Decolonization in Long-Term Care to Address Infections, Hospitalizations, and MDROs

Susan Huang, MD, MPH
Chancellor's Professor, Division of Infectious Diseases
Medical Director, Epidemiology & Infection Prevention
University of California Irvine School of Medicine

The High Risk of Infections in U.S. Nursing Homes

- In the U.S., 1.3 million persons receive care in nursing homes each year
- On average, each resident has at least 2 infections per year
- Every year, nursing home residents experience:
  - 2 to 3 million nursing home-associated infections
  - 150,000 infection-related hospitalizations
  - 380,000 infection-related deaths

https://health.gov/sites/default/files/2019-09/hai-action-plan-ltcf.pdf

MDROs in Long Term Care

- Methicillin Resistant *Staphylococcus aureus* (MRSA)
- Vancomycin Resistant Enterococcus (VRE)
- MultiDrug-Resistant Pseudomonas
- Extended Spectrum Beta Lactamase Producers (ESBLs)
- Carbapenem Resistant Enterobacterales (CRE)
- Carbapenem Resistant *Acinetobacter baumanii* (CRAB)
- *Candida auris*

10-15% of U.S. hospital patients harbor at least one MDRO

64% of U.S. nursing home residents harbor at least MDRO

80% of U.S. long-term acute care patients harbor at least one MDRO

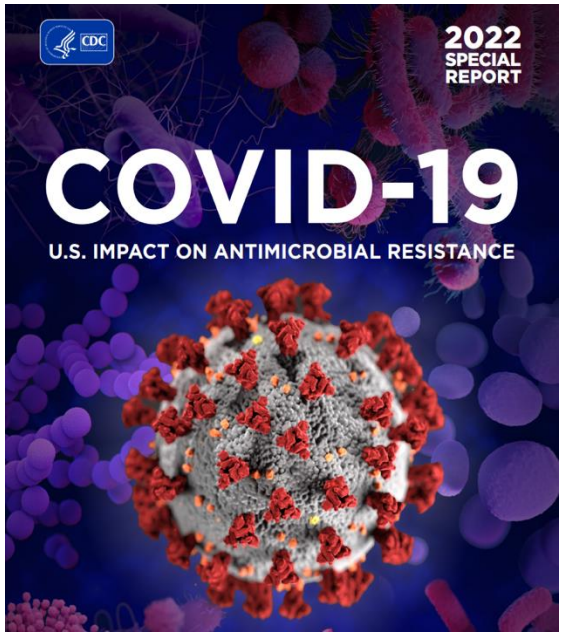
MDROs in Nursing Homes

High prevalence in nursing homes may be related to:

- Shared activities
- Shared rooms
- Longer lengths of stay
- More chronic illness and devices, including feeding tubes
- Less stringent hand hygiene, contact precautions vs hospitals
- Less infection prevention training

U.S. Antimicrobial Resistance Progress Erased by COVID

- 80% of COVID patients received antibiotics in 2020
- Hospital-onset MDROs between 2019 to 2020
  - CRAB increased 78%
  - *Candida auris* increased 60%
  - CRE increased 35%
  - ESBL increased 32%
  - MDR-Pseudomonas increased 32%
  - VRE increased 14%
  - MRSA increased 13%



https://www.cdc.gov/drugresistance/pdf/covid19-impact-report-508.pdf

What is Decolonization and How Does It Work?

Decolonization: Pathogen Burden Reduction

Decolonization: use of topical antiseptic soaps and nasal ointments to reduce the body's bacteria during high-risk times for infection

Moments when our body bacteria becomes our own worst enemy

- Surgery
- Wounds
- Devices
- Difficulty with hygiene, clearance of secretions
- Hospitalization and nursing home stays

Why is Decolonization Needed?

Because human pathogen transmission is a cascade of unfortunate events

- Humans shed pathogens
  - Environment contaminated
    - Contamination persists
      - Failure to clean or disinfect
        - Staff acquires pathogen
          - Staff fails to remove
            - Transfers to patient
              - Risk for infection

Interventions to Prevent Transmission

- Humans shed pathogens ← Decolonization
- Environment contaminated
- Contamination persists
- Failure to clean or disinfect ← Better cleaning
- Staff acquires pathogen ← Contact precautions
- Staff fails to remove
- Transfers to patient ← Hand hygiene
- Risk for infection ← Decolonization, Future vaccines

Value of Decolonization

Stops a cascade of unfortunate events

- Humans shed pathogens ← **Prevents shedding**
  - Environment contaminated
    - Contamination persists
      - Failure to clean or disinfect
        - Staff acquires pathogen
          - Staff fails to remove
            - Transfers to patient
              - Risk for infection

Broad solution for all MDROs
Benefits carriers too

Which Products?

- **Most common products studied in clinical trials:**
  - Chlorhexidine gluconate (CHG)
  - Iodophor (povidone-iodine)
  - Mupirocin
- **Work better than soap and water**
- **Years of use in healthcare:**
  - CHG: >60 years
  - Iodophor: >60 years
  - Mupirocin >20 years

Use of Chlorhexidine

- Antiseptic uses in healthcare
  - Hand antisepsis at 2% and 4%
  - Dental hygiene

Use of Chlorhexidine

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  - Dental hygiene
  - **1990s: Cleaning of skin prior to line insertion**

Skin antisepsis with chlorhexidine–alcohol versus povidone iodine–alcohol, with and without skin scrubbing, for prevention of intravascular-catheter-related infection (CLEAN): an open-label, multicentre, randomised, controlled, two-by-two factorial trial

*Olivier Mimoz, Jean-Christophe Lucet, Thomas Kerforne, Julien Pascal, Bertrand Souweine, Véronique Goudet, Alain Mercat, Lila Bouadma, Sigismond Lasocki, Serge Alfandari, Arnaud Friggeri, Florent Wallet, Nicolas Allou, Stéphane Ruckly, Dorothée Balayn, Alain Lepape, Jean-François Timsit, for the CLEAN trial investigators**

THE LANCET

VOL 338: AUGUST 10, 1991 THE LANCET 339

Prospective randomised trial of povidone-iodine, alcohol, and chlorhexidine for prevention of infection associated with central venous and arterial catheters

DENNIS G. MAKI MARILYN RINGER CARLA J. ALVARADO

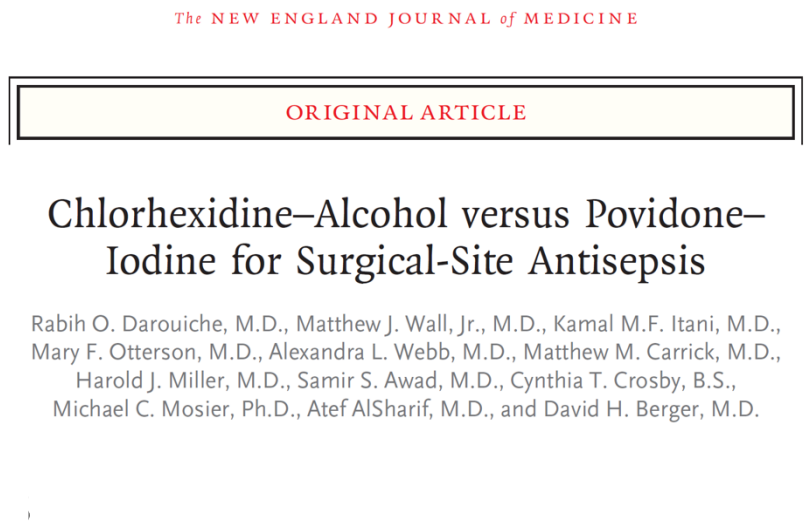
More than 90% of all intravascular device-related septicaemias are due to central venous or arterial catheters. To assess the efficacy of cutaneous antisepsis to prevent catheter-associated infection, we prospectively studied three antiseptics for disinfection of patients' central venous and arterial catheter insertion sites in a surgical intensive care

commonly in North America, an iodophor such as 10% povidone-iodine, is regarded as one of the most important measures for prevention of intravascular device-related infection.

Chlorhexidine-gluconate is a potent germicide that has been widely used throughout Europe for more than 30 years for skin disinfection;[4] handwashing;[5] oral care;[6] irrigation of

Use of Chlorhexidine

- Antiseptic uses in healthcare
  - Hand antisepsis at 2% and 4%
  - Dental hygiene
  - 1990s: Cleaning of skin prior to line insertion
  - 1990s: Pre-operative bathing
  - **2000s: Surgical prep**



The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Chlorhexidine–Alcohol versus Povidone–Iodine for Surgical-Site Antisepsis

Rabih O. Darouiche, M.D., Matthew J. Wall, Jr., M.D., Kamal M.F. Itani, M.D., Mary F. Otterson, M.D., Alexandra L. Webb, M.D., Matthew M. Carrick, M.D., Harold J. Miller, M.D., Samir S. Awad, M.D., Cynthia T. Crosby, B.S., Michael C. Mosier, Ph.D., Atef AlSharif, M.D., and David H. Berger, M.D.

Use of Chlorhexidine

- Antiseptic uses in healthcare
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  - 1990s: Cleaning of skin prior to line insertion
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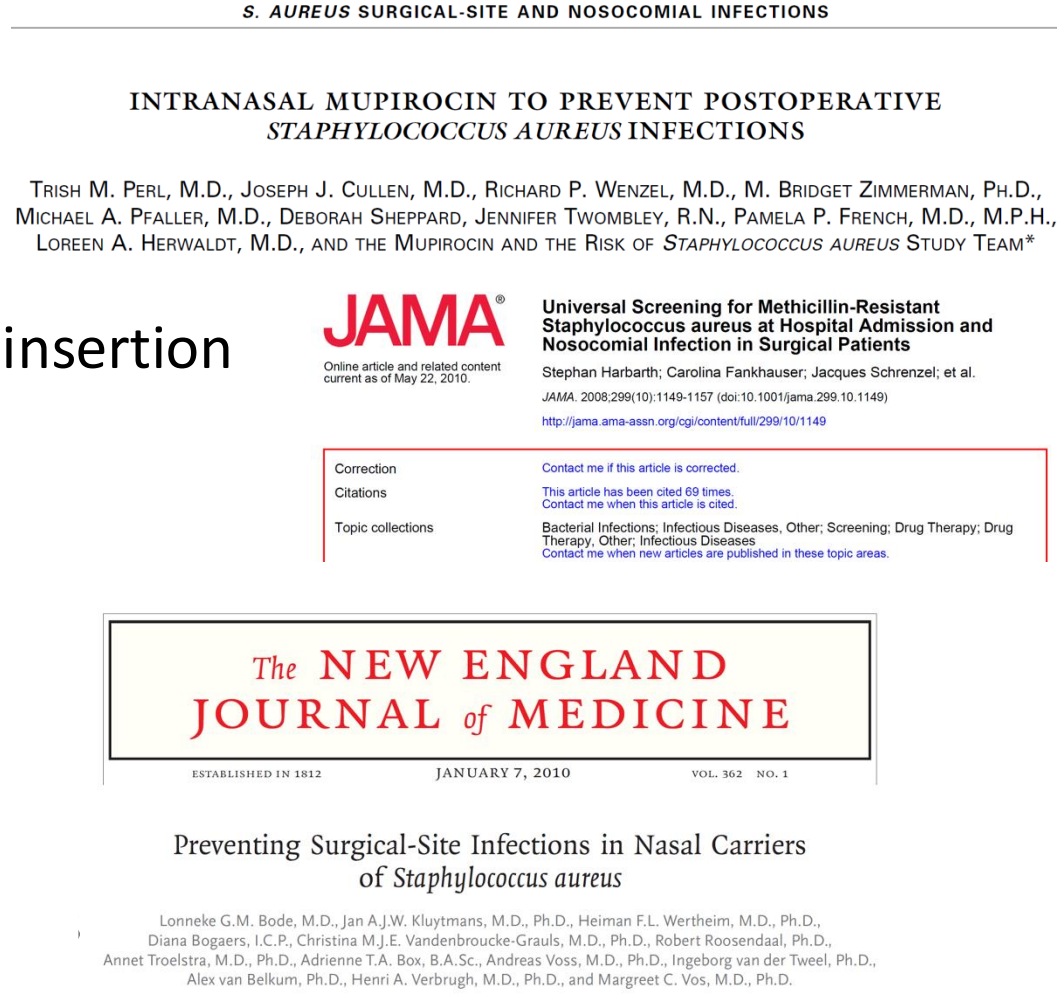
  - **2000s: Pre-op *S. aureus* carriers**



S. AUREUS SURGICAL-SITE AND NOSOCOMIAL INFECTIONS

INTRANASAL MUPIROCIN TO PREVENT POSTOPERATIVE *STAPHYLOCOCCUS AUREUS* INFECTIONS

TRISH M. PERL, M.D., JOSEPH J. CULLEN, M.D., RICHARD P. WENZEL, M.D., M. BRIDGET ZIMMERMAN, PH.D., MICHAEL A. PFALLER, M.D., DEBORAH SHEPPARD, JENNIFER TWOMBLEY, R.N., PAMELA P. FRENCH, M.D., M.P.H., LOREEN A. HERWALDT, M.D., AND THE MUPIROCIN AND THE RISK OF *STAPHYLOCOCCUS AUREUS* STUDY TEAM*

JAMA®

Online article and related content current as of May 22, 2010.

