ARE WE THERE YET?
SMOOTH TRANSITIONING FROM ACUTE CARE TO LONG-TERM CARE

DISCLOSURE

I HAVE NOTHING TO DISCLOSE

OBJECTIVES

• REVIEW CHANGES THAT HAVE OCCURRED IN LONG-TERM CARE
• DISCUSS HOW DELIVERY OF CARE DIFFERS IN LONG-TERM CARE FROM ACUTE CARE
• DISCUSS THE CHALLENGES LTCF CURRENTLY FACE
• REVIEW MDRO MANAGEMENT AND STRATEGIES IN LTC FOR PREVENTION AND CONTROL
CHANGES IN LTC

- Increase in admissions and discharges
- Increase in level of acuity
  - More short term stay
  - Rehabilitation
  - Specialized care units
- "Culture change" within the LTC community
  - Shift from institutional setting to home-like environment
- Post-acute care is no longer a place to go to die or spend last years of life
  - Focus is on wellness and targeted care
  "Personalized care is a fact, not the exception to the rule!"

CHALLENGES WE FACE

- According to CDC, LTCF are considered to be a "non-hospital" setting.
- Communication between acute care and LTC
- Caring for residents with MDROs
- Policies may differ from acute care

EXAMPLE OF CULTURE CHANGE

From institutional dining  Home-like environment
OTHER EXAMPLES OF CULTURE CHANGE

• Changing the care environment: Humanizing the environment
• Holistic approach—managing the "whole person" with dignity, elder vitality, respect and autonomy
• Allowing residents to choose activities and have an influence on their environment
• Eden Alternative began in 1991 in NY
• Green House project: Deinstitutionalize care with new communal living environments

OTHER CHALLENGES WE FACE IN LTC

• Receiving adequate information on the resident's clinical condition (i.e. recent lab tests, X-rays, history of illnesses, alerts on recent treatment)
• Families of resident unhappy with placement (feel it is inferior care)
• Patient and family having difficulty transitioning from acute care hospital
• Rapid turnover in nursing staff (creates problems with adequate staffing of shifts)
• Management of complex cases involving patients with multiple health conditions on an on-going basis
• Finger pointing between acute care and long-term care facilities

INFECTION CONTROL INFRASTRUCTURE DIFFERENCES

ACUTE CARE HOSPITALS
• Infection Control Program
  • Hospital Epidemiologist
  • Full-time Infection Preventionists
• Infection Control Committee

NON-ACUTE CARE SETTINGS
• Infection Control Program
• Staff member with or without infection control training
DIFFERENCES AMONG INFECTION PREVENTION & CONTROL PROGRAMS

ACUTE CARE HOSPITAL
- HIGH TECHNOLOGY
- PHYSICIAN-CENTERED CARE
- GOAL IS PROMPT PATIENT DISCHARGE
- RESOURCES AVAILABLE ON SITE
- DIAGNOSTICS ON-SITE
- TREAT ACUTE ILLNESS

LONG-TERM CARE FACILITY
- LOW TECHNOLOGY
- NURSE-CENTERED CARE
- LTCF MAY BECOME PATIENT’S PRIMARY RESIDENCE
- LIMITED RESOURCES
- DIAGNOSTICS OFF-SITE
- PREVENTION OF ILLNESS

DIFFERENCES
- MANAGEMENT OF MDRO COLONIZED RESIDENT VS. ACTIVELY INFECTED RESIDENT
- AVAILABILITY OF PRIVATE ROOM FOR ISOLATION PURPOSES
- ABILITY TO COHORT RESIDENTS
- ACTIVE SURVEILLANCE CULTURES ON ADMISSION TO SNF
- NO FULL-TIME INFECTION PREVENTIONIST
- PHYSICIANS DO NOT VISIT LTCF AS OFTEN AS ACUTE CARE HOSPITAL

INTER-FACILITY TRANSFER FORM
- ONE OF OUR GREATEST CHALLENGES IN LTC, IS RECEIVING ADEQUATE INFORMATION ON ADMISSION (IT MAY BE YOURS AS WELL)
- IS OUR PATIENT ON ISOLATION? WHY? WHICH ORGANISM? IS PATIENT SYMPTOMATIC? DO YOU HAVE CULTURE RESULTS OR XRAY REPORTS?
- HAS THE PATIENT RECEIVED ANTIBIOTICS?
- HAS PATIENT RECEIVED ANY IMMUNIZATIONS? INFLUENZA? PNEUMOVAX?
CDPH Interfacility Infection Control Transfer Form

Disclaimer: This form should be sent with the patient upon transfer. Please fax to Infection Control department of receiving facility. It is NOT meant to be used as criteria for admission, only to foster the continuum of care once admission has been accepted.

