HALT 2016 - FREQUENTLY-ASKED QUESTIONS (FAQ)

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IMPORTANT UPDATES FROM HALT TRAINING DAYS

When you are e-mailing your LTCF's data back to HPSC as a zip file, please be aware that the size of the zip file may be quite large (potentially up to 4MB). If there is a limit on the amount of data that your workplace e-mail account will allow you to send via e-mail, you may need to request that the information technology (IT) department increases the capacity of data that can be sent via e-mail from your e-mail account to facilitate e-mailing your data back to HPSC. It is for this reason that it is advisable to ensure you get your LTCF data e-mailed back to HPSC well ahead of the deadline of May 31st to allow time for any local IT issue to be resolved.

GENERAL QUESTIONS

Q1- What should I do if there is a suspected outbreak of infection on a ward/unit on the planned HALT survey date for my facility?

A1 – In the event that there is a suspected outbreak of infection on a ward/unit on the planned HALT survey date, it is advised that the survey is not undertaken in that ward/unit during the outbreak. You have two options:

1) Exclude that ward/unit from the HALT data collection – when you have your final data collected and your software data entry completed, please add a note to your e-mail, when sending your final data to HPSC, stating that because of an outbreak of infection due to '***state infection type e.g., influenza, norovirus***' one ward/unit with ***XX*** beds was excluded from the HALT survey in your facility
2) If you have an on-going outbreak in a ward/unit, the other option would be to defer your facility's HALT survey until later on in the month of May, when the outbreak has been closed off, bearing in mind that all data must be collected, entered into the software and returned by e-mail to HPSC by the deadline of 31st May 2016

Q2 – Several questions on the questionnaires have the options 'yes' or 'no' as the potential answer. What happens if I don't know the answer? Is there an option 'don't know/unknown'?

A2 – Where the option provided for the answer is 'yes' or 'no' only, rather than leaving the question unanswered, tick the 'no' box to cover an unknown option. Only tick the 'yes' box if you know the answer to be true.

Q3 – My facility has only one unit, but that unit has a large number of residents. I don't think it is feasible for me to collect all of the HALT data for this large unit in the same working day. What should I do?

A3 – The HALT protocol states that *all of the data for a particular ward or unit should be collected on the same working day.* If your facility has one large unit and it does not seem feasible that you can get all of the residents surveyed on the same day, it is advised that you subdivide that unit by the number of residents that you think you can survey on the one day.

For example, Shakespeare Unit has 60 residents. The HALT local coordinator has decided to subdivide Shakespeare Unit into two separate units, for the purpose of HALT data collection over two separate days:

- Shakespeare Unit A has 30 residents and is surveyed on May 7th
- Shakespeare Unit B has 30 residents and is surveyed on May 8th

INSTITUTIONAL QUESTIONNAIRE

INSTITUTIONAL QUESTIONNAIRE – SECTION A - GENERAL INFORMATION

Q1 - If a resident bedroom is closed and not available/open to accommodate a resident, should I include it as resident room?

A1 – No. Only rooms that are vacant/available/staffed and open to accommodate resident(s) should be counted. If the room is closed, it is not included.

INSTITUTIONAL QUESTIONNAIRE – SECTION C – MEDICAL CARE AND COORDINATION

Q1 – Regarding question 4 'can the physicians in charge of medical coordination in the facility consult the medical/clinical records of all residents in the facility?' My facility does not have a physician in charge of medical coordination. How should I answer this question?

A1 – Unfortunately, there is no option to answer 'not applicable'. Rather than leaving the question unanswered, tick the 'no' box to cover the 'not applicable' option.

INSTITUTIONAL QUESTIONNAIRE – SECTION D – INFECTION CONTROL PRACTICE

Q1 – Our facility has a representative on a regional infection control committee (ICC), rather than a local ICC, does that count as an ICC?

A1 - Because regional ICC generally tend to be larger committees which deal with strategic regional issues, rather than local operational issues, that would not suffice for membership of a local ICC. The ICC should deal with local issues to do with the day-to-day infection prevention and control (IPC) matters in one LTCF or alternatively, a smaller group of LTCF with the same managerial structures may have a shared operational ICC.

Q2 – Our facility does not have a separate named infection control committee, but IPC matters are routinely discussed as part of the local management team meeting or a quality/safety/risk committee agenda. Will that suffice as a local ICC?

A2 – Yes. As long as the IPC matters are discussed systematically and part of a standing agenda at your local facility, that is appropriate. Ideally, the ICC should have a named IPC professional as part of the committee, an IPC nurse or a link nurse would be considered to have IPC experience.

