Judith Meppem Scholarships

Report of
Management of Multi Resistant Organisms (MRO) in the Perioperative Environment
Study Tour

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April 2012
Preventing and controlling infection is a concern every day for every surgical patient. It is no secret that a bundled approach to fighting infection can lead to better patient outcomes. But what factors go into a comprehensive plan to fight infection and what new approaches can facilities, and in particular, perioperative nurses, take to reduce their infection rates in 2012, especially within the perioperative setting?

In general, MROs are defined as micro-organisms – predominantly bacteria – that are resistant to one or more classes of antimicrobial agents. Although the names of certain MROs suggest resistance to only one agent (e.g., methicillin-resistant Staphylococcus aureus [MRSA], vancomycin resistant enterococcus [VRE]), these pathogens are usually resistant to all but a few commercially available antimicrobial agents.

MROs are transmitted by the same routes as antimicrobial susceptible infectious agents. Patient-to-patient transmission in healthcare settings, usually via hands of Health Care Workers (HCW), has been a major factor accounting for the increase in MRO incidence and prevalence, especially for MRSA and VRE in acute care facilities. Preventing the emergence and transmission of these pathogens requires a comprehensive approach that includes administrative involvement and measures (e.g., nurse staffing, communication systems, performance improvement processes to ensure adherence to recommended infection control measures), education and training of medical and other healthcare personnel, judicious antibiotic use, comprehensive surveillance for targeted MROs, application of infection control precautions during patient care, environmental measures (e.g., cleaning and disinfection of the patient care environment and equipment, dedicated single-patient-use of non-critical equipment), and decolonization therapy when appropriate.

There are two main methods of transmission of infectious organisms within hospitals. These are:

**Contact transmission** The most common mode of transmission, contact transmission is divided into two subgroups: direct contact and indirect contact.

**Direct contact transmission** Direct transmission occurs when microorganisms are transferred from one infected person to another person without a contaminated intermediate object or person. Opportunities for direct contact transmission between patients and healthcare personnel can be summarised and include:

- blood or other blood-containing body fluids from a patient directly enters a caregiver’s body through contact with a mucous membrane or breaks (i.e., cuts, abrasions) in the skin
- mites from a scabies-infested patient are transferred to the skin of a caregiver while he/she is having direct ungloved contact with the patient’s skin.
a healthcare provider develops herpetic whitlow on a finger after contact with HSV when providing oral care to a patient without using gloves or HSV is transmitted to a patient from a herpetic whitlow on an ungloved hand of a healthcare worker (HCW)

**Indirect contact transmission** Indirect transmission involves the transfer of an infectious agent through a contaminated intermediate object or person. In the absence of a point-source outbreak, it is difficult to determine how indirect transmission occurs. However, extensive evidence suggests that the contaminated hands of healthcare personnel are important contributors to indirect contact transmission. Examples of opportunities for indirect contact transmission include:

- Hands of healthcare personnel may transmit pathogens after touching an infected or colonized body site on one patient or a contaminated inanimate object, if hand hygiene is not performed before touching another patient.
- Patient-care devices (e.g., electronic thermometers, glucose monitoring devices) may transmit pathogens if devices contaminated with blood or body fluids are shared between patients without cleaning and disinfecting between patients.
- Shared toys may become a vehicle for transmitting respiratory viruses (e.g., respiratory syncytial virus or pathogenic bacteria (e.g., *Pseudomonas aeruginosa*) among paediatric patients.
- Instruments that are inadequately cleaned between patients before disinfection or sterilization (e.g., endoscopes or surgical instruments) or that have manufacturing defects that interfere with the effectiveness of reprocessing may transmit bacterial and viral pathogens.

**Background**

Currently in Australia, the approach to the management of MROs in the perioperative setting has taken a scattergun approach. Every perioperative suite and department is writing their own policy on how to manage MROs. The only consultation is the exchange of draft polices; from which each suite picks and chooses points that may be relevant to them. While policies are written, what happens in practice may be quite different. Constraints within both fiscal and human budgets results in very different practices. The terminal cleaning of operating theatres following a MRO case is clearly documented. What is not covered is how these patients are managed within the hospital and operating suite.

