Clostridioides difficile
Infection Prevention
Objectives

• Describe the cause and epidemiology of *Clostridioides difficile* infection (CDI)
• Review evidence-based CDI prevention strategies
• Describe importance of adherence monitoring and feedback
Clostridioides difficile

• An anaerobic, gram-positive, spore-forming, toxin-producing bacillus
• Transmitted among humans via the fecal-oral route
• The cause of Clostridioides difficile infection (CDI); severity ranges from mild diarrhea to severe intestinal infection (colitis); death in up to 9% of cases
• The leading cause of antibiotic-associated colitis in adults, in both acute and long-term care settings

U.S. CDI Burden

Of the estimated cases of community-associated CDI, 82% were estimated to be associated with outpatient health care exposure. CO-HCA denotes community-onset health care–associated infection, HO hospital onset, and NHO nursing home onset.

Healthcare-Associated CDI in California

- *C. difficile* is the most frequently reported HAI by California hospitals
  - 7,783 hospital-onset CDI reported in 2017
- Patients often cycle between multiple hospitals, long term acute care, and long term care facilities
  - 26% of CDI patients in Orange County were readmitted to another facility within 12 weeks of discharge

Huang et al., Infect Control Hosp Epidemiol, 31(11), 1160-1169, 2010
2020 CDI Prevention Goal for Hospitals

• National HAI Prevention Action Plan target goal:
  – 30% CDI reduction from 2015 baseline

• 2017: California hospitals are on track - 26% decrease in CDI from 2015
  – Recommended by the CDPH HAI Advisory Committee for all California hospitals
**C. difficile Pathogenesis**

The following events may take place separately and in any order, but both are required for CDI to occur.

- Ingest *C. difficile* spores transmitted to patients via the hands of healthcare personnel and environment
- Spores germinate into a growing vegetative form
- Changes in lower intestinal flora due to antimicrobial use allows proliferation of *C. difficile* in colon
- Toxin A & B production leads to colon damage

Two Preventable Events in CDI

The following events may occur separately and in any order, but **both are required for infection to occur:**

1. The normal **intestinal flora must be compromised** (for example, due to antibiotics) allowing for *C. difficile* to establish itself and proliferate

2. ***C. difficile* bacteria or spores must be ingested**

---

Risk Factors for CDI

- Acquisition of *C. difficile* bacteria *...(Modifiable risk factor)*
- Antimicrobial exposure *...(Modifiable risk factor)*
- Advanced age
- Immunosuppression
- Tube feedings
- Gastric acid suppression
- Prolonged stay in healthcare facility
- Inflammatory bowel disease
- GI surgery
CDI Diagnosis

- Presence of symptoms, usually diarrhea
  - ≥3 unformed stools over 24 hours (specifically, stool conforms to shape of container)
- Positive stool test for *C. difficile* or toxins
- Diagnostic imaging
  - Endoscopic or histologic (for example, pseudomembranous disease)
- CDI relapse occurs in 10-25% cases

CDI Testing Methods

- Only test patients with clinically significant diarrhea without other identified causes
  - Consider alternate etiologies for diarrhea
  - Discontinue laxatives for 24-48 hours and reevaluate prior to testing
- Use laboratory-based system for immediate notification of positive CDI test results
- Single stool specimen at onset of symptoms is sufficient
- Repeat testing is of limited value; “test of cure” is not recommended
Clinical Practice Guidelines for *Clostridium difficile* Infection in Adults and Children: 2017 Update by the Infectious Diseases Society of America (IDSA) and Society for Healthcare Epidemiology of America (SHEA)

L. Clifford McDonald,† Dale N. Gerding,‡ Stuart Johnson,§ Johan S. Bakken,∥ Karen C. Carroll,¶ Susan E. Coffin,∥ Erik R. Dubberke,∥ Kevin W. Garey,∥ Carolyn V. Gould,∥ Ciaran Kelly,∥ Vivian Loo,∥ Julia Shaklee Sammons,∥ Thomas J. Sandora,∥∥ and Mark H. Wilcox∥∥∥

†Centers for Disease Control and Prevention, Atlanta, Georgia; ‡Edward Hines Jr Veterans Administration Hospital, Hines, and §Loyola University Medical Center, Maywood, Illinois; ¶St Luke’s Hospital, Duluth, Minnesota; §§Johns Hopkins University School of Medicine, Baltimore, Maryland; ¶¶Children’s Hospital of Philadelphia, Pennsylvania; ¶¶¶Washington University School of Medicine, St Louis, Missouri; ‖University of Houston College of Pharmacy, Texas; ‖‖Beth Israel Deaconess Medical Center, Harvard Medical School, Boston, Massachusetts; ‖‖‖McGill University Health Centre, McGill University, Montréal, Québec, Canada; ‖‖‖‖Boston Children’s Hospital, Massachusetts; and ‖‖‖‖‖Leeds Teaching Hospitals NHS Trust, United Kingdom