Sending Facility Name

Sending Facility Address

Patient Last Name

First Name

Date of Birth

Medical Record Number

Name of Person Completing Form

Contact Telephone #

Contact Fax #

Alternate Contact Name

Alternate Telephone #/Fax #

Name Receiving Facility

Name Person Contacted Prior to Transfer

Contact Telephone #

Fax #

Does patient currently have OR is known to have a positive culture of a multidrug-resistant organism (MDRO) or other organism of epidemiological significance? *Please send copy of culture report with susceptibilities to receiving facility

Colonization or history

Check if YES

Active infection with Current Treatment

Check if YES

Methicillin-resistant Staphylococcus aureus (MRSA)

Vancomycin-resistant Enterococcus (VRE)

Clostridium difficile (C. diff)

Acinetobacter species, multi-drug resistant*

Enterobacteriaceae† w/Extended Spectrum Beta-Lactamase (ESBL)*

Carbapenem-Resistant Enterobacteriaceae (CRE)*

Other infectious agent (identify)

†Enterobacteriaceae spp. include Klebsiella, E. coli, Enterobacter, Proteus, Serratia, and Citrobacter among others.

Does the patient currently have any of the following symptoms?

Productive cough

Urinary incontinence

Diarrhea

Dysuria (chronic)

Vomiting (persistent)

Draining wound(s) - drainage not contained by dressing

Fever (fever of unknown origin)

Other (specify)

Is the patient currently in isolation (other than Standard Precautions)?

□ NO

□ YES

If yes, identify type of isolation (Contact, Droplet, Airborne): __________________

Does the patient currently have any of the following devices?

Central Line/PICC (Approx. date inserted) __/__/____

Suprapubic catheter

Hemodialysis Catheter

Percutaneous gastrostomy tube

Urinary Catheter (Approx. date inserted) __/__/____

Tracheostomy

Is the patient currently on antibiotics?

□ NO

□ YES:

Antibiotic and dose

Treatment for:

Start date

Anticipated stop date

Does Patient self report receiving vaccine?

Influenza (seasonal)

Yes

No

Pneumococcal

Yes

No

Other:_______________

Yes

No

COMMUNICATION

• WE NEED OPEN CHANNELS AND GOOD CONNECTIONS BETWEEN ACUTE CARE HOSPITAL AND THE LTCF
• PERIODICAL MEETINGS BETWEEN ACH AND LTCF WITH EDUCATION OPPORTUNITIES
• USE OF SBAR TOOL
• ANTI BIODEMORGAMS COULD BE SHARED BETWEEN ACH AND LTCF TO SELECT APPROPRIATE ANTIMICROBIAL AGENTS

ENHANCED STANDARD PRECAUTIONS (ESP)

• ESP WAS RELEASED IN SEPTEMBER, 2010 BY CDPH (COLLABORATION BETWEEN CAHF & CDPH) FOR LTC
• ESP STATES A RESIDENT CANNOT BE REFUSED ADMISSION TO LTCF ON THE BASIS OF HAVING AN MDRO.
• CDC RECOMMENDS THESE PRECAUTIONS
• THREE TIERED SYSTEM
  • STANDARD PRECAUTIONS
  • TRANSMISSION BASED ISOLATION PRECAUTIONS
  • INTENSIFIED INTERVENTIONS
WHAT'S WRONG WITH THIS PICTURE?

Have you ever seen a clean linen cart in the hallway looking like this?

PROCESS MEASURES

• ADMISSION ASSESSMENT
• HAND HYGIENE
• USE OF PPE
• ENVIRONMENTAL SANITATION
• RESIDENT TRANSPORT
• SOILED LINEN HANDLING
• OUTCOME SURVEILLANCE (MCGEER'S CRITERIA)
• OUTBREAK MANAGEMENT
"When developing a room placement policy for new admissions, readmissions as well as permanent residents, it is important to develop a policy that specifically defines conditions that facilitate transmission rather than on knowledge of a positive or negative test result."

