

	H&S Code IC Definitions		
<p><b>1288.9</b></p>	<p><b>1288.9.</b> By January 1, 2009, the department shall do all of the following:</p> <p>(a) Require each general acute care hospital to develop, implement, and periodically evaluate compliance with policies and procedures to prevent secondary surgical site infections (SSI). The results of this evaluation shall be monitored by the infection prevention committee and reported to the surgical committee of the hospital.</p> <p>(b) Require each general acute care hospital to develop policies and procedures to implement the current Centers for Disease Control and Prevention guidelines and Institute for Healthcare Improvement (IHI) process measures designed to prevent ventilator associated pneumonia.</p> <p>(c) During surveys, evaluate the facility's compliance with existing policies and procedures to prevent HAI, including any externally or internally reported HAI process and outcome measures.</p>	<p>Surgical procedures are performed in a manner consistent with current CDC guidelines to maximize the prevention of infection and communicable disease including the following:</p> <p><b><u>1. Preoperative</u></b></p> <p>a. Preparation of the patient</p> <ul style="list-style-type: none"> <li>• Remote infections are treated prior to surgery</li> <li>• Preop hair removal is avoided</li> <li>• If hair removal is done, it is performed immediately prior to surgery with clippers</li> <li>• Serum blood glucose levels are controlled perioperatively</li> <li>• Tobacco cessation education was done preoperatively</li> <li>• Blood products were not withheld to avoid infection</li> <li>• Patients are required to do preoperative bathing</li> <li>• The incision site is cleaned prior to prep if gross contamination is present</li> <li>• An appropriate antiseptic skin prep agent is used for site prep.</li> </ul> <p>b. Hand/forearm antisepsis for surgical team members</p> <ul style="list-style-type: none"> <li>• Nails are kept short and artificial nails are not in use</li> <li>• Preop surgical scrub is done from the hands &amp; forearms, and up to the elbows for at least 2 minutes to 5 minutes with appropriate antiseptic</li> </ul>	<p><b>GUIDELINE FOR PREVENTION OF SURGICAL SITE INFECTION, 1999</b></p> <p>Alicia J. Mangram, MD; Teresa C. Horan, MPH, CIC; Michele L. Pearson, MD; Leah Christine Silver, BS; William R. Jarvis, MD; The Hospital Infection Control Practices Advisory Committee</p> <p><b>Rationale</b></p> <p>Category I recommendations, including IA and IB, are those recommendations that are viewed as effective by HICPAC and experts in the fields of surgery, infectious diseases, and infection control. Both Category IA and IB recommendations are applicable for, and should be adopted by, all healthcare facilities; IA and IB recommendations differ only in the strength of the supporting scientific evidence.</p>

		<ul style="list-style-type: none"><li>• Scrubbed hands are kept up and away from the body so that water runs from the tips of fingers to the elbows</li><li>• Hands are dried with a sterile towel prior to donning sterile gown and gloves.</li></ul> <p>c. Management of infected or colonized surgical personnel</p> <ul style="list-style-type: none"><li>• Surgical personnel with signs and symptoms of transmissible infectious illness report conditions promptly to their supervisor or occupational health service.</li><li>• Policies are defined concerning patient care responsibilities with potentially infectious personnel<ul style="list-style-type: none"><li>○ The persons who have the authority to remove personnel from duty</li><li>○ Personnel responsibility in using the health service and reporting illness</li><li>○ Work restrictions</li><li>○ Clearance to resume work after illness resolved</li></ul></li><li>• Surgical personnel with draining skin lesions are excluded from duty until the infection has been ruled out or personnel have received adequate therapy and infection has resolved.</li><li>• Surgical personnel who are colonized with organisms such as <i>S. aureus</i> or group A <i>Streptococcus</i> are not routinely excluded unless such personnel are linked epidemiologically to dissemination of the organism.</li></ul> <p>d. Antimicrobial prophylaxis</p> <ul style="list-style-type: none"><li>• Prophylactic antimicrobials are administered when indicated and are selected based on</li></ul>	
