CLEANING: MORE THAN A SWIFFER AND MR. CLEAN

DECEMBER 7, 2021

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Hosted by Great Plains Quality Innovation Network

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Project Firstline—Cleaning: More than a Swiffer and Mr. Clean

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This webinar aims to emphasize the importance of adhering to the basics of environmental cleaning and disinfection to promote patient and resident safety, staff wellness, and reduce healthcare acquired infections. Content is geared for environmental services workers, certified nurse aides, and nurses in long term care, hospitals, outpatient settings and clinics.

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TODAY'S PRESENTERS

Nicole Galler, MPH
Epidemiologist and Project Firstline Coordinator-North Dakota

Cheri Fast, RN, BSN, Certified Infection Prevention
Project Firstline Coordinator-South Dakota

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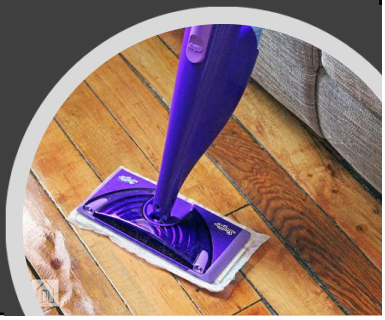
Project Firstline—Cleaning: M… than a Swiffer and Mr. Clean

- **Objectives:**
  - Identify the chain of infection and environment of care in the spread of infections
  - Differentiate between cleaning and disinfecting
  - Understand contact time and high touch surfaces
  - Apply strategies and tips to support cleaning and disinfection compliance in healthcare environments
  - Describe Project Firstline and available training



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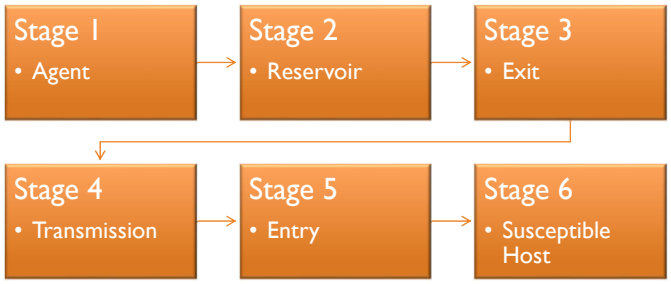
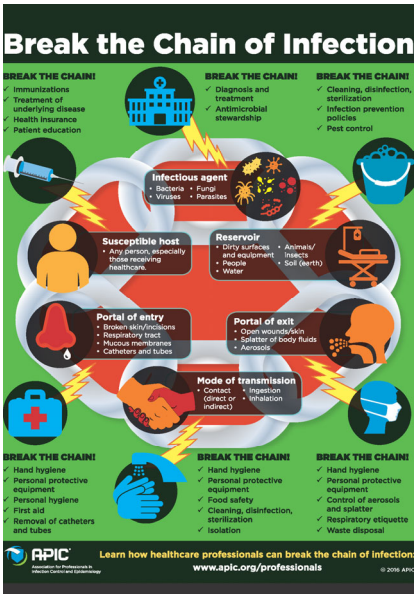
THE ENVIRONMENT OF CARE IS ONE OF THE MOST IMPORTANT ASPECTS IN REDUCING THE TRANSMISSION OF INFECTIONS.





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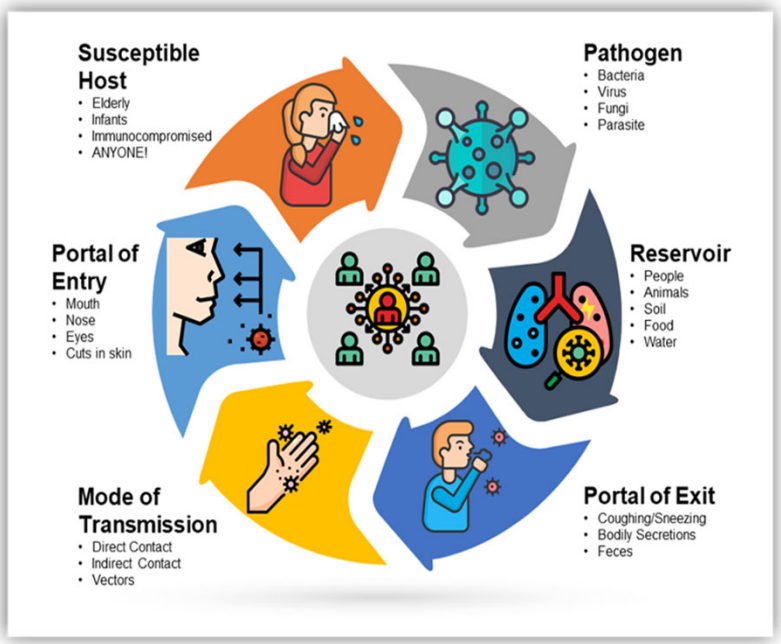

FIND THE RIGHT TOOL FOR YOUR LEARNER.

https://apps.hhs.texas.gov/providers/NF/credentialing/cna/infectioncontrol/module2/Module_2_Chain_of_Infection_print.html

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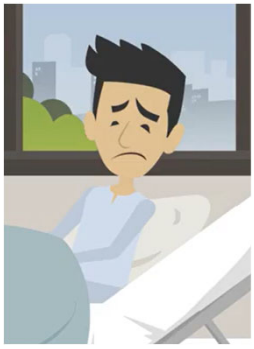
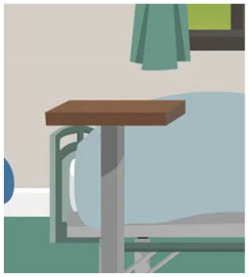
INFECTION TRANSMISSION

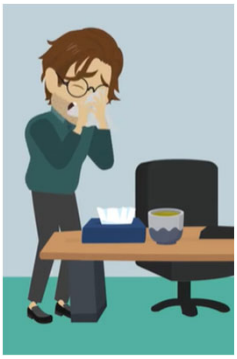
Colonized or infected patient

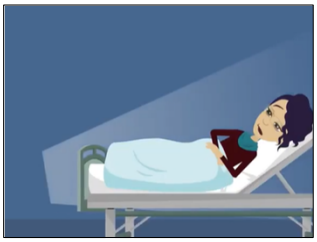


Surface/non-critical care item



Contaminated hands or gloves of healthcare personnel/caretakers/visitors





Susceptible Patient

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WHAT IS YOUR WEAKEST LINK WHEN IT COMES TO INFECTION CONTROL?

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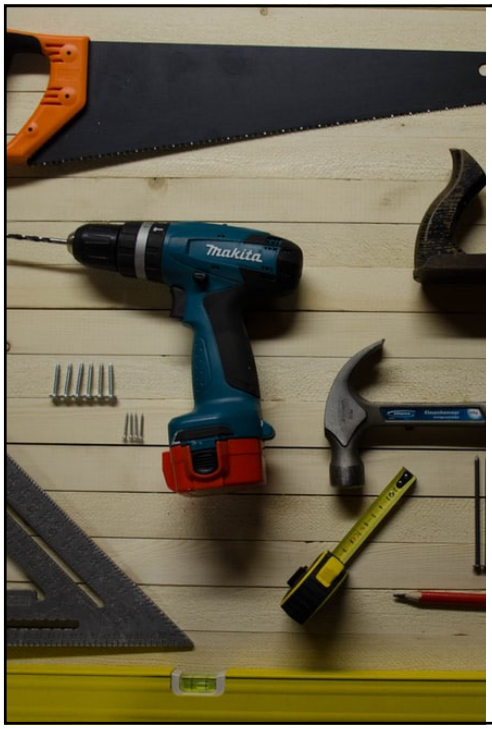

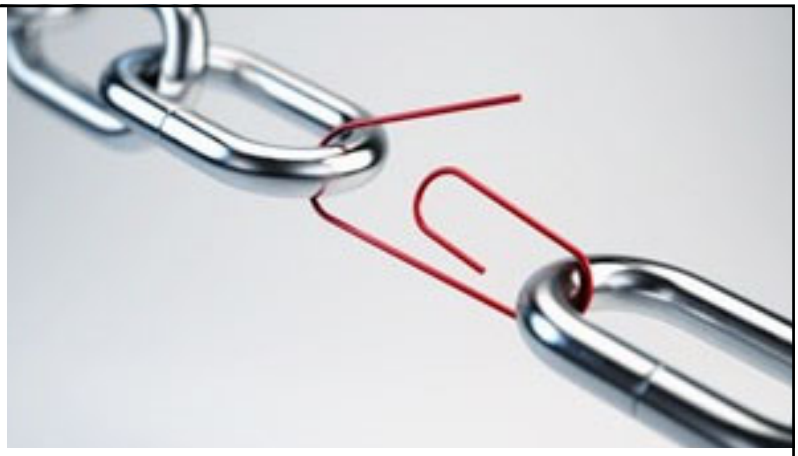

HOW CAN WE FIX THAT WEAKEST LINK?

