Indiana Department of Health

Infection Prevention Press

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IP and EVS Partnerships—Rounding Together

By Jennifer Spivey, IP Program Manager

If you do not know it by now, I hope this edition of our newsletter helps you confirm that the cleanliness of the environment plays a vital role in keeping us and our residents free from infection. In congregate care settings such as LTC, we are all gathered closely, increasing the number of people touching or contacting the same surfaces. This causes a greater risk of transferring germs from these surfaces to our hands and spreading them in the environment. Cleaning and disinfecting high-touch surfaces daily is very important, but just as important is spending time doing what I call "shoe leather" team rounding. The IP partnering with the EVS manager and going on rounds frequently together shows teamwork. Facilities that implement these collaborative roundings have seen better outcomes with correct IP practices for proper cleaning.

Rounding is most useful to detect process failures that are readily apparent in real-time resident care situations. The value of the IP collaboration with EVS managers is that they can detect and teach at point of care. Examples include lack of hand hygiene before and after glove use, incorrect donning and doffing of PPE, improper use of cleaning cloths, contact dwell time of disinfectants and breaches in handling soiled laundry and supplies. When rounding, it is important to use coaching styles that educate instead of blaming or criticizing to instill a culture of safety in which all healthcare workers can improve their daily practices for the safety of the residents. It is a lot for IPs to add one more thing to their weekly activities, but this one will become your guaranteed best time out of your office once you make it a priority on your calendar.

To become more comfortable with proper cleaning practices of LTC rooms and feel more confident in your observations, **watch this video**. In addition, **CDC Project Firstline** has quick 10-, 20- and 60-minute learning tools for environmental cleaning you can check out and use with your teams.

Shared Medical Equipment Cleaning and Disinfection

By Mary Land, District 9 IP

Properly **cleaning/disinfecting** surfaces is one of the single most important measures to decrease the spread of infection. Cleaning and disinfecting are different. Cleaning a surface is the process of removing debris., while disinfecting a surface kills the organisms on the surface.

As infection preventionists, it is our job to know which disinfectants are being used throughout our facilities and their contact times (or wet times), to observe/audit proper use and to educate all disciplines on the proper use of each product. I want to take a moment to focus on shared equipment disinfection. Typically, EVS staff and nursing staff use different disinfectant products, so be sure you have a complete list of all items used in your facility and on which surfaces they are used.

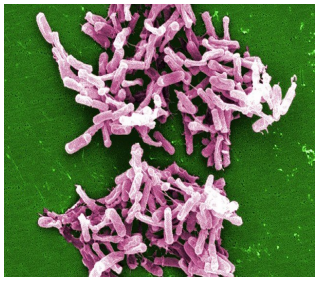
A variety of disinfectants can be used in healthcare settings. Ensure your nursing staff have easy access to disinfectants that are suitable for disinfecting medication carts, lifts, shared vital signs equipment, etc. Equipment must be disinfected between each resident. It is best to choose a product that has a lower contact time and can be used on multiple surfaces. You may need to be creative to decide the best places to store disinfectants in your facility. Disinfectants should be easy to access by staff but out of the reach of residents for safety purposes (paying special attention in locked units or around residents with decreased cognition).

As a regional infection preventionist, I spend a lot of time discussing "Whose 'job' is it?" Is it a nursing responsibility, or is it an EVS responsibility? The answer is: both! I see soiled utility rooms full of equipment such as bedside commodes, IV poles, pumps, etc. These should be disinfected and/or marked as clean when the resident is finished using the item and BEFORE taking the item into the hallways, common areas or resident rooms. This is a great opportunity to have a round table discussion to decide who will disinfect equipment and when. Make a list of all the equipment that no one knows whose responsibility it is to clean, and then decide whose primary job it is to clean and disinfect it to be ready for resident care. Keep in mind that your soiled utility rooms should be routinely disinfected, just like the rest of the facility.

Our goal is to have excellent resident outcomes. Decreasing the spread of germs throughout your facility will decrease the risk to your population. Good policies and procedures will give clear expectations to all staff, and decreasing infections will decrease hospital stays, antibiotic use and overall facility cost. Contact your district IDOH infection preventionist with any questions or to discuss strategies and disinfectants.

What's Bugging you?

Can you guess this germ?



This mystery germ is a bacterium that causes severe diarrhea and colitis. Some people can be colonized without active infection, but can still spread the germ to others. It is shed in feces and can contaminate any surface or material. The spore of this germ can survive on surfaces for months to years.

Symptoms: Diarrhea, Colitis, Fever, Stomach tenderness or pain, Loss of appetite**,** Nausea. Can be deadly! 1 in 11 people over 65 diagnosed with this HAI infection die within in a month

Risks: Over 65 (but anyone can get), recently hospitalized or on antibiotics, previous infection (1 in 6 that have been infected will become infected again), or immunocompromised

Isolation and prevention: Contact precautions (with soap and water hand washing), Be antibiotic aware, environmental cleaning, washing hands with soap and water, private room and bathroom. *Hand sanitizer does not kill this germ.*

Testing: If patient has 3 or more loose stools per day get a doctor's order for stool sample testing. If sample can not be tested immediately, the sample should be refrigerated.

