

Critical Care Units

Purpose: To identify sound infection control practices used in the intensive care setting to prevent, reduce and control Health-care associated transmission of infectious organisms.

I. General Practices:

- A. A conscious-careful attitude must be incorporated into each patient care practice in these high-risk areas to reduce the risk of healthcare-associated colonization or infection.
- B. Handwashing is the single most important practice to reduce the healthcare-associated infection risk. All individuals in the intensive care setting should practice hands hygiene appropriate to the task. Refer to the Infection Control Hand Hygiene policy (IC 2.0) for additional information. Facility approved alcohol based hand sanitizers, antimicrobial soap, and hand lotions are available for use in the intensive care units. Individuals with hand hygiene product special needs, i.e. chlorhexidine hypersensitivity, are referred to Occupational Health for consultation/evaluation and product identification.
- C. The Nursing Policy and Procedure manual is followed for routine patient care.
- D. Infection Control policies “Methods To Prevent Healthcare-Associated Intravascular Device-Related Infections” (IC 16.0) and “Methods To Prevent Healthcare-associated Pneumonia” (IC 17.0) and Invasive Procedures Not Done in the OR (IC 15.0) are followed.
- E. A copy of the Infection Control Guidelines is made assessable to each nurse and each resident when they begin their rotation and/or the guidelines are available online at http://www.medcom.lsuhs-c.edu/cfdocs/policies/IC_Revisions.cfm

II. Occupational Health Assessment

- A. An assessment for bloodborne pathogen exposure risk is required within 10 working days of employment. It is the joint responsibility of the employee and the Unit manager to assure this is done.
- B. Vaccination history and vaccination requirements are also assessed at this time.
- C. When employees are suspected or known to be infected (i.e., draining skin lesions, productive cough, or fever) they are to be evaluated by their supervisor and the Occupational Health Nurse.
- D. An annual Tuberculosis assessment is done by Occupational Health Clinic.
- E. When a needlestick or infectious disease exposure occurs, the employee goes to OHC during clinic hours. If the clinic is closed, the employee goes to Emergency Medical Services. The appropriate paperwork and follow-up is completed. Occupational Health Guidelines are followed.

III. Isolation Practices

- A. The Infection Control “BIT” (Bloodborne Pathogens Control Plan, Isolation Guidelines, TB Control Plan) http://www.medcom.lsuhs-c.edu/cfdocs/policies/IC_Revisions.cfm is followed.
- B. Standard precautions are used for all patients.
- C. Patients are assessed individually to determine any infectious process that would require additional isolation precautions. See Isolation Guidelines (IC 1.0) in the

Infection Control Manual for alphabetical list of specific infectious processes and isolation requirements.

- D. Personnel protective Equipment is readily available and easily accessible to all staff in the patient care area.
 - 1. Splash-proof gowns, mask and eye protection are available for situations where splashing may occur.
 - 2. Gloves are used when handling all body fluids. Gloves are used when handling all body fluids. Hands are washed thoroughly after gloves are removed. Gloves are changed between patients and between clean and dirty procedures on the same patient.
 - 3. Cover gowns are available for resistant microbe isolation.
 - 4. Submicron (duckbill) mask are available for infectious conditions requiring airborne isolation, such as TB or Chickenpox.
- E. Isolation rooms with negative pressure are available (Except in the Burn Unit). Patients who require Respiratory Precautions have priority for these rooms.
- F. Patients with multiple-resistant microbes and/or patients with body fluids that cannot be confined and contained should be placed in an isolation room if possible.
- G. Patients requiring Respiratory Isolation are not sent to the holding room or the PACU but are sent directly to the OR. They are recovered in the OR or in a negative pressure room in the unit with anesthesia personnel in attendance.

VI. Appropriate aseptic measures in patient care practices

- A. All solutions in large containers, i.e., mouthwash, glycerine, antiseptics, body powder, as well as supplies taken to the patient's bed side are to be discarded after the patient is discharged. Solutions should be labeled per nursing policy.
- B. All asepto syringes, irrigation sets, and unused open irrigation bottles are labeled and discarded 24 hours after opening.
- C. Scissors are not carried in pockets for use on patients. If scissors are needed, disposable suture removal sets are obtained from Central Medical Supply and are discarded after every patient use.
- D. Safety devices are available for many practices and should be used where available.

V. Cleaning

- A. Departmental Cleaning
 - 1. Only hospital approved disinfectants are used for cleaning. Refer to the Antiseptics and Disinfectants policy for additional information. (IC 3.0)
 - 2. Wheel chairs and stretchers are cleaned daily, PRN when soiled by body fluids or after use with a patient in Resistant Microbe Precautions. Refer to the Infection Control BIT for resistant microbe precautions
 - 3. Cardiac chairs, bedside chairs, bedside commodes, IV poles, fluid warmers, etc. are cleaned with housekeeping disinfectant after each patient use.
 - 4. If toys are brought into any unit, the toy section of the policy "Pediatric Play Room" will be followed. This policy is available in the applicable areas or from the Infection Control Department.
- B. Environmental Services Cleaning
 - 1. All horizontal surfaces and high touch surfaces are cleaned daily and more frequently as needed (Countertops, sinks, light fixtures, doorknobs, etc.) Exception: Nursing is responsible for cleaning and dusting the crash carts and MAK carts.

2. Unoccupied beds are cleaned as they come available per Environmental Services policy and procedure.
3. Floors are cleaned daily and more often as needed.

VI. Infection Control Consultation

- A. When there are questions regarding infection control practices, the Infection Control Department is consulted.
- B. As individual, departmental policies are written or reviewed that concern the insertion and maintenance of invasive devices, sterilization and disinfection, cleaning of supplies, wound care, isolation procedures, the Infection Control Department is consulted.
- C. When an infection rate exceeds the set threshold for more than one quarter, the unit manager sends a written response to the Infection Control Department regarding measures taken to reduce the infection rate. Responses are also requested from related areas' department heads.

VII. Visitors

- A. Hand washing is required before and after visiting in the unit. Soap and water or alcohol based hand gel is made accessible. (Refer to Hand Hygiene IC 2.0)
- B. Instructions are given prior to visiting patients on isolation precautions. (See Isolation Guidelines IC1.0 in the BIT. Appropriate PPE is provided.

References:

LSUHSC Infection Control Bloodborne Pathogen, Isolation, Tuberculosis, Control Plan (B.I.T)

CDC Hand hygiene in Healthcare Settings, 2002, accessed online at www.cdc.gov/handhygiene September 2009

Centers for Disease Control, Guidelines for Prevention of Nosocomial Pneumonia. *Monthly Morbidity and Mortality Report*, 53(RR03); 1-36, 2004.

Association for Professionals in Infection Control and Epidemiology, Inc. (APIC), APIC Text of Infection Control and Epidemiology - Intensive Care Unit, 3rd Edition, 2009.

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