A review of the literature and practises within Australia has shown that there is not a standard approach to the intraoperative management of patients with a MRO. When reviewing the literature from overseas, there appears not to be a great deal published on how the intraoperative management of patients with a MRO should be undertaken. In fact, the literature is silent on the intraoperative management of patients; articles focus on terminal cleaning and other environmental issues within the general hospital setting.
The study tour to the United States was to examine, not the cleaning methods used, but rather how perioperative departments manage the patient with an MRO.

**Method**

The facilities chosen for inclusion the study trip were in California, Nevada and Hawaii. These facilities were both stand-alone facilities or those as part of a larger hospital group. The facilities were selected as they have tertiary affiliations and are of a similar size and casemix to St George Public Hospital, Kogarah.

In preparing for the trip, I contacted all of the facilities, firstly via their Directors of Nursing and then as a follow up to the Perioperative Managers. As some of the facilities are members of commercial groups, and thus would need permission from head office for any release of information, I also included documentation on areas that I would be discussing and wanting information (see Appendix 1). Also by providing them with the areas that I would like to review and discuss before the visit, meant that the appropriate people would be aware of my visit and be available.

In planning the visit, I had allowed two (2) working days to be spent at each facility. All facilities kindly accommodated me. This length of each visit allowed me to see what happened in practice as well as to compare with their written policies.

I confirmed my appointments with each of the facilities the day prior to the scheduled appointment. This allowed for any unforeseen scheduling issues. In the case of Doctor’s Medical Centre in Modesto, Ca, this was important as the Nurse Manager I was scheduled to meet had resigned and had left no follow up. As a result, I met with the Perioperative Nurse Educator.

The way in which the visits were managed was that I met with the appropriate staff member, and after about an hour of exchanging information, answering my specific questions and obtaining copies of the relevant policies, I was then “embedded” into the operating room to observe the actual practice.

This enabled me to observe if policy was practiced in reality and also what worked and what did not work. It also allowed me to observe other areas of the perioperative service and compare and contrast these in relation to my own facility, St George Public Hospital in Kogarah. I was given total freedom within each of the suites and this allowed for very rich data collection.

**Results**

**General:**

The majority of the facilities for visit were in the US state of California.
Cases of MRSA increased four-fold in California hospitals between 1999 and 2007 to 52,000 cases, according to a new state report, which also suggests the annual number of MRSA deaths are 3.2 times more than estimates for seasonal influenza (California Office of Statewide Health Planning and Development). As a result of this incidence, in 2008 California passed legislation governing the use of antibiotics and the monitoring and reporting of Hospital Acquired Infections (HAI). This Act, known as the Medical Facility Infection Control and Prevention Act (or Nile’s Law) (Appendix 2) sets out how and what HAIs are monitored and how they are reported. It even goes into how patients should be tested.

The effect of this law on the perioperative, and indeed hospital wide setting is that patients who meet the criteria must be tested for MRSA within 24hrs of admission. These include patients undergoing surgery and have a documented medical condition making the patient susceptible to infection (based on CDC recommendations), patients who have been admitted and discharged from an acute facility within the previous 30 days, patients to be admitted to the ICU or burns unit, patients undergoing dialysis and patients being transferred from an nursing home.

It was interesting to note that the facilities visited also added additional testing for MRSA with a specific cohort of patients. Both cardiac and orthopaedic patients were tested for MRSA prior to surgery. This testing consisted of nasal swabs. Patients who tested positive were given both written and oral instructions regarding aftercare and precautions to prevent the spread of the infection to others. In addition, there is a MRSA colonisation eradication protocol to be followed.

Given this need for testing, it was interesting to see who paid for the testing, given the costs associated with this. The health insurance companies have stated that the costs associated with testing are incorporated in the benefits they already pay the facilities. With regard to those patients that are covered by Medicare/Medicaid (US public hospital type coverage), this is also absorbed by the facility.

The results of the screening and decolonisation have been reported for the first time in January 2012. The results showed that there was a 57.1% incidence of MRSA and a 46.3% incidence of VRE in Californian facilities.

In 2009, NSW was the first state in Australia to introduce mandatory monitoring and reporting of HAIs. Current data shows that the reductions in infections in 2009 are being maintained in 2011 (2011: NSW Healthcare Associated Infections Data Collection).

A snapshot of the data for both California and NSW for March 2011 shows that per 10,000 bed days NSW had a rate of 0.8 and California had a rate of 1.0 for MRSA BSI (Blood Stream Infection). This illustrates how similar the problem of HAI is to both States.

