Indiana State Department of Health

Long Term Care Newsletter

ISDH Long Term Care
Newsletter Issue 2012-01
January 13, 2012

In Today's Issue:
- A New Year
- Cervical Health Awareness
- Norovirus Toolkit
- Glucose Monitoring
- Insulin Pens
- Recall Information

Beginning A New Year

This is the first Indiana State Department of Health (ISDH) Long Term Care Newsletter for 2012. In 2011, we published 28 Long Term Care Newsletters. Our goal is to continue publishing a newsletter an average of every two weeks. Through the newsletter, we hope to keep you informed about health care quality issues and program activities related to long term care facilities. The newsletter is free and available to anyone. Individuals may subscribe via the ISDH web site at http://www.in.gov/isdh/24526.htm.

The new year began with several changes within the agency. The ISDH Health Care Quality and Regulatory Commission added a new responsibility. Resulting from some reorganization within the agency, the Office of Vital Records has moved to our Commission. The Office of Vital Records is responsible for birth, death, and marriage records and is under the direction of Erin Kellam.

The ISDH also has a few leadership changes. Ellen Whitt is the new Assistant Commissioner for the Health and Human Services Commission. That Commission includes the Office of Women's Health, Office of Minority Health, Women Infant and Children (WIC) Program, Nutrition Program, and Chronic Disease Prevention Program. Our Assistant Commissioner for the ISDH Tobacco Prevention and Cessation Commission has accepted a position at CDC. A new Director will be announced soon and will be beginning responsibilities at the end of January. I look forward to continuing our health promotion and improvement partnership with these individuals and commissions.

As we begin a new year, I have been asked several times about program plans for 2012. The following are a few of our plans for 2012 for long term care.

SURVEY ACTIVITIES:

Quality indicator survey process: In 2011 the ISDH completed approximately one-third of the quality indicator survey (QIS) implementation. By the end of 2012, the ISDH expects to be very close to completing training of surveys and fully implementing the quality indicator survey process for nursing home surveys.

Independent informal dispute resolution: The ISDH is implementing the independent informal dispute resolution option for nursing homes. An independent entity will be selected in the very near future. The last newsletter of 2011 provided information on the option.

Certified nurse aide curriculum: The ISDH began working with our partners in 2011 to revise the nurse aide curriculum. The curriculum has not been updated in many years. The ISDH hopes to complete this project in 2012.

HEALTHCARE QUALITY IMPROVEMENT ACTIVITIES:

March 20, 2012 Leadership Conference: The March 2012 Leadership Conference will focus on patient safety. The ISDH is currently working on the conference agenda but expects it to include patient safety, fall prevention, medication error prevention, and injury prevention. Look for information sometime in February.

September 20, 2012 Leadership Conference: Continuing the theme of patient safety, the ISDH has tentatively selected life safety code as the topic for the fall conference. Providers have requested additional guidance on this topic.

Care coordination project: Continuing the topic of the fall 2011 Leadership Conference, the ISDH would like to develop a project to support care coordination activities. This is in planning stages but would assist in implementing healthcare quality collaboratives, consistent resident transfer tools, medication reconciliation tools, and other quality improvement projects.

Healthcare training: Continuing the Indiana Pressure Ulcer Initiative and Indiana Healthcare Associated Infection Initiative, the ISDH would like to support training efforts to increase the number of certified staff in wound care, infection prevention, and other healthcare areas. This project is in the planning stages.

Civil money penalty fund: As part of the Patient Protection and Affordable Care Act, the ISDH will be creating descriptions of all civil money penalty funded projects and posting on the ISDH web site. Although the ISDH has regularly provided this information in the past, this increases transparency and makes the information readily available.

Cervical Health Awareness Month

January 6, 2012

PROTECT YOURSELF FROM CERVICAL CANCER

Women urged to get a Pap test as part of New Year's Resolution

INDIANAPOLIS-As Hoosiers begin making positive changes in 2012, state health officials urge women to make getting a Pap test part of any New Year's resolution to be healthier.

Each year, approximately 12,000 women in the United States get cervical cancer. From 2004 to 2008, 1,291 Hoosier women were diagnosed with cervical cancer and 424 women died of cervical cancer in Indiana.

Cervical cancer used to be the leading cause of cancer death for women in the United States. However, within the past 40 years, the number of deaths has decreased significantly as a large result of women getting regular Pap tests.

January is Cervical Health Awareness Month and highlights the importance of women to have a regular Pap test.

"The beginning stages of cervical cancer usually have no symptoms, but a regular Pap test can diagnose cervical cancer in its early, most treatable stage," said State Health Commissioner Gregory Larkin, M.D. "This is crucial as 90 percent of cervical cancers are beatable if found early. Physicians can also diagnose precancerous cervical changes that, when treated appropriately, may prevent cancer from ever occurring."

