TSICP Members, Welcome to 2007!!!!

Please allow me to introduce myself to those who may not know me. My name is Charlotte Wheeler, I work as one of two ICPs at Baptist St. Anthony’s Health System in Amarillo Texas. I first stumbled into the IC profession 17 years ago and have never left. I am very passionate about many things, especially making a difference in patient safety, and equipping others with resources to do the same. This is my second tour in TSICP and I am here because I think together our members can make a huge impact upon Patient Safety and the reputation of Infection Control Practitioners in Texas. My mentor is Patti Grant who was my first TSICP president.

I have the awesome honor and responsibility of being your President this year. This is a special year for TSICP as we are celebrating 30 years of providing services, education, support and motivation to Texas ICPs. I hope you will join us in Austin March 29th-30th to celebrate our birthday celebration.

The Education committee has prepared an impressive conference for you this year. During the 1st day, we have 5 of Texas Infection Control Giants that have helped mold TSICP, our past presidents. Patti Grant, Sue Sebazco, Ona Montgomery, Beverly Gray, and Neil Pascoe. Following the conference, you will be able to “Have your Cake and Eat it TOO”. Network with other ICP and have a piece of birthday cake, let your hair down, have fun and view the historical journey of TSICP beginning with Gerry Haynes.

The 2nd day we will have leading National Infection leaders as Dr. Robert Haley, Dr. Dale Bratzler, Dr. Glenn Mayhall, and Barb Bancroft.

The 2007 TSICP Board Members met in January with great excitement and expectations for the year ahead of us. Some of the immediate strategic goals we anticipate for 2007 are as follows:

- A new image for TSICP in 2007
- A new name proposed which will be voted on by our members

March 29th, “Texas Society of Infection Control Prevention”

- Update means of communication with our members including new software that allows instant updates, registration and voting online, renewing membership online, and providing our members with current and relevant information on infection control news.
- Contact and work collaboratively with Texas APIC and local ICP communities to better communicate and provide added services to all Texas ICP’s.
- Encourage and enlist members to assist Board in all committees. Education, Membership, Legislation, Gerry Haynes, Sponsorship
- Increase Membership by 15% in each Texas Region.
- Assess and make changes to Intermediate and Fundamental Education courses, providing more working and interactive education rather than lecture.
- Provide education for Texas ICP in Mandatory Reporting after State legislation is completed.

The Board will brainstorm together March 28th developing TSICP strategic goals for the next 5 years. We are here to serve you, to equip you for success in your individual hospital. We ask that you join us in creating a successful future for TSICP. In creating this future, we ask for your opinions, and help. If you have not, please complete the willingness to serve form and select your strengths to make our organization stronger. Every one that fills out a form WILL be used for the tasks ahead.

Your ideas, input and support will build another 30 years of success for TSICP.

If you have some ideas for improvement or input in any area of TSICP, we want to hear them, please email me directly. Charlotef.wheeler@bsahs.org.

Thank you for investing your time and support of TSICP. We look forward to a year of change, excitement, and productivity with your help.

*Never doubt that a small group of thoughtful, committed people can change the world. Indeed. It is the only thing that ever has.* --Margaret Mead
TSICP extends a big “Thank You!” to our retiring board members for their dedication and hard work for TSICP. We look forward to your continued involvement in TSICP!

Michelle Peninger  
Letha Mosley  
Tjin Koy  
Doris Bergerson

TSICP extends a big “Welcome” to President-Elect Jessica Hilburn and new board members Renae Harris, Sylvia Trevino, and Val Sparks.

Jessica Hilburn  
Renae Harris  
Sylvia Trevino  
Val Sparks
Alcohol Usage in the OR

Texas Department of State Health Services Regulations.

It is a true statement to say Alcohol Gel has changed my life as an ICP. I LOVE IT!!!! It has improved hand hygiene by 120% at our hospital. It is easy to use, no towels or water is needed. It can be used any place by anyone at anytime. And the most important quality!!!!!!!!!!! It is 99.9% effective in killing most microorganisms! It doesn’t get any better. The Alcohol Based Surgical Skin Preparations have also been a break through in decreasing Surgical Site Infections.

