### Section Title Page

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>MRSA Screening</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Policy</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Definition of Terms</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Purpose</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Circumstances</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Procedure (Appendix A)</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Documentation / Record Keeping</td>
<td>5</td>
</tr>
<tr>
<td>II</td>
<td>Nurse-Driven Indwelling Urinary Catheter Removal</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Policy</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Definition of Terms</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Purpose</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Circumstances</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Procedure (Appendix B)</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Documentation/Record Keeping</td>
<td>13</td>
</tr>
<tr>
<td>III</td>
<td>Clostridium difficile (C. diff.) Specimen Collection</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>Policy</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>Definition of Terms</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>Purpose</td>
<td>19</td>
</tr>
</tbody>
</table>

### Date and Approval Information

<table>
<thead>
<tr>
<th>INITIATED BY:</th>
<th>DATE</th>
<th>REVIEWED/REVISED BY:</th>
<th>DATE</th>
<th>DELETED BY:</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention and Control</td>
<td>04/13</td>
<td>IDPC</td>
<td>08/13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mary Gonzales, R.N., / Susan Parke, R.N.</td>
<td>04/13</td>
<td>Policy and Procedure Committee</td>
<td>08/13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Katie Skelton, R.N., V.P.</td>
<td>08/13</td>
<td>Medicine Core</td>
<td>05/13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CREDENTIALS COMMITTEE:</td>
<td></td>
<td>BOARD OF TRUSTEES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Executive Committee</td>
<td>08/13</td>
<td>Nursing Leadership Team</td>
<td>08/13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OTHER:</td>
<td></td>
<td>Clinical Policy and Procedure Committee</td>
<td>05/13</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
I. POLICY: METHICILLIN RESISTANT *STAPHYLOCOCCUS AUREUS* (MRSA) SCREENING

A. Function: To give authority to the Registered Nurse (RN) at St. Joseph Hospital (SJO) to perform the following procedures, without the direct supervision or order from a physician:

1. MRSA Screening

II. DEFINITION OF TERMS:

A. MRSA Screening:

1. Active surveillance testing (AST) – specimen collection performed on patients on admission, transfer into Critical Care, discharge, or when patient is determined to be at risk for use in epidemiologic studies of the prevalence, incidence, and transmission of MRSA. AST contributes to the annual MRSA risk assessment.

2. Community-onset infection: on or before 3rd calendar day (day of admission as day 1)

3. Day of admission: determined as the date a patient occupies a room for an overnight stay, not the date of an outpatient and/or emergency department visit
III. PURPOSE:
A. To establish a process to screen patients for MRSA and/or colonization that meet the regulatory requirements.
B. To provide a measure to differentiate between hospital-onset and community-onset MRSA infections.
C. To establish a standardized hospital-based surveillance process to prevent transmission of MRSA among patients in the hospital setting.
D. To conduct voluntary, sentinel surveillance to include community-associated MRSA and reporting of results through state and local health departments.

IV. CIRCUMSTANCES:
A. Setting: All SJO inpatients
   1. At the time of inpatient admission to the hospital.
   2. Any transfer to Critical Care units.
   3. Upon discharge.
B. Patient population/patient conditions: All inpatient adults and only maternity patients that meet the following criteria:
   1. Criteria for Maternity:
      a) Patient was hospitalized within the past 30 days in any hospital.
      b) Patient is hospitalized for antepartum pregnancy complications with anticipated length of stay greater than 24 hours.
      c) Patient is a dialysis patient.
      d) Patient is a scheduled Cesarean section.
   2. Observation patients that convert to inpatients are included in the above patient population and will be screened according to this standardized procedure.
3. Certain populations have been determined to have a high risk for MRSA infections and colonization. These include:
   a) Dialysis patients
   b) Residents of long-term care facilities
   c) HIV positive patients
   d) Recent hospital admission of patient with a chronic illness
   e) Patients diagnosed with skin or soft-tissue infection on admission
   f) Patients who inject drugs
   g) Patients previously determined to have MRSA infection or colonization
   h) Elderly patients
   i) Patients previously incarcerated

4. Contraindications of nasal/nares screening include:
   a) Nasal/nares testing in patients with nasal packing or ENT/neuro/facial issues or other conditions that prohibit the testing of the nasal tract/nares. Axillary screening may be done in these circumstances.
   b) Maternity patients who do not meet the criteria as stated in the patient population.
   c) Patients identified as positive for MRSA on the Meditech EMR Status Board or identified through patient’s history.

5. Surveillance:
   a) RNs shall perform active surveillance testing at the specified times listed above.
   b) The infection prevention team shall enter MRSA positive patient information into Meditech.

III. PROCEDURE:

Addendix A for procedure-specific details.
IV. DOCUMENTATION/RECORD KEEPING:

A. RN will document active surveillance testing procedure in the patient EMR once performed.

B. All MRSA positive patients will have their testing results entered into Meditech for future reference.

C. Ongoing Evaluation/Skills Validation: Continuing evaluation based on quality outcomes. Skills validation is repeated when practice change occurs.
I. **Patient Conditions:**

This standardized procedure covers patient testing and documentation for MRSA on admission, upon transfer into Critical Care, and before discharge. The measure for hospital-onset and community onset MRSA infection differentiation as previously outlined.