**Room Placement**

- When developing a room placement policy, it is important to specifically define conditions that facilitate transmission rather than on knowledge of a positive or negative test result.

**Cohorting**

- We never cohort MRSA or VRE colonized or infected residents in one room.
- If private room unavailable for active MDRO resident, the resident can be placed in:
  - The same room with a resident who has a similar organism (no matter what site).
  - The same room with a resident who has no wounds or invasive procedure sites without Hx of MDRO (low risk).

**Standard Precautions**

- The basic standard of practice for infection prevention and control to be applied when caring for all residents, regardless of their diagnosis.
- Created for the protection of the healthcare worker.
- Personal protective equipment to be used at the discretion of the HCW whenever they anticipate exposure to blood or other potentially infectious materials:
  - Includes handling of skin that is not intact and rashes of the skin.
  - Includes giving injections.
  - Equipment includes: gloves, gown, face-shield, goggles or mask.
TRANSMISSION BASED ISOLATION

* AIRBORNE ISOLATION (RESPIRATORY ISOLATION)
* MOST NURSING HOMES CANNOT ACCOMMODATE A PATIENT REQUIRING AIRBORNE ISOLATION
* DROPLET ISOLATION
* CONTACT ISOLATION
* NURSING HOMES DO NOT HAVE DESIGNATED ISOLATION ROOMS

INTENSIFIED INTERVENTIONS

* TO BE USED:
  * WHEN A NEW OR NOVEL ORGANISMS IS FOUND TO BE CIRCULATING IN THE COMMUNITY
  * WHEN AN UNUSUAL INFECTIOUS AGENT OR A COMMON ORGANISM IS FOUND WITH UNUSUAL OR EXTENSIVE RESISTANCE PATTERNS
  * WHEN THE INCIDENCE OF NEW CASES OF A SPECIFIC INFECTIOUS AGENT IS EITHER INCREASING OR FAILS TO DECREASE DESPITE THE IMPLEMENTATION OF AND ADHERENCE TO STANDARD INFECTION PREVENTION PROCEDURES.

INTENSIFIED INTERVENTIONS (2)

* THE INTERVENTION RECOMMENDATIONS INCLUDE:
  * ACTIVE SURVEILLANCE TESTING TO IDENTIFY COLONIZED AND INFECTED RESIDENTS
  * COHORTING INFECTED AND COLONIZED RESIDENTS AND CONSIDERING DEDICATED STAFF
  * RESTRICTING NEW ADMISSIONS OR CLOSING AFFECTED UNITS
  * ENHANCED ENVIRONMENTAL SANITATION
MDRO MANAGEMENT

- According to Enhanced Standard Precautions:
  - Residents are to be managed in the “least restrictive” environment possible.
  - MDRO policies allow residents who are colonized (asymptomatic) to be removed from isolation.
  - Residents who have active infection with MDRO are placed on transmission-based isolation precautions (i.e., contact precautions or droplet precautions) in addition to standard precautions.

CMS INTERPRETIVE GUIDELINES

- September 30, 2009 CMS released new interpretive guidelines.
- This guideline combined several F tags into one—F Tag 441 (ICP).
- This guidance establishes an infection control program (ICP) in LTC which mandates:
  - P & P and practices which promote consistent adherence to evidence-based practices.
  - Designated IP to coordinate infection prevention & control program.
  - IP to conduct surveillance which collects, monitors, and analyzes data with documentation of findings and interventions.
  - Education.
  - Antimicrobial review.

IN SUMMARY

- Change for residents can be difficult, regardless of which direction they go (ACH>LT C or LTC>ACH).
- It is our responsibility to make the transition as seamless as possible.
- In order to do that, we need as much information on the resident’s clinical condition as you have (history of illness, physician’s orders, resident’s special needs, meds, labs, X-rays etc).
- In order to do that, we need to realize that one setting may not handle the same situation exactly the same way the other does and respect that!
- Care should be a collaboration, not an exercise in who takes the blame! (No room for finger-pointing.)
REMEMBER!

- The cheapest and most effective way to prevent the spread of infection and disease is through HH
- ABHR are good adjuncts for a hand washing program
- HH is vital for the protection of us all!

QUESTIONS?

Questions are guaranteed in life; Answers aren't.