Unfortunately, Alcohol does have its safety risks. We all know the elements needed to start a fire.

1. **Fuel** (Alcohol)
2. **Heat** (Spark, Cautery)
3. **Oxygen**

Recently I have seen warning from the alcohol gel company stating alcohol gel can ignite hands… HOW? The basics of a fire. The person had just used alcohol gel (fuel), he light a cigarette(heat) in the open air (Oxygen) and his hands erupted in fire.

The most important question. Did he allow the alcohol to dry? Probably not. Is this a big risk to healthcare workers? NO not if they use the alcohol gel as intended. LET IT DRY

Recently it came to our attention to address our use of Alcohol Solution in the OR. We referred to our Texas Department of State Health Services Position Statement of Alcohol Based Surgical Skin Preparations. The current position statement can be found at this website:

http://www.dshs.state.tx.us/HFP/PDF/PositionStatement_%20AlcoholBasedSkinPrep.pdf

Both the hospital Licensing Rules and the Ambulatory Surgical Center Rules state:

“Flammable germicides. Flammable germicides shall not be used for preoperative preparation of the surgical field”

Vicki Cowling, Division for Regulatory Services states although this wording is a very literal statement, they have written the DSHS position statement to give hospitals and ambulatory services leeway for usage. Their intent is not to establish rules that prohibit the use of new and more effective products and technology as long as there is evidence to support they are safe for patients.

Texas DSHS also has proposed new rules on the use of alcohol usage in the OR. The proposed rules are in §133.143. They are as listed below:

(1) use only self-contained, single-use, pre-measured applicators to apply the surgical skin preparations;

(2) follow all manufacturer product safety warnings and guidelines;

(3) develop, implement and enforce written policies and procedures outlining the safety precautions required related to the use of the products, which, at a minimum, must include minimum drying times, prevention and management of product pooling, parameters related to draping and the use of ignition sources, staff responsibilities related to ensuring safe use of the product, and documentation requirements sufficient to evaluate compliance with the written policies and procedures;

(4) ensure that all staff working in the surgical environment where flammable surgical skin preparation products are in use have received training on product safety and the facility policies and procedures related to the use of the product;

(5) develop, implement and enforce an interdisciplinary team process for the investigation and analysis of all surgical suite fires and alleged violations of the policies; and

(6) report all occurrences of surgical suite fires to the department in care of the Facility Licensing Group within two business days, and complete an investigation of the occurrence and develop and implement a corrective action plan within 30 days.

For our patients safety, we have addressed all these in our OR department to assure we have education and meet these guidelines.

For any further questions, Vicki can be reached at (512) 834-6660 ext. 3701 – direct

Charlotte Wheeler, RN, BSN, CIC
Baptist St. Anthony Hospital, Amarillo
Infection control practitioners are facing an overwhelming, daily struggle to meet the various demands for access to their facilities’ infection control data. ICPs often find themselves “drowning in data” without having the luxury of time to analyze any of it! A few enterprising companies have recently developed software and services to assist ICPs in meeting the expectations of their administrators, patients and public.

Electronic surveillance systems can run the gamut from simple “flags” when a specific event occurs (ex. an e-mail notification is sent to the ICP whenever a previously identified VRE patient is readmitted) to data mining services that literally wade through oceans of data to find what is meaningful and what is not. Some of these services actually provide the data in graph and chart format, making it very easy for the ICP to present to his/her administrators.

These services may appear to be a lifeboat to the drowning ICP; however take heed! Here are a few things you should know and do before signing that contract:

Visit with your facility leaders—what types of data/reports are they requesting? What are their real questions about what’s going on in your facility?
Shop around to get a sense of different companies’ philosophies and the services they provide.
Obtain a complete breakdown for all product services and associated fees—technical support, maintenance, training, upgrades, etc.
Get examples of all types of data/reports the software/service is capable of collecting and generating—do these meet your needs?
Visit with your IT or MIS department first to find out what resources, if any, will be dedicated to the installation and maintenance of any required software; and most importantly...

Carefully review the entire contract before signing!

