GOAL AND OBJECTIVES
SURVEILLANCE PREVENTION AND CONTROL OF INFECTION
TOTAL BODY WASH-SKIN DECOLONIZATION

Setting Aims:
1. Improve patient hygiene
2. Reduce resistant endogenous bacterial colonization
3. Elimination of MRSA, VRE
4. Elimination of unnecessary antibiotic therapy and LOS
5. Cost savings

Establishing Measures:
The idea behind is to reduce endogenous resistant flora colonization by normal flora of the patient and reduce unnecessary isolation practice and antibiotic therapy.

Selecting Changes:
Byotrol non-rinse body wash will bring the effectiveness required to provide the appropriate care to meet each patient care.

Testing Changes:
The implementation of total body wash step-by-step Plan of Care will help the healthcare provider to determine timely, appropriate intervention by simplifying care and eliminating guesswork. The process will promote the healing process by reducing bacteria known to cause most dysfunction, including MRSA, and VRE.

**Nosocomial S. aureus Infections:**
Excess Cost and Length of Stay
Case-control study of patients with nosocomial Bacteremia with MRSA (n=8) vs. MSSA (n=11)

<table>
<thead>
<tr>
<th>Increase in Attributable LOS (Days)</th>
<th>MSSA</th>
<th>MRSA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4</td>
<td>12</td>
</tr>
</tbody>
</table>

| Increase in Attributable Cost      | $9,661 | $27,083 |

Abramson MA. Infect Control Hosp Epidemiol. 1999; 20:408-11

References:
Meeting the Challenges of Today’s Hospital Infections
[Where we started and where we’re going.....]

Presented by:
Alfonso Torress-Cook, Dr.P.H.
Epidemiologist
The Landscape of Healthcare-Associated (HCA) Infections

- Healthcare system is evolving to an increased use of outpatient procedures and long-term care

Many long-term-care facilities now experience infection rates comparable to those in acute hospital settings

Outbreaks are common
Close to 60% of S. aureus isolates from hospitalized patients are methicillin-resistant. MRSA isolated from 59% of patients with community-acquired skin and skin structure infections.

Healthcare facilities-acquired infections in most cases, are the results of environmental contamination, and poor patient hygiene during hospitalization, and not how sick the patient were at the time of admission.
The Way We Were at PHLB

- In years past. It was generally accepted that a well designed Infection Control Program could prevent about 30% of infections acquired in the hospital.

- As long as we are below the national level.

- “Because we’ve always done it that way

  The times they are a changing........

  Bob Dylan
The Difference Between Reporting Well and Performing Well

**Limited Focus Understating Problem**

- "Aren’t we doing well?"
  The focus of most hospital surveillance and reporting efforts

- "There’s only so much time"
  Limited surveillance conducted
Cultural Change [The Initial Push]

Cultural Change Never Easy

**Staff Concerns**

- **Increased Workload**
  More steps per patient without additional staffing resources

- **Complex Processes**
  Difficult processes without sufficient education

- **Cultural Upheaval**
  Reactions of physicians, families to process change

**Physician Concerns**

- **Standardization**
  ‘Cookbook’ medicine limits room for individual options

- **Inadequate Support**
  Proper supplies not present, forced to go off protocol

- **Patient Outcomes**
  Fear poorer outcomes using unfamiliar processes
## Looming Proposal to Cut Payments

<table>
<thead>
<tr>
<th>Condition</th>
<th>Selected in FY08 Rule</th>
<th>Future Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Serious preventable event—object left in surgery</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>2. Serious preventable event—air embolism</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>3. Serious preventable event—blood incompatibility</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>4. Catheter associated urinary tract infections</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>5. Pressure ulcers (Decubitus ulcers)</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>6. Vascular catheter associated infection</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>7. Surgical site infection (Mediastinitis after CABG surgery)</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>8. Falls</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>9. Ventilator associated pneumonia</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>10. Staphylococcus aureus septicemia</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>11. Deep vein thrombosis/Pulmonary embolism</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>12. Methicillin resistant staphylococcus aureus</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>13. Clostridium difficile-associated disease</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>
Infections are not longer considered inevitable consequences of treating older, sicker or uninsured patients.

