Disinfection Manual

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Book Descriptions:

Disinfection Manual

CDC twenty four seven. Saving Lives, Protecting People Disinfection Strategies for Other Semicritical Devices 11. Disinfection by Healthcare Personnel in Ambulatory Care and Home Care 12. Microbial Contamination of Disinfectants 13. Flash Sterilization 14. Methods of Sterilization 15. Packaging 16. Monitoring of Sterilizers 17. Load Configuration 18. Storage of Sterile Items 19. Quality Control 20. Reuse of SingleUse Medical Devices Because of state differences, readers should not assume that the absence of an IC recommendation implies the absence of state regulations. The information should be consistent with Occupational Safety and Health Administration OSHA requirements and identify the areas and tasks in which potential exists for exposure. PPE can include gloves, gowns, masks, and eye protection. The exact type of PPE depends on the infectious or chemical agent and the anticipated duration of exposure. The employer is responsible for making such equipment and training available. Use cleaning agents that are capable of removing visible organic and inorganic residues. Dried or baked materials on the instrument make the removal process more difficult and the disinfection or sterilization process less effective or ineffective. Discard or repair equipment that no longer functions as intended or cannot be properly cleaned, and disinfected or sterilized. Most EPAregistered hospital disinfectants have a label contact time of 10 minutes. However, multiple scientific studies have demonstrated the efficacy of hospital disinfectants against pathogens with a contact time of at least 1 minute. By law, all applicable label instructions on EPAregistered products must be followed. If the user selects exposure conditions that differ from those on the EPAregistered product label, the user assumes liability from any injuries resulting from offlabel use and is potentially subject to enforcement action under FIFRA.https://collectorwiz.com/userfiles/canon-c7000-manual.xml

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See recommendation 5n for recommendations requiring cleaning and disinfecting bloodcontaminated surfaces. Prepare the disinfectant or detergent as recommended by the manufacturer. Most EPAregistered hospital disinfectants have a label contact time of 10 minutes. However, many scientific studies have demonstrated the efficacy of hospital disinfectants against pathogens with a contact time of at least 1 minute. By law, the user must follow all applicable label instructions on EPAregistered products. If the user selects exposure conditions that differ from those on the EPAregistered product label, the user assumes liability for any injuries resulting from offlabel use and is potentially subject to enforcement action under FIFRA. If disinfectants e.g., phenolics are used for the terminal cleaning of infant bassinets and incubators, thoroughly rinse the surfaces of these items with water and dry them before these items are reused. Discard bloodcontaminated items in compliance with federal regulations. Use protective gloves and other PPE e.g., when sharps are involved use forceps to pick up sharps, and discard these items in a punctureresistant container appropriate for this task. Disinfect areas contaminated with blood spills using an EPAregistered

tuberculocidal agent, a registered germicide on the EPA Lists D and E i.e., products with specific label claims for HIV or HBV or freshly diluted hypochlorite solution. Follow this decontamination process with a terminal disinfection, using a 1100 dilution of sodium hypochlorite. Specifically, the 2003 and 2008 Guidelines state Category IB" Category II" Furthermore, some of these chemicals are not EPAregistered for use in foggingtype applications. These newer technologies were assessed by CDC and HICPAC in the 2011 Guideline for the Prevention and Control of Norovirus Gastroenteritis Outbreaks in Healthcare Settings, which makes the recommendation This issue will be revisited as additional evidence becomes
available.http://dreamfuturegroup.com/userfiles/canon-calculator-manual-f-604.xml

Remove from clinical use any instrument that fails the leak test, and repair this instrument. Cleaning is necessary before both automated and manual disinfection. Steam sterilize these components if they are heat stable. Clean the external surfaces and accessories of the devices by using a soft cloth or sponge or brushes. Continue brushing until no debris appears on the brush. Cleaning items e.g., brushes, cloth should be disposable or, if they are not disposable, they should be thoroughly cleaned and either highlevel disinfected or sterilized after each use. Highlevel disinfection of arthroscopes, laparoscopes, and cystoscope should be followed by a sterile water rinse. Replace these endoscopes with steam sterilizable instruments when feasible. The exposure times vary among the Food and Drug Administration FDAcleared highlevel disinfectants Table 2. Avoid using reprocessing chemicals on an endoscope if the endoscope manufacturer warns against using these chemicals because of functional damage with or without cosmetic damage. As soon as is feasible, phase out nonimmersible endoscopes. After sterilizing or highlevel disinfecting the water bottle, fill it with sterile water. Use airexchange equipment e.g., the ventilation system, outexhaust ducts to minimize exposure of all persons to potentially toxic vapors e.g., glutaraldehyde vapor. Do not exceed the allowable limits of the vapor concentration of the chemical sterilant or highlevel disinfectant e.g., those of ACGIH and OSHA. Discard the solution if the chemical indicator shows the concentration is less than the minimum effective concentration.Require competency testing on a regular basis e.g., beginning of employment, annually of all personnel who reprocess endoscopes. In addition, after each use, sterilize dental instruments that are not intended to penetrate oral soft tissue or bone e.g.