By comparison, the rate in 2010-2011 is 1.56 at St George Public Hospital.
Perioperative:

The specific areas that I was interested in seeing was the management of the patient during their perioperative journey. This was facilitated by having a set of questions to guide this process.

These questions were developed by reviewing the current practice at St George (Appendix 1).

The questions can be grouped into a number of common themes:

1. Documentation
2. PPE
3. Cleaning
4. Physical management

**Documentation:**

All of the facilities visited used a computer system that communicated information to the staff. The infection status of each patient is documented on the master schedule and this in turn appeared on the theatre list for that day. It was up to each staff member to review the list and put in place the required precautions. This included the orderlies who were assigned to retrieve the patient’s from the specific wards.

It was expected that at each point of the patient’s journey a nursing “hand off” or handover occurred and that the patient’s infection status was included.

The patient’s notes or chart were placed in a clear plastic bag.

All paperwork that is generated in the theatre that is hard copy (i.e. not soft copy) is discarded at the end of the case. This includes the instrument tracking sheet and count sheet. All counts are documents on a white board!

**PPE:**

Contact precautions were implemented for all patients with a known MRO. For the transporting of patients throughout the facilities, gloves only were worn as to protect the patient’s confidentiality regarding their known MRO status.

Patients were not held in either pre op holding or anaesthetic bays but were taken directly into the operating theatre.

It was interesting to note what attire the nursing and medical staff wore both inside and outside the theatre. All staff throughout the facilities wore scrubs. These were
provided by the facilities and were of the “pull over head” style (rather than the front opening style of scrub top). On leaving the theatre complex, staff did not wear cover gowns but rather wore either white coats or no gowns at all.

Visitors to the suites, such as maintenance teams etc wore a disposable “jumpsuit” made of paper similar to that to single use surgical gowns. Shoe and head covers were also required. Scrub attire was only required if a staff member was going into a theatre where a case was underway.

At the entrance of each of the suites, an antistatic mat was to be found. This was for the purpose of attracting stray particles from shoes and wheels of trolleys to prevent them being transported into the theatre complex.

Cleaning:

The scope of the study did not include the general cleaning of rooms etc following a case of a known MRO; however, the cleaning of specialised equipment was of interest. Specialised equipment can be classed as monitors, keyboards and other sensitive equipment. All keyboards were of the standard type. They were however covered with a clear plastic “skin”. This allowed for the keyboard to be wiped over at the conclusion of the case. Monitors and keyboards were wiped down with a neutral dermacidal detergent.

Specialised equipment, such as anaesthetic carts were exchanged out and then terminally cleaned and restocked.

It is interesting to note, that due to nursing awards in the US, nurses do not clean the theatres between cases. There is a housekeeping team available to clean the room and turn it over, making it ready for the next case. This does slow down the turnaround time of cases and makes for large gaps in the theatre list.

Physical Management:

Patients who are admitted via Day Surgery or Ambulatory care are treated in the same manner as patients who come from the wards. They are nursed with contact precautions in situ.

Cases with a known MRO are not placed at the end of the theatre list. The theatre list order is based on patient acuity and availability of equipment. When the case is underway, there are no additional staff assigned to that theatre. If additional equipment or supplies are required, the staff are reliant upon available staff outside the theatre to act as “clean” staff.

When the patients are transferred to the Post Acute Care Unit (PACU), again contact precautions are instituted. If room allows, the patient is sectioned off from the other
patients. In PACU in one facility visited, they have a negative pressure room where, if possible, they recover the patient.

**Other:**

It was interesting to note that through discussions with staff, the hand hygiene message is having difficulty being implemented. They are attempting to implement the “5 Moments of Hand Hygiene” but are finding great reluctance. In one facility, the Nurse Manager reported to me that only about 20% of the staff (both medical and nursing) washed their hands (outside of the surgical scrub).

It is also of note that one facility has implemented use of an alcohol-based rub in place of the surgical scrub. This has not increased their Surgical Site Infection (SSI) rate over the last 3 years.

**Discussion**

From the extended stay with a number of US facilities, I found that their practices are both similar and behind those implemented within my own facility in Australia.

The practices that are similar are those related to treating the patient with a known MRO are nursing the patient with contact precautions in place, using the master schedule (or theatre) list as the means of communicating the status of a patient, cleaning specialised equipment and managing the patient within the suite.