Now we hear terms like “zero tolerance”, “pursuing perfection”, “irreducible minimum”, “lean”, and “six sigma”.

The idea is to aim for perfection rather than just matching your competition – benchmarks contain a lot of defects. (NHSN, APIC, SHEA)
Raising the bar for health care

- Recent shift in health care with patient safety becoming a priority, and quality care delivered using evidence based practice and expectation.

- IHI Collaborative 5 Million Lives Campaign
- CMS Measures (New changes October 2008)
- Joint Commission National Patient Safety Goals
- Media coverage of high profile errors
The proposed changes for PHLB

- A clear vision of what we want, for our patients – to walk out the door free from a HAI’s
- A cultural shift that views infection as preventable until proven otherwise.
- A culture that expects compliance with proven intervention to prevent errors from everyone

It takes a great deal of courage to stand up to your enemies, but even more to stand up to your friends. J.K. Rowling
New Technology [Residual Products]

- A cleaning algorithm [Steiros Algorithm]
- Skin decolonization [Hand/Skin Sanitizer]
- ByoSkin [Residual effect products]
- Standardization of Infection Control Practices.
- Education
Frequency of Bacteria - Colonization

- Forehead: 51%
- Nose: 54 – 93%
- Neck: 35%
- Axilla: 13% - 28%
- Hands: 40%
- Groin: 30% - 39%

*69% of positives patients were colonized at more than one extra nasal site

Rohr U et al. Int J. Hyg Environ Health 2004; 207;51
The Patient [The Skin is The Source]

Biofilm

MRSA
Changing our Practice

PACIFIC HOSPITAL OF LONG BEACH
2776 Pacific Ave, Long Beach, CA, 90806
Luke R. Watson, M.D., Medical Director

PATIENT:  
I.D. #:  
MRN:  
DOB: 09/11/1944  
LOCATION: MU-248-A  
AGE: 64  
SEX: M

MICROBIOLOGY

ORDER#: 26110090
SOURCE: Back UPPER
ANTIBIOTICS AT COLL.:

<table>
<thead>
<tr>
<th>ANTIBIOTICS</th>
<th>P.aeruginosa</th>
<th>E.coli</th>
<th>MRSA</th>
<th>E.faecalis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MIC</td>
<td>INTP</td>
<td>MIC</td>
<td>INTP</td>
</tr>
<tr>
<td>Ampicillin</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ampicillin/sulbactam</td>
<td>&lt;=4</td>
<td>R</td>
<td>&lt;=2</td>
<td>S</td>
</tr>
<tr>
<td>Piperacillin/tazobac</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cefazolin</td>
<td>&lt;=4</td>
<td>S</td>
<td>&lt;=4</td>
<td>S</td>
</tr>
<tr>
<td>Ceftriaxone</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Cefepime</td>
<td></td>
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</tr>
<tr>
<td>Aztreonam</td>
<td>&gt;64</td>
<td>R</td>
<td>&gt;64</td>
<td>S</td>
</tr>
<tr>
<td>Imipenem</td>
<td>&lt;=4</td>
<td>S</td>
<td>&lt;=4</td>
<td>S</td>
</tr>
<tr>
<td>Ertaipenem</td>
<td>&lt;=4</td>
<td>S</td>
<td>&lt;=4</td>
<td>S</td>
</tr>
<tr>
<td>Gentamicin</td>
<td>&lt;=4</td>
<td>S</td>
<td>&lt;=4</td>
<td>S</td>
</tr>
<tr>
<td>Tobramycin</td>
<td>&lt;=4</td>
<td>S</td>
<td>&lt;=4</td>
<td>S</td>
</tr>
<tr>
<td>Amikacin</td>
<td>&lt;=4</td>
<td>S</td>
<td>&lt;=4</td>
<td>S</td>
</tr>
<tr>
<td>Levofoxacin</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trimethoprim/Sulfa</td>
<td>&lt;=64</td>
<td>R</td>
<td>&lt;=64</td>
<td>S</td>
</tr>
<tr>
<td>ESBL</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benzylpenicillin</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxacillin MIC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Erythromycin</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Vancomycin</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tetracycline</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rifampin</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gentamicin High Leve</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Streptomycin High Lev</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Restricted to ID

