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Cdc guidelines for dialysis catheter care

The following audit tools and checklists are designed to promote the CDC's recommended infection prevention practices in haemodialysis facilities. Individuals may use audit tools and checklists to assess staff practices. They can also be used by the equipment staff themselves to help them follow their own practices. To download coalition tools with placeholders to add an organization logo, see the hyperlinks below that begin with add your organization logo. To add your organization's logo to coalition resources, first get the logo in one of the following file formats: .ai, .pdf, .jpeg, .png, or .eps. Files in .ai format must be converted to a different format before attempting to insert a placeholder for the .pdf logo. Download the resource version Add your organization logo, click the logo placeholder, follow the instructions to import the logo file, and then click OK. You may need to consult your organization's communications department to get the correct logo file format if your logo is in a different format from the one mentioned above. For more suggestions and ideas on how to use these tools, see Make Dialysis Safer for Patients Coalition. The guidelines and recommendations contained in this chapter reflect existing evidence-based guidelines developed by the Centers for Disease Control and Prevention and the Advisory Committee on Health Infection Control Practices. The 2001 CDC Haemodialysis Recommendation 2016 Update of the CDC's 2001 Haemodialysis Recommendations in the 2016 update provides an overview of current recommendations on infection prevention and dialysis control. Table 1 provides references to the current recommendations of the 2001 document on specific topics. Table 2 lists topics not covered by the 2001 document and provides the latest CDC recommendations on the subject. Centers for Disease Control and Prevention 2016 Update on 2001 recommendations for the transmission of infections to patients with chronic hemodialysis This paper, the Centers for Disease Control and Prevention 2016 Update on the 2001 recommendations on the transmission of infections among chronic hemodialysis patients update selected information and recommendations for 2001 guidelines, recommendations for the transmission of infection among chronic hemodialysis patients. This 2016 update provides new references and/or references to information, updated recommendations (Table 1) and related CDC recommendations that were not addressed in the 2001 guidelines (Table 2). Some of the information and recommendations of the 2001 Guidelines were replaced by information that led to the adoption of more recent CDC recommendations. These topics include but are not limited to: Testing hepatitis C virus (HCV) infection Testing human immunodeficiency virus (HIV) infection Standard precautions for healthcare Online version 2001 (MMWR) Printable version 2001 (MMWR) with page numbers pdf iconpdf icon[PDF – 386 KB] Table 1: 1: and recommendations of the 2001 guidelines, which were replaced by the latest CDC information and recommendations, by topic (Old Content) Infection Control Topic Dialysis Settings (chapters and page numbers refer to 2001 guideline pdf) (Updated content) Latest CDC recommendations Topic: Laboratory tests for hepatitis C virus (HCV) infection sections: – Screening and diagnostic tests (p. 11) – Routine serological tests (p. 24) Subject: Testing for HCV Infection Recommendations (MMWR 2013): HCV Infection Test: Update of doctors and laboratories' recommendations pdf pictogram[PDF – 256 KB] Subject: Laboratory tests for human immunodeficiency virus (HIV) infection unit: – Human immunodeficiency virus infection (p. 12) Topic: Laboratory tests for HIV infection Diagnosis Recommendations (CDC/NCHHSTP 2014): Laboratory tests for HIV infection – Updated recommendations : HIV testing indications for patients Section: – Prevention and management of HIV infection (p. 29) Topic : HIV testing of patients in healthcare facilities Recommendations (MMWR 2006): Revised recommendations for HIV testing in health care facilities for adults, adolescents and pregnant women Subject: Cleaning and disinfection of equipment and environmental surfaces Chapters: – Equipment, supplies and environmental surfaces (p. 15) – Cleaning and disinfection (p. 22) Subject: Cleaning and disinfection of surfaces of equipment and the environment in all health care facilities Recommendations (HICPAC 2008): Guidelines for disinfection and sterilization in health care facilities, 2008 pdf icon[PDF – 948 KB] Subject: Standard precautions to prevent the spread of infectious agents Chapters: – Infectious precautions for outpatient haemodialysis settings, vs. Inpatient Hospital Settings (p. 17) – Infectious precautions for all patients (p. 19) – Cleansing and disinfection (p. 22) As described in the 2011 CDC/Health Infection Control Advisory Committee (HICPAC) Guidelines