It’s a Gas! Anesthesia and Infection Prevention

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(No Disclosures)
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  Infection Prevention Directors Forum
Anesthesia

😊
Recommendations for Infection Control for the Practice of Anesthesiology (Third Edition) 2011

Developed by the ASA Committee on Occupational Health Task Force on Infection Control

Disclaimer:
This document has been developed by the ASA Committee on Occupational Health Task Force on Infection Control, but has not been reviewed or approved as a practice parameter or policy statement by the ASA House of Delegates. Variances from recommendations contained in this document may be acceptable based on the judgment of the responsible anesthesiologist. The recommendations are designed to encourage quality patient care and safety in the workplace, but cannot guarantee a specific outcome. They are subject to revision from time to time as warranted by the evolution of technology and practice. This document is not intended to provide legal advice. Federal and state laws and regulations referenced in this document are subject to change and there are considerable variations among state requirements. We strongly encourage consultation with legal counsel regarding specific laws and requirements applicable to your practice.

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Robbin Stackhouse, MD
Dept of Anesthesiology
Univ. of California San Francisco

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Hand Hygiene

I heard they have very clean mouths!
“Quantification of anesthesia providers’ hand hygiene in a busy metropolitan operating room: What would Semmelweis think?”

Department of Nurse Anesthesia/Anesthesiology  Virginia Commonwealth University Medical Center, Richmond, VA.

• Hand hygiene
  – prior to first interacting with the patient
  – prior to donning sterile gloves
  – after any invasive procedure
  – after manipulation of the airway (e.g. artificial airway placement, suctioning)
  – after hanging a blood product
  – after touching the patient for surgical positioning
  – after patient handoff
  – after retrieving a soiled or dropped item off the OR floor

• Gloving
  • prior to arterial or IV line placement or other invasive procedure
  • gloving before and hand cleansing after suctioning of the airway

Major categories of failure

1. Moving between/among patients during the preoperative assessment phase.
2. Before, during, and after pain service interventions (e.g. placing perioperative nerve blocks).
4. During the placement of IV and blood draws.
5. Preparing drugs and equipment for the case to follow with soiled hands.
6. Soiled gloves left on after airway manipulations.
   - endotracheal intubation, suctioning of the airway, laryngeal mask airway insertion, and others.
7. Soiled gloves left on after Foley catheter or central or arterial line manipulation.
8. Other: picking up something off the floor (e.g. pen, tape roll, tongue blade, suction catheter) and using it.

• **Results:**
  – Nearly 8,000 HH opportunities were observed.
  – Aggregate failure rate was 82% with a range of 64% to 93% by provider group.

• **Conclusion:**
  – HH was very poor among anesthesia providers.
  – The “task density of anesthesia” care may conspire with an intrinsic HH failure rate to create great opportunity for horizontal and vertical vectors for nosocomial infection.

*Biddle C, Shah J. AJIC 2012:40(8):756-9*
Hand contamination of anesthesia providers is an important risk factor for intraoperative bacterial transmission

Dartmouth-Hitchcock Medical Center, New Hampshire

• 164 patients (82 1st case, 2nd case pairs)
• All providers with access to hand sanitizer on anesthesia cart and in room
• 11.5%: bacterial transmission to IV stopcock
  – 47% from anesthesia team
• 89% contamination of anesthesia environment
  – 12% from anesthesia team

• 1 case of horizontal transmission

• Independent risk factors for environmental transmission
  – Anesthesia provider supervising more than one room
  – First case of the day (66%)
  – Patient age
  – Discharge to ICU from the OR

employees must wash hands.
Reduction in Intraoperative Bacterial Contamination of Peripheral Intravenous Tubing Through the Use of a Novel Device
Darthmoth-Hitchcock Medical Center, New Hampshire

- 27-fold increase in hourly hand decontamination events compared with baseline rates
- Intravenous tubing contamination
  - 32.8% of cases in the control group
  - 7.5% of cases in the treatment group
- Healthcare-associated infection rates were reduced (VAP, SSI, BSI, UTI)
  - 3.8% Novel device group
  - 17.2% Control group
- 5 pt with same organism on IV stopcock/anesth workspace and HAI

What to recommend?