**Renae Harris**, RN, BSN, CIC
Covenant Health System, Lubbock

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In an effort to see how different or similar we in the infection control world think, my friends and colleagues at Methodist Dallas put together 5 scenarios for line associated bloodstream infections. They emailed the scenarios to a group of us in the DFW area and then presented the same scenarios at our APICDFW meeting in January. Of those that answered the scenarios, we were in agreement on only one scenario. Now in our defense, we feel that a couple of the scenarios required more information and of course each of us feels we answered correctly given the information at hand. Yet it gives us an idea of how differently we think when making decisions. Mary Andrus, BA, RN, CIC with the National Healthcare Safety Network is the speaker at our March meeting. We plan to ask her, an expert, how she would answer the same scenarios. We will have her answers in the next TSICP Times. If you are interested in submitting your answers, fax them to Kim Strelczyk at 214-947-2540.

**Sylvia Trevenio**, MT(ASCP)SM, CIC
Parkland Memorial Hospital, Dallas
CVC_BSI Surveillance Survey

Background Information: Hospital Size ___800___ beds Years as ICP ___4___ years
Follow NNIS/ NHSN definition for CVC_BSI surveillance  Xq Yes  q No
Follow NNIS/ NHSN definition with modification     q Yes     q No

BSI Scenarios

1. Patient admitted to the ICU for R/O CVA. In Ed patient is intubated and has CVC placed. Within 48 hours CXR shows progressive consolidation in left lower lobe, and patient is placed on therapy for pneumonia. Day 10, patient is febrile and 2 sets of blood cultures are +ve for S. maltophilia. Day 16, an ETA culture grows S. maltophilia.
Would you count this as CVC-BSI?
Xq Yes  Reason q No simultaneous positive cultures and VAP/ HAP criteria not met
q Other ____________________________________________
q No  Reason q Patient with a concurrent diagnosis of pneumonia
q Other ____________________________________________

2. Patient transferred from LTAC for AMS, and has CVC placed in ICU. Admission blood cultures done as part of a sepsis work-up are negative. Patient is comfort care only per patient and family wishes, given patient is terminally ill from underlying metastatic cancer unresponsive to chemotherapy. Day 10, patient is febrile and 2 sets of blood cultures and CVC Catheter tip are +ve for A. baumani. Day 11 the life support is withdrawn and patient dies.
Would you count this as CVC-BSI?
Xq Yes  Reason q No simultaneous positive cultures
q Other ____________________________________________
q No  Reason q Patient terminally ill and comfort care only
q Other ____________________________________________

3. Patient transferred from LTAC with AMS, and placed on broad-spectrum antibiotics including vancomycin for diagnosis of Meningitis. Admitted to ICU and CVC placed. A week later, patient is hypotensive and CVC site noted to be "red". Blood cultures (1 of 4 bottles) +ve for S. epidermidis. Patient is continued on broad spectrum antibiotics x 21 d.
Would you count this as CVC-BSI?
q Yes  Reason q Patient is hypotensive and on appropriate therapy (i.e. vancomycin)
q Other ____________________________________________
Xq No  Reason q Patient already on vancomycin for meningitis
q Other ____________________________________________

4. Patient admitted to ICU with ischemic gut and undergoes bowel resection; CVC placed in OR. A week later blood cultures are positive for E. faecalis (1/2 bottle from CVC, 2/2 from arterial line); two days later 2/4 bottles from arterial line grow E. faecalis and Candida. No simultaneous positive cultures noted from other sites, although patient had CT showing intra-abdominal abscess. Subsequent surgery 10 days later showed bowel leakage.
Would you count this as CVC-BSI?
q Yes  Reason q No simultaneous positive cultures are documented
q Other ____________________________________________
Xq No  Reason q Intra-abdominal abscess is likely source given GI pathogens
q Other ____________________________________________

