Pneumonia guidelines 2018 pdf idsa

Guidelines

- 2001 ATS & 2003 IDSA Guideline Update
- Expert panels
- Evidence-based recommendations
- Recommend patient stratification to identify likely pathogens and suggested empiric abx
  - Site of care
  - Presence of cardiopulmonary disease
  - Presence of "modifying factors"

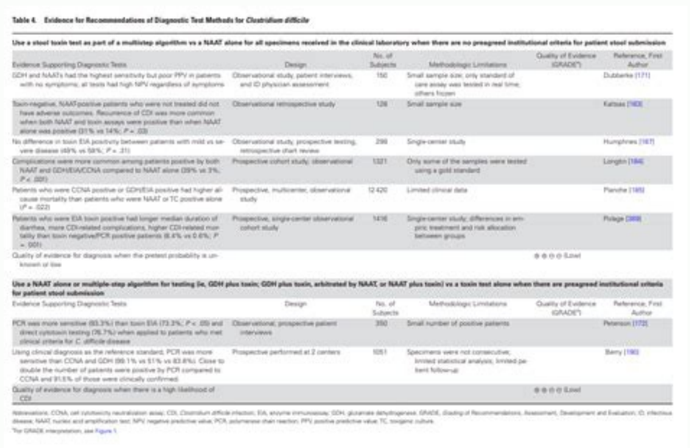

Table 4. Evidence for Recommendations of Diagnostic Test Methods for *Clostridium difficile*

Use a stool toxin test as part of a multistep algorithm vs a NAAT alone for all specimens received in the clinical laboratory when there are no preagreed institutional criteria for patient stool submission

Evidence Supporting Diagnostic Tests	Design	No. of Subjects	Methodologic Limitations	Quality of Evidence (GRADE[a])	Reference, First Author
GDH and NAATs had the highest sensitivity but poor PPV in patients with no symptoms; at tests had high NPV regardless of symptoms	Observational study; patient interviews, and ID physician assessment	150	Small sample size; only standard of care assay was tested in real time; others frozen		Dubberke [171]
Toxin-negative, NAAT-positive patients who were not treated did not have adverse outcomes. Recurrence of CDI was more common when both NAAT and toxin assays were positive than when NAAT alone was positive (31% vs 14%; $P = .03$)	Observational retrospective study	126	Small sample size		Kelsey [160]
No difference in toxin EIA positivity between patients with mild vs severe disease (49% vs 58%; $P = .21$)	Observational study, prospective testing, retrospective chart review	299	Single-center study		Humphries [167]
Complications were more common among patients positive by both NAAT and GDH/EIA/CCNA compared to NAAT alone (39% vs 3%; $P < .001$)	Prospective cohort study; observational	1321	Only some of the samples were tested using a gold standard		Longtin [184]
Patients who were CCNA positive or GDH/EIA positive had higher all-cause mortality than patients who were NAAT or TC positive alone ($P = .022$)	Prospective, multicenter, observational study	12 420	Limited clinical data		Planche [185]
Patients who were EIA toxin positive had longer median duration of diarrhea, more CDI-related complications, higher CDI-related mortality than toxin negative/PCR positive patients (8.4% vs 0.4%; $P = .001$)	Prospective, single-center observational cohort study	1416	Single-center study; differences in empiric treatment and risk allocation between groups		Polage [369]
Quality of evidence for diagnosis when the pretest probability is unknown or low				⊕⊕⊖⊖ (Low)	

Use a NAAT alone or multiple-step algorithm for testing (ie, GDH plus toxin; GDH plus toxin, arbitrated by NAAT, or NAAT plus toxin) vs a toxin test alone when there are preagreed institutional criteria for patient stool submission

Evidence Supporting Diagnostic Tests	Design	No. of Subjects	Methodologic Limitations	Quality of Evidence (GRADE[a])	Reference, First Author
PCR was more sensitive (93.3%) than toxin EIA (73.3%; $P < .05$) and direct cytotoxin testing (76.7%) when applied to patients who met clinical criteria for *C. difficile* disease	Observational; prospective patient interviews	350	Small number of positive patients		Peterson [172]
Using clinical diagnosis as the reference standard, PCR was more sensitive than CCNA and GDH (98.1% vs 81% vs 83.6%). Close to double the number of patients were positive by PCR compared to CCNA and 91.5% of those were clinically confirmed.	Prospective performed at 2 centers	1051	Specimens were not consecutive; limited statistical analysis; limited patient follow-up		Berry [190]
Quality of evidence for diagnosis when there is a high likelihood of CDI				⊕⊕⊖⊖ (Low)	

Abbreviations: CCNA, cell cytotoxicity neutralization assay; CDI, *Clostridium difficile* infection; EIA, enzyme immunoassay; GDH, glutamate dehydrogenase; GRADE, Grading of Recommendations, Assessment, Development and Evaluation; ID, infectious disease; NAAT, nucleic acid amplification test; NPV, negative predictive value; PCR, polymerase chain reaction; PPV, positive predictive value; TC, toxigenic culture.