on the Prevention of Vascular Infections before entering the catheter hub, it should be disinfected with an appropriate antiseptic (more than 0.5% chlorhexidine with alcohol, 70% alcohol or 10% povidone iodine). There is not enough evidence to recommend one antiseptic over another. As a rule, antiseptics should be allowed to dry out in order to maximise the effect. If you use 70% alcohol, you need to use sterile antiseptic cushions (sterile cushions are marked with sterile, and the packaging for non-sterile cushions often does not stop, whether the pads are sterile or non-sterile). For practical reasons, the disinfection of the catheter may be preferred for cushions or similar products, rather than other forms of antiseptics (e.g. tampons), as they are potassium and allow for vigorous cleaning of small spaces. If you are using an antiseptic that leaves residues (e.g. chlorhexidine), avoid large amounts of antiseptics to the catheter lumen to avoid toxicity to the patient. If you use chlorhexidine, the removal of all blood residues is especially important to maximize the effect of the antiseptic. Soaking the caps Before removing them, the role of the hat-soaking antiseptic is not clear. This is not a CDC/HICPAC recommendation. This procedure is described in 2000. The National Kidney Disease Outcome Quality Initiative (KDOQI) guidelines for vascular access were not included in the 2006 update. The handling of catheter concentrators should always be handled aseptically. Disinfected catheter concentrators should not touch non-sterile surfaces. This may be best done by holding them until the antiseptic dries. During this time, the worker carrying out the procedure should also ensure that the catheter remains clamped. Clean, non-slip gloves may be used for disinfection of catheter concentrators, provided that aseptic technique is maintained. Disinfection of the blood line in order to get to the line, disinfection of sterile ends of blood lines is not necessary if it has been taken to avoid contamination of the ends of the blood lines (i.e. using careful aseptic technique). Blood lines can be contaminated during connections and disconnections, as well as during the priming process. Contact with contaminated first waste in soils which have not been properly cleaned and disinfected or through reversible flows from waste disposal ports must be avoided. Disinfection of blood lines will not deal with this problem. Cut-off and line restoration catheter concentrators should be disinfected again after disconnection from blood lines and before replacing the new cap at the end of treatment. This should be done in a similar way to disinfecting the hub before entry. Disinfection of the catheter hub and the end of the extracorporation blood line should also be carried out if the patient needs to be disconnected during treatment and their blood is circulating again. At any time the patient's circuit is disconnected it should be done aseptically and how many times the patient's catheter is disconnected from the blood lines should be reduced as much as possible. Temporary additional recommendations for infection prevention and control recommendations for patients suspected or approved in COVID-19 outpatient haemodialysis facilities on Facebook Twitter LinkedIn Syndicate review, available October 21, 2020. Adds references to the updated definition of a close contact. Updated language to be matched with updated definition. The following are the recommendations of the Guidelines from 24 August 2020: Updated screening recommendations, which include questions about the effects on others with SARS-CoV-2 infection. Additional recommendation on the use of universal eye protection (without medical face mask) in the care of all healthcare personnel (HCP) patients working in communities with moderate to high transmission of SARS-CoV-2. The language added is that safety goggles (e.g. protective traumatic glasses) with gaps glasses and face probably do not protect the eyes from all splashes and sprays. Recommendations are attached on how dialysis devices should respond to newly identified patients and HCP with SARS-CoV-2 infection. Background This information is provided to clarify the recommendations of SARS-CoV-2 2019 coronavirus disease (COVID-19), infection prevention and control (IPC) characteristic of outpatient haemodialysis institutions. This information complements, but does not replace, the general CDC IPC recommendations sars-cov-2 contained in the interim recommendations for infection prevention and control for healthcare workers during the Coronavirus Disease 2019 (COVID-19) pandemic. These guidelines are based on the information currently available on SARS-CoV-2. This approach will be improved and updated as more information is available and the response in the United States will change. It is important to be informed about SARS-CoV-2 to avoid the introduction and reduced spread of dialysis in the device. Consult