



## **COVID-19 and HAI Updates and Q&A Webinars for Long-Term Care and Congregate Residential Settings**

June 23<sup>rd</sup> , 2023

# Housekeeping

- All attendees in listen-only mode
- Submit questions via Q&A pod to **All Panelists**
- Slides and recording will be made available later
- For continuing education credit, complete evaluation survey upon end of webinar
  - Must be registered individually to receive credit

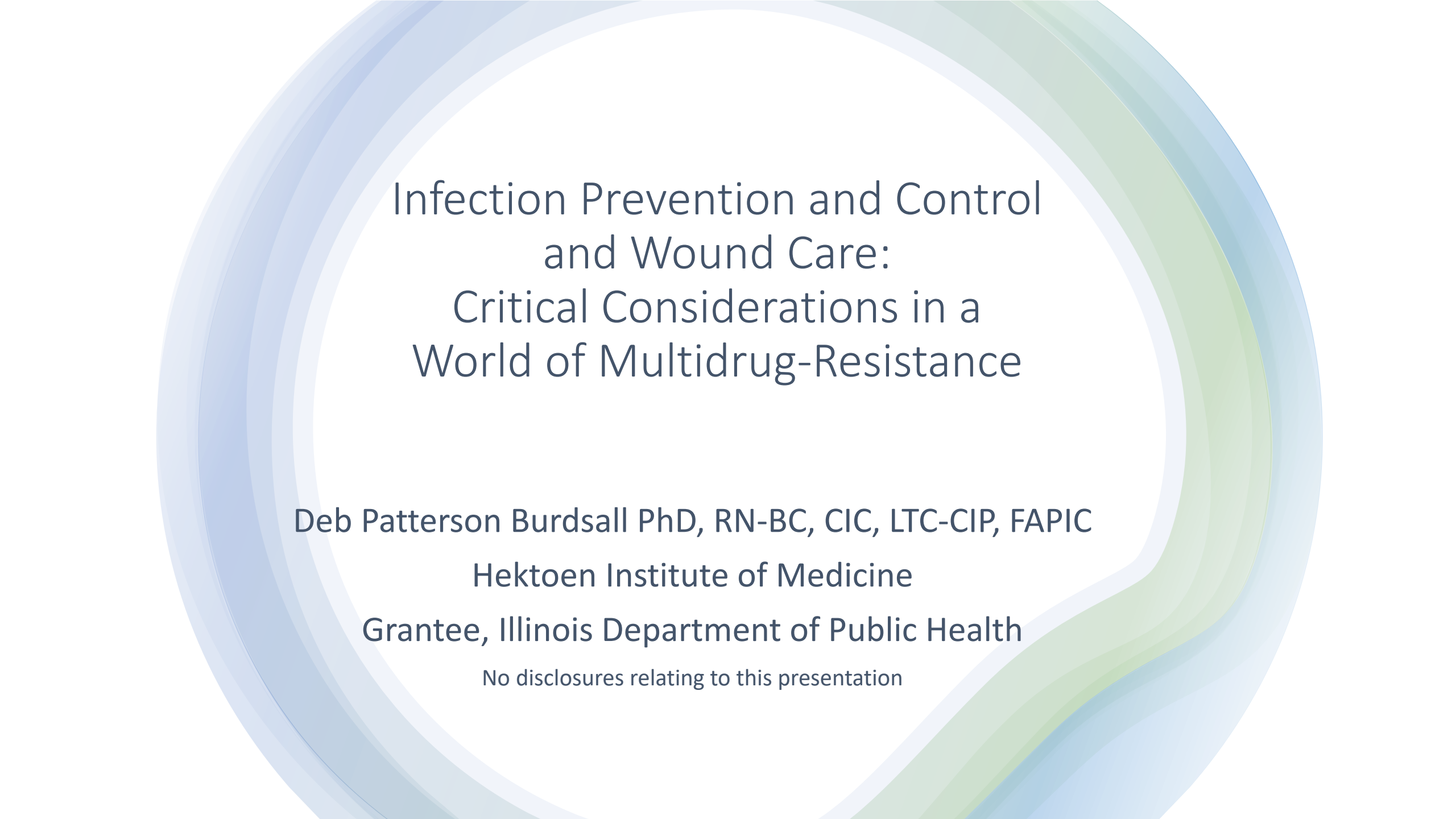
# Agenda

- Upcoming Webinars
- Infection Prevention and Control and Wound Care
- Open Q & A

# Upcoming Infection Prevention and Control Q&A

1:00 pm - 2:00 pm

Date	Infection Control Topic	Registration Link
Friday, July 21 <sup>st</sup>	Healthcare Laundry	<a href="https://illinois.webex.com/weblink/register/r1d0d83d188662760ff7fe7798dbba0d3">https://illinois.webex.com/weblink/register/r1d0d83d188662760ff7fe7798dbba0d3</a>
Friday, August 4 <sup>th</sup>	Training, Audit, Feedback	<a href="https://illinois.webex.com/weblink/register/rb6431b64bf7a47cbb0ff408c415bba8f">https://illinois.webex.com/weblink/register/rb6431b64bf7a47cbb0ff408c415bba8f</a>
Friday, August 18 <sup>th</sup>	Respiratory Protection	<a href="https://illinois.webex.com/weblink/register/r0f40c1aff7aad66e31b0c07bb567b898">https://illinois.webex.com/weblink/register/r0f40c1aff7aad66e31b0c07bb567b898</a>



Infection Prevention and Control  
and Wound Care:  
Critical Considerations in a  
World of Multidrug-Resistance

Deb Patterson Burdsall PhD, RN-BC, CIC, LTC-CIP, FAPIC

Hektoen Institute of Medicine

Grantee, Illinois Department of Public Health

No disclosures relating to this presentation

# Learning Objectives

- Identify the risk of wound infections.
- Design a wound management program based on facility risk assessment that identifies need for certified wound care providers and includes comprehensive assessment of types of residents who receive care.
- Describe the need for interdisciplinary collaboration between Wound Care professionals and Infection Preventionists (IPs).
- Develop wound care rounds that identify high risk practices and target staff training, competency, and rates of wound infection and wound healing.





Images: YAY Images



## The Real

AHRQ: Approximately 3% of patients who contract an SSI will die as a consequence  
157,500 for surgical site infections (SSI), with an estimated mortality of 8,205

<https://psnet.ahrq.gov/primer/surgical-site-infections>

Mondragon & Zito, 2022. An increased risk of death in both elderly and intensive care patients has been associated with the presence of pressure injuries

<https://www.ncbi.nlm.nih.gov/books/NBK557868/>





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## Intact Skin is a Primary Defense against Infection

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- *The integumentary system (skin) is the largest organ of the body.*
- *Forms a physical barrier between the external environment and the internal environment.*
- *Protects and maintains.*
- *The integumentary system includes the epidermis, dermis, hypodermis, associated glands, hair, and nails.*



# Disruption of the Integument

- Skin thins as people age, increasing risk of disruption
- Breaks in the skin allow pathways for germs and other organisms to enter
- Pressure and friction increase risk for pressure areas and skin tears
- Maintaining an intact integument and healing wounds if they occur is a primary care consideration

## Cellulitis: All You Need to Know

[Español \(Spanish\)](#) [Print](#)

Cellulitis is a common bacterial skin infection that causes redness, swelling, and pain in the infected area of the skin. If untreated, it can spread and cause serious health problems.

Good wound care and hygiene are important for preventing cellulitis.



Mommarazzi Images © 2023

Gram Negative and Gram Positive bacteria don't need help!

- The presence of multidrug-resistant organisms in the facility, combined with residents and patients with breaks in their skin, is a recipe for infection.



MRSA Bacteria  
[View image 1](#)



General information about CRE

CRE stands for carbapenem-resistant Enterobacterales.

# Group A Streptococcal (GAS) Disease

CDC > Group A Strep Home > Outbreaks and Public Health Response > Controlling Outbreaks in Long-term Care Facilities

## Group A Strep Home

Diseases Caused by Group A Strep +

For Clinicians +

For Laboratorians

Surveillance

Outbreaks and Public Health Response -

Controlling Outbreaks in Long-term Care Facilities -

Investigation Tools

Increased Risk for Serious Outcomes

Transmission Within and Between LTCFs

Additional Resources

### Increase in Invasive Group A Strep Infections, 2022–2023

CDC is looking into an increase in invasive group A strep (iGAS) infections among children in the United States. iGAS infections include necrotizing fasciitis and streptococcal toxic shock syndrome.