[a] For GRADE interpretation, see Figure 1.

Poor prognostic factors at onset

- Poor control of underlying disease
- ECOG PS >2
- Long-term glucocorticosteroids
- Delayed onset of PCP treatment
- Hypoalbuminaemia
- Co-infection with HSV or CMV
- High neutrophil count in BAL
- High APACHE-II or SAPS-II score

Poor prognostic factors during PCP treatment

- Vasopressor use/shock
- Need for high-dose glucocorticosteroid treatment
- Respiratory failure/high oxygen support
- Need for mechanical ventilation
- ARDS
- Clinical worsening at day 8

ARDS, acute respiratory distress syndrome; CMV, cytomegalovirus; ECOG Eastern Cooperative Oncology Group; HSV, herpes simplex virus; PS performance score; SAPS, simplified acute physiology score.

Table 1. Recommendations for the Treatment of *Clostridium difficile* Infection in Adults

Clinical Definition	Supportive Clinical Data	Recommended Treatment[a]	Strength of Recommendation/ Quality of Evidence
Initial episode, non-severe	Leukocytosis with a white blood cell count of ≤15 000 cells/mL and a serum creatinine level <1.5 mg/dL	• VAN 125 mg given 4 times daily for 10 days, OR	Strong/High
		• FDX 200 mg given twice daily for 10 days	Strong/High
		• Alternate if above agents are unavailable: metronidazole, 500 mg 3 times per day by mouth for 10 days	Weak/High
Initial episode, severe[b]	Leukocytosis with a white blood cell count of ≥15 000 cells/mL or a serum creatinine level >1.5 mg/dL	• VAN, 125 mg 4 times per day by mouth for 10 days, OR	Strong/High
		• FDX 200 mg given twice daily for 10 days	Strong/High
Initial episode, fulminant	Hypotension or shock, ileus, megacolon	• VAN, 500 mg 4 times per day by mouth or by nasogastric tube. If ileus, consider adding rectal instillation of VAN. Intravenously administered metronidazole (500 mg every 8 hours) should be administered together with oral or rectal VAN, particularly if ileus is present.	Strong/Moderate (oral VAN); Weak/Low (rectal VAN); Strong/Moderate (intravenous metronidazole)
First recurrence	…	• VAN 125 mg given 4 times daily for 10 days if metronidazole was used for the initial episode, OR	Weak/Low
		• Use a prolonged tapered and pulsed VAN regimen if a standard regimen was used for the initial episode (eg, 125 mg 4 times per day for 10–14 days, 2 times per day for a week, once per day for a week, and then every 2 or 3 days for 2–8 weeks), OR	Weak/Low
		• FDX 200 mg given twice daily for 10 days if VAN was used for the initial episode	Weak/Moderate
Second or subsequent recurrence	…	• VAN in a tapered and pulsed regimen, OR	Weak/Low
		• VAN, 125 mg 4 times per day by mouth for 10 days followed by rifaximin 400 mg 3 times daily for 20 days, OR	Weak/Low
		• FDX 200 mg given twice daily for 10 days, OR	Weak/Low
		• Fecal microbiota transplantation[c]	Strong/Moderate

Abbreviations: FDX, fidaxomicin; VAN, vancomycin.

[a] All randomized trials have compared 10-day treatment courses, but some patients (particularly those treated with metronidazole) may have delayed response to treatment and clinicians should consider extending treatment duration to 14 days in those circumstances.

[b] The criteria proposed for defining severe or fulminant *Clostridium difficile* infection (CDI) are based on expert opinion. These may need to be reviewed in the future upon publication of prospectively validated severity scores for patients with CDI.

[c] The opinion of the panel is that appropriate antibiotic treatments for at least 2 recurrences (ie, 3 CDI episodes) should be tried prior to offering fecal microbiota transplantation.

