

**ATTAINING THE GOLD
STANDARD IN
NOSOCOMIAL INFECTION
CONTROL**

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OBJECTIVE.

**ACHIEVEMENT OF A ZERO PERCENT
HOSPITAL INFECTION RATE.**

METHODS

- ❖ **HAND WASHING CAMPAIGN.**
- ❖ **THEATRE PROCEDURE GUIDE.**
- ❖ **WOUND CARE PROTOCOLS.**
- ❖ **HOSPITAL ANTIBIOTIC POLICY.**
- ❖ **INCREASED CRITICAL AREA SURVEILLANCE.**
- ❖ **HAP COMPLIANCE AUDITS**
- ❖ **COLLATION OF DATA FROM THE WARDS ON SURGICAL INFECTIONS,PNEUMONIA AND UTI ON A MONTHLY BASIS AND CALCULATION OF HOSPITAL INFECTION RATE EVERY QUARTER**

HAND WASHING CAMPAIGN.



CDC
Centers for Disease Control and Prevention

CLEAN HANDS SAVE LIVES

Protect patients, protect yourself

Influenza

Staphylococcus

Candida

RSV

Klebsiella

Pseudomonas

Enterococcus

Alcohol-rub or wash
before and after *EVERY* contact.

www.cdc.gov/handhygiene



THEATRE POLICIES.

SKIN PREPARATION.

There are several products available for surgical preparation of the skin.

They include:

Iodophors- These act by penetrating the organism cell wall with oxidation of the contents and free iodine substitution. They are active against gram positive and negative organisms, TB organisms, viruses and fungi but are rapidly inactivated in the presence of organic material. Iodophors are safe and effective.

Chlorhexidine Gluconate- Act by disrupting the organism cell wall with precipitation of the cell wall. It has good activity against gram positive and negative organisms and viruses, fair activity against fungi and minimal activity against TB organisms.

Alcohol- This acts by coagulating and denaturing cell protein. It has excellent activity against gram negative

PROTOCOLS FOR WOUND MANAGEMENT

PROTOCOL FOR THE MANAGEMENT OF INFECTED AND CONTAMINATED WOUNDS.

Basic principles.

- ✓ Never close infected wounds. Meticulous wound toilet and debridement is compulsory.
- ✓ Do not close contaminated wounds and clean wounds more than 6 hours old. Exceptions to this rule may be at the surgeon's discretion.
- ✓ Manage contaminated and infected wounds until they are clean and then do secondary closure. Delayed primary closure after 48 hours should only be used in selected cases.
- ✓ Prevent wound infection by:
 - Early and adequate resuscitation.
 - Do not use tourniquets.
 - Apply universal precautions to prevent transmission of infection.
 - Antibiotic prophylaxis in appropriate cases.
 - Adequate wound toilet and debridement within 8 hours if possible.
 - Keep the patient warm and provide adequate pain relief and high energy nutrition.
- ✓ The use of topical antibiotics or the washing of wounds with antibiotic solutions is not recommended.

HOSPITAL ANTIBIOTIC POLICY.

ANTIBIOTIC FORMULARY.

GROUP 1- UNRESTRICTED PRESCRIBING.

PENICILLINS-

Benzylpenicillin.
Ampicillin.
Cloxacillin.
Amoxicillin.
Co-amoxiclav.

TETRACYCLINES-

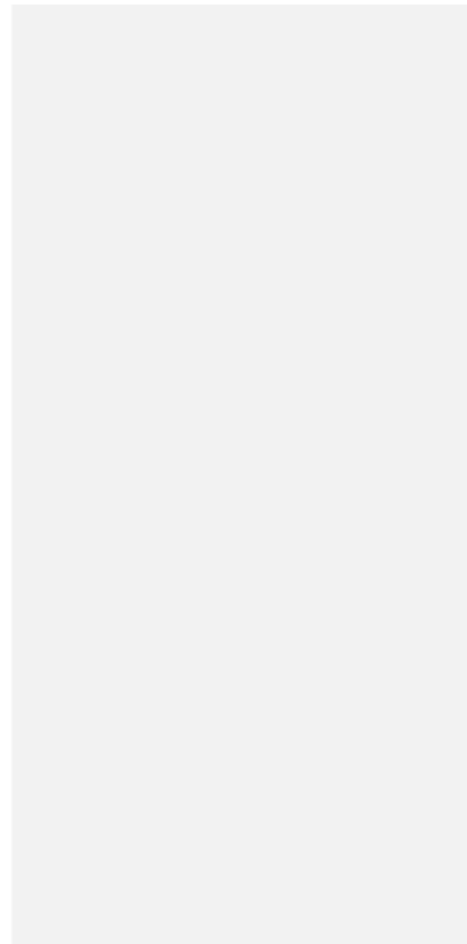
Tetracycline.
Doxycycline.