II. **Procedures/Competencies:**

A. Refer to EMR admission sheet for ordering and collecting nasal swab for MRSA.

B. Ascertain that the patient is not already known to be MRSA positive by checking the Meditech EMR Status Board.

C. A signed consent is not needed to perform testing. Inform the patient that you will be performing a test to screen for MRSA. Give the patient or patient decision maker the “MRSA testing patient information sheet” prior to testing. Answer any questions before proceeding. If nasal testing is contraindicated or the patient does not want to give a nasal specimen then offer a culture of the axillas. If the patient declines testing, document in the nursing admission record that the patient declined testing and notify the attending physician.

1. Within 24 hours of admission, inpatients are to be screened for MRSA unless contraindicated as stated in this Standardized Procedure, by obtaining an anterior nares specimen of each nostril using a culturette swab.

2. Confirm that information regarding the test has been given to the patient prior to the procedure.

3. Document in the nursing notes if the patient refuses testing and notify the attending physician.

4. The attending physician will inform the patient of any positive culture results during their hospital stay and after discharge when applicable.

5. Nasal/Nares testing:
a) Obtain a Nasal/Nares MRSA Screening Culture:

1) Using the culturette swab, insert tip approximately ¾ - 1 inch into the anterior nares.

2) Rub swab in a 360° circle 2-5 times over the septal area of each nostril.

3) Insert swab into culture tube and label the tube with the patient identifiers.

4) Enter order into Meditech using “MRSAC” code

5) Place label on specimen: “MRSA Nasal Surveillance Screening.” Make sure the swab tube is properly labeled with the patient identifiers. Send the culture as soon as possible to SJO laboratory.

6. Axilla testing:

a) Obtain an axilla MRSA Screening Culture:

1) Swab both axillas using a culturette swab.

2) Insert swab into culture tube and label the tube with the patient identifiers.

3) Enter order into Meditech using “MRSAC” code

4) Place label on specimen: “MRSA Axilla Surveillance Screening.” Make sure the swab is properly labeled with the patient identifiers. Send the culture as soon as possible to SJO laboratory.

7. Any transfer to Critical Care Units

8. Upon discharge:

a) All patients who have remained negative for MRSA during their hospital stay will be screened again just prior to discharge.
9. Test results:

a) The laboratory services will communicate all positive MRSA results promptly to the nursing units involved.

b) Nursing will notify the patient’s physician of positive results when received.

c) The attending physician shall inform the patient of the results and discuss with the patient any concerns as soon as possible.

d) Infection Prevention will also provide notification to physicians for inpatient education with pamphlet placed in chart.

e) If the patient has a positive culture identified after discharge, the Microbiology laboratory will notify the Infection Prevention department. The Infection Prevention department will notify the attending physician by letter with a copy of the lab report and a patient educational brochure.

D. Contact precautions shall be implemented once a patient is determined to be MRSA positive. In addition, decolonization or chlorhexidine bathing may be implemented. Infection Control Policy IC-226 Contact Precautions

III. References:

References may include but are not limited to the references in section XI of this document as sources of evaluation and management.
<table>
<thead>
<tr>
<th>DATE ORIGINATED</th>
<th>REVIEWED/REVISED</th>
<th>DELETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/13</td>
<td>08/13</td>
<td>______</td>
</tr>
</tbody>
</table>

**INITIATED BY:**

Infection Prevention and Control 04/13

**INTERDISCIPLINARY PRACTICE COMMITTEE (if applicable)**

Interdisciplinary Practice Committee 08/13

**REVIEWED/REVISED BY:**

Mary Gonzales, R.N. / Susan Parke, R.N. 04/13

**POLICY AND PROCEDURE COMMITTEE (if applicable)**

Policy and Procedure Committee 08/13

**ADMINISTRATIVE APPROVAL:**

Mary Gonzales, R.N. / Susan Parke, R.N. 04/13

**BOARD OF TRUSTEES (if applicable)**

Katie Skelton, R.N., V.P. 08/13

**MEDICAL STAFF:**

Credentials Committee 10/13

**OTHER:**

Infection Control Committee 04/13

Emergency Committee 06/13

**OTHER:**

Clinical Policy and Procedure Committee 05/13
I. POLICY: NURSE-DRIVEN INDWELLING URINARY CATHETER REMOVAL

A. Function: To give authority to the Registered Nurse (RN) at St. Joseph Hospital (SJO) to perform the following procedures, without the direct supervision or order from a physician:

1. Nurse-driven indwelling urinary catheter (IUC) removal

II. DEFINITION OF TERMS:

A. Bladder scanner: machine that creates an ultrasound image of the patient’s bladder, calculates and displays the urine volume present in the bladder

B. Catheter- associated urinary tract infection (CAUTI): an infection involving any part of the urinary system, including urethra, bladder, ureters, and kidney attributed to prolonged use of the urinary catheter

C. Foley catheter: indwelling urinary catheter

D. IAD: incontinence- associated skin damage

E. IUC: indwelling urinary catheter

F. MRSD: moisture-related skin damage

III. PURPOSE:

A. To decrease the risk of CAUTI by identifying appropriate indications for continuation, and criteria for timely discontinuation, of an IUC.

B. To allow the RN to discontinue an IUC, without a physician order, when continuation of an IUC is no longer indicated.

C. To provide a process to outline nursing responsibilities and care of the patient that will assist in bladder management and bladder emptying following the removal of an IUC.