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Strategies to prevent ventilator-associated pneumonia, ventilator-associated events, and nonventilator hospital-acquired pneumonia in acute-care hospitals: 2022 UpdateThe purpose of this document is to highlight practical recommendations to assist acute care hospitals to prioritize and implement strategies to prevent ventilator-associated pneumonia (VAP), ventilator-associated events (VAE), and non-ventilator hospital-acquired pneumonia (NV-HAP) in adults, children, and neonates. This document updates the Strategies to Prevent Ventilator-Associated Pneumonia in Acute Care Hospitals published in 2014. This expert guidance document is sponsored by the Society for Healthcare Epidemiology (SHEA), and is the product of a collaborative effort led by SHEA, the Infectious Diseases Society of America, the American Hospital Association, the Association for Professionals in Infection Control and Epidemiology, and The Joint Commission, with major contributions from representatives of a number of organizations and societies with content expertise. Strategies to prevent central line-associated bloodstream infections in acute-care hospitals: 2022 UpdatePreviously published guidelines provide comprehensive recommendations for detecting and preventing healthcare-associated infections (HAIs). The intent of this document is to highlight practical recommendations in a concise format designed to assist acute-care hospitals in implementing and prioritizing their central line-associated bloodstream infection (CLABSI) prevention efforts. This document updates the Strategies to Prevent Central Line-Associated Bloodstream Infections in Acute-Care Hospitals published in 2014. This expert guidance document is sponsored by the Society for Healthcare Epidemiology of America (SHEA). It is the product of a collaborative effort led by SHEA, the Infectious Diseases Society of America (IDSA), the Association for Professionals in Infection Control and Epidemiology (APIC), the American Hospital Association (AHA), and The Joint Commission, with major contributions from representatives of a number of organizations and societies with content expertise. SHEA NICU White Paper Series: Practical approaches for the prevention of central line-associated bloodstream infectionsThis document is part of the "SHEA neonatal intensive care unit (NICU) white paper series." It is intended to provide practical, expert opinion, and/or evidence-based answers to frequently asked questions about CLABSI detection and prevention in the NICU. This document serves as a companion to the CDC Healthcare Infection Control Practices Advisory Committee (HICPAC) Guideline for Prevention of Infections in Neonatal Intensive Care Unit Patients. Central line-associated bloodstream infections (CLABSIs) are among the most frequent invasive infections among infants in the NICU and contribute to substantial morbidity and mortality. Infants who survive CLABSIs have prolonged hospitalization resulting in increased healthcare costs and suffer greater comorbidities including worse neurodevelopmental and growth outcomes. A bundled approach to central line care practices in the NICU has reduced CLABSI rates, but challenges remain. This document was authored by pediatric infectious diseases specialists, neonatologists, advanced practice nurse practitioners, infection preventionists, members of the HICPAC guideline-writing panel, and members of the SHEA Pediatric Leadership Council. For the selected topic areas, the authors provide practical approaches in question-and-answer format, with answers based on consensus expert opinion within the context of the literature search conducted for the companion HICPAC document and supplemented by other published information retrieved by the authors. Two documents in the series precede this one: "Practical approaches to Clostridioides difficile prevention" published in August 2018 and "Practical approaches to Staphylococcus aureus prevention," published in September 2020.Authors: Martha Muller, Kristina A. Bryant, Claudia Espinosa, Jill A. Jones, Caroline Quach, Jessica R. Rindels, Dan L. Stewart, Kenneth M. Zangwill, and Pablo J. Sánchez Antimicrobial Stewardship: A Collaborative Partnership between Infection Preventionists and Healthcare EpidemiologistsMisuse and overuse of antimicrobials, primarily involving therapeutic agents used to treat infection in humans, is considered one of the world's most pressing public health problems. Not only does such inappropriate use diminish the therapeutic benefit of essential medications, it also facilitates the development and spread of multidrug-resistant organisms (MDROs). Antimicrobial resistance and the rise in MDROs globally are associated with increased morbidity and mortality, cross-transmission within and between healthcare settings, and increased consumption of limited patient-care resources. Despite elevated awareness, publication of guidelines on antimicrobial stewardship, and several initiatives, the proportion of resistant strains causing both health care- and community-associated infections continues to increase and the number of new antimicrobials continues to decline.Authors: Julia Moody, Sara E. Cosgrove, Russell Olmsted, Edward Septimus, Kathy Aureden, Shannon Oriola, Gita Wasan Patel and, Kavita K. Trivedi Guidance for the Knowledge and Skills Required for Antimicrobial Stewardship LeadersAntimicrobial stewardship (AS) refers to coordinated interventions to improve and measure the appropriate use of antimicrobials by promoting the selection of the optimal antimicrobial drug regimen, dose, duration of therapy and route of administration. The objectives of antimicrobial stewardship are to achieve the best clinical