Universal Screening for Methicillin-Resistant Staphylococcus aureus at Hospital Admission and Nosocomial Infection in Surgical Patients

Stephan Harbarth; Carolina Fankhauser; Jacques Schrenzel; et al.

JAMA. 2008;299(10):1149-1157 (doi:10.1001/jama.299.10.1149)

http://jama.ama-assn.org/cgi/content/full/299/10/1149

Correction	Contact me if this article is corrected.
Citations	This article has been cited 69 times. Contact me when this article is cited.
Topic collections	Bacterial Infections; Infectious Diseases, Other; Screening; Drug Therapy; Drug Therapy, Other; Infectious Diseases Contact me when new articles are published in these topic areas.

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 JANUARY 7, 2010 VOL. 362 NO. 1

Preventing Surgical-Site Infections in Nasal Carriers of *Staphylococcus aureus*

Lonneke G.M. Bode, M.D., Jan A.J.W. Kluytmans, M.D., Ph.D., Heiman F.L. Wertheim, M.D., Ph.D., Diana Bogaers, I.C.P., Christina M.J.E. Vandenbroucke-Grauls, M.D., Ph.D., Robert Roosendaal, Ph.D., Annet Troelstra, M.D., Ph.D., Adrienne T.A. Box, B.A.Sc., Andreas Voss, M.D., Ph.D., Ingeborg van der Tweel, Ph.D., Alex van Belkum, Ph.D., Henri A. Verbrugh, M.D., Ph.D., and Margreet C. Vos, M.D., Ph.D.

Prior Precedence:

Clinical Trial Evidence for Decolonization in Hospitals

Use of Chlorhexidine

- Antiseptic uses in healthcare
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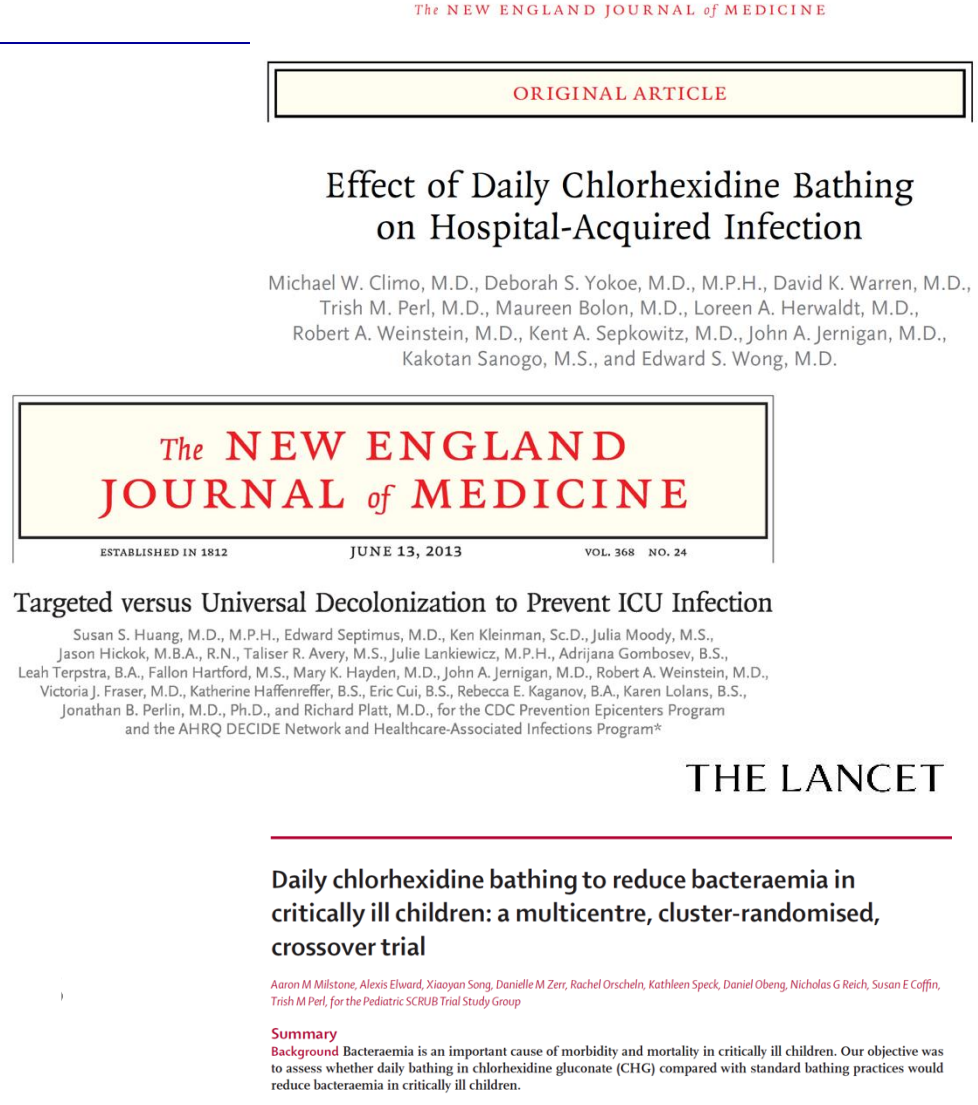
  - **2010s: Universal ICU bathing**



The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Effect of Daily Chlorhexidine Bathing on Hospital-Acquired Infection

Michael W. Climo, M.D., Deborah S. Yokoe, M.D., M.P.H., David K. Warren, M.D., Trish M. Perl, M.D., Maureen Bolon, M.D., Loreen A. Herwaldt, M.D., Robert A. Weinstein, M.D., Kent A. Sepkowitz, M.D., John A. Jernigan, M.D., Kakotan Sanogo, M.S., and Edward S. Wong, M.D.

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 JUNE 13, 2013 VOL. 368 NO. 24

Targeted versus Universal Decolonization to Prevent ICU Infection

Susan S. Huang, M.D., M.P.H., Edward Septimus, M.D., Ken Kleinman, Sc.D., Julia Moody, M.S., Jason Hickok, M.B.A., R.N., Taliser R. Avery, M.S., Julie Lankiewicz, M.P.H., Adrijana Gombosev, B.S., Leah Terpstra, B.A., Fallon Hartford, M.S., Mary K. Hayden, M.D., John A. Jernigan, M.D., Robert A. Weinstein, M.D., Victoria J. Fraser, M.D., Katherine Haffenreffer, B.S., Eric Cui, B.S., Rebecca E. Kaganov, B.A., Karen Lolans, B.S., Jonathan B. Perlin, M.D., Ph.D., and Richard Platt, M.D., for the CDC Prevention Epicenters Program and the AHRQ DECIDE Network and Healthcare-Associated Infections Program*

THE LANCET

Daily chlorhexidine bathing to reduce bacteraemia in critically ill children: a multicentre, cluster-randomised, crossover trial

Aaron M Milstone, Alexis Elward, Xiaoyan Song, Danielle M Zerr, Rachel Orscheln, Kathleen Speck, Daniel Obeng, Nicholas G Reich, Susan E Coffin, Trish M Perl, for the Pediatric SCRUB Trial Study Group

Summary

Background Bacteraemia is an important cause of morbidity and mortality in critically ill children. Our objective was to assess whether daily bathing in chlorhexidine gluconate (CHG) compared with standard bathing practices would reduce bacteraemia in critically ill children.

Use of Chlorhexidine

- Antiseptic uses in healthcare
  - Hand antisepsis at 2% and 4%
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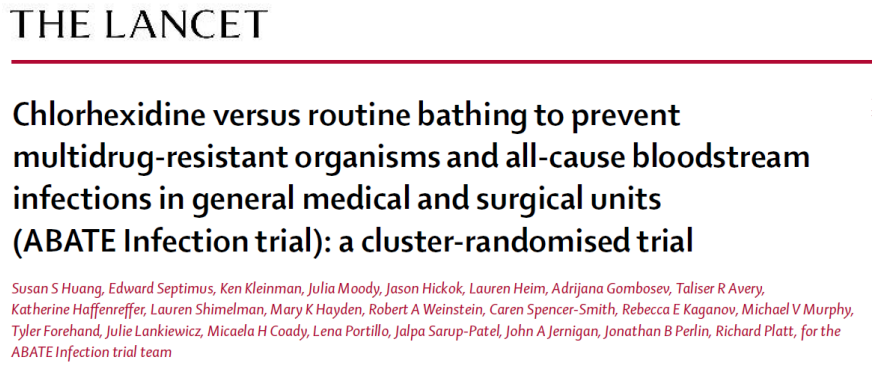
  - 1990s: Pre-operative bathing
  - 2000s: Surgical prep
  - 2000s: Pre-op *S. aureus* carriers
  - 2010s: Universal ICU bathing
  - **2019: CHG for non-ICU bathing**



THE LANCET

Chlorhexidine versus routine bathing to prevent multidrug-resistant organisms and all-cause bloodstream infections in general medical and surgical units (ABATE Infection trial): a cluster-randomised trial

Susan S Huang, Edward Septimus, Ken Kleinman, Julia Moody, Jason Hickok, Lauren Heim, Adrijana Gombosev, Taliser R Avery, Katherine Haffenreffer, Lauren Shimelman, Mary K Hayden, Robert A Weinstein, Caren Spencer-Smith, Rebecca E Kaganov, Michael V Murphy, Tyler Forehand, Julie Lankiewicz, Micaela H Coady, Lena Portillo, Jalpa Sarup-Patel, John A Jernigan, Jonathan B Perlin, Richard Platt, for the ABATE Infection trial team

Universal Decolonization Trials in Hospitals

Trial	Setting	N	Intervention	Decolonization Impact
Climo et al. ICU Trial [1]	7 Academic Hospitals 9 Adult ICUs	7700	Daily CHG	23% ↓ MRSA/VRE acquisition 28% ↓ Bloodstream infections
Pediatric Scrub Trial [2]	5 Academic Hospitals 10 Pediatric ICUs	1500	Daily CHG	36% ↓ Bloodstream infections
REDUCE MRSA Trial [3]	43 Community Hospitals 74 Adult ICUs	74,000	Daily CHG 5d bid mupirocin	37% ↓ MRSA clinical cultures 44% ↓ Bloodstream infections
Mupirocin-Iodophor Swap Out Trial [4]	137 Community Hospitals 233 Adult ICUs	353,000	Mupirocin-CHG vs Iodophor-CHG	Mupirocin superior to Iodophor by 18% for *S. aureus*; 14% for MRSA
ABATE Infection Trial [5]	53 Community Hospitals 194 Adult Non-ICUs	340,000	Daily CHG Mupirocin if MRSA+	Subset effect in patients with devices: 37% ↓ MRSA/VRE clinical cultures 32% ↓ Bloodstream infections
CLEAR Trial [6]	Post Hospital Discharge	2,100	CHG, Mupirocin qoweek x 6 mo	30% ↓ MRSA Infection at 1y 17% ↓ All infection; 85% rehospitalized

[1] Climo MW et al. NEJM 2013;368:533-542
[2] Milstone AM et al. Lancet 2013:381(9872):1099-1106
[3] Huang SS et al. NEJM 2013:368:2255-2265
[4] Huang SS et al. JAMA 2023;330(14):1337-1347
[5] Huang SS et al. Lancet 2019;393(10177):1205-1215
[6] Huang SS et al. NEJM 2019:380:638-650

Decolonization Beyond the Hospital

Use of Chlorhexidine

- Antiseptic uses in healthcare
  - Hand antisepsis at 2% and 4%
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  - 1990s: Cleaning of skin prior to line insertion
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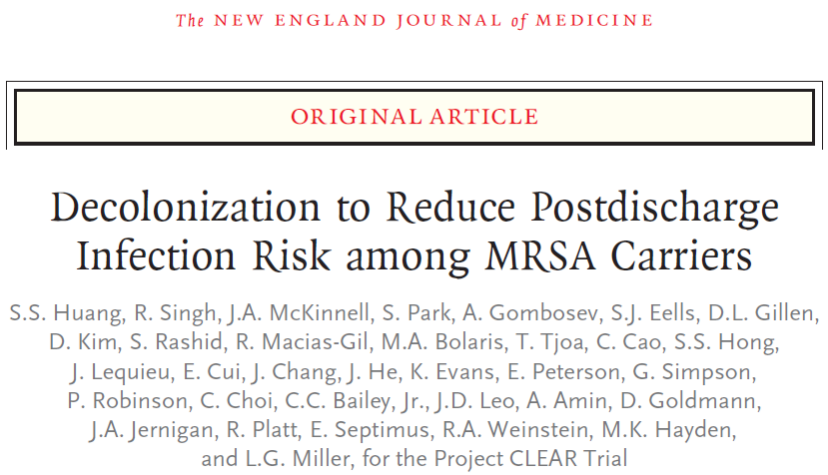
  - 2000s: Pre-op *S. aureus* carriers
  - 2010s: Universal ICU bathing
  - 2019: CHG for non-ICU bathing
  - **2019: Post-discharge for MRSA carriers**