What you should do

## Group A *Streptococcus* can be easily transmitted within and between long-term care facilities

[Print](#)

### What you need to know

- Group A *Streptococcus* (GAS) spread easily in long-term care facilities (LTCFs) once it has been introduced.
- There are many opportunities for introduction of GAS into LTCFs because GAS colonization and infection are commonly present in the community.
- Strong infection prevention and control practices are critical to stopping GAS transmission and preventing outbreaks in LTCFs.

<https://www.cdc.gov/groupastrep/outbreaks/lcfc/transmission.htm>



# SNF: Georgia, Group A Strep (GAS) Outbreak

- Protracted GAS outbreak in a skilled nursing facility in Georgia in 2009, housing patients requiring 24-hour nursing or rehabilitation
- Three investigations, spanning 36 months, identified
- 19 residents with a total of 24 GAS infections
  - 15 invasive (3 recurrent)
  - 9 noninvasive (2 recurrent) episodes
- All invasive cases required hospitalization
- 4 patients died. Seven residents were GAS carriers. All invasive cases and resident carrier isolates were type emm 11.0.
  - Hand hygiene lapses
  - Inadequate infection documentation
  - More frequent wound care staff turnover on wing A versus wing B
- *Conclusions: Staff turnover, **compromised skin integrity** in residents, a **suboptimal infection control program**, and **lack of awareness of infections** likely contributed to continued GAS transmission. In widespread, prolonged GAS outbreaks in skilled nursing facilities, facility-wide chemoprophylaxis may be necessary to prevent sustained person-to-person transmission.*



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# SNF: Chicago Group A Strep (GAS) Outbreak

- *Wounds are a well-known risk factor for GAS infections*
- *Two consecutive outbreaks of group A Streptococcus (GAS) infections occurred from 2015-2016 among residents of a Chicago skilled nursing facility*
- *Evaluation of wound care practices*
- *All wound teams were observed irrigating residents' wounds in a similar fashion without recognizing that spraying sterile saline may lead to splashing of body fluids*
- *Infection control lapses during wound VAC management*
- *Residents AND staff infected*
- *Crucial for identifying transmission factors and implementing prevention measures.*
- *Demonstrated shedding of GAS on settle plates during care of a colonized wound.*
- *Group A Strep can be shed from a colonized wound during wound care*

<https://pubmed.ncbi.nlm.nih.gov/30680292/>



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# *Prolonged and large outbreak of invasive group A Strep (GAS) within Illinois nursing home: repeated intrafacility transmission of a single strain*

- *Prolonged outbreak of GAS infections that lasted 28 months and included 19 invasive and 60 noninvasive cases among residents and staff*
- *From May 2014 through August 2016, 19 invasive and 36 noninvasive (30 wound infections, five pharyngitis and one urinary tract infection) GAS infections were identified among 50 residents at facility A, leading to four deaths*
- Hand hygiene compliance rates of 14% to 25%
- PPE compliance 33% during observed care
- **Deficient observed wound-care practices**
- *Tracked the transmission of a single strain of emm89.0 GAS among both vulnerable residents and healthy workers within a single facility. The unusual duration and magnitude of this outbreak **highlights the importance of maintaining good infection control practices at skilled nursing care facilities.***



# Break the Chain of Infection!

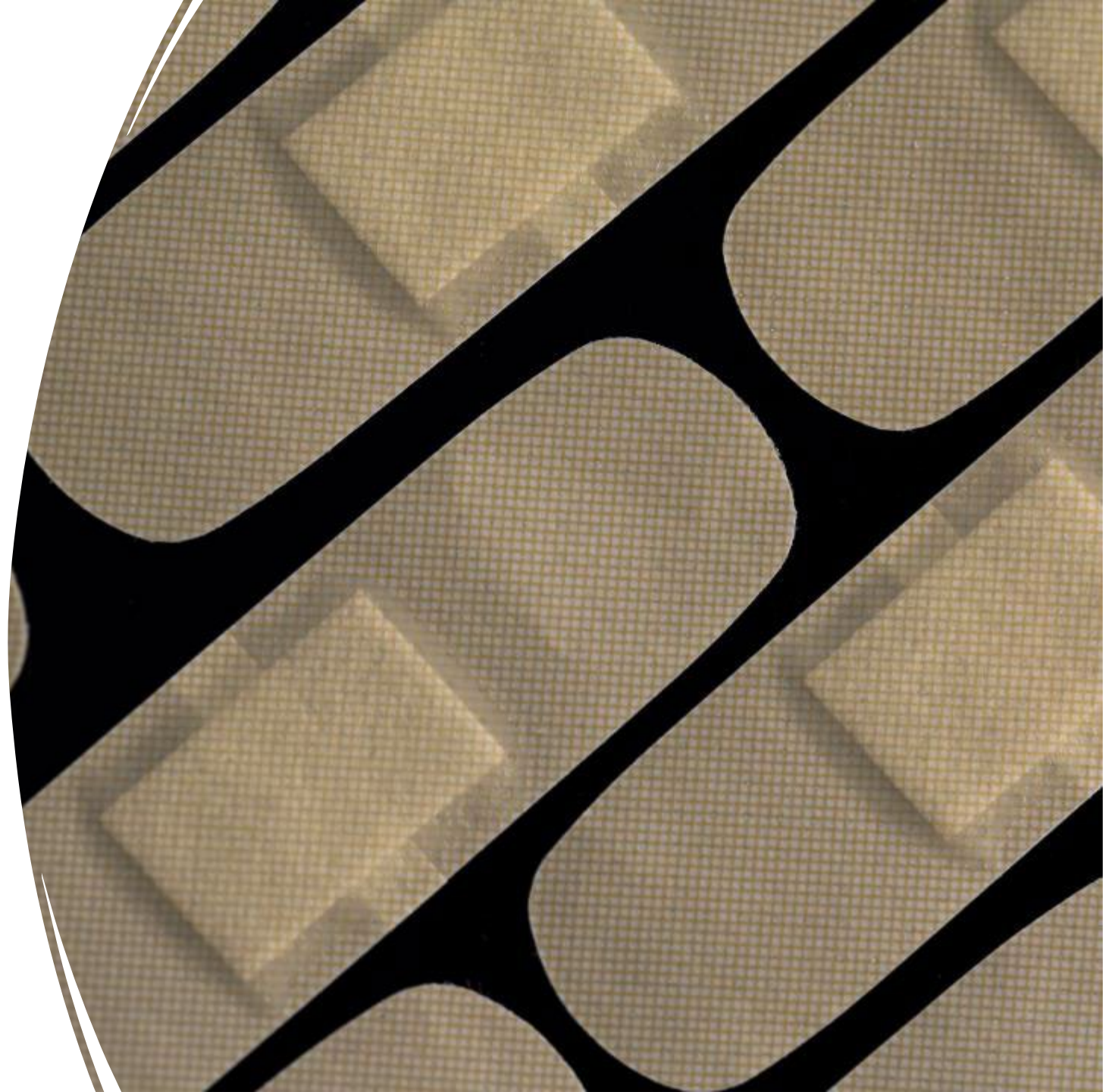




# Principles of Infection Prevention

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- Hand Hygiene
- Personal protective equipment (PPE)
- Environmental cleanliness
- Sterile technique and aseptic practices
- Wound cart/dressing/treatment management
- Proper waste management