outcomes related to antimicrobial use while minimizing emergence of antimicrobial resistant organisms, Clostridium difficile infection, and other adverse events and reducing excessive costs attributable to suboptimal antimicrobial use.Authors: Sara E. Cosgrove, Elizabeth D. Hermsen, Michael J. Rybak, Thomas M. File, Sarah K. Parker, and Tamar F. Barlam Research Methods in Healthcare Epidemiology and Antimicrobial Stewardship—Quasi-Experimental DesignsQuasi-experimental studies evaluate the association between an intervention and an outcome using experiments in which the intervention is not randomly assigned. Quasi-experimental studies are often used to evaluate rapid responses to outbreaks or other patient safety problems requiring prompt, nonrandomized interventions. Quasi-experimental studies can be categorized into 3 major types: interrupted time-series designs, designs with control groups, and designs without control groups. This methods paper highlights key considerations for quasi-experimental studies in healthcare epidemiology and antimicrobial stewardship, including study design and analytic approaches to avoid selection bias and other common pitfalls of quasi-experimental studies.Authors: Marin L. Schweizer, Barbara I. Braun, Aaron M. Milstone Research Methods in Healthcare Epidemiology and Antimicrobial Stewardship—Mathematical ModelingMathematical modeling is a valuable methodology used to study healthcare epidemiology and antimicrobial stewardship, particularly when more traditional study approaches are infeasible, unethical, costly, or time-consuming. We focus on 2 of the most common types of mathematical modeling, namely compartmental modeling and agent-based modeling, which provide important advantages—such as shorter developmental timelines and opportunities for extensive experimentation—over observational and experimental approaches. We summarize these advantages and disadvantages via specific examples and highlight recent advances in the methodology. A checklist is provided to serve as a guideline in the development of mathematical models in healthcare epidemiology and antimicrobial stewardship.Authors: Sean L. Barnes, Parastu Kasaie, Deverick J. Anderson, Michael Rubin Research Methods in Healthcare Epidemiology: Survey and Qualitative ResearchSurveys are one of the most frequently employed study designs in healthcare epidemiology research. Generally easier to undertake and less costly than many other study designs, surveys can be invaluable to gain insights into opinions and practices in large samples and may be descriptive and/or be used to test associations. In this context, qualitative research methods may complement this study design either at the survey development phase and/or at the interpretation/extension of results stage. This methods article focuses on key considerations for designing and deploying surveys in healthcare epidemiology and antibiotic stewardship, including identification of whether or not de novo survey development is necessary, ways to optimally lay out and display a survey, denominator measurement, discussion of biases to keep in mind particularly in research using surveys, and the role of qualitative research methods to complement surveys. We review examples of surveys in healthcare epidemiology and antimicrobial stewardship and review the pros and cons of methods used. A checklist is provided to help aid design and deployment of surveys in healthcare epidemiology and antimicrobial stewardship.Authors: Nasia Safdar, Lilian M. Abbo, Mary Jo Knobloch, Susan K. Seo Research Methods in Healthcare Epidemiology and Antimicrobial Stewardship: Use of Administrative and Surveillance DatabasesAdministrative and surveillance data are used frequently in healthcare epidemiology and antimicrobial stewardship (HE&AS) research because of their wide availability and efficiency. However, data quality issues exist, requiring careful consideration and potential validation of data. This methods paper presents key considerations for using administrative and surveillance data in HE&AS, including types of data available and potential use, data limitations, and the importance of validation. After discussing these issues, we review examples of HE&AS research using administrative data with a focus on scenarios when their use may be advantageous. A checklist is provided to help aid study development in HE&AS using administrative data.Authors: Marci Drees, Jeffrey S. Gerber, Daniel J. Morgan, Grace M. Lee Research Methods in Healthcare Epidemiology and Antimicrobial Stewardship: Randomized Controlled TrialsRandomized controlled trials (RCT) produce the strongest level of clinical evidence when comparing interventions. RCTs are technically difficult, costly, and require specific considerations including the use of patient- and cluster-level randomization and outcome selection. In this methods paper, we focus on key considerations for RCT methods in healthcare epidemiology and antimicrobial stewardship (HE&AS) research, including the need for cluster randomization, conduct at multiple sites, behavior modification interventions, and difficulty with identifying appropriate outcomes. We review key RCTs in HE&AS with a focus on advantages and disadvantages of methods used. A checklist is provided to aid in the development of RCTs in HE&AS.Authors: Deverick J. Anderson, Manisha Juthani-Mehta, and Daniel J. Morgan Research Methods in Healthcare Epidemiology and Antimicrobial Stewardship—Observational StudiesObservational studies compare outcomes among subjects with and without an exposure of interest, without intervention from study investigators. Observational studies can be designed as a prospective or retrospective cohort study or as a case-control study. In healthcare