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IT IS CRITICAL TO MAINTAIN PROPER KNOWLEDGE AND RESOURCES TO INTERRUPT THE MODE OF TRANSMISSION AND MINIMIZE RISKS. THIS IS CAN BE DONE WITH PROPER CLEANING & DISINFECTION.

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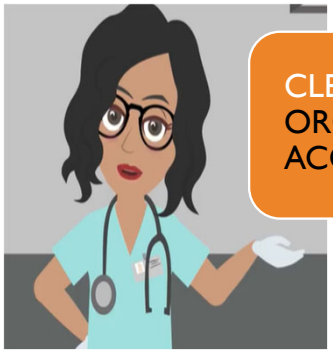
CLEANING VS DISINFECTION



CLEANING: REMOVAL OF FOREIGN MATERIAL (SOIL, DUST, ORGANIC MATERIAL) FROM OBJECTS AND IS NORMALLY ACCOMPLISHED USING WATER WITH DETERGENTS.

DISINFECTION: ELIMINATION OF MANY OR ALL PATHOGENIC ORGANISMS EXCEPT BACTERIAL SPORES. SURFACES MUST BE CLEANED BEFORE THEY ARE DISINFECTED.

APIC text 2014

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ENVIRONMENTAL SURVIVAL OF KEY PATHOGENS ON HOSPITAL SURFACES

Pathogen	Survival Time
S. aureus (including MRSA)	7 days to >12 months
Enterococcus spp. (including VRE)	5 days to >46 months
Acinetobacter spp.	3 days to 11 months
Clostridium difficile (spores)	>5 months
Norovirus (and feline calicivirus)	8 hours to >2 weeks
Pseudomonas aeruginosa	6 hours to 16 months
Klebsiella spp.	2 hours to >30 months

Adapted from Hota B, et al. Clin Infect Dis 2004;39:1182-9 and Kramer A, et al. BMC Infectious Diseases 2006;6:130

SARS-CoV-2 can be viable on surfaces for 3 days (plastic, stainless steel ~2-3 days, cardboard ~24h)

https://vtwqt464m234djrhbie88e10-wpengine.netdna-ssl.com/wp-content/uploads/2021/11/BestPracticesSurfDisBundleCANov2021f.pdf

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- Infested patients, visitors, and HCP can bring bed bugs into healthcare facilities on their clothing, in their personal belongings (purses, computers), and in assistive devices such as wheelchairs and walkers. Bed bugs can survive for a year without feeding.

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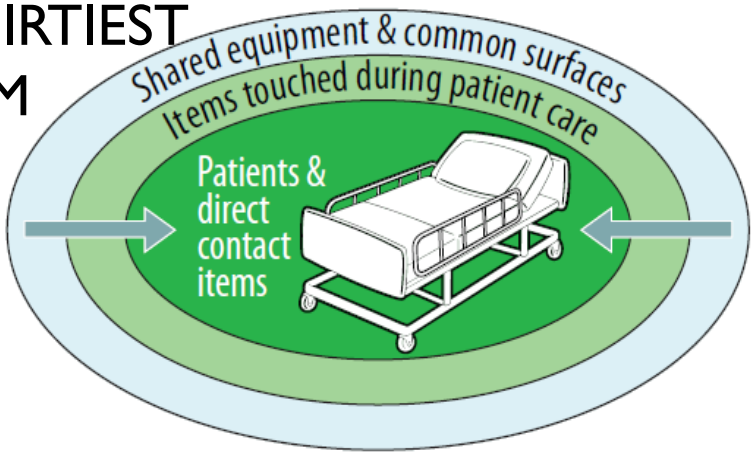
BEFORE CLEANING, MAKE AN INSPECTION OF THE ROOM. THINK ABOUT WHAT DO I NEED? DO I HAVE EVERYTHING!

CLEANEST TO DIRTIEST
TOP TO BOTTOM



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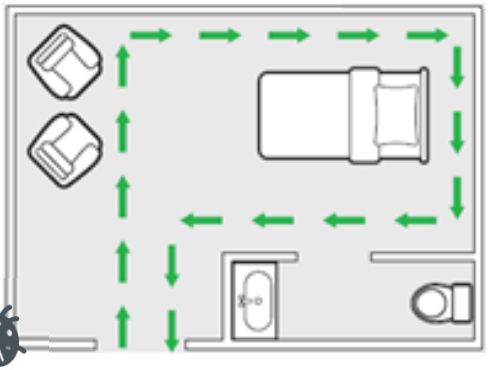
CLEANING SCHEDULES AND PROCEDURES SHOULD PROGRESS FROM LEAST SOILED AREAS TO THE MOST SOILED AREAS (PATIENT ZONES) AND FROM HIGH TO LOW.

- CLEAN BED RAILS BEFORE BED LEGS
- CLEAN SURFACE BEFORE FLOORS

TO ENSURE ALL SURFACES ARE REACHED, CLEANING SHOULD BE PERFORMED IN A SYSTEMATIC MANNER. EVERYONE IN FACILITY SHOULD CLEAN BASICALLY THE SAME.



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HOW TO USE YOUR CLEANING CLOTH

1. THOROUGHLY WET FRESH CLEANING CLOTH IN THE SOLUTION.
2. FOLD CLOTH IN HALF UNTIL SIZE OF YOUR HAND. THIS MAKES SURE YOU CAN USE ALL THE SURFACE AREA EFFICIENTLY. THEN FOLD IN HALF, AND IN HALF AGAIN. (SHOULD HAVE 8 SIDES)
3. CLEAN TO DIRTY, HIGH TO LOW, SYSTEMATICALLY.
4. MAKE SURE SURFACES STAY WET FOR THE ALLOTTED CONTACT TIME.
5. ROTATE AND UNFOLD THE CLOTH TO USE ALL 8 SIDES.
6. WHEN ALL 8 SIDES ARE USED, GET A CLEAN CLOTH.
7. DO NOT REWET THAT SAME CLOTH IN THE SOLUTION!

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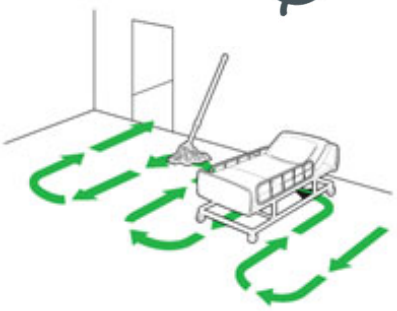
CDC RECOMMENDS CHANGING FLOOR MOPPING SOLUTIONS EVERY 3 ROOMS AND AT LEAST EVERY 60 MINUTES.

USED MOPS AND CLEANING CLOTHS SHOULD NEVER BE RETURNED TO CONTAINERS OR CLEANING SOLUTIONS. THEY SHOULD BE LAUNDERED OR DISCARDED AFTER USE.

A DISINFECTANT MUST BE USED TO CLEAN FLOORS IN CRITICAL AREAS SUCH AS ISOLATION ROOMS.



NEVER LEAVE SOILED MOP HEADS AND CLEANING CLOTHS SOAKING IN BUCKETS.