Decolonization Post-Hospitalization

- 2019
  - ➢ **CLEAR Trial**
    - 2100 recently discharged MRSA+ adult patients
    - Decolonization vs routine care
    - 5-day CHG & mupirocin twice monthly for 6 months
      - ✓ Reduced MRSA infection by 30%
      - ✓ Reduced all-cause infection by 17%

Huang SS et al. NEJM 2019:380:638-650

Use of Chlorhexidine

- Antiseptic uses in healthcare
  - ➢ Hand antisepsis at 2% and 4%
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  - ➢ 2000s: Pre-op *S. aureus* carriers
  - ➢ 2010s: Universal ICU bathing
  - ➢ 2019: CHG for non-ICU bathing
  - ➢ 2019: Post-discharge for MRSA carriers
  - ➢ **2023: Long-term care**

The Evidence in Long Term Care

Two studies

- SHIELD Regional Collaborative
- Protect Trial

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Decolonization in Nursing Homes to Prevent Infection and Hospitalization

L.G. Miller, J.A. McKinnell, R.D. Singh, G.M. Gussin, K. Kleinman, R. Saavedra, J. Mendez, T.D. Catuna, J. Felix, J. Chang, L. Heim, R. Franco, T. Tjoa, N.D. Stone, K. Steinberg, N. Beecham, J. Montgomery, D.A. Walters, S. Park, S. Tam, S.K. Gohil, P.A. Robinson, M. Estevez, B. Lewis, J.A. Shimabukuro, G. Tchakalian, A. Miner, C. Torres, K.D. Evans, C.E. Bittencourt, J. He, E. Lee, C. Nedelcu, J. Lu, S. Agrawal, S.G. Sturdevant, E. Peterson, and S.S. Huang

Research

JAMA | Original Investigation

Reducing Hospitalizations and Multidrug-Resistant Organisms via Regional Decolonization in Hospitals and Nursing Homes

Gabrielle M. Gussin, MS; James A. McKinnell, MD; Raveena D. Singh, MA; Loren G. Miller, MD, MPH; Ken Kleinman, ScD; Raheeb Saavedra, AS; Thomas Tjoa, MPH, MS; Shruti K. Gohil, MD, MPH; Tabitha D. Catuna, MPH; Lauren T. Heim, MPH; Justin Chang, MD; Marlene Estevez, BA; Jiayi He, MS; Kathleen O'Donnell, MPH; Matthew Zahn, MD; Eunjung Lee, MD, PhD; Chase Berman, BS; Jenny Nguyen, BA; Shalini Agrawal, BS; Isabel Ashbaugh, MSc; Christine Nedelcu, BS; Philip A. Robinson, MD; Steven Tam, MD; Steven Park, MD, PhD; Kaye D. Evans, BA, MT; Julie A. Shimabukuro, BS; Bruce Y. Lee, MD, MBA; Emily Fonda, MD, MMM; John A. Jernigan, MD, MS; Rachel B. Slayton, PhD, MPH; Nimalie D. Stone, MD, MS; Lynn Janssen, MS; Robert A. Weinstein, MD; Mary K. Hayden, MD; Michael Y. Lin, MD, MPH; Ellena M. Peterson, PhD; Cassiana E. Bittencourt, MD; Susan S. Huang, MD, MPH; for the CDC Safety and Healthcare Epidemiology Prevention Research Development (SHEPheRD) Program

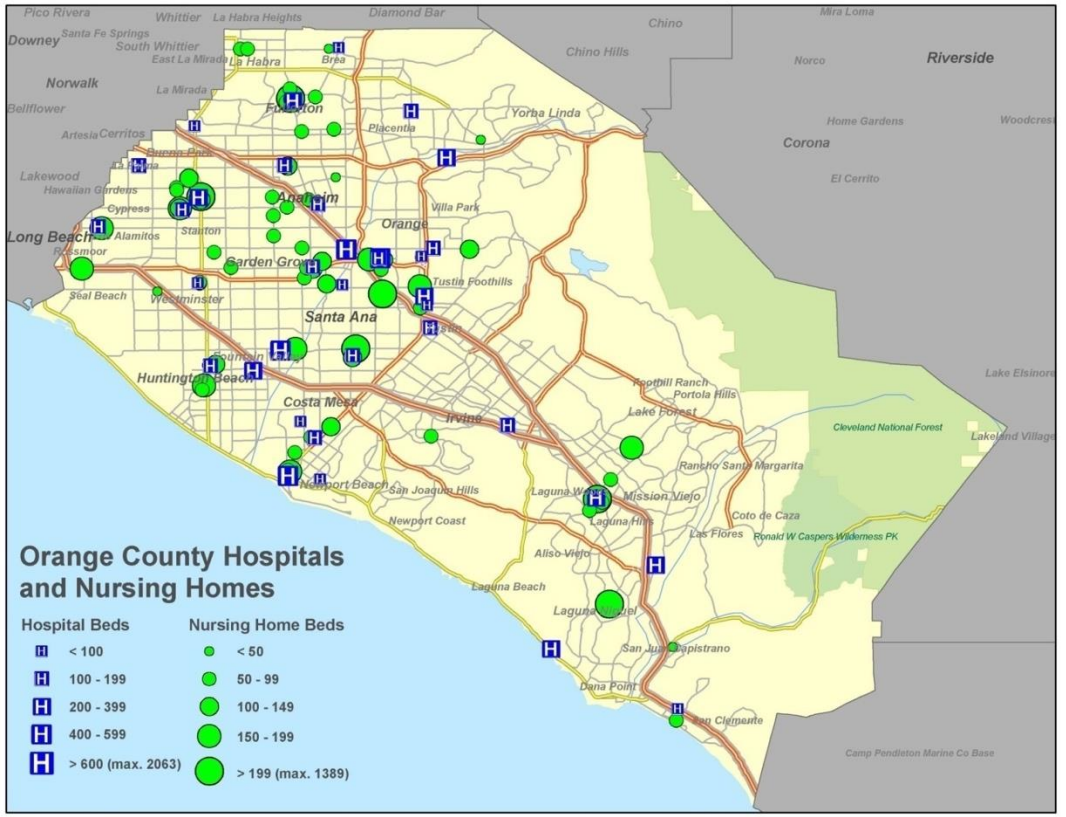
Shared **H**ealthcare **I**ntervention to **E**liminate **L**ife-threatening **D**issemination of MDROs in Orange County

Orange County, California

3.2 million people

32 hospitals

70 nursing homes

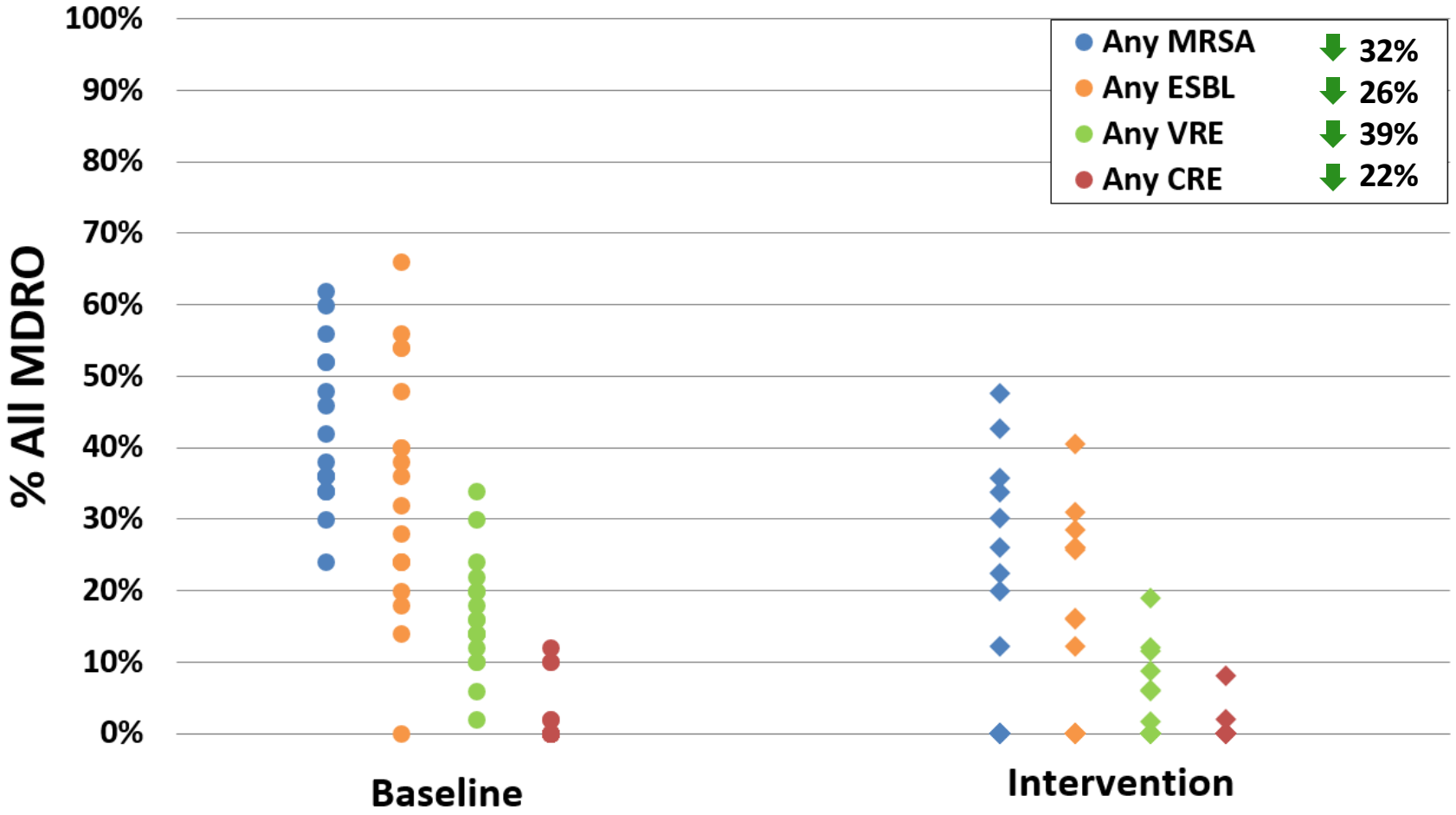


SHIELD OC: 35 Facility Regional Decolonization

- **28-month regional intervention:** April 2017-July 2019
- **Participants:** 16 nursing homes (NHs), 3 long-term acute care hospitals (LTACHs), 16 hospitals with high patient sharing in Orange County, CA
- **NHs and LTACHs:** universal decolonization
  - ✓ CHG antiseptic soap for routine bathing/showering
  - ✓ Nasal iodophor for 5 days on admission and every other week
- **Hospitals:** decolonize patients on contact precautions
  - ✓ Daily CHG bathing/showering
  - ✓ Nasal iodophor decolonization for 5 days
  - ✓ Support ongoing ICU CHG daily bathing

