, the Department is authorized "to enter, examine, and survey all grounds, vehicles, apartments, buildings, and places, within the Commonwealth." (71 P.S. § 532).

During a public health investigation, it is often necessary for authorized representatives from the Department to examine medical records without the written consent of the individual who is the subject of the record. The authority to examine records for these purposes is set forth in Article XXI of the Administrative Code of 1929, P.L. 177 as amended; the Disease Prevention and Control Law of 1955, the Act of April 23, 1956, P.L. 1510 as amended, and other applicable Department regulations.
Number of Infection Control Breach Investigations by Year—Pennsylvania, 2011-Oct 10, 2017

Number of Investigations

<table>
<thead>
<tr>
<th>Year</th>
<th>Investigations</th>
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<tbody>
<tr>
<td>2011</td>
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<tr>
<td>2012</td>
<td>1</td>
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<td>8</td>
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</tr>
<tr>
<td>2016</td>
<td>5</td>
</tr>
<tr>
<td>2017*</td>
<td>5</td>
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*incomplete data for 2017
### IC Breach Investigations

#### 2014-Oct 2017

<table>
<thead>
<tr>
<th>Year</th>
<th>DOS</th>
<th>Other</th>
<th>On-site Visit</th>
<th>Patient notification</th>
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<td>5 (71%)</td>
<td>2</td>
<td>6 (86%)</td>
<td>6 (86%)</td>
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<tr>
<td>2015</td>
<td>2 (67%)</td>
<td>1</td>
<td>2 (67%)</td>
<td>1 (33%)</td>
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<tr>
<td>2016</td>
<td>4 (80%)</td>
<td>1</td>
<td>5 (100%)</td>
<td>3 (60%)</td>
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<td>2017</td>
<td>2 (40%)</td>
<td>3</td>
<td>1 (20%)</td>
<td>1/2 (50%)*</td>
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</tbody>
</table>

*incomplete data for 2017
Infection Control Breach Investigations

Case Study
DATE: May 30, 2014
TO: State Survey Agency Directors
FROM: Director
Survey and Certification Group

SUBJECT: Infection Control Breaches Which Warrant Referral to Public Health Authorities

***Additional Information has been added to Breaches to Be Referred. This policy memorandum supersedes policy memorandum S&C: 14-36-ALL***

Ref: S&C: 14-36-ALL

REVISED 10.28.16
October 2016:
Added “believe the breaches require public health assessment and management.”

Examples include:
- Improper cleaning and disinfection of endoscopy equipment; and,
- Improper cleaning and sterilization of surgical instruments.
In June, 2017 our HAI coordinator received an email from The Joint Commission (TJC)

Notification that infection control breaches were identified
Case Study

- Identified breaches in both HLD and Sterilization
  - 12 of 12 double peel packed items had a folded inner peel pack
  - Failure to use quality control testing indicators to evaluate the efficacy of the mechanical instrument washers as required per AAMI.
  - Failure to verify that each batch of Rapicide test strips were functioning properly
  - Failure to store fiberoptic bronchoscope hung vertically in a ventilated environment as recommended by evidence-based guidelines.
  - Magill forceps were stored in a fashion that did not protect them from contamination.
Case Study: Steps Taken

- Notified state licensing agency
- Requested all materials related to identified breaches from facility
  - TJC accreditation report
  - Facility plan of correction
- Call with licensure, Epi, facility
- Requested TJC 30-day follow-up visit report
Bronchoscope: Future Risk

- Describe adequate reprocessing
  - Manager
- New storage container (photo)
Bronchoscope: Past Risk

- Other than storage, were all other steps for cleaning and disinfecting done properly?
  - In isolation, improper storage not likely to be high risk

- FDA determined the risk of infection transmission by bronchoscopes lower than risk via endoscopes
  - Likely bacterial infection
  - No reported HIV, HBV transmission
Bronchoscopes: Past Risk

- Reprocessing adequate
  - Risk minimal
  - Bacterial infections already identified
  - Category B breaches only
  - Patient notification not indicated
Best Practices/Lessons Learned

• Leverage internal partners
  - Dept of State
  - Licensing bureaus

• Build capacity
  - Include field staff, DOS, local HDs
  - Certification in Infection Control (CIC)

• Consistency is key
  - Forms & tools also help build capacity
Acknowledgements

PADOH

- Allison Longenberger
- Jeff Miller