public health authorities to understand whether the transmission of SARS-CoV-2 is taking place in your community. As part of routine infection control, outpatient dialysis bodies should have established policies and practices to reduce the spread of contagious respiratory tract and other pathogens. Implement Universal source control measures Source control means the use of masks or medical face masks to cover a person's mouth and nose to prevent the spread of respiratory secretions during breathing, speaking, sneezing or coughing. Due to asymptomatic and pre-symptomatic transmission potential, all health care facilities recommend source control measures, even if they do not have symptoms of COVID-19. Patients and visitors should, ideally, wear their mask (if tolerated) upon arrival at and throughout their presence in the facility. If they do not have a mask, they should be offered a medical face mask or mask, as allowed by the accessories. Masks (including medical face masks) should not be placed in young children under 2 years of age, anyone who has difficulty breathing, or anyone who is unconscious, incapacitated or otherwise unable to remove the mask without help. Health care workers (HCP) should always wear a medical face mask while they are in a health care facility, including break rooms or other spaces where they may encounter coworkers. If possible, medical facemasks are preferred over masks of HCP as medical facemasks offer both source control and protection for the wearer from exposure to splashes and sprays of infectious material from others. Masks should not be worn instead of a respirator or medical face mask, if necessary more than source control. Respirators with exhalation valves are not recommended for source control; If there is only a respirator with an exhalation valve and the control of the source is required, cover the exhalation valve with a medical face mask or mask that does not interfere with the respirator is suitable. Screening, triage and management of persons suspected or confirmed of SARS-CoV-2 infection Implement processes to detect and triaging individuals with suspected or confirmed SARS-CoV-2 infection before arrival. Remind HCP not to report work when they are sick and report occupational health services if they have an unprotected effect on a person with SARS-CoV-2 infection (in the community or dialysis device). Instruct patients to call and report close contact in advance within the last 14 days with a person with SARS-CoV-2 infection or COVID-19 symptoms so that the device can be prepared for their arrival or triage in a more suitable environment (e.g. acute care in a hospital). Since these exposed patients may further develop SARS-CoV-2 infection, they should be cared for using all personal protective equipment (PPE) and the precautions described in the patient with confirmed SARS-CoV-2 infection, even if the virus tests are negative during their 14-day quarantine period. This includes remaining at least 6 feet from other patients all the time in the institution. If it is not confirmed that there is SARS-CoV-2 infection in contact with patients, they should not be cohorted with patients with confirmed SARS-CoV-2 infection. Infection developments in exposed patients, all SARS-CoV-2 precautions should be followed until patients meet the criteria to discontinue transmission precautions. Post signs at the entrances of the clinic and strategic locations around the facility with instructions for patients and visitors who experience symptoms of COVID-19 or who have had close contact with a person with SARS-CoV-2 infection to alert staff to implement appropriate precautions. Provide patients, HPS and visitors with instructions (in appropriate languages) on screening and triage procedures, including information on the importance of source control practices, where possible, support of at least 6 feet of distance from all others and frequent hand hygiene. The instructions should specify how to use masks and medical face masks, how to use fabrics to cover nose and mouth with coughing or sneezing (if the mask cannot be tolerated), how to remove tissues and contaminated objects in waste tanks, how and when to perform hand hygiene. Positioning supplies close to dialysis chairs and nursing stations promote adherence to hand and respiratory hygiene and cough etiquette. These are fabrics and untouched containers for the disposal of fabrics and hand hygiene products (e.g. alcohol-based hand disinfectants). Make sure that triage treatments comply with THE HIPAA guidelines. Although the verification and triage process depends on the location of the installation and the staff, the joint action includes: putting a staff member at all entrances (outside, if air and room layout permit) or in the waiting room to ensure that all (patients, HCP, visitors) covid-19 or close symptoms with someone with SARS-CoV-2 infection before entering the treatment area and ensuring that they practice