Gussin GM et al. JAMA 2024 May; 331 (18):1544-57

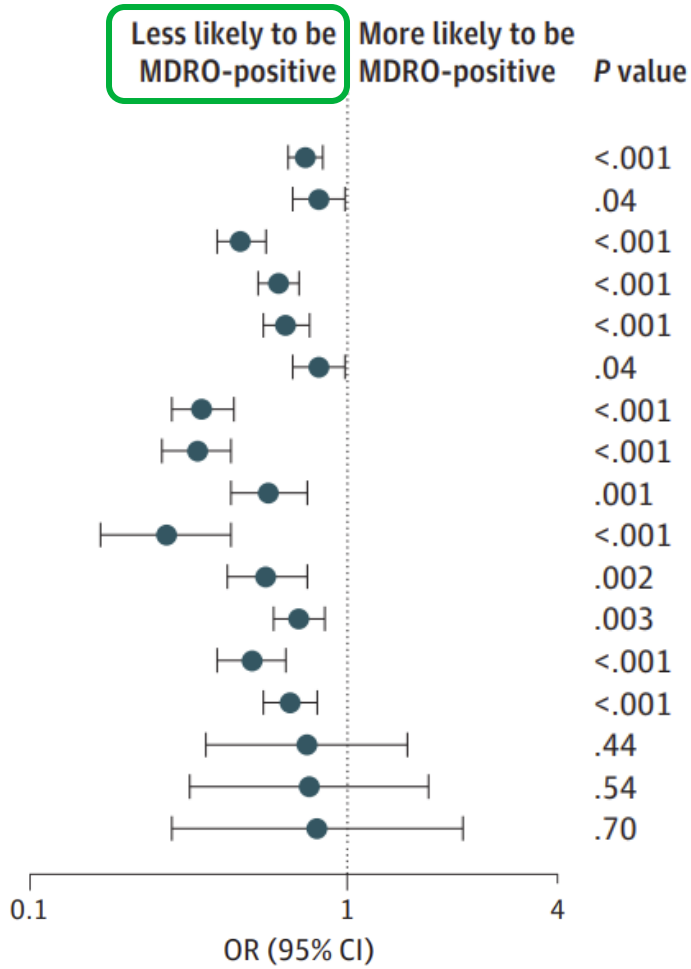
Nursing Home Impact: 23% MDRO Reduction



Gussin G et al. JAMA 2024; 331(18):1544-57

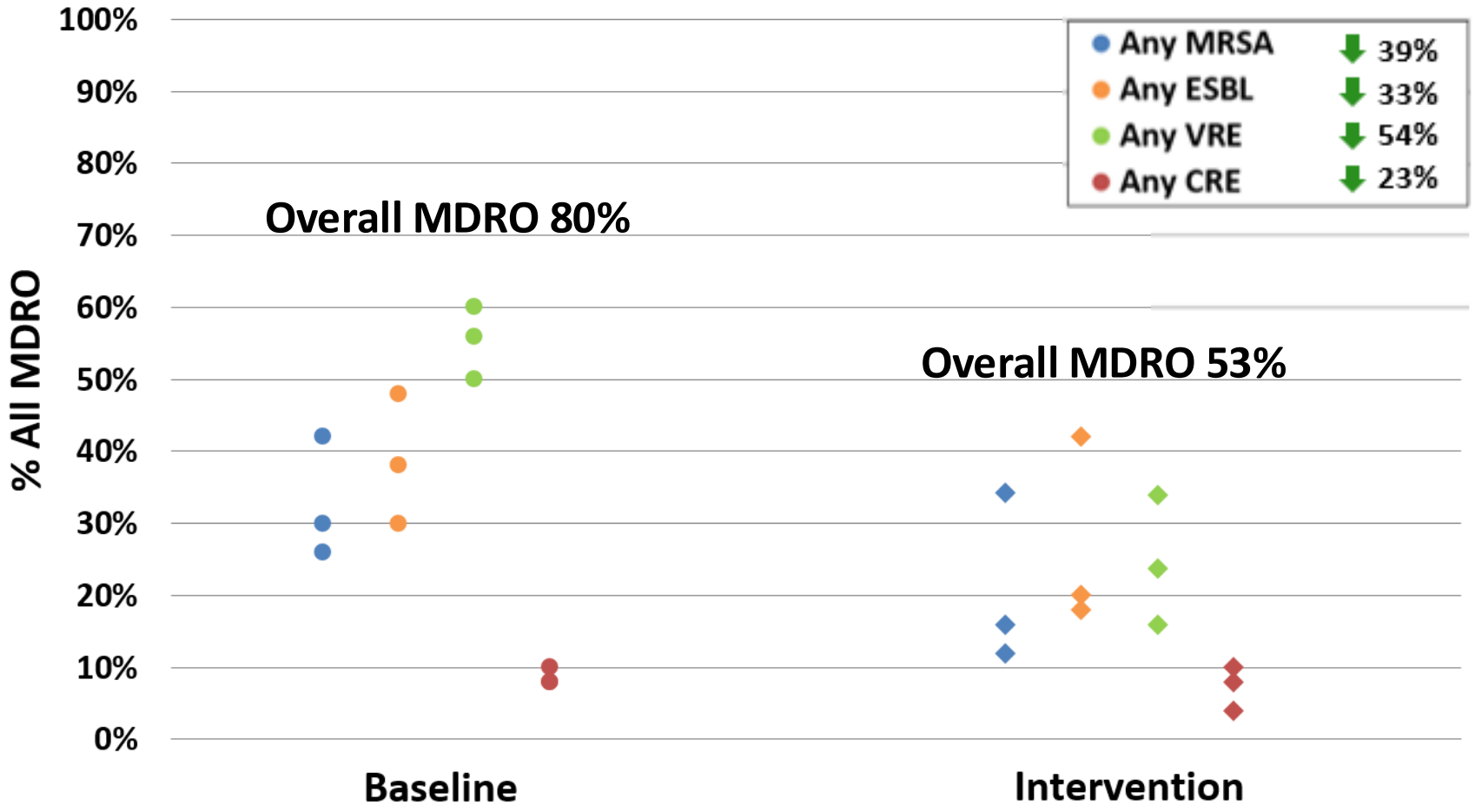
Figure 1. MDRO Point Prevalence (Screening) Among Facilities Participating in the Regional Decolonization Collaborative, Baseline and End of Intervention

Colonization	Baseline		Intervention		OR (95% CI)	P value
	No. of MDRO-positive persons	Mean (SD) prevalence across facilities, %	No. of MDRO-positive persons	Mean (SD) prevalence across facilities, %		
Nursing homes						
Any MDRO	511	63.9 (12.2)	709	49.9 (11.3)	0.77 (0.69-0.86)	<.001
Nares	236	29.5 (7.3)	360	25.1 (8.6)	0.84 (0.71-0.99)	.04
Axilla or groin	370	46.3 (13.7)	337	24.7 (8.0)	0.51 (0.44-0.60)	<.001
Perirectal	412	51.5 (13.5)	473	34.1 (11.1)	0.65 (0.57-0.74)	<.001
Any MRSA	343	42.9 (11.2)	422	29.8 (9.3)	0.68 (0.59-0.79)	<.001
Nares	236	29.5 (7.3)	360	25.1 (8.6)	0.84 (0.71-0.99)	.04
Axilla or groin	247	30.9 (10.5)	176	13.1 (6.5)	0.40 (0.33-0.49)	<.001
Perirectal	207	25.9 (9.2)	142	10.8 (5.5)	0.39 (0.31-0.48)	<.001
Any VRE	125	15.6 (7.6)	134	9.4 (6.7)	0.61 (0.48-0.78)	.001
Axilla or groin	68	8.5 (5.4)	37	2.7 (3.3)	0.32 (0.21-0.48)	<.001
Perirectal	114	14.3 (7.8)	120	8.4 (5.8)	0.60 (0.47-0.78)	.002
Any ESBL	269	33.6 (17.2)	356	25.5 (10.5)	0.74 (0.63-0.87)	.003
Axilla or groin	167	20.9 (12.0)	163	12.1 (6.1)	0.55 (0.44-0.68)	<.001
Perirectal	248	31.0 (16.5)	310	22.3 (9.5)	0.70 (0.59-0.83)	<.001
Any CRE	17	2.1 (4.3)	22	1.6 (2.8)	0.78 (0.41-1.47)	.44
Axilla or groin	12	1.5 (3.5)	16	1.1 (2.0)	0.79 (0.37-1.68)	.54
Perirectal	8	1.0 (2.1)	11	0.9 (1.5)	0.83 (0.33-2.09)	.70



Gussin G et al. JAMA 2024; 331(18):1544-57

Long Term Acute Care: 33% MDRO Reduction



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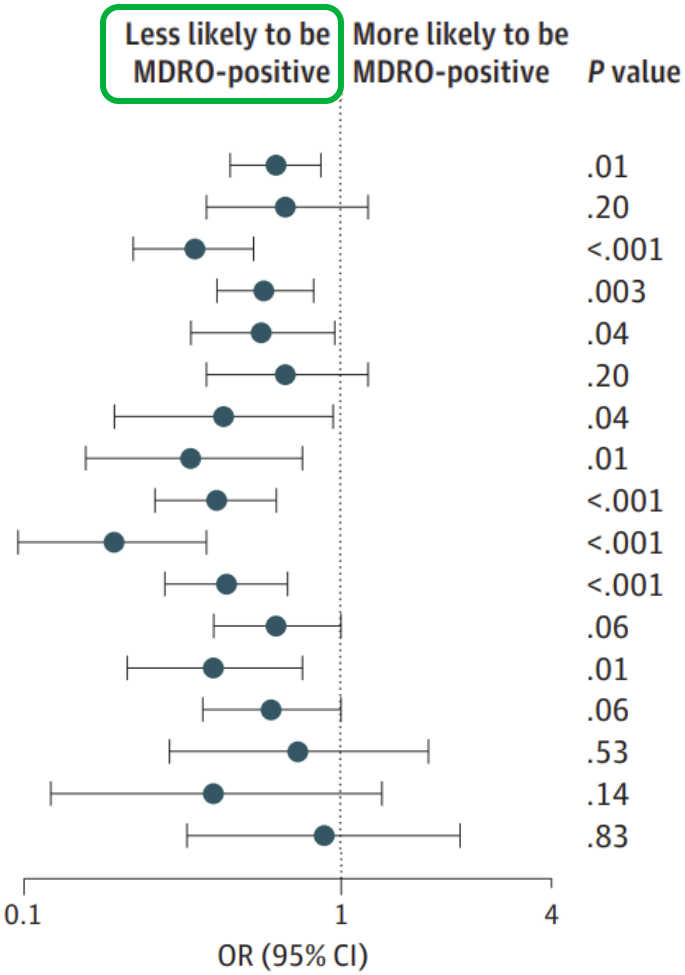
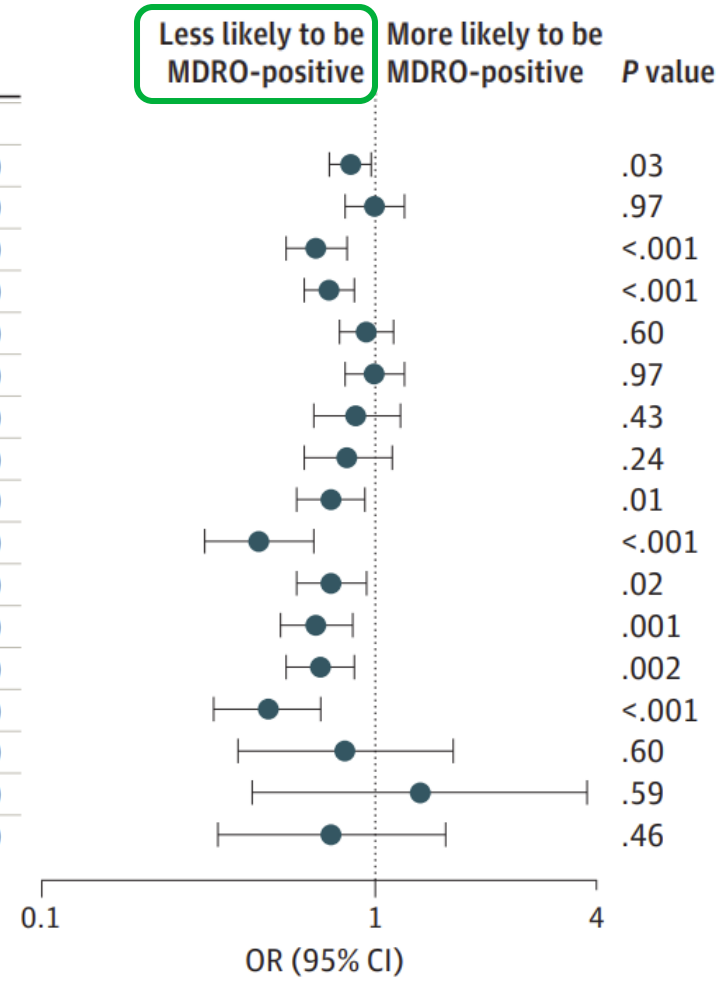
	Baseline		Intervention			
Colonization	No. of MDRO-positive persons	Mean (SD) prevalence across facilities, %	No. of MDRO-positive persons	Mean (SD) prevalence across facilities, %	OR (95% CI)	*P* value
Long-term acute care facilities						
Any MDRO	120	80.0 (7.2)	80	53.3 (13.3)	0.67 (0.50-0.89)	.01
Nares	35	23.3 (9.5)	25	16.7 (8.3)	0.71 (0.43-1.20)	.20
Axilla or groin	91	60.7 (9.0)	36	24.0 (6.0)	0.40 (0.27-0.58)	<.001
Perirectal	109	72.7 (9.5)	68	45.3 (12.9)	0.62 (0.46-0.85)	.003
Any MRSA	49	32.7 (8.3)	30	20.0 (10.6)	0.61 (0.39-0.97)	.04
Nares	35	23.3 (9.5)	25	16.7 (8.3)	0.71 (0.43-1.20)	.20
Axilla or groin	25	16.7 (3.1)	12	8.0 (2.0)	0.48 (0.24-0.96)	.04
Perirectal	28	18.7 (11.0)	11	7.3 (7.6)	0.39 (0.20-0.79)	.01
Any VRE	83	55.3 (5.0)	38	25.3 (10.1)	0.46 (0.31-0.67)	<.001
Axilla or groin	55	36.7 (6.4)	13	8.7 (3.1)	0.24 (0.13-0.43)	<.001
Perirectal	78	52.0 (5.3)	38	25.3 (10.1)	0.49 (0.33-0.72)	<.001
Any ESBL	58	38.7 (9.0)	39	26.0 (10.4)	0.67 (0.45-1.01)	.06
Axilla or groin	40	26.7 (5.8)	18	12.0 (3.5)	0.45 (0.26-0.79)	.01
Perirectal	52	34.7 (8.1)	34	22.7 (11.7)	0.65 (0.42-1.01)	.06
Any CRE	13	8.7 (1.2)	10	6.7 (3.1)	0.77 (0.34-1.76)	.53
Axilla or groin	11	7.3 (1.2)	5	3.3 (3.1)	0.45 (0.16-1.31)	.14
Perirectal	11	7.3 (1.2)	10	6.7 (3.1)	0.91 (0.38-2.15)	.83