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GENERAL MOPPING GUIDELINES

1. IMMERSE THE MOP IN THE BUCKET WITH SOLUTION AND WRING OUT.
2. MOP IN FIGURE 8 PATTERN WITH OVERLAPPING STROKES TURNING THE MOP HEAD FREQUENTLY. (EVERY 5-6 STROKES)
3. AFTER CLEANING A SMALL AREA, IMMERSE THE MOP IN THE BUCKET WITH RINSE WATER AND WRING OUT.
4. REPEAT.
5. MOP CLEANER TO DIRTY. START AT FARTHEST POINT AND WORK TOWARD EXIT.
6. CHANGE SOLUTION AFTER EVERY ISOLATION ROOM.

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CLEANING PROCEEDS FROM HIGH TO LOW SURFACES, ALLOWING DUST AND DEBRIS FROM HIGH SURFACES TO FALL ONTO LOWER ONES BEFORE LOWER SURFACES ARE CLEANED.

DUSTING CONTAINS FUNGAL SPORES, SUCH AS ASPERGILLUS. TO CAPTURE DUST WITHOUT AEROSOLIZING SPORES, DUSTING SHOULD BE DONE USING A CLOTH OR DUST MOP THAT IS CHEMICALLY TREATED OR MADE OF MICROFIBER.

DUSTING SHOULD BE PERFORMED FIRST! PARTICLES THAT FALL WILL BE CAPTURED WHEN THE FLOOR IS CLEANED.

AVOID DUSTING METHODS THAT DISPERSE DUST SUCH AS FEATHER DUSTING.

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Bathrooms

Must be cleaned and disinfected at least daily and when visibly soiled. During *C. difficile* and other diarrheal outbreaks, the frequency should be at least 3X per day. The toilet seat and flusher handle, faucet handles, handrails, soap dispenser, nurse call cord, bedpan dispenser, light switch, and doorknobs are high-touch surfaces that require special attention.

When a patient has a bedside commode, it must be cleaned and disinfect it at least daily and when visibly soiled. When no longer needed, the basin must be emptied and the surfaces of the commode decontaminated before it is moved out of the patient's room.

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Researchers have shown that alcohol-based hand rubs (ABHR) are highly effective hand hygiene agents. The CDC strongly recommends using ABHR except when hands are visibly soiled, before eating, and after using the restroom. Wash your hands!

Regulatory agencies have established strict guidelines on placement of ABHR in corridors to prevent fires.

The corridor must be at least 6 feet wide.

- Dispensers must be at least 4 feet apart.
- Dispenser may not be installed less than 6 inches adjacent to an electrical outlet or switch (measured from the center of the container to the electrical source).
- If mounted over carpeting, the area must have sprinklers and smoke alarms.

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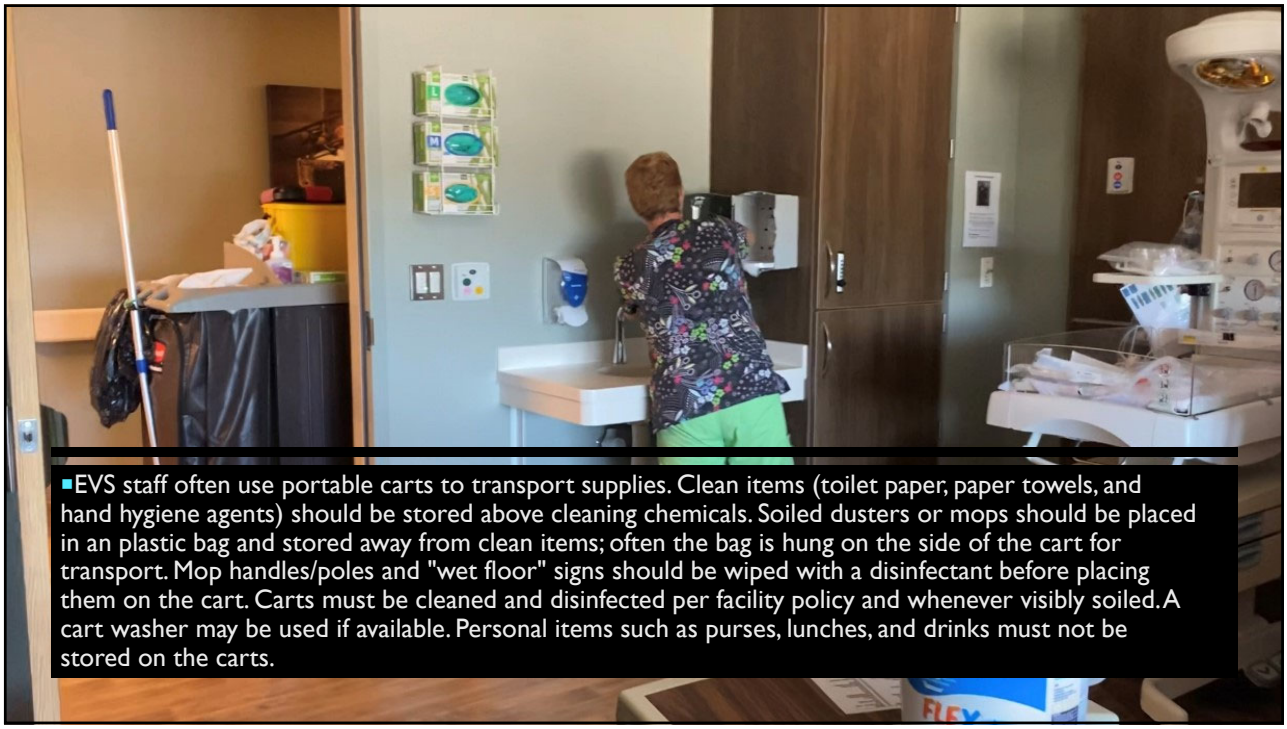

- EVS staff often use portable carts to transport supplies. Clean items (toilet paper, paper towels, and hand hygiene agents) should be stored above cleaning chemicals. Soiled dusters or mops should be placed in an plastic bag and stored away from clean items; often the bag is hung on the side of the cart for transport. Mop handles/poles and "wet floor" signs should be wiped with a disinfectant before placing them on the cart. Carts must be cleaned and disinfected per facility policy and whenever visibly soiled. A cart washer may be used if available. Personal items such as purses, lunches, and drinks must not be stored on the carts.

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Operating Rooms

The operating room suite should have dedicated cleaning tools (e.g., carts, buckets, mop handles, dusting poles, vacuums, floor machines). To prevent aerosolization of chemicals, EVS staff should wipe surfaces with disinfectant-saturated wipes or microfiber cloths instead of using spray bottles of disinfectants. Because blood and body fluid spills are common in the OR, EVS staff should use disinfectants that are EPA-registered as effective against HBV and HIV. Sodium hypochlorite is not recommended for routine use because it can cause pitting of metal and some other surfaces.
Alcohol is not recommended for damp dusting large environmental surfaces because it dries too quickly.
Reusable cleaning cloths must be freshly laundered and lint-free.

Three distinct cleaning times for operating rooms: before the first case of the day, between cases, and at the end of the day. Before the first case of the day, horizontal surfaces in the operating room should be damp-dusted with a clean lint-free cloth or a wipe dampened with a disinfectant. This task may be performed by nursing personnel.

Floors in the operating rooms must be cleaned and disinfected after each case. Reusable string or microfiber mops may be used in between cases and should be changed after each use. A clean mop head and fresh disinfectant solution must be used for each case. It is only necessary to clean a 3- to 4-foot perimeter around the operative table after each case unless wider perimeter of contamination is identified. Placing tacky mats on the floor at the entrances to operating rooms is not recommended. There is no evidence that they help prevent infections.

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Outpatient Settings

The CDC's guidelines for cleaning outpatient settings are similar to those for inpatient areas.
*High-touch surfaces in the patient zone (examination rooms, procedure rooms, and waiting areas) must be cleaned and disinfected with an EPA-registered product.
*Floors may be cleaned with a detergent instead of a disinfectant unless contaminated with blood and body fluids. Because there are a minimum number of areas at risk for blood and body fluid spills, more carpeting may exist in this setting. Carpets should be vacuumed daily, spot cleaned as needed, and thoroughly cleaned on a routine schedule.
*Waste should be collected daily. Because there is significantly less biohazardous waste in this setting, facilities may utilize one large biohazard container in a central location. However, a biohazardous waste container must be available in procedure rooms.
*Outpatient facilities must have written cleaning policies and procedures and provide training to staff who perform these functions. Facilities should assign responsibility for overseeing environmental cleaning and disinfecting to a qualified person.