IV. CIRCUMSTANCES:
A. Setting: All SJO inpatients and patients admitted to outpatient observation. Nurse-Driven Indwelling Urinary Catheter (IUC) Removal Algorithm

1. Upon daily RN shift assessment for IUC necessity.

2. Patient population/patient conditions: All inpatients and outpatient observation patients.

   a) Appropriate indications to continue an IUC:

   (1) Strict intake & output monitoring, critically ill patient per Critical Care/DSU Foley Catheter Placement Decision Tree or requires nephrology consultation

   (2) Urinary obstruction/retention where intermittent catheterization is difficult or contraindicated/requires urological consultation to place IUC

   (3) Chemically paralyzed

   (4) Spinal or epidural anesthesia/continuous drip

   (5) Neurogenic bladder

   (6) Post-operative patients: renal transplant; gynecologic peri-rectal or urological procedures; coccyx/sacral ulcer plastic surgery repairs

   (7) Surgery or diagnostic procedures lasting longer than 2 hours with post-op order to continue longer than post-op day 2 (requires physician order to continue IUC /foley longer than day 2 post-op)

   (8) Incontinent patients actively receiving parenteral chemotherapy for up to 48 hours

   (9) Stage 2, 3, 4, or unstageable pressure ulcers on coccyx/sacrum with /IAD MRSD when incontinence impairs healing

   (10) In comfort measures when turning patients for incontinence care is too painful and/or terminal status

   (11) Pelvic fracture
(12) Post-partum patient with vulvar edema until resolved

(13) Obstetric patient receiving magnesium drip

b) IUC should be removed:

(1) Ending of strict intake and output or when patient is able to cooperate with strict intake and output monitoring

(2) Patient is able to resume usual voiding pattern

(3) When surgical flap for pressure ulcer is healed

(4) Following an invasive procedure: fluoroscopy or radiology assisted (e.g. cardiac catheterization, interventional radiology)

(5) Six hours post discontinuation of an epidural catheter for short-term pain management

c) Inappropriate indications for IUC use:

(1) Diarrhea

(2) Receiving a diuretic and not on strict input and output

(3) Invasive procedure less than 2 hours in length

(4) As a substitute for nursing care for patients with incontinence

(5) As means of obtaining a urine culture or other diagnostic tests when the patient can voluntarily void

(6) For postoperative duration without appropriate indications

NOTE: A physician order to “continue indwelling urinary catheter/foley and do not discontinue catheter without physician order” shall be followed, and the RN-driven foley removal protocol will not apply.

V. PROCEDURE:

Addendix B for procedure-specific details.
VI. DOCUMENTATION/RECORD KEEPING:

A. RN will assess and document the need for the IUC every shift in the plan of care.

B. RN will document the IUC removal date, time, amount, and character of the urine.

C. RN will document bladder management and bladder emptying activities performed after IUC removal.
I. Patient Conditions:

This standardized procedure covers the indwelling urinary catheter removal by a registered nurse, without an order from a physician, when it is no longer clinically indicated. This supports CDC (Centers for Disease Control) guidelines addressing catheter insertion only for appropriate indications and limiting catheter use to within the time period it is needed to decrease the risk of CAUTI.

NOTE: A physician order to “continue indwelling urinary catheter/foley and do not discontinue catheter without physician order” shall be followed, and the RN-driven foley removal protocol will not apply.

Nurse-driven Indwelling Urinary Catheter Removal Algorithm

A. Clinical indications for catheter use:
   1. **Surgical**: renal transplant; gynecologic; peri-rectal or urologic procedure; coccyx/sacral ulcer plastic surgery repairs; surgery or diagnostic procedures lasting longer than 2 hours with post-op order to continue (**requires MD order to continue longer than POD 2**); intraoperative monitoring (only when necessary).
   2. **Urologic**: documented obstruction or retention when I&O cath is difficult or contraindicated; requires urologic consult for foley placement (Coude cath); or foley has been placed by a physician due to difficult insertion or for special purposes
   3. **Oncology**: incontinent patient receiving parenteral chemotherapy for up to 48 hours
   4. **Wound care**: stage 2, 3, 4, or unstageable pressure ulcers on coccyx/sacrum with IAD/MRSD when incontinence impairs healing
   5. **Comfort measures**: when turning patient for incontinence care is too painful/or terminal status
   6. **Pelvic fracture
   7. **Anesthesia**: spinal or epidural anesthesia/continuous drip
8. Obstetrics: post-partum patient with vulvar edema until resolved; OB patient receiving magnesium sulfate drip

9. Nephrologic: to obtain strict I&O for patients requiring nephrology consultation

10. Critical care: to obtain strict intake and output when applicable (Critical Care/DSU Foley Catheter Placement Decision Tree)
   a) Furosemide (Lasix) drip
   b) Chemically paralyzed
   c) Hemodynamically unstable on pressors
   d) Respiratory compromise with positioning
   e) Hypothermia protocol
   f) Ventilator patients on continuous sedation
   g) Nephrology consult

II. Procedures/Competencies:

A. The Registered Nurse assesses the need for the indwelling urinary catheter every shift using the “inclusion criteria” above and documents in the plan of care.

1. If the criterion for continuing catheter use is met, the registered nurse should continue daily shift evaluation of need for Foley catheter.

