

Required Annual Provider Education
Infection Prevention & Control

I. Handwashing Essentials

- A. Entry into and immediately before leaving patient's room.
- B. Before invasive procedure.
- C. When moving from a dirty area to a clean one on the same patient (i.e.: dressing changes or multiple wounds).
- D. Before gloving and after removing gloves- (a "hot spot" for surveyors).
- E. After contact with blood/body fluids.
- F. Alcohol gel/foam can be used as long as the hands are not visibly contaminated or as long as the patient being cared for does not have *Clostridium difficile*, (alcohol-containing product is not as effective, and hands should be washed with soap and water).
- G. If staff see you approaching a patient without sanitizing your hands, they are tasked with reminding you by heading toward the hand gel dispenser while saying "Let's all gel up".
- H. We do quarterly hand hygiene audits, and hope to be able to provide more provider data. Traditionally provider compliance has been lower than others have, but the sample sizes have been small.

II. Isolation Precautions

- A. **Contact Precautions** – Gown and gloves upon room entry; mask if pathogen is in respiratory tract. Ex: MRSA pneumonia and patient is actively coughing. Mask if pathogen can be transmitted via aerosolization. Ex: Norovirus with vomiting.
- B. **Contact Plus Precautions**—Gown and gloves upon room entry. For *C-diff*, candida auris Shoe covers if floors are contaminated. Room will be cleaned with bleach which is effective on spores.
- C. **Droplet Precautions** – Require mask when within three feet of patient. Ex: influenza, meningitis.
- D. **Airborne Precautions** – Respirator (PAPR or CAPR) or N95/P100 or equivalent, required. Ex: TB, chicken pox, measles, disseminated shingles, SARS-Cov-2.

III. Multi-Drug Resistant Organism Precautions

- A. The following are Multi-Drug Resistant Organisms (MDRO).
 - 1. **MRSA** – Staphylococcus aureus resistant to Oxacillin.
 - 2. **VISA/VRSA** – Staphylococcus aureus showing intermediate sensitivity or resistance to Vancomycin
 - 3. **VRE**- Enterococcus faecium or Enterococcus faecalis that is resistant to Vancomycin.
 - 4. **DRSP** -Strep pneumo resistant to Penicillins and cephalosporin's
 - 5. **Gram negative organisms** - Intermediate or Resistant to Amikacin, Gentamicin and Tobramycin.
 - 6. Any organism, Resistant or Intermediate, to all antibiotics being reported out.

7. **Extended spectrum beta lactamase producing organisms (ESBLs).** These are members of the Enterobacteriaceae class that show intermediate sensitivity or resistance to 3rd generation cephalosporins (ceftriaxone, cefotaxime, ceftazidime).
 8. **Klebsiella pneumo** Intermediate or resistant to Imipenem.
 9. **Carbapenem Resistant Enterobacteriaceae (CRE) and Klebsiella pneumo resistant to Carbapenems (KPC).**
- B. Patients found to be actively infected or colonized with any of these organisms will be placed in **Contact Isolation** on the admission then tagged for isolation with future admissions.
- C. Isolation rooms of patients infected or colonized with MDROs will harbor the MDRO on surfaces and equipment throughout the patient's room. Strictly adhere to Contact Isolation Precautions and don gown and gloves before entering the patient's room regardless of whether or not any patient contact will be made. Many MDROs have the ability to live on surfaces: a. MRSA - 7 days to > 12 months.
- b. VRE - 5 days to > 46 months.
 - c. Clostridium difficile (spores) - > 5 months.
 - d. Pseudomonas – 6 hours to 16 months.
 - e. Klebsiella – 2 hours to > 30 months.
- D. Once culture and sensitivity reports are received, re-evaluate antibiotic choice and use. Discontinue/change antibiotics if prudent to reduce the potential development of antibiotic resistance. Pharmacy is very active in this process.