Environmental cleaning: Bleach or sporicidal, EPA List K, frequent cleaning of high touch surfaces

Answer: *Clostridioides difficile* (aka C. *diff*, formerly *Clostridium difficile*)

EVS– Yes! Yes!

By Jennifer Brinegar, District 8 IP

I think we can all agree that the past couple of years have brought many new experiences and concepts to light, and for all of us has come a greater appreciation for our environmental services teams and the value they bring to any healthcare setting. As stated on the CDC website, "It is well documented that environmental contamination in healthcare settings plays a role in the transmission of HAIs. Therefore, environmental cleaning is a fundamental intervention for infection prevention and control (IPC)."

Environmental service teams have always been by our sides assisting in protecting our residents and other staff from harm. Sometimes, they are placed in new and frightening situations, like nursing staff, and they never waiver in their commitments to perform their jobs of being the "Champions of Clean" to stop the cycles of infections. EVS teams have many responsibilities and requirements, such as knowledge of proper cleaning techniques, kill times on products, proper PPE requirements for any resident in precautions, ongoing training, audits, daily cleans, terminal cleans, utilizing proper cleaning techniques (such as, high to low, bathrooms last, high-touch surfaces, UV lights, etc.). Their work does not stop with patient rooms; it also includes the entrances, common areas, dining rooms, bathrooms, breakrooms, offices, dusting of pictures, railings, stairwells, soiled and clean utility rooms, terminal cleanings and daily cleanings.

Our recent experiences with COVID-19 have only reinforced the need to include EVS departments in our meetings to keep them aware of the potential infectious hazards in the facilities. We need to have their representation in our quality, infection prevention, team huddles, etc. to list their concerns, visions, routine observations or suggestions for changes in our policies and procedures. They can be the eyes and ears of a facility as they are in our hallways, breakrooms and every inch of our buildings every day. They have so much value to bring to the table.

Our EVS staff work hard to keep our facilities as clean as possible to keep our residents and staff safe, and we must return that favor and strive to always inform them of changing resident conditions and intertwine them into all our departments and meetings. Develop processes to ensure that we have communication related to change in patient precautions or a process change. The EVS teams are and will continue to be our vital connection to breaking the chain of infection and reducing the risk of pathogen or germ transmission that can cause an infection and make us sick.

High-touch Surfaces and Contact Kill Time

By Jason Henderson, District 5 IP

When it comes to working in healthcare, everyone has a role or a part to play. No one part is any more important than the others. The end goal is to provide the best care possible and keep all the patients or residents safe while they are being cared for. Most people think of the obvious when it comes to care, such as turning and repositioning, passing meds, doing treatments and assisting with ADLs, all of which is provided by the medical staff of the facility. While environmental services (EVS) play a tremendous role in keeping everyone safe by cleaning and disinfecting, it's not solely their responsibility. Environmental cleaning and disinfecting equipment and surfaces close to the resident is a shared responsibility of all. Cleaning and disinfecting of high-touch surfaces regularly and knowing the contact kill time of the products being used are two of the most important ways to ensure safety in a healthcare setting.

What are high-touch surfaces? High-touch surfaces are areas that are frequently touched by everyone in your facility. Some of those surfaces consist of elevator buttons, door handles/knobs, pens that are used to sign into a facility, bed rails, bedside tables and call buttons, to name a few. How do we know if these surfaces have been disinfected correctly? Obviously, this is done by following the contact kill time that is set by the manufacturer of the product being used.

"Contact kill time", "dwell time" and "wet to dry time" are terms that can be used interchangeably when it comes to disinfectant products. What do they all mean, and why is it important? These things are what all HCPs should know because disinfecting and cleaning does not just fall on the shoulders of environmental services. Thanks to **CDC's Project Firstline** education modules, we have a clearcut definition of what contact kill time means: "the amount of time a disinfectant needs to sit on a surface, without being wiped away or disturbed, to effectively kill germs". Dwell times vary from product to product. One product may have a 1 minute dwell time, and another may have 5 minutes—typically this information can be found on the product label. The best way to know that time is always have HCPs look at the label of the product they are using and to contact their supervisor before using the product if they have a question. Some products display it very clearly for staff to see, but it should still be listed even if that's not the case. Why is this important? In the healthcare industry we encounter a variety of bacteria through contact. Most people do not think about what is on a surface if it appears clean, but there are a lot of germs that can survive on surfaces for prolonged periods. For example, *Clostridioides difficile* (C. *diff*) spores can last on a surface beyond 5 months. E. coli can survive anywhere from 1.5 hours to 16 months. There are too many different organisms to list, but knowing that bacteria and viruses can survive on surfaces for months when not disinfected properly is kind of scary. Therefore, it is so important for HCPs to be educated on the dwell times of the disinfectants they are using.