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EXAM TABLES- DON'T STORE UNUSED SUPPLIES IN THESE DRAWERS!

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CONTACT TIME-THE TIME A DISINFECTANT MUST BE IN CONTACT WITH A SURFACE OR DEVICE TO ENSURE THAT THE APPROPRIATE DISINFECTION HAS OCCURRED. THE SURFACE SHOULD REMAIN WET FOR THE REQUIRED CONTACT TIME.

"CONTACT TIME"
"DWELL TIME"
"WET TIME"

WHAT IS CONTACT TIME?

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CLEANING PRECAUTIONS

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HOW OFTEN SHOULD I CLEAN?

Depends on:
***Probablity of contamination**
***Vulnerability of patients**
***Potential for exposure (high/low touch surfaces)**

DO A RISK ASSESSMENT FOR YOUR FACILITY?

https://www.cdc.gov/hai/pdfs/resource-limited/environmental-cleaning-RLS-H.pdf

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Appendix A – Risk-assessment for determining environmental cleaning method and frequency

[Reproduced directly from PIDAC, 2018]

Step 1: Categorize the risk factors that determine the need for environmental cleaning:

Probability of Contamination with Pathogens

Heavy Contamination (score = 3)

An area is designated as being heavily contaminated if surfaces and equipment are routinely exposed to copious amounts of fresh blood or other body fluids (e.g., birthing suite, autopsy suite, cardiac catheterization laboratory, hemodialysis station, emergency room, client/patient/resident bathroom if visibly soiled).

Moderate Contamination (score = 2)

An area is designated as being moderately contaminated if surfaces and equipment do not routinely (but may) become contaminated with blood or other body fluids and the contaminated substances are contained or removed (e.g., wet sheets). All client/patient/resident rooms and bathrooms should be considered to be, at a minimum, moderately contaminated.

Light Contamination (score = 1)

An area is designated as being lightly contaminated if surfaces are not exposed to blood, other body fluids or items that have come into contact with blood or body fluids (e.g., lounges, libraries, offices).

Vulnerability of Population to Infection

More Susceptible (score = 1)

Susceptible clients/patients/residents are most susceptible to infection because of their medical condition or lack of immunity. These include those who are immunocompromised (oncology, transplant and chemotherapy units), neonates (level 2 and 3 nurseries), and those who have severe burns (i.e., requiring care in a burn unit).

Less Susceptible (score = 0)

For the purpose of risk stratification for cleaning, all other individuals and areas are classified as less susceptible.

Potential for Exposure

High-touch surfaces (score = 3):

High-touch surfaces have frequent contact with hands. Examples include doorknobs, telephone, call bells, bedrails, light switches, wall areas around the toilet and edges of privacy curtains.

Low-touch surfaces (score = 1):

Low-touch surfaces have minimal contact with hands. Examples include walls, ceilings, mirrors.

Step 2: Determine the total risk stratification score:

The frequency of cleaning is based on the factors listed above. A score is given if the factors are present, and the frequency of cleaning is based on the total score as derived in the following matrix:

Appendix A Table 1. Risk Stratification Scores for *High-Touch Surfaces* (Score for Potential for Exposure = 3)

Probability of contamination with pathogens	More susceptible population (score = 1)	Less susceptible population (score = 0)
Heavy (score = 3)	7 (3+3+1)	6 (3+3+0)
Moderate (score = 2)		
Light (score = 1)		

Appendix A Table 2. Risk Stratif for Exposure = 1)

Probability of contamination with pathogens
Heavy (score = 3)
Moderate (score = 2)
Light (score = 1)

Step 3: Determine the cleaning frequency based on the risk stratification matrix:

Cleaning frequencies for each patient care area are derived from the total score that results from the risk stratification matrix above.

Appendix A Table 3. Cleaning Frequencies Based on Total Risk Score

Total Risk Score	Risk Type	Minimum Cleaning Frequency
7	High Risk	Clean after each case/event/procedure and clean additionally as required
4–6	Moderate Risk	Clean at least once daily Clean additionally as required (e.g., gross soiling)
2–3	Low Risk	Clean according to a fixed schedule Clean additionally as required (e.g., gross soiling)

Appendix A Table 4. Patient Care Area Examples

Location	Probability of Contamination	Potential for Exposure	Vulnerability of Population	Total Score	Minimum Cleaning Frequency
Burn Unit	2–3	3	1	6–7	Clean after each case/event/procedure, at least twice daily and clean additionally as required
General inpatient	1–2	3	0	4–5	Clean at least once daily and clean additionally as required

https://www.cdc.gov/hai/pdfs/resource-limited/environmental-cleaning-RLS-H.pdf

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Appendix B1 – Cleaning procedure summaries for general patient areas

General outpatient area (Adult)

This is a low-risk area because the probability of contamination and the vulnerability of the patients to infec procedural areas are moderate risk and therefore require more frequent and rigorous environmental cleanir

Appendix B1 Table 1. Cleaning Procedure Summaries for General Outpatient Areas (A

Area Description	Frequency	Person / Staff Responsible	Products/Technique	Additior Descrip
Waiting/ admission areas (Adult)	At least daily	Cleaning staff	**Clean** (neutral detergent and water): • high-touch surfaces • floors	In additic surfaces (e.g., we
Consultation/ examination areas (Adult)	At least twice per day	Shared cleaning possible: clinical and cleaning staff	**Clean** (neutral detergent and water): • high-touch surfaces	Last clea the entir detergen In additic surfaces (e.g., we
Minor operative procedure rooms	Before and after (i.e., between) every procedure	Shared cleaning possible: clinical and cleaning staff	**Clean and disinfect:** • any surface visibly soiled with blood or body fluids • high-touch surfaces in the patient zone • floors in the patient zone	Last clea clean an • other • low-to • handw • scrub/ • the en

General inpatient area (Adult)

This is a low-risk area because the probability of contamination and the vulnerability of the patients to infection is low.

Appendix B1 Table 2. Cleaning Procedure Summaries for General Inpatient Areas (Adult)

Type of Clean	Frequency	Person / Staff Responsible	Products/Technique	Additional Guidance / Description of Cleaning
Routine clean	At least daily	Cleaning staff	**Clean** (neutral detergent and water): • high-touch surfaces in the patient zone • handwashing sinks • floors	In addition, **clean** low-touch surfaces on a scheduled basis (e.g., weekly)
Terminal clean	At patient discharge or transfer	Shared cleaning possible: clinical and cleaning staff	**Clean and disinfect:** • high-touch surfaces • low-touch surfaces • floors	1. Remove soiled/used personal care items (e.g., cups, dishes) for reprocessing or disposal. 2. Remove facility-provided linens for reprocessing or disposal; see Appendix D – Linen and laundry management (page 92). 3. Inspect window treatments. If soiled, clean blinds on-site, and remove curtains for laundering. 4. Reprocess all reusable (noncritical) patient care equipment; see Noncritical patient care equipment (page 81). 5. Clean and disinfect all low- and high-touch surfaces, including