Gussin G et al. JAMA 2024; 331(18):1544-57

Figure 1. MDRO Point Prevalence (Screening) Among Facilities Participating in the Regional Decolonization Collaborative, Baseline and End of Intervention

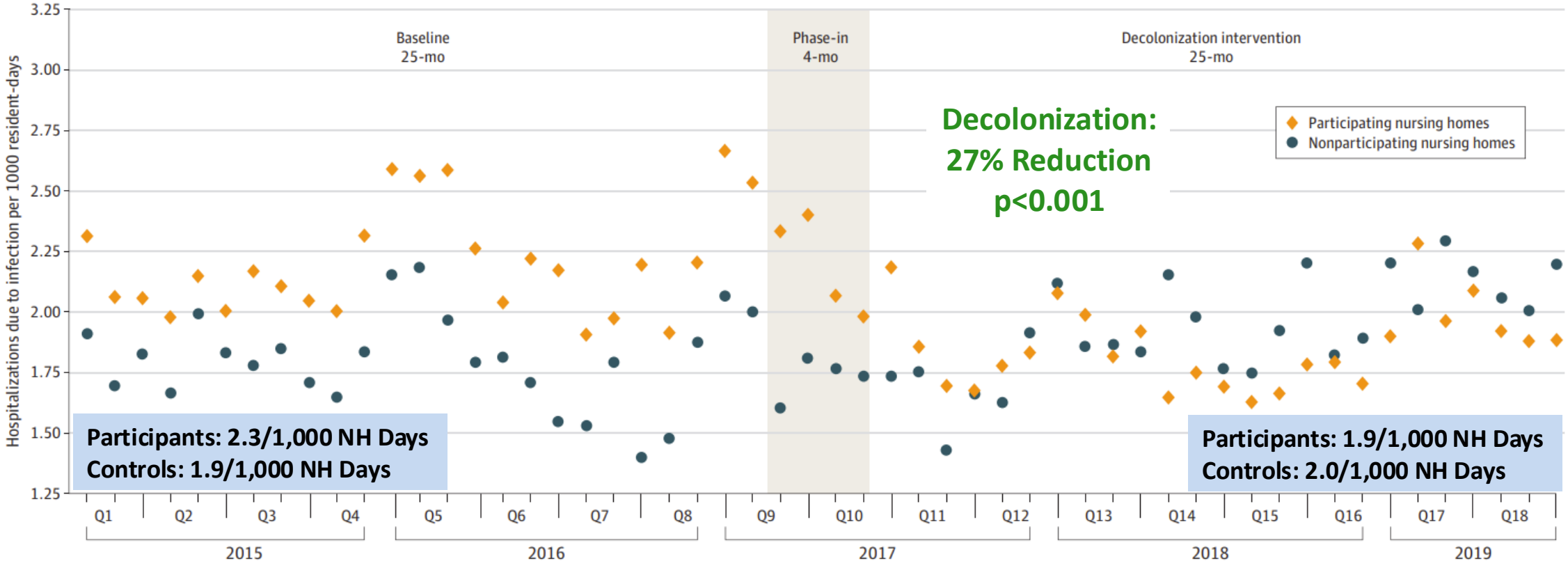
Colonization	Baseline		Intervention		OR (95% CI)	P value
	No. of MDRO-positive persons	Mean (SD) prevalence across facilities, %	No. of MDRO-positive persons	Mean (SD) prevalence across facilities, %		
Hospitals with patients in contact precautions						
Any MDRO	474	64.1 (8.5)	409	55.4 (13.8)	0.86 (0.75-0.98)	.03
Nares	221	29.9 (6.5)	220	29.7 (10.9)	1.00 (0.83-1.21)	.97
Axilla or groin	242	32.9 (10.8)	167	22.5 (14.1)	0.69 (0.57-0.84)	<.001
Perirectal	363	49.2 (9.0)	273	37.2 (13.2)	0.75 (0.64-0.88)	<.001
Any MRSA	265	35.9 (7.6)	252	34.2 (13.3)	0.95 (0.80-1.13)	.60
Nares	221	29.9 (6.5)	220	29.7 (10.9)	1.00 (0.83-1.21)	.97
Axilla or groin	104	14.1 (7.5)	93	12.8 (11.0)	0.89 (0.68-1.18)	.43
Perirectal	105	14.3 (6.7)	88	12.1 (9.2)	0.84 (0.64-1.12)	.24
Any VRE	185	25.1 (7.1)	141	19.3 (11.9)	0.76 (0.61-0.94)	.01
Axilla or groin	101	13.8 (6.6)	49	6.7 (5.9)	0.48 (0.34-0.68)	<.001
Perirectal	175	23.8 (6.7)	134	18.4 (11.6)	0.76 (0.61-0.95)	.02
Any ESBL	202	27.3 (6.8)	143	19.3 (6.0)	0.69 (0.55-0.87)	.001
Axilla or groin	97	13.1 (5.9)	49	6.7 (3.4)	0.71 (0.57-0.88)	.002
Perirectal	181	24.5 (5.5)	125	16.9 (6.6)	0.51 (0.36-0.71)	<.001
Any CRE	18	2.4 (2.3)	15	2.1 (3.0)	0.83 (0.42-1.65)	.60
Axilla or groin	6	0.8 (1.3)	8	1.1 (1.6)	1.34 (0.46-3.86)	.59
Perirectal	17	2.3 (2.0)	13	1.8 (2.5)	0.76 (0.37-1.57)	.46



Gussin G et al. JAMA 2024; 331(18):1544-57

Impact: NH Hospitalizations Due to Infection

Figure 5. Monthly Infection-Related Hospitalization Rates Among Nursing Homes Residents in Participating (Decolonization) vs Nonparticipating Nursing Homes



Gussin G et al. JAMA 2024; 331(18):1544-57

NH Hospitalization-Related Costs & Deaths

Costs Associated with Infection-Related Hospitalization					
Decolonization Group	Costs per 1,000 Resident Days		Adjusted Analysis [b]		
			Clustered Cost Ratio	Group-By-Period Interaction Effect	
	Baseline	Intervention		% Reduction (95% CI)	P-value
Participant	$64,651	$55,149	0.96	-26.8% (-26.7, -26.9)	<0.001
Non-Participant	$55,151	$59,327	1.31		
Deaths Associated with Infection-Related Hospitalization					
Decolonization Group	Events per 1,000 Resident Days		Adjusted Analysis [b]		
			Clustered Hazard Ratio	Group-By-Period Interaction Effect	
	Baseline	Intervention		% Reduction (95% CI)	P-value
Participant	0.29	0.25	0.62	-23.7% (-4.5, -43.0)	0.006
Non-Participant	0.23	0.24	0.81		

Gussin G et al. JAMA 2024; 331(18):1544-57

The Protect Trial

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Decolonization in Nursing Homes to Prevent Infection and Hospitalization

L.G. Miller, J.A. McKinnell, R.D. Singh, G.M. Gussin, K. Kleinman, R. Saavedra, J. Mendez, T.D. Catuna, J. Felix, J. Chang, L. Heim, R. Franco, T. Tjoa, N.D. Stone, K. Steinberg, N. Beecham, J. Montgomery, D.A. Walters, S. Park, S. Tam, S.K. Gohil, P.A. Robinson, M. Estevez, B. Lewis, J.A. Shimabukuro, G. Tchakalian, A. Miner, C. Torres, K.D. Evans, C.E. Bittencourt, J. He, E. Lee, C. Nedelcu, J. Lu, S. Agrawal, S.G. Sturdevant, E. Peterson, and S.S. Huang

Miller LG et al. NEJM 2023 (Nov 9); 389:1766-1777

The Protect Trial

Pragmatic Trial

- 28 nursing homes
- Involved nearly 14,000 residents
- All activities performed by usual nursing home staff

Group 1: Routine Care

- Usual soap for showering/bathing

Group 2: Decolonization

- CHG for all bathing/showering
- Nasal iodophor for all residents, M-F twice daily, every other week

Miller LG et al. NEJM 2023 (Nov 9); 389:1766-1777

Nursing Home Characteristics

Variable	Decolonization Arm	Routine Arm
	Mean (SD)	
Number of Facilities	14	14
Mean Age	74.8 (5.2)	77.1 (5.4)
% Male	42.8 (5.8)	41.9 (10.2)
Mean Licensed Beds	117.9 (36.4)	114.6 (55.8)
Average Daily Census	109.4 (35.8)	102.0 (36.6)
Length of Stay	216.2 (29.9)	217.8 (16.4)
Elixhauser Comorbidity Score	3.6 (0.4)	3.6 (0.6)
% Diabetes	37.7 (6.3)	40.0 (7.0)
% Chronic Lung Disease	26.2 (14.6)	26.8 (12.6)
% Renal Failure	20.1 (5.8)	21.0 (6.8)

Miller LG et al. NEJM 2023 (Nov 9); 389:1766-1777

CHG for All Routine Bathing and Showering

- Liquid CHG for showering
  - 4% rinse off CHG
- CHG cloths for bed bathing
  - 2% leave on CHG

4% rinse off for shower

2% cloths for bath

Iodophor for Nasal Decolonization

- 10% povidone-iodine swabs (iodophor) to each nostril
- Facility-wide universal strategy
- Twice daily for 5 days
- On admission and M-F every other week

MDRO Carriage Reduction (Skin/Nares)

Table 3. Prevalence of MDRO Carriage during the Baseline Period and near the End of the Intervention Period.*

MDRO or sample	Prevalence in the Routine-Care Group		Prevalence in the Decolonization Group		Risk Ratio (95% CI)†
	Baseline (N=700)	Intervention (N=650)	Baseline (N=700)	Intervention (N=550)	
	percent (number of positive samples)				
Any MDRO	48.3 (338)	47.2 (307)	48.9 (342)	32.0 (176)	0.70 (0.58–0.84)
Any MRSA	37.6 (263)	36.9 (240)	36.4 (255)	25.1 (138)	0.73 (0.59–0.92)
Nostril swab sample	29.1 (203)	27.1 (176)	29.9 (209)	22.0 (121)	0.81 (0.62–1.05)
Skin swab sample	26.1 (183)	25.4 (165)	22.6 (158)	11.6 (64)	0.58 (0.42–0.79)
VRE	5.9 (41)	5.1 (33)	8.3 (58)	2.2 (12)	0.29 (0.14–0.62)
ESBL producer	15.9 (111)	17.9 (116)	16.7 (117)	9.2 (51)	0.50 (0.34–0.75)
CRE	1.4 (10)	0.6 (4)	0.4 (3)	0.4 (3)	3.53 (0.44–28.52)

Miller LG et al. NEJM 2023 (Nov 9); 389:1766-1777

Trial Outcomes

Outcome	Infection-Related Hospitalization	Any Hospitalization
Reason among hospitalizations Reason among discharges	**17% reduction** in infection–related hospitalizations, among hospitalized	**15% reduction** in hospitalizations, among discharged
Per 1,000 Resident Days	**31% reduction** in infection–related hospitalizations per 1,000 resident days	**18% reduction** in hospitalizations per 1,000 resident days
Number Needed to Treat (NNT)	**9.7 residents**	**8.9 residents**

1.9 infection-related hospitalizations averted per month per 100-bed nursing home

Miller LG et al. NEJM 2023 (Nov 9); 389:1766-1777

Implementation
Top 10 Pearls

Top 10 Pearls for Success
#1: Ensure Compatibility

- Remove other soaps
- Assess compatibility for prophylactic skin products
  - Check with manufacturers for CHG compatibility
  - Replace incompatible products with compatible ones
  - Do not worry about prescribed medicated creams
- All shampoos and some lotions and creams inactivate CHG
- Keep shampoo off skin as possible or use CHG on hair

Top 10 Pearls for Success
#2: Admission Bathing is Key

- Admission is one of the **most important** times to get rid of germs being brought into the facility
- Patients don't feel well when they arrive and may not have bathed in days. They bring in germs, including MDROs.
- Helps clean skin before procedures and devices
- Bathing on admission protects the patient and the entire unit

Top 10 Pearls for Success
#3: Importance of Face and Hair

- CHG is safe on face and hair
- Face and nose harbor substantial germs
- **Like all soap, avoid eyes and ears.** Concern is direct contact with nervous tissue, e.g. ruptured ear drum
- CHG is inactivated by shampoos. Use CHG as a shampoo or keep shampoo off the body as much as possible before applying CHG.

