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| **SSMED- 1611** | **Infection Control Mitigation** |
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|  | **Standard Precautions**   * 1. Standard precautions are foundational practices for preventing the movement of pathogens during the course of care. Medical Staff appropriately using Standard Precautions assume that all patients may be infected or colonized with an organism that could be spread in the healthcare setting. Emphasis on blood borne pathogens by the Occupational Safety and Health Administration Bloodborne Pathogens Standard, may result in the belief that standard precautions involve only certain body fluids.   2. Essential elements of Standard Precautions include the following core practice elements: * hand hygiene * environmental cleaning and disinfection * Aseptic techniques * Sterilizing Processes   1.3 Procedure for changing a simple wound dressing and inserting urinary catheters   * Equipment:   + Wipeable dedicated dressing tray or trolley.   + Detergent wipes or detergent and disposable cloth.   + Sterile dressing pack.   + Cleansing solution.   + Apron.   + Sterile and/or non-sterile gloves as required.   + Appropriate wound dressing. |
|  | **IV Considerations**   * 1. Monitor the infusion rate. Realize that some products, such as blood, must be discarded if not promptly delivered. Checking the drip rate ensures that the therapy is being completed in a timely manner. It also alerts you to blockages. Compare the doctor’s orders with the actual infusion time to ensure that they match. Adjust the infusion monitor as necessary to reach the target rate.   2. Maintain the IV site. Keep the site clean and dry. Flush the IV catheter with normal saline between active therapies to help prevent blockages. Change the tape at the site regularly to prevent the catheter from being dislodged from the vein.   3. Assess the IV site for signs of infiltration. This means that the fluid is collecting in surrounding tissues and isn’t flowing through the vein as desired. Look for adverse signs including redness and swelling. Ask the patient if her IV site feels itchy or irritated, as this could indicate a problem. Discontinue IV therapy at the site if you find positive signs of infiltration. Monitor the site regularly to identify problems promptly.   4. The IV should not stay on for longer than 48 hours. |
|  | **Urinary Catheter Considerations**   * 1. Indwelling catheters * Clean the area around your urethra every day. In female patients, this area also must be cleaned after every bowel movement. Your caregiver probably will empty the urine drainage bag about once every eight hours (sooner, if the bag is full).   1. Considerations * Foley (Latex) / Silicone (non-latex) * Foley < 5 days / Silicone (Long term > 30 days)   1. Remove when: * Pain in the abdomen, flank or lower back * Urine that smells foul or unusually strong * Urine that is thick, cloudy or tinged with blood * (Indwelling catheter) Little or no output of urine into the drainage bag, in spite of attempts to irrigate the catheter * (Indwelling catheter) Leakage of urine past the catheter |
|  | **NG Tubes—Considerations:**  **Tube Insertion and Stabilization**   * 1. Approximate the length of the tube to be inserted by measuring from the tip of nose to the earlobe, and then from the earlobe to the xiphoid process.   2. pH Testing: A combination of aspirate appearance and pH testing can be used to help make correct predictions about tube placement in the stomach.   3. Maintaining Tube Patency: Flush feeding tubes with 30 ml of water before and after intermittent feeding, every 4-hourly during continuous feeding and after checking for gastric residuals. More frequent flushing might be ordered according to patient’s condition.   4. Monitoring and Management of Gastro-intestinal Tolerance: Gastric residual volume (GRV) should be checked 4-8 hourly in continuously fed patients and before each intermittent feeding.   5. GRV greater than 200 ml should prompt careful bedside evaluation and initiation of appropriate feeding method and feeding volume. GRV reading should be evaluated in conjunction with physical examination for abdominal distension, absence of bowel sounds, and presence of nausea and vomiting**.**   6. Management of Feeding Intolerance When patient shows signs of feeding intolerance such as nausea, vomiting, abdominal distension and pain: * Perform a physical examination of the abdomen including assessment for presence of abdominal pain and bowel sounds. * Feeding should only be stopped abruptly for those patients who demonstrate overt regurgitation or aspiration. * Know all your complications |