https://www.cdc.gov/hai/pdfs/resource-limited/environmental-cleaning-RLS-H.pdf

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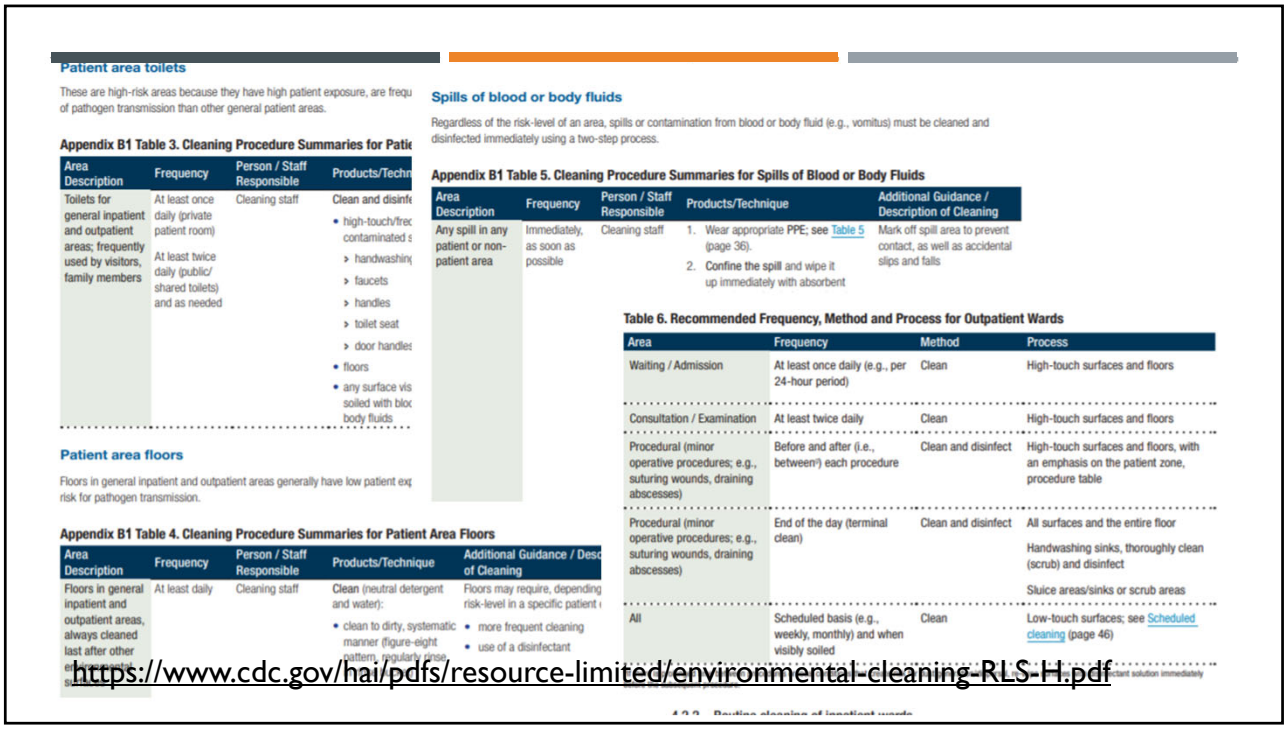

Patient area toilets

These are high-risk areas because they have high patient exposure, are frequ
of pathogen transmission than other general patient areas.

Appendix B1 Table 3. Cleaning Procedure Summaries for Patie

Area Description	Frequency	Person / Staff Responsible	Products/Techn
Toilets for general inpatient and outpatient areas; frequently used by visitors, family members	At least once daily (private patient room) At least twice daily (public/ shared toilets) and as needed	Cleaning staff	Clean and disinfe • high-touch/frec contaminated s › handwashin › faucets › handles › toilet seat › door handles • floors • any surface vis soiled with bloc body fluids

Patient area floors

Floors in general inpatient and outpatient areas generally have low patient exp
risk for pathogen transmission.

Appendix B1 Table 4. Cleaning Procedure Summaries for Patient Area Floors

Area Description	Frequency	Person / Staff Responsible	Products/Technique	Additional Guidance / Desc of Cleaning
Floors in general inpatient and outpatient areas, always cleaned last after other	At least daily	Cleaning staff	Clean (neutral detergent and water): • clean to dirty, systematic manner (figure-eight pattern, regularly rinse	Floors may require, depending risk-level in a specific patient • more frequent cleaning • use of a disinfectant

Spills of blood or body fluids

Regardless of the risk-level of an area, spills or contamination from blood or body fluid (e.g., vomitus) must be cleaned and disinfected immediately using a two-step process.

Appendix B1 Table 5. Cleaning Procedure Summaries for Spills of Blood or Body Fluids

Area Description	Frequency	Person / Staff Responsible	Products/Technique	Additional Guidance / Description of Cleaning
Any spill in any patient or non-patient area	Immediately, as soon as possible	Cleaning staff	1. Wear appropriate PPE; see Table 5 (page 36). 2. Confine the spill and wipe it up immediately with absorbent	Mark off spill area to prevent contact, as well as accidental slips and falls

Table 6. Recommended Frequency, Method and Process for Outpatient Wards

Area	Frequency	Method	Process
Waiting / Admission	At least once daily (e.g., per 24-hour period)	Clean	High-touch surfaces and floors
Consultation / Examination	At least twice daily	Clean	High-touch surfaces and floors
Procedural (minor operative procedures; e.g., suturing wounds, draining abscesses)	Before and after (i.e., between[a]) each procedure	Clean and disinfect	High-touch surfaces and floors, with an emphasis on the patient zone, procedure table
Procedural (minor operative procedures; e.g., suturing wounds, draining abscesses)	End of the day (terminal clean)	Clean and disinfect	All surfaces and the entire floor Handwashing sinks, thoroughly clean (scrub) and disinfect Sluice areas/sinks or scrub areas
All	Scheduled basis (e.g., weekly, monthly) and when visibly soiled	Clean	Low-touch surfaces; see Scheduled cleaning (page 46)

https://www.cdc.gov/hai/pdfs/resource-limited/environmental-cleaning-RLS-H.pdf

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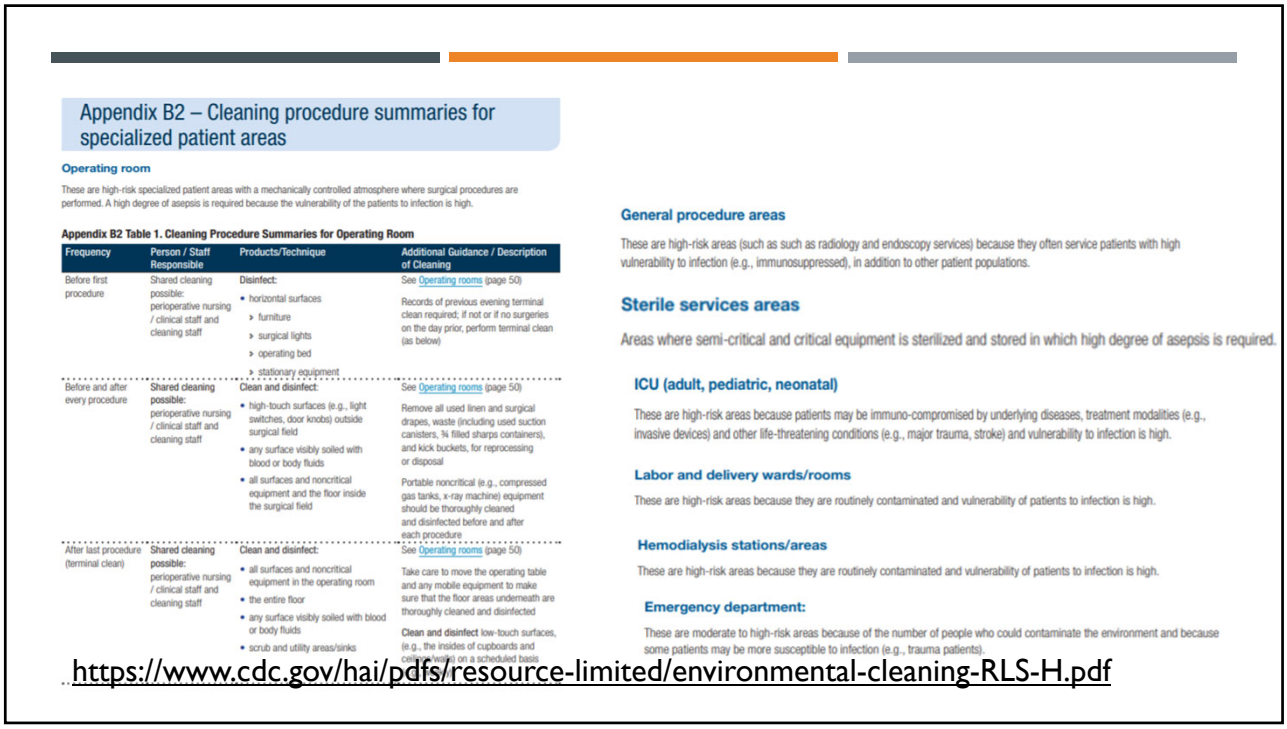

Appendix B2 – Cleaning procedure summaries for specialized patient areas

Operating room

These are high-risk specialized patient areas with a mechanically controlled atmosphere where surgical procedures are performed. A high degree of asepsis is required because the vulnerability of the patients to infection is high.