2. The RN assesses the patient’s elimination needs and if they can be managed by an alternate method.
   a) Alternatives to IUC should be considered.
      (1) External male condom catheter: sized and applied correctly
      (2) Intermittent I&O catheterization, at regular intervals and multiple times per day to prevent bladder over-distension
      (3) Use of the “Bladder Volume Indicator (BVI)” (bladder scanner), to assess post-void residual need for urinary catheterization.
      (4) Appropriate absorbent products
         (a) Adult briefs with tabs for bed bound patients
         (b) Adult brief pull-up type for ambulatory patients
         (c) Ultrasorb pad
         (i) Provide skin care every 2-3 hours as needed. Use appropriate skin care products to prevent skin breakdown
(ii) Measure urine output using above named briefs and pads by weighing: 1gm=1ml
(iii) Address bowel management issues. Consider fecal containment product (rectal tube/collection bag) for liquid stool, when urine output measurement is needed

3. If the patient no longer meets inclusion criteria for an IUC, the RN should remove the catheter, following the post-removal protocol, and document removal in the EMR.

   a) Post-Removal Protocol

      (1) Assess for voiding every two hours X 8 hours then resume I&O assessment/monitoring as ordered
      (2) Assist patient to sit or stand up to attempt voiding, if condition allows
      (3) If patient is unable to void after 6-8 hours and/or complains of discomfort or voids < 250 ml over 2-4 hours, RN assesses and documents bladder volume by one of these methods:
          (a) Bladder scanner ultrasound (preferred)
          (b) I & O straight cath (if bladder scanner not available)
      (4) If bladder volume < 350 ml (with no discomfort/retention), continue to monitor every 1-2 hours for spontaneous voiding
      (5) Perform I & O catheterization if bladder volume > 350 ml or symptoms of bladder discomfort/distention X 1
      (6) I & O catheterization may be repeated X 1 in 6-8 hours as above
      (7) Physician will be notified if third straight cath is required.
      (8) If patient is incontinent, appropriate alternatives shall be considered.

   b) Removal of an IUC is by clean technique. Refer to Lippincott’s Manual of Nursing Procedures.

      (1) Explain the procedure to the patient prior to beginning the procedure.
      (2) Ensure that all of the solution is drained from the catheter balloon before pulling out catheter as this may cause trauma to urethra.
      (3) Provide perineal care after urinary catheter removal.
B. Use of Bladder Scanner to determine bladder volume by a noninvasive method
PC-322 Urinary Catheter (Foley), Care of: Indication for and Care of the Patient
with an Indwelling Urinary Catheter, Including use of the Bladder Scanner

III. References:

References may include but are not limited to the references in section XI of this
document as sources of evaluation and management.
I. POLICY: CLOSTRIDIUM DIFFICILE SPECIMEN COLLECTION

A. Function: To give authority to the Registered Nurse (RN) at St. Joseph Hospital to perform the following procedures, without the direct supervision or order from a physician:

1. Clostridium difficile (C. diff.) specimen collection

II. DEFINITION OF TERMS:

A. Antimicrobial stewardship program: a program designed to optimize the use of the right drug, for the right purpose, at the right dose, and for the right duration in an effort to promote judicious use of the antimicrobial agent

B. Cleaning: physical removal of organisms on a surface and the step that should precede disinfection

C. C. diff. (Clostridium difficile): an anaerobic, spore-forming, gram-positive bacillus that produces two exotoxins: toxin A and toxin B. It is the common cause of antibiotic-associated colitis and antibiotic-associated diarrhea (AAD)

D. CDI (Clostridium difficile infection): infection caused by the C.diff. bacteria responsible for the majority of infectious diarrhea in healthcare settings. It is characterized by the presence of symptoms (usually diarrhea) and either a stool test result positive for the C. diff. toxins or toxigenic C. diff., or colonoscopic findings demonstrating pseudomembranous colitis

E. Colonization: occurs when a patient carries a microorganism, but has no signs or symptoms of infection. However, it is important to note that a colonized person may have the potential to infect others without clinical signs or symptoms

F. Diarrhea: one unformed bowel movement (i.e. stool taking the shape of a container [Type 5, 6 or 7 per the Bristol stool chart]) within 24 hours

G. Disinfection: process used to kill or render pathogen organisms inert. The disinfection process does not result in sterilization. An important factor in the efficacy of the disinfection process involves the time the disinfectant spends on the surface being disinfected (contact time)

H. Exotoxin: protein produced by a bacterium and released into its environment causing damage to the host by destroying other cells or disrupting cellular metabolism

I. Probiotics: naturally occurring, live microorganisms that are administered to confer a health benefit to a host

J. Pseudomembranous colitis: an inflammatory condition of the colon consisting of a characteristic membrane with adherent plaques associated with severe
symptoms including profuse watery diarrhea and abdominal pain. The condition is considered pathognomonic for CDI

K. Spore: the dormant stage some bacteria will enter when environmental conditions cause stress to the organism or no longer support its continued growth. C. diff. spores are highly resistant to cleaning and disinfection measures and the spores also make it possible for the organism to survive passage through the stomach, resisting the killing effect of gastric acid

L. Toxic megacolon: a life-threatening complication of intestinal conditions, characterized by a dilated colon with severe colitis and systemic symptoms such as fever, abdominal pain, or shock

M. Toxigenic: producing a toxin or toxin effect

III. PURPOSE:
A. To establish the type of stool sample needed to be collected for C. diff. testing.
B. To allow the RN to collect a stool sample when C. diff. infection is suspected in a patient.
C. To specify the importance of hand hygiene in compliance with CDC/WHO (Centers for Disease Control/World Health Organization) while caring for patients suspected/determined to be positive for C. diff.