, amalgam condensers, airwater syringes but that might contact oral tissues and are heattolerant, although classified as semicritical. Clean and, at a minimum, highlevel disinfect heatsensitive semicritical items. Change these coverings when they are visibly soiled, when they become damaged, and on a routine basis e.g., between patients. Disinfect protected surfaces at the end of the day or if visibly soiled. No changes in these procedures for cleaning, disinfecting, or sterilizing are necessary for removing bloodborne and emerging pathogens other than prions. Use a highlevel disinfectant at the FDAcleared exposure time. See Recommendation 7p for exceptions. None of these listed disinfectant products are FDAcleared highlevel disinfectants. If the internal chemical indicator is visible, an external indicator is not needed. These nonsterile items should be retrieved if possible and reprocessed. If additional spore tests remain positive, consider the items nonsterile and recall and reprocess the items from the implicated loads. If eventrelated storage of sterile items is used, then packaged sterile items can be used indefinitely unless the packaging is compromised see recommendations f and g below. The pack can be used unless the integrity of the packaging is compromised. Once this date expires, reprocess the pack. Document all deviations from policy. All stakeholders should identify what corrective actions will be implemented. Consult the Association for the Advancement of Medical Instrumentation or the manufacturers of surgical instruments, sterilizers, and container systems for guidelines for the density of wrapped packages. FDA considers the hospital that reprocesses a singleuse device as the manufacturer of the device and regulates the hospital using the same standards by which it regulates the original equipment manufacturer.

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Staff undertaking cleaning should follow agreed protocols and have access to adequate resources and equipment to achieve the required standard of cleaning. COSHH regulations should always be adhered to and staff should use appropriate personal protective equipment PPE to protect themselves at all times. It is only effective if surfaces and equipment have been cleaned thoroughly with detergent and water beforehand. The hypochlorite or chlorine dioxide solution will kill both bacteria and viruses provided it is used as per manufactures' instructions. Hypochlorite solutions are corrosive and it is recommended that the solution is rinsed off commodes, mattresses and stainless steel surfaces with warm water at the end of the process. Some chlorine dioxide solutions do not need to be rinsed off. Thorough cleaning with neutral detergent and water is commonly used. If using a hypochlorite solution the area should then be rinsed and dried although this is not required with some chlorine dioxide solutions.Always ensure that surfaces that are being disinfected are compatible with the product being used. Depending on the type of outbreak in the healthcare facility, certain areas will require more frequent cleaning and disinfection, e.g. sanitary areas during an outbreak of gastrointestinal infection. This may be required in the following circumstances Do not mix chemicals and only use a cleaning product provided by your employer. Also the Control of Substances Hazardous to Health COSHH regulations must be adhered to when using chemical disinfectants. In particular it is important to rinse chlorine containing solutions from stainless steel surfaces to prevent corrosion. Where available and appropriate, use disposable mop heads.THOROUGH PREPARATION AND A SYSTEMATIC APPROACH IS KEY TO ACHIEVING SUCCESSFUL TERMINAL CLEAN Cleaning and disinfection of the environment Disinfect with 1000ppm chlorine releasing agent or chlorine dioxide solution if soiled.

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When dirty clean with detergent and water. Disinfect with 1000ppm chlorine releasing agent or a chlorine dioxide solution if soiled. If there is soiling with body fluids clean with a detergent and water prior to disinfection. Store dry; inverted and tilted forward. Refer to manufacturer instructions for disinfection of these items. If their use is essential use disposable brushes. If possible disassemble commode for full daily clean and disinfection. Do not soak or disinfect unnecessarily as this may compromise the impermeability of the cover. If contaminated with blood or infected body fluids refer to manufacturer instructions When the laryngoscope is opened and checked it should then be placed inside the loose packaging to protect it from environmental contamination. Then disinfect with 1,000ppm available chlorine or a chlorine dioxide solution, rinse and dry. Dry in a tumble dryer. Dispose of in clinical waste. Clean electronic hand piece after each use per manufacturer instructions Wash weekly or when soiled. If appropriate refer to manufacturer instructions. Before each use disinfect surfaces with 70% alcohol wipe. This is often due in part to a variety of personnel issues that many Environmental Services departments encounter. Failure to follow manufacturer's recommendations for disinfectant use and lack of antimicrobial activity of some disinfectants against healthcareassociated pathogens may also affect the efficacy of disinfection practices. Improved hydrogen peroxidebased liquid surface disinfectants and a combination product containing peracetic acid and hydrogen peroxide are effective alternatives to disinfectants currently in widespread use, and electrolyzed water hypochlorous acid and cold atmospheric pressure plasma show potential for use in hospitals.