Q3 – Our facility uses the national guidelines for the prevention of catheter-associated UTI. Does that suffice as having a 'written protocol for the management of urinary catheters'?

A3 – Yes this guideline would suffice, provided it is actually in use by staff in the facility.

Q4 – Regarding Q13; How many hand hygiene opportunities were observed in your facility last year?

A4 – Provide the total number of opportunities/moments for hand hygiene (as per the WHO five moments for hand hygiene) that were **observed** during observational audits of hand hygiene compliance in your facility during 2015. The question is only asking about observed opportunities, **not the actual compliance with the opportunities**. If you are not sure of the exact total observed, you can provide an estimate. If you did not conduct any formal hand hygiene audits to observe hand hygiene opportunities in 2015, record 0 as the answer to this question.

Please note that facility audits of equipment for hand hygiene (e.g., hand hygiene sinks and availability of alcohol-based hand rub are not the same as auditing actual opportunities/moments for hand hygiene during resident care.

INSTITUTIONAL QUESTIONNAIRE – SECTION E – ANTIMICROBIAL POLICY

Q1 – Our facility does not have a separate named antimicrobial committee, but antimicrobial use and prescribing matters are routinely discussed as part of the local management team meeting or a quality/safety/risk committee agenda?

A1 – If your facility has a local management team meeting, which includes antimicrobial use and prescribing matters as a standing item on the agenda that may be considered as a local antimicrobial committee.

Q2 – Our facility uses the national antimicrobial prescribing guidelines for primary care. Would this suffice as having a 'written guideline for appropriate antimicrobial use in the facility'?

A2 – Yes this guideline would suffice, provided it is actually in use by prescribers in the facility.

Q3 – Our facility has participated in past HALT surveys in Ireland. Would that be considered as having a 'programme for surveillance of antimicrobial consumption and feedback in place in the facility'?

A4 – Yes. HALT is a prevalence surveillance survey. If you have participated in previous HALT surveys, this demonstrates that you are measuring this information over time and that you are sharing the results.

WARD LIST

Q1 – What do we mean by living 'full-time' in the LTCF, when we decide whether a resident is eligible for HALT?

A1 - Full-time refers to the resident availing of overnight accommodation in the facility. The length-of-stay to date, or the anticipated duration of residence is not taken into account. Therefore, residents who are admitted for convalescence and short-term respite are considered to be full-time residents if they are availing of overnight accommodation.

Q2 – Would a resident who requires the assistance of staff to walk be considered to be bed-bound or wheelchair bound?

A2 – No. If the resident can walk with assistance of staff or with aid of cane/stick/walker, the resident is not wheelchair bound or bedridden. The **X** is not placed in the box for this resident.

Q3 – If a resident who is usually bed bound can be transported around the facility in a wheelchair, are they considered wheelchair bound or bed bound?

A3 – If the resident can mobilise themselves in the wheelchair, categorise the resident as wheelchair bound. If the resident needs a staff member to push the wheelchair, categorise them as bed bound.

Q4 – If a resident is intermittently incontinent, but it's not a daily occurrence, would we count that resident as incontinent on the HALT survey date?

A4 – Because HALT is a snapshot survey, take into consideration, the situation for that resident on the date of the HALT survey. If the resident has been incontinent in the past 24

hours, then the urinary and or faecal incontinence box should be ticked. If the resident has been continent for the past 24 hours, then the urinary and/or faecal incontinence box is left blank.

Q5 – A resident is prescribed subcutaneous fluids –How would that be recorded? Would it be recorded as a vascular catheter?

A5 – No. It would be recorded as 'other wound'. In the HALT protocol, a vascular catheter is defined as a tube system placed in the body to access the vascular system.

Q6 – A resident practices self-intermittent catheterisation. Would that be recorded as a urinary catheter?

A6 – No. As the catheterisation is intermittent and the resident may not be catheterised at the time you do the HALT prevalence survey. Self-intermittent catheterisation is not regarded as an indwelling urinary catheter for HALT data collection.

Q7 – How do you deal with the question asking if your resident is 'Disoriented in time or space' (Column 11 in the Ward List and page 1 of the Resident Questionnaire) if your resident is intellectually disabled and is routinely disoriented?

A7 – This question is looking at the care load associated with caring for your residents. If a resident is disoriented in time/space then a higher level of care is required for them. Therefore if an intellectually disabled resident meets the definition of being disoriented (i.e. a resident who suffers from periods of confusion, especially for time, place or recognition of people they know) then this should be recorded.

RESIDENT QUESTIONNAIRE

Q1 – My facility is a residential care unit, which is located on the campus of an acute hospital. On the first section of the resident questionnaire titled 'resident data', should I tick 'yes' for the box titled 'admission to a hospital in the last three months'?

