



Infection Prevention and Control Updates and Q&A Webinars for Long-Term Care and Congregate Residential Settings

May 17th, 2024

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
- Wounds: An Infection Prevention and Control Perspective
- Open Q & A

Upcoming Infection Prevention and Control Q&A

1:00 pm - 2:00 pm

| Date | Infection Control Topic | Registration Link |
|-------------------------------|---|---|
| Friday, May 31 st | Hepatitis | https://illinois.webex.com/weblink/register/r373ba b959328a8c3f0d3173175c31cb0 |
| Friday, June 28 th | Best Practice for Specimen Collection and Storage | https://illinois.webex.com/weblink/register/r4db9e 0331ce42a0ab89facf6b3f5fbce |

Wounds: An Infection Prevention and Control Perspective

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Presenters have no conflicts of interest



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Learning Objectives

- Identify the types of wounds and 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/>



Intact Skin is a Primary Defense against Infection

- *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.*

Physiology, Integument

Joyce Y. Kim; Harry Dao. StatPearls:

<https://www.ncbi.nlm.nih.gov/books/NBK554386/>

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.

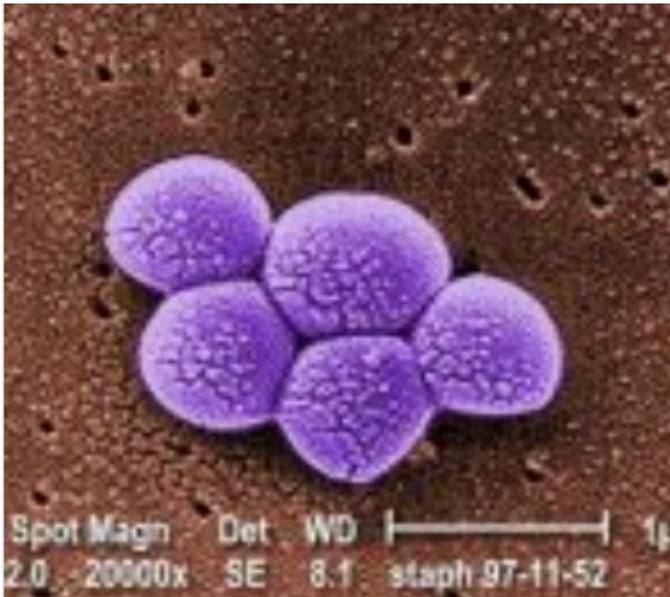
Good wound care and hygiene are important for preventing cellulitis.



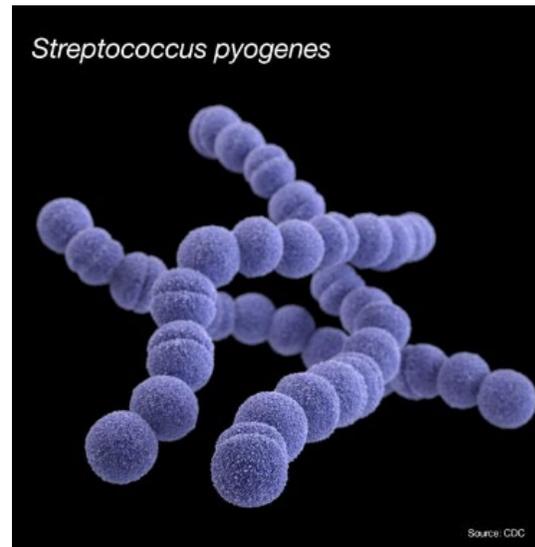
Mommarazzi Images © 2023

Gram Negative and Gram Positive bacteria and yeasts 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.



<https://www.cdc.gov/mrsa/community/photos/index.html>



Group A Strep (GAS)
<https://www.cdc.gov/streplab/groupa-strep/index.html>



General information about CRE

CRE stands for carbapenem-resistant Enterobacterales

<https://www.cdc.gov/hai/organisms/cre/index.html>



 Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

Candida auris

<https://www.cdc.gov/fungal/candida-auris/candida-auris-qanda.html>

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



SNF: Georgia, Group A Strep (GAS) Outbreak (con't)

- *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.*



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 and settle plates (environmental contamination)
- 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.***



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<https://pubmed.ncbi.nlm.nih.gov/29783026/>

Wounds

A **wound** is defined as any disruption of the integrity of skin, mucous membrane, or organ tissue.