**Hand hygiene**

- Hand sanitizer readily available
  - At each workspace
  - ? Portable device
- Prior to: start of each case; donning sterile gloves
- Accessing clean supplies from supply cart
- Before charting
- When changing from dirty to clean
  - environmental areas
    - Anesthesia machine → anesthesia work cart/station
  - procedural tasks
    - Intubation → administering IV meds
- After glove removal (Controversy?)
• Work flow issues:
  – Intubation → adjusting gases and vent settings
    • Double glove?
    • Remove gloves and not perform HH?
    • Wear gloves for identified “dirty environment”?
Hand sanitizers in the OR environment?

• Flash points of alcohol-based hand rubs range from 21°C to 24°C, depending on the type and concentration of alcohol present

• Store away from high temperatures or flames

• Alcohol rub users should rub their hands until dry, which indicates that the flammable alcohol has evaporated

• Incidence of fires associated with such products has been low

• “I've seen surgeons blow up in the operating room but never saw an operating room blow up.”
• **Gloves**
  – PPE (self protection)
    • Body fluids
      – Intubation
      – Airway management
      – Starting IV’s

Room for improvement
  – For contact with dirty environment
    • Anesthesia machine
  – Remove and HH before contact with clean work space
PUT ON THAT MASK AND WASH YOUR HANDS BEFORE YOU EVEN THINK ABOUT TOUCHING ME!
The “Clean” Environment

- Anesthesia work station
- Supply cart
  - Orderly
  - user friendly
- IV and supplies
- IV solution and tubing
- Medications
- Work space/shelf for clean supplies
- Hand hygiene products, gloves
- Keyboard
The “Dirty” Environment
• The environment
  – Anesthesia machine
    • Buttons and knobs
  – Location of
    • Used supplies – e.g. intubation
    • Trash
    • Sharps container
    • Used suction catheter/tubing
Anesthesia Checklist for Room Turnover

HH (hand hygiene) & Glove

**REMOVE** from anesthesia machine:
- Airway bag, CO2 line, suction, tape
- Laryngoscope handle, peel bag off dirty airway tray enclosing dirty contents (leave tray)

Unglove, HH, Reglove

**CLEAN** with lemonquat wipe:
- Anesthesia Cart
  - Surfaces / handles / under emergency tray
- IV pole & stopcock clamp
- Anesthesia Machine
  - Computer, anesthesia monitor
  - Monitor cords, APL valve/mount, airway tree, gel donuts
  - Knobs & surfaces
  - Laryngoscope handle & dirty airway tray
- Take dirty airway bag and garbage bag and set outside door to OR

Unglove, HH

**SET UP** clean items for next case:
- Airway circuit & machine check
- Monitors / suction
- Airway tray & new bag
- Laryngoscope handle & cover

Good to go → put “CLEANED” tape on anesthesia machine control knob

Take dirty airway and garbage bags to soiled utility, if not already done

**Courtesy of:**
Joan Heath, RN BSN CIC
Seattle Children’s Hospital
Infection Prevention
Dirty to Clean
The Children's Hospital

Room Turn Over Completed by:

Name: [Blank]
Date: [Blank]
Safe Injection Practices
POSTOPERATIVE INFECTIONS TRACED TO CONTAMINATION OF AN INTRAVENOUS ANESTHETIC, PROPOFOL

Shiri N. Bennett, M.D., Michael M. McNeil, M.B., B.S., M.P.H., Lee A. Bland, M.A., M.P.H., Matthew J. Arduino, M.S., Dr.P.H., M. Elsa Villarino, M.D., M.P.H., Dennis M. Perrotta, Ph.D., Dale R. Burwen, M.D., Sharon F. Welbel, M.D., David A. Pegues, M.D.,


