Key Safety, Quality and Infection Prevention Information for Medical Staff

We share your dedication to providing safe, effective and quality patient care. One important aspect of high reliable patient care is to help us prevent infection, Healthcare-Associated Infections (HAI’s) and cross transmission during care delivery. In addition, there are Joint Commission (JC) accreditation requirements that physicians, residents and Advanced Practice Professionals (APP’s) (providers) must receive training in infection prevention measures. The following is a summary of key training points for providers to be aware of and follow when caring for patients receiving care through Saint Joseph Mercy Health System facilities.

Note: More details on content contained in this document can be found on the Infonet. Seasonal Influenza & Booster Dose of Tdap are work requirements for all SJMAA and SJML personnel; SMML requires seasonal influenza only. Refer to your local hospital policies for more information.

I. Hand Hygiene

5 Moments for Hand Hygiene

Hand hygiene by providers during delivery of patient care is the most important strategy to prevent cross transmission of pathogens that cause HAIs. Two methods in use at SJMHS facilities include:

1. Wash hands with soap a water when visibly dirty or visibly soiled with blood or other body fluids.

2. If hands are not visibly soiled use alcohol-based handrub (ABHR).
II. Health-Care Associated Infection (HAI) Prevention Strategies

Prevention of CLABSI (Central line-associated blood stream infection)
- Use the CLABSI Prevention Bundle during insertion, care and maintenance of central lines.
- Use SJMHS catheter insertion checklist [available in central line kits] to ensure adherence to infection prevention practices/strategies at time of central line insertion. Elements of this checklist include:
  ♦ We require the patient’s nurse be present for the central line insertion to assist with maintaining sterile technique as required on the checklist.
  ♦ Hand hygiene prior to insertion
  ♦ Prep insertion site on patient with 2% chlorhexidine gluconate
  ♦ Use maximal sterile barrier precautions for insertion: full body drape over patient, health professional inserting line wears head cap, mask, and sterile gown + gloves.
  ♦ Avoid insertion of central line into the femoral vein unless absolutely necessary.
  ♦ Evaluate continued need for central line each day of use; discontinue as soon as feasible.
- Use Hand hygiene before catheter manipulation, care and maintenance.
- Use an all-inclusive catheter insertion kit.
- Disinfect catheter hubs, needleless connectors, or injection ports with alcohol before access and place disinfection caps on all ports
- For non-tunneled catheters, change dressing, perform site care every 7 days or more often if dressing is loose, soiled or non-intact, or bloody.

Prevention of VAE (Ventilator-associated Events)
- Ensure all patients (except with a medical contra-indication) are maintained in semi-recumbent position (30 – 45 degrees elevation of head of the bed)
- Ensure all ICU beds have built in tool for continuous monitoring of angle of incline
- Perform regular oral care using pre-packaged oral care kit
- Provide easy access to noninvasive ventilation equipment and institute protocols to promote use of non-invasive ventilation.
- Extubate the patient as soon as clinically feasible.
- Additional prevention strategies:
  - Assess, prevent and manage pain
  - Perform Spontaneous Awakening Trials (SAT) daily for patients who pass the safety screen and perform Spontaneous Breathing Trial (SBT) daily for patients who pass the safety screen
  - Choose the appropriate sedative and analgesia
  - Assess, manage and prevent delirium
  - Provide early mobility and exercise
  - Use subglottal suction endotracheal tube if expected to be intubated longer than 48-72 hours.

Prevention of CAUTI (Catheter-Associated Urinary Tract Infection)
Up to 80% of UTIs in hospitalized patients are caused by indwelling urinary catheters. Follow these prevention strategies:
- Avoid unnecessary urinary catheter (Foley)
- Insert urinary catheters using aseptic technique
- Properly secure indwelling catheters after insertion to prevent movement and urethral traction
- Do not clean the perirethral area with antiseptics to prevent CAUTI while catheter is in place. Routine hygiene (ie, cleansing of meatal surface during daily bathing) is appropriate to maintain sterile, continuously closed drainage system
- Keep the collecting bag below level of bladder at all times
- Keep collecting bag off the floor and empty frequently
- Maintain unobstructed flow of urine
- Review urinary catheter daily and remove promptly when indication is no longer present

Indications:
- a. Acute urinary retention/obstruction
- b. Need precise measurement of urinary output in ICU patient
- c. Perioperative use for selected surgical procedures.
  For example: Prolonged procedure, urologic surgery
  ◆ if indicated for surgical patient then remove by post-op day 1 or 2 – Be aware there are exceptions to timing of removal, e.g. catheters in patients under care by urology should only be removed by order from the attending urologists.
- d. Healing of open sacral or perineal wounds in incontinent patients.
- e. Prolonged immobilization required, e.g., trauma patient on spinal precautions
- f. Comfort for end of life care
- g. Epidural anesthesia/analgesia – check with pain service

Indwelling urinary catheters aren't indicated for following:
- a. Patient request
- b. Incontinence
- c. Confusion
- d. To obtain urine for culture when patient can voluntarily void