Skin changes in the elderly:

- Thinner, more fragile
- Reduced dermal vascularity
- Decreased collagen production
- Less adhesion between skin layers
- Redistribution of fat
- Decrease in sensation
- Decrease in sweat production

Source: Nursing2003:January 2003-Volume 33-Issue 1-84 Wound and skin care; Zulkowski, Karen RN, CWs, DNS



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Braden Scale

- tool commonly used in health care to provide an **objective assessment** of a patient's/resident's **risk** for developing pressure injuries.
- The six risk factors included are **sensory perception, moisture, activity, mobility, nutrition, and friction/shear**, and these factors are **rated on a scale from 1-4** with 1 being “completely limited” to 4 being “no impairment.”
- Ranges of scores - generally, a score of **18 or less indicates at-risk status.**
 - **mild risk** for scores 15-19
 - **moderate risk** for scores 13-14
 - **high risk** for scores 10-12
 - **severe risk** for scores less than 9

Use the Braden Scale for Predicting Pressure Ulcer Risk

Background: This tool can be used to identify patients at-risk for pressure ulcers. The Braden Scale was developed by Barbara Braden and Nancy Bergstrom in 1988 and has since been used widely in the general adult patient population. The scale consists of six subscales and the total scores range from 6-23. A lower Braden score indicates higher levels of risk for pressure ulcer development. Generally, a score of 18 or less indicates at-risk status.

Reference: <http://www.bradenscale.com/images/bradenscale.pdf>. Reprinted with permission.

Instructions: Complete the form by scoring each item from 1-4 (1 for low level of functioning and 4 for highest level of functioning) for the first five risk factors and 1-3 for the last risk factor.

Use: Use this tool in conjunction with clinical assessment to determine if a patient is at risk for developing pressure ulcers and plan the care accordingly. In addition to the overall score, abnormal scores on any of the subscales should be addressed in the care plan.

Braden Pressure Ulcer Risk Assessment

Patient's Name _____ Evaluator's Name _____ Date of Assessment _____

| | | | | | | | | |
|---|---|--|---|--|--|--|--|--|
| Sensory Perception ability to respond meaningfully to pressure-related discomfort | 1. Completely Limited: Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR limited ability to feel pain over most of body surface. | 2. Very Limited: Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness. OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body. | 3. Slightly Limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned. OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities. | 4. No Impairment: Responds to verbal commands, has no sensory deficit which would limit ability to feel or voice pain or discomfort. | | | | |
| Moisture degree to which skin is exposed to moisture | 1. Constantly Moist: Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned. | 2. Very Moist: Skin is often, but not always, moist. Linen must be changed at least once a shift. | 3. Occasionally Moist: Skin is occasionally moist, requiring an extra linen change approximately once a day. | 4. Rarely Moist: Skin is usually dry, linen only requires changing at routine intervals. | | | | |
| Activity degree of physical activity | 1. Bedfast: Confined to bed. | 2. Chairfast: Ability to walk severely limited or non-existent. Cannot bear weight and/or must be assisted into chair or wheelchair. | 3. Walks Occasionally: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair. | 4. Walks Frequently: Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours. | | | | |
| Mobility ability to change and control body position | 1. Completely Immobile: Does not make even slight changes in body or extremity position without assistance. | 2. Very Limited: Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently. | 3. Slightly Limited: Makes frequent though slight changes in body or extremity position independently. | 4. No Limitations: Makes major and frequent changes in position without assistance. | | | | |
| Nutrition usual food intake pattern | 1. Very Poor: Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement. OR is NPO and/or maintained on clear liquids or IV's for more than 5 days. | 2. Probably Inadequate: Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. OR receives less than optimum amount of liquid diet or tube feeding. | 3. Adequate: Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement if offered. OR is on a tube feeding or TPN regimen which probably meets most of nutritional needs. | 4. Excellent: Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation. | | | | |
| Friction and Shear | 1. Problem: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation lead to almost constant friction. | 2. Potential Problem: Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down. | 3. No Apparent Problem: Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times. | | | | | |

Sources: <https://www.ncbi.nlm.nih.gov/books/NBK593201/> ;

<https://www.ahrq.gov/patient-safety/settings/hospital/resource/pressureulcer/tool/pu7b.html>;

Types of Wounds

Vascular (arterial, venous, and mixed)

Neuropathic (diabetic)

Moisture-associated dermatitis

Skin tear

Pressure ulcer

Mixed Etiologies- e.g. (both venous and arterial insufficiency or diabetic and pressure)

Source: Nursing Skills. Chapter 20 Wound Care: <https://www.ncbi.nlm.nih.gov/books/NBK593201/>;



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Vascular Ulcer

1. Venous ulcer

- caused by pooling of fluid in the veins of the lower legs. resulting in **elevated hydrostatic pressure in the veins** causing fluid to seep out, macerate the skin, and cause venous ulcerations.
- occur on the **medial lower leg** and have irregular edges
- often a dark-colored discoloration of the lower legs
- **compression dressings must be used**, along with multilayer bandage systems, to control edema and absorb large amounts of drainage



Figure 20.8

Venous Ulcer

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Vascular Ulcer

2. Arterial ulcers

- caused by **lack of blood flow and oxygenation to tissues.**
- wound base may become **necrotic** (black) due to tissue death
- typically occurs in the **distal areas** of the body such as the **feet, heels, and toes.**
- well-defined borders with a “**punched out**” appearance
- Wound dressings must maintain a **moist environment**, and treatment must include the **removal of necrotic tissue.** In severe arterial ulcers, **vascular surgery** may be required



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Diabetic/Neuropathic Ulcer

- because of **peripheral neuropathy** (decreased sensation of pain and pressure), especially in the **lower extremities** commonly present in patients/residents with diabetes.
- **plantar aspect of the feet and toes** of a patient/resident with diabetes due to lack of sensation of pressure or injury
- is vital for nurses to teach meticulous foot care to patients/residents with diabetes and encourage the use of well-fitting shoes.



