INFECTION PREVENTION

- Perform hand hygiene before entering the room and after leaving the room, before patient contact, before aseptic task, after body fluid exposure, after patient contact, and after contact with the patient surroundings.
- Remember F.R.O.G. – Friction Rubs out Germs!
- Wash your hands with soap & water (scrub for a least 15 seconds, but preferably 30 to 60 seconds) when they are visibly soiled, before eating, after using the restroom, and after exiting a contact isolation room.
- Use an alcohol-based hand rub in all other recommended situations when hands are not visibly soiled. When using alcohol hand sanitizer, apply and rub until all surfaces of hands are dry, 20 to 30 seconds.
- Gloves are not a substitute for hand hygiene. Hand Hygiene must be performed after the removal of gloves.
- Artificial fingernail enhancements are not permitted for Patient Care Staff and Patient Support Staff.
- For any Infection Prevention and Control questions or concerns, please call extension 9134.

Multi-Drug Resistent Organisms (MDRO)

- **MRSA** - methicillin/oxacillin-resistant Staphylococcus aureus
- **VRE** - vancomycin-resistant Enterococci
- **ESBLs** - extended-spectrum beta-lactamases (which are resistant to cephalosporins and monobactams)
- **VISA** – vancomycin intermediate Staph aureus,
- **VRSA -** vancomycin resistant Staph aureus,
- **CRE** – carbapenem resistant Enterobacteriaceae
- **Multi-drug resistant (MDRO)** Enterobacter cloacae, Enterobacter aerogenes, Pseudomonas species and Acinetobacter species

A patient's current and past history of multi-drug resistant organisms (MDRO) is located in the patient header in Epic. Please inform your patient if they have an MDRO.

The decision to discontinue contact precautions for MDRO(s) will be made by the Chairperson of Infection Control, Epidemiology and Prevention (ICEP).

- For VRE – 3 negative stool, rectal or perirectal swabs collected one or more weeks apart under the direction of the Chairperson of ICEP is required.
- For ESBL, CRE and MDRO Enterobacter cloacae, Enterobacter aerogenes, Pseudomonas species and Acinetobacter species, the tag in the hospital computer will be discontinued after 12 months from the original culture date if the organism has not been subsequently cultured from any other body site. No screening cultures will be performed.
- Further consideration to discontinue contact precautions can be made by the Chairperson of ICEP in consultation with the Infection Preventionist.

Clostridium difficile:

The operational definition of C-difficile (CDI) associated diarrhea is loose or watery stools with recent antibiotic history in the past 60 days.

- The Lab will reflex all positive or indeterminate PCR C. difficile tests to a C. difficile toxins A&B by Enzyme Immunoassay (EIA) test.
- A positive PCR and a positive C. difficile toxins A &/or B EIA → treat with oral vancomycin per IDSA guidelines and DLP Conemaugh recommendations for empiric treatment of infections.
- A positive PCR and a negative C. difficile toxins A&B EIA → clinicians should use their judgement for treatment decisions, as patients with diarrhea for > 24 hours without laxative use may still be experiencing mild C. difficile infection.
- A CDI risk score is calculated in Epic for every inpatient based upon known risk factors.
- A Best Practice Advisory (BPA) will fire to nursing if your patient has a risk score of 4 or greater and documented Bristol score of 6 or 7. The nurse may order a C. diff test from the BPA.
- Multiple tests are unnecessary and not required. If the provider chooses to reorder the test, he/she will have to wait 7 days after the initial test if it was negative, and 14 days if the initial test was positive.
- If the nurse calls and asks to send a C. diff specimen, please ask if the patient has had recent antibiotic or laxative use.
- To facilitate early identification of community onset C. diff and prompt isolation to prevent transmission, the admitted patient from the ER, ASU post-surgery and a direct admission will be screened on admission for CDI and a stool is sent for testing if the screen is positive.
- Lab testing has been increased to twice a day batches to accommodate early identification. C. diff patients will remain in contact isolation for the duration of their encounter.

<u>Central Line Associated Bloodstream Infections</u>

- Use a catheter checklist and a standardized protocol for central venous catheter insertion.
- Please request a staff RN to attend Central Venous Prssure (CVP) line placement to conduct a time out prior to insertion and to follow responsibilities for central line assistance.
- Perform hand hygiene prior to catheter insertion or manipulation.
- Do not insert catheters into the femoral vein unless other sites are unavailable. If the femoral vein is used, indicate the rationale in your central venous catheter insertion procedure note.
- Use a standardized protocol for sterile barrier precautions during central venous catheter insertion.
- Use an antiseptic for skin preparation during central venous catheter insertion. (ChloraPrep – follow the dry time per manufacturer instructions).
- Epic template with smart text is available for provider documentation for central line insertion and includes: informed consent, indication, type, insertion for line, number of attempts, insert over guide wire, use of ultrasound, use of central line checklist and standard protocol followed (cap, gown, mask, gloves and sterile drape) prep procedure site with ChloraPrep per manufacturer instructions, and post procedure x-ray.
- Use a standardized protocol to disinfect catheter hubs and injection ports before accessing the ports.
- Patients with central venous catheters, including Peripherally Inserted Central Catheter (PICC), will receive a daily bath with chlorhexidine gluconate (CHG).
- Evaluate all central venous catheters routinely and remove nonessential catheters. Insert mid-line or PICC when possible. (When placing a PICC line, the provider will get a consent signed

from the patient and/or significant other as appropriate. If the provider that will be inserting the PICC line is a RN, the attending / ordering physician must get the consent signed for the procedure from the patient and or significant other as appropriate.)