epidemiology, these observational studies often take advantage of existing healthcare databases, making them more cost-effective than clinical trials and allowing analyses of rare outcomes. This paper addresses the importance of selecting a well-defined study population, highlights key considerations for study design, and offers potential solutions including biostatistical tools that are applicable to observational study designs.Authors: Graham M. Snyder, Heather Young, Meera Varman, Aaron M. Milstone, Anthony D. Harris, and Silvia Munoz-Price Moving Toward Elimination of Healthcare-Associated Infections: A Call to Action CDC, SHEA, APIC, ASTHO, CSTE, IDSA, PIDSA framework for achieving elimination of HAIs using successful preventive practices and public health strategies to achieve the goal of eliminating HAIs builds upon the basis of lessons from recent successes and require constant action and vigilance. These are: implement evidence-based practices that protect patients; align incentives to promote system-wide strategies for HAI prevention; address gaps in knowledge to push beyond the current medical knowledge; and collect data to target prevention efforts and to measure progress.Authors: Denise Cardo, Penelope H. Dennehy, Paul Halverson, Neil Fishman, Mel Kohn, Cathryn L. Murphy, Richard J. Whitley, and HAI Elimination White Paper Writing GroupPage 2 Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals SHEA, IDSA, AHA, APIC, The Joint CommissionThis complete update in Infection Control and Healthcare Epidemiology to the 2008 Compendium. Published in July 2014 with evidence-based, practical recommendations for acute care hospitals for the prevention of common HAIs.Synthesizes evidence and expert consensusHighlights basic HAI prevention strategiesProvides special approaches for outbreak managementDescribes implementation strategies and frameworks Policy Statement on Mandatory Immunization of Health Care PersonnelJoint policy statement of IDSA, the Society for Healthcare Epidemiology of America (SHEA), and the Pediatric Infectious Diseases Society (PIDS) supporting universal immunization of health care personnel by health care employers as recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC). Policy Statement on Antimicrobial Stewardship by the Society for Healthcare Epidemiology of America (SHEA), the Infectious Diseases Society of AmericaAntimicrobial resistance has emerged as a significant healthcare quality and patient safety issue in the twenty-first century that, combined with a rapidly dwindling antimicrobial armamentarium, has resulted in a critical threat to the public health of the United States. Antimicrobial stewardship programs optimize antimicrobial use to achieve the best clinical outcomes while minimizing adverse events and limiting selective pressures that drive the emergence of resistance and may also reduce excessive costs attributable to suboptimal antimicrobial use. Therefore, antimicrobial stewardship must be a fiduciary responsibility for all healthcare institutions across the continuum of care. This position statement of the Society for Healthcare Epidemiology of America, the Infectious Diseases Society of America, and the Pediatric Infectious Diseases Society of America outlines recommendations for the mandatory implementation of antimicrobial stewardship throughout health care, suggests process and outcome measures to monitor these interventions, and addresses deficiencies in education and research in this field as well as the lack of accurate data on antimicrobial use in the United States.Authors: Neil Fishman, Society for Healthcare Epidemiology of America, Infectious Diseases Society of America and, Pediatric Infectious Diseases Society Raising Standards While Watching the Bottom Line: Making a Business Case for Infection ControlThe SHEA Board of Directors appointed a task force to draft this evidence-based guideline to assist hospital epidemiologists in justifying and expanding their programs. Part 1 describes the basic steps needed to complete a business-case analysis for an individual institution. A case study based on a representative infection control intervention is provided. Part 2 reviews important basic economic concepts and describes approaches that can be used to assess the financial impact of infection prevention, surveillance, and control interventions, as well as the attributable costs of specific healthcare-associated infections. Both parts of the guideline aim to provide the hospital epidemiologist, infection control professional, administrator, and researcher with the tools necessary to complete a thorough business-case analysis and to undertake an outcome study of a nosocomial infection or an infection control intervention.Authors: Eli N. Perencevich, Patricia W. Stone, Sharon B. Wright, Yehuda Carmeli, David N. Fisman, and Sara E. Cosgrove Revised SHEA Position Paper: Influenza Vaccination of Healthcare PersonnelIn large part, the discussion about the rationale for influenza vaccination of healthcare personnel, the strategies designed to improve influenza vaccination rates in this population, and the recommendations made in the 2005 paper still stand. This position paper notes new evidence released since publication of the 2005 paper and strengthens SHEA's position on the importance of influenza vaccination of HCP. This document does not discuss vaccine allocation during times of vaccine shortage, because the 2005 SHEA Position Paper still serves as the society's official statement on that issue. SHEA views influenza vaccination of HCP as a core patient and HCP safety practice with which noncompliance should not be tolerated. Therefore, for the safety of both patients and HCP, SHEA endorses a policy in which annual