5. Patient admitted to NeuroICU for recurrent Brain tumor, and Right IJ CVC placed. Two weeks later, patient is febrile, CVC site noted to be "red", and 1 set of peripheral blood cultures drawn are +ve for E. cloacae. CVC is removed and culture of the Cath tip is negative.
Would you count this as CVC-BSI?
q Yes  Reason q No simultaneous positive cultures from other sites
q Other ____________________________________________
Xq No  Reason Q No cultures drawn from CVC and Catheter tip culture are negative
q Other ____________________________________________
WOW! I can’t believe that by the time you read this I will have retired. I have 31 years of service and am moving on to begin a new life in a new city. I started here at the University of Texas Medical Branch (Galveston) in 1974 as a Research Technician and then went to nursing school and became involved in the area of Infection Control in 1985. Infection Control has been good to me. I look at it as an area whereby you learn something new just about every day. I will never forget one of the first calls that came in to me as a new ICP. I had a physician (now this is absolutely the truth!) that called and asked me what he should do because he needed to report that he had been exposed to syphilis. Well frankly, I really didn’t want to know and was afraid of how this may have occurred, ha! He told me he had performed a rectal exam on a patient and had a cut on his hand and had not been wearing gloves. I was thinking in my head, yeah, right, I sure hope your wife really believes that one! I don’t know about you, but it can get pretty exciting in this line of work.

When I first starting working in IC, we were doing housewide surveillance (1200 beds) and had 4 practitioners. Now we are basically doing surveillance in our ICU’s (we are at about 500 total bed capacity at the present time including the prison hospital) and have 6 practitioners, our own laboratory and our own laboratory technologist. For about 13 years now, I have been responsible for all the education here at UTMB as well as for the community. I remember for several years I taught the Galveston Police Department on Bloodborne Pathogens (MANY classes). They honored me with a plaque as a token of their appreciation. I zeroxed it, put it in my glove compartment in case of emergency, ha! Never had to use it, but just thought if I was going a little fast one day, I could just whip that out and say, “Hey, remember me, and all the support I gave you guys!”

I have also become heavily involved in the Bioterrorism issue throughout the state. The School of Nursing here at UTMB received a federal grant and we have been providing the 2 hour CNE requirement for nurses (which was extended to include LVN’s in case anyone needed to know that). The mandate for bioterrorism education officially expires September, 2007, which I think is a shame. New nurses could use this information as well. If anyone still needs education in this area, just let me know. I plan to continue to teach for this grant as long as they need me.

Anyway, it’s amazing how infection control has emerged as a topic of discussion not only by our peers, but the public as well. It’s great to see patients becoming involved in their own care. I don’t know if those of you who have been in this for a long time like me have noticed the change. We had an instance that occurred just the other day, whereby a physician went into an exam room and a family member questioned why he didn’t remove the instrument from a sterile package. The physician replied that he had wiped it before he came in the room with alcohol. I received a call from risk management to verify if this was the correct practice or not because the family complained and asked for the head of the department. Mind you, the instrument was not entering a sterile body cavity, therefore did not need to be sterilized. However, it did enter a mucous membrane and required high-level disinfection. Need I say more! How interesting that the family even thought of this or was even forthright enough to question the physician. They were not healthcare workers by the way.

Now, with the consumer’s union issues regarding reporting of HAI’s, our profession is going to be an even more important asset to the healthcare industry. Maybe now we will get the recognition we deserve from administration and others. Those of you out there who are not certified, I highly recommend it. Many hospitals, etc., are requiring certification now when hiring. It is something you’ll never regret and keeps you abreast of changes in infection control. And, of course, I would be remiss if I didn’t at least mention the word HAND-WASHING! We decided to try candy as a motivational factor for people to wash their hands. We gave out candy bars as a reward for proper hand hygiene. Well, to make a long story short, the ants got to the candy bars before we could give them all out. That was pretty sad to have to admit. They seem to be doing a little better now. I think the glow germ demonstrations helped. We actually put glow germ on a toilet handle in one area (yes, we did) and found it all the way to a microwave. Boy did that get a message across! We had people begging us to come do it in their area.

Well, I guess I have been writing more in generalities than about my years as an ICP. I can only say that I will miss the challenges, miss my dear colleagues and friends, and miss the thrill of educating all the little baby doctors, etc. However, I probably won’t miss getting up at 5:30 a.m. EVERY morning, employee exposures, swabbing butts (that’s another story!), or people who call on the phone with strange (or not so strange) questions and issues.

I will remain a member of TSICP, remain on the Board until they remove me, and remain an advocate for all of us dedicated to infection control. Take care, be happy, and I will see you at the Annual Conference! (I think I’ll go take a nap now!).