• 1991-1993, 7 hospitals experienced outbreaks traced to mishandling of propofol
• Six different bacterial pathogens
• Wide variety of lapses in aseptic technique
• “...the larger vials look like multidose vials, and our investigations revealed that the vials are sometimes being used for an extended period of time, for more than one patient or procedure, and to refill syringes meant to be used only once.”
Prolonged Survival of Hepatitis C Virus in the Anesthetic Propofol

- Explored the influence of propofol on Hepatitis C virus stability and infectivity
- Viral titers prolonged in propofol emulsion vs. control (standard cell culture medium)

Clinical Infectious Diseases (Vol 53) November 1, 2011 p. 963-4
• Issue: Using Propofol syringe for multiple pts and changing the microbore tubing between pts.

• Contamination can occur:
  – Handling
  – Fluid splatter
  – Retrograde flow
    • Specific gravity Blood > IV solutions so passive backflow against forward flowing fluid possible.
  – Lack of visible blood
    • Blood contamination found in 3.3% of tubing injection sites
      – Only 33% visible to naked eye¹

¹ Greene ES. ASA Newsletter. 2002;66(12):22-23
Stability/transmission of HCV in different anesthetic agents

Behrendt P. et al. AJIC (Oct 2013: Vol 41 No10)
Provider-to-Patient Transmission of Hepatitis C Virus Associated with Diversion of Fentanyl, Colorado 2009

• HCV-infected surgery technician stole fentanyl syringes that had been pre-drawn and left unattended in ORs
• Contaminated syringes were refilled with saline and swapped with unused syringes
• 24 patients infected; nearly 6000 notified

Hepatitis C nurse to be questioned by prosecutors

Associated Press - December 10, 2009 3:54 PM ET

DENVER (AP) - Hospital patients who say a surgery technician infected them with hepatitis C want a federal judge to let them be present during an upcoming interrogation with prosecutors and while she takes a blood test and polygraph.

The case involves 26-year-old Kristen Parker, who pleaded guilty to stealing painkillers intended for hospital patients and refilling the contaminated needles with saline solution. She is expected to be sentenced in Jan. 22 and prosecutors are asking for a 20-year-sentence.
Dear "patient",

Rose Medical Center is sending you this letter because a terminated employee – a surgical scrub technician – may have put some surgery patients at risk for exposure to hepatitis C. We are working closely with the Colorado Department of Public Health and Environment in its investigation of this situation. Hepatitis C is a virus that can potentially cause serious damage to the liver.

Our records indicate that you had surgery at Rose between October 21, 2008 and April 13, 2009 – either in the hospital or the outpatient surgery department in the Wolf Building. If this is correct, we believe, as does the State Health Department, that you should take a free, confidential blood test. This test may help determine if you were exposed to hepatitis C as a result of your surgery.

We first learned of this when the State Health Department contacted us about a cluster of cases with hepatitis C who had surgery at Rose between the dates listed above. We do not know at this point if those patients were exposed to the virus at our hospital, but we are cooperating with the State Health Department to try to get the facts.
March 16, 2011

MINNEAPOLIS — A nurse is suspected of inadvertently tainting intravenous painkillers at St. Cloud Hospital while seeking drugs, spreading bacterial infections to 23 patients since October, the hospital said on Wednesday.

• 23 patients
• The nurse was identified as the common factor linking the patients via patient and medication access records.
• Klebsiella oxytoca and Ochrobactrum anthropi
Narcotics Theft a.k.a. “Diversion”

• Diversion has emerged as the leading cause of provider to patient HCV transmission

• Prevention needs extend beyond traditional “infection control”
  – Limit opportunities for access or deception

• Good example of need for safety-engineered solutions and system approach
- Controlled meds securely stored
- Secure medication waste system
- Pharmacy reconciliation
- Testing of waste for authenticity of medication
### Viral Hepatitis Outbreaks (n=15) in Outpatient Settings due to Unsafe Injection Practices, 2001-2009