influenza vaccination is a condition of both initial and continued HCP employment and/or professional privileges.Authors: Thomas R. Talbot, Hilary Babcock, Arthur L. Caplan, Deborah Cotton, Lisa L. Maragakis, Gregory A. Poland, Edward J. Septimus, Michael L. Tapper and, David J. Weber Guidance for Infection Prevention and Healthcare Epidemiology Programs: Healthcare Epidemiologist Skills and CompetenciesSince its inception in the 1960s, the specialty of infection prevention and control has grown considerably. The field took shape in the 1970s following the landmark Study on the Efficacy of Nosocomial Infection Control (SENIC) project and grew in importance with the emergence of employee safety and multidrug-resistant organisms in the 1980s.1,2 In the 1990s and into the 2000s, the focus on hospital-acquired infection (HAI) prevention grew, so the field played a larger role in regulatory, patient safety, and quality improvement issues. In the present day, infection control data are frequently available to the public and impact hospital finances and healthcare insurance reimbursements.Authors: Keith S. Kaye, Deverick J. Anderson, Evelyn Cook, Susan S. Huang, Jane D. Siegel, Jerry M. Zuckerman, and Thomas R. Talbot Infection Prevention and Control in Residential FacilitiesThis SHEA guideline is the first infection prevention and control guideline to address preventing transmission of infectious agents in “home away from home” residential settings, of which the Ronald McDonald Houses (RMHs) serve as a prototype. Pediatric patients are frequent guests of the family-centered facilities while receiving or recovering from specialized medical therapy. Examples of high-risk populations served in these facilities include families of patients with cancer, recipients of stem cell or solid organ transplants, surgical and/or very-low-birthweight infants who receive care in neonatal intensive care units (NICUs), those with cystic fibrosis, and women with high-risk pregnancies awaiting.Authors: Guzman-Cottrill JA, Ravin KA, Bryant KA, Zerr DM, Kociolek L, Siegel JD Necessary Infrastructure of Infection Prevention and Healthcare Epidemiology ProgramsThe scope of a healthcare institution’s infection prevention and control/healthcare epidemiology program (IPC/HE) should be driven by the size and complexity of the patient population served, that population’s risk for healthcare-associated infection (HAI), and local, state, and national regulatory and accreditation requirements. Essential activities of all IPC/HE programs are reviewed in this white paper.Authors: Kristina A. Bryant, Anthony D. Harris, Carolyn V. Gould, Eve Humphreys, Tammy Lundstrom, Denise M. Murphy, Russell Olmsted, Shannon Oriola and Danielle ZerrReviewed: November 2018 Healthcare Personnel Attire in Non-Operating-Room SettingsThis SHEA expert guidance gives general guidance to the medical community regarding HCP attire outside the operating room. In addition to the initial guidance statement, the article has 3 major components: review and interpretation of the medical literature regarding, review of hospital policies related to HCP attire, and a survey of the SHEA Research Network to assess institutional HCP attire policies and perceptions. Although the optimal choice of HCP attire for inpatient care remains undefined, the document provides recommendations on the use of white coats, neckties, footwear, the bare-below-the-elbows strategy, and laundering.Authors: Bearman G, Bryant K, Leekha S, Mayer J, Munoz-Price LS, Murthy R, Palmore T, Rupp ME, White JReviewed: June 2018 Animals in Healthcare FacilitiesThis SHEA expert guidance provides general guidance to the medical community regarding the management of animals in healthcare based on analysis of the medical literature regarding risks and evidence for animal-to-human transmission of pathogens in the healthcare setting, along with the potential benefits of animal-assisted activities in healthcare, review of hospital policies related to animals in healthcare, and a SHEA Research Network survey assessing institutional policies. It offers specific guidance for acute care hospitals and ambulatory care facilities to develop or modify policies related to animals based on their role (i.e., animal-assisted activities, service animals, research animals, and personal pet visitation). It is not intended to guide the management of animals in other healthcare facilities such as assisted living, nursing homes, or extended-care facilities.Authors: Murthy R, Bearman G, Brown S, Bryant K, Chinn R, Hewlett A, George BG, Goldstein EJC, Holzmann-Pazgal G, Rupp ME, Wiemken T, Weese JS, Weber DJReviewed: April 2019 Implementing an Antibiotic Stewardship ProgramIDSA and SHEA evidence-based guidelines for implementation and measurement of antibiotic stewardship interventions in inpatient populations including long-term care, with recommendations that address the best approaches for antibiotic stewardship programs to influence the optimal use of antibiotics.Authors: Barlam T, Cosgrove S, Abbo L, MacDougall C, Schuetz A, Septimus E, Srinivasan A, Dellit T, Falck-Ytter Y, Fishman