M. Angela Tabaracci, RN, BS, CIC
Retired
Thinking out of the proverbial Crayon Box

Did you ever think of soap bubbles (Mr. Bubbles) as a risk to patients? In pediatrics, we use bubbles to divert the attention of small children during painful procedures. But did you know that Susan Dolan, RN, at The Children’s Hospital of Denver found that commercial soap bubbles could contain millions of bacteria and fungi? Doesn’t sound like a good liquid to blow in the faces of sick children whose skin is being punctured for an IV or PICC line does it, or who is having a sterile procedure at bedside or a bone marrow transplant patient at risk for Aspergillosis! We have found we can make much safer bubbles from baby shampoo although they are not as “bubbly.”

How about Santa Claus visiting the nursery to hold neonates so they can get their first Christmas picture with Santa? We at Texas Children’s Hospital had to ban Santa this year from NICU and PICU and other critical care areas as Santa wears white gloves, a fake beard, and a Red Suit and could go from patient to patient spreading bacteria as well as Christmas cheer. The parents love the pictures and we are (were) a family “friendly” institution. We did allow Santa on some units but he had to have all his immunizations, wear a freshly dry cleaned or washed costume and beard. He also had to wash or sanitize his hands between each patient and the white gloves were out! We replaced the white gloves with our purple nitrile gloves! And he could not go to isolation rooms—which here at TCH can be half of the children in a unit as Christmas is smack dab in the middle of RSV and flu season! Oh well. the blue isolation gown and mask would take the glow off old Saint Nick anyway. And he is not the only one we worry about—the Easter bunny, clowns, celebrity guests like “Destiny’s Child” and Roger Clemens also come to visit. If one of them has a sore throat—does anyone besides us see that as a risk and call us? Yes-sometimes. And last year, we had to ban a 7 foot tall “Shrek” with the long draping fur from our cardiology clinic. No one took kindly to us mentioning he was a “fomite” that could not be cleaned.

Oh, did I tell you that one Christmas about 15 years ago (before Varicella vaccine) that Santa came to visit our Bone Marrow Transplant unit on Christmas Eve? He brought his elf—who was also his daughter. On Christmas day, the elf broke out with chickenpox. So much for that Christmas dinner for our Infection Control nurse who worked at TCH at the time. Last year, on Christmas Eve at Texas Children’s Hospital, 3 of the 4 of us worked until 10 PM on a measles exposure. Turns out the patient was thought to have Kawasaki’s and rode around the floor in a wagon right before he was discharged visiting all the other patients. (Did I mention, many of the patients were solid organ transplant patients or short gut patients on TPN?) Public Health called us to tell us several relatives were in other Houston area hospitals and had been diagnosed with measles, and they took a titer on him—and he had measles as well. Oh the joys of Christmas past.

How do you sanitize crayons? Or should you even try? But what kid wants a 4 pack of crayons? I always wanted the 64 pack myself when I liked crayons. How about you? How do you sanitize grains of rice? Or lima beans? We use them in occupational therapy for texture and sensory stimulation for certain children. What about play dough? Each kid needs their own, or you can cut the dough apart and put in plastic bags. Can you sanitize children’s books—the regular kind not the ones with the plasticized pages?

Better yet—how do you keep a 2-year-old isolation patient in his room if he does not want to stay there and Mom went home? You are the nurse, but you have 5 more patients in 5 more rooms and did I mention he has diarrhea and is running down the hall with a dripping diaper?

And then there is visitation. Mom, who has other kids, brings them all to the hospital. Some of them have the same illness as the one in the hospital but not as severe. Many of the little ones crawl on the floor. I did not worry so much about the floor when I worked in adult care—I always told the nurses the germs did not jump off the floor onto the patients. Unfortunately though, in pediatrics, they don’t have to!—the kids go down to the floor and get them and put everything that was on the floor into their mouth.

I have learned a lot about children and pediatric infection control and more to learn—one has to think out of the “crayon box” to work here!

Jessica Hilburn, BSMT(ASCP), CIC
Texas Children’s Hospital, Houston
What! You do not know this star? You can’t recall what hit movie or TV show she was in?