<table>
<thead>
<tr>
<th>State</th>
<th>Setting</th>
<th>Year</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>NY</td>
<td>Private MD office</td>
<td>2001</td>
<td>HCV</td>
</tr>
<tr>
<td>NY</td>
<td>Private MD office</td>
<td>2001</td>
<td>HBV</td>
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<tr>
<td>NE</td>
<td>Oncology clinic</td>
<td>2002</td>
<td>HCV</td>
</tr>
<tr>
<td>OK</td>
<td>Pain remediation clinic</td>
<td>2002</td>
<td>HBV+HCV</td>
</tr>
<tr>
<td>NY</td>
<td>Endoscopy clinic</td>
<td>2002</td>
<td>HCV</td>
</tr>
<tr>
<td>CA</td>
<td>Pain remediation clinic</td>
<td>2003</td>
<td>HCV</td>
</tr>
<tr>
<td>NV</td>
<td>Endoscopy clinic</td>
<td>2008</td>
<td>HCV</td>
</tr>
<tr>
<td>NC</td>
<td>Cardiology clinic</td>
<td>2008</td>
<td>HCV</td>
</tr>
<tr>
<td>NJ</td>
<td>Oncology clinic</td>
<td>2009</td>
<td>HBV</td>
</tr>
<tr>
<td>FL</td>
<td>Alternative medicine clinic</td>
<td>2009</td>
<td>HCV</td>
</tr>
</tbody>
</table>

Nearly half of these outbreaks were caused by unsafe injection practices related to anesthesia/sedation.
Survey Finds ‘Discouraging’ Injection Habits Among Anesthesiologists

- 49% - same vial for > 1 patient
- 31% - use Propofol on > 1 patient
- ~25% don’t always use a new needle or syringe when drawing from a vial
- ~25% use an open vial w/o knowing who accessed it prior
- Reused syringes on different patients
  - 8% residents
  - 2% anesthesiologists

*Reported in Anesthesiology News Jan 2012: (Gounder P. et.al. Formal publication pending…)*
Single-use/Single-dose Medication Vials

• **Single-dose (SDV):**
  – A vial containing a single unit of a parenteral drug product.

• **Single-use:**
  – A vial where a single dose can be removed and then the vial and its remaining contents is discarded.

*FDA, C-DRG-00907*

**Recommended whenever possible (a.k.a. unless unavailable)**

• APIC
• CDC
• WHO
Medication Shortages

2005 – 61; 2010 - 178

Primary causes:

- 43% Manufacturing
  - Contamination/Stability
    - particulates/organisms
- 15% Delays in manufacturing or shipping
- 10% Active pharmaceutical ingredient shortages

2010/2011 – reviewed 127

- 80% sterile injectables
  - 28 % oncology drugs
  - 13% antibiotics
  - 11% electrolyte/nutrition

- Neostigmine –reverses paralyzing agents
- Norepinephrine - BP
Medication Shortages

- Even if a single-dose or single-use vial appears to contain multiple doses or contains more medication than is needed for a single patient, that vial should not be used for more than one patient nor stored for future use on the same patient.

- In times of “critical need”, contents from unopened single-dose/single-use vials can be repackaged for multiple patients.
  - performed by qualified healthcare personnel
  - USP General Chapter <797> Pharmaceutical Compounding – Sterile Preparations.

- Healthcare facilities can proactively arrange for these doses to be split, in accordance with USP standards, when necessary.