Appendix B2 Table 1. Cleaning Procedure Summaries for Operating Room

Frequency	Person / Staff Responsible	Products/Technique	Additional Guidance / Description of Cleaning
Before first procedure	Shared cleaning possible: perioperative nursing / clinical staff and cleaning staff	Disinfect: • horizontal surfaces › furniture › surgical lights › operating bed › stationary equipment	See Operating rooms (page 50) Records of previous evening terminal clean required; if not or if no surgeries on the day prior, perform terminal clean (as below)
Before and after every procedure	Shared cleaning possible: perioperative nursing / clinical staff and cleaning staff	Clean and disinfect: • high-touch surfaces (e.g., light switches, door knobs) outside surgical field • any surface visibly soiled with blood or body fluids • all surfaces and noncritical equipment and the floor inside the surgical field	See Operating rooms (page 50) Remove all used linen and surgical drapes, waste (including used suction canisters, ¾ filled sharps containers), and kick buckets, for reprocessing or disposal Portable noncritical (e.g., compressed gas tanks, x-ray machine) equipment should be thoroughly cleaned and disinfected before and after each procedure
After last procedure (terminal clean)	Shared cleaning possible: perioperative nursing / clinical staff and cleaning staff	Clean and disinfect: • all surfaces and noncritical equipment in the operating room • the entire floor • any surface visibly soiled with blood or body fluids • scrub and utility areas/sinks	See Operating rooms (page 50) Take care to move the operating table and any mobile equipment to make sure that the floor areas underneath are thoroughly cleaned and disinfected Clean and disinfect low-touch surfaces, (e.g., the insides of cupboards and ceiling) weekly on a scheduled basis

General procedure areas

These are high-risk areas (such as such as radiology and endoscopy services) because they often service patients with high vulnerability to infection (e.g., immunosuppressed), in addition to other patient populations.

Sterile services areas

Areas where semi-critical and critical equipment is sterilized and stored in which high degree of asepsis is required.

ICU (adult, pediatric, neonatal)

These are high-risk areas because patients may be immuno-compromised by underlying diseases, treatment modalities (e.g., invasive devices) and other life-threatening conditions (e.g., major trauma, stroke) and vulnerability to infection is high.

Labor and delivery wards/rooms

These are high-risk areas because they are routinely contaminated and vulnerability of patients to infection is high.

Hemodialysis stations/areas

These are high-risk areas because they are routinely contaminated and vulnerability of patients to infection is high.

Emergency department:

These are moderate to high-risk areas because of the number of people who could contaminate the environment and because some patients may be more susceptible to infection (e.g., trauma patients).

https://www.cdc.gov/hai/pdfs/resource-limited/environmental-cleaning-RLS-H.pdf

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Noncritical patient care equipment

These items are high-touch surfaces that are touched by both patients and by healthcare workers and may be used on multiple patients. They include portable or stationary noncritical patient care equipment such as IV poles, commode chairs, blood pressure cuffs, wheel chairs and stethoscopes.

Appendix B2 Table 13. Cleaning Procedure Summaries for Noncritical Patient Care Equipment

Area Description	Frequency	Person / Staff Responsible	Products/Technique	Additional Guidance / Description of Cleaning
Shared equipment (including transport equipment - e.g., wheelchairs) -shared between patients	Before and after every patient, and as needed	Shared cleaning possible (clinical staff and cleaning staff)	Clean and disinfect: Select a compatible disinfectant; see Material compatibility considerations (page 63)	Ensure division of cleaning responsibility between nursing and cleaning staff Clean and disinfect heavily soiled items (e.g., bedpans) in Sluice rooms (page 63) • Disinfect bedpans with a washer-disinfector or boiling water instead of a chemical disinfection process
Dedicated equipment - when dedicated to a particular patient during their stay	Consistent with cleaning frequency for patient area, and as needed	Shared cleaning possible (clinical staff and cleaning staff)	Products based on the risk level of the patient care area	Ensure division of cleaning responsibility between nursing and cleaning staff
Shared and dedicated equipment	At patient discharge/transfer	Shared cleaning possible (clinical staff and cleaning staff)	Clean and disinfect: Select a compatible disinfectant; see Material compatibility considerations in (page 63)	Conduct terminal cleaning of all noncritical patient care equipment in dedicated Sluice rooms (page 63)

https://www.cdc.gov/hai/pdfs/resource-limited/environmental-cleaning-RLS-H.pdf

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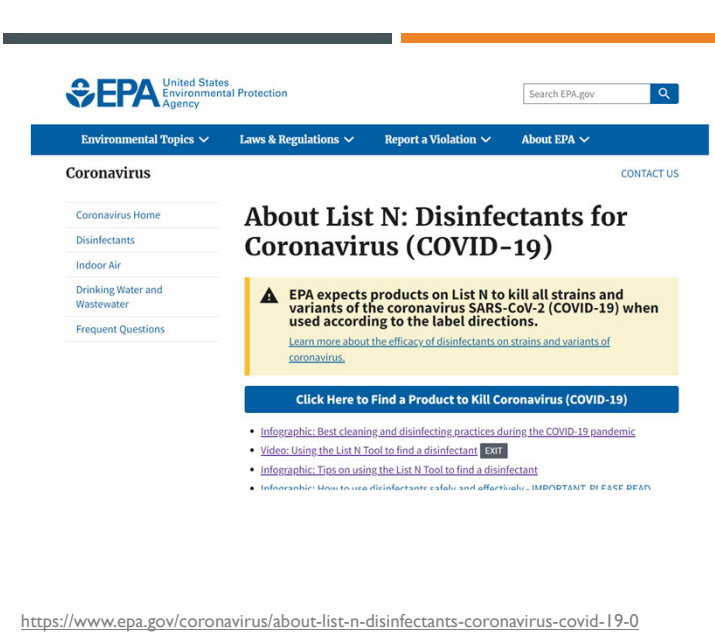
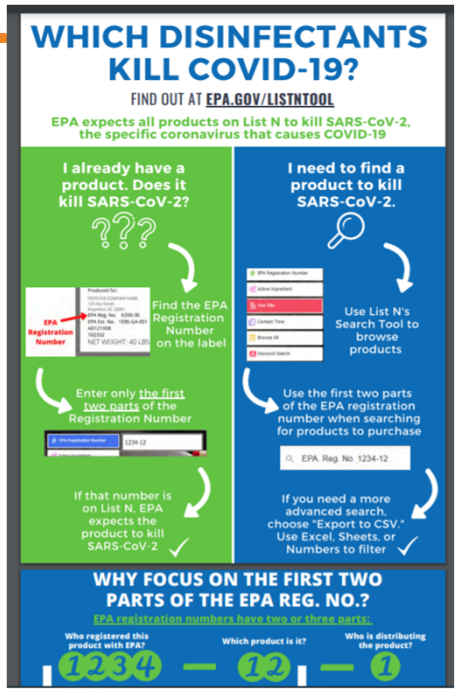
ALWAYS FOLLOW THE MANUFACTURER DIRECTIONS AND PRECAUTIONS ON ALL CLEANING AND DISINFECTION PRODUCTS.

34



https://www.epa.gov/coronavirus/about-list-n-disinfectants-coronavirus-covid-19-0



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36

WHAT ARE HIGH TOUCH SURFACES?

SURFACES OFTEN IN PATIENT CARE AREAS THAT ARE FREQUENTLY TOUCHED BY BOTH HEALTHCARE WORKERS AND PATIENTS.