Well, Jerry Haynes is a star – she is a TSICP star. She has been a star since 1973, the early days for infection control professionals in Texas. She was a pioneer, a leader who knew the importance and necessity of infection control in health care.

Whether you are new or a seasoned ICP, you have a bit of Gerry Haynes in you. Often we are so busy we forget to stop and reflect, to think about what you or others have accomplished in your departments, through PI, community involvement, education, just to name a few.

Let’s all take the time to recognize the Gerry Haynes in our ICP peers. Take the time to complete the nomination form so that others can applaud and appreciate the Gerry Haynes in another ICP.

Kathleen Byrne, RN, BSN, ICP
Northeast Medical Center, Humble

Viking Infection Control Practitioner

Educational Opportunities

Summer Fundamentals
July, 2007
Tyler, Texas

Intermediate Workshop
October, 2007
Corpus Christi, TX
Gerry Haynes Nomination Form

Candidate Name:___________________________________________________________

Hospital/Work Site:________________________________________________________

Address:_________________________  City:_____________  State:______ Zip:_____  
Work phone:______________   Fax:_____________  E-mail:___________________

Current professional position:_____________________________________________

Name of Nominator:________________________________________________________

Hospital/Work Site:________________________________________________________

Address:__________________________City:______________State:_____Zip:________  
Work phone:_______________ Fax:_______________  E-mail:___________________

Current professional position:_____________________________________________

Short statement of nomination about the candidate:

______________________________________________________________________________________
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FAX NOMINATION FORM TO:  
Doris Kraft, 512-402-1875
Just about the time you think you’ve identified all the waste streams in your healthcare facility, another emerges...pharmaceutical waste. You ask why should I care, I’m the infection control practitioner? There is a lot of training of nurses and pharmacists to prevent access to drugs by the public, to prevent accidental poisoning and diversion, but nurses & some pharmacists use red sharps containers to dispose of partially used vials and syringes. These containers or their contents are subject to treatment to render the contents non-infectious. Then the contents are shredded and sent to a landfill. This does nothing to destroy any drugs remaining in the containers. They are deposited in the landfill, where they will most probably leach into the ground water or get recycled through the local wastewater treatment facility.

Because of this, waste pharmaceuticals have become a high-profile area due to the prevalence of drugs in surface waters and studies have shown that damage has occurred to aquatic species from extremely low concentrations of drugs. Waste pharmaceuticals are not only inappropriate in infectious waste, but may often be placed illegally, putting the organization at risk of substantial fines, ranging to date from $40,000 to $280,000. Because ICPs have strived for years to keep pizza boxes out of red bags, they are the catalysts to bring this issue to the forefront in their respective facilities.

So how to begin, involve your safety officer, pharmacy, key nursing personnel, environmental services and begin by looking at current waste stream practices. Review the Resource Conservation and Recovery Act which applies to all waste generated outside households. It defines hazardous chemical waste. One of the first is the chemotherapy waste stream which defines chemotherapy waste as only empty vials, syringes, and IVs to be placed in the yellow or white chemotherapy containers. This is because nine chemotherapy drugs are considered hazardous chemical waste and must be segregated and disposed of in a federally permitted hazardous-waste incinerator.

Look at the P and U listed drugs (see below to obtain list of drugs). If a drug is on the P or U list, is the sole active ingredient, and is unused, then it must be managed as hazardous waste. Because P-listed drugs are considered to be acutely hazardous, additional regulations apply. The only exception to this is a used syringe that has held epinephrine. This used syringe may be disposed of as infectious waste. All other containers such as used vials and IV bags containing epinephrine or any other P-listed drug must be managed as hazardous waste.

In addition to looking at the types of drugs, the generator status of the facility must be established.....large-quantity, small-quantity, and conditionally exempt. A minimum of 1 kg (2.2 pounds) of P-listed waste generated in any calendar month causes the facility to become a large-quantity generator for that month. Safety officers must be aware in order to stay in compliance.

Other hazardous waste characteristics such as ignitability, corrosivity, toxicity, and reactivity are formulation-dependent, and different formulations of the same drug may or may not be hazardous when discarded, making their status difficult to identify. Of the 4 characteristics, ignitability and toxicity apply most often are attributed to waste pharmaceuticals.