|  | **ET Tube**   * 1. Before Procedure: * Size: In general, a 7.0 to 7.5 mm diameter tube is often used for women and an 8.0 to 9.0 mm diameter tube for men. Use Braslow Measurements for Children under 8   1. During the Procedure * the procedure for placing an endotracheal tube will vary depending on whether a person is conscious or not. Know your RSI sequence. First, the patient is preoxygenated with 100 percent oxygen (ideal is five minutes) to give the intubator more time to intubate. An oral airway may be used to keep the tongue of the way and reduce the chance that the patient will bite the ET tube.   1. Intubate * The scope is then carefully threaded down between the vocal cords and into the lower trachea. When it's thought that the endotracheal tube is in the proper location, the doctor will listen to the patient's lungs and upper abdomen to make sure that the endotracheal tube was not inadvertently inserted into the esophagus. * Other signs that suggest the tube is in the proper position may include seeing chest movement with ventilation and fogging in the tube. When a doctor is reasonably sure the tube is in position, a balloon cuff is inflated to keep the tube from moving out of place. (In infants, a balloon may not be needed). The tube is then taped to the patient's face   1. Verifying Proper Placement * Once the tube is in place, it's important to verify that it is truly in the proper location to ventilate the patient's lungs. Improper positioning is particularly common in children, especially children who have experienced trauma. * A chest X-ray vary valuable but do not except additional verifications. * In addition to directly visualizing the endotracheal tube pass between the vocal cords with an end-tidal carbon dioxide detector (capnography) in patient's that had good tissue perfusion, with continued monitoring to make sure the tube does not become displaced. * In the setting of a cardiac arrest, they recommended using ultrasound imaging or an esophageal detector device.   1. After the Procedure * After the endotracheal tube is in place and a patient connected to a ventilator, the medical staff will continue to monitor the tubing, settings, and provide breathing treatments and suctioning as needed. Careful attention to oral care will also be provided. Due to the location of the tube, patients who are conscious will be unable to talk while the tube is in place.   1. Complications and Risks * There are both short-term and long-term risks and complications associated with endotracheal tube placement. Short-term complications may include: * Bleeding * Esophageal placement of the tube: One of the most serious complications is improper placement of the endotracheal tube into the esophagus. If this goes unnoticed, the lack of oxygen to the body could result in brain damage, cardiac arrest, or death. * Temporary hoarseness when the tube is removed * Injury to the mouth, teeth or dental structures, tongue, thyroid gland, voice box (larynx), vocal cords, windpipe (trachea), or esophagus. Dental injuries (particularly to the upper incisors) * Infection * Pneumothorax (collapse of a lung): If the endotracheal tube is advanced too far such that it only enters one bronchus (and thus ventilates only one lung), inadequate ventilation may occur or collapse of one lung. * Aspiration of contents of the mouth or stomach during placement which can, in turn, result in aspiration pneumonia * Persistent need for ventilatory support * Atelectasis: Inadequate ventilation (a respiratory rate that is too low) can result in collapse of the smallest of airways, the alveoli resulting in atelectasis (partial or complete collapse of a lung).   1. Long term complications that may persist or arise later on may include: * Tracheal stenosis, or narrowing of the trachea: Most common in people who require prolonged intubation, and once occurring in around 1% of people who were intubated * Tracheomalacia * Spinal cord injuries * Tracheoesophageal fistula (an abnormal passageway between the trachea and esophagus) * Vocal cord paralysis: A rare complication that can cause permanent hoarseness |
|  | **Removing the Endotracheal Tube**   * 1. Before removing an endotracheal tube (extubation) and stopping mechanical ventilation, doctors carefully assess a patient to predict whether or not he or she will be able to breathe on her own. This includes: * Ability to breathe spontaneously: If a patient had anesthesia during surgery, they will usually be allowed to wean off of the ventilator. If an endotracheal tube is placed for another reason, different factors may be used to determine if it is time, such as using arterial blood gasses or looking at peak expiratory flow rate. * Level of consciousness: In general, a higher level of consciousness (Glasgow coma scale over eight) predicts a greater chance that weaning will be successful. * If it's thought that the tube can be reasonably removed, the tape holding the endotracheal tube on the face is removed, the cuff is deflated, and the tube is pulled out. |
|  | The same care should be taken if any of the below procedures Done   * Emergency Cricothyroidotomy * CVP lines * Intracoastal drains * Incisions * Any other Invasive Techniques or Procedures |
|  | References  <https://www.cdc.gov/infectioncontrol/guidelines/index.html>  <https://www.cdc.gov/hai/infectiontypes.html> |