IV. CIRCUMSTANCES:
A. Setting: All SJO inpatient and patients admitted to outpatient observation.
   1. Patient condition: Upon presentation of diarrhea (one unformed stool taking the shape of a container [Type 5, 6 or 7 per the Bristol stool chart]) within 24 hours.
B. Patient population: All adult inpatient and outpatient observation patients who present with diarrhea.
   1. CDI should be suspected in any patient with diarrhea or abdominal pain and a recent history of antibiotic use, healthcare exposures, or in patients with unexplained leukocytosis.
   2. Only watery or loose stool should be collected and tested to establish the diagnosis of CDI.
   3. Contraindications to C. diff. testing include:
      a) Patient without diarrhea (non-diarrheal stool specimens should not be sent for C. diff. testing).
C. Surveillance

1. Laboratory diagnostic data permits diagnostic data to be used without clinical evaluation of the patient.

2. The Infection Prevention and Control Department shall report laboratory-identified C. difficile infections via National Healthcare Safety Network (NHSN) as required by Centers for Medicare and Medicaid Services (CMS).

   a) NHSN uses two surveillance and reporting classifications for C.diff. infections: gastroenteritis or gastrointestinal tract infection.

V. PROCEDURE:

See Appendix C for procedure-specific details

VI. DOCUMENTATION/RECORD KEEPING:

If a specimen tests positive for C. diff., the nurse will document notification of the physician in the medical record.
APPENDIX C: C. Diff. Specimen Collection

I. Patient Conditions:

This standardized procedure covers the collection of a stool specimen by a Registered Nurse, without an order from a physician, when a patient is presenting with diarrhea. The SIGHT protocol is used in the management of suspected potentially infectious diarrhea.

II. Procedures/Competencies:

A. SIGHT protocol:

   S – Suspect that a patient may be infective where there is no clear alternative cause for diarrhea

   I – Isolate the patient in Contact Spore Precautions and consult with the Infection Prevention Team (IP) while determining the cause of the diarrhea

   G – Gloves and gowns must be used for all contacts with the patient and their environment

   H – Hand washing with soap and water only (no hand gels or hand foam) should be carried out before and after each contact with the patient and their environment

   T – Test the stool for toxin/s by sending a specimen immediately

B. Pre-procedure:

   1. Place patient with diarrhea in Contact Spore Precautions isolation and in a private room if available (empiric isolation until C. diff. is ruled out).

      a) Ensure placement of isolation sign (placed outside patient room), and availability of gloves, gown and soap/water

      b) When possible, dedicate the use of noncritical patient-care equipment to a single patient. If not, clean equipment between each patient use with bleach wipes.
(1) Disposable equipment should be utilized in place of non-disposable equipment.

c) Notify Infection Prevention prior to placing an isolation patient with another patient who is not in isolation.

2. Consult with the physician if patient condition is unstable or with any questions.

C. Procedure:

1. Explain to the patient/family the rationale for the diagnostic test.
   a) Provide brochure about C. diff. from KRAMES on Demand (CARENNet).

2. Gather supplies, perform hand hygiene, don gown and gloves.

3. Identify the patient using the required two patient identifiers.

4. Obtain stool specimen and label at the bedside.

5. Remove gown and gloves and perform hand hygiene when leaving the room.
   a) Use soap (or antimicrobial soap) and water for hand hygiene when caring for patients with diarrhea.
   b) Alcohol-based hand hygiene products are not effective against C. diff. spores.

6. Complete a laboratory order entry for C. difficile Ag and Toxins A,B on Meditech.

7. Send specimen to lab in appropriate biohazard lab- transport bag.
   a) Send in specimen container without preservative.
   b) Send collected specimen to the lab as quickly as possible (within 2 hours) or refrigerate.

8. Notify attending physician of pending C. diff. test and empiric isolation status per the standard hospital reporting protocol.

D. Post-procedure:

1. Initiate empirical treatment as ordered.

2. Obtain test result and relay to attending physician.

3. Use standard infection control precautions and maintain Contact Spore Precautions until C. diff. is ruled out (refer to Additional Precautions for C.diff. in the Infection Control Manual found on Carenet). CDI can be ruled out with one negative result.
4. In positive cases, the use of Contact Spore Precautions shall be extended for the duration of hospital stay.
   a) Patients can continue to shed the bacteria in their stool even after resolution of the diarrhea or the infection.

5. Educate patient and family on the prevention of C. diff. transmission.
   a) Explain the importance of proper hand washing and bathing with soap and water to prevent the spread and ingestion of spores.
   b) Explain the reason for placing patient on Contact Spore Precautions.

6. Avoid repeat testing. Subsequent specimens will not be tested within a 7-day period of a previously negative result.
   a) It is unnecessary to send multiple specimens for C. diff. given the high sensitivity/specificity of the laboratory Polymerase Chain Reaction (PCR) assay with the specific toxins.

7. Ensure that surfaces and equipment that are handled often (“high touch” areas) and may be contaminated with C. diff. bacterium are routinely cleaned and disinfected.
   a) Chlorine-containing cleaning agents or other sporicidal agents shall be used in areas associated with increased rates of CDI.