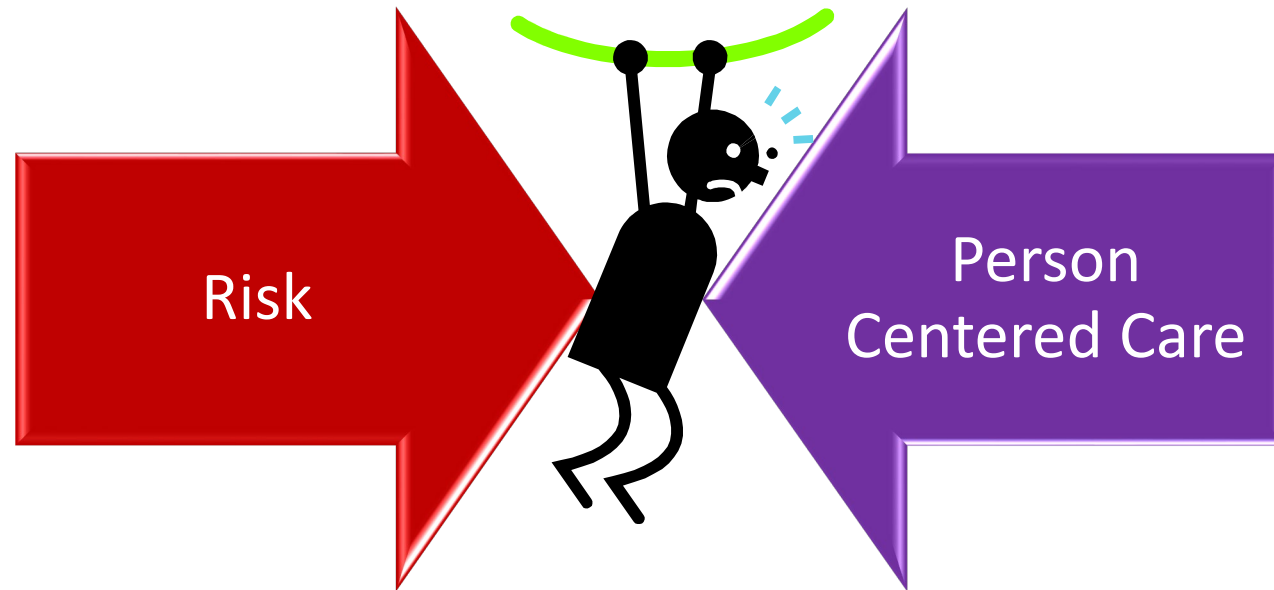
# High C's of Infection Prevention



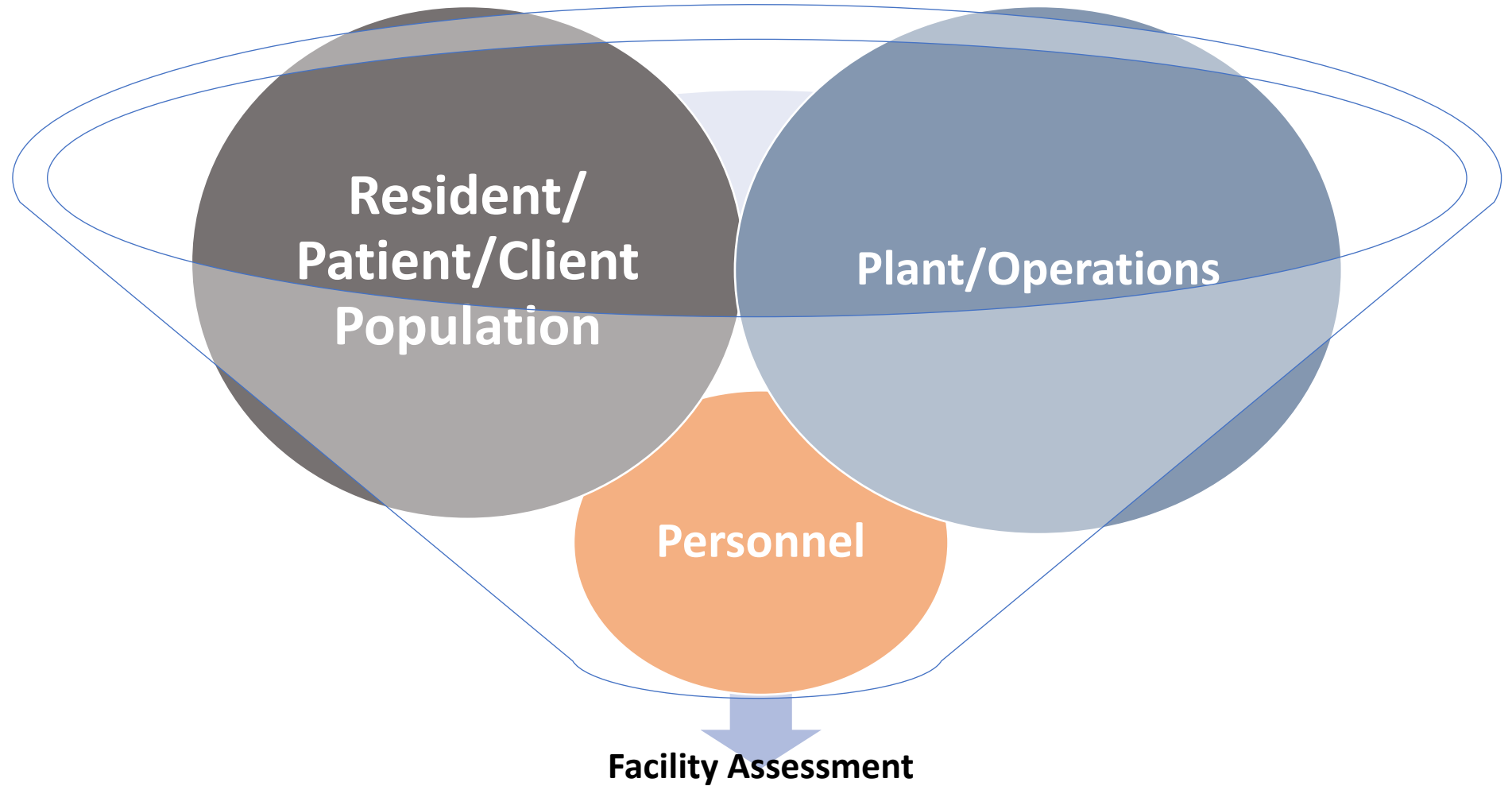
Burdsall, 2011

Slides: Baldwin Hill Solutions, Mommarazzi Images (c) 2018

# Balancing Risk and Person-Centered Care



# Facility Wide Assessment



**Infection Prevention and Control and Antibiotic Stewardship**

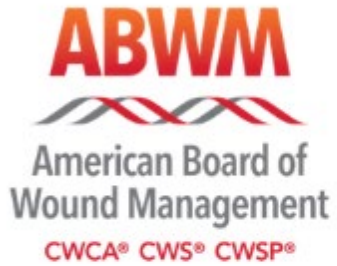
Wound Care  
and Infection  
Prevention go  
Hand in Hand



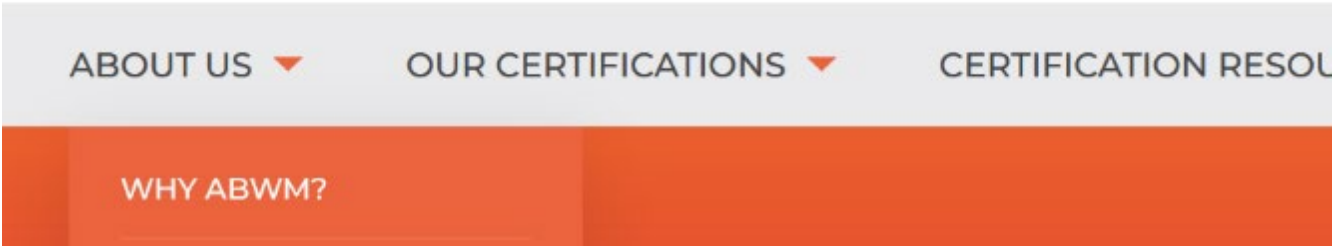
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<https://abwmcertified.org/abwm-cwca/>



Wound Care Nurse Education Courses

Wound care education designed to help you build advanced clinical knowledge. Pick the option that best suits your demanding life.

Select Path

<https://www.wcei.net/>

Wound Certificates and Certifications: Be Prepared!  
Average Pass Rate: 72%



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<https://woundeducators.com/compare-wound-care-certifications/>

- <https://www.cbic.org/>

Certification Board of Infection Control and Epidemiology, Inc.

## The CIC® by the numbers

**How many CICs are there?**

# 7,350

The CIC® examination is offered by appointment at hundreds of Prometric testing sites continuously throughout the year. As such, the number of CICs is constantly growing!

As of May 1st, 2019

**# of CICs who took the examination in 2018: 2,186**

**The passing rate for the initial certification exam**

# 72.4%

1st time candidates, those whose certification lapses, and those who do not pass are all included in this statistic.

**The passing rate for the recertification exam**

# 90.2%

Recertifiers are those who have passed the initial certification five years prior and passed the Internet-based recertification examination.

**Where are CICs located?**

Currently there are CICs in over **40** countries worldwide.