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Source: Nursing Skills. Chapter 20 Wound Care: <https://www.ncbi.nlm.nih.gov/books/NBK593201>



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Pressure Injuries/Ulcers

- localized damage to the skin and underlying soft tissue usually **over a bony prominence or related to a medical or other device.**
- can present as **intact skin or an open ulcer** and may be painful.
- occurs as a result of **intense and/or prolonged pressure or pressure in combination with shear.**

Source: https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf;



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Pressure Injuries/Ulcers Staging

Stage 1 Pressure Injury: Non-blanchable erythema of intact skin

Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis

Stage 3 Pressure Injury: Full-thickness skin loss

Stage 4 Pressure Injury: Full-thickness skin and tissue loss

Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss

Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration



Source: https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf;



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Pressure Injury Prevention Bundle/Checklist

- I. Risk Assessment
- II. Skin Care
- III. Nutrition
- IV. Repositioning
- V. Education

| Pressure Injury Prevention Points | |
|---------------------------------------|---|
| RISK ASSESSMENT | |
| 1 | Consider bedfast and chairfast individuals to be at risk for development of pressure injury. |
| 2 | Use a structured risk assessment, such as the Braden Scale, to identify individuals at risk for pressure injury as soon as possible (but within 8 hours after admission). |
| 3 | Refine the assessment by including these additional risk factors: <ul style="list-style-type: none">A. Fragile skinB. Existing pressure injury of any stage, including those ulcers that have healed or are closedC. Impairments in blood flow to the extremities from vascular disease, diabetes or tobacco useD. Pain in areas of the body exposed to pressure |
| 4 | Repeat the risk assessment at regular intervals and with any change in condition. Base the frequency of regular assessments on acuity levels: <ul style="list-style-type: none">A. Acute care Every shiftB. Long term care . . . Weekly for 4 weeks, then quarterlyC. Home care At every nurse visit |
| 5 | Develop a plan of care based on the areas of risk, rather than on the total risk assessment score. For example, if the risk stems from immobility, address turning, repositioning, and the support surface. If the risk is from malnutrition, address those problems. |
| SKIN CARE | |
| 1 | Inspect all of the skin upon admission as soon as possible (but within 8 hours). |
| 2 | Inspect the skin at least daily for signs of pressure injury, especially nonblanchable erythema. |
| 3 | Assess pressure points, such as the sacrum, coccyx, buttocks, heels, ischium, trochanters, elbows and beneath medical devices. |
| 4 | When inspecting darkly pigmented skin, look for changes in skin tone, skin temperature and tissue consistency compared to adjacent skin. Moistening the skin assists in identifying changes in color. |
| 5 | Cleanse the skin promptly after episodes of incontinence. |
| 6 | Use skin cleansers that are pH balanced for the skin. |
| 7 | Use skin moisturizers daily on dry skin. |
| 8 | Avoid positioning an individual on an area of erythema or pressure injury. |
| NUTRITION | |
| 1 | Consider hospitalized individuals to be at risk for under nutrition and malnutrition from their illness or being NPO for diagnostic testing. |
| 2 | Use a valid and reliable screening tool to determine risk of malnutrition, such as the Mini Nutritional Assessment. |
| 3 | Refer all individuals at risk for pressure injury from malnutrition to a registered dietician/nutritionist. |
| 4 | Assist the individual at mealtimes to increase oral intake. |
| 5 | Encourage all individuals at risk for pressure injury to consume adequate fluids and a balanced diet. |
| 6 | Assess weight changes over time. |
| 7 | Assess the adequacy of oral, enteral and parenteral intake. |
| 8 | Provide nutritional supplements between meals and with oral medications, unless contraindicated. |
| REPOSITIONING AND MOBILIZATION | |
| 1 | Turn and reposition all individuals at risk for pressure injury, unless contraindicated due to medical condition or medical treatments. |
| 2 | Choose a frequency for turning based on the support surface in use, the tolerance of skin for pressure and the individual's preferences. |
| 3 | Consider lengthening the turning schedule during the night to allow for uninterrupted sleep. |
| 4 | Turn the individual into a 30-degree side lying position, and use your hand to determine if the sacrum is off the bed. |
| 5 | Avoid positioning the individual on body areas with pressure injury. |
| 6 | Ensure that the heels are free from the bed. |
| 7 | Consider the level of immobility, exposure to shear, skin moisture, perfusion, body size and weight of the individual when choosing a support surface. |
| 8 | Continue to reposition an individual when placed on any support surface. |
| 9 | Use a breathable incontinence pad when using microclimate management surfaces. |
| 10 | Use a pressure redistributing chair cushion for individuals sitting in chairs or wheelchairs. |
| 11 | Reposition weak or immobile individuals in chairs hourly. |
| 12 | If the individual cannot be moved or is positioned with the head of the bed elevated over 30°, place a polyurethane foam dressing on the sacrum. |
| 13 | Use heel offloading devices or polyurethane foam dressings on individuals at high-risk for heel ulcers. |
| 14 | Place thin foam or breathable dressings under medical devices. |
| EDUCATION | |
| 1 | Teach the individual and family about risk for pressure injury. |
| 2 | Engage individual and family in risk reduction interventions. |