IV. Clostridium Difficile (C. diff.)

- A. Carried asymptotically by 3% of adults, and 20-30% of hospitalized patients will become infected.
- B. These bacteria produce spores, which require special precautions as follows:
 1. Patients who have C. diff. infection are placed into Contact Plus Isolation until 48 hours after last loose stool. If a patient is admitted for suspicion of c-diff, precautions will be maintained until result is known, or if no stool in 24 hours, precautions can be discontinued.
 2. All hand hygiene should be done with soap and water, as alcohol products are not as effective for removal of spores from hands.
 3. Use disinfectant wipes with bleach to disinfect common provider equipment after caring for C. diff. infected patients.

V. Surgical Site Infections (SSI)

**Please notify Infection Prevention is you suspect a patient has an SSI. IP will investigate.*

- A. Use antibiotics preoperatively when indicated for patients in accordance with SCIP and literature (SHEA/CDC/IDSA) recommendations.
- B. When prophylaxing patients, it is important to keep the following in mind:
 1. Antibiotics need to be dosed by weight to ensure adequate tissue levels to afford protective effects.
 2. **Surgeries > 3 hours** in duration may need re-dosing to ensure adequate antimicrobial levels throughout the duration of the surgery.
 3. Begin antibiotic infusion prior to the incision, but within 60 minutes of incision.
 4. The antibiotic should not be continued past **24 hours** in most cases.
- C. All surgical patients should receive a chlorhexidine shower or cloths prior to surgery.

- D. **Diabetic patients** should have glucose levels monitored so that they ideally do not exceed 200mg/dL in the 24-hour period prior to surgery and for 48 hours after surgery.
- E. All surgical personnel should don fresh scrubs at the beginning of the day and when coming back into the hospital building from the outside during the course of the day.
- F. All surgical hats/caps should cover all of the wearer's hair and ears/beard.
- G. Surgical hand antisepsis should be done in strict accordance with the manufacturer's guidelines.
- H. Appropriate hair removal (no razors).
- I. **ChloroPrep is the preferred prep.** Betadine is inactivated in the presence of blood and proteins.
- J. It is an FDA requirement to let any skin prep containing alcohol to dry for 3 minutes to eliminate fire risk, ensure surgical drape adherence, and allow for maximum microbial killing.
- K. Avoid bringing items from other areas inside the restricted area that are not crucial for the procedure being done (lab coats, briefcases, etc.). If cell phones are necessary, they must be wiped upon entry to the OR.
- L. Minimize traffic flow and keep the OR doors closed as much as possible during the surgery.

VI. Catheter Associated Urinary Tract Infection(CAUTI)

- A. Urinary catheters should only be inserted for reasons based on medical necessity. Rationale should be documented – reasons are as follows:
 - 1. Patient has acute urinary retention or bladder obstruction.
 - 2. Accurate measurement of urinary output is needed for critically ill patient.
 - 3. Perioperative use for select surgical procedures.
 - 4. To allow for healing of open sacral or perineal wound in incontinent patient.
 - 5. Comfort care for end of life.
 - 6. Patient will have prolonged period of immobility.
- B. Inappropriate reasons for urinary catheters include:
 - 1. For nursing staff convenience when caring for incontinent patient or patient with difficult mobility.
 - 2. To obtain urine for testing when patient is continent (most cases).
 - 3. For a prolonged period postoperatively, unless the surgery involved structural repair of urethra or contiguous structures; prolonged effects of epidural anesthesia.
- C. Consider alternatives to insertion of indwelling catheter when possible:
 - 1. Use of external catheter in male patient.
 - 2. Intermittent catheterization, bladder scanning.
 - 3. Attends - which can be weighed to obtain accurate output.
- D. All indwelling catheters should be assessed for medical necessity and necessity documented daily. Remove catheter promptly when no longer needed. The risk for CAUTI increases approximately 3-7% each day of catheter use.