The American Cancer Society recommends that all women begin having regular Pap tests three years after having sexual intercourse, or no later than age 21. Screening should be done every year. By age 30, many women who have had three normal Pap tests in a row may be advised to screen less often, such as every two to three years. It is important to talk to your doctor to see what is right for you in regard to screening.

The most important risk factor for cervical cancer is exposure to human papilloma virus (HPV). The virus is spread through sexual contact and two high-risk HPV strains (HPV 16 and HPV 18) account for more than 70 percent of all cervical cancer cases, according to the National Cancer Institute.

There are two vaccines, Gardasil and Cervarix, that can help prevent the two most common high-risk types of HPV and are licensed, safe and effective. Talk with your doctor to see if HPV vaccination is right for you

and/or your child.

Another high risk factor for cervical cancer is smoking. Women who smoke are about twice as likely as non-smokers to get cervical cancer. To quit smoking or to help someone you care about quit, contact the Indiana Tobacco Quitline at 1-800-QUIT NOW (1-800-784-8669).

The Indiana Breast and Cervical Cancer Program provides access to breast and cervical cancer screenings, diagnostic testing, and treatment for underserved and underinsured women who qualify for services. To find out if you qualify for this program, call the Indiana MCH MOMS Helpline at 1-855-MCH-MOMS (1-844-624-6667).

For more information on cervical cancer, visit the Indiana State Department of Health website at www.statehealth.in.gov.

Norovirus Toolkit

As you know, we are at the peak of the 2011/2012 norovirus season. Norovirus continues to be the most common cause of gastroenteritis outbreaks in the U.S. with the majority occurring in healthcare settings, including long-term care facilities and acute care hospitals. Recently, CDC published new guidelines for the prevention and management of norovirus outbreaks. Today, we're pleased to share with you a new norovirus toolkit that complements these guidelines and is designed to assist healthcare facilities prevent the spread of norovirus infections. The new norovirus toolkit features recommended infection control measures and tools for outbreak response, coordination, and reporting.

Glucose Monitoring and Infection Prevention

The Indiana State Department of Health (ISDH) recently cited an immediate jeopardy violation related to glucose monitoring. The ISDH would therefore like to remind facilities about good glucose monitoring infection prevention practices.

The Centers for Disease Control and Prevention (CDC) has become increasingly concerned about the risks for transmitting hepatitis B virus (HBV) and other infectious diseases during assisted blood glucose (blood sugar) monitoring and insulin administration.

CDC is alerting all persons who assist others with blood glucose monitoring and/or insulin administration of the following infection control requirements:

- Fingerstick devices should **never** be used for more than one person
- Whenever possible, blood glucose meters should **not** be shared. If they must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions. If the manufacturer does not specify how the device should be cleaned and disinfected then it should not be shared.

For further information, see the CDC Infection Prevention during Blood Glucose Monitoring web site.

CDC Clinical Reminder: Insulin Pens

Summary

The Centers for Disease Control and Prevention (CDC) has become increasingly aware of reports of improper use of insulin pens, which places individuals at risk of infection with pathogens including hepatitis viruses and human immunodeficiency virus (HIV). This notice serves as a reminder that insulin pens must **never** be used on more than one person.

Background

Insulin pens are pen-shaped injector devices that contain a reservoir for insulin or an insulin cartridge. These devices are designed to permit self-injection and are intended for single-person use. In healthcare settings, these devices are often used by healthcare personnel to administer insulin to patients. Insulin

pens are designed to be used multiple times, for a single person, using a new needle for each injection. Insulin pens must **never** be used for more than one person. Regurgitation of blood into the insulin cartridge can occur after injection [1] creating a risk of bloodborne pathogen transmission if the pen is used for more than one person, even when the needle is changed.

In 2009, in response to reports of improper use of insulin pens in hospitals, the Food and Drug Administration (FDA) issued an alert for healthcare professionals reminding them that insulin pens are meant for use on a single patient only and are not to be shared between patients [2]. In spite of this alert, there have been continuing reports of patients placed at risk through inappropriate reuse and sharing of insulin pens, including an incident in 2011 that required notification of more than 2,000 potentially exposed patients [3]. These events indicate that some healthcare personnel do not adhere to safe practices and may be unaware of the risks these unsafe practices pose to patients.

Recommendations

Anyone using insulin pens should review the following recommendations to ensure that they are not placing persons in their care at risk for infection.

- Insulin pens containing multiple doses of insulin are meant for use on a single person only, and should **never** be used for more than one person, even when the needle is changed.
- Insulin pens should be clearly labeled with the person's name or other identifying information to ensure that the correct pen is used **only** on the correct individual.
- Hospitals and other facilities should review their policies and educate their staff regarding safe use of insulin pens and similar devices.
- If reuse is identified, exposed persons should be promptly notified and offered appropriate follow-up including bloodborne pathogen testing.