Source: https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/1a_pressure-injury-preventi.pdf;



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Skin/Nutritional Care

Skin Care

- Inspect all of the skin upon admission (within 8 hours) and daily, especially during shower or bathing
- Assess pressure points
- Cleanse the skin promptly after episodes of incontinence
- Use skin cleansers that are pH balanced
- Moisturize skin daily to prevent dry skin

Nutrition

- Use valid and reliable screening tool to determine the risk of malnutrition (Mini Nutritional Assessment).
- Refer individuals with malnutrition to a registered dietitian/nutritionist
- Assist residents at mealtimes to increase oral intake
- Assess weight changes over time, and adequacy of oral, enteral, and parenteral intake.
- Provide nutritional supplements between meals and with oral medications, unless contraindicated.



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Source: https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/1a_pressure-injury-preventi.pdf;

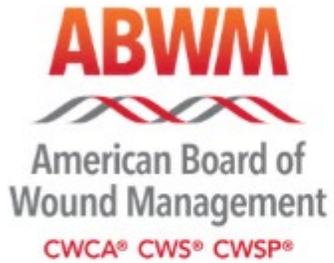
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3601862/#:~:text=For%20elderly%20patients%2C%20liquid%20protein%20formula%20supplementation,the%20gut%20doesn't%20work%2C%20of%20cut%20by>

Wound Care
and Infection
Prevention go
Hand in Hand



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GET CERTIFIED



<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/>

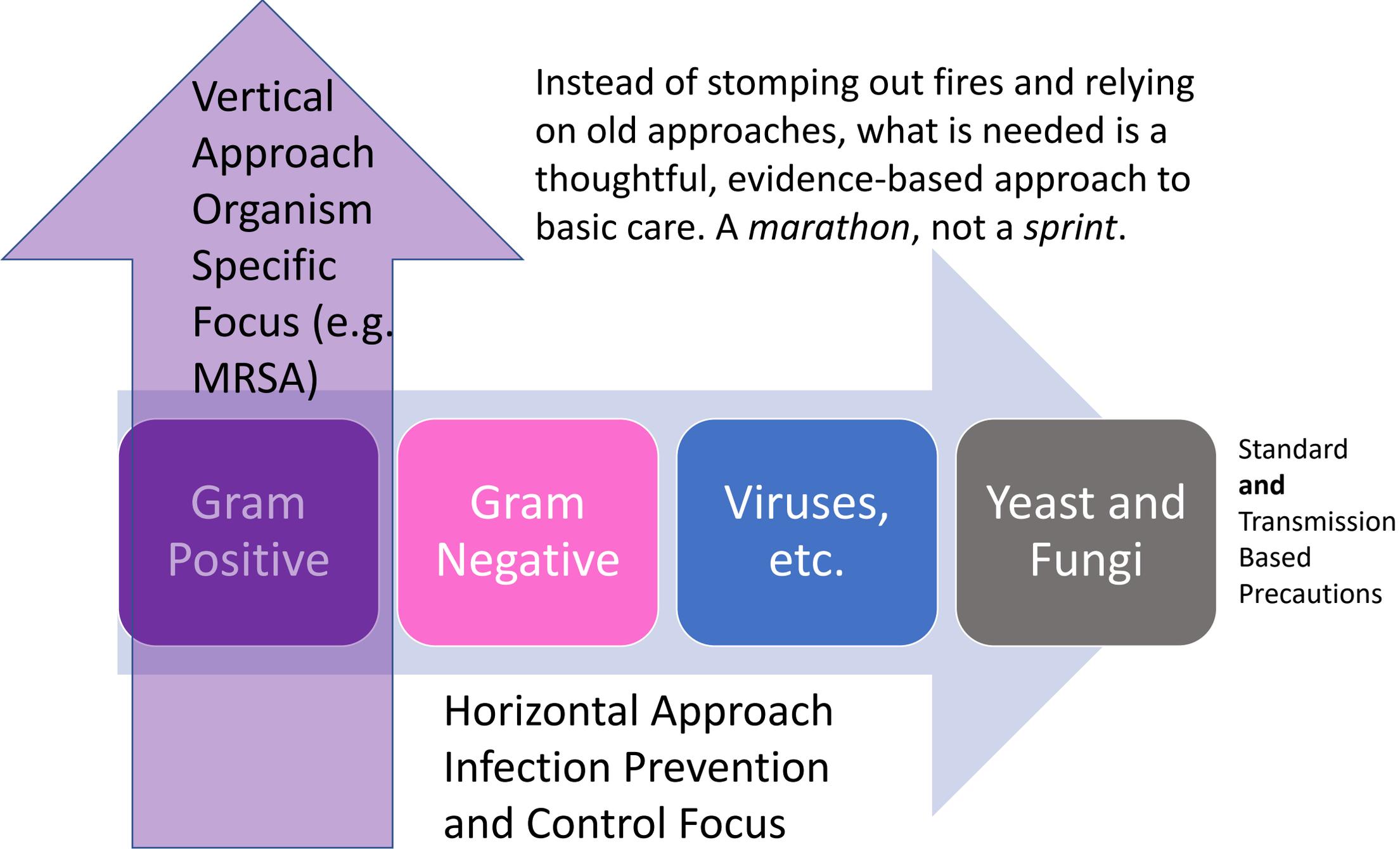
Wound Certificates and Certifications: Be Prepared!
Average Pass Rate: 72%