COMMENTS

- MIC: Minimum Inhibitory Concentration
- INTP: Inhibitory
- R: Resistant
- S: Sensitive
- SYN: Synthesis
- SYN-R: Synthesis - Resistant
- SYN-S: Synthesis - Sensitive

- Restricted to ID indicates that the use of this antibiotic is restricted to inpatient use.
Cleaning the Patient [ByoSkin Cleanser]

2776 Pacific Ave, Long Beach, CA, 90806
Luke R. Watson, M.D., Medical Director

PATIENT: 
.D.#: 

MRN: 
DOB: 09/11/1944

MICROBIOLOGY

ORDER#: 26110090
SOURCE: Back UPPER

ANTIBIOTICS AT COLLECT.: 

- Gram 
  No WBC's seen
  1+ Epithelial cells
  No organisms seen

ORDERED BY: 
COLLECTED: 02/1
RECEIVED: 02/1
- FINAL 02/1
Contamination by the patient

Bacteria under finger nails
Bacteria [MRSA, VRE]
The skin supports its own ecosystem of micro-organisms including yeast and bacteria which cannot be removed by any amount of cleaning.
Just because there is no direct evidence linking surface levels hygiene and bacteria acquisition, does not mean to say that there is not any.

There is evidence for every stage of the staphylococcal transmission cycle between man and his environment.
UV Light
Evidence-Based-Demonstration to our Partners [EVS]

Surface evaluation using ATP bioluminescence

Swab surface → Luciferase tagging of ATP → Hand held luminometer

Used in the commercial food preparation industry to evaluate surface cleaning before reuse and as an educational tool for more than 30 years.
The importance of cleaning

The Inanimate Environment Can Facilitate Transmission

X represents VRE culture positive sites

~ Contaminated surfaces increase cross-transmission ~

Consecutive Results

- Reduction of SWI by 90%
- Reduction of MRSA by 99%
- Reduction of CLABS by 85%
- Reduction of VAP’s by 85%
- Reduction of C. difficile by 100%

No one changes anything by playing it safe ........
Work Worthwhile Doing!

- MRSA infection increases LOS x 20 days
- Mortality increases 100% vs. MSSA
- Mean attributable cost = $6,916
- Cost of isolation and screening = $655
- Pre-intervention 108 cases of MRSA in 2008. 108 x 6,916 = $746,928
- Post-intervention a total of 5 cases x $6,916 = $34,580
- Savings = $746,928 - $34,580 = $712,348
Other Cost Savings

- Peripheral I.V. catheter change from 72 hours to 96 hours = $30,000
- In-line suction catheter daily versus no change = $10,000
- Central Line Catheter new Arrow kit change from 7 days to 14 days = $78,840
- Total savings of $118,840
Pursuing Perfection

*Increasing Appropriateness, Decreasing Infections*

Percentage of Foley Catheters Removed Before Transfer from ICU

<table>
<thead>
<tr>
<th></th>
<th>Pre-intervention</th>
<th>Post-intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage</td>
<td>6%</td>
<td>20%</td>
</tr>
</tbody>
</table>

UTI Infection Rate¹

Per 1,000 Catheter Days

<table>
<thead>
<tr>
<th></th>
<th>Pre-intervention</th>
<th>Post-intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate</td>
<td>6.4</td>
<td>1.9</td>
</tr>
</tbody>
</table>
Clean Care is Safe Care……..

Steiros – Algorithm a system in place at PHLB and Ernest Health Care LLC. Since 2006.
Surveillance Prevention and Control of Infection
STEIROS ALGORITHM™-TRACER-FLOW CHART

Assessment: Entry to Appropriate Setting

Assessment: History and physical examination

Diagnostic testing: BD-Gene-Ohm MRSA Test & PVL-Marker

Care decision

Care delivered

Reassessment of patient

Change in patient’s condition

Yes

Pharmacy Microbiology

I.C. consultation

- Body wash
- Oral Care
- Vitamin C.
- Antibiotic Eval.

No

Continue care

Yes

No

Change setting (discharge)

Pre-Surgery Instruction

Yes

Home

Hospital

Long term care org.