source control. Confirm that there are no symptoms corresponding to COVID-19. Fever is or is measured at a temperature ≥ 100.0°F or subjective fever. Ask them if they have been advised to self-quarantine due to contact with someone who has SARS-CoV-2 infection. Properly manage all who have experienced COVID-19 symptoms or have been advised to self-quarantine: HCP should return home and report it to occupational health services to provide further assessment. Visitors should be restricted from accessing the site. Patients should be treated as described in the patient's location below. Follow local legislation on reporting newly identified infections to public health authorities. Patients with suspected or confirmed SARS-CoV-2 infection Ideally, there should be room for all patients to wait, separated by at least 6 feet. Medically stable patients can choose to wait in a personal vehicle or outside the health care facility, where they can be contacted by mobile phone when their turn is visible. Patients with suspected or confirmed SARS-CoV-2 infection or who have reported close exposure should be returned to the appropriate treatment area as soon as possible in order to keep waiting times as short as possible. If they have to wait, the premises should ensure: Patients with confirmed SARS-CoV-2 infection can cohort together (for example, in the same waiting room); however, they should always maintain a separation of at least 6 feet from other patients in the dialysis establishment. Patients with suspected SARS-CoV-2 infection and patients who have been in close contact with a person with SARS-CoV-2 infection should also always maintain a separation of at least 6 feet from each other and from other patients in the dialysis facility. Separation should be maintained in the treatment zone. Premises should consider separating all patients during 6-foot dialysis treatment, especially in areas with moderate to high community transfer. Ideally, a patient with suspected or confirmed SARS-CoV-2 infection or who has reported close contact should be dialed in a separate room (if any) when the door closed. Hepatitis B isolation facilities should only be used in these patients if: (1) the patient has a positive hepatitis B surface antigen or (2) there are no patients in the establishment who would be subject to a census of hepatitis B infection and who would require treatment in an isolation room. In the absence of a separate room, the patient with suspected or confirmed SARS-CoV-2 infection or who has reported close contact should be treated at a corner or at the end of the queue away from the main traffic flow (if any). The patient should be separated at least 6 feet from the nearest patient (all if the haemodialysis device dialys more than one patient with confirmed SARS-CoV-2 infection, consideration should be given to cohort these and HCP, you'll be looking at them together in the same part of the device and/or in the same shift (e.g. consider the last shift of the day). At the same time, cohort should only be cohorted in patients with confirmed SARS-CoV-2 infection. Patients who report close contact with a person with SARS-CoV-2 infection and patients with symptoms for which SARS-CoV-2 infection has not been confirmed should not be cohort with or with patients with confirmed SARS-CoV-2 infection, as their diagnosis is unclear. These patients should be dialyzed at the station, which is at least 10 meters from the other in all directions. Recommended PPE For the care of a patient suspected or confirmed of SARS-CoV-2 infection with HCP, who cares for patients with suspected or confirmed SARS-CoV-2 infection or who have reported close contact with a person with SARS-CoV-2 infection should use all of the following: N95 or equivalent or higher level respirator (or medical face mask in the absence of a respirator) mask (e.g. tissue face covering) is not considered to be PPE and HCP should not be worn when AAP is indicated. In the event of a deficiency, particular attention should be paid to the provision of respirators only in cases where respiratory protection is paramount, e.g. the conduct of aerosol formation procedures in patients with suspected or confirmed SARS-CoV-2 infection or the care of patients with other infections strongly indicated for respiratory protection (e.g. tuberculosis, measles, varicella). The respirator should be worn by suitable personnel in the context of the respiratory protective program; Consider implementing a respiratory protection programme that meets the OSHA respiratory protection standard for workers if it has not yet been implemented. The programme should include medical assessments, training and appropriate tests. Eye protection (i.e. glasses, face shield covering the front and sides of the face). Safety goggles (e.g. goggles, traumatic glasses) with gaps between glasses and face may not protect the eyes from all splashes and sprays. Personal glasses and contact lenses are not