8. Terminal cleaning of the isolation room shall be done by Environmental Services (EVS) once patient is discharged.

III. References:

References may include but are not limited to the references in section X of this document as sources of evaluation and management.
<table>
<thead>
<tr>
<th>DATE ORIGINATED</th>
<th>REVIEWED/REVISED</th>
<th>DELETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>INITIATED BY:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infection Prevention and Control</td>
<td>04/13</td>
<td>INTERDISCIPLINARY PRACTICE COMMITTEE (if applicable)</td>
</tr>
<tr>
<td>REVIEWED/REVISED BY:</td>
<td>DEPARTMENTAL APPROVAL:</td>
<td></td>
</tr>
<tr>
<td>Mary Gonzales, R.N. / Susan Parke, R.N.</td>
<td>04/13</td>
<td>POLICY AND PROCEDURE COMMITTEE (if applicable)</td>
</tr>
<tr>
<td>ADMINISTRATIVE APPROVAL:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Katie Skelton, R.N., V.P.</td>
<td>08/13</td>
<td>BOARD OF TRUSTEES (if applicable)</td>
</tr>
<tr>
<td>CREDENTIALS COMMITTEE:</td>
<td></td>
<td>OTHER</td>
</tr>
<tr>
<td>Credentials Committee</td>
<td>10/13</td>
<td>Infection Control Committee</td>
</tr>
<tr>
<td>MEDICAL STAFF:</td>
<td></td>
<td>OTHER</td>
</tr>
<tr>
<td>Medical Executive Committee</td>
<td>08/13</td>
<td>Nursing Leadership Team</td>
</tr>
<tr>
<td>OTHER:</td>
<td></td>
<td>OTHER</td>
</tr>
<tr>
<td>Emergency Committee</td>
<td>06/13</td>
<td>Clinical Policy and Procedure Committee</td>
</tr>
</tbody>
</table>
I. POLICY: INFLUENZA SCREENING

A. Function: To give authority to the Registered Nurse (RN) at St. Joseph Hospital (SJO) to perform the following procedures, without the direct supervision or order from a physician:

1. Influenza Screening

II. DEFINITION OF TERMS:

A. California Department of Public Health (CDPH) Influenza Surveillance Program: a collaborative effort between CDPH, the CDC, Kaiser Permanente, California local health jurisdictions and participating sentinel providers and laboratories. Their goal is to analyze clinical, pharmacy and laboratory data year-round in an effort to determine the timing and impact of influenza activity and to determine how well circulating strains of the virus match those used in the current influenza vaccines.

B. Healthcare personnel (HCP): refers to all persons, paid and unpaid, working in healthcare settings who have the potential for exposure to patients and/or to infectious materials, including body substances, contaminated medical supplies and equipment, contaminated environmental surfaces, or contaminated air. HCP include, but are not limited to, physicians, nurses, nursing assistants, therapists, technicians, emergency medical service personnel, pharmacists, laboratory personnel, students and trainees, contractual personnel, and persons not directly involved in patient care (e.g., clerical, dietary, housekeeping, laundry, security, maintenance, billing, chaplains, and volunteers) but potentially exposed to infectious agents that can be transmitted to and from HCP and patients.

C. Healthcare settings: include, but are not limited to, acute-care hospitals; physician offices; urgent-care centers; and outpatient clinics.

D. Influenza: symptoms include a fever > 100 °F or 37.8 °C and cough and/or sore throat, in the absence of a known cause.

E. Nasal/nares: area within the cavity of the nose.

F. Nasopharyngeal (NP): the area behind the nose including the uppermost part of the throat.

G. Rapid flu: screening tests for influenza virus infection that can provide results within 15 minutes.

H. Respiratory hygiene and cough etiquette: measures designed to minimize potential exposures to all respiratory pathogens, including influenza virus, in healthcare settings.
I. **Subtyping and strain typing**: laboratory identification and classification of specific strains of microorganisms

J. **Transport media**: a medium for transporting clinical specimens to the laboratory for examination

**III. PURPOSE:**

A. To screen patients for the influenza virus without a physician order.

B. To establish the need for patient specimen collections for hospital diagnosis and Health Department influenza surveillance.

C. To provide a process to efficiently meet both of the regulatory requirements for screening.

   1. The local Health Department performs influenza surveillance by requesting hospitals and other healthcare providers to collect and forward to them a specimen for subtyping and possible strain typing. This allows them to monitor for outbreaks and develop vaccines specific to current infection-causing strains.

   2. Healthcare personnel shall by in close communication and collaboration with local and state health authorities for prompt alertness about increased influenza activity in the community or outbreak occurrence.

**IV. CIRCUMSTANCES:**

A. Setting: All SJO inpatients.

   1. At the time of inpatient admission to the hospital.

   2. Patient population/patient conditions: All inpatient patients that present with signs and symptoms of influenza.

      a) Uncomplicated influenza illness is characterized by the abrupt onset of the following respiratory signs and symptoms:

         (1) fever
         (2) myalgia
         (3) headache
         (4) malaise
         (5) nonproductive cough
         (6) sore throat
(7) rhinitis

b) The CDC recommends influenza testing for the situations listed below:

(1) Hospitalized, intensive care unit (ICU) and/or fatal cases with ILI (influenza like illness)

(2) Acute respiratory outbreaks

(3) ILI in any person with recent swine exposure or contact with a confirmed case of swine influenza.