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Creating "selfdisinfecting" surfaces by coating medical equipment with metals such as copper or silver, or applying liquid compounds that have persistent antimicrobial activity surfaces are additional strategies that require further investigation. Newer "notouch" automated decontamination technologies include aerosol and vaporized hydrogen peroxide, mobile devices that emit continuous ultraviolet UVC light, a pulsedxenon UV light system, and use of highintensity narrowspectrum 405 nm light. These "notouch" technologies have been shown to reduce bacterial

contamination of surfaces. A microcondensation hydrogen peroxide system has been associated in multiple studies with reductions in healthcareassociated colonization or infection, while there is more limited evidence of infection reduction by the pulsedxenon system. A recently completed prospective, randomized controlled trial of continuous UVC light should help determine the extent to which this technology can reduce healthcareassociated colonization and infections. In conclusion, continued efforts to improve traditional manual disinfection of surfaces are needed. In addition, Environmental Services departments should consider the use of newer disinfectants and notouch decontamination technologies to improve disinfection of surfaces in healthcare. Other individuals believe that manual disinfection of surfaces using currently available disinfectants is adequate, and that newer approaches to disinfection are not necessary. The purpose of this article is to summarize the many factors that affect standard cleaning and disinfection practices and to discuss modern technologies that can supplement traditional cleaning and disinfection methods. Personnelrelated issues Multiple studies have shown that manual cleaning and disinfection of surfaces in hospitals is suboptimal.

Issues related to disinfection protocols and practices In addition to the above personnelrelated issues, there are many other factors that can potentially have adverse effects on the efficacy of traditional cleaning and disinfection practices. The type of surface being cleaned or disinfected can affect the completeness with which bacteria are removed. For example, Ali et al. Disinfectants may be applied using inadequate contact times. Quaternary ammonium concentrations of solutions dispensed were tested using commerciallyavailable test strips. The audit revealed that several dispensing stations yielded solutions with less than 200 ppm, approximately 50 % of stations delivered solutions with 200 to 400 ppm. An investigation revealed several flaws in the dispensing system. Inexpensive test strips and more complicated titration kits are available to monitor quaternary ammonium concentrations of disinfectants. For example, Kampf et al. Buckets and roles of wipes had not been handled according to manufacturer recommendations. Pulsedfield gel electrophoresis demonstrated that Serratia isolates recovered from the disinfectant were the same strains as those recovered from surfaces in the patient room. Genome sequencing of one of the Serratia strains by collaborating investigators revealed that it contained four different qac resistance genes that permitted the organism to grow and survive in the disinfectant unpublished data. If disinfectant contamination is suspected, a sample of the product can be used to inoculate a broth medium or solid agar containing neutralizers effective against the active agents in the disinfectant solution. Fig. 1 Contact agar plate cultures showing bacterial colonies recovered from a patient’s overbed table before left and after right the surface was cleaned by a housekeeper using contaminated quaternary ammonium disinfectant.

Colonies on right are Serratia marcescens and Achromobacter xylosoxidans Monitoring housekeeping practices In order to improve standard cleaning and disinfection practices, it is recommended that the practices of housekeepers be monitored and that they receive feedback regarding their performance.Step 1 a special swab is used to sample the surface. The higher the RLU value, the greater the amount of ATP detected on the surface Full size image New technologies fall into several categories, including A new liquid surface disinfectants, B improved methods for applying disinfectants, C selfdisinfecting surfaces, D lightactivated photosensitizers, and E notouch automated technologies. New liquid disinfectants New disinfectants that are currently available or under development include improved hydrogen peroxide liquid disinfectants, peracetic acidhydrogen peroxide combination, electrolyzed water, cold atmospheric pressure plasma, and polymeric guanidine. These newer disinfectants have Environmental Protection Agency EPA safety rating of category IV housekeepers do not need to wear any personal protective equipment while using these products. The product has a smell similar to vinegar that may be of concern when it is initially introduced. The combination product gives hospitals a potential alternative to sodium hypochlorite when a sporicidal disinfectant is needed. Spraying equipment was simple, required only

approximately 15 s per application, and could be left to dry without wiping. Further studies of this phenomenon are warranted. Electrolyzed water has the advantage of not leaving any toxic residues on surfaces. Issues related to stability of such products and logistic issues related to its use require additional study. Much more experience with coldair atmospheric pressure plasma systems is needed to determine the practicality, efficacy and safety of using such systems in hospital settings.