Ignitability as it pertains to waste pharmaceuticals is related to the alcohol content of 24% or more and a flashpoint of less 140 ° F (60 ° C). Alcohol is used to solubilize a number of drugs not soluble in water, primarily chemo drugs. If the drug is diluted and the alcohol content is below 24%, waste may be managed as a chemotherapy drug. Determining the drug ignitability is based on knowing the initial hazardous-waste classification and the final status adding further complexity to identifying the status of such waste. Toxicity is more difficult to identify and manage, but poses a greater threat to the environment than ignitability or corrosivity. The EPA has listed 40 chemicals that it considers a threat for leaching into ground water above certain concentrations. Each chemical has its own concentration limit above which the waste must be managed as hazardous waste.

Identifying the drugs will require pharmacy to do an analysis with respect to the ignitability and toxicity characteristics. There are some cost effective commercially available analysis suitable for this purpose. Once identified then develop a process for segregating hazardous pharmaceutical waste at the various points of use. Containers should meet the Department of Transportation (DOT) shipping requirements for hazardous waste. Other drugs which may not fall in the above categories, but nonetheless, are very potent such as antibiotics, antihypertensives, and anticholesterolemics may continue to be sewered and require decisions on how they need to be disposed of. In many states virtually all non-RCRA-hazardous drugs must be incinerated at a facility comparable to a medical waste incinerator.

So while the hazardous waste process falls under the Environment of Care standards for JCAHO and the safety officer should be coordinating these processes, ICPs can provide valuable expertise in helping sort out the different waste streams. Please see the following websites for a list of drugs mentioned above and a more thorough explanation of the various requirements.

http://www.infectioncontrolresource.org
http://www.tceq.state.tx.us
http://www.epa.gov

Susan Jones, MPH, M(ASCP), CIC, CHSP, ICP
Laredo Medical Center, Laredo
2007 is a year of change in the Infection Control world. As ICPs we have been monitoring our surgical wounds, reportable diseases, preparing for the pandemic flu and immunizing everybody against everything. Now the Institute for Healthcare Improvement (IHI) has a new campaign to save 5 million lives over the next 2 years and the ICP is in the middle of most of these 12 initiatives.

Over the past 18 months ICPs have been active in the Ventilator Bundle and monitoring VAP in our intensive care units. Along with the Central line bundle, getting our physicians to wear maximum barrier precautions and prep with CHG and then monitoring the line days to see how many bloodstream infections we can attribute to those lines. Now IHI has added the MRSA reduction program. They call it “getting to ZERO” and recommend instituting surveillance cultures for the high risk or ALL admissions to our institutions. Do they not know how busy we are already?

Our hospital actually started doing high risk surveillance cultures seven years ago and we have seen a dramatic reduction in HA-MRSA. Prior to doing the admission cultures on nursing home, rehab care, transfer patients and those with previous known MRSA we had a tough time getting those patients discharged when they had been culture positive for MRSA during their hospital stay. We had to start somewhere so we had to prove they were colonized on admission. Once the physicians allowed Infection Control to adopt a protocol and allowed nursing to collect the culture as a standing order, we really saw a rate reduction begin. We placed the patient in contact isolation until proven negative; we really began getting compliance with the protocol. I’m guessing we’ve already saved 4.5 million lives!!!

Well, now with the nudge from IHI we will begin increasing our active surveillance cultures. We are working with microbiology to get the rapid test (PCR) in house and stressing hand hygiene until the test results are determined. Hopefully this will decrease the contact isolation carts littering the halls.

With the community acquired MRSA so high in our county, we embrace the chance to identify those who might already be colonized and look forward to “getting to ZERO” our hospital acquired MRSA infection rate. We will save those 5 million lives.

Val Sparks RN, BSN, CIC
Midland Memorial Hospital
Developing a New Image for Infection Prevention

TSICP 2007 Annual Conference
March 29-30th 2007
Austin Texas

Be sure to check out TSICP’s website. You can read the newsletter; download brochures; register online; contact members of the board and the TSICP office; find topics of interest; find links to information you need; and much more.