N, Hamilton C, Jenkins T, Lipsett P, Malani P, May L, Moran G, Neuhauser M, Newland J, Ohl C, Samore M, Seo S, Trivedi K Management of healthcare personnel living with hepatitis B, hepatitis C, or HIV in US healthcare institutions SHEA, endorsed by IDSA, HIVMA, and SISThis SHEA white paper updates the 2010 SHEA guideline, following advances in interventions that reduce risk for occupational exposures and injuries, antiretroviral therapy that can now fully suppress HIV, and evidence of very low risk for transmission from HCP to patients (only 5 occurrences worldwide since 2010). This white paper provides recommendations regarding Category III/exposure-prone procedures. It details factors that contribute to the pathogenesis and transmission risk for HBV, HCV, and HIV, viral load thresholds for any restrictions on HCP practice, categorization of healthcare-associated procedures according to level of risk for bloodborne pathogen transmission, and responsibilities of healthcare organizations, including academic institutions, professional schools, hospitals, and other healthcare facilities.Authors: Henderson DK, Dembry L-M, Sifri CD, Palmore TN, Dellinger EP, Yokoe DS, Grady C, Heller T, Weber D, del Rio C, Fishman NO, Deloney VM, Lundstrom T, Babcock HMPage 3 Multisociety guideline on reprocessing flexible GI endoscopes and accessories Written by ASGE, endorsed by SHEA, AASLD, AGA, AORN, APIC, ASCA, ASCRS, SGNAThis ASGE-led multisociety guideline updates the 2016 version, to address gaps and variation in implementing infection prevention practices are common in endoscopy units across the United States. Given the rising concerns of endoscope-related infections, this guideline evaluates the current literature and standards for endoscope reprocessing and expands details related to the critical reprocessing steps of cleaning and drying and incorporates recent evidence as it pertains to improving the reprocessing of GI endoscopes. Disinfection of Ultrasound Transducers Use for Percutaneous Procedures ACEP, with AIUM, SHEA, APIC, AVAThis intersociety position statement addresses the issue of disinfection of transcutaneous ultrasound transducers used for percutaneous procedures or for monitoring other invasive procedures. Some organizations are not congruent in their recommendations for disinfection, with recommendations for high-level disinfection of sheathed probes for percutaneous procedures being not evidence-based and resulting in unwarranted and unnecessary use of resources, increase the possibility of safety events if procedures are performed without ultrasound guidance. This statement addresses several specific points for determining when to use high-level disinfection appropriately. Disinfection and Sterilization of Prion-Contaminated Medical InstrumentsThis SHEA guideline provides recommendations for disinfection and sterilization of medical instruments in order to prevent Creutzfeldt-Jakob disease (CJD), a degenerative neurologic disorder caused by a proteinaceous infectious agent. Prion diseases elicit no immune response, result in a noninflammatory pathologic process confined to the central nervous system, have an incubation period of years, and usually are fatal within 1 year after diagnosis.Authors: Rutala WA, Weber DJReviewed: 2014 Infection Prevention and Control in the Long-Term Care FacilityThis SHEA/APIC guideline provides recommendations for prevention and control of infections in long-term care facilities, including UTIs, respiratory tract infections, skin and soft-tissue infections and infestations, gastrointestinal infections, infections caused by antibiotic-resistant organisms, and epidemic infections. It also reviews the structure and elements of infection control programs in the long-term care setting, regulatory considerations, education, and surveillance.Authors: Bratzler D, Dellinger EP, Olsen K, Perl T, Autwaerter P, Bolon M, Fish D, Napolitano L, Sawyer R, Slain D, Steinberg J, Weinstein R Antimicrobial Prophylaxis in SurgeryThese ASHP, SHEA, IDSA, and SIS clinical practice guidelines provide practitioners with a standardized approach to the rational, safe, and effective use of antimicrobial agents for the prevention of surgical-site infections based on available clinical evidence and emerging issues.Authors: Bratzler D, Dellinger EP, Olsen K, Perl T, Autwaerter P, Bolon M, Fish D, Napolitano L, Sawyer R, Slain D, Steinberg J, Weinstein RReviewed: 2/4/2013 Infection Prevention and Control Guideline for Cystic Fibrosis: 2013 Update Cystic Fibrosis Foundation, SHEAThis CFF and SHEA guideline updates the 2003 Cystic Fibrosis Foundation recommendations for infection prevention and control to reduce the risk of acquisition and transmission of pathogens among people with CF.Authors: Saiman L, Siegel JD, LiPuma JJ, Brown RF, Bryson EA, Chambers MJ, Downer VS, Fliege J, Hazle LA, Jain M, Marshall BC, O’Malley C, Pattee SR, Potter-Bynoe G, Reid S, Robinson KA, Sabadosa KA, Schmidt HJ, Tullis E, Webber J, Weber DJReviewed: 8/1/2014 Outbreak Response and Incident Management SHEA, cleared by CDC and endorsed by AACN, ACEP, CSTE, HCA