When using microfiber cloths or mops, is important to know that the durability of these products is adversely affected by hypochlorite and high temperatures used during laundering and drying, and that their performance may decrease after multiple washings. However, presently, it is not clear how much the lower binding of microfiber cloths to quaternary ammonium disinfectants effects eradication of bacteria from contaminated surfaces. Additional studies are needed to better define the relative advantages and disadvantages of applying surface disinfectants with microfiber, cotton cloths and spunlace nonwoven disposable wipes. Further studies of the longterm antimicrobial potency, practicality and costeffectiveness of coppercoated surfaces are needed. Organosilane compounds are comprised of a surfactant plus an antimicrobial substance such as a quaternary ammonium moiety. These compounds are designed to minimize bacterial contamination of surfaces by maintaining their antimicrobial activity on surfaces for weeks or months. To date, the ability of these compounds to prevent contamination of surfaces for prolonged time periods is unclear. Further evaluation of organosilanetype compounds using a variety of application methods appears warranted. Activated titanium dioxide has been shown to have varying antimicrobial activity, with the relative susceptibility of agents against pathogens. Research on the use of lightactivated photosensitizers is in early stages, and much more information about the feasibility and safety of using this strategy is needed. Aerosols which are not vapor generally have particle sizes ranging from 2 to 12 , are injected into a room, followed by passive aeration. These systems have been shown to significantly reduce bacteria, generally a 4 log 10 reduction of spores, although in several studies spores were not completely eradicated. One system has a sporicidal claim from the EPA in the United States.

Like many other strategies in infection control, there are currently no randomized controlled trials of the efficacy of these systems in preventing healthcareassociated infections. However, long cycle times have made it difficult to implement this system in healthcare facilities. A microcondensation hydrogen peroxide vapor system, which utilizes 35 % hydrogen peroxide, is effective in eradicating important pathogens including MRSA, VRE, C. difficile, Klebsiella, Acinetobacter, Serratia, Mycobacterium tuberculosis, fungi, and viruses. A prospective, controlled trial performed by Passaretti et al. Despite the demonstrated ability of this system to eradicate nosocomial pathogens from surfaces, concerns over its cost and room turnaroundtimes have hampered adoption of this technology in healthcare settings. Recent improvements in the efficiency of the system permit more rapid turnaroundtimes than earlier equipment, which may lead to wider adoption. To date, there are no randomized, controlled trials establishing the impact of the microcondensation hydrogen peroxide system on reduction of healthcareassociated infections. Ultraviolet light devices Automated mobile ultraviolet light devices that continuously emit UVC in the range of 254 nm can be placed in patient rooms after patient discharge and terminal cleaning has been performed. A number of these devices can be set to kill vegetative bacteria or to kill spores. Advantages of the mobile, continuous UVC light devices include their ease of use, minimal need for special training of environmental services personnel, and unlike hydrogen peroxide vapor systems, the ability to utilize the devices without having to seal room vents or doors. Results of the trial should be published in the near future. Additional evaluation of the pulsedxenon UV system by independent investigators is needed. Its antimicrobial efficacy is lower than UVC light, but it can be used in areas occupied by patients.

Further investigation of this technology, including its level of activity against C. difficile, appears warranted. Given the increasing interest in the abovementioned new technologies for cleaning and