Home as outpatient

Home care Org.

Another ambulatory care setting

#### Multidrug Résistant Organisms (MRSA, VRE, )

<table>
<thead>
<tr>
<th>Infection Condition</th>
<th>Type</th>
<th>Duration</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multidrug-resistant organisms (MDRO’s), infection or colonization (e.g., MRSA, VRE, VISA/VRSA, ESBL, resistant S. pneumonia)</td>
<td>S/C</td>
<td></td>
<td>Contact Precautions is recommended in settings with evidence of on-going transmission, acute care settings with increased risk for transmission or wounds that can not be contained by dressing.</td>
</tr>
</tbody>
</table>

S= Standard Precautions, C = Contact Precautions

---

**Let’s simplify the process**

- We will embrace **Standard Precautions** as the main component of our prevention practice. The process encompasses the utilization of gloves, gown and mask if required, with strict hand washing before and after patient care.
- Every patient admitted to PHLB will be cleaned with Byotrol Body Wash in order to reduce endogenous flora.
- Rapid testing will be done using the BD Gene Ohm StaphSR Assay.
- Those patients admitted with large open wounds that can not be contained by dressing will be place on **Contact Precautions if MRSA positive.**
- Our EVS team will decontaminate the environment and equipment systematically.

**Remember:** MRSA is spread through touch and contaminated items. It is not spread through the air.

---

**Responsibility:**

- Every single employee is to ensure that they wash their hands before and after using restroom, eating, having patient contact and after sneezing, coughing, etc.
- We have a responsibility not to spread infection.

---

**Good Health is in Your Hands**

Do you know that one of the most effective way to stop the spread of infection is by washing your hands?

That’s right. The Centers for Disease Control and Prevention say that one of the most important means of preventing the spread of gastrointestinal (stomach flu) and respiratory (colds and the flu) illness is hand washing.

There are other ways to prevent passing on germs to friends, family and co-workers:

- Cover your mouth when sneeze or cough
- Avoid other people when you are ill with a cold or the flu.
CDC 12 STEPS TO PREVENT ANTIMICROBIAL RESISTANCE AMONG HOSPITALIZED PATIENTS

PREVENT INFECTION
1. Vaccinate
2. Get the catheters out (Central Line, Foley Catheter)

DIAGNOSE AND TREAT INFECTION EFFECTIVELY
3. Target the pathogen
4. Access the experts

USE ANTIMICROBIAL WISELY
5. Practice Antibiotics Control
6. Use your hospital data
7. Treat infection, not contamination
8. Treat infection, not colonization
9. Know when to say "no" to Vancomycin & Zyvox or de-escalated treatment.

PREVENT TRANSMISSION
10. Break the chain
11. Improve patient hygiene
12. Hand washing

This brochure provides basic general information only, and is to be used as a guide, not as a complete resource on the subject....

If you have any further questions, please call The Epidemiology Department Ext. 3071

 grooming
**Standard Precautions**

We will embrace *Standard Precautions* as the main component of our prevention practice. The process encompasses the utilization of proper personal protective equipment (PPE) when providing care to our patients, and anticipating any potential exposure. Gloves when touching open areas of the skin of the patient, gowns when the possibility of soiling your uniform or garments, and mask when providing care such as suction, intubation or the healthcare worker feel the need for the protection.

Every patient admitted to PHLB will be cleaned with a body wash cleanser in order to reduce the patient’s endogenous flora 80% of patients bring resistant transitional flora.

Those patient admitted with large open wounds that can not be contained by dressing will be place on **Contact Precautions if MDRO’s positive.**

MDRO’s (Multiple Drug Resistant Organisms) are spread through touch and contaminated items. *They are not spread through the air.*

Our EVS Team will decontaminate the environment and equipment systematically in order to reduce the accumulation of bio-burden in our facility.

**In Addition to Standard Precautions**

There are 3 systems in place that prevent the spread of certain conditions. The process is based on the way the disease be spread.

**Airborne Precautions**

These precautions will be use when a patient is diagnosed or suspected of having an infection that can be transmitted by the air such as (Tuberculosis, SARS, Chicken Pox, Measles, and N. Meningitis). Patients with these conditions will be placed in our special negative air-pressure rooms and adequate diagnostic test will be implemented.