A panel of experts was convened by the Infectious Diseases Society of America (IDSA) and Society for Healthcare Epidemiology of America (SHEA) to update the 2010 clinical practice guideline on *Clostridium difficile* infection (CDI) in adults. The update, which has incorporated recommendations for children (following the adult recommendations for epidemiology, diagnosis, and treatment), includes significant changes in the management of this infection and reflects the evolving controversy over best methods for diagnosis. *Clostridium difficile* remains the most important cause of healthcare-associated diarrhea and has become the most commonly identified cause of healthcare-associated infection in adults in the United States. Moreover, *C. difficile* has established itself as an important community pathogen. Although the prevalence of the epidemic and virulent ribotype 027 strain has declined markedly along with overall CDI rates in parts of Europe, it remains one of the most commonly identified strains in the United States where it causes a sizable minority of CDIs, especially healthcare-associated CDIs. This guideline updates recommendations regarding epidemiology, diagnosis, treatment, infection prevention, and environmental management.
Test Recommendations Algorithm

Clinicians and lab personnel agree at the institutional level to **not submit stool specimens on patients receiving laxatives** and to submit stool specimens only from patients with unexplained and new onset ≥3 unfomed stools in 24hr for CDI testing

NO

Stool toxin test* as part of a multiple step algorithm, (GDH plus toxin; GDH plus toxin, arbitrated by NAAT; or NAAT plus toxin) rather than a nucleic acid amplification test (NAAT) alone

YES

NAAT alone OR stool toxin test* as part of a multiple step algorithm (GDH plus toxin; GDH plus toxin arbitrated by NAAT; or NAAT plus toxin), rather than a toxin test alone

*Approved stool EIA toxin tests vary widely in sensitivity. Lab should choose a toxin test with sensitivity in the upper range of sensitivity as reported in literature.
Preventing CDI: The MOST Important Things

Prevent C. difficile Acquisition / Reduce Antimicrobial Exposure

- Isolate patients with diarrhea pending CDI confirmation
- **Lab alert system** for immediate notification of positive CDI tests
- **Contact precautions** for duration of diarrhea plus 48 hours
  - Private room, dedicated toilet
  - Gloves/gown to enter room
  - Remove gloves, perform hand hygiene prior to room exit
- **Hand hygiene** before/after patient contact & after glove removal
  - Patient hand hygiene

- **Disposable equipment**
- **Sporicidal disinfectant** for cleaning reusable equipment
- Sporicidal disinfectant for **terminal cleaning**
- **Quality cleaning**, daily & terminal
- CDI-targeted **antimicrobial stewardship program**
  - Improve overall prescribing, stop unnecessary antibiotics
  - Restrict high-risk antibiotics based on local epidemiology
  - Stop inciting antibiotic
Contact Precautions for CDI

Place on contact precautions for duration of diarrhea

- Extend contact precautions beyond duration of diarrhea (Example: for 48 hours after diarrhea ceases)
- Emphasize **glove use** and removal of gloves prior to exiting room of CDI patient
  - Gloves are effective at preventing *C. difficile* contamination of hands
  - Adherence to glove use is critical to preventing *C. difficile* transmission via hands of health care providers
- Emphasize compliance with **hand hygiene**
Contact Precautions – Special Approaches

When CDI rates remain high or during an outbreak, isolate patients with diarrhea pending CDI confirmation

• Rationale: Patients with CDI may contaminate the environment and hands of health care providers before results of testing are known.

• For patients with possible recurrent CDI, isolate and test following first unformed stool
Hand Hygiene for CDI

Perform hand hygiene before and after contact with CDI patient and after removing gloves

- Routinely use alcohol hand rub or soap and water
  - *C. difficile* spores are resistant to alcohol; however, studies did not find increases in CDI with alcohol-based hand hygiene, but several did find reductions in MRSA or VRE

- Use soap and water during CDI outbreak, “hyper-endemic setting,” or hand fecal contamination
  - Be aware: Hand hygiene adherence may decrease when soap and water is the only option provided
Hand Hygiene and Gloves – Special Approaches

When CDI rates remain high or during an outbreak, implement universal glove use for facilities or units with high CDI rates

• Rationale: *C. difficile* spores are difficult to remove even with hand washing.