**What practice settings are represented among applicants?**



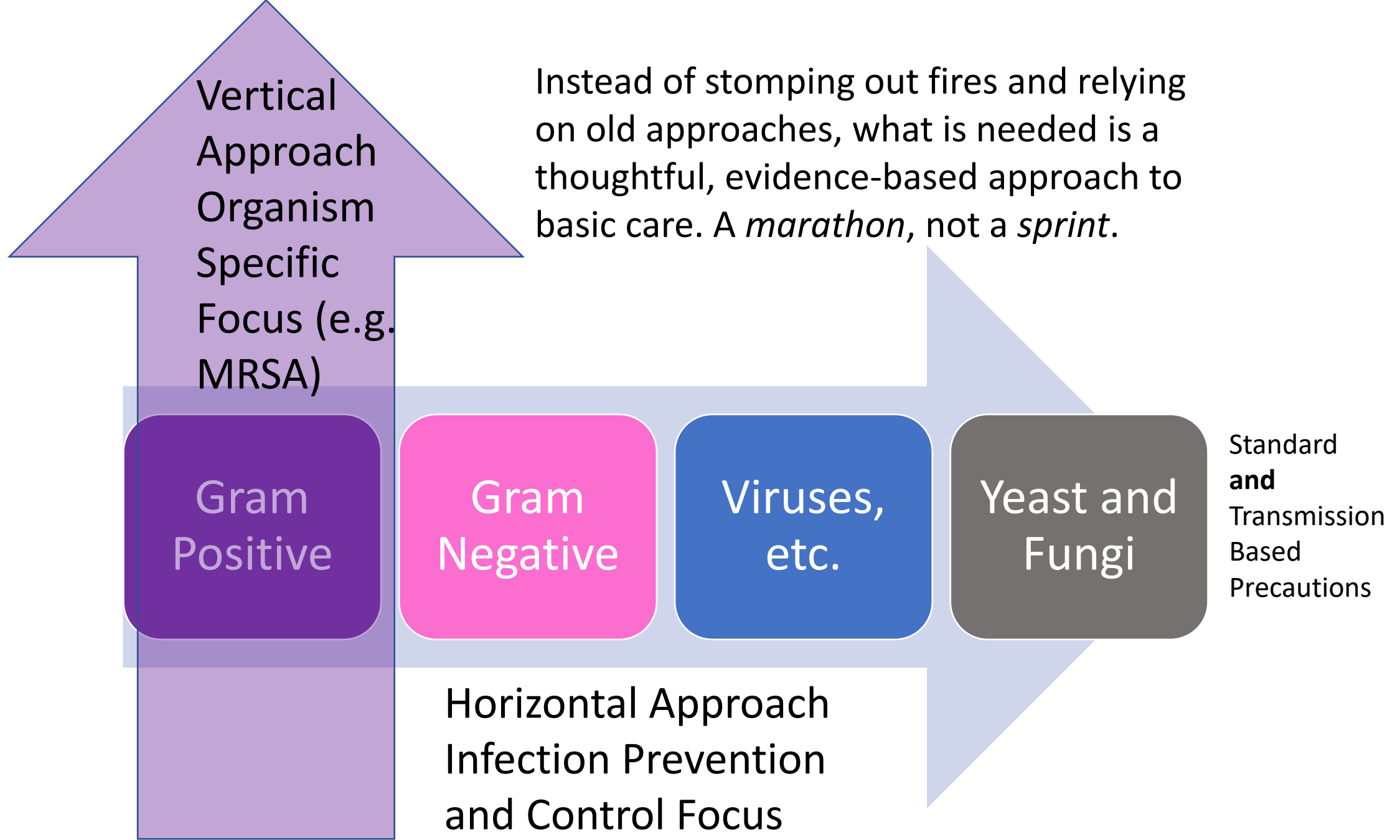
Acute Care/Hospital	62.6%
Ambulatory Care	10%
EMS/Public Health	6%
Long Term Care	6.7%
Behavioral Health	4.7%
Home Care/Consultant	4.6%
Other practice setting	5.2%

## Certification Board of Infection Control and Epidemiology (CBIC)

## NEW Long Term Care Certification in Infection Prevention and Control (LTC-CIP)







# Infection Control Assessment and Response (ICAR) Tool for General Infection Prevention and Control (IPC) Across Settings

## Module 8. Wound Care Facilitator Guide

**Wound Care:** This form is intended to aid an ICAR facilitator in the review of wound care practices at the healthcare facility (Part A) and guide observations (Part B). For the purposes of this tool, wound care refers to local care (e.g., debridement, dressing changes) to facilitate healing of breaks in the skin (e.g., ulcers, surgical wounds). While the practices being assessed (e.g., prevention of cross-transmission) apply wherever wound care is performed, the level of detail included in the tool is likely not sufficient to fully assess practices in specialty areas like burn units.

- <https://www.cdc.gov/infectioncontrol/pdf/icar/IPC-mod8-wound-care-508.pdf>

### Part A. Wound Care Interview Questions

1. What type(s) of wound care activities are performed at the facility? (select all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> Dressing changes     | <input type="checkbox"/> Unknown          |
| <input type="checkbox"/> Irrigation           | <input type="checkbox"/> Not Assessed     |
| <input type="checkbox"/> Sharp debridement    | <input type="checkbox"/> Other (specify): |
| <input type="checkbox"/> Wound vac management |   |

2. Which of the following categories of HCP provide wound care and what activities do they perform? (select all that apply)

- Dedicated (in-house) wound care team  
If **YES**, describe services provided: \_\_\_\_\_
- Dedicated (external/consultant) wound care team  
If **YES**, describe services provided: \_\_\_\_\_
- Nursing personnel  
If **YES**, describe services provided: \_\_\_\_\_
- Other (specify): \_\_\_\_\_  
If **YES**, describe services provided: \_\_\_\_\_
- Unknown
- Not Assessed

Many facilities will have a dedicated wound care team. However, in many circumstances, nursing personnel at the facility will still perform dressing changes (e.g., routinely, as needed). In these circumstances, observations and interviews should target both the wound care team and nursing personnel.

CDC Dialysis Collaborative Facility Name: \_\_\_\_\_ Date: \_\_\_\_\_ Start time: \_\_\_\_\_ AM / PM  
 Day: M W F Tu Th Sa Shift: 1<sup>st</sup> 2<sup>nd</sup> 3<sup>rd</sup> 4<sup>th</sup> Observer: \_\_\_\_\_ Location within unit: \_\_\_\_\_

**Audit Tool: Catheter exit site care observations**

(Use a "√" if action performed correctly, a "Φ" if not performed. If not observed, leave blank)

Discipline	Mask worn properly (if required)	Hand hygiene performed	New clean gloves worn	Skin antiseptic applied appropriately	Skin antiseptic allowed to dry	No contact with exit site (after antiseptis)	Antimicrobial ointment applied	Dressing applied aseptically	Gloves removed	Hand hygiene performed	Comments

Discipline: P=physician, N=nurse, T=technician, S=student, O=other  
 Number of observations: \_\_\_\_\_ Number of facilities observed: \_\_\_\_\_ Number of facilities where performed correctly: \_\_\_\_\_

## Checklist for Prevention of Central Line Associated Blood Stream Infections

Based on 2011 CDC guideline for prevention of intravascular catheter-associated bloodstream infections:  
<https://www.cdc.gov/infectioncontrol/guidelines/bsi/index.html>  
 Strategies to Prevent Central Line–Associated Bloodstream Infections in Acute Care Hospitals: 2014 Update

# CDC Tools

- <https://www.cdc.gov/hai/pdfs/bsi/checklist-for-clabsi.pdf>
- <https://www.cdc.gov/dialysis/PDFs/collaborative/Catheter-Exit-Site-Care-Observations.pdf>



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## Wound Care Observation Checklist for Infection Control

The following represent best practices for infection control during wound dressing changes, assessment and care. To evaluate wound practices, observe wound care procedures from start to finish, marking whether practices were appropriate (yes) or not (no) or not observed (n/a). Make notes of all deviations from best practices (areas for improvement).

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<https://www.health.pa.gov/topics/Documents/Programs/HAIP-AS/Wound%20care%20observation%20checklist.FINAL.pdf>

# Myths About Wound Care

- Cheaper is always more cost effective (penny wise and pound foolish).
- We have treated wounds with a variety of products and techniques even though there was no evidence it worked, (e.g., dry heat, Maalox, sugar, etc.).
- We can't throw that out! Do you know how much that costs?
- Anyone with a license can do wound care, even if no one is here to teach them or they have not taken advanced wound care courses.
- Everyone always changes the dressing the exact same way.



# Evidence Based Practice

- We use things today that were used hundreds and even thousands of years ago that have proven their effectiveness through research and study (honey, moist healing, maggot therapy).
- We have many new products and techniques that have been shown to speed up wound healing (wound vacs, new biologic products).
- Speeding wound healing and proper wound management decreases pain, risk of infection, and cost, even if initially they might seem more expensive.
- Wound management requires expertise, just like managing an infection prevention and control program!