Areas in which we in Australia appear more advanced include the abolition of antistatic mats, wearing of overshoes and in the turnover of theatres between cases. Mats with tacky surfaces placed in operating rooms and other patient-care areas only slightly minimize the overall degree of contamination of floors and have little impact on the incidence rate of health-care-associated infection in general. An exception, however, is the use of tacky mats inside the entry ways of cordoned-off construction areas inside the health-care facility; these mats help to minimize the intrusion of dust into patient-care areas.

There is continued debate within Australia as to whether cover gowns should be worn outside the operating suite. As found in the US facilities, this is not the case. The use of cover gowns is not universally worn but many staff wear white coats when they leave the suite.

Research has shown that clothing, uniforms, laboratory coats, or isolation gowns used as personal protective equipment (PPE), may become contaminated with potential pathogens after care of a patient colonized or infected with an infectious agent, (e.g., MRSA, VRE, and *C. difficile*). Although contaminated clothing has not been implicated directly in transmission, the potential exists for soiled garments to transfer infectious agents to successive patients.

There were a number of areas observed that were not related to the management of MROs that were of interest in all facilities. These included the overcrowding of the departments with equipment. This is a common problem with all operating suites the
world over. There is never enough storage space. What was a standout was the vast amount of equipment each site had. Not only was equipment stored in corridors, but also the operating theatres themselves were used as storage areas. The theatres were considerably small in size compared to those at St George and with equipment stored in the theatres; this reduced the amount of workable area.

Another area in which Australian perioperative settings are more advanced is in the placement of nursing students and new graduate nurses. In the facilities that I visited, they did not have undergraduate nursing students or new graduates. Nursing staff were required to have at least 2 years post graduate experience. Those staff who were not perioperative experienced undertook a course entitled “Periop 101”. This is a course that is run by the Association of Operating Room Nurses (AORN). It is a generic course conducted by course work and interactive computer skills.

At St George Hospital, we accept new graduates for a 6 month placement and they undertake a 20 week “Transitions to Perioperative Nursing” course. This is based on the now defunct “Foundations in Perioperative Nursing” previously run by the Area Perioperative Educators.

At St George Hospital perioperative services, we accept first, second and third year nursing students as well a Bachelor Midwifery students. We have developed a plan that ensures the students are exposed to perioperative nursing. This has formed the basis of recruiting perioperative nurses for the future.

Another area in which facilities differ from those in the US is that the US do not have anaesthetic nurses nor do they have nurses as instrument nurses. This means that the only registered nurse in each theatre is the circulating nurse (scout nurse). This means that the nurse is responsible for the running of the room. It may also mean sub optimal patient care. Career wise, this means that the nurse is never in a position to scrub for cases and it was explained to me that the nurses are not particularly happy with this.

**Conclusion:**

The trip was a great success. I was able to experience firsthand the manner in which a number of selected facilities managed MROs in the perioperative environment. I found that our practices at St George Hospital are comparable with those in the United States. In some instances, our practices are more advanced. In addition, by embedding myself, I was able to observe and learn more about how the different suites were managed and was able to bring “home” some ideas that might be worth trialling.

I would like to thank the Scholarship Assessment Committee for the opportunity to travel to the US and to review and contrast different perioperative settings to our own.
Appendix 1

- How is the OR made aware that a patient has an MRO?
- Is the patient with MRO scheduled last on list?
- How is this documented?
- How are the OR staff made aware that they have a patient with an MRO on their list?
- How are patient charts handed over from floor/unit staff? Are they in a separate bag?
- Do floor/unit staff wear special PPE when accompanying the patient?
- Does orderly collecting pt from floor/unit wear special PPE?
- Do the anestheologists take any precautions?
- How is the anaesthetic bay cleaning managed- is all equipment and supplies emptied out or covered over?
- What cleaning product/protocol is used after surgery?
- How is special equipment cleaned?
- How and with what is computer keyboard/screen cleaned?
- Is there an outside of Room circulator? If not how does the circulator in room, manage his/herself when collecting supplies from outside the room- do they wear special PPE inside and take off when stepping outside or what?
- How do you manage the "contaminated" count sheet copy?
- How is the patients are managed in PACU?
- Is the patient transferred to the floor/unit with staff wearing PPE?
- How are ambulatory care patients managed?
Appendix 2


Existing law provides for the licensure and regulation of health facilities by the State Department of Public Health. A violation of these provisions is a crime.