VII. Catheter Associated Bloodstream Infection (CLABSI)

***Thank you for all you have done to make 2021 safe by minimizing infections in patients. You have helped make our campaign to reduce catheter-associated infections successful. As of September 30th, Tomah Health was at **2,141** days without a CA-UTI on Acute Care! Our utilization ratio is well below the national average for an acute care unit.

- A. TOMAH HEALTH Central Line Insertion best practice guidelines, shown to reduce CLABSIs, include adherence to the following:
1. **Hand hygiene** before donning sterile gloves.
 2. **Avoid use of femoral vein** for non-tunneled catheters. Any use of the femoral vein requires valid medical reasons documented on the checklist.
 3. **Use of chlorhexidine** containing solution for skin antisepsis unless working with an infant < 2 months of age.
 4. Daily review and documentation of medical necessity of central line, with prompt removal when no longer needed.
 5. Replacement of line ASAP when inserted in an emergent situation where sterility could have been compromised.
 6. Sterile gloves, gown, mask and cap to be worn at time of insertion/patient to be masked.
 7. A checklist for all central line insertions is required to be completed at time of insertion to ensure that insertions are performed in accordance with best practice guidelines. The only exception are central lines placed in the OR, which do not require a separate checklist to be completed as long as the OR documentation for the patient specifies that there was compliance with each item on the central line checklist. If this is not evident in the OR documentation, then a central line checklist needs to be completed.

VIII. Antimicrobial Stewardship

- A. Increasing use of antibiotics has led to the development of multidrug resistant organisms (MDROs). Studies of antimicrobial use have found that up to 50% may be inappropriate (includes wrong dose or duration). The CDC's campaign "Get Smart about Antibiotics" raises awareness to this issue. B.

Consider the following scenarios:

1. **S**hortest Course Necessary
 2. **M**ost appropriate dose for the patient's condition
 3. **A**void treating syndromes not caused by infections (i.e. viral)
 4. **R**estrict therapy to the narrowest spectrum to cover the infection
 5. **T**reat true infection, not colonization
- C. Cold Care Kits and Sinus Kits are available to give to outpatients to support, "While we can't give you an antibiotic, we can help you manage your symptoms" discussions.
- D. Patient handouts are available from the CDC to assist you in educating patients.
- E. We plan to look at individual prescribing habits and give you your results.

While we have always had a very good informal antibiotic stewardship program for inpatients due to our small size and interactions with pharmacy, we working on a more formal program as TJC and CDC require. Progress has not been as fast as we would like since we don't "own" our EPIC, but as per all national guidelines we will be looking to add an indication when antibiotics are ordered, and a formal review of necessity after a few days. We hope to expand to outpatient prescribing as well.

IX. Influenza Prevention

- A. Influenza vaccination offered annually **for all healthcare workers**, regardless of direct patient contact or not.
- B. Disinfect stethoscopes after each use with alcohol swab or disinfectant wipe. Disinfect any other personal equipment used with disinfectant wipe. Large size alcohol wipes are available at most bedsides.
- C. Place a mask on anyone suspicious of flu-like illness when in common areas with others or move the patient to a private location or separate from other people by three or more feet.

D. Encourage everyone to practice respiratory hygiene – coughs and sneezes should be done in the sleeve, if possible. If hands become contaminated in the process, they should be cleaned with alcohol gel/foam or soap and water.

X. Practice reminders

- A. Instruments can no longer be rinsed in a sink that is used for hand washing. This new directive from TJC has had many clinics struggling as that had been the practice for many years. Please do not place instruments in the sink if that has been your practice. Staff will wipe them of any debris in the room, place in a rigid container and take to the soiled utility room for rinsing. They will be treated with a foam to prevent drying and transported to CS for reprocessing.
- B. Please note that if you are ordering a GI panel on an inpatient, contact precautions will be in place until results come back.
- C. Please remember to wear eyewear to protect yourself!

THANK YOU