Expensive treatments can be more cost effective over time

Faster wound healing decreases infection risk

Sultan Qaboos Univ Med J. 2018 Nov; 18(4): e433–e439.

Published online 2019 Mar 28. doi: [10.18295/squmj.2018.18.04.002](https://doi.org/10.18295/squmj.2018.18.04.002)

## Cost-Effectiveness of Wound Care

A concept analysis

[Koukab A. Al-Gharibi](#),<sup>1,\*</sup> [Sajana Sharstha](#),<sup>2</sup> and [Maria A. Al-Faras](#)<sup>2</sup>

▶ [Author information](#) ▶ [Article notes](#) ▶ [Copyright and License information](#) [Disclaimer](#)

- *Treatment with becaplermin dressing gel was more effective compared to standard wound care*
- *Rapid wound healing and the greater decrease in wound size over a shorter time period*
- *4 cm<sup>2</sup> decrease over three months versus a 3 cm<sup>2</sup> decrease over six months*
- *Cost per dressing change was higher, still more economical in the long term*
- *USD \$1,040 versus USD \$3,456*

Al-Gharibi, Sharstha, Al-Faras, 2019.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6474463/>



## Honey in wound healing: An updated review

Hanaa Tashkandi<sup>1</sup>

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Open Life Sci



Figure 1

Some physicochemical properties of honey.

**Medical-grade honey (MGH)** is a promising wound healing agent because it has a broad spectrum of antimicrobial efficacy with no known resistant pathogens. It has been shown to be effective against clinical bacterial and fungal isolates and their associated biofilm formation in a dose-dependent manner. It is safe and cost-effective, especially in the treatment of different types of wounds. MGH should be considered a potential alternative to antibiotics or complementary therapy for treating locally infected wounds. An improved delivery system and a structure to support wound healing could tremendously enhance the treatment process and result in better outcomes.

# Example: Medical Grade Honey and Wound Healing

# Supplies: Case Examples and Best Practices

Presenting successful cases of infection prevention in wound management and best practices



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- “Reusable dressing care equipment (e.g., bandage scissors) cleaned or reprocessed if shared between residents?”
- Clean wound dressing supplies need to be handled in a way to prevent cross-contamination
- Wound care supply cart remains outside of resident care areas
- Unused supplies are discarded or remain dedicated to the resident
- Multi-dose wound care medications such as ointments, creams should be dedicated to one resident”

- Found in Survey Resources:

<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes>

This pathway for a resident facing or at risk of developing a pressure ulcer (PU) or pressure injury (PI) is determining if facility does routinely evaluate, and intervene to prevent or treat heel pressure ulcers.

Review the following in Advance to Guide Observations and Interviews:

— The most current comprehensive MDS (e.g., MDS 3.0) for Section C – Leg Ulcers, Padams, Ul – Functional Status, H – Shaker and Hoosel, J – Conditions (ain, K – Bowel/Urinary/Nutritional Status, M – Skin Conditions (including history of a pressure ulcer or pressure injury), a pressure relieving device.

Physician's orders (e.g., wound treatment) and treatment room (TAR).

Wound care supplies.

Can provide information related to: resident's medical history, scheduled skin/wound inspections, or pressure ulcer or pressure injury history.

Observations:

Observe wound care and assess the wound interventions as seen as possible.

Is the wound care performed in accordance with accepted standards of treatment, physician's orders, and care plan?

Is there pain during wound care? If so, what did the nurse do?

Does the wound look infected?

Use of clean gloves and clean technique for each resident. When handling multiple ulcers on the same resident, provide wound care to the most contaminated ulcer last (i.e., in the perineal region).

Reuse gloves and decontaminate hands between residents.

Staff ensure that if normal or maintenance care is performed gloves are not used, that multi-dose dressing is removed, hand hygiene is performed, and clean gloves are donned before clean routine is applied.

Do wound dressing supplies need to be handled in a way to prevent cross-contamination (e.g., wound care supply cart remains outside of resident care areas, unused supplies are discarded or remain dedicated to the resident, multi-dose wound care medications, ointments, creams are dedicated to one resident)?

Is hand hygiene and approved glove use performed when providing wound care? Are precautions taken to not unnecessarily contaminate the wound or clean equipment supplies during routine care?

Are reusable dressing care equipment (e.g., bandage scissors) cleaned or reprocessed if shared between residents?

Has the resident's skin been exposed to urinary or fecal incontinence? Was the dressing set in place? What did you do?

How are care plan interventions being implemented?

How are staff following the care plan?

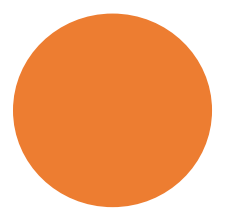
Is the resident repositioned timely and in the correct or usual practice on an existing PUMP or areas at risk for PU/PI?

Use of proper technique when turning, repositioning, repositioning to avoid skin damage and the pressure relief device.

Pressure relief devices are in place and used per the manufacturer's instructions.

Does the resident show signs of PU/PI?

Are ordered nutritional interventions appropriate and hydrated?





Respiratory Therapy  
gives a good example  
of boxed and wrapped  
equipment

Supplies stored, dry,  
clean, and away from  
direct  
resident/patient  
contact



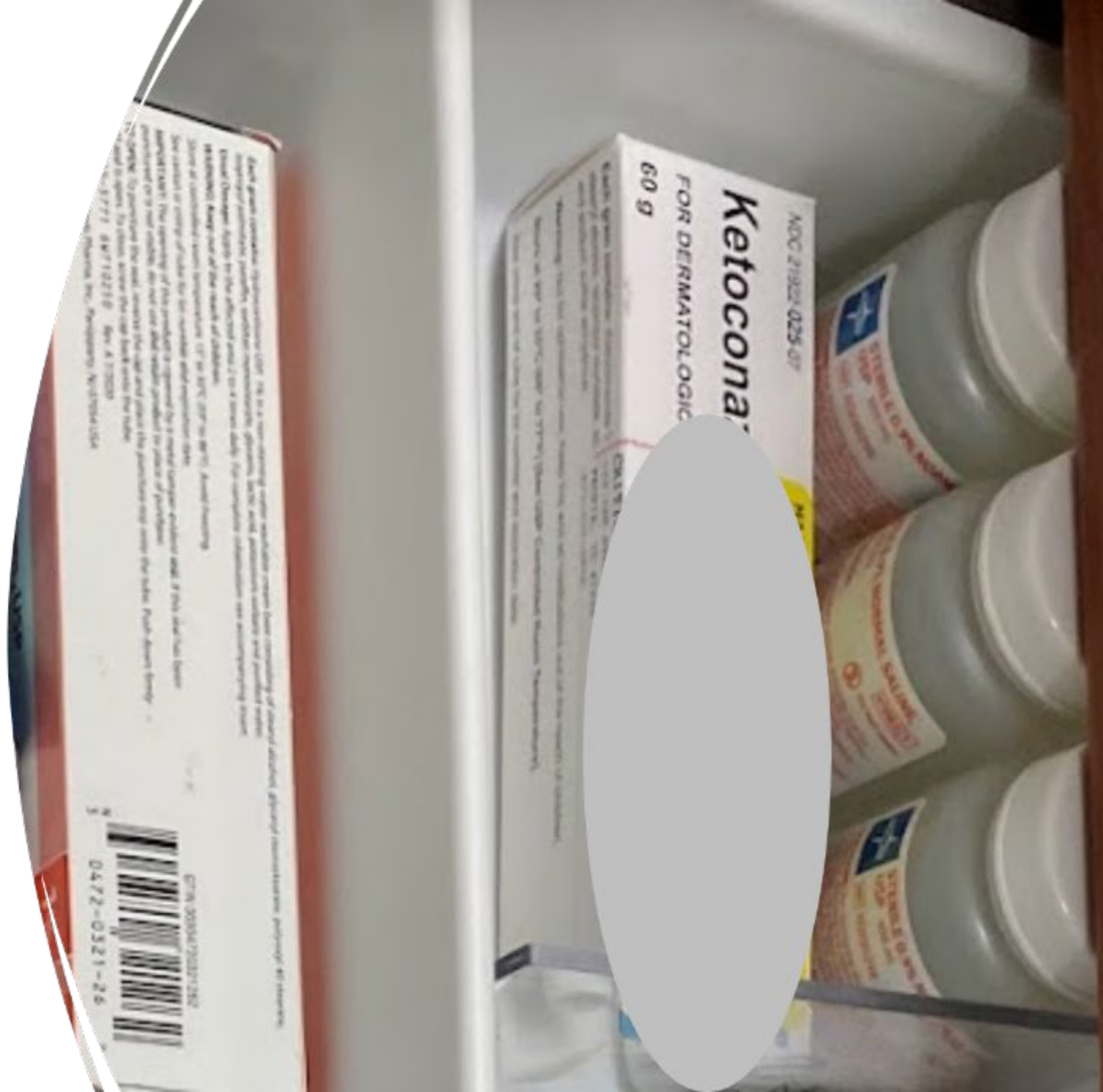
# Good Example

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- Separated resident/patient supplies in a CLEAN wound cart
- Boxes and bags are also infection control as they prevent contamination from one ointment tube to another



