



Physician Infection Prevention and Control Education

- I. **Exposures to blood/body fluids or sharp object injury**-Notify the supervisor of that area immediately to get the paperwork for labs on employee and patient. Supervisor can notify the infection prevention office where all follow-up lab work will be handled.
When the exposure occurs, the employee should initiate immediate treatment by:
 - A. Cleaning the wound/skin area with soap and water.
 - B. Flushing mucous membranes with tap water or saline.
 - C. Serious injuries requiring suturing or other physician intervention should be promptly evaluated and reported to the Employee Health Nurse to initiate a report for Workers Compensation.

- II. **Antibiogram**-Located on **TJ Intranet**-under forms-then antibiogram (inpatient and outpatient)

- III. **Hand washing Essentials**
 - A. **Entry** into and Immediately upon **leaving** patient's room
 - B. Before invasive procedure
 - C. When moving from a dirty to a clean task on the same patient.
 - D. Before gloving and after removing gloves
 - E. After contact with blood/ body fluids
 - F. Alcohol gel/ foam can be used as long as the hand are not visibly contaminated or as long as the patient being cared for does not have Clostridium difficile, (alcohol containing product is not effective, hands must be washed with soap and water.)

- IV. **Isolation Precautions**
 - A. **Contact Precautions- Gown and gloves** upon room entry, mask if pathogen is in respiratory tract. i.e. MRSA, Clostridium difficile, VRE
 - B. **Droplet Precautions**- Requires gown, gloves and **mask** upon room entry.
 - C. **Airborne Precautions- N-95 mask or PAPR** required. Gown and gloves = Standard precautions i.e. TB, chicken pox, disseminated shingles, novel flu virus.

- V. **Multidrug Resistant Organism Precautions**
 - A. the following are **multidrug resistant organisms (MDRO)**:
 - **MRSA**- Staphylococcus aureus resistant to oxacillin
 - **VRE**- This is Enterococcus faecium or Enterococcus faecalis that is resistant to Vancomycin.

- **Acinetobacter baumannii.** It can be an opportunistic pathogen in humans, is inherently resistant, and occurs rarely outside the hospital setting.
 - **ESBL-** Extended Spectrum Beta Lactamases; It is bacteria that produce enzymes which are able to resist extended-spectrum (third generation) cephalosporin's.
 - **CRE-**Carbapenem-Resistant Enterobacteriaceae are nonsusceptible (i.e., intermediate or resistant) to a carbapenem.
 - **Any organism that shows resistance to all antibiotics that are tested.**
- B. Patients found to be actively infected or colonized with any of these organisms will be placed into contact isolation on the current admission and then tagged for isolation on future admissions.
- The isolation rooms of patients infected or colonized with MDROs harbor the MDRO on surfaces and equipment throughout the patient's room. **Reminder: 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.**
- C. All patients directly admitted to the ICU, repeat admissions (within 30 days), verbalized history, surgery with an implant, patient from another institution will be tested for nasal colonization by MRSA upon admission and placed into contact precautions until ruled out.

VI. Clostridium difficile infection (CDI)

- A. CDI responsible for only ~ 30-40% of hospital-onset diarrhea.
- B. However, CDI more likely among patients with ≥ 3 unformed stools within 24 hours.
- C. These bacteria produce spores, which require special precautions as follows:
- Patients who have Clostridium difficile infection should be placed into contact isolation until free of diarrhea for ≥ 48 hours.
 - All hand hygiene must be done with soap and water, as alcohol containing products are ineffective against removal of spores from hands.

VII. Central Line Associated Bloodstream Infection (CLABSI)

- A. Central Line Insertion best practice guidelines, shown to reduce CLABSIs, include adherence to the following:
- Hand hygiene before donning sterile gloves
 - Avoid use of femoral vein for non tunneled catheters.
 - Use of chlorhexidine containing solution for skin antisepsis unless working with an infant < 2 months of age.
 - Daily review of medical necessity of central line, with prompt removal when no longer needed.
 - Replacement of line ASAP when inserted in an emergent situation where sterility could have been compromised.

A checklist for all central line insertions is required to be completed, by the nursing staff, at time of insertion to ensure that insertions are performed in accordance with best practice guidelines.

VIII. Catheter Associated Urinary Tract Infection

- A. Urinary catheters should only be inserted for indications based on medical necessity. Indications are as follows:
- Patient has acute urinary retention or bladder obstruction.
 - Patient with neurogenic bladder.
 - Accurate measurement of urinary output.
 - Preoperative use for select surgical procedures
 - To allow for healing of open sacral or perineal wound in incontinent patient.
 - Patient will have prolonged period of immobility due to trauma.
 - Comfort care for end of life.
- B. Inappropriate reasons for urinary catheters include:
- For nursing staff convenience when caring for incontinent patient.
 - To obtain urine for testing when patient is capable of voiding.
 - For a prolonged period postoperatively, unless the surgery involved structural repair of urethra or contiguous structures, prolonged effects of epidural anesthesia.
 - Patient request when patient is capable of voiding
- C. All indwelling catheters should be assessed for medical necessity at least once per day. Remove catheter promptly when no longer needed. The risk for catheter associated urinary tract infections increases 5% for each day the urinary catheter remains in place.
- D. Surgical patients should have their urinary catheter removed by the second post-op day (day of surgery being zero) unless an indication for the catheter is documented in the orders or progress notes.

IX. Ventilator Associated Pneumonia

- A. VAP is the leading cause of death amongst HAI, exceeding the rate of death due to CLABSI, severe sepsis and respiratory tract infection on the non-intubated patients. TJS uses the best-practice guidelines for the VAP prevention bundle:
- Elevation of the head of the bed.
 - Daily “sedation Vacation” and assessment of readiness for extubation.
 - Peptic ulcer disease prophylaxis.
 - Deep Venous thrombosis prophylaxis.
 - Daily oral care with bi-hourly oral care kit.
- B. The bundle, when implemented together, will achieve significantly better outcomes than when implemented individually.