MACROLIDES-

Erythromycin.
Azithromycin.
Clarithromycin.

SULPHONAMIDES-

Co-Trimoxazole.



EMPIRICAL ANTIBIOTHERAPY GUIDELINES.

Vaginal thrush.	Candida albicans.	Clotrimazole pessaries,oral fluconazole.
Bacterial vaginosis.	Gardnerella vaginalis.	Metronidazole.
Trichomoniasis.	Trichomonas vaginalis.	Metronidazole.
Pelvic inflammatory disease.	Anaerobes, Chlamydia Gonococcus, others.	Co-amoxiclav, Cefuroxime+Metronidazole.
Urethritis.	Neisseria gonorrhoeae.	Ciprofloxacin, Doxycycline.
Acute prostatitis.	Neisseria gonorrhoeae, Chlamydia, coliforms.	Ciprofloxacin, Doxycycline. Treat for 4 weeks.
Epididymo-orchitis.	Neisseria, Chlamydia, coliforms.	Ciprofloxacin, Doxycycline. Treat for 2 weeks.
Impetigo.	Staph.aureus, Strep. Pyogenes.	Cloxacillin.
Cellulitis.	As above.	Cloxacillin, Cefuroxime.
Diabetic foot ulcers.	Staph aureus, Strep pyogenes, Anaerobes.	Co- amoxiclav+Metronidazole.
Post-operative wound infection (Abdominal or female genital tract).	Staph aureus, Streptococci, Coliforms, anaerobes.	Cefuroxime+Metronidazole Add Gentacin if severe. Use co-amoxiclav once oral route is available. Drain pus.
Post-operative wound infection (Head and neck)	Mixed aerobic and anaerobic flora.	Co-amoxiclav. Drain pus.
Post-operative wound infection (Other sites).	Staph.aureus.	Cloxacillin. Drain pus.
Bites.	Streptococci, Staph aureus, Anaerobes, Pasteurella multocida.	Co-amoxiclav, Doxycycline+Metronidazole
Burns	Staph aureus, Strep pyogenes (1 st week). Coliforms,Pseudomonas (2 nd week).	Co-amoxiclav. Ciprofloxacin. Subsequent therapy