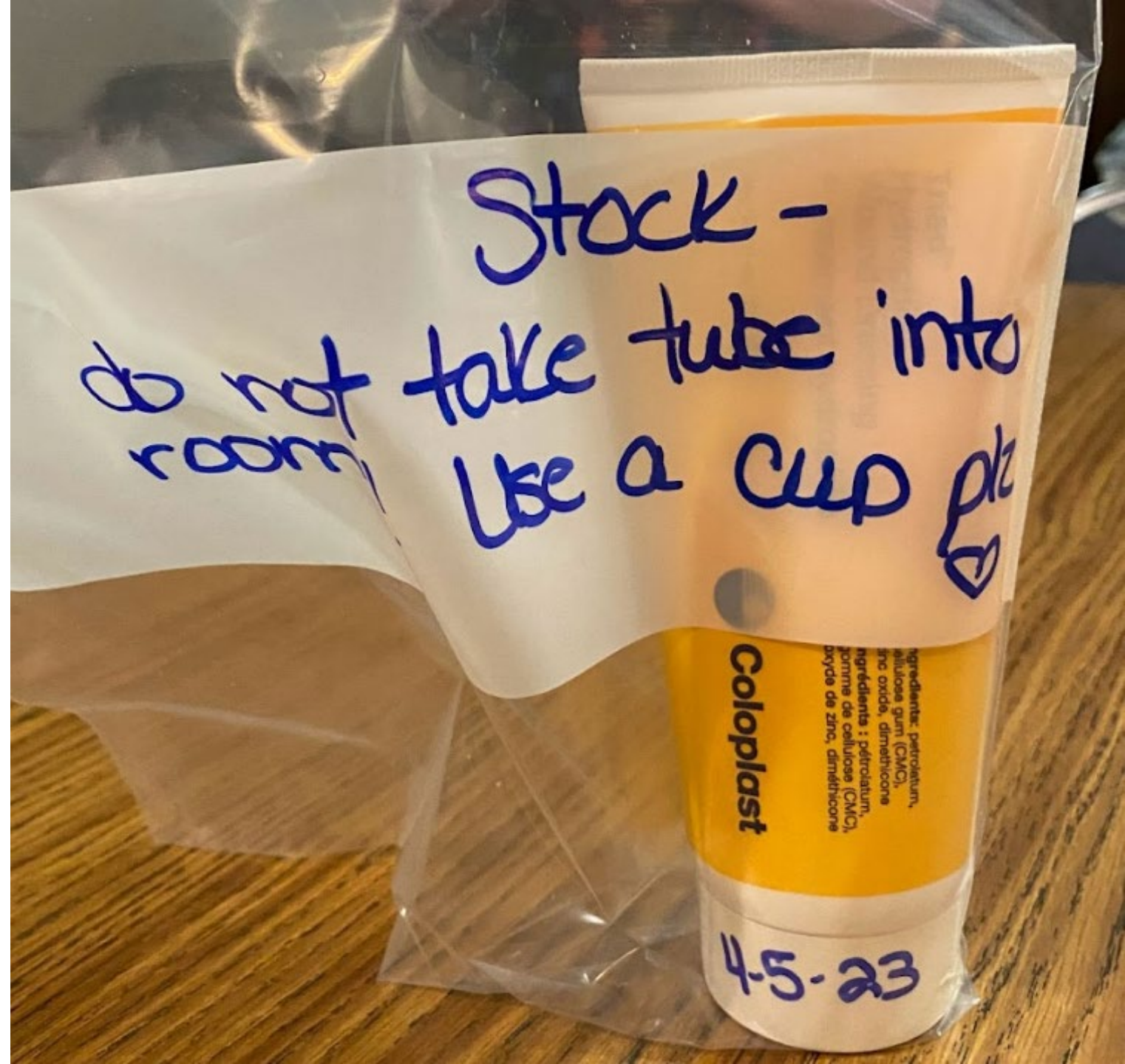
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# Clear Messaging

- Stock items are not preferred
- Stock items are sometimes necessary
- Example of clearly labeled, dated, and separated ointment
- Addressing practice deficits found on infection prevention rounds with pragmatic approach



# Supplies: Opportunities for Improvement

Why Infection Prevention Rounding needs to include  
Wound and Respiratory Carts!

Find the “real” so you can have the “ideal”



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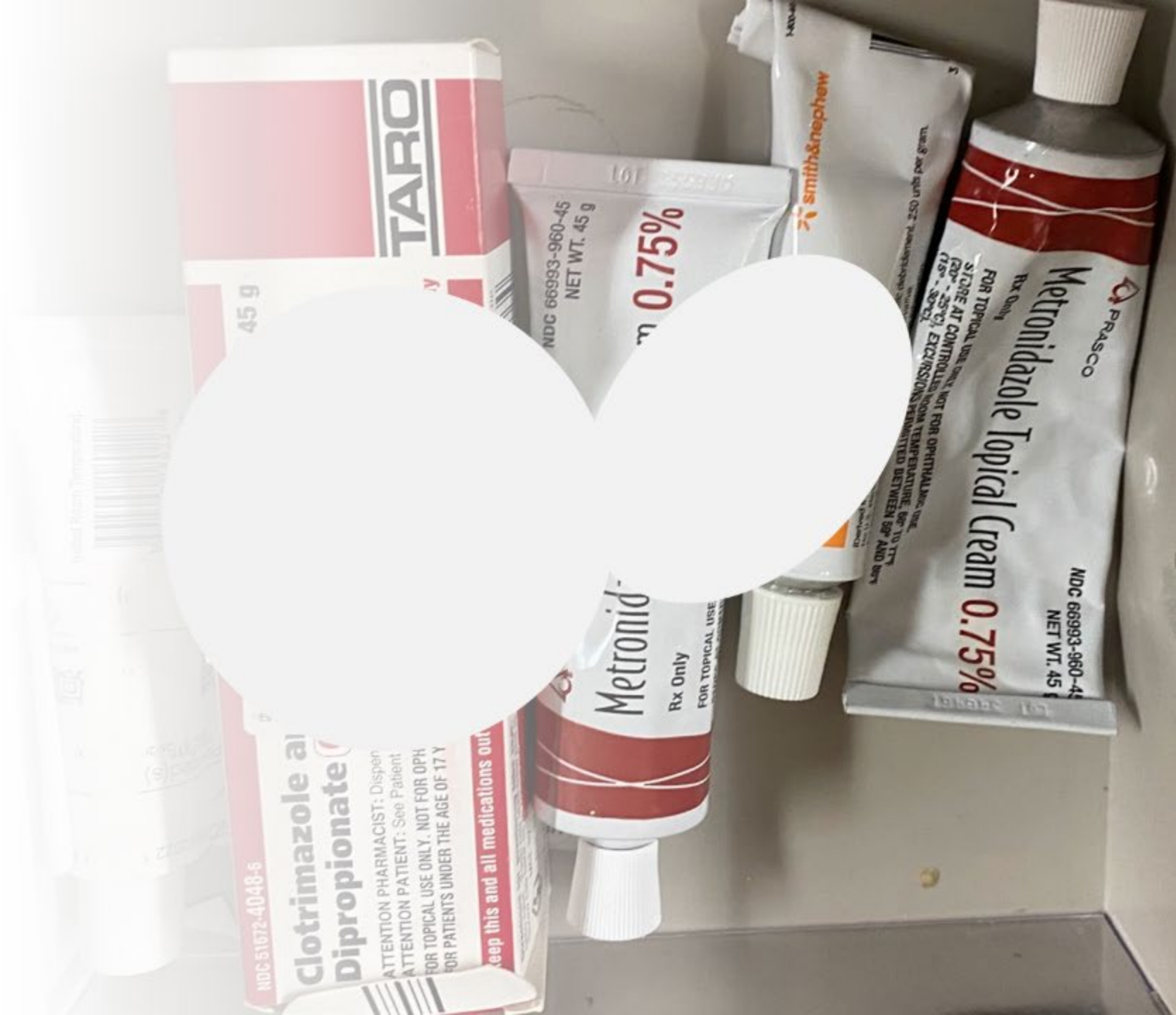
## Mixed and Mingled

- Imagine having to sort through to find the ointment you need
- Many have no labels
- How do you know whose is whose?
- How many people sort through the ointments on a daily basis?