• Asymptomatic carriers play a role in transmission (though magnitude of contribution unknown)

• Adherence to glove use with or without contact precautions is critical to preventing *C. difficile* transmission via hands of health care providers
CDI-Targeted Antimicrobial Stewardship

Implement an antimicrobial stewardship program (ASP)

• Goal: Minimize the frequency and duration of antimicrobials and the number of antimicrobials prescribed.

• Target antimicrobials based on local epidemiology
  – Restricting fluoroquinolones, cephalosporin, and clindamycin has been effective

• Reduce use of broad-spectrum antibiotics
  – Enforcing a narrow-spectrum antibiotic policy with feedback to prescribing physician resulted in significant CDI reduction in 3 acute geriatric medical wards

CDI-Targeted Antimicrobial Stewardship - continued

- Increased risk of CDI has been linked to specific antibiotics

<table>
<thead>
<tr>
<th>High Risk</th>
<th>Medium Risk</th>
<th>Low Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aminopenicillins</td>
<td>Beta-lactam/beta-lactamase inhibitors</td>
<td>Macrolides</td>
</tr>
<tr>
<td>Clindamycin</td>
<td>Carbapenems</td>
<td>Trimethoprim/sulfamethoxazole</td>
</tr>
<tr>
<td>Cephalosporins</td>
<td></td>
<td>Tetracyclines</td>
</tr>
<tr>
<td>Fluoroquinolones</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Examples of CDI-Targeted ASP Interventions

• Formulary restriction and prospective audit with feedback
  – Target antibiotic(s) most associated with CDI at your facility
  – Recommend lower-risk alternatives, and optimizing dosing, route, and duration of therapy
• Target patients with CDI diagnoses for medication review to identify and discontinue unnecessary antibiotics

ASP Interventions Reduce Risk of *C. difficile* Transmission

- Improved overall antimicrobial prescribing
  - Fewer patients on antimicrobials
  - Fewer patients develop CDI
  - Fewer CDI patients contribute to transmission
- Stopping unnecessary antibiotics in patients with new CDI diagnoses
  - Improved clinical response to treatment and reduced risk of recurrent CDI
  - Fewer CDI patients contribute to transmission

California Antimicrobial Stewardship Initiative

- CDPH HAI Program activity
- Objective: Assist California hospitals and long-term care facilities with optimizing antimicrobial use to improve patient outcomes
- CDPH Antimicrobial Stewardship Program Initiative web page: [www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/CA_AntimicrobialStewardshipProgramInitiative.aspx](http://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/CA_AntimicrobialStewardshipProgramInitiative.aspx)
Environmental Cleaning and Disinfection

- Patients with CDI can shed bacteria and spores into the environment both during and after treatment of CDI
- Ensure thorough daily and terminal cleaning of patient care areas
  - Focus on high-touch surfaces and the bathroom
- Assess adequacy of cleaning
  - Study in 3 hospitals used fluorescence to assess cleaning
  - Only 47% of high-touch surfaces cleaned
Equipment

- Identify and **remove unnecessary** equipment that can be environmental sources of *C. difficile* transmission
  - Use **disposable** equipment when possible
  - Ensure **reusable equipment** is cleaned with a **sporicidal disinfectant**
Environmental Cleaning and Disinfection-Special Approaches

When CDI rates remain high or during an outbreak, use a *sporicidal disinfectant* for daily and terminal cleaning (for example, bleach), in conjunction with other measures:

- Limited data suggest cleaning with bleach (1:10 dilution prepared fresh daily) reduces *C. difficile* transmission.
- Two before-after studies showed benefit on units with high endemic CDI rates.
- Sporicidal disinfectants may be most effective in reducing burden where CDI rates high.
CDI in the Hospital Environment

"C. difficile" Transmission from Prior Room Occupants

110% Increased risk

Shaunnessey et al. Abstract K-4194
IDSA / ICAAC. October 2008
Infection Prevention Role in CDI Prevention

- Ensure policies reflect current evidence-based practice recommendations
- Ensure staff competency upon hire and at least annually (Examples: new hire orientation, annual skills fair, return demonstration to ensure competency)
- Establish an adherence monitoring program for core care practices
  - Use available adherence monitoring tools
  - Ensure feedback provided to frontline staff
- Present adherence results and CDI incidence to leaders
Adherence Monitoring Tool - Hand Hygiene

Healthcare-Associated Infections Program Adherence Monitoring
Hand Hygiene

Regular monitoring with feedback of results to staff can improve hand hygiene adherence. Use this tool to identify gaps and opportunities for improvement. Monitoring may be performed in any type of patient care location.