Healthcare, IDSA, The Joint Commission, NACCHO, and PIDSThis SHEA expert guidance document, developed as part of the SHEA/CDC Outbreak Response Training Program (ORTP), provides recommendations for incident management during infectious diseases outbreaks and how to work within an emergency response framework. The guidance’s recommendations are not pathogen-specific and are meant to apply to a range of potential infectious diseases outbreaks.Authors: Banach DB, Johnston BL, Al-Zubeidi D, Bartlett AH, Bleasdale SC, Deloney VM, Enfield KB, Guzman-Cottrill JA, Lowe C, Ostrosky-Zeichner L, Popovich KJ, Patel PK, Ravin K, Rowe T, Shenoy ES, Stienecker R, Tosh PK, Trivedi KK Duration of Contact Precautions for Acute-Care SettingsThis SHEA expert guidance advises hospitals in when they can safely discontinue contact precautions for patients with multidrug-resistant bacteria, addressing how long hospital staff should use these safety protocols to reduce the spread of pathogens within the hospital, in most cases ranging from one to three negative cultures prior to discontinuation. The guidance also outlines the use of molecular testing in care decisions.Authors: Banach DB, Bearman G, Barnden M, Hanrahan JA, Leekha S, Morgan DJ, Murthy R, Munoz-Price LS, Sullivan KV, Popovich KJ, Wiemken TL Clinical Practice Guidelines for CDI in Adults and Children: 2017 UpdateIDSA and SHEA update to the 2010 clinical practice guideline on Clostridium difficile infection (CDI) in adults, incorporating recommendations for children (following the adult recommendations for epidemiology, diagnosis, and treatment) and significant changes in the management of CDI reflecting the evolving controversy over best methods for diagnosis. This evidence-based guideline updates recommendations regarding epidemiology, diagnosis, treatment, infection prevention, and environmental management.Authors: McDonald LC, Gerding D, Johnson S, Bakken J, Carroll K, Coffin S, Dubberke E, Garey K, Gould C, Kelly C, Loo V, Sammons JS, Sandora T, Wilcox MPartial Update: January 2021 NICU White Paper Series: Respiratory Infections NICU White Paper Series: Practical approaches to C. difficile prevention SHEA, endorsed by APIC, IDSA, The Joint Commission, NANN, PIDS, and VONThese white papers serve as companion to CDC’s Healthcare Infection Control Practices Advisory Committee (HICPAC) Recommendations for Prevention and Control of Infections in Neonatal Intensive Care Unit Patients and provide practical, expert opinion and/or evidence-based answers to frequently asked questions on infection detection and prevention in the NICU on S. aureus, C. difficile, CLABSI, and respiratory infections.Authors: Sandora TJ, Bryant KK, Cantey JB, Elward AM, Yokoe DS, Bartlett AH NICU White Paper Series: Practical approaches to S. aureus disease prevention SHEA, endorsed by APIC, IDSA, The Joint Commission, NANN, PIDS, and VONThese white papers serve as companion to CDC’s Healthcare Infection Control Practices Advisory Committee (HICPAC) Recommendations for Prevention and Control of Infections in Neonatal Intensive Care Unit Patients and provide practical, expert opinion and/or evidence-based answers to frequently asked questions on infection detection and prevention in the NICU on S. aureus, C. difficile, CLABSI, and respiratory infections.Authors: Akinboyo IC, Zangwill KM, Berg WM, Cantey JB, Huizinga B, Milstone AMPage 4 Infection Prevention in the Operating Room Anesthesia Work Area SHEA, endorsed by AAAA, AANA, AORN, and ASPFThis SHEA expert guidance gives infection prevention and control recommendations related to hand hygiene (activities, glove use, alcohol-based hand sanitizer), reusable versus single-use devices, environmental cleaning and management, use of injection ports, barrier precautions, and vials, syringes, and IV bags.Authors: Munoz-Price LS, Bowdle A, Johnston BL, Bearman G, Camins BC, Dellinger EP, Geisz-Everson MA, Holzmann-Pazgal G, Murthy R, Pegues D, Prielipp RC, Rubin ZA, Schaffzin J, Yokoe D, Birnbach DJ Evaluation and Management of Penicillin Allergy Shenoy ES, Macy E, Rowe T, Blumenthal KGβ-Lactam antibiotics are among the safest and most effective antibiotics; however, many patients report allergies to these drugs despite few having clinically significant reactions, resulting in the use of broad-spectrum antibiotics that increase the risk for antimicrobial resistance and adverse events. This review provides recommendations for the evaluation of penicillin allergies to support antimicrobial stewardship. Reliability of Nonlocalizing Signs and Symptoms as Indicators of the Presence of Infection in Residents of Nursing Homes SHEA, endorsed by AMDA, AMMI Canada, IDSA, and SIDPThis SHEA expert guidance provides a framework to guide practitioners in when to evaluate nursing home residents for infection if they exhibit non-specific signs or symptoms, including fever, hypothermia, low blood pressure, high blood sugar, delirium, behavioral changes, functional decline, falls, and anorexia.Authors: Rowe TA, Jump RLP, Andersen BM, Banach DB, Bryant KA, Doernberg SB, Loeb M, Morgan DJ, Morris AM, Murthy RK, Nace DA, Crnich CJ