Top 10 Pearls for Success
#4: Wounds, Pressure Ulcers, Rashes

- Infection risk is highest with breaks in skin
- CHG safe on rashes, friable skin, abrasions, superficial burns and wounds that are not packed or deep
- CHG approved as a wound cleanser
- Used on superficial wounds, stage 1 and 2 pressure ulcers in trials
- Encourage wound care nurses to provide support to staff who are uncomfortable

Top 10 Pearls for Success
#5: Medical Devices

- **All lines/tubes/drains provide an opportunity for germs**
- CHG is safe on devices
- Central lines, drains, G-tube, J-tubes, urinary catheters
  - Clean skin around device to remove bacteria
  - Clean over semi-permeable dressings
  - Use clean part of CHG cloth to clean 6 inches closest to body
  - Clean devices when unwrapped after showering

Top 10 Pearls for Success
#6: Empower Nursing Assistants

- Certified nursing assistants (CNAs) need support from RNs and formal training to bathe wounds, devices, and over dressings
- Many taught not to touch wounds, devices, and rashes
- Not practical for RNs to find each patient with wounds, devices, and rashes and to spot bathe those areas
- RNs need to empower CNAs to bathe the whole body
- CNAs need to feel empowered and to ask for help when needed

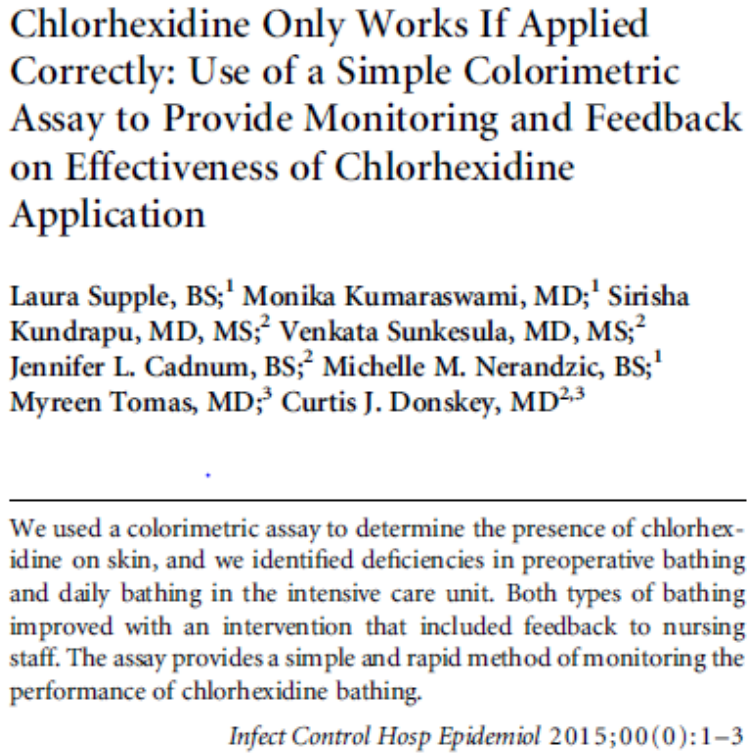
Top 10 Pearls for Success
#7: Allow CHG to Air Dry

Do NOT wipe off CHG or towel dry after application

- CHG binds to skin proteins and continues to kill germs
- Works for up to 24 hours
- CHG residual on skin helps protect – do not rinse or wipe off
- CHG is effective against candida
  - ✓ **Allow folds to dry – fan dry or prop with rolled towels**
  - ✓ **Improves candida/yeast rashes**
  - ✓ **If moisture stays within folds, can make candida worse**

Top 10 Pearls for Success
#8: Training Matters

- How CHG is applied is key to success
- Bathing is not intuitive due to friable skin, wounds, medical devices
- If not done right → no benefit
  - ✓ CHG must bind to skin proteins to provide up to 24h protection by killing invisible germs



Chlorhexidine Only Works If Applied Correctly: Use of a Simple Colorimetric Assay to Provide Monitoring and Feedback on Effectiveness of Chlorhexidine Application

Laura Supple, BS;[1] Monika Kumaraswami, MD;[1] Sirisha Kundrapu, MD, MS;[2] Venkata Sunkesula, MD, MS;[2] Jennifer L. Cadnum, BS;[2] Michelle M. Nerandzic, BS;[1] Myreen Tomas, MD;[3] Curtis J. Donskey, MD[2,3]

We used a colorimetric assay to determine the presence of chlorhexidine on skin, and we identified deficiencies in preoperative bathing and daily bathing in the intensive care unit. Both types of bathing improved with an intervention that included feedback to nursing staff. The assay provides a simple and rapid method of monitoring the performance of chlorhexidine bathing.

Infect Control Hosp Epidemiol 2015;00(0):1–3

[1] Popovich et al. Intensive Care Med 2010; 36(5):854-8
[2] Supple et al. ICHE 2015;36(9):1095-7

Top 10 Pearls for Success
#9: Importance of Nasal Decolonization

- *S. aureus* is responsible for 25% of ICU infections and is a common cause of CLABSI, VAP, and SSI
- 10-15% of inpatients are MRSA carriers
- Nose is the favorite place for MRSA/MSSA to live
- Nasal decolonization is **critical** to protecting patients from MRSA
- Nasal product is lead actor while CHG is supporting cast

Top 10 Pearls for Success
#10: Try, Try Again

- Create plan on how staff can re-approach refusers
- Determine why patient is refusing

  (i.e. in pain, uncomfortable, too tired, cold, depressed)

  - Ask if a later time would be better
  - #1 reason for refusing nasal decolonization or CHG is not understanding its importance
  - Re-approach patient to confirm understanding
  - Escalate to manager for another discussion

Implementation Resources

SHIELD MDRO Acute & Long-Term Care Toolkits

Is SHIELD Right for You?

Shared
Healthcare
Intervention to
Eliminate
Life-threatening
Dissemination of MDROs

The SHIELD intervention is right for you if:

- Your facility is experiencing cultures or infections due to MDROs
- Your facility is worried about MDROs in general
- Your facility is willing to do a campaign to reduce MDROs
- Your facility is interested in the benefits of "decolonization" but needs "how to" help

The SHIELD program is effective against the following organisms:

- CRE: carbapenem-resistant Enterobacteriaceae
- MRSA: methicillin resistant *Staphylococcus aureus*
- VRE: vancomycin-resistant Enterococcus
- ESBL: extended spectrum beta-lactamase producers

Hospital Toolkit | Nursing Home Toolkit | LTACH Toolkit

www.ucihealth.org/shield

Nursing Home Decolonization Toolkit

ucihealth.org/shield

Step 1: Adopt SHIELD program as Quality Assurance Performance Improvement (QAPI)

1. QAPI Project Documentation Form (PDF) (DOC)
2. Universal Plan of Care (PDF) (DOC)
3. Resident Plan of Care (PDF) (DOC)
4. Pre-Launch Checklist for the Infection Preventionist (PDF) (DOC)

Step 2: What to Expect? (PDF) (DOC)

Step 3: Communication to Residents

1. Admission Packet Letter (PDF) (DOC)
2. Resident/Ombudsman Information Sheet (PDF) (DOC

Step 4: Products & Protocols

1. Products (PDF) (DOC)
2. CHG Compatibility (PDF) (DOC)
3. Protocol: Bed Bath With CHG Cloths (PDF) (DOC)
4. Protocol: Bed Bath With CHG Liquid (PDF) (DOC)
5. Protocol: Showering With CHG (PDF) (DOC)
6. Protocol: Nasal Iodophor (PDF) (DOC)
7. Order Set Examples (PDF)
8. Admission – SHIELD Checklist (PDF) (DOC)

Step 5: Staff Education & Training

1. Paper or Computer Based Training (PDF) (PPT)
2. Staff Post-Training Test and Answer Key: Basin Bed Bathing
3. Staff Post-Training Test and Answer Key: CHG Cloths (PDF)
4. Physician and Staff Notification Flyer (PDF) (DOC)
5. Staff Handouts for CHG Bathing/Showering (PDF) (PUB)
6. Staff Handout for Basin Bed Bathing With CHG (PDF) (PUB)
7. Staff Handout for Nasal Iodophor (PDF) (PUB)
8. Staff Huddle Reminder Documents (PDF) (DOC)
9. FAQ: General (PDF) (DOC)
10. FAQ: Nasal Iodophor (PDF) (DOC)
11. FAQ: CHG for Bathing (PDF) (DOC)
12. FAQ: Wound Care (PDF) (DOC)
13. FAQ: Do and Don't (PDF) (DOC)

Step 6: Resident Education & Training

1. Resident Handout for CHG Bed Bath (PDF) (PUB)
2. Resident Handout for CHG Shower (PDF) (PUB)
3. Resident Handout for Nasal Iodophor (PDF) (PUB)
4. Waterproof Shower Poster for Residents (PDF) (DOC)
5. Resident Talking Points: CHG (PDF) (DOC)
6. Resident Talking Points: Iodophor (PDF) (DOC)

Step 7: Skills Assessments and Compliance Checks

1. CHG Cloth Skills Assessment Checklist (PDF) (DOC)
2. CHG Liquid Bed Bath Skills Assessment Checklist (PDF) (DOC)
3. Resident Self-Showering Assessment (PDF) (DOC)
4. Resident Self-Bed Bath Assessment (PDF) (DOC)

Step 8: Safety and Side Effects

1. Safety and Side Effects (PDF) (DOC)
2. Side Effect Tracking Form (PDF) (DOC)

Staff Decolonization Training

Prevent infections during each nursing home stay

BATHE or SHOWER with Chlorhexidine (CHG) soap

STAFF

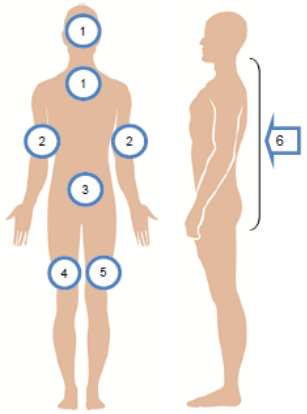
Bathe with CHG to remove germs and prevent infection

CHG works better than soap and water

CHG is a protective bath

CHG cloths are less drying than soap

Apply as shown below



Avoid eyes, mouth, & ear canals

REMINDERS

- **Your enthusiasm** helps residents understand why CHG is important
- Bathing on admission removes germs to protect the resident and nursing home
- CHG works for 24 hours to kill germs
- **Firmly massage** CHG onto skin
- Clean **6 inches** of lines, drains, tubes
- Safe on surface wounds, rashes, burns
- Use only CHG-compatible lotions
- If barrier protection needed, apply CHG then apply barrier protection

Clean all skin areas with attention to:

- Neck
- All skin folds
- Skin around all devices (line/tube/drain)
- Wounds unless deep or large
- Armpit, groin, between fingers/toes

SHOWERING with CHG soap

1. Rinse body with warm water
2. Wash hair and face with CHG
3. Avoid getting into eyes and ears
4. Turn off water and lather mesh sponge with plenty of CHG
5. Massage CHG onto all skin areas
5. Leave CHG on for **2 minutes** then rinse

BATHING with CHG cloths

1. Tell residents these cloths are their protective bath
2. Use all 6 cloths. More, if needed.
3. **Firmly massage** skin with cloth
4. Clean over semi-permeable dressings
5. Clean 6 inches of lines, tubes, and drains
6. Air dry. Do not wipe off.
7. Put used cloths in trash. Do not flush.