**Contact Precautions**

Is recommended in settings with evidence of on-going transmission or settings with increased risk for transmissions such as, C. difficile, Scabies or wounds that can not be contained by dressing and a resistant pathogen is found in the culture.

**Droplet Precautions**

Use these precautions when a patient is diagnosed or suspected of an infection that can be spread from the respiratory tract of the infectious individual. Respiratory droplets are generated during coughing, sneezing, talking or during suctioning and intubations. Wear a mask if working within 3 feet of the patient. If the patient leaves the room for therapy or other reasons, please place a mask on the patient. included such as: H1N1 Influenza.

<table>
<thead>
<tr>
<th>Isolation Precaution Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type</strong></td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>Airborne</td>
</tr>
<tr>
<td>Contact</td>
</tr>
<tr>
<td>Droplet</td>
</tr>
</tbody>
</table>

Every single employee is to ensure that they wash their hands before and after having patient contact.
cause a delay or cancellation of your surgery.

Exercise to prevent complications.

If you are to have general anesthesia, you will learn some exercises to help you after surgery. These include deep breathing and leg exercises.

This brochure provides basic general information only, and is to be used as a guide, not as a complete resource on the subject....

If you have any further questions, please ask your physician.
Preparing for surgery.

Your doctor has determined that surgery is needed as part of your treatment plan. Most patients and families are understandably anxious about having surgery. You probably have many questions. Please do not hesitate to discuss with your doctor or nurse any concerns that you may have. This material will provide you with information on what will take place before your surgery.

Before surgery.

Consent form

Your surgeon will explain the details of your surgery, including its risks and benefits. He or she will then ask you to sign a consent form. (The consent form gives your surgeon permission to perform the surgery he or she discussed with you). It is important that you ask your surgeon questions so you will have a good understanding of the surgery.

Time of surgery

You will be told the time of your surgery in advance. If you are an inpatient, you will be informed what time family or friends should arrive before the surgery. If you are an outpatient, same-day surgery patient, or ambulatory surgery patient you will be called the day before surgery and told what time to come to the hospital on the day of surgery.

Tests and examination

Before the surgery, laboratory tests and x-rays may be done. These tests may be different for each patient and may include blood tests, a chest x-ray, and an EKG (electrocardiogram). You will have a physical examination and a discussion about your medical history before surgery.

Anesthesia

The anaesthesiologist is a physician who administers the medication that puts you to sleep during the surgery or who gives you local or spinal anesthesia. He or she will talk with you before the surgery and will decide which type of anesthetic is best for you. You should tell the anaesthesiologist if you have any allergies, if you have been taking any medication and you also should tell the anaesthesiologist if you or an immediate family member has had complications with anesthesia in the past.

Bathing and personal hygiene.

Before your surgery, you can play an important role in your health. Because skin is not sterile, we need to be sure that your skin is free of certain organisms. You can reduce the number of your skin bacteria by carefully washing before surgery.

Please follow these instructions:

1. Shower or bathe with liquid Dial soap the night before your surgery. Do not shave the area of your body where your surgery will be performed.
2. With each shower wash your hair.
3. Rinse your hair and body thoroughly.
4. Pat yourself dry with a clean, soft towel.
5. Clean under your finger nails.

Shave preparation

Sometimes body hair in the area involved in the surgery must be removed by clipping. This will be done by the staff at the hospital before the surgery unless you are instructed otherwise.

Smoking

You are advised to stop smoking 24 hours before your surgery. While this may be difficult, it will help improve your breathing and circulation. It also will help decrease breathing problems after your surgery.