These recommendations apply to any setting where insulin pens are used, including assisted living or residential care facilities, skilled nursing facilities, clinics, health fairs, shelters, detention facilities, senior centers, schools, and camps as well as licensed healthcare facilities. Protection from infections, including bloodborne pathogens, is a basic expectation anywhere healthcare is provided. Use of insulin pens for more than one person, like other forms of syringe reuse [4], imposes unacceptable risks and should be considered a 'never event'.

References

1. Sonoki K, Yoshinari M, Iwase M, Tashiro K, Iino K, Wakisaka M, Fujishima M. Regurgitation of blood into insulin cartridges in the pen-like injectors. Diabetes Care. 2001;24(3):603-4.

2. Information for healthcare professionals: risk of transmission of blood-borne pathogens from shared use of insulin pens (2009). U.S. Food and Drug Administration Postmarket Drug Safety Information for Patients and Providers.

3. Important Patient Safety Notification (2011). Dean Clinic.

4. Centers for Disease Control and Prevention (CDC) and the Safe Injection Practices Coalition (SIPC).

Recall Information

Bedford Laboratories Polymyxin B For Injection USP And Vecuronium Bromide For Injection: Recall - Glass Particles

January 12, 2012

ISSUE: Bedford Laboratories issued guidance on the nationwide voluntary product recalls originally issued on August 2, 2011. The recalls were initiated after the discovery of a visible glass particle in a limited number of vials within the lots listed below to the user level.

- Polymyxin B for Injection USP, 500,000 Units per vial - NDC #55390-139-10
  Lot 1942980 - Exp. Date August 2013 and Lot 1895027 - Exp. Date June 2013
- Vecuronium Bromide for Injection, 10 mg per vial - NDC #55390-037-10
  Lot 1865067 - Exp. Date May 2012

- Vecuronium Bromide for Injection, 20 mg per vial - NDC #55390-039-10
  Lot 1865069 - Exp. Date February 2012

Particulate matter in injections can be harmful when introduced into the bloodstream. Potential adverse events after intravenous administration may include vein irritation and phlebitis, pulmonary dysfunction and granulomas, local tissue infarction, occlusion of capillaries and arteries, anaphylactic shock, and death. The introduction of particulate matter via the intrathecal route into the cerebrospinal fluid may serve as a nidus for the development of chemical meningitis. Introduction of a foreign body to the eye via topical or subconjuntive routes can cause corneal abrasion/laceration, lacrimal tear and general irritation. To date, there have been no reports of adverse events for the lots being recalled.

BACKGROUND: Polymyxin B is indicated in the treatment of acute infections caused by susceptible strains of Pseudomonas aeruginosa. Vecuronium Bromide is indicated as an adjunct to general anesthesia, to facilitate endotracheal intubation and to provide skeletal muscle relaxation during surgery or mechanical ventilation.

RECOMMENDATION: Hospitals, emergency rooms, clinics, physician offices and other healthcare facilities and providers should not use the product lots listed above for patient care and should immediately quarantine any product for return.

Novartis Consumer Health Over-The-Counter Products: Recall - Potential Presence of Foreign Tablets or Chipped or Broken Tablets or Gelcaps including Excedrin, NoDoz, Bufferin, Gas-X Prevention

January 9, 2012

ISSUE: Novartis Consumer Health Inc. is voluntarily recalling all lots of over-the-counter products Excedrin, Bufferin, Gas-X Prevention and NoDoz. Reports were received of chipped and broken pills and inconsistent bottle packaging clearance practices at the Lincoln, Nebraska facility, which could result in the bottles containing foreign tablets, caplets, or capsules.

Mixing of different products in the same bottle could result in consumers taking the incorrect product and receiving a higher or lower strength than intended or receiving an unintended ingredient. This could potentially result in overdose, interaction with other medications a consumer may be taking, or an allergic reaction if the consumer is allergic to the unintended ingredient.

BACKGROUND: This voluntary recall pertains to all lots of select bottle packaging configurations from retailers of Excedrin and NoDoz products (expiry dates of December 20, 2014 or earlier), and Bufferin and Gas-X Products (expiry dates of December 20, 2013 or earlier), in the United States.

RECOMMENDATION: All of the pills in the bottle should look the same. If patients find a pill that is different in shape, size, color, or markings, they should bring their medicine bottle to their pharmacist and not take any of those pills.

For additional information, visit the FDA MedWatch Safety Alerts for Human Medical Products web site.

We look forward to continuing our collaboration on healthcare quality! Best wishes to all for the new year.

Terry Whitson
Assistant Commissioner
Indiana State Department of Health