L.D. 267

Date: (Filing No. H-)

HEALTH AND HUMAN SERVICES

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STATE OF MAINE

HOUSE OF REPRESENTATIVES

125TH LEGISLATURE

FIRST REGULAR SESSION

COMMITTEE AMENDMENT " " to H.P. 220, L.D. 267, Bill, "An Act To Strengthen the Laws on Methicillin-resistant Staphylococcus Aureus and To Improve Health Care"

Amend the bill by striking out everything after the enacting clause and before the summary and inserting the following:

'**PART A**

Sec. A-1. 22 MRSA §§8762, 8763 and 8764 are enacted to read:

§8762. Definitions

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings.

1. Colonized. "Colonized" means carrying MRSA but not infected with MRSA.

2. Decolonization. "Decolonization" means the process of following a prescribed medical regime that includes nasal topical antibiotics and antibiotic soap bathing for up to 5 days prior to a high-risk medical or surgical procedure or hospital admission.

3. High-risk patient. "High-risk patient" means a patient who is very likely to be colonized or become infected with MRSA because of the patient's medical or social history or because of the medical problems or surgical procedure for which the patient is hospitalized.

4. Infected with MRSA. "Infected with MRSA" means actively infected, with clinical symptoms and diagnostic tests to confirm the infection.

5. MRSA. "MRSA" means methicillin-resistant Staphylococcus aureus.

6. Nosocomial. "Nosocomial" means, of an infection, first appearing 48 hours or more after hospital admission or within 30 days after discharge.

7. Screening. "Screening" means taking a nasal culture unless otherwise medically indicated.

§8763. MRSA screening and control measures

A hospital or a nursing or intermediate care facility or unit licensed under chapter 405 shall perform screening for MRSA and shall perform control measures in accordance with this section.

1. Hospital screening. A hospital shall screen high-risk patients for MRSA upon admission, on transfer into intensive care units from other units within the hospital and up to 3 weeks prior to elective admission, allowing time for decolonization if prescribed. Factors indicating that a patient is a high-risk patient who must be screened include:

A. Admission of the patient directly from a different hospital, nursing facility or rehabilitation hospital or facility or admission within a year of discharge from a hospital, nursing facility or rehabilitation hospital or facility;

B. Admission of the patient from a correctional facility;

C. Admission of the patient to an intensive care department of the hospital or transfer from within a hospital into an intensive care unit;

D. That the patient receives renal dialysis treatment;

E. That the patient has an open lesion that is moist, with redness and swelling, in which case screening is required, including screening of the nose and the lesion;

F. That the patient has had in the past or is admitted to have surgical implantation of any medical device or hardware;

G. That the patient is from a geographic area with a local epidemic of MRSA;

H. That the patient is admitted in order to have a medical or surgical procedure or is admitted into a hospital department within the hospital that has been identified with the occurrence of MRSA infection in the previous month; and

I. That the patient has tested positive for MRSA in the past.

2. Nursing or intermediate care facility screening. A nursing or intermediate care facility or unit shall screen all patients for MRSA upon admission.

3. Controlling the spread of MRSA. A hospital or nursing or intermediate care facility, when admitting or providing care or treatment for a patient known to have tested positive for MRSA upon admission or in the preceding 12 months, shall:

A. Place the patient in a private room or place the patient in a room only with another patient who has tested positive for MRSA, except that a patient who has tested positive for MRSA and who also has another infection must be placed in a private room; and

B. Use contact precautions as described by the Maine Center for Disease Control and Prevention, including but not limited to practicing hand hygiene before and after contact with the patient, using gloves and gowns and, if the identified MRSA infection is respiratory, using masks.

§8764. Public reporting of nosocomial infections

Beginning January 1, 2012, a hospital shall report nosocomial MRSA, methicillin-sensitive Staphylococcus aureus, Clostridium difficile and vancomycin-resistant Enterococcus infections of its patients to the Maine Center for Disease Control and Prevention, referred to in this section as "the center," as provided in this section.

1. Reporting. A hospital shall report all nosocomial MRSA, methicillin-sensitive Staphylococcus aureus, Clostridium difficile and vancomycin-resistant Enterococcus infections to the center using the surveillance system designed and operated by the United States Department of Health and Human Services, Centers for Disease Control and Prevention National Healthcare Safety Network on a yearly basis.

2. Information from the center. The center shall collect the information reported under this section; organize the information by hospital, organism, diagnosis and medical or surgical procedure; protect the confidentiality of patients and health care practitioners; and make the information available without charge to the public, easily accessible and available in a format that is easily understood by the general public.

3. Information from hospitals. A hospital shall make the information reported under this section available to the public upon request and shall provide additional information regarding the reported nosocomial infections as long as information designated by law or rule as confidential is appropriately protected from disclosure.

PART B

Sec. B-1. 22 MRSA §§1711-G and 1711-H are enacted to read:

§1711-G. Patient's right to personal advocacy in a hospital

A patient admitted to a hospital licensed under chapter 405 has the right to a patient advocate, as chosen by the patient and at the discretion of the patient, to stay at the side of the patient at all times within the hospital including during procedures, examinations, consultations and any interactions that may affect the patient's medical or surgical outcome, except as provided in this section, and to assist the patient in health care decisions and to monitor and help with the patient's care. The hospital may limit the right to personal advocacy in sterile areas and if the presence of an advocate poses a risk to the patient. A patient may designate more than one person to act as the patient's advocate. If the presence of a patient advocate is denied, a member of the hospital staff shall state in writing the reason for the denial and provide a copy to the patient and the patient's advocate.

§1711-H. Patient's right to personal advocacy in a nonhospital setting

A patient in a nonhospital health care setting governed by this chapter has the right to a patient advocate, as chosen by the patient and at the discretion of the patient, to stay at the side of the patient at all times including during procedures, examinations, consultations and any interactions that may affect the patient's medical or surgical outcome, except as provided in this section, and to assist in health care decisions made with the patient. The nonhospital health care setting may limit the right to personal

advocacy in sterile areas and if the presence of an advocate poses a risk to the patient. A patient may designate more than one person to act as the patient's advocate. If the presence of a patient advocate is denied, a member of the staff at the nonhospital health care setting shall state in writing the reason for the denial and provide a copy to the patient and the patient's advocate.'

SUMMARY

This amendment is the minority report of the committee. The amendment adds mandatory screening for methicillin-resistant Staphylococcus aureus on transfer into an intensive care unit in a hospital and screening up to 3 weeks prior to elective admission. It requires screening of certain lesions. It requires screening of patients admitted for surgical implantation of any medical device or hardware and of patients who have had those procedures in the past. It qualifies the authority of a patient advocate, making it dependent on the discretion of the patient. It makes other changes in the proposed law on patient advocates.