Food and fluids

You will not be permitted to eat or drink anything for a period of at least 8 hours before your surgery. This is important because your stomach must be empty when you receive anesthesia. Eating or drinking before your surgery can
<table>
<thead>
<tr>
<th>QUESTIONS</th>
<th>RESPONSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our medical director would like to request the detailed “Clean Care” protocol. Is that a possibility?</td>
<td>The process encompasses many items in place. We constantly change things that will work for rather than a specific manual. I will tell you that you need a commitment from your organization to change the present mentality re-training your healthcare workers and implement simple procedures.</td>
</tr>
<tr>
<td>Related to the Early Results slide, I was wondering how your hospital initiatives were able to decrease the Community Acquired MRSA cases. Is it because the staff clean the patient before the MRSA testing is done?</td>
<td>By cleaning the patient upon arrival</td>
</tr>
<tr>
<td>Related to the patient Biofilm slide, we understood you to say that after cleaning the wound, the culture results were negative. Does this mean that there is no wound infection for this patient, and if so, what caused it?</td>
<td>That is correct. In most cases, the first cultures are the endogenous flora of the patient rather than the infected organisms.</td>
</tr>
<tr>
<td>How is the competency training done at your facility for MRSA room cleaning?</td>
<td>Every six months our EVS group participates in a cleaning process in order to obtain the competency.</td>
</tr>
<tr>
<td>How long is the uv light left in place on the air filters to effectively decontaminate them?</td>
<td>The U.V. Light system you can find any company within your areas that provide the system for filtration.</td>
</tr>
<tr>
<td>I looked at the website for PBLH and did not see anything in their patient handbook or surgical instructions regarding patient hygiene procedures. I am wondering what type of patient and communication education they have provided regarding hygiene and environmental cleaning.</td>
<td>The patient receives a brochure that outlines the recommendation. I can send the brochure. See separate attachment.</td>
</tr>
<tr>
<td>At the end of your MRSA presentation today, you mentioned that your hospital no longer isolates MRSA patients. Were you referring to colonized patients or all MRSA patients? I would be interested in any data you can share regarding why you no longer isolate your MRSA patients to prevent MRSA transmission.</td>
<td>We do not isolate MRSA. The reason behind this is that we really look close at the process of isolation. The CDC, in 2007, change some of the recommendations and many good studies also prove that isolation does not prevent the transmission of the pathogen.</td>
</tr>
<tr>
<td>Question</td>
<td>Answer</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>We find that most of our patients with CA-MRSA do not have it in their nares. What site do you screen?</td>
<td>Axilla</td>
</tr>
<tr>
<td>Since these patients were coming into your facility with CA-MRSA, were you seeing a reduction in the rates of CA-MRSA at admission by doing a MRSA screening after you gave them their daily bath?</td>
<td>Yes</td>
</tr>
<tr>
<td>Please, I looked up Biguanid that the doctor mentioned as a waterless bathing product – on the Internet it is described as a surface environmental disinfectant. Will you ask him what he is using as a waterless patient bathing product? Thanks</td>
<td>Two Products Byotrol and SteirosLotin</td>
</tr>
<tr>
<td>We would like a list of the products Dr. Torress-Cook mentioned and the vendor who supplies.</td>
<td>The Hygiena ATP is Khani Pathmalingan phone (805) 388-8007 ext 217 the tool helps to show our EVS the importance to the cleaning process.</td>
</tr>
<tr>
<td>He talked about Arrow catheter going from 7 to 14 days. Does that mean they change central lines every 14 days?</td>
<td>If the line required changes and only then</td>
</tr>
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<td>We would like the EVS checklist, competency, and clarification of the standardization of IC practices he put in place.</td>
<td>The Hygiena ATP is Khani Pathmalingan phone (805) 388-8007 ext 217 the tool helps to show our EVS the importance to the cleaning process.</td>
</tr>
<tr>
<td>Could you share the entire algorithm? Would you also be able to share the checklists used for Foley cath removal prior to discharge from ICU? The environmental services competencies? And is any data available about rates before and after re-instating cleaning patients on a daily basis? Did you include daily linen changes too? Checklist for Surgery?</td>
<td>The final piece of the process at PHLB the web site for Germcure products <a href="http://www.germcure.com">www.germcure.com</a> what every body need to know is that before the used any of the items they need to have a plan in place proper education for EV, commitment from administrator, DON's physicians etc, etc.</td>
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<tr>
<td>What is the cleaning algorithm and pt. cleaning protocol?</td>
<td>See separate attachment</td>
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<tr>
<td>Do you bathe your patients with a central line with chlorohexadine?</td>
<td>Only during the insertion of the line. After that, we use either Byotrol or SteirosLotin.</td>
</tr>
</tbody>
</table>