This bill would establish the Medical Facility Infection Control and Prevention Act or Nile’s Law, which would require general acute care hospitals to implement certain procedures for the screening, prevention, and reporting of specified health-care-associated infections. This bill would require the department to carry out certain duties in order to implement the bill. Because a violation of the health facility provisions is a crime, the bill would impose a state-mandated local program.

This bill would require health facilities to report to the department and the federal Centers for Disease Control and Prevention, specified infections.

This bill would require the department to develop and implement various Internet-based reporting systems, as prescribed. The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement. This bill would provide that no reimbursement is required by this act for a specified reason.

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares all of the following:

(a) (1) The protection of patients in California health facilities is of paramount importance to the citizens of this state.

(2) During the past two decades health-care-associated infections, especially those that are resistant to commonly used antibiotics, have increased dramatically.

(3) The State Department of Public Health needs to develop a better, more efficient system to monitor and report the incidence of antibiotic-resistant and other organisms causing infection that are acquired by patients in health facilities.

(4) The department needs to establish and maintain a comprehensive inspection and reporting system for health facilities that will ensure that those facilities comply with state laws and regulations designed to reduce the incidence of health-care-associated infections.

(b) It is, therefore, the intent of the Legislature to enact legislation that will do all of the following:

(1) Ensure that California’s standards for protecting patients from exposure to pathogens in health facilities, including Methicillin-resistant Staphylococcus aureus (MRSA), are adequate to reduce the incidence of antibiotic-resistant organisms causing infection acquired by patients in these facilities.
(2) Ensure that the department develops and implements an Internet-based public reporting system that provides updated information regarding the incidence of infections, including associated pathogens acquired in health facilities, as well as the number of infection control personnel relative to the number of licensed beds.

(3) Ensure that health facilities implement improved procedures intended to maintain sanitary standards in these facilities, reduce transmission of pathogens that cause infection, and provide adequate training to health care professionals regarding the prevention and treatment of health-care-associated MRSA and other health-care-associated infections in these facilities.

SEC. 2. This act shall be known, and may be cited, as the Medical Facility Infection Control and Prevention Act or Nile’s Law.

SEC. 3. Section 1255.8 is added to the Health and Safety Code, to read:

1255.8. (a) For purposes of this section, the following terms have the following meanings:

(1) “Colonized” means that a pathogen is present on the patient’s body, but is not causing any signs or symptoms of an infection.

(2) “Committee” means the Healthcare Associated Infection Advisory Committee established pursuant to Section 1288.5.

(3) “Health facility” means a facility as defined in subdivision (a) of Section 1250.

(4) “Health-care-associated infection,” “health-facility-acquired infection,” or “HAI” means a health-care-associated infection as defined by the National Healthcare Safety Network of the federal Centers for Disease Control and Prevention, unless the department adopts a definition consistent with the recommendations of the committee or its successor.

(5) “MRSA” means Methicillin-resistant Staphylococcus aureus.

(c) (1) Each patient who is admitted to a health facility shall be tested for MRSA in the following cases, within 24 hours of admission:

(A) The patient is scheduled for inpatient surgery and has a documented medical condition making the patient susceptible to infection, based either upon federal Centers for Disease Control and Prevention findings or the recommendations of the committee or its successor.

(B) It has been documented that the patient has been previously discharged from a general acute care hospital within 30 days prior to the current hospital admission.
(C) The patient will be admitted to an intensive care unit or burn unit of the hospital.

(D) The patient receives inpatient dialysis treatment.

(E) The patient is being transferred from a skilled nursing facility.

(2) The department may interpret this subdivision to take into account the recommendations of the federal Centers for Disease Control and Prevention, or recommendations of the committee or its successor.

(3) If a patient tests positive for MRSA, the attending physician shall inform the patient or the patient’s representative immediately or as soon as practically possible.

(4) A patient who tests positive for MRSA infection shall, prior to discharge, receive oral and written instruction regarding aftercare and precautions to prevent the spread of the infection to others.

(d) Commencing January 1, 2011, a patient tested in accordance with subdivision (b) and who shows evidence of increased risk of invasive MRSA shall again be tested for MRSA immediately prior to discharge from the facility. This subdivision shall not apply to a patient who has tested positive for MRSA infection or colonization upon entering the facility.