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



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.

Ensure there
are
appropriate
reasons to use
antimicrobials

Suspected Skin and Soft-tissue Infection

- New or increasing purulent drainage at a wound, skin, or soft-tissue site
- or*
- *At least 2* of the following:
 - Fever ($>37.9^{\circ}\text{C}$ [100°F] or a 1.5°C [2.4°F] increase above baseline temperature)
 - Redness
 - Tenderness
 - Warmth
 - New or increasing swelling

Source: Loeb et al. Development of Minimum Criteria for the Initiation of Antibiotics in Residents of Long-Term Care Facilities: Results of a Consensus Conference. *Inf Control Hosp Epi.* 2001



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Surveillance Definition Revisiting McGeer 2012

TABLE 6

Surveillance Definitions for Skin, Soft Tissue, and Mucosal Infections

| Criteria | Comments |
|---|---|
| A. Cellulitis, soft tissue, or wound infection (at least 1 of the following criteria must be present) | |
| 1. Pus present at a wound, skin, or soft tissue site | Presence of organisms cultured from the surface (eg, superficial swab sample) of a wound is not sufficient evidence that the wound is infected. More than 1 resident with streptococcal skin infection from the same serogroup (eg, A, B, C, G) in a long-term care facility (LTCF) may indicate an outbreak. |
| 2. New or increasing presence of at least 4 of the following sign or symptom subcriteria | |
| a. Heat at the affected site | |
| b. Redness at the affected site | |
| c. Swelling at the affected site | |
| d. Tenderness or pain at the affected site | |
| e. Serous drainage at the affected site | |
| f. One constitutional criterion (see Table 2) | |

Surveillance Definitions of Infections in Long-Term Care Facilities: Revisiting the McGeer Criteria

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<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3538836/>

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.



- “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”

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

- Found in Survey Resources:

Pressure Ulcer/Injury Critical Element Pathway

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 heat pressure ulcers.

Review the following in Advance to Guide Observations and Interviews:

- The most current comprehensive MDS 3.0 AA for Section C - Lifestyle Factors, G - Functional Status, H - Shaker and Hoist, J - Conditions-Drm, K - Bowel/Urinary/Nutritional Status, M - Skin Condition-Intact/Intact, history of a pressure ulcer or pressure injury, a pressure relieving device.
- Physician's orders (e.g., wound treatment) and treatment room (TAB) for care regimen.
- Care plans (e.g., pressure relief devices, repositioning schedule, mattress, specialized skin-care support), or pressure ulcer or pressure injury.

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 primal order).
 - Remove 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 outside of resident care areas, unused supplies are discarded or remain dedicated to the resident, multi-dose wound care containers, sources credit to dedicated)?
- Are 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 order? What did you do?