*CDC, April 27, 2012*
Safe Use of Single Dose/Single Use Medications to Prevent Healthcare-associated Infections

June 15, 2012

Deficiency Citation Policy

- Healthcare facilities that do not adhere to USP <797> standards but reuse SDVs for multiple patients must be cited for deficiencies under the applicable infection control standards for each type of provider/supplier

Multi-dose vials

• No MDV in the immediate patient Treatment Area (CDC)
• “Immediate Patient Treatment Area”
  – Surgery/Proc. room where anesthesia is administered
  – Any anesthesia med carts used in or for those rooms
• 2 acceptable techniques
  – Draw entire contents of vial (SDV/MDV) into a sterile syringe
    • Sequential doses for same patient
  – Sequential doses taken from MDV vial
    • Use a new needle/cannula/syringe each time
• Drugs that do not come in SDV?
  – Neostigmine, succinylcholine
  – Discard vial after using for one patient
• On-site satellite pharmacy
SECONDS COUNT!

“SCRUB-A-HUB”
Minimize contamination risk by scrubbing the access port with an appropriate antiseptic (chlorhexidine, povidone iodine, an iodophor, or 70% alcohol) and accessing the port only with sterile devices [189, 192, 194–196]. Category IA
Stopcocks

• Closed catheter access systems are associated with fewer CRBSIs than open systems and should be used preferentially.

• Stopcocks represent a potential portal of entry for microorganisms into vascular access catheters and IV fluids.

• Stopcocks not in use
  – Sterile cap or syringe

Why is nonsterile tape being used *initially* to secure a catheter hub at the patient’s fresh puncture wound?

- Concern: Chevroning IV sites with tape under TSM dsg.


Sterilely handled “new” tape roll

Sterilely handled “old” tape roll
New tape roll handled with un gloved hand

Old tape roll handled with un gloved hand
Opening Ampules

Drug contamination from opening glass ampules.
Department of Anesthesiology, University of California, San Diego

- Glass ampules of 1% propofol (#8) and 1% lidocaine (#8) swabbed with *S. epi*
- 50% alcohol pad prep prior to being opened. 50% no alcohol prep
- Aliquot from each ampule was cultured
- Results: Not cleaned with alcohol = bacterial contamination
  - 3 of 8 lidocaine ampules
  - 6 of 8 propofol ampules
  - No growth from ampules wiped with alcohol
    - \( p < 0.001 \) for propofol ampules
    - \( p = 0.20 \) for lidocaine ampules

Department of Anesthesiology, Univ of California, San Diego
• Weenig CS. Anesthesiology: March 1998 - Volume 88 - Issue 3 - p 838 Correspondence
The effect of alcohol swabs and filter straws on reducing contamination of glass ampoules used for neuroaxial injections

Chelsea and Westminster Hospital, London, UK.

Study #1
- 100 fentanyl and diamorphine ampoules
  - 50 wiped with alcohol
  - 50 not wiped with alcohol
- Contents aspirated and cultured.
- Alcohol group - No growth (0/50)
- Non-wiped group (18%) (9/50) $\{ p = 0.004 \}$

Study #2
- 100 glass ampoules of saline - coated with Staphylococcus aureus
- 4 groups:
  - wiped/not wiped with alcohol and with/without a filter straw.
- Most contamination occurred in the unwiped groups and although numbers were small, filtering appeared to reduce contamination further.
  - also reduce the risk of injecting glass particles (even if not contaminated)
Spiking/priming IV bags “in advance”

• **USP**
  - 1 hour time limit from preparation (spiking bag) until beginning administration if not prepared in a *ISO 5 environment*
    - Precludes microbial growth in the event of contamination
    - Organism replication can occur within 1-4 hours
      - Exponential ↑ thereafter (if contaminated)
    - ? Role for 4 hours?
    - Trauma circuits? Risk assessment important for longer hang times.

  - Longer timeframes if primed by pharmacy in *ISO 5 environment*

*International Organization for Standardization (laminar flow, air quality, ventilation, personnel and surface sanitation requirements)*
Concerns

• Cost
• Technique in busy setting
• ? Higher risk of contamination due to breaks in technique
• Many settings don’t have ISO 5 environments
• Difficult to comply
• Limited data on actual contamination in real practice
• **Unresolved issue** for non-ISO 5 environment

• Supports
  – Risk Assessment
  – Preparing as close as possible to time of administration as feasible
    • Not night before (e.g. OR settings)
    • Trauma circuits (longer for pt safety?)
  – Educate designated staff
    • Tactile learning environment
    • Verify competency
    • Periodic monitoring
  – Clean, dry workspace
  – Controlled setting
  – Properly labeled bag/tubing. Date/time/initials
  – Facility P&P

_Dolan SA, et al. APIC position paper: Safe injection, infusion, and medication vial practices in health are. AJIC. 38(3): 167-172._
What would a Joint Commission surveyor look for?