Cleaning and disinfection should be everyone's responsibility, not just environmental services staff. Also, a surface looking clean does not mean it is because bacteria can survive on a surface for a prolonged period. High-touch surfaces should be cleaned and disinfected at least daily. Contact kill time should be adhered to per the manufacturer's recommendations by anyone using the product. All of this is to keep not only the residents/patients safe, but also the staff working in the facility.

Back to the Basics: Standard and Transmission-based Precautions, Navigating the CDC Appendix A for Organisms and How to Find Organisms Not Listed in Appendix A

By Angela Badibanga, District 4 IP; Janene Gumz-Pulaski, District 1 IP; Mary Enlow, District 10 IP

There is a seemingly endless number of possible bacteria and viruses that your residents and staff could bring into your facility. Therefore, it is important to know the basics of standard precautions, the categories of transmission-base precautions, how to use Appendix A from CDC and how to find information about organisms not in Appendix A.

Standard precautions include a group of **infection prevention practices** that apply to all patients, regardless of suspected or confirmed infection status, in any setting in which healthcare is delivered. These include hand hygiene; use of gloves, gown, mask, eye protection or face shield, depending on the anticipated exposure; and safe injection practices.

The categories of transmission-based precautions (TBP) are used either singularly or in combination. They are used in addition to standard precautions to help prevent the spread of organisms.

Contact precautions are intended to prevent transmission of infectious agents, including epidemiologically important microorganisms that are spread by direct or indirect contact with the patient or the patient's environment as described in **I.B.3.a.**	**Droplet precautions** are intended to prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions as described in **I.B.3.b.** Because these pathogens do not remain infectious over long distances in a healthcare facility, special air handling and ventilation are not required to prevent droplet transmission.	**Airborne precautions** are intended to prevent transmission of infectious agents that remain infectious over long distances when suspended in the air (e.g., rubeola virus [measles], varicella virus [chickenpox], *M. tuberculosis* and possibly SARS-CoV-2) as described in **I.B.3.c.**

NOTE: Diagnosis of many infections requires laboratory confirmation. Since laboratory tests, especially those that depend on culture techniques, often require two or more days for completion, Transmission-based precautions must be implemented while test results are pending based on the clinical presentation and likely pathogens (i.e., Candida *auris*, Clostridioides difficile).

Appendix A is a searchable list on the CDC website that has information on which precautions specific infections and organisms require and the recommended duration for precautions. **Appendix A can be found here**. Conditions and infections are listed alphabetically.

How do you find information not in Appendix A? If a condition or an organism is not in the Appendix A alphabetical list, follow these steps:

1. Is the organism an MDRO? See the MDRO section of Appendix A under *M*.
2. If it is not on the MDRO list, use the search bar at the top of Appendix A's webpage to search for the condition's or organism's CDC page.
3. Read through the organism's specific CDC page, as it may provide information on isolation/ precautions.
4. Contact your District IP if you still can't find the information you need!

Long Term Care Infection Prevention Team Districts

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Full Links and References

If you are viewing this newsletter online, you can open the links by the clicking on the bold blue links. If you are viewing this newsletter in printed form and would like to view the links or resources, the full URLs are below:

Shared Medical Equipment Cleaning and Disinfection

1. Reference: https://www.cdc.gov/infectioncontrol/projectfirstline/resources/facilitator-toolkit.html

What's Bugging you?

1. Reference: https://www.cdc.gov/cdiff/index.html

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1. Proper cleaning practices of LTC rooms video: https://www.youtube.com/watch?app=desktop&v=yhPj0vshVcg&feature=youtu.be
2. Project Firstline Videos: https://www.cdc.gov/infectioncontrol/projectfirstline/resources/videos.html

High-touch Surfaces and Contact Kill Time

1. Environmental Cleaning PowerPoint from Project Firstline: https://www.cdc.gov/infectioncontrol/pdf/strive/EC101-508.pdf

EVS—Yes! Yes!

1. Reference: EVS and the Battle Against Infections: https://www.cdc.gov/infectioncontrol/training/evs-battle-infection.html
2. Reference: EVS Appreciation Week: https://www.ahe.org/EVSWeek
3. Reference: Environmental Cleaning Checklist: https://www.cdc.gov/hai/pdfs/toolkits/environmental-cleaning-checklist-10-6-2010.pdf

Back to the Basics: Standard and Transmission-based Precautions, Navigating the CDC Appendix A for Organisms and How to Find Organisms Not Listed in Appendix A

Thank you to Christi Howell, RN, SDC/IP, for the article suggestion!

1. Standard Precautions: https://www.cdc.gov/infectioncontrol/guidelines/isolation/appendix/standard-precautions.html
2. Transmission of Infectious Agents in Healthcare Settings: https://www.cdc.gov/infectioncontrol/guidelines/isolation/scientific-review.html
3. Appendix A: https://www.cdc.gov/infectioncontrol/guidelines/isolation/appendix/type-duration-precautions.html

If you have any suggestions or requests for what you would like to see in future editions of the IPP, please email Bethany Lavender or Jennifer Spivey.

To promote, protect, and improve the health and safety of all Hoosiers

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