37

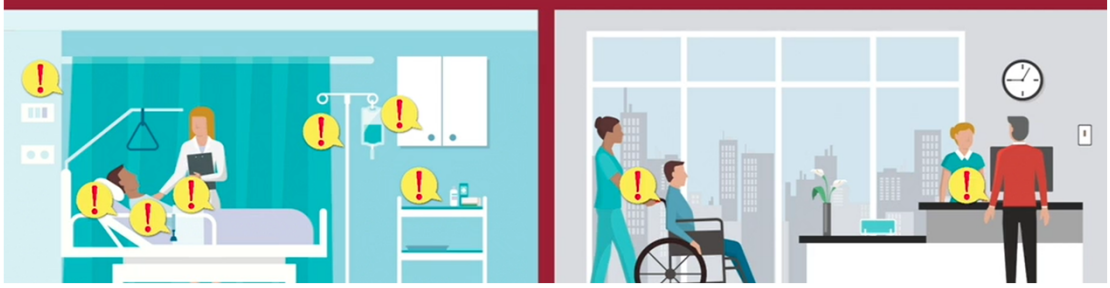
38

WHAT TO DO?
THE CALL LIGHT FELL ON THE FLOOR?

39

COMMON HIGH-TOUCH SURFACES

Doorknobs	Bedside Tables	Call Bells
Over-bed tables	Counters (Medication & Supplies)	Telephones
Bedrails	Edges of Privacy Curtains	
IV Poles	Monitoring Equipment	
Toilet and Sink Handles	Transport Equipment	



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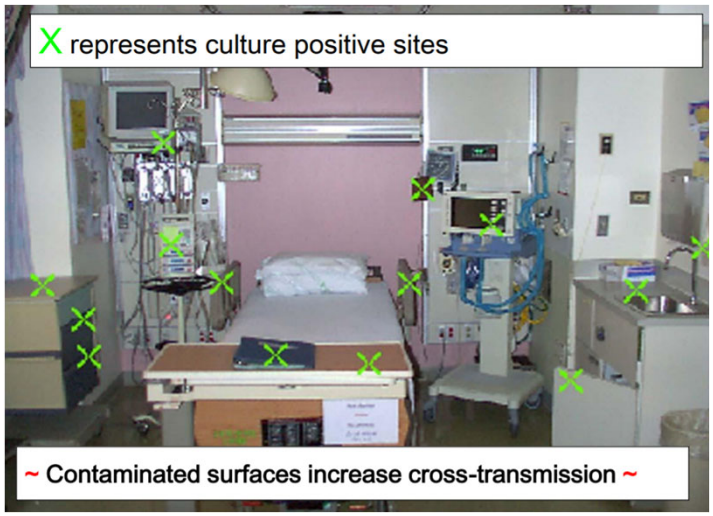
Appendix C – Example of high-touch surfaces in a specialized patient area

High touch surfaces include, but are not limited to:

bed rails • bed frames • moveable lamps • tray table • bedside table • handles • IV poles • blood-pressure cuff



https://www.cdc.gov/hai/pdfs/resource-limited/environmental-cleaning-RLS-H.pdf

https://www.mnhospitals.org/Portals/0/Documents/ptsafety/CDICleaning/3.%20Environmental%20Services%20Cleaning%20Protocol%20Educational%20Presentation.pdf

41

COLLECT THE RIGHT MATERIALS, ESTABLISH A THOUGHTFUL PLAN, AND PUT IT INTO PRACTICE

APPLY STRATEGIES AND TIPS TO SUPPORT CLEANING IN HEALTHCARE ENVIRONMENTS

42

ICE CHEST/COOLER/HYDRATION STATION

Store ice scoop on a clean hard surface when not in use. Do NOT store in the ice bin. Metal scoop preferred over plastic.

- Always clean and disinfect the cooler between uses. Cooler should be dried after cleaning and do not store when wet to prevent water bugs such as pseudomonas and aspergillus from growing.

Use a large liner in the cooler.

43

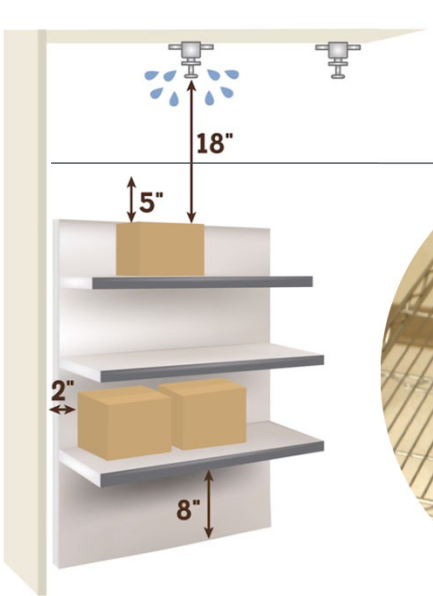
LAUNDRY

* Use rubber gloves before handling soiled linen (sheets, towels, curtains)
* Never carry soiled linen against your body.
* Carefully roll up soiled linen.
* Do not shake linen.
* Do not take linen out of patient rooms without it being contained. * Soiled bags can be laundered with the soiled linen they contained.
* If soiled with feces or vomit, remove as much as possible.
* If risk of splashing, (doing by hand), always wear appropriate PPE.
* Have designated area for folding and sorting clean linen.
* Keep laundry carts covered at all times.

44

REHAB/THERAPY ROOMS

45



"WHAT DO YOUR SUPPLY CLOSETS LOOK LIKE?"

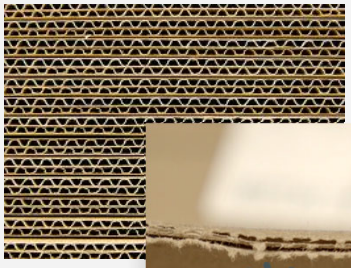
46

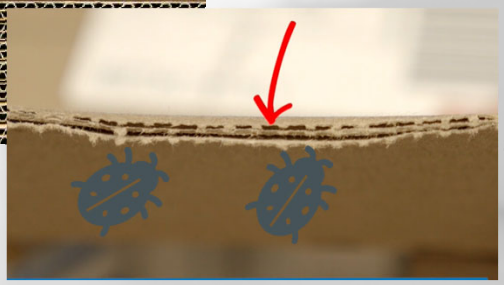
"DRAW A LINE ON WALL"

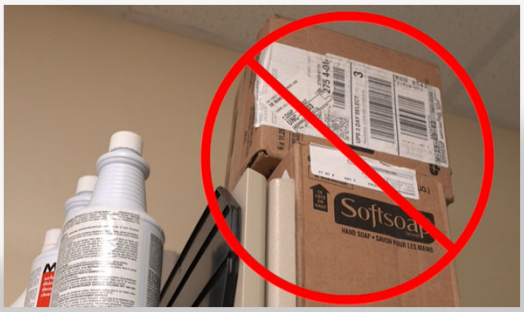
47

NO CORRUGATED CARDBOARD CONTAINERS.

Storage in any cardboard is discouraged!

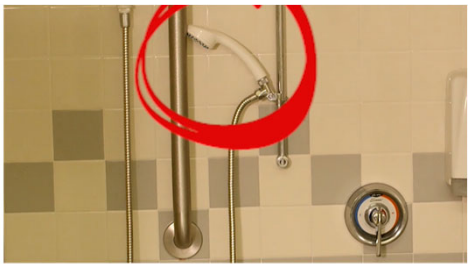






Items should be removed from shipping cartons and boxes. Outer shipping boxes should not be left in clinical areas due to risk of environmental contamination. Supplies should be stored in plastic, washable containers.