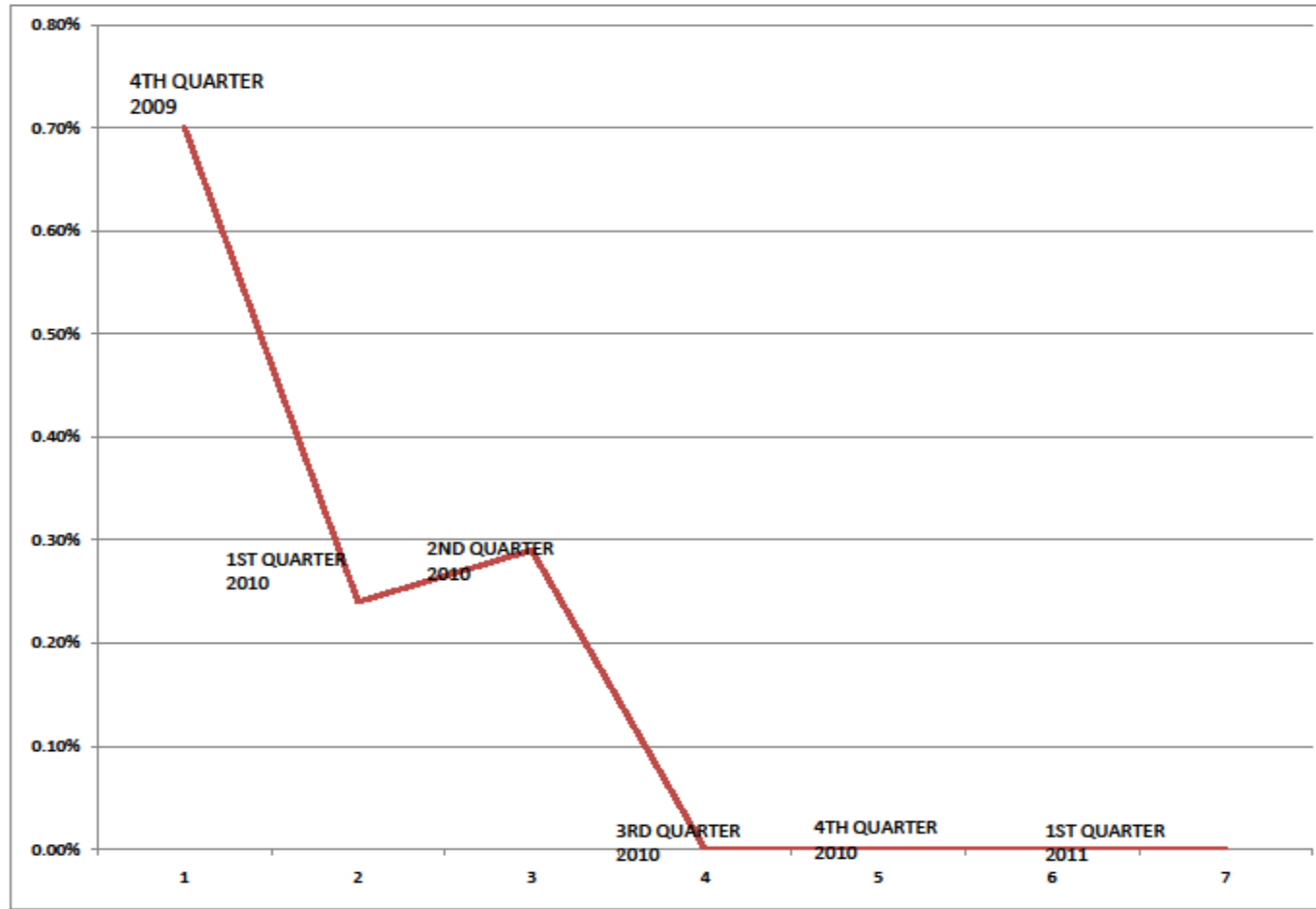
- INCREASED CRITICAL AREA SURVEILLANCE.
- COLLATION OF DATA FROM THE WARDS ON NOSOCOMIAL INFECTIONS ON A MONTHLY BASIS AND CALCULATION OF HOSPITAL INFECTION RATE QUARTERLY.

RESULTS.

- 4TH QUARTER 2009-0.9%
- 1ST QUARTER 2010-0.24%
- 2ND QUARTER 2010-0.27%
- 3RD QUARTER 2010-0%
- 4TH QUARTER 2010-0%
- 1ST QUARTER 2011-0%

RESULTS

SHELL IA HOSPITAL WARRI.



NOSOCOMIAL INFECTION RATES FROM LAST QUARTER 2009 TO FIRST QUARTER 2011.

Achieved Objectives.

- Attainment and maintenance of nosocomial infection rate of zero.
- Reduced duration of hospital stay.
- Reduced expenditure on dressings, antibiotics and other drugs.

CONCLUSION.

- CONTROL OF NOSOCOMIAL INFECTIONS REQUIRES AN INTEGRATED APPROACH DRIVEN BY A FUNCTIONAL INFECTION CONTROL UNIT ANCHORED ON GLOBAL BEST PRACTICES.THE COST IMPLICATIONS OF THIS EFFORT ARE USUALLY QUITE MODEST.

- ATTAINMENT OF VERY LOW NOSOCOMIAL INFECTION RATES IS AN ACHIEVEABLE OUTCOME IN ALL HOSPITALS.
- HAND WASHING IS THE SINGLE MOST IMPORTANT INTERVENTION AND CAN BE INSTITUTED AT VERY LITTLE COST.