- **A:** Joint Commission standards do not specifically address this issue. However, IC.01.05.01 EP 1 requires that, “When developing infection prevention and control activities, the hospital uses evidence-based national guidelines or, in the absence of such guidelines, expert consensus.”

- **Therefore,** The Joint Commission does not require that an organization place a specific time restriction on most IV fluids (other than those specified in **CDC IX.C.1-3**). However, if an accredited organization has a policy that specifies a hang time, or delineates how quickly fluids must be hung after being spiked, a surveyor may issue a Requirement For Improvement related to compliance with the organization’s own policy.

- Additional guidance can be obtained from the Association for Professionals in Infection Control and Epidemiology, Inc. (APIC) or U.S. Pharmacopeia. State health departments, pharmacy boards or hospital licensing acts may also contain further regulations.

July 30th, 2010
“You’ll be awake during the entire procedure. The anesthesiologist is on vacation.”
Statement: All instruments used for intubation of the trachea (endotracheal tubes, LMAs, laryngoscopes, fiberoptic devices, stylets, forceps, or other airway devices) should be properly cleaned using standard methods for decontamination and high-level disinfection between each patient use and stored in a clean environment. Sterility is not required (1). Prepackaged endotracheal tubes can be opened, cuffs checked for any leaks, stylets placed for future use, cuff syringes attached, and placed back into the package. Data suggest that storage and subsequent use of such prepared endotracheal tubes is reasonable for up to 48 hours (2, 3).

Rationale: The mouth (where such instruments pass on their way to the trachea) is not a sterile environment. However, cleanliness and prevention of contamination from patient to patient is essential and consistent with patient safety.

A focused review of the ASA Closed Claim Database (data search of 8954 claims through December 2008), shows that there were no cases of infection from placement of an endotracheal tube or LMA. Neither were there any claims of infections from dirty instruments for tracheal intubation in this database.

References:
1. Guidelines for Preventing Health-Care-Associated Pneumonia, 2003
Laryngoscope blades

- Semi-critical item – mucous membranes
- HICPAC\(^1\)
  - Reprocess between patients (1A)
  - Sterilization
  - Pasteurization (\(>158^\circ F (>70^\circ C)\) for 30 minutes)
  - Packaging (not specific)
- TJC\(^2\)
  - Sterilization or HLD disinfection.
  - Storage – prevent recontamination
    - Long term: Peel pack
    - Short term: sterile towel
  - Noncompliance = unwrapped blades in anesthesia drawer or on top of code cart.

\(^1\) HICPAC Guidelines for prevention healthcare-associated pneumonia, 2003
\(^2\) TJC FAQ laryngoscope Blades. October 24, 2011.
Neuraxial procedures

• Epidural anesthesia, lumbar puncture
  • epidural, spinal, or combined spinal– epidural administration of anesthetics, analgesics, or steroids; lumbar puncture or spinal tap; epidural blood patch; epidural lysis of adhesions; intrathecal chemotherapy; epidural or spinal injection of contrast agents for imaging; lumbar or spinal drainage catheters; or spinal cord stimulation trials

• Infection
  – epidural abscess
    • 50-60% Staph aureus
    • 15-20% Streptococcus species
  – meningitis
    • 49% Viridans Streptococcus
      – 16% Strep. Salivarius

***Practice Advisory...Anesthesiology 2010;112:530-545***
• What to wear:
  – CAP
  – MASK
  – STERILE GLOVES
     …and Eye protection!