adequate eye protection. Gloves Insulation gown The insulating gown should be worn above or in place of a lid bathrobe (e.g. laboratory coat, bathrobe or apron with sleeves) normally worn by haemodialysis staff. In the event of a lack of bathrobes, they should be given the decision to start and discontinue dialysis treatment, manipulate access needles or catheters, help the patient to get to and from the station, clean and disinfect patient care equipment and dialysis station. When the gowns are removed, insert the bathrobe into a special container of waste or linen before leaving the dialysis station. Disposable bathrobes should be discarded after use. Fabric gowns should be washed after each use. Recommended PPE For patients who are not suspected of SARS-CoV-2 infection HCP works in premises with minimal or Should continue to comply with standard and transmission-based precautions, including the use of eye protection and/or N95 or equivalent or higher level respirators, based on expected effects and suspected or confirmed diagnoses. HCP is recommended for universal use of a medical face mask for source control. Cleansing and disinfection Of the current dialysis stations routine cleaning and disinfection procedures are suitable for patients with SARS-CoV-2 infection; however, it is important to confirm that the product used for surface disinfection affects the sars-cov-2external icon. Premises should ensure that they follow the instructions provided by the manufacturer for the proper use and dilution of the disinfectant. The manufacturer's instructions are specific to the product and must be followed (e.g. this does not necessarily correspond to a dilution of 1:100 or 1:10); some products do not require preparation or dilution and are sold as ready for use. The product currently in use may need to be used at a different concentration or at other exposure times. On the EPA website, see the list Nexternal icon for EPA-registered disinfectants that are qualified under the EPA-emerging viral pathogen program used against SARS-CoV-2. When using N-list products, make sure that the products also contain a blood pathogen claim (e.g. hepatitis B, HIV). Note on the N list: Products can be sold and sold under different brands, but if they have the same EPA registration number, they are the same product. Staff should be educated, trained and competent for all cleaning and disinfection procedures at the facility. Ensure that workers use appropriate PPE when cleaning in accordance with the manufacturer's recommendations. Ensure that patients with suspected or confirmed SARS-CoV-2 infection or who report close contact with a person with sars-cov-2 infection are followed consistently and correctly by the usual cleaning and disinfection procedures. All surfaces, accessories or equipment, such as dialysis apparatus 6 feet from symptomatic patients, must be properly disinfected or discarded. Disposable medical devices brought to the dialysis station must be discarded. All undetected, disposable medical equipment used for patient care must be cleaned and disinfected in accordance with the manufacturer's instructions and indoor policy. Follow standard procedures for the containment and disposal of used PPE and regulated medical waste. If bed linen or disposable caps are used in dialysis chairs, follow standard procedures for washing used items and/or washing them. For additional information on the recommended practice for cleaning and disinfection of premises and PPE to be worn by cleaning and disinfection workers, see the COVID-19 HEALTHCARE INFECTION PREVENTION AND CONTROL FAQ. Response in newly identified patients HCP with SARS-CoV-2 infection devices should be patients or HCP with newly identified SARS-CoV-2 infection, including an assessment of the risk to others at the facility who may have been in close contact with infected individuals. Individuals with symptoms of COVID-19 are considered potentially infectious, starting 2 days before the first symptoms, until they meet the criteria to discontinue transmission precautions (in patients) or return to work (HCP). If the infected person did not have symptoms, the collection of information on when they may have been exposed may help to inform about the estimated period of time when they were infectious. If exposure is found: A person can be considered potentially infectious starting 2 days after exposure, until the criteria for discontinuation of transfer-based precautions or return to work are met. If the exposure date cannot be determined: for contact tracing purposes, it is appropriate to use a limit of 2 days until a positive SARS-CoV-2 sample test is collected, continuing until the criteria for discontinuation of the transmission precautionary measures or return to work are met. If the infected person is HCP: Patients who were within 6 feet of infected HCP for a total of 15 minutes (close contact) should be considered potentially exposed. In general, they should be