Interviews:

- How are care plan interventions being implemented?
- How are staff following the care plan?
- Is the resident repositioned timely and in the correct or most appropriate manner (e.g., PUMP or manual) as indicated?
- Use of proper technique when turning, repositioning, repositioning to avoid skin damage and the pressure reduction.
- 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

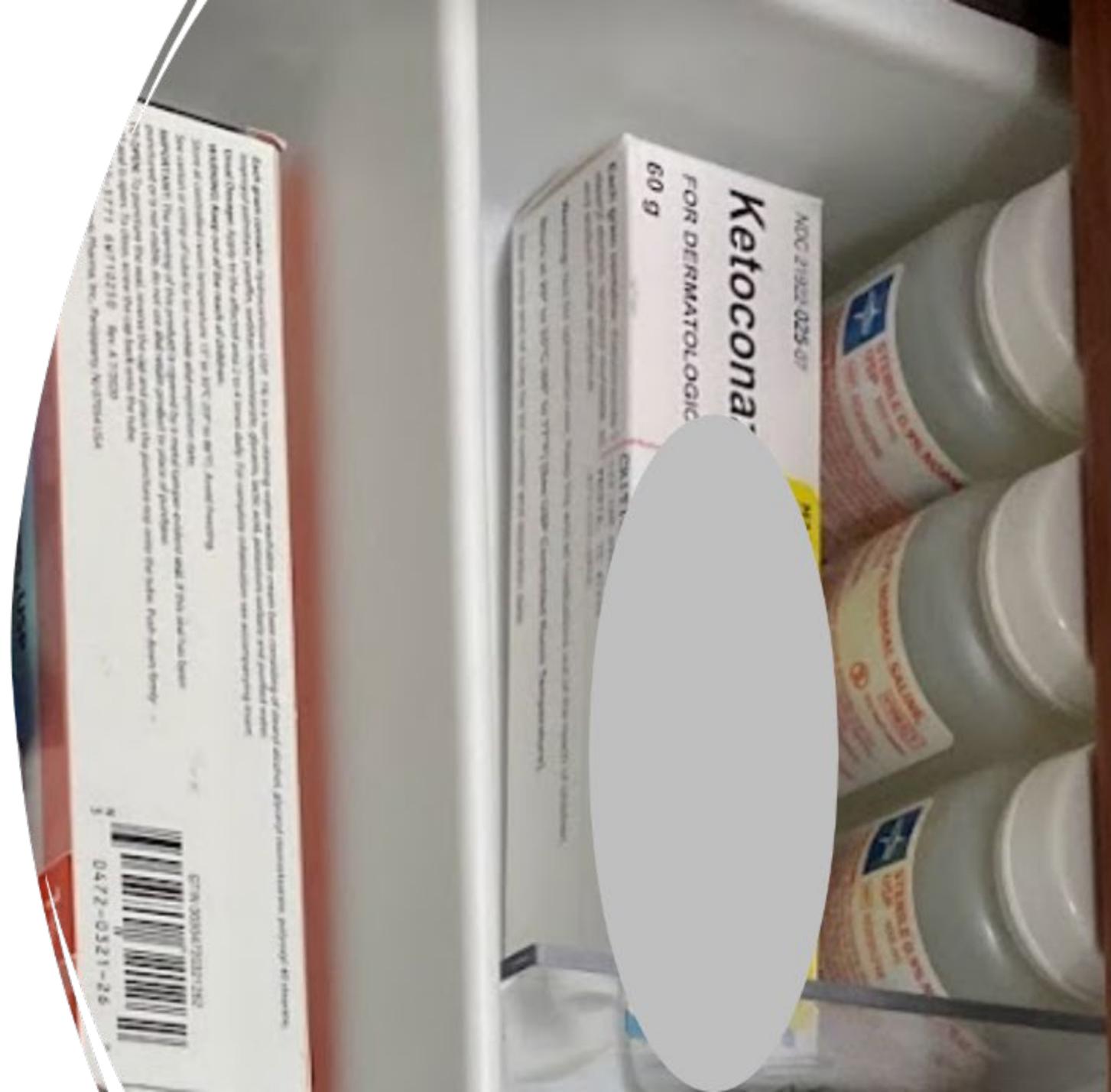


Good Example

- 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
- Internal boxes only, not external shipping boxes