disinfection of environmental surfaces, the Agency for Healthcare Research and Quality AHRQ recently commissioned an expert panel to review data regarding these modern technologies. Conclusions In conclusion, manual cleaning and disinfection of environmental surfaces in healthcare facilities daily and at patient discharge are essential elements of infection prevention programs. Because many factors make it difficult to achieve high rates of effective disinfection on a routine and sustained basis, continued efforts to improve the quality and consistency of traditional cleaning and disinfection practices are needed. Given the many challenges in achieving desired levels of surface disinfection, adoption of modern technologies is indicated to supplement traditional methods. Further research into the efficacy and costeffectiveness of newer technologies, and when to best apply them, is needed. As additional data become available, it is likely that newer liquid disinfectants and some notouch room decontamination systems will be more widely adopted to supplement traditional cleaning and disinfection practices. Disinfectants used for environmental disinfection and new room decontamination technology.Cleaning hospital room surfaces to prevent health careassociated infections.Evaluating hygienic cleaning in health care settings what you do not know can harm your patients.Lowwage America How employers are reshaping opportunity in the workplace.The deleterious consequences of privatization and outsourcing for hospital support work the experiences of contractedout hospital cleaners and dietary aids in Vancouver, Canada.Developing standardized cleaning procedures and effective monitoring techniques.Cleanliness audit of clinical surfaces and equipment who cleans what.

Effect of surface coating and finish upon the cleanability of bed rails and the spread of Staphylococcus aureus.Efficacy of “sporicidal” wipes against Clostridium difficile.Pathogen transfer and high variability in pathogen removal by detergent wipes.Bacterial growth in an inuse hospitalgrade quaternary ammoniumbased disinfectant. Presented at the 21st Annual Scientific Meeting of the Society for Healthcare Epidemiology of America, April 2, 2011, Dallas, TX, abstr 113, 2011. 21. Kampf G, Degenhardt S, Lackner S, Jesse K, von Baum H, Ostermeyer C. Poorly processed reusable surface disinfection tissue dispensers may be a source of infection. BMC Infect Dis. 2014;1437. PubMed Reduction of Clostridium difficile and vancomycinresistant Enterococcus contamination of environmental surfaces after an intervention to improve cleaning methods. BMC Infect Dis. 2007;761. PubMed Tackling contamination of the hospital environment by methicillinresistant Staphylococcus aureus MRSA a comparison between conventional terminal cleaning and hydrogen peroxide vapour decontamination.Controlling methicillinresistant Staphylococcus aureus MRSA in a hospital and the role of hydrogen peroxide decontamination an interrupted time series analysis. BMJ Open. 2014;4e004522. PubMed Reduction in acquisition of vancomycinresistant Enterococcus after enforcement of routine environmental cleaning measures.The effect of terminal cleaning on environmental contamination rates of multidrugresistant Acinetobacter baumannii.Improved eradication of Clostridium difficile spores from toilets of hospitalized patients using an accelerated hydrogen peroxide as the cleaning agent. BMC Infect Dis. 2010;10268. PubMed Efficacy of improved hydrogen peroxide against important healthcareassociated pathogens.Evaluation of a new hydrogen peroxide wipe disinfectant.Effectiveness of improved hydrogen peroxide in decontaminating privacy curtains contaminated with multidrugresistant pathogens.

Comparison of cleaning efficacy between inuse disinfectant and electrolysed water in an English residential care home.Effectiveness of an electrochemically activated saline solution for disinfection of hospital equipment.Evaluating use of neutral electrolyzed water for cleaning nearpatient surfaces.Cold air plasma to decontaminate inanimate surfaces of the hospital environment.Can it contribute to preventing hospitalacquired infections.Microbiologic evaluation of microfiber mops for surface disinfection.The efficacy of the inorganic copperbased biocide CuWB50 is compromised by hard water.Spread and persistence of Clostridium difficile spores during and after cleaning with sporicidal disinfectants.Spread of bacteria on surfaces when cleaning with microfibre

cloths.Microfiber cloths reduce the transfer of Clostridium difficile spores to environmental surfaces compared with cotton cloths.Selfdisinfecting surfaces review of current methodologies and future prospects.Sustained reduction of microbial burden on common hospital surfaces through introduction of copper.Copper continuously limits the concentration of bacteria resident on bed rails within the intensive care unit.Copper surfaces reduce the rate of healthcareacquired infections in the intensive care unit.The silver lining of disposable sporicidal privacy curtains in an intensive care unit.In vitro evaluation of a novel process for reducing bacterial contamination of environmental surfaces.Longterm efficacy of a selfdisinfecting coating in an intensive care unit.Antimicrobial surfaces and their potential in reducing the role of the inanimate environment in the incidence of hospitalacquired infections.Fluorinated TiO2 as an ambient lightactivated virucidal surface coating material for the control of human norovirus.Nanoscale Res Lett. 2015;101023. PubMed Effect of MVX titanium dioxide on the microbial colonization of surfaces in an intensive care unit. Clinical Trials.gov identifier NCT02348346, 2015. 71.

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