INFECTIONS WEBINAR Q&A April 4, 2013

Q: Is it contact precautions or isolation that is recommended?
A: While in hospitals often the terms “contact precautions” and “isolation” are used interchangeably, in nursing homes, these terms can have distinct meanings. We recommend placing a resident in contact precautions for *C.difficile* infection (CDI), which includes having people wear gowns/gloves when interacting with residents to provide care; using dedicated equipment to care for a resident whenever possible; and providing separate toileting equipment (for example, dedicated commode) for the resident. These precautions should be in place for at least as long as the resident is having active diarrhea and many facilities extend the use of contact precautions for an additional 2-3 days after the diarrhea resolves.

In hospitals, most patients have private rooms and infrequently leave those rooms because much of their care is provided in their room, so they are effectively “isolated to their room” while in contact precautions. In a nursing home, a resident may need to be placed in “single-room isolation” if their diarrhea is so severe that it is hard to contain it and often soils the resident’s environment. In that situation, all of the resident’s services, including nutrition and therapy must be provided in the resident’s room. However, most homes have very few or no private rooms, so residents with CDI, who are continent or whose diarrhea can be managed and contained may either be cohorted (placed in a room with another resident who also has CDI) or remain in a semi-private room with a healthy roommate. In those situations, the resident would be placed in contact precautions (as described above), but would not be in “single room isolation” because they may continue to leave their room for dining or rehab services.

Q: If a person is on antibiotics to treat known *C.diff* and becomes asymptomatic while on the antibiotics, can you remove them from transmission based precautions?
A: Current guidelines recommend maintaining residents with CDI in contact precautions for the duration of diarrhea [1, 2], suggesting that you can discontinue contact precautions for CDI once diarrhea has resolved as long as there isn’t evidence of ongoing spread of *C.diff* in the facility (for example, new cases occurring on the same unit). Some facilities may choose to extend the duration of contact precautions for 2-3 days after resolution of diarrhea because there are studies showing that people can continue to shed C. difficile and contaminate their skin or environment even after diarrhea has resolved. However, it is less clear how long precautions should be extended beyond resolution of diarrhea.

Q: If we no longer retest for C. diff in the stool after treatment, then when should we discontinue the contact precautions?
A: As noted above, recommendations for when to discontinue contact precautions are based on clinical resolution of the infection (i.e., diarrhea resolves). Guidelines do not recommend repeating stool testing during the same episode of diarrhea nor do they recommend using C. diff laboratory testing to determine “cure” of the infection [2].

Q: Should residents colonized or having a PMH of a C. Diff infection share bathrooms with other residents?
A: Guidelines do recommend providing separate commodes for residents with active CDI when they are sharing a semi-private space with non-infected roommates [2]. However, the guidance does not extend that recommendation for people known to be colonized or previously infected.

Q: When will NHSN reporting become mandatory for nursing homes
A: The Centers for Disease Control and Prevention (CDC) developed the NHSN reporting option for long-term care facilities as a tool to support infection surveillance programs in nursing homes and other long-term care settings. Use of this reporting system is not mandated by CDC, however, there have been state and federal programs which have required infection reporting into NHSN for certain healthcare providers such as hospitals, long-term (acute) care hospitals, inpatient rehabilitation facilities, and dialysis clinics. At this time, there are very few state programs and no federal programs requiring use of the NHSN LTCF reporting option.

Q: Will the stools be loose or actually watery and foul smelling. You don't want to isolate a resident unless absolutely necessary.
A: Recent guidance on definitions of infections for surveillance in long-term care facilities defines diarrhea as “liquid or watery stools”, (i.e., conforming to the shape of the specimen collection container) and “3 or more stools above what is normal for a resident in a 24-hour period” [3]. Odor of the stool has not been found to be an accurate way to identify diarrhea from C.diff.

QUESTIONS ABOUT THE DATA COLLECTION TOOL

Q: When will the data collection tool be available for review and use on the website?
A: All the resources and tools for the Infection campaign goal are in the process of being updated based on pilot testing before posting on the website. Look for the new materials in May.

Q: When using the data collection tool, is it necessary to enter the names of all residents in the facility in order to complete the specimen log?
A: You don’t have to enter all the residents in the facility into the drop-down list, just those who have events which are tracked by the tool. In order for the data collection tool to keep track of residents who have had previous specimens recorded in the log, the residents have to be entered into the drop down list in addition to the specimen log. Otherwise, the tool may not appropriately identify a “duplicate” specimen because the resident’s name is misspelled in the specimen log. Also, in order for a facility to de-identify their specimen log, all the residents which appear in the specimen log must also be listed in the drop-down list.

References:

1. CDC/HICPAC 2007 Guideline for isolation precautions: preventing transmission of infectious agents in healthcare settings. Available at: **http://www.cdc.gov/hicpac/2007IP/2007isolationPrecautions.html**

2. Clinical Practice Guidelines for Clostridium difficile Infection in Adults: 2010 Update by the Society for Healthcare Epidemiology of America (SHEA) and the Infectious Diseases Society of America (IDSA), Infection Control Hospital Epidemiology. 2010; 31 (5): 431-455. Available for download at: **http://www.jstor.org/stable/10.1086/651706**

3. Stone ND, Ashraf MS, Calder J, Crnich CJ, et al. Surveillance definitions of infections in long term care facilities: revisiting the McGeer criteria. Infect Control Hosp Epidemiol 2012; 33: 965-977 Available at: **http://www.jstor.org/stable/10.1086/667743?origin=JSTOR-pdf**