(e) A patient who is tested pursuant to subdivision (c) and who tests positive for MRSA infection shall receive oral and written instructions regarding aftercare and precautions to prevent the spread of the infection to others.

(f) The infection control policy required pursuant to Section 70739 of Title 22 of the California Code of Regulations, at a minimum, shall include all of the following:

(1) Procedures to reduce health care associated infections.

(2) Regular disinfection of all restrooms, countertops, furniture, televisions, telephones, bedding, office equipment, and surfaces in patient rooms, nursing stations, and storage units.

(3) Regular removal of accumulations of bodily fluids and intravenous substances, and cleaning and disinfection of all movable medical equipment, including point-of-care testing devices such as glucometers, and transportable medical devices.

(4) Regular cleaning and disinfection of all surfaces in common areas in the facility such as elevators, meeting rooms, and lounges.

(g) Each facility shall designate an infection control officer who, in conjunction with the hospital infection control committee, shall ensure implementation of the testing and reporting provisions of this section and other hospital infection control policies.
control efforts. The reports shall be presented to the appropriate committee within the facility for review. The name of the infection control officer shall be made publicly available, upon request.

(h) The department shall establish a health care acquired infection program pursuant to this section.

SEC. 4. Section 1288.55 is added to the Health and Safety Code, to read:

1288.55. (a) (1) Each health facility, as defined in paragraph (3) of subdivision (a) of Section 1255.8, shall quarterly report all cases of health-care-associated MRSA bloodstream infection, health-care-associated clostridium difficile infection, and health-care-associated Vancomycin-resistant enterococcal bloodstream infection, and the number of inpatient days.

(2) Each health facility shall report quarterly to the department all central line associated bloodstream infections and the total central line days.

(3) Each health facility shall report quarterly to the department all health-care-associated surgical site infections of deep or organ space surgical sites, health-care-associated infections of orthopaedic surgical sites, cardiac surgical sites, and gastrointestinal surgical sites designated as clean and clean-contaminated, and the number of surgeries involving deep or organ space, and orthopaedic, cardiac, and gastrointestinal surgeries designated clean and clean-contaminated.

(b) The department's licensing and certification program shall do all of the following:

(1) Commencing January 1, 2011, post on the department's Web site information regarding the incidence rate of health-care-acquired central line associated bloodstream infections acquired at each health facility in California, including information on the number of inpatient days.

(2) Commencing January 1, 2012, post on the department's Web site information regarding the incidence rate of deep or organ space surgical site infections, orthopaedic, cardiac, and gastrointestinal surgical procedures designated as clean and clean-contaminated, acquired at each health facility in California, including information on the number of inpatient days.

(3) No later than January 1, 2011, post on the department's Web site information regarding the incidence rate of health-care-associated MRSA bloodstream infection, health-care-associated clostridium difficile infection, and health-care-associated Vancomycin-resistant enterococcal bloodstream infection, at each health facility in California, including information on the number of inpatient days.

(c) Any information reported publicly as required under this section shall meet all of the following requirements:

(1) The department shall follow a risk adjustment process that is consistent with the federal Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN), or its successor, risk adjustment, and use its definitions, unless the
department adopts, by regulation, a fair and equitable risk adjustment process that is consistent with the recommendations of the Healthcare Associated Infection Advisory Committee (HAI-AC), established pursuant to Section 1288.5, or its successor.

(2) For purposes of reporting, as required in subdivisions (a) and (b), an infection shall be reported using the NHSN definitions unless the department accepts the recommendation of the HAI-AC or its successor.

(3) If the federal Centers for Disease Control and Prevention do not use a public reporting model for specific health-care-acquired infections, then, the department shall base its public reporting of incidence rate on the number of inpatient days for infection reporting, or the number of specified device days for relevant device-related infections, and the number of specified surgeries conducted for surgical site infection reporting, unless the department adopts a public reporting model that is consistent with recommendations of the HAI-AC or its successor.

(d) Health facilities that report data pursuant to the system shall report this data to the NHSN and the department, as appropriate.

SEC. 5. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.
References:


Medical Facility Infection Control and Prevention Act (Niles Law) 2008

'My 5 moments for Hand Hygiene',


What is Medicare / Medicaid? Centers for Medicare and Medicaid Services. US Department for Health and Human Services