- BPA will fire if the central line may have been placed in less than ideal conditions; it must be removed or replaced within 48 hours. If removed, document in procedure note. If unable to remove, document reason in progress note.
- BPA will fire if the patient has an active femoral central line in place for greater than 24 hours. Change the line and document in procedure note or indicate reason for not changing and document in progress note.

Preventing Surgical Site Infection (SSI)

The likelihood of developing an SSI depends on patient related factors and procedure related factors. Patient related factors that can be modified includes: glucose control and encouraging smoking cessation 30 days prior to surgery. Procedure related factors that could be controlled: hair removal if indicated immediately before surgery using electric clippers, appropriate use of antiseptic agent for surgical scrub, appropriate antiseptic agent for skin preparation, and administration of antimicrobial prophylaxis which includes appropriate timing, choice, and duration of therapy.

Urinary Tract Infections

The daily risk of acquisition of bacteriuria varies from 3% to 7% when an indwelling urinary catheter remains in place. When a urinary catheter is in place, a daily discussion between the nurse and the provider is required. Does the patient meet criteria for continued use of the urinary catheter? A urinary catheter can be ordered by the provided with the inclusion of the nurse driven protocol for catheter removal. If the order for the nurse driven protocol for removal is in place, the RN can assess the patient and remove the catheter when the patient meets criteria, without any additional discontinuation orders from the physician. Limit use and duration of catheters to situations necessary for patient care. Use aseptic techniques for equipment, supplies, site preparation, insertion, daily care, and maintenance. Consider alternatives to urinary catheters when the patient is able to void on their own. Purewick women's and men's alternative are available for use. Both products offer accurate Input and Output (I&O) and keep the patient dry and comfortable.

Ventilator Associated Event (VAE)

Key components of the ventilator bundle: elevate the head of bed; daily sedation vacations and assessment of readiness to extubate; peptic ulcer disease prophylaxis; venous thromboembolism (VTE) prophylaxis, and daily oral care with chlorhexidine. Endotracheal tubes for the removal of subglottic secretions are standard in the Emergency Room, Critical Care and on crash carts.

Isolation Precautions

- All physicians are required to follow isolation precautions and wear appropriate personal protective equipment. Example: Gown and gloves to enter a Contact Isolation room.
- The isolation sign will tell you what you need to wear and what type of hand hygiene is required.

- Each isolation cart has a dedicated BP cuff, thermometer and stethoscope for you to use.
- All equipment used on any patient, including your own stethoscope, must be cleaned after use with a disinfectant wipe regardless of isolation precautions.

Example: Contact and VZV precautions = bleach wipe.
Droplet, Airborne, and AFB = hydrogen peroxide wipe.
Non Isolation Patient = hydrogen peroxide wipe.

- Remove all personal protective equipment upon exit of the patient room. Perform hand hygiene with alcohol hand rub or soap and water.
- Contact Isolation – When exiting the room use alcohol hand rub then immediately go to a sink and hand wash with soap and water for 20 seconds.
- Limit the number of individuals entering an isolation room on teaching rounds.

<u>Donning and Doffing of Personal Protective Equipment (PPE)</u>

- **Order for donning PPE**
  1. Preform hand hygiene
  2. Gown
  3. Mask or Respirator
  4. Goggles or face shield
  5. Gloves

- **Order for Removal of PPE**
  1. Gloves
  2. Goggles or face shield
  3. Gown
  4. Mask or respirator
  5. Preform hand hygiene

Safe work practices

- Keep hands away from face
- Work from clean to dirty
- Limit surfaces touched
- Change when torn or heavily contaminated
- Preform hand hygiene

<u>Bloodborne Pathogen</u>

- Hepatitis B, C and HIV are pathogens of concern for transmission of a bloodborne pathogen. Always put infectious waste directly into infectious waste containers - each container is lined with a bag that is red in color and labeled with a biohazard symbol. If in doubt, place in infectious waste.
- The Bloodborne Pathogen Exposure Control plan is located in PolicyStat in Infection Prevention.
- Three step procedure to clean a blood or body fluid spill. Wear personal protective equipment (PPE)
  1. Wipe up gross organic material with a paper towel.

2. Clean the area contaminated by the spill with a bleach wipe.
3. Decontaminated with a bleach wipe.

- PPE includes: gloves, gown, mask, eye protection and face shields.
- Standard Precautions needs to be used by all health care workers (HCW) with all patients. If a HCW comes in contact with blood, body fluids, non-intact skin or mucus membranes they must follow Standard Precautions and wear personal protective equipment.
- All sharps, broken or unbroken glass that has come in contact with infectious agents, and Luer-Lok syringes, with or without needles, are to be disposed of immediately after use in a sharps container.