**Instructions:** Observe at least 10 hand hygiene (HH) opportunities per unit. Observe a staff member and record his/her discipline. Check the type of hand hygiene opportunity you are observing. Indicate if HH was performed. Record the total number of successful HH opportunities and calculate adherence.

<table>
<thead>
<tr>
<th>HH Opportunity</th>
<th>Discipline</th>
<th>What type of HH opportunity was observed? (select ✓ 1 per line)</th>
<th>Was HH performed for opportunity observed? ✓ or Ø</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example</td>
<td>N</td>
<td>□ before care/entering room* □ before task □ after body fluids □ after care* ✓ upon leaving room</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>*Remember: Hand hygiene should be performed before and after glove use</td>
<td></td>
</tr>
<tr>
<td>HH1.</td>
<td></td>
<td>□ before care/entering room □ before task □ after body fluids □ after care □ upon leaving room</td>
<td></td>
</tr>
<tr>
<td>HH2.</td>
<td></td>
<td>□ before care/entering room □ before task □ after body fluids □ after care □ upon leaving room</td>
<td></td>
</tr>
<tr>
<td>HH3.</td>
<td></td>
<td>□ before care/entering room □ before task □ after body fluids □ after care □ upon leaving room</td>
<td></td>
</tr>
<tr>
<td>HH4.</td>
<td></td>
<td>□ before care/entering room □ before task □ after body fluids □ after care □ upon leaving room</td>
<td></td>
</tr>
</tbody>
</table>

**Disciplines:**
- P = Physician
- RT = Respiratory Therapist
- S = Student
- VOL = Volunteer
- W = Social Worker
- OTH = Other, Specify
- U = Unknown

For HH1-HH10:

<table>
<thead>
<tr>
<th>Total # HH Successful (“✓”):</th>
<th>Total # HH Opportunities Observed:</th>
<th>Adherence: _____%</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Total # HH Successful + Total HH Opportunities Observed x 100)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

[CDPH Adherence Monitoring tools](http://www.cdph.ca.gov/HAI)
Adherance Monitoring Tool – Contact Precautions

Regular monitoring with feedback of results to staff can maintain or improve adherence to contact precautions practices. Use this tool to identify gaps and opportunities for improvement. Monitoring may be performed in any type of patient care location where patients are on contact precautions.

**Instructions:** Observe 3-4 patients/residents on contact precautions. Observe each practice and check a box if adherent, Yes or No. In the column on the right, record the total number of “Yes” for adherent practices observed and the total number of observations (“Yes” + “No”). Calculate adherence percentage in the last row.

<table>
<thead>
<tr>
<th>Contact Precautions Practices</th>
<th>Contact Precautions Patient/Resident 1</th>
<th>Contact Precautions Patient/Resident 2</th>
<th>Contact Precautions Patient/Resident 3</th>
<th>Contact Precautions Patient/Resident 4</th>
<th># Yes</th>
<th># Observed</th>
</tr>
</thead>
<tbody>
<tr>
<td>CP1. Gloves and gowns are available and located near point of use.</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CP2. Signs indicating the patient/resident is on contact precautions are clear and visible.</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CP3. The patient/resident on contact precautions is housed in single-room or cohorted based on a clinical risk assessment.</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CP4. Hand hygiene is performed before entering the patient/resident care environment.</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CP5. Gloves and gowns are donned before entering the patient/resident care environment.</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CP6. Gloves and gowns are removed and discarded, and hand hygiene is performed before leaving the patient/resident care environment. Soap &amp; water is used if it is hospital policy or if the patient/resident has C. difficile infection.</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CP7. Dedicated or disposable noncritical patient-care equipment (e.g., blood pressure cuffs) is used; if dedicated/disposable equipment is unavailable, then equipment is cleaned and disinfected prior to use on another patient/resident according to manufacturers’ instructions.</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

# of Correct Practices Observed (“# Yes”): ______

Total # Contact Precautions Observations (“# Observed”): ______

(Up to 28 total)

Adherence ______% 

(Total “# Yes” / Total “# Observed” x 100)

If practice could not be observed (i.e. cell is blank), do not count in total # Observed.
Adherence Monitoring Tool – Environmental Cleaning and Disinfection

Regular monitoring with feedback of results to staff can maintain or improve adherence to environmental cleaning practices. Use this tool to identify gaps and opportunities for improvement. Monitoring may be performed in any type of patient care location.

Instructions: Observe at least two different environmental services (EVS) staff members. Observe each practice and check a box if adherent, Yes or No. In the column on the right, record the total number of “Yes” for adherent practices observed and the total number of observations (“Yes” + “No”). Calculate adherence percentage in the last row.