V. PROCEDURE:

See Appendix D for procedure-specific details

VI. DOCUMENTATION/RECORD KEEPING:

A. The RN will document in the patient record whether or not the patient has received the influenza vaccine.

B. The RN will document education provided to patient in the patient record.
I. Patient Conditions:

This standardized procedure covers patient testing for the influenza virus and the Orange County Public Health request for specimen collection for influenza surveillance by a registered nurse, without the order from a physician. The Health Department requests that influenza-positive specimens be forwarded to the Orange County Public Health Laboratory for subtyping and possible strain typing. All patients who are being evaluated for influenza must have one nasal specimen collected. If the rapid flu result is positive for any patient admitted to the hospital, one nasopharyngeal specimen will be collected during their hospital stay to send to the Health Department.

II. Procedures/Competencies:

A. Considerations:

1. Rapid flu tests have limited ability to detect variant Influenza A viruses and have varied sensitivities (higher in children) and specificities compared to PCR.

   a) Rapid flu tests produce a rapid result in 15 minutes or less, are simple to perform, and some are approved for office/bedside use.

   b) These tests only rule in influenza; they do not rule out.

   c) Sensitivity is higher for Influenza A than for Influenza B.

   d) These can be particularly useful in identifying influenza virus infection as a cause of respiratory outbreaks in healthcare settings.

2. Specimens should be collected within the first 24-72 hours of onset of symptoms and no later than 5 days after onset of symptoms.

B. Hospital and Health Department Specimen Collection:

1. The nurse will obtain a hospital rapid flu AND a Health Department influenza specimen, without orders from a physician.
2. A mask and eye protection is to be used during NP specimen collection.  
3. Order the **MIC Rapid Influenza A & B Antigen** for the hospital rapid flu specimen in Meditech.

4. Hospital rapid flu specimens are to be obtained with a white culture swab (no preservative) via nares.

5. Health Department specimens are to be obtained from nasopharynx using a green top, wire, CultureSwab (has a preservative at the bottom in the sponge).

6. If there are no green top wire CultureSwabs on the unit, call the lab to obtain one.

7. For the Health Department specimen, utilize the Universal Requisition and include:
   a) Patient sticker  
   b) Location of the patient  
   c) Specimen source: nares  
   d) Specimen description: NP swab  
   e) Comments: Influenza specimen to Health Department

8. On the specimens, note the date, time and initials of specimen collector.

C. Nasal swab collection:

If a patient has nasal discharge, ask the patient to attempt (only once) to blow his/her nose into tissue paper to clear the discharge. Do not try to clear the discharge with swabs, as this might be excessively traumatic.

1. After washing hands, put on clean gloves.

2. Peel open the CultureSwab sterile pouch at the point indicated by the diagram on the outside of the package.

3. Twist to remove the cap from the transport tube.

4. Remove the swab.
5. Tilt the patient’s head back gently and steady the chin.

6. Insert the swab (cotton bud end) approximately 2 cm (approximately ¾ inches) into one nostril.

7. Rotate the swab against the anterior nasal mucosa for 3 seconds to ensure there is a sufficient amount of cells and mucus for the specimen collected.

8. Using the same swab, repeat for the other nostril.

9. Place swab back into the transport tube.

10. Push the end of the swab firmly to ensure that the swab is inserted into the end of the transport tube.

11. Secure the transport tube cap.

12. Label the specimen with patient sticker and include date, time, and initials of specimen collector.

13. Remove and discard gloves.

14. Wash hands.

D. Nasopharyngeal swab collection:

NP swabs are preferred because the specimens can be tested for influenza and a variety of other respiratory pathogens using PCR based technology.

1. Put on mask and gloves.

2. Eye protection is to be used during specimen collection.

3. Have patient sit with head stabilized as patients have a tendency to pull away during this procedure.

4. Insert swab into one nostril straight back (not upwards) and continue along the floor of the nasal passage for several centimeters until reaching the nasopharynx (resistance will be met). The distance from the nose to the ear gives an estimate of the distance the swab should be inserted. Do not
force swab, if obstruction is encountered before reaching the nasopharynx, remove swab and try the other side.

5. Rotate the swab gently for 5-10 seconds to loosen the epithelial cells.

6. Remove swab and immediately inoculate the transport media by inserting the swab at least ½ inch below the surface of the media. Bend or clip the wire swab handle to fit the transport medium tube and reattach the cap securely.

7. Remove gloves and wash hands after specimen collection.

E. Prevention:

1. Promote and administer the seasonal influenza vaccine. **STP 907 Administration of Influenza & Pneumococcal Vaccine to Inpatient Adults**
   
   (a) HCP who decline to get vaccinated will wear a mask during their shift to prevent possible spread of disease to patients and other HCP and vice versa.

2. Implement respiratory hygiene and cough etiquette. These measures shall be adhered to by everyone – patients, visitors, and HCP – upon entry and continued for the entire duration of stay in healthcare settings.
   
   a) Educate patients and visitors about respiratory hygiene, cough etiquette, and hand hygiene procedures through verbal teaching, demonstration, and brochures.