Prevent infections during each nursing home stay

BASIN BED BATHING with Chlorhexidine (CHG) Liquid

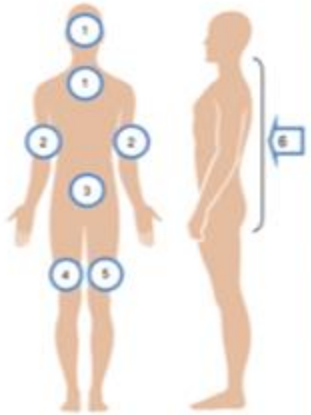
STAFF

Bathe with CHG to remove germs and prevent infection

CHG works better than soap and water

CHG is a protective bath

Apply as shown below



Avoid eyes, mouth, & ear canals

BASIN BATH Instructions

1. Prepare 4% liquid CHG, a measuring cup, a bed basin, and 6 disposable wipes (more if needed).
2. Dispense 1/2 cup of 4% CHG liquid into basin.
3. Add 1/2 cup of water. **Do not dilute more than equal part of water to CHG.**

4. Soak wipes in basin and wring before use. Do not place back into basin after use.
5. **Firmly massage** skin with wipes.
6. Clean over semi-permeable dressings.
7. Clean 6 inches of lines, tubes, and drains.

REMINDERS

- **Your enthusiasm** helps residents understand why CHG is important
- Bathing on admission removes germs to protect the resident and nursing home
- CHG works for 24 hours to kill germs
- **Firmly massage** CHG onto skin
- Clean **6 inches** of lines, drains, tubes
- Safe on surface wounds, rashes, burns
- Use only CHG-compatible lotions
- If barrier protection needed, apply CHG then apply barrier protection

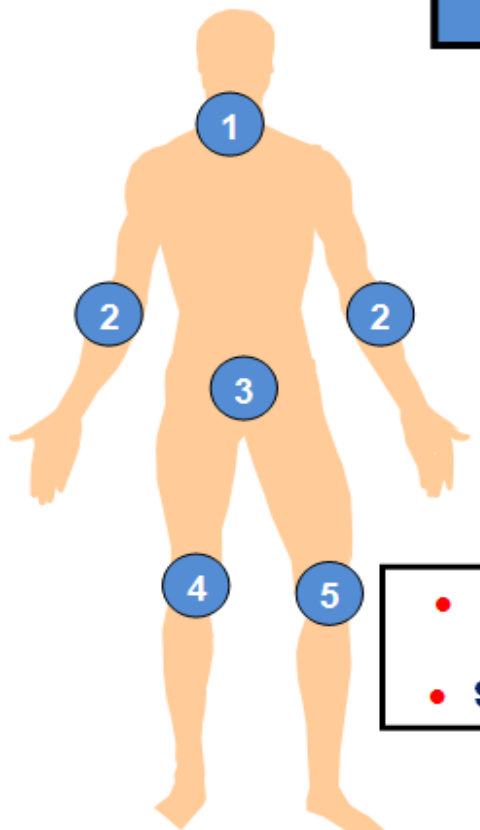
Clean all skin areas with attention to:

- Neck
- All skin folds
- Skin around all devices (line/tube/drain)
- Wounds unless deep or large
- Armpit, groin, between fingers/toes

ucihealth.org/shield

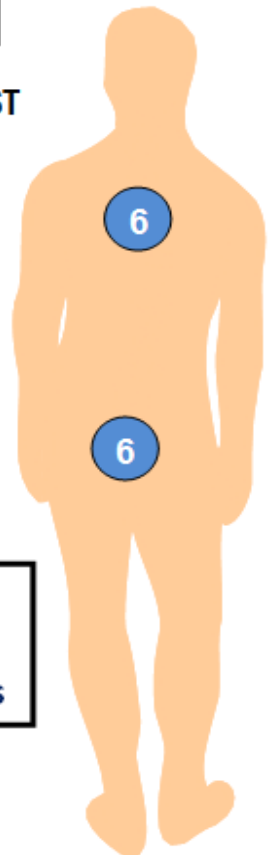
Apply Chlorhexidine WITH FIRM MASSAGE to remove bacteria

USE ALL 6 CHG CLOTHS
Avoid EYES & EAR CANAL



FRONT

1. FACE, NECK SHOULDERS & CHEST
2. BOTH ARMS & HANDS
3. ABDOMEN, GROIN & PERINEUM
4. RIGHT LEG & FOOT
5. LEFT LEG & FOOT
6. BACK, THEN BUTTOCKS



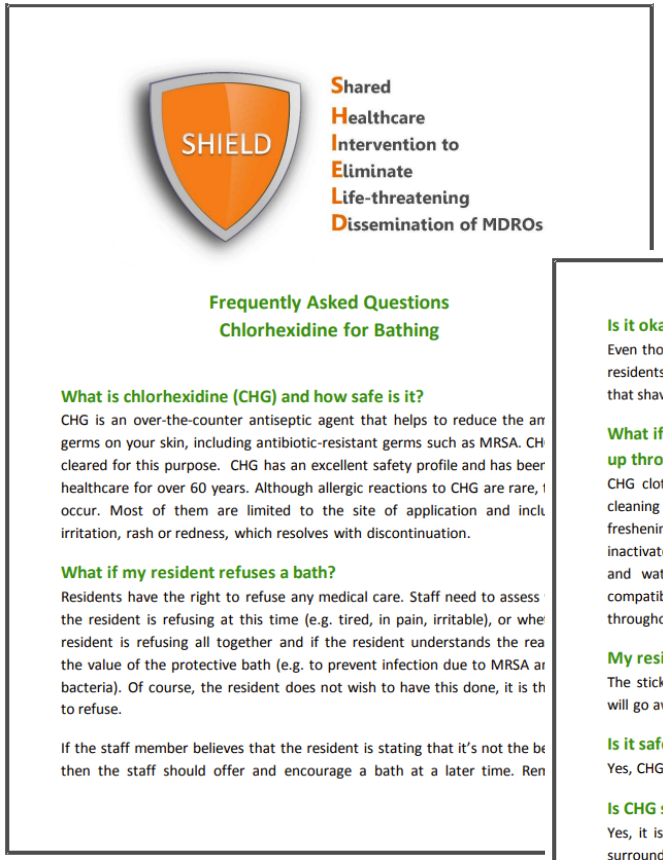
BACK

- Clean 6 inches of all tubes, lines, and drains closest to patient with CHG
- Safe on superficial wounds, rash, burns

Skin may feel sticky for a few minutes after CHG application.
Do NOT wipe off. Allow to air dry.

THIS IS a PROTECTIVE BATH
Do not use soap which can inactivate CHG

Decolonization FAQs



SHIELD

Shared
Healthcare
Intervention to
Eliminate
Life-threatening
Dissemination of MDROs

Frequently Asked Questions
Chlorhexidine for Bathing

What is chlorhexidine (CHG) and how safe is it?

CHG is an over-the-counter antiseptic agent that helps to reduce the an germs on your skin, including antibiotic-resistant germs such as MRSA. CH cleared for this purpose. CHG has an excellent safety profile and has beer healthcare for over 60 years. Although allergic reactions to CHG are rare, t occur. Most of them are limited to the site of application and inclu irritation, rash or redness, which resolves with discontinuation.

What if my resident refuses a bath?

Residents have the right to refuse any medical care. Staff need to assess the resident is refusing at this time (e.g. tired, in pain, irritable), or whe resident is refusing all together and if the resident understands the rea the value of the protective bath (e.g. to prevent infection due to MRSA ar bacteria). Of course, the resident does not wish to have this done, it is th to refuse.

If the staff member believes that the resident is stating that it's not the be then the staff should offer and encourage a bath at a later time. Ren

Is it okay for my residents to shave and use deodorant?

Even though shaving cream and deodorant may inactive CHG, we understand that residents will want to shave and use deodorant. If shaving is performed, ensure that shaving cream only contacts body area that is being shaved.

What if my resident has an incontinence episode or needs freshening up throughout the day?

CHG cloths should be used for all bathing purposes, including full-body bathing, cleaning after soiling, or any other reasons for additional cleaning such as freshening up. Do not use soap to cleanse incontinent residents because soap can inactivate CHG. First remove urine/stool with usual incontinence wipes or cloths and water. Next, clean with CHG and allow to air dry. Finally, apply CHG compatible barrier protection over the area. Repeat as often as needed throughout the day.

My resident reports that their skin feels sticky after the bath.

The sticky feeling is due to the moisturizing ingredients in the CHG cloths and it will go away as it dries. The cloths contain aloe vera.

Is it safe to use on the perineum?

Yes, CHG is safe to use on the perineum and external mucosa.

Is CHG safe to use on lines, tubes, and drains?

Yes, it is very important to clean lines, tubes, and drains in addition to the skin surrounding these devices in order to prevent infection. The 6 inches of any tube, drain, or line nearest the body should be cleaned. Non-absorbable (non-gauze) dressings should also be wiped over with the CHG cloth after the skin is cleaned.

Should gloves be worn or changed during bathing with CHG cloths?

Yes. Although it is safe to handle the CHG cloths with bare skin, gloves should be worn for bathing residents. If gloves become soiled, they should be changed.

SHIELD

Shared
Healthcare
Intervention to
Eliminate
Life-threatening
Dissemination of MDROs

Frequently Asked Questions
Wound Care

The majority of our nurses and certified nursing assistants (CNAs) feel comfortable using chlorhexidine (CHG) cloths on superficial wounds, but some do not. How would you suggest easing their concerns?

Remind all nursing staff that CHG cloths are safe to use on superficial wounds and stage 1 & 2 decubitus ulcers. Using the buddy system, in which nursing staff who are comfortable using CHG on superficial wounds buddy up with staff who are less comfortable, can also help.

Should I be concerned about CHG having a stinging effect on wounds?

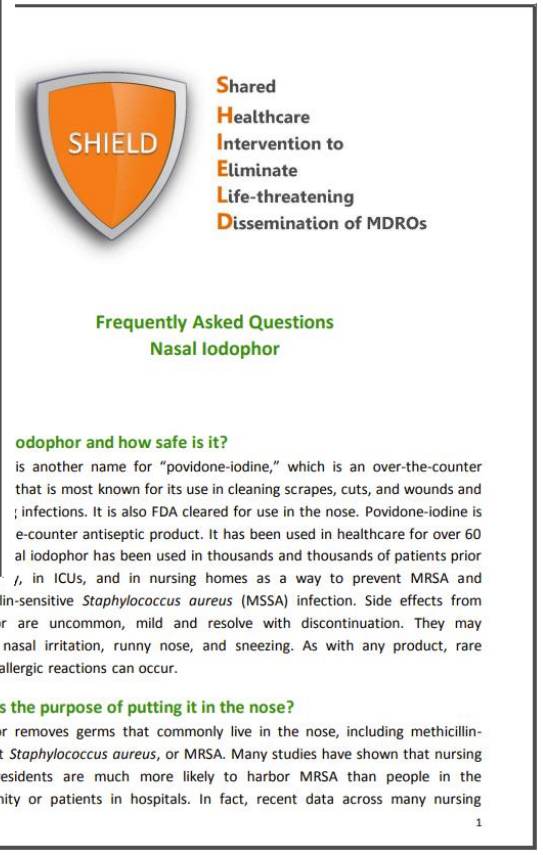
Antiseptic over-the-counter products often contain alcohol and will sting when applied to wounds. In contrast, CHG cloths do not contain alcohol and will not sting. In fact, CHG cloths contain dimethicone and aloe vera which are moisturizers and actually have a soothing effect on the superficial wound area.

Will CHG be absorbed if I put it on a wound?

There is minimal to no systemic absorption when using CHG on a superficial wound. In addition, the CHG may be particularly important to get rid of bacteria in an open wound and prevent infection.

For what types of wounds is CHG safe?

CHG can be gently applied to any superficial wound, including stage 1 and 2 decubitus ulcers, friable skin/rash, and superficial burns. We do not recommend



SHIELD

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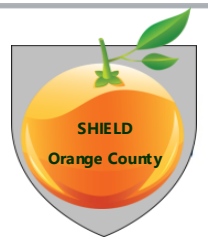
Frequently Asked Questions
Nasal Iodophor

odophor and how safe is it?

is another name for "povidone-iodine," which is an over-the-counter that is most known for its use in cleaning scrapes, cuts, and wounds and ; infections. It is also FDA cleared for use in the nose. Povidone-iodine is e-counter antiseptic product. It has been used in healthcare for over 60 al iodophor has been used in thousands and thousands of patients prior , in ICUs, and in nursing homes as a way to prevent MRSA and methicillin-sensitive *Staphylococcus aureus* (MSSA) infection. Side effects from iodophor are uncommon, mild and resolve with discontinuation. They may include nasal irritation, runny nose, and sneezing. As with any product, rare serious allergic reactions can occur.