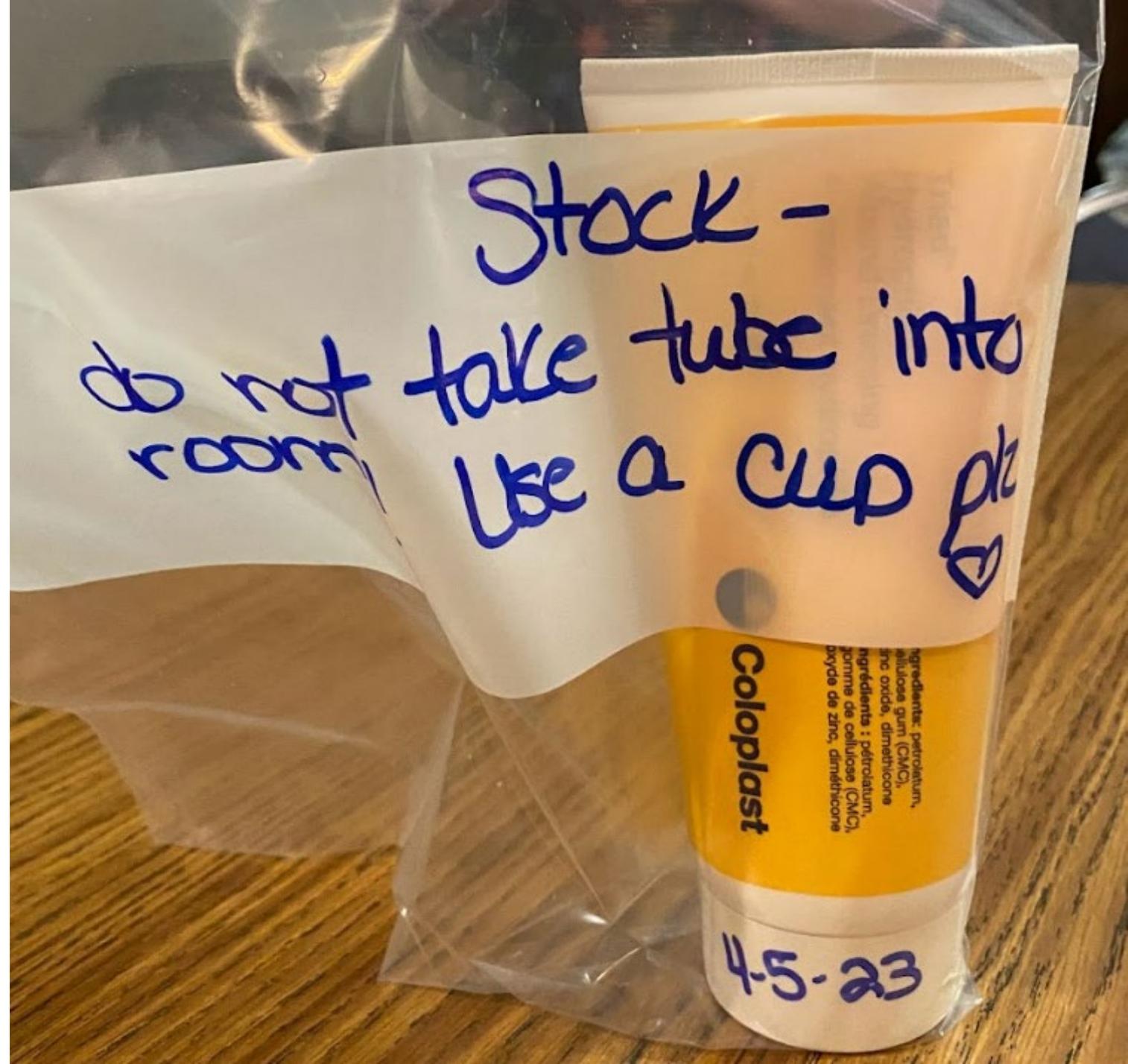


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Clear Messaging

- 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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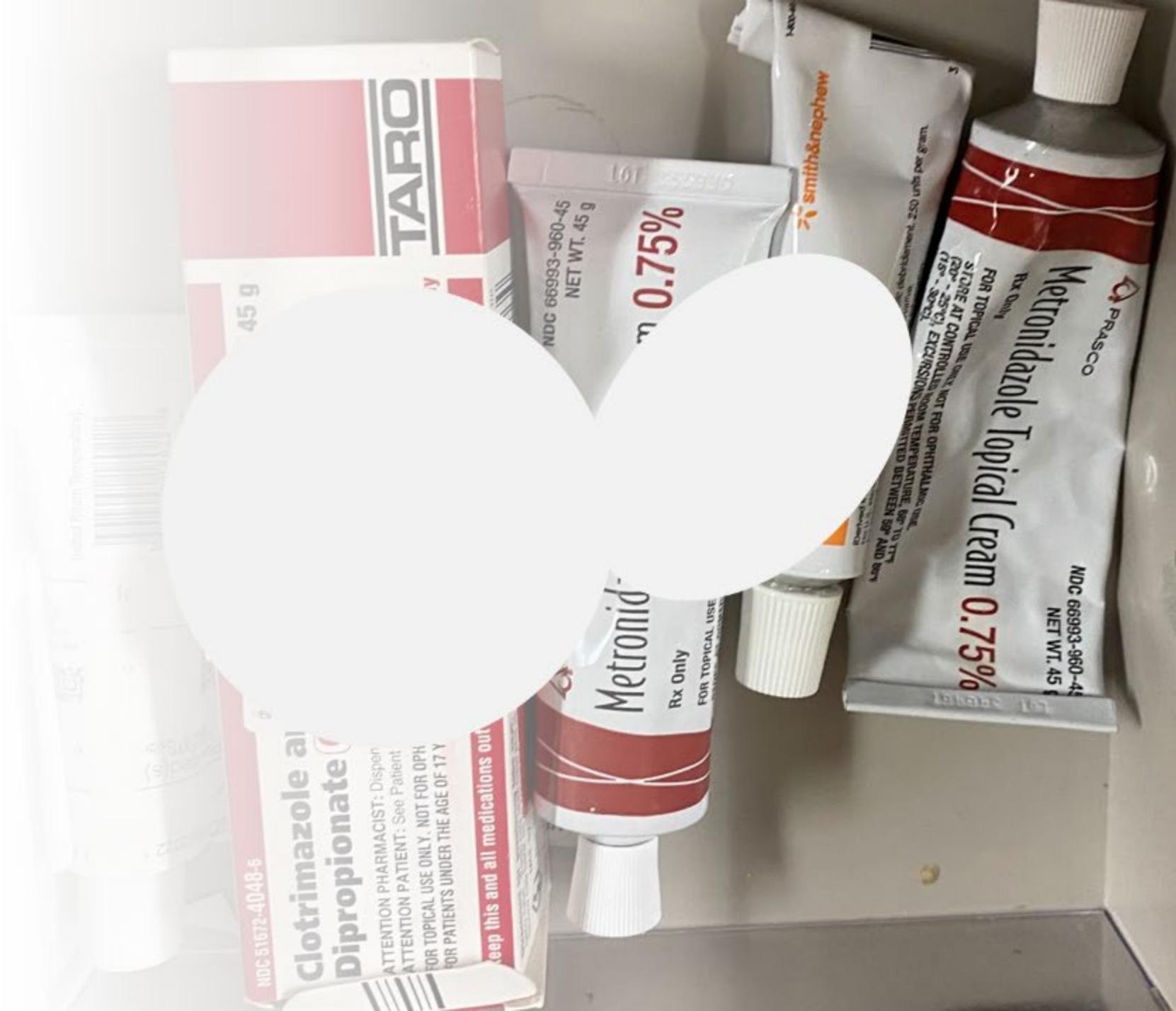
Mixed and Mingled