3. HCP who develop fever and respiratory symptoms should be instructed not to report to work, or if at work, to stop patient-care activities, don a facemask, and promptly notify their supervisor and infection prevention personnel/occupational health before leaving work.
   
   a) HCP who are infected shall be considered for temporary reassignment or exclusion from work for 7 days from symptom onset or until the resolution of symptoms, whichever is longer, if returning to care for severely immunocompromised.

4. Healthcare personnel shall adhere to standard precautions during the care of any patient in all healthcare settings.
5. Droplet precautions shall be implemented for patients with suspected or confirmed influenza for 7 days after illness onset or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer, while a patient is in a healthcare facility.

   a) Patients with suspected or confirmed influenza shall be placed in a private room or area. If a private room is not available, infection control personnel shall be consulted before cohorting.

   b) If patient requires movement or transport outside the room, the patient shall be instructed to wear a facemask and follow respiratory hygiene and cough etiquette.

6. HCP shall use caution when performing high-risk aerosol-generating procedures such as bronchoscopy, sputum induction, elective intubation and extubation, autopsies, cardiopulmonary resuscitation, emergent intubation, and open suctioning of airways.

   a) These procedures shall only be performed in infected patients when medically necessary and cannot be postponed.

   b) Limit number of HCP present during procedure to only those essential for patient care and support.

   c) Conduct procedures in an airborne infection isolation room (AIIR) when feasible.

   d) Consider use of portable HEPA filtration units to further reduce contaminants in the air.

   e) HCP should wear a PAPR (Powered Air Purifying Respirator) during high risk procedures as defined in #6.

   f) Unprotected HCP shall not be allowed in a room where these procedures are being conducted.

   g) EVS shall conduct environmental surface cleaning following these procedures.

7. Manage visitor access and movement within the facility.
### III. References:

References may include but are not limited to the references in section XI of this document as sources of evaluation and management.
<table>
<thead>
<tr>
<th>DATE ORIGINATED</th>
<th>REVIEWED/REVISED</th>
<th>DELETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/13</td>
<td>10/13</td>
<td>______</td>
</tr>
</tbody>
</table>

**INITIATED BY:**

- Infection Prevention and Control 04/13
- Katie Skelton, R.N., V.P. 08/13

**REVIEWED/REVISED BY:**

- Mary Gonzales, R.N. / Susan Parke, R.N. 04/13
- Credentials Committee 10/13
- Medical Executive Committee 08/13
- Emergency Committee 06/13

**DATE:**

- 04/13
- 08/13
- 05/13
- 04/13
- 08/13
- 05/13
- 06/13

**DATE OF INITIATION:**

- 04/13
- 08/13
- 05/13
- 10/13
- 08/13
- 05/13
- 06/13
VII. QUALIFICATIONS/REQUIREMENTS FOR RNs:

A. Education: Current California RN license and/or Certified in California as a Nurse Practitioner.

B. Training: Completion of SJO Infection Prevention Standardized Procedure self-learning education.

C. Initial Evaluation/Skill Validation:

1. Completion of training for this Standardized Procedure.

2. Initial documented competence in performing procedure by passing score on the self-learning module post-test.

D. Ongoing Evaluation/Skills Validation: Continuing evaluation based on quality outcomes. Skills validation is repeated when practice change occurs.

VIII. DEVELOPMENT, REVISION AND REVIEW:

A. This standardized procedure was developed through collaboration with the Department of Nursing, Laboratory, the Infection Prevention and Control Department and the Infection Control Committee.

B. Revisions to this Standardized Procedure will be approved by the Infection Control Committee and the Interdisciplinary Practice Committee.

C. Review will occur every 3 years or as practice changes.

IX. RELATED FORMS:

A. MRSA testing patient information sheet
B. EMR Admission Sheet
C. Universal Requisition
D. Nurse–Driven Indwelling Urinary Catheter Removal Algorithm
E. Critical Care/DSU Foley Catheter Placement Decision Tree
F. Bristol Stool Chart
G. Standardized Procedure for Administration of Vaccines to Adult Inpatient Screening & Order Form
X. RELATED POLICIES:

Antimicrobial Susceptibility Profile, Infection Control Manual
Administration of Influenza & Pneumococcal Vaccine to Inpatient Adults, Clinical Manual
Clostridium Difficile – Additional Precautions, Infection Control Manual
Contact Precautions, Infection Control Manual
Influenza Vaccination Program, Infection Control Manual
MRSA Active Surveillance Screening, Infection Control Manual
Pandemic Influenza & Other Highly Infectious Respiratory-Transmitted Diseases (RTD) Influenza and Response Plan, Infection Control Manual
PAPR use for High Hazard Procedures, Infection Control Manual
Patient and Visitor Education, Infection Control Manual
Resistant Organism Registry, Infection Control Manual
Specimen Identification, Clinical Manual
Urinary Catheter (Foley), Care of: Indication for and Care of the Patient with an Indwelling Urinary Catheter, Including use of the Bladder Scanner, Clinical Manual
Urinary Tract Infection, Infection Control Manual
Visitation for Patients in Isolation Precautions, Infection Control Manual

XI. AUTHORITY/REFERENCES:


California State Senate Bill 1058


XII. APPENDICES:

    MRSA Screening
    Nurse-Driven Urinary Catheter Removal
    C. Diff Specimen Collection
    Influenza Screening

Committee Approval Dates:

OB GYN Core: 5/14/13
QSCMS: 6/3/13
Surgery Core: 8/3/13
Urology Core: 6/26/13