What is the purpose of putting it in the nose?

Iodophor removes germs that commonly live in the nose, including methicillin-resistant *Staphylococcus aureus*, or MRSA. Many studies have shown that nursing home residents are much more likely to harbor MRSA than people in the community or patients in hospitals. In fact, recent data across many nursing



CHG Cloth Observation Checklist

Please complete for **THREE** different staff **per unit**

Individual Giving CHG Bath

Please indicate who performed the CHG bath.

☐ Nursing Assistant (CNA) ☐ Nurse ☐ Other: _____

Observed CHG Bathing Practices

Please check the appropriate response for each observation.

☐ Y	☐ N		Patient received CHG cloth bathing handout
☐ Y	☐ N		Patient told that bath is a no rinse cloth that provides protection from germs
☐ Y	☐ N		Provided rationale to the patient for not using soap at any time while in unit
☐ Y	☐ N		Massaged skin *firmly* with CHG cloth to ensure adequate cleansing
☐ Y	☐ N		Cleaned face and neck well
☐ Y	☐ N		Cleaned between fingers and toes
☐ Y	☐ N		Cleaned between all folds in perineal and gluteal area
☐ Y	☐ N	☐ N/A	Cleaned occlusive and semi-permeable dressings with CHG cloth
☐ Y	☐ N	☐ N/A	Cleaned 6 inches of all tubes, central lines, and drains closest to body
☐ Y	☐ N	☐ N/A	Used CHG on superficial wounds, rash, and stage 1 & 2 decubitus ulcers
☐ Y	☐ N	☐ N/A	Used CHG on surgical wounds (unless primary dressing or packed)
☐ Y	☐ N		Used all 6 cloths (more if needed)
☐ Y	☐ N		Allowed CHG to air-dry / does not wipe off CHG
☐ Y	☐ N		Disposed of used cloths in trash /does not flush

Query to Bathing Assistant/Nurse

1. Do you ever use soap in conjunction with a CHG bathing cloth? If so, when?

_____

2. Do you reapply CHG after an episode of incontinence has been cleaned up?

_____

3. Are you comfortable applying CHG to superficial wounds, including surgical wounds?

_____

4. Are you comfortable applying CHG to lines, tubes, drains and non-gauze dressings?

_____

5. Do you ever wipe off the CHG after bathing?

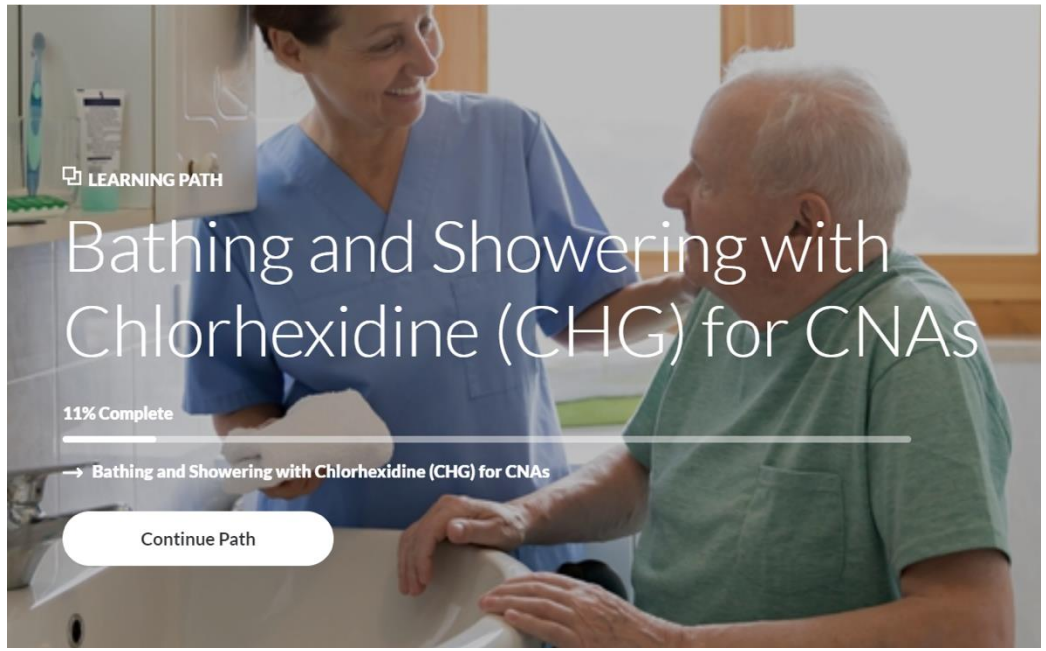
_____

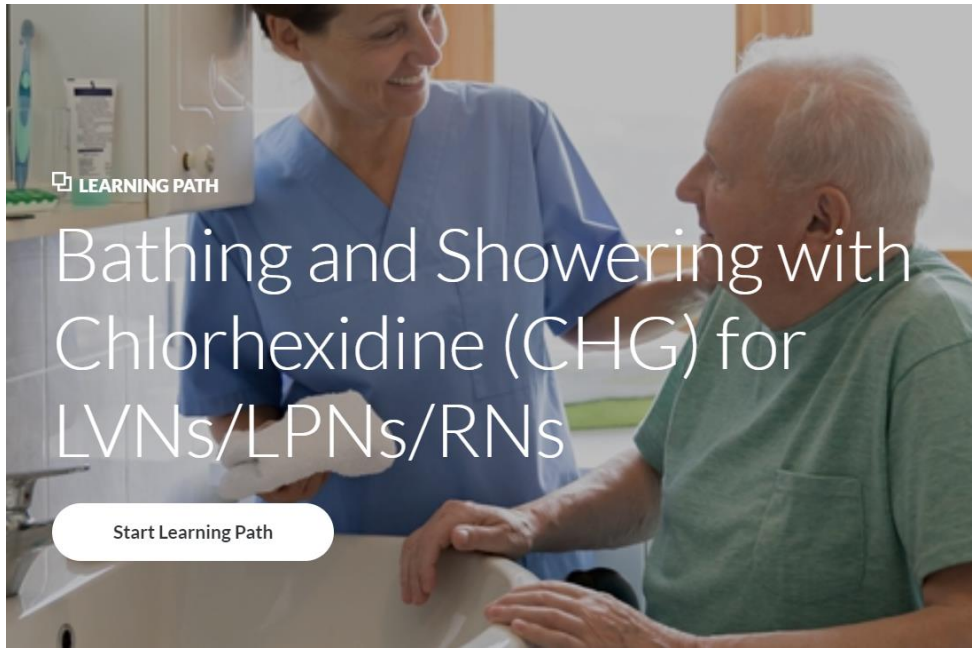
NACCHO
National Association of County & City Health Officials

UNIVERSITY

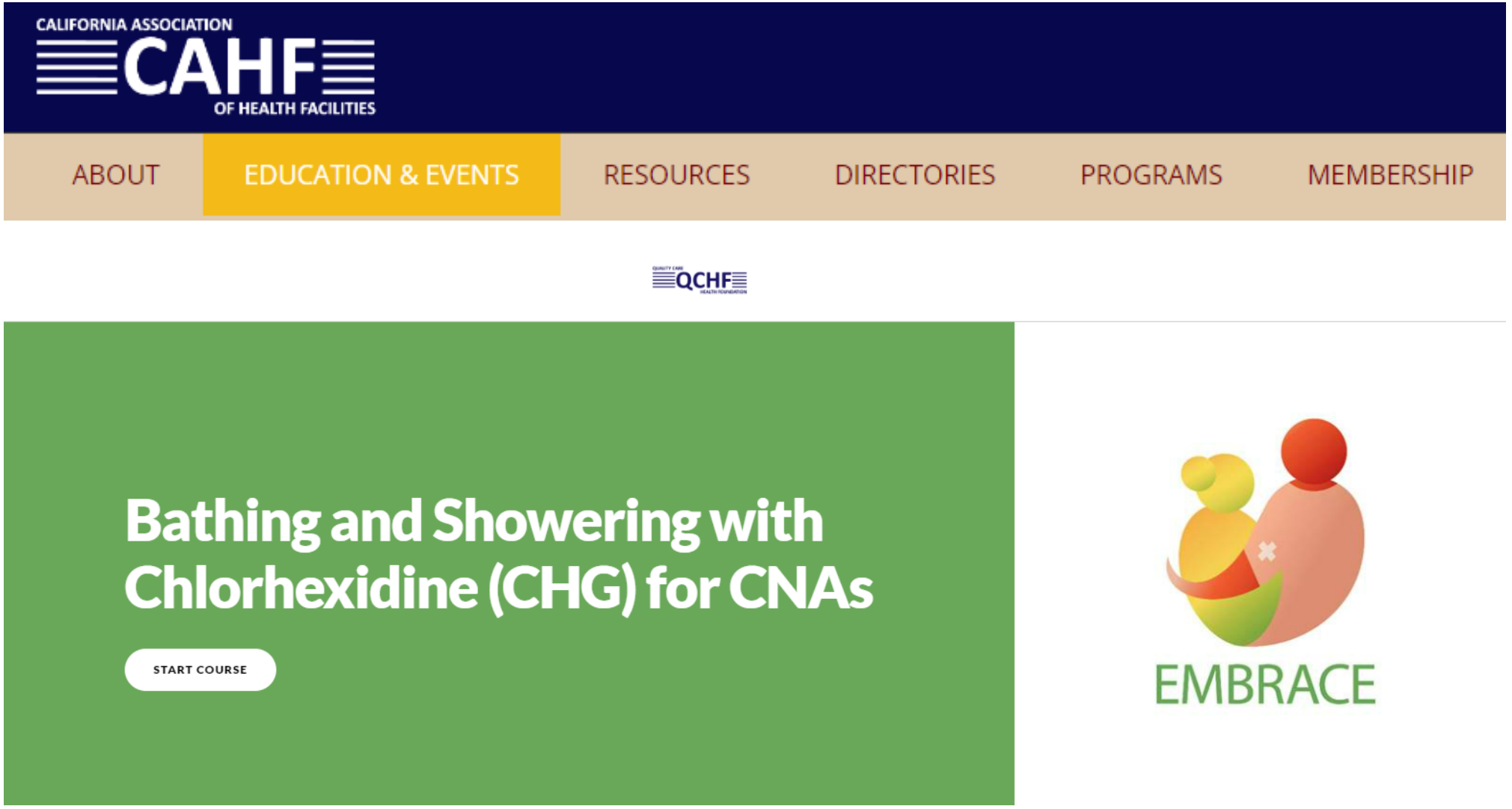
an online education and training resource to develop knowledge and competencies for local public health

Search “Bathing and Showering” for CHG and non-CHG modules





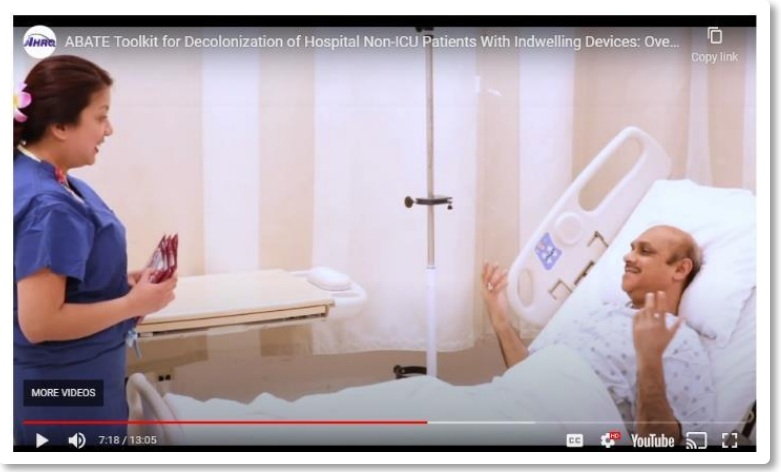
https://www.pathlms.com/naccho/courses/
Free registration gives free access



https://www.cahf.org/Education-Events/QCHF
Free registration for free access

Training Video for CHG Bathing

- CHG bathing and showering instructions
- Scenarios for how to encourage patients to accept bath
- Commonly missed and important protocol details
  (i.e., cleaning lines, tubes, drains, superficial wounds)
- Instructions for patients wishing to self-bathe



https://www.ahrq.gov/hai/tools/abate/index.html

Decolonization to Prevent Infection and MDROs

- Residents in long term care settings are at high risk for infection & MDROs
- Topical decolonization of skin and nose in long-term care:
  - ✓ Reduces MDROs, Gram+ and Gram-
  - ✓ Reduces hospitalizations from serious infections
  - ✓ Reduces related costs and deaths
- Universal application most effective in high-risk populations
- Quality of training and application matters
- Free, online tools can help with implementation