Prevention of SSI (Surgical Site Infection)
- Administer antibiotic prophylaxis in accordance with evidence-based guidelines
- Antibiotic prophylaxis should be completed less than 1 hour BEFORE the surgical incision (see Pharmacy guidelines for details in specific anti-infective agents)
- Discontinue the antibiotic prophylaxis within 24 hours after anesthesia end time
- Do not remove hair at operative site unless it will interfere with operation. If hair removal needed, use electric clippers. DO NOT USE RAZORS.
- Cardiac Surgery: Control blood glucose levels intra-op thru day 1-2 post-op. Check glucose levels in morning after surgery
- Maintain patient normothermia during procedure through recovery
- Do not routinely use vancomycin as prophylaxis or delay surgery to provide parenteral nutrition
III. Prevention of Cross Transmission & Isolation Precautions

- Infection Prevention and Control Services (IPCS) has a policy on use of Standard & Transmission-Based precautions to prevent cross transmission.
- Personal protective equipment and the appropriate door sign for patients in isolation are available in a cart or door caddy at the patient’s room entrance.
- IPCS website is available from the SJMHS and SMMH home page and provides information about isolation precautions, infection prevention and control policies and patient education fact sheets.

At St. Joseph Mercy Ann Arbor and Livingston initiate order for isolation precautions by:
- Typing in the term “Infection Control (AA)” to place order.
- Select appropriate isolation precautions; Include the organism or suspected infection AND appropriate communication and patient education orders

At SMMH – order under the term “Isolation”

Multidrug-resistant organisms (MDROs) are present in or on some patients admitted to SJMHS facilities. IPCS recommends the following strategies to contain and prevent transmission:
- Support the SJMHS antimicrobial stewardship program to avoid overuse or inappropriate use of antibiotics
- MDROs include methicillin-resistant Staphylococcus aureus (MRSA), vancomycin-resistant Enterococci (VRE), extended spectrum beta lactamase (ESBL) producing gram negative bacteria, carbapenem-resistant Enterobacteriaceae (CRE) and other select bacteria.
- Assist with education of patients and their family/visitors about MDROs, isolation precautions. The patient/family will be provided a MDRO fact sheet
- Use dedicated patient care equipment, or if needed for use for other patients, ensure cleaning and disinfection of equipment is done prior to use for other patients.
IV. Key Safety & Quality Initiatives

Computerized Provider Order Entry (CPOE)
SJMHS has implemented the Cerner PowerChart information system for documentation and order entry. All patient care and medication orders must be entered into PowerChart whenever possible. Verbal orders can be utilized in limited situations (urgent issues, no computer available) but will require a read-back of the order by the nurse. Orders will need to be signed within 24 hours. CPOE utilization is part of ongoing physician practice evaluation.

Anticoagulation & Anticoagulation Safety
SJMHS has developed a robust system for evaluating the effectiveness of our anticoagulation with heparin and warfarin. When prescribing unfractionated heparin for therapeutic purposes, the powerplans developed should be utilized. These powerplans reflect the routine data analysis that is conducted regarding protocol effectiveness. In addition, warfarin should be prescribed utilizing the powerplan that contains pharmacy monitoring and oversight. Pop up guidance windows for the direct acting oral anticoagulants (DOAC) lead the prescriber to order the correct regimen and dose for the specific patient. The discern advisor guides VTE prophylaxis prescribing decisions based on VTE risk assessment. An Anticoagulation Collaborative Practice Team (CPT) exists that reviews cases and newest evidenced-based data in order to develop initiatives and implement new interventions to maintain best practice in our health system.

- Follow protocols for initiating and maintaining heparin, enoxaparin or warfarin.
- Follow protocols for initiating and maintaining direct acting oral anticoagulants.
- Must have baseline INR/coagulation labs and creatinine when appropriate.
- Use a pump for giving a heparin infusion.
- Be aware of need for ongoing lab draws and dose adjustments based on results.
- Be aware of dietary education/modifications with warfarin.
- Educate your patient.

Pain Management
Nursing staff assess and document pain score and sedation scale before and after pain medication. A multimodal pain plan using opioid and adjuvant pain meds (acetaminophen, NSAIDs, antiepileptics, local anesthetics) should be utilized for all patients. When using opioids, appropriate strength oral opioids combined with adjuvant medications are usually best pain regimen. Intravenous opioids pain medication can be used intermittently for patients who can’t tolerate oral meds or as a rescue dose until appropriate oral med levels are achieved. For patients with acute uncontrolled pain, patient controlled analgesia (PCA) pumps can be utilized to gain control of pain quickly and establish what the pain medication needs may be. For chronic pain, the World Health Organization paradigm of utilizing around the clock (long-acting) meds and demand (short-acting medications) should be utilized. Before and during opioid therapy patients should be assessed to determine risk of opioid induced respiratory depression.

V. Prevention of Tuberculosis (TB)

- Maintain high index of suspicion for TB in a patient with symptoms of active TB disease, e.g. cough, hemoptysis, night sweats, fever…
- Order AIRBORNE PRECAUTIONS and admit patient to negative pressure room.
- Wear N95 respirator or positive air purifying respirator (PAPR) prior to entering the room.
- Encourage patient to stay in room. If procedures can’t be performed in room provide patient with procedure mask when they leave room.

TB Skin Testing for Medical Staff
- Provide evidence or obtain a tuberculin skin test (TST) from Employee Health Services during initial application for privileges.
- TB screening is required annually for active and associate medical staff privileges at St. Mary Mercy Livonia (SML).
- Should you develop symptoms of active TB, seek medical attention as indicated in med staff bylaws and notify the Medical Staff Office.