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		<p>efficacy against the most common pathogens causing SSI for a specific operation and published recommendations</p> <ul style="list-style-type: none"><li>• The initial dose of prophylactic antimicrobials is administered by the intravenous route and timed to establish serum and tissue bactericidal concentrations when the incision is made. Therapeutic levels are maintained until the incision is closed.</li><li>• Mechanical colon preps are administered before elective colorectal operations (in addition to prophylactic antimicrobials).<ul style="list-style-type: none"><li>○ Nonabsorbable oral antimicrobials are administered in divided doses on the day before the operation.</li></ul></li><li>• Prophylactic antimicrobials are administered to high-risk cesarean sections immediately after the umbilical cord is clamped.</li><li>• Vancomycin is not routinely used for antimicrobial prophylaxis.</li></ul> <p><b><u>2. Intraoperative</u></b></p> <p>a. Ventilation</p> <ul style="list-style-type: none"><li>• Positive-pressure ventilation is maintained in the operating room with respect to the corridors and adjacent areas.</li><li>• There is a minimum of 15 air changes per hour, with 3 of them being fresh air.</li><li>• Recirculated and fresh air is filtered through appropriate filters per the American Institute of Architect's recommendations</li><li>• Air is introduced at ceiling level and exhausted near the floor.</li><li>• UV radiation is not used in the operating room to prevent SSI.</li></ul>	
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		<p>and face when entering the operating room</p> <ul style="list-style-type: none"><li>• Shoe covers are not worn for the prevention of SSI.</li><li>• Sterile gloves are worn by all scrubbed surgical team members. Gloves are donned after the sterile gown.</li><li>• Surgical gowns and drapes are liquid resistant.</li><li>• Scrub suits that are visibly soiled, contaminated, and/or penetrated by blood or other potentially infectious materials are changed.</li></ul> <p>f. Asepsis and surgical technique</p> <ul style="list-style-type: none"><li>• Aseptic principals are followed when placing intravascular devices, spinal or epidural anesthesia catheters, or when dispensing and administering intravenous drugs.</li><li>• Sterile equipment and solutions are assembled immediately prior to use.</li><li>• Tissue is handled gently, effective hemostasis is maintained, devitalized tissue and foreign bodies are minimized, and dead space at the surgical site is eradicated.</li><li>• If the surgeon considers the surgical site to be heavily contaminated, then primary skin closure is delayed or the incision left open to heal</li><li>• A closed suction drain placed through a separate incision distant from the operative incision is used if drainage is necessary. The drain is removed as soon as possible.</li></ul> <p><b><u>3. Postoperative incision care</u></b></p> <ul style="list-style-type: none"><li>• <i>An incision that has been closed primarily is protected with a sterile dressing for 24-48</i></li></ul>	
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		<p><i>hours postoperatively</i></p> <ul style="list-style-type: none"><li>• <i>Hands are washed before and after dressing changes or when any contact with the surgical site is anticipated</i></li></ul> <p><b><u>4. Surveillance</u></b></p> <ul style="list-style-type: none"><li>• CDC definitions without modifications for SSI are used to identify SSI among surgical inpatients and outpatients.</li><li>• Direct prospective observation, indirect prospective detection, or a combination of both methods is used for case-finding</li><li>• Post discharge surveillance by a method that accommodates available resources and data needs is performed to detect SSI</li><li>• Outpatient case-finding by a method that accommodates available resources and data needs is performed</li><li>• variables shown to be associated with increased SSI risk (i.e. wound class, ASA class, duration of operation, etc.) are recorded for each patient undergoing an operation</li><li>• operation-specific SSI rates stratified by variables shown to be associated with increased SSI risk are periodically calculated</li><li>• Appropriately stratified, operation-specific SSI rates are reported to surgical team members at an optimum frequency and format determined by stratified case-load sizes and local, continuous quality improvement initiative objectives.</li></ul>	
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