## Routine Rounds

- The IP needs to be aware of how ointments and medications are being handled
- Routine rounds take time, but are so important
- Routine rounds give the IP the opportunity for just in time training of staff





**ACTIVIA Tube**

100% Medical Grade Manuka Honey

1. 2. 3.

OR

1. 2. 3.

25g (zoz)

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**Bactracin Ointment**

BACITRACIN ZINC

FIRST AID ANTIBIOTIC

NET WT. 1 OZ. (28g)

Helps to Heal Burns, Scrapes & Cuts  
 Prevents Infections

**40g 1.4oz**

6602-1250-40

9602-1250-40

CAUTION: For External Use Only

Each gram of ointment contains 0.9% of Bacitracin Zinc and 0.9% of Zinc Iodine. For use in the eyes. Keep out of the reach of children. See or Imp for Expiration Date and Lot No.

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RECP





Not Just Wound Carts –  
Medication Carts, Respiratory Therapy

## What About This?

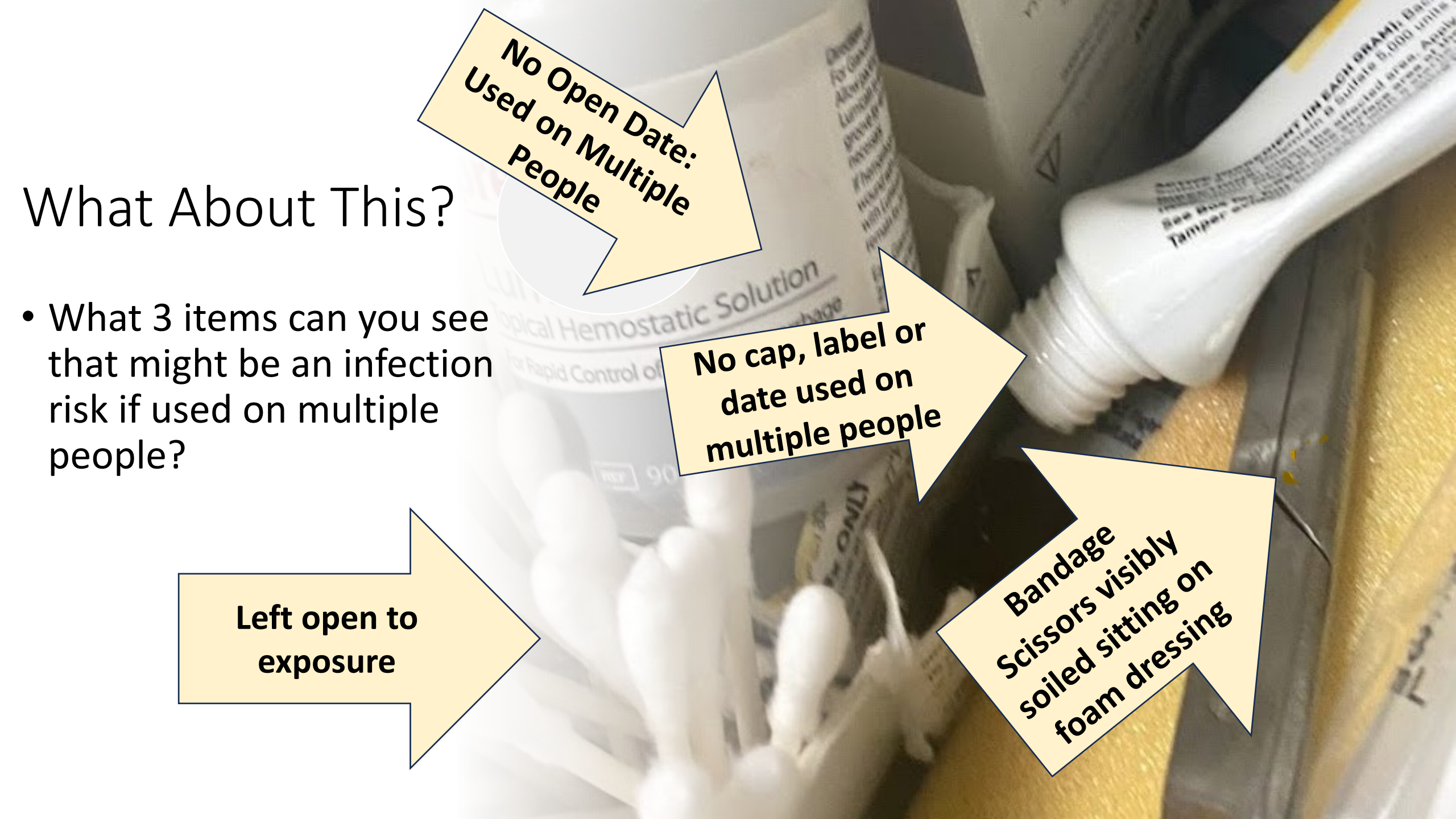
- What 3 items can you see that might be an infection risk if used on multiple people?

**Left open to exposure**

**No Open Date:  
Used on Multiple  
People**

**No cap, label or  
date used on  
multiple people**

**Bandage  
Scissors visibly  
soiled sitting on  
foam dressing**





# Equipment: Watch Out! How You Use it Determines How You Clean and Disinfect it!

Why Infection Prevention Rounding needs to include  
Wound and Respiratory Carts!

Find the “real” so you can have the “ideal”



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# Spaulding Classification

- Non-Critical Surfaces/Items Equipment contact intact skin – (e.g., bandage scissors, blood pressure cuffs, stethoscopes, pulse ox)
  - Low or Intermediate EPA disinfectant between each resident
- Semi-Critical – Contact mucous membranes or non-intact skin – (e.g., clippers, some podiatry and dentistry tools, toothbrushes, razors)
  - Single use, dedicate to one person
  - High level disinfection or sterilization if used with multiple people (not recommended- dedicate to one person)
- Critical Items (e.g., surgical instruments, scalpels, dental scalers)
  - **SINGLE USE**, or high-level disinfection or sterilization **in acute care**



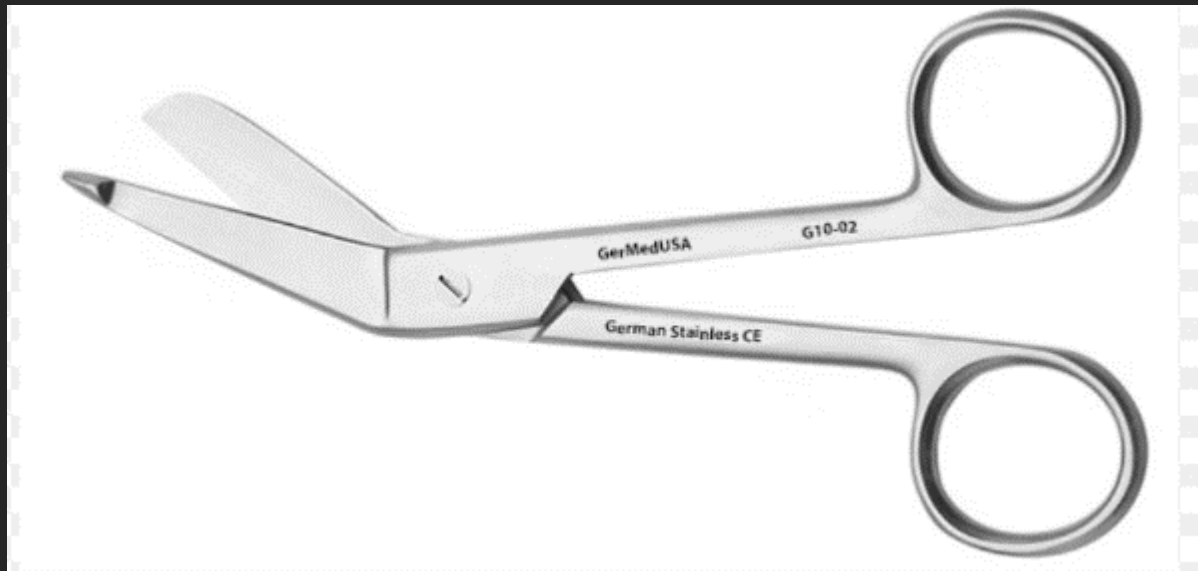
Accessible version: <https://www.cdc.gov/infectioncontrol/guidelines/disinfection/>



## Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008

Update: May 2019

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## Bandage Scissors for cutting and removing dressings: Blunt ends

- Noncritical surface/item
- equipment (scissors, hemostats, clamps, blood pressure cuffs, stethoscopes)
- Disinfected with an EPA-registered disinfectant
- If item is visibly contaminated with blood; use a tuberculocidal agent (or a disinfectant with specific label claims for HBV and HIV)”

<https://www.cdc.gov/infectioncontrol/pdf/guidelines/disinfection-guidelines-H.pdf>

## **Semi-critical Instruments used on multiple people require high level disinfection or sterilization**

- “Semi-critical instruments contact mucous membranes or non-intact skin. These include instruments used in debridement of ulcerations, abscesses or other non-intact skin or subcutaneous tissues.
- **Semi-critical items minimally require high-level disinfection using chemical disinfectants.**
- Examples include: Instruments used in debridement of ulcerations or abscesses such as tissue nippers, curettes, dissecting scissors, etc. and instruments used in nail care such as nail cutting instruments and nail burrs.”
- “It is recommended that metal files, corn and callus rasps, nail nippers/cutters, scissors, probes, curettes, and rotary tool burr (if not disposable) **be reprocessed as though they are semi-critical if they are used for multiple clients.**”

DISINFECTION AND STERILIZATION GUIDELINE RECOMMENDATIONS

FOR PODIATRIC PHYSICIANS <http://www.rainiermeded.com/v/vspfiles/assets/images/apma%20disinfectin%20guideline.pdf>

[https://www.picnet.ca/wp-content/uploads/PICNet-Foot-Care-Equipment-Reprocessing-Discussion-Paper\\_March-2015.pdf](https://www.picnet.ca/wp-content/uploads/PICNet-Foot-Care-Equipment-Reprocessing-Discussion-Paper_March-2015.pdf)



## Critical- SINGLE USE (disposable scalpels)

- Sterilization is a complex process generally outside the scope of long-term care
- Single Use, Disposable is best (Dispose in sharps container)



# What About These Instruments Used on Multiple People?

Found in shower room

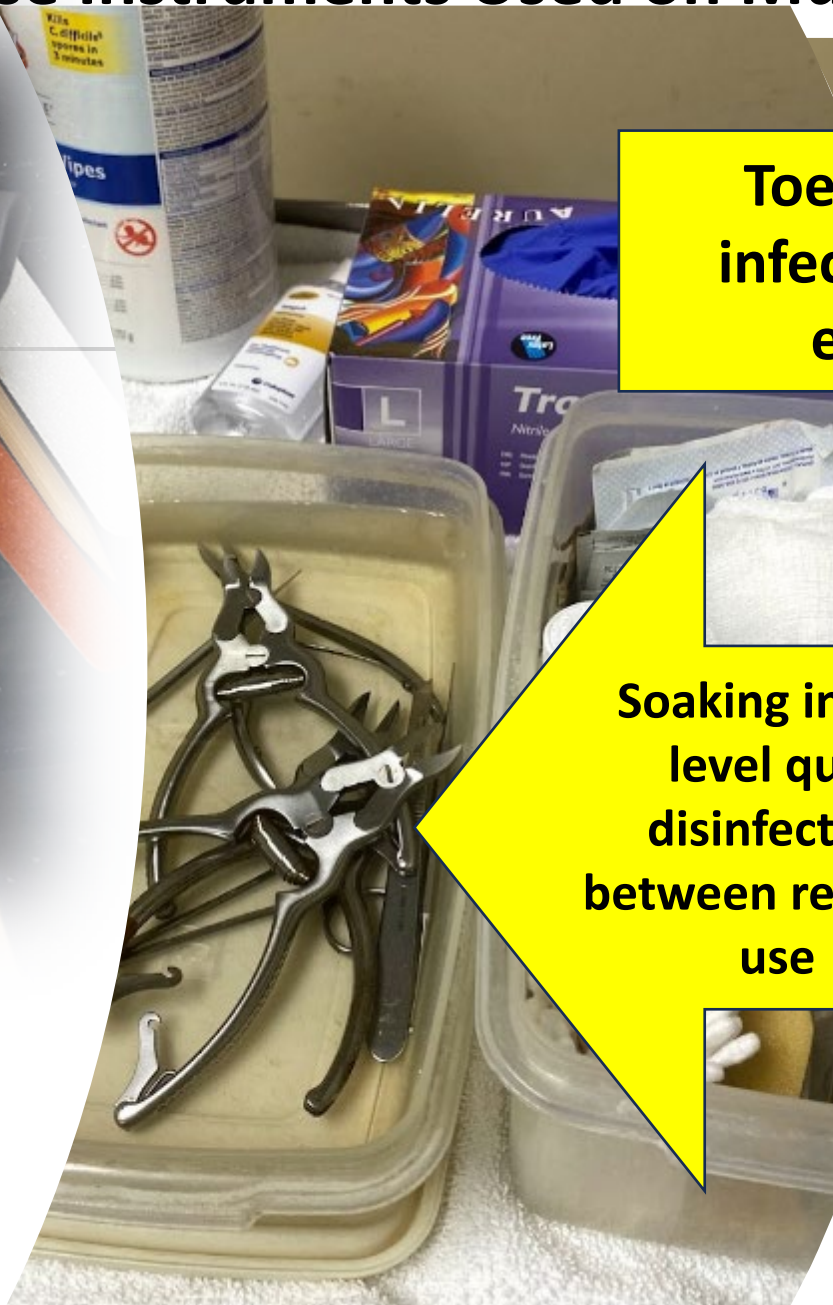
Toe bacterial/fungal infection r/t improper equipment use



Soaking in low level quat disinfectant between resident use



NO!!  
NO!!  
LOW  
LEVEL



# Trash and Regulated Waste: A Reminder

There is a large difference between trash and regulated waste

*OSHA: “Regulated waste as liquid or semi-liquid blood or other potentially infectious material (OPIM); contaminated items that would release blood or OPIM in a liquid or semi-liquid state if compressed; items that are caked with dried blood or OPIM and are capable of releasing these materials during handling; contaminated sharps; and pathological and microbiological wastes containing blood or OPIM [29 CFR 1910.1030(b)].... Employers must evaluate their individual workplaces and institute measures to eliminate or minimize employee exposure to blood or OPIM based on the unique set of scenarios or tasks in the facility. An exposure control plan is the employer's written program which is required to outline the protective measures taken.”*

<https://www.osha.gov/laws-regs/standardinterpretations/2009-06-02>



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## NOT Regulated Waste

- Once it is in the red biohazard bag it needs to be treated as regulated waste
- Very expensive and unnecessary
- Some wound materials may be considered regulated (e.g., debrided tissue or blood soaked bandages)



# Summary: Back to the basics about environment and care of instruments, dressings, treatments

- Do not use medication/dressing prescribed for one person on another person
- Do not “save” ointments, creams, opened dressings
- Keep your wound cart clean and disinfected
- Beware of caddies and containers taken room to room
- Basic infection control for ointments clean plastic bags and boxes






# Summary: Why the Infection Preventionist needs to be a full-time job!!!

- More complex the care, the more human hands providing that care
- More ointments, creams, equipment, supplies, and dressings used
- Greater need for surveillance, rounding, competencies, and just in time training
- Greater need for persons trained and certified in wound management as well as a person trained in infection prevention and control
- Core principles of infection prevention and control apply EVERY TIME



A network diagram with nodes and connections on a dark background. The nodes are represented by small, colored circles in various colors including blue, orange, purple, green, and grey. They are interconnected by thin, grey lines, forming a complex web of connections. The background is dark grey with a gradient and scattered small black dots.

Thank you for the work  
you do!

Questions?

# Open Q&A

Submit questions via Q&A pod to **All Panelists**

**Please do not resubmit a single question multiple times**

Slides and recording will be made available after the session.

# Reminders

- For continuing education credit, please fill out the evaluation survey upon end of webinar
- SIREN Registration
  - To receive situational awareness from IDPH, please use this link to guide you to the correct registration instructions for your public health related classification: <http://www.dph.illinois.gov/siren>
- NHSN Assistance:
  - Contact Telligen: **nursinghome@telligen.com**