48



SHOWER AND TUB ROOMS

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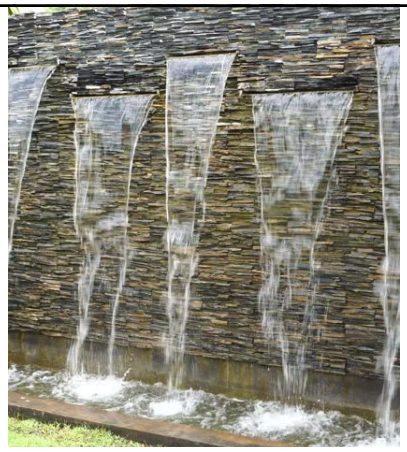

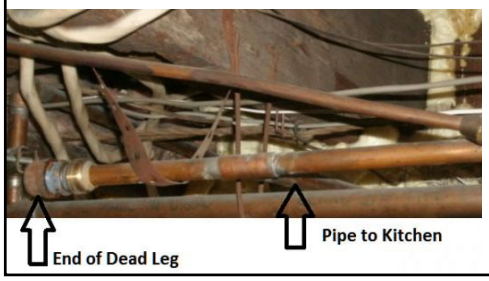

"WATER BUGS"

50


EVERY PATIENT/RESIDENT SHOULD HAVE THEIR OWN PERSONAL CARE ITEMS.
ANTI-STATIC

51


Non-Critical Is Critical
APIC
Association for Professionals in Infection Control and Epidemiology
Strategies to Mitigate Cross Contamination of Non-critical Medical Devices
Multiple-use,"non-critical," non-invasive, portable clinical items, such as medical tape and stethoscopes, can become star players in cross contamination and pathogen transmission. Unlike medical devices deemed critical, non-critical medical devices may not be accompanied by Instructions for Use (IFUs)—documents outlining the proper handling, storage, and processes required to clean and reach the parameters of safe use on patients. As a result, proper handling and storage of "non-critical" medical devices is often overlooked.
What are examples of non-critical medical devices?
THERAPY TOYS
OXYGEN SATURATION MONITORS
BLOOD PRESSURE CUFFS
STETHOSCOPES
MEDICAL TAPE


accompanied by IFUs, be sure to review the documents to ensure the compatibility of disinfectants with the equipment.
But...
...How do you reduce the risk of NON-CRITICAL DEVICES from being a source of transmission when IFUs are not included?
STEP 1: Identify Non-Critical Medical Devices
• Non-invasive portable clinical items shared among patients
STEP 2: Consider surfaces to be "unclean" rather than "clean"
STEP 3: Conduct a Risk Assessment
Identify:
• Items used on patients that cannot be cleaned or disinfected
• Potential for exposure: Is it high touch or low touch?
• Probability of contamination
• Vulnerability of the patients to infection
STEP 4: Recognize how staff and patients interact with non-critical medical devices and your facility's environment.
• Identify risk behaviors when staff are in contact with patients and equipment
• Strategically address environmental obstacles
• Consider how systems can be set up to minimize handling errors
• Manage workloads, responsibilities, and priorities of staff
STEP 5: Develop a Protocol
• Use multi-use and single-use items as guided by the FDA
• Use items on one patient during a single procedure as intended
• Identify simple solutions for frequently handled products, including packaging of items that traditionally do not have that extra layer of protection
• If reprocessing instructions are not provided, consider items single-use and dispose of appropriately after one use
• Define cleaning and disinfection frequency
• Identify materials and methodology to be used
STEP 6: Assign Cleaning Responsibilities
• Ensure all patient care equipment (including non-critical devices) is assigned to be cleaned by a designated staff person.
STEP 7: Train Staff on Assigned IPC Protocols
STEP 8: Monitor Compliance with Feedback
• Incorporate into environment of care rounds

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PREVENTION AND PROTECTION

"WHAT DO I PUT ON FIRST?"

"WHAT CAN WE DO TO PROTECT OUR PATIENTS & RESIDENTS AND OURSELVES?"

53

PREVENTION AND PROTECTION

"WHAT DO I TAKE OFF FIRST?"

"GLOVES ARE DIRTY. THEY COME OFF FIRST"

54

PREVENTION AND PROTECTION

"WHAT DO I TAKE OFF FIRST?"

"GLOVES, FACE SHIELD, GOWN, WASH HANDS, MASK, WASH HANDS"

55

WHAT IS PROJECT FIRSTLINE?

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WHAT IS PROJECT FIRSTLINE?

PROJECT FIRSTLINE IMPACTS ALL OF US IN SOUTH DAKOTA.

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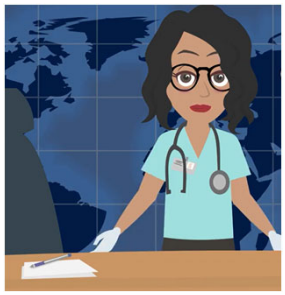
LEARNING NEEDS ASSESSMENT-

1900 RETURNED



4 Jurisdictions

- *Jurisdiction 1-Hospital, CAH, Outpatient Settings*
- *Jurisdiction 2-Long Term Care, Assisted Living, Home Care*
- *Jurisdiction 3-EMS/Paramedics/Fire Fighters/Public Work Force*
- *Jurisdiction 4- Correctional Facilities/Schools*

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3 Phases

Learning Needs Assessment

Focused Listening Sessions

Education

Training

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TRAINING NEEDS

Implementing IC with vulnerable populations

Strategies for putting IC in place

COVID 19

Source Control

Cleaning and Disinfection

Triage

Device Reprocessing

PPE

60

PFL INTRODUCTORY VIDEO

Create excitement and interest in training!

Play video! https://www.facebook.com/ProjectFirstlineSouthDakota

61

7 TRAINING SESSIONS MADE EASY

62

*7 MODULES ARE ON THE WEBSITE, YOU CAN EARN A CERTIFICATE OF ATTENDANCE.

*APPROVED FROM SD EMS PROGRAM TO OFFER 30 MINUTES OF CONTINUING EDUCATION CREDITS

*RESOURCE PAGE .

*WE CAN DO CUSTOMIZED EDUCATION FOR FACILITIES

*TRAINING CAN BE SHORT, 10 MINUTES OR UP TO 1 HR.

WWW.SDPROJECTFIRSTLINE.ORG

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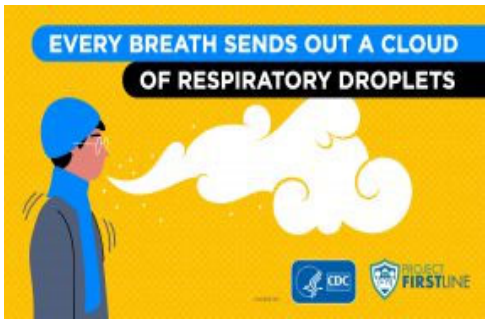

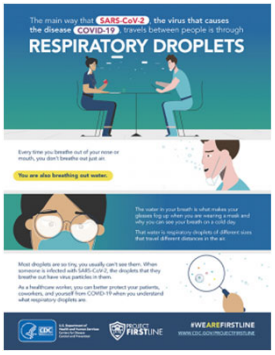

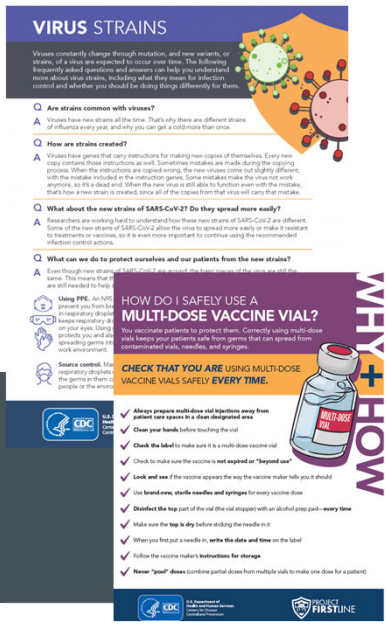

GRAPHICS, POWERPOINTS…

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VIDEOS, TWITTER, FACEBOOK…

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PROJECT FIRSTLINE
CDC's National Training Collaborative for Healthcare Infection Prevention & Control
NORTH Dakota | Health
Be Legendary.

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QUESTIONS

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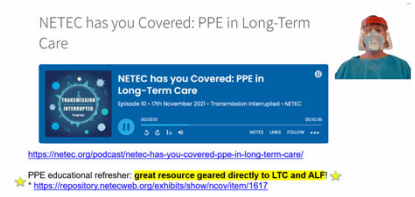
RESOURCES



https://www.sdprojectfirstline.org/

https://www.cdc.gov/infectioncontrol/projectfirstline/index.html

https://www.facebook.com/CDCProjectFirstline/

https://apic.org/wp-content/uploads/strive/B-Module-2/203A-EVS%20Module%202%20Infographic.pdf

https://youtu.be/P_UhDT9Zzgg

It's in Your Hands - the official song for the World Hand Hygiene Day (5th of May) - YouTube

https://apic.org/resources/overview/

Infection Prevention and Control (IPC) for COVID-19 Virus | OpenWHO

https://www.cdc.gov/infectioncontrol/guidelines/environmental/index.html

Disinfection & Sterilization Guidelines | Guidelines Library | Infection Control | CDC

https://www.youtube.com/c/TheSterileGuy

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