dialed separately from other patients at least 6 feet and associated with HCP using all recommended AAP SARS-CoV-2, up to 14 days after the last exposure. If the patient was wearing a medical face mask (instead of a mask) during all exposure, a risk assessment should be carried out (the circumstances of the risk assessment can be found here). Patients in this group with a lower risk may be monitored for symptoms without other precautions. If the patient wore a mask (instead of a medical face mask) or did not wear any type of face covering (masks or medical face masks), then they should be considered unprotected close contact. If the affected patient develops SARS-CoV-2 infection, he should be cared for using all recommended AAP SARS-CoV-2 until the patient meets the criteria to discontinue transfer-based precautions. Exposed patients who are determined to be in close contact should be advised to self-quarantine at home for 14 days after last contact with a person with SARS-CoV-2 infection, unless they need to leave their homes for the treatment of hemodialysis or other necessary medical appointments. Perform a risk assessment and apply work restrictions to other HCP exposed providers, depending on whether these HCP lengthened, close-contact external icon and what PPE they wore. For more details, see the interim U.S. guidelines on risk assessment and work restrictions for health workers who may be exposed to COVID-19. If the infected person is a patient: Patients who were within 6 feet of the infected patient total 15 minutes (close potentially exposed, even if the masks were worn. Normally exposed patients should have at least 6 feet separate from other patients and associate HCP using all recommended AAP SARS-CoV-2 for up to 14 days after the last exposure. If the patient who is clothed wore a medical face mask instead of a mask, a risk assessment (as described above) may be considered to determine whether precautions are necessary. If they develop SARS-CoV-2 infection, they should be taken care of using all recommended AAP SARS-CoV-2 until the patient meets the criteria for discontinuation of transmission precautions. Identification of outbreaks of SARS-CoV-2 infection at dialysis unit Since patients or HCP may develop SARS-CoV-2 infection due to exposure outside the dialysis unit, it may be difficult to detect transmission at the dialysis device. People with SARS-CoV-2 infection, epidemiological contacts at the dialysis facility and no other observed exposure indicate that the transmission may have occurred at the dialysis device. Any transmission to a dialysis facility should be considered an outbreak. In the case of a suspected outbreak, premises should consider the use of PPE recommended for the care of patients with suspected or confirmed SARS-CoV-2 infection in all patients treated at the facility until further testing and testing is carried out. Notify local public health authorities of suspected or confirmed outbreaks at the dialysis facility. If there are a large number of newly infected HCP or patients in the premises in the short term (e.g. one week), the possibility of universal use of PPE and/or an enterprise-wide study (especially in premises located in moderate to high transmission zones) may also be considered. Definitions: Mask: Textile (fabric) face coverings designed to keep a person wearing one of the respiratory secretions spreading when it comes to sneezing or coughing. They are not PPE, and it is unclear whether the masks protect the wearer. Guidelines for the design, use and maintenance of masks are provided. Medical Facemask: Medical facemasks are AAP and are often referred to as surgical masks or procedure masks. Use medical facial scales according to product labeling and local, state and federal requirements. FDA cleaned surgical masks are designed to protect against splashes and sprays and are a priority for use when such exposures are anticipated, including surgical procedures. Some medical face masks that are not regulated by the FDA, such as some procedure masks that are commonly used for insulation purposes, may not be protected against splashes and sprays. Respirator: The respirator is a personal protective device that is worn on the face, covers at least the nose and mouth and is used to reduce the wearer's risk of inhaling dangerous airborne particles (including dust particles and infectious agents), gases or vapors. Respirators are certified by CDC/NIOSH, including those for use in healthcare community transfer: large-scale community transfer, including community information (e.g. schools, workplaces) Minimum or moderate community transfer: long-term transfer with high probability or confirmed impact in a communal environment and the possibility of rapidly increasing cases from not to a minimum transfer of the community; case-by-case evidence or limited community transfer, case studies taking place; there is no evidence of exposure in large communal environments