A1 – Although your facility is located on the same campus as an acute hospital, you should only tick 'yes' for the box titled 'admission to a hospital in the last three months' if the resident was transferred out of your facility and admitted into the acute hospital at least overnight. If the resident has remained in your facility in the past three months, you should tick the box 'no'.

Q2 – What happens if the resident has been prescribed oral nitrofurantoin for urinary tract prophylaxis for the past six months and on the date of the HALT survey is also prescribed oral co-amoxiclav for a suspected respiratory tract infection for the past four days? Should I record both antimicrobial prescriptions on the resident questionnaire?

A2 – Yes. There is space to record information on four separate antimicrobial prescriptions on the resident questionnaire (page 2). In this scenario, there are two separate prescriptions, so data on both antimicrobials is recorded in two separate columns:

- Antimicrobial 1 = nitrofurantoin, oral, prophylactic, urinary tract etc…
- Antimicrobial 2 = co-amoxiclav, oral, therapeutic, respiratory tract, etc…

Q3 – Resident questionnaire – Isolated microorganisms – What if the resident's microbiology laboratory report mentions *E. coli?*

A3 – This is the shorthand term used for the microorganism *Escherichia coli*. Therefore, *E. coli* & *Escherichia coli* are the same microorganism and if you have *E. coli/Escherichia coli* on your resident's microbiology report, the microorganism code on the code list is ESCCOL on the microorganism code list on page 90 in Appendix F

Q4 – Resident questionnaire – Isolated microorganisms – How do you report 'Coliform' in the Antimicrobial section of the HALT software if you see it on a resident's microbiology report?

A4 – If you see 'Coliform' on a resident's microbiology report, record it as ETBNSP on page 2 of the resident's questionnaire and record it as '*Enterobacteriaceae*, not specified' in the drop down menu within the Isolated Microorganism tab in the HALT software.

Q5 – Antimicrobial prescribing data (resident questionnaire page 2) – If a systemic antimicrobial is given by the per rectal (PR)/suppository route, per nasogastric (NG) tube or per gastrostomy (PEG) tube, where is that recorded?

A5 – As all of those routes are also via the enteric tract/gut/enteral route – select the 'administration route' = oral

Q6 – If a systemic antimicrobial is given by the inhaled or nebulised administration route, where is that recorded?

A6 – As the nebulised route is neither the enteral nor parenteral, the administration route chosen should be 'other'.

Q7 – If a systemic antimicrobial is given as a vaginal pessary or PV route, where is that recorded?

A7 – For PV/vaginal pessary antimicrobials, the administration route chosen should be 'other'.

Q8 – A long-term resident is on treatment for tuberculosis (TB). Can that be regarded as a healthcare-associated infection?

A8 – In the majority of cases, the diagnosis of TB arises as a result of reactivation of a latent/old TB infection, which may have been originally acquired many years ago. Residents who are treated for TB are usually prescribed three or four different antimicrobials. Each of the different TB antimicrobials may be recorded on page 2 of the resident questionnaire, with the answer to the question 'antimicrobial given for' as 'Tuberculosis'.

As the vast majority of TB infections result from reactivation of an old TB infection, it would be less common for TB infection to be a healthcare-associated infection. As TB is a notifiable infectious disease, the relevant Department of Public Health would be involved in the management and investigation in the event that a resident is diagnosed with TB.

Q9 – On the HALT survey date, we know that a specimen was recently taken from a resident and sent to the microbiology laboratory and we have already received a verbal/telephoned result or an electronic result for that microbiology report. We don't have the final written report on the HALT survey date. Can we use the information provided over the telephone or via the electronic report?

A9 – Yes. If you have already received and recorded the preliminary verbal information from the microbiology laboratory, this will suffice.

Q10 – On the HALT survey date, a resident has developed new signs and symptoms suggestive of a respiratory tract infection and awaits review by the doctor. If the resident's signs and symptoms meet the criteria for a confirmed other lower respiratory tract HCAI, can I record that infection before the resident has been reviewed by the doctor?

A10 – Yes. You are applying HCAI surveillance definitions to the resident. Definitions for HCAI surveillance and clinical judgement are not the same thing.

Q11 – What happens if the doctor comes along later in the day and diagnoses an infection type that differs from the HCAI definition I have applied to the resident?

A11 - For example, you may have decided that the resident meets a HCAI confirmed definition for an 'other lower respiratory tract infection'. If the doctor reviews the resident later that day and decides upon performing otoscopy that the resident has a middle ear infection, that is entirely appropriate.