<table>
<thead>
<tr>
<th>Environmental Cleaning Practices</th>
<th>EVS Staff 1</th>
<th>EVS Staff 2</th>
<th>EVS Staff 3</th>
<th>Adherence by Task</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># Yes</td>
<td># Yes</td>
<td># Yes</td>
<td># Observed</td>
</tr>
<tr>
<td>ES1. The room is clean, dust free, and uncluttered.</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
<td></td>
</tr>
<tr>
<td>ES2. Detergent/disinfectant solution is mixed and stored according to manufacturer’s instructions.</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
<td></td>
</tr>
<tr>
<td>ES3. Solution remains in wet contact with surfaces according to manufacturer’s instructions.</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
<td></td>
</tr>
<tr>
<td>ES4. Cleaning process avoids contamination of solutions and cleaning tools; a clean cloth is used in each patient area, and the cloth is changed when visibly soiled.</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
<td></td>
</tr>
<tr>
<td>ES5. Environmental Services staff use appropriate personal protective equipment (e.g. Gowns and gloves are used for patients/residents on contact precautions upon entry to the contact precautions room.)</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
<td></td>
</tr>
<tr>
<td>ES6. High-touch surfaces* are thoroughly cleaned and disinfected after each patient.</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
<td>☐ Yes ☐ No</td>
<td></td>
</tr>
</tbody>
</table>

*Some examples of high touch surfaces:

- Bed rails
- Tray table
- IV pole (“grab area”)
- Call button
- Bedside table handle
- Chair
- Room sink
- Room light switch
- TV remote
- Room inner door knob/handle
- Bathroom door knob/handle
- Bathroom light switch
- Bathroom handrails
- PPE container(s)
- Bathroom sink
- Toilet seat
- Toilet flush handle
- Toilet bedpan cleaner
- In-room medical carts
- In-room cabinets
- In-room computers/keyboard

# of Correct Practice Observed ("# Yes"): ______

Total # Environmental Services Observations ("# Observed"): ______

(Upto 15 Total)

Adherence _______%

(Total "# Yes" ÷ Total "# Observed" x 100)

If practice could not be observed (i.e. cell is blank), do not count in total # Observed.
Provide Feedback on Adherence Monitoring

- Share adherence monitoring results and CDI incidence with unit staff
- Present results to managers and leadership
  - Use data to focus prevention efforts
  - Use data to get needed resources
Feedback Report Sample

CDPH Contact Precautions Observations, 131 Facilities, 2016

- Single or cohorted correctly: 95%
- HH before entering room: 43%
- PPE before entering room: 78%
- PPE Removed & HH before exiting room: 68%
- Equip cleaned & disinfected: 81%

#Observations

Successful | Missed
Feedback Report Sample

CDPH Environmental Cleaning Observations, 131 Facilities, 2016

<table>
<thead>
<tr>
<th>Observations</th>
<th>Successful</th>
<th>Missed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solution mixed to mfg instructions</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>Contact time to mfg instructions</td>
<td>37%</td>
<td></td>
</tr>
<tr>
<td>New clean, saturated cloth used in each room</td>
<td>84%</td>
<td></td>
</tr>
<tr>
<td>Proper PPE</td>
<td>94%</td>
<td></td>
</tr>
<tr>
<td>High touch objects cleaned daily-w/EPA disinfectant</td>
<td>49%</td>
<td></td>
</tr>
</tbody>
</table>
Preventing CDI: The MOST Important Things

**Prevent C. difficile Acquisition / Reduce Antimicrobial Exposure**

- Isolate patients with diarrhea pending CDI confirmation
- **Lab alert system** for immediate notification of positive CDI tests
- **Contact precautions** for duration of diarrhea plus 48 hours
  - Private room, dedicated toilet
  - Gloves/gown to enter room
  - Remove gloves, perform hand hygiene prior to room exit
- **Hand hygiene** before/after patient contact & after glove removal
  - Patient hand hygiene
- **Dispose**ble equipment
- **Sporicidal disinfectant** for cleaning reusable equipment
- Sporicidal disinfectant for **terminal** cleaning
- **Quality cleaning**, daily & terminal
- **CDI-targeted** antimicrobial stewardship program
  - Improve overall prescribing, stop unnecessary antibiotics
  - Restrict high-risk antibiotics based on local epidemiology
  - Stop inciting antibiotics
Resources


Questions?

For more information, please contact any HAI Liaison IP Team member or email HAIProgram@cdph.ca.gov