• Remove rings/watches
• Skin prep w/ dry time
• Sterile drape
• Sterile occlusive dsg.

• Limit opening line
• Remove unwitnessed disconnects

Practice Advisory…Anesthesiology 2010;112:530-545
Breathing circuits and filters

• Bacterial filter
  – efficiency rating of >95% for particle sizes 0.3micron
  – Routinely placed on anesthesia circuit
    • Protect the machine from contamination
  – Expiratory → machine → Inspiratory circuit
# ANESTHESIA INFECTION PREVENTION ASSESSMENT TOOL

<table>
<thead>
<tr>
<th>Surveyed by: □ Name</th>
<th>Date:</th>
<th>C = compliant</th>
<th>NC = Not compliant</th>
<th>N/A = not applicable</th>
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<table>
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<th>Survey Items</th>
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<th>NC</th>
<th>N/A</th>
<th>Comments</th>
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<tr>
<td><strong>Policies and Procedures</strong></td>
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<tr>
<td>A policy/procedure (P&amp;P) for Infection Prevention and Control (IPC) exists for anesthesia practices.</td>
<td>□</td>
<td>□</td>
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</tr>
<tr>
<td>Staff are trained upon hire/appointment and annually on IPC P&amp;Ps.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Anesthesia staff are able to articulate and practice per the anesthesia P&amp;P, or hospital policies should a focused anesthesia one not exist.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td></td>
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<tr>
<td><strong>Hand Hygiene/Glove use</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Approved hand hygiene products are readily available and easy to access.</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Staff verbalizes understanding of when waterless products may not be used (e.g., visibly soiled hands).</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>No jewelry on fingers, hands, wrists in semirestricted/restricted areas or for sterile procedures</td>
<td>□</td>
<td>□</td>
<td>□</td>
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<tr>
<td>Nails. Adherence to facility P&amp;P.</td>
<td>□</td>
<td>□</td>
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<td>Hand Hygiene (HH) consistently used during movement from dirty to clean.</td>
<td>□</td>
<td>□</td>
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<td>Gloves in various sizes are available and easy to access.</td>
<td>□</td>
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<tr>
<td>Gloves are worn for procedures where contamination is likely (e.g., intubation, suctioning) Gloves are then removed and HH performed prior to contact with clean environment (meds, keyboard).*</td>
<td>□</td>
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<tr>
<td>HH is performed before donning sterile gloves (e.g., central line placement).</td>
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</tbody>
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Contact Information

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• Meds in pockets
  – “TJC has also changed it’s stringency on this as it is necessary to transport meds to the patient for premedication and sometimes to have rescue medications when transporting a patient."

  – Assessment Tool now states:
    • Vials/syringes should not be stored or transported in clothing or pockets except when an organization specifically allows this for the purposes of facilitating pre-medication or to have rescue meds readily available when transporting a patient.
Evidence for use of Scrub the Hub

• **Methods:**
  – **Ports (cap hubs) of 4 models of needleless access ports were inoculated.**
    • $10^5$ S. epi, S. aureus, Pseudo, Candida alb.
      – (let air dry for 18 hours after inoculated)
    • **Positive control** – hubs were inoculated but did not get disinfected after.
    • **Negative control** – no inoculation with organisms.
  – **Ports were disinfected.**
    • 15 seconds with 70% alcohol alone
    • 3.15% chlorhexidine/70% alcohol

Evidence for use of “Scrub the Hub”

- **Saline flush solutions were collected and cultured at 0 and 24 hours**
- (in between 0 and 24 hours), TPN dwell for 8 hours and 16 hours then cultured

**Results:** Disinfection with either 70% alcohol alone or with 3.15% chlorhexidine/70% alcohol for 15 seconds was effective (no growth from cultured broth).
  - $10^3$ grew from pos. controls.
  - NG from neg. controls.

**Conclusions:** All models of needleless access ports were effectively disinfected using these two methods.