We must remember that for HALT, the clinical impression and the HCAI surveillance definition are two different things. You should not go back later on that day, after the GP has reviewed the resident and alter the original definition you applied on the resident questionnaire. You applied the HCAI definition based on the information that was available to you at the time of the HALT survey because HALT is a snapshot/prevalence survey. You

should not go back later on, when more information becomes available and retrospectively change your original decision.

Q12 - In the resident questionnaire, page 3 - urinary tract infection (UTI) algorithm – resident without a catheter, underneath signs and symptoms, for the first option '① Acute dysuria OR acute pain/swelling or tenderness of the testes, epididymis, or prostate' – Does this definition just refer to male residents?

A12 - No. The first part of the option ① 'acute dysuria' can apply to both male and female residents. The second part of the option ① 'acute pain/swelling or tenderness of the testes, epididymis or prostate' applies to male residents only.

Q13 - A resident has signs and symptoms of infection at the site of a surgical wound/site. How do I decide if that infection is a hospital-acquired or an infection acquired in a long-term care facility?

A13 – Firstly, remember that the HALT protocol defines a surgical wound as an incision which was then closed. To make the decision as to whether the suspected surgical wound infection is an infection acquired in a long-term care facility or a hospital-acquired infection, you need to know the following information:

A) The date that the surgery was performed
B) The date that the signs and symptoms of surgical wound infection developed
C) The type of surgical procedure and whether or not it involved the insertion of an implant (e.g., prosthetic hip, prosthetic knee, metal or plate following fracture, pacemaker, prosthetic cardiac valve etc.)

<u>Surgery did not involve insertion of an implant:</u>

Any signs or symptoms of suspected surgical site infection that start within 30 days of the date of the surgical procedure are regarded as hospital-acquired infection and you will answer 'Hospital' for the question 'Origin of Infection'.

Any signs or symptoms of suspected surgical site infection that start more than 30 days after the date of the surgical procedure are regarded as acquired in the long-term care facility and you will answer 'Current LTCF' for the question 'Origin of Infection'.

<u>Surgery involved insertion of an implant:</u>

Any signs or symptoms of suspected deep or organ space surgical site infection that start within 90 days/three months of the date of the surgical procedure are regarded as hospital-acquired infection and you will answer 'Hospital' for the question 'Origin of Infection'.

Any signs or symptoms of suspected infection of the surgical site that start after 90 days/three months of the date of the surgical procedure are regarded as acquired in the

long-term care facility and you will answer 'Current LTCF' for the question 'Origin of Infection'.

Q14 – A resident meets the HCAI case definition 'Infection Confirmed' for two separate HCAI, but they are both within the same body site. Should I code the resident as having two different HCAI?

A14 – Where you have two confirmed HCAI in the same body site, it is recommended that you code one infection only, choosing the more severe/potentially more significant infection. For example, a resident meeting the case definition for both gastroenteritis and *Clostridium difficile* infection should be coded as confirmed *Clostridium difficile* infection. A resident meeting the case definition for both common cold/pharyngitis and flu should be coded as flu.

Where a resident meets the HCAI case definition for two separate HCAI at different body sites, you should code both infections in part B of the resident questionnaire. For example, a resident may be coded as having both a UTI and a respiratory tract infection simultaneously, provided all the criteria to define each infection are met.

Q15 – A resident is attending haemodialysis and is receiving vancomycin at the dialysis unit three times per week, for the treatment of a suspected dialysis catheter infection. If the HALT survey is done on Tuesday and the resident's vancomycin is scheduled to be administered Monday, Wednesday and Saturday, would that resident be regarded as being prescribed a systemic antimicrobial?

A15 – Yes. Even though the resident is not scheduled to receive a dose of the antimicrobial on the HALT survey date, he/she is still on a prescribed course of treatment which is ongoing and the vancomycin should be recorded as a prescribed antimicrobial on page 2 of the resident questionnaire.

Q16 – A resident is prescribed nystatin oral suspension or pastilles for treatment of oral candidiasis, can I include this prescription?

A16 – Yes, you can record this prescription as 'Nystatin', 'oral' administration route, 'therapeutic' for indication 'eye/ear/nose/mouth'.

Q17 – A resident is known to have had a positive microbiology laboratory result for an antimicrobial resistant organism (e.g., MRSA groin swab, VRE in urine or ESBL *E. coli* in leg ulcer swab), will I record them as having a HCAI?

A17 – The resident will only be recorded as having a HCAI if the resident meets all of the criteria for the HCAI in question – you can decide this by working your way along the HCAI case definition algorithms on pages 3 – 8 of the resident questionnaire. If the HCAI criteria are confirmed, you will record the microbiology result related to that infection. Known

colonisation with an antimicrobial resistant organism does not necessarily mean the resident has an infection caused by that organism.