- 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

25g (1oz)

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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 0.5g of bacitracin zinc and 0.5g of zinc. 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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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?

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

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

**Left open to
exposure**

**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**



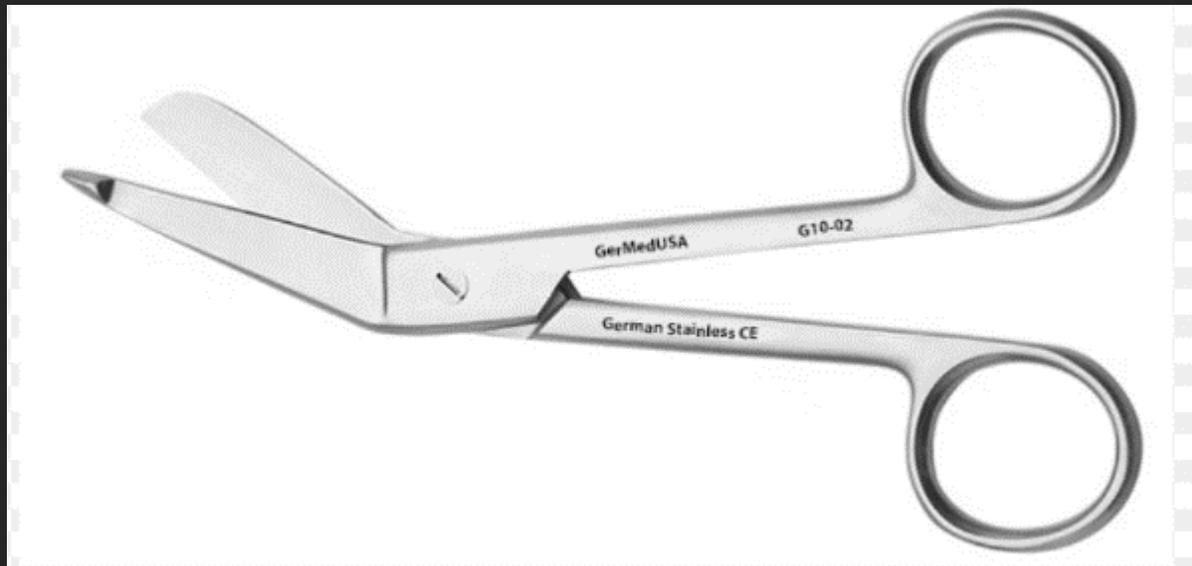
Accessible version: <https://www.cdc.gov/infectioncontrol/guidelines/disinfection/>



Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008

Update: May 2019

William A. Rutala, Ph.D., M.P.H.^{1,2}, David J. Weber, M.D., M.P.H.^{1,2}, and the Healthcare Infection Control Practices Advisory Committee (HICPAC)³



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



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 is not acceptable!!



**NO!!
NO!!
LOW
LEVEL**

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 a dense web of thin, grey lines. 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
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<https://www.telligenqiconnect.com/infectionpreventionandcontrol/>
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