“BEST” PRACTICES FOR DISINFECTION OF NON-CRITICAL SURFACES AND EQUIPMENT AND MEDICAL WASTE MANAGEMENT

William A. Rutala, Ph.D., M.P.H., C.I.C.
Director, Statewide Program for Infection Control and Epidemiology and Professor of Medicine, University of North Carolina at Chapel Hill, NC, USA
Former Director, Hospital Epidemiology, Occupational Health and Safety, UNC Health Care, Chapel Hill, NC
LECTURE OBJECTIVES

- Review the CDC Guideline for Disinfection and Sterilization: Focus on role of environmental surfaces
- Review “best” practices for environmental cleaning and disinfection
- Review the use of low-level disinfectants and the activity of disinfectants on key hospital pathogens
- Review medical waste management
Environmental Contamination Leads to HAIs

Evidence environment contributes
- EPI-MRSA, VRE, C. difficile
- Surfaces are contaminated-~25%
- EIP survive days, weeks, months
- Contact with surfaces results in hand contamination
- Disinfection reduces contamination
- Disinfection (daily) reduces HAIs
- Rooms not adequately cleaned
Admission to Room Previously Occupied by Patient C/I with Epidemiologically Important Pathogen

- Results in the newly admitted patient having an increased risk of acquiring that pathogen by 39-353%
- For example, increased risk for *C. difficile* is 235% (11.0% vs 4.6%)
- Exposure to contaminated rooms confers a 5-6 fold increase in odds of infection, hospitals must adopt proven methods for reducing environmental contamination (Cohen et al. ICHE. 2018;39:541-546)
Acquisition of EIP on Hands of Healthcare Providers after Contact with Contaminated Environmental Sites and Transfer to Other Patients
Acquisition of EIP on Hands of Patient after Contact with Contaminated Environmental Sites and Transfers EIP to Eyes/Nose/Mouth
EH Spaulding believed that how an object will be disinfected depended on the object’s intended use:

- **CRITICAL** - objects which enter normally sterile tissue or the vascular system or through which blood flows should be sterile.
- **SEMICRITICAL** - objects that touch mucous membranes or skin that is not intact require a disinfection process (high-level disinfection [HLD]) that kills all microorganisms; however, small numbers of bacterial spores are permissible.
- **NONCRITICAL** - objects that touch only intact skin require low-level disinfection.
LECTURE OBJECTIVES

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- Review medical waste management
GUIDELINE FOR DISINFECTION AND STERILIZATION IN HEALTHCARE FACILITIES, 2008

Rutala WA, Weber DJ., HICPAC
Available on CDC web page-www.cdc.gov
Disinfection of Noncritical Surfaces Bundle

- Develop policies and procedures
- Select cleaning and disinfecting products
- Educate staff-environmental services and nursing
- Monitor compliance (thoroughness of cleaning, product use) and feedback
- Implement “no touch” room decontamination technology and monitor compliance
Blood Pressure Cuff
Non-Critical Patient Care Item
Disinfecting Noncritical Patient-Care Items

- Process noncritical patient-care equipment with a EPA-registered disinfectant at the proper use dilution and a contact time of at least 1 min. *Category IB*

- Ensure that the frequency for disinfecting noncritical patient-care surfaces be done minimally when visibly soiled and on a regular basis (such as after each patient use or once daily or once weekly). *Category IB*
Disinfecting Environmental Surfaces in HCF

- Disinfect (or clean) housekeeping surfaces (e.g., floors, tabletops) on a regular basis (e.g., daily, three times per week), when spills occur, and when these surfaces are visibly soiled. Category IB

- Use disinfectant for housekeeping purposes where: uncertainty exists as to the nature of the soil on the surfaces (blood vs dirt); or where uncertainty exists regarding the presence of multi-drug resistant organisms on such surfaces. Category II
Use of a Daily Disinfectant Cleaner Instead of a Daily Cleaner Reduced HAI Rates
Alfa et al. AJIC 2015.43:141-146

- Method: Improved hydrogen peroxide disposable wipe was used once per day for all high-touch surfaces to replace cleaner

- Result: When cleaning compliance was $\geq 80\%$, there was a significant reduction in cases/10,000 patient days for MRSA, VRE and C. difficile

- Conclusion: Daily use of disinfectant applied to environmental surfaces with a 80% compliance was superior to a cleaner because it resulted in significantly reduced rates of HAIs caused by C. difficile, MRSA, VRE
It appears that not only is disinfectant use important but how often is important

Daily disinfection vs clean when soiled
Daily disinfection of high-touch surfaces (vs cleaned when soiled) with sporicidal disinfectant (PA) in rooms of patients with CDI and MRSA reduced acquisition of pathogens on hands after contact with surfaces and of hands caring for the patient. Daily disinfection less hand contamination.
MICROBIAL BURDEN ON ROOM SURFACES AS A FUNCTION OF FREQUENCY OF TOUCHING

<table>
<thead>
<tr>
<th>Surface</th>
<th>Prior to Cleaning</th>
<th>Post Cleaning (mean)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean CFU/RODAC (95% CI)</td>
<td>Mean CFU/RODAC (95% CI)</td>
</tr>
<tr>
<td>High</td>
<td>71.9 (46.5-97.3)</td>
<td>9.6</td>
</tr>
<tr>
<td>Medium</td>
<td>44.2 (28.1-60.2)</td>
<td>9.3</td>
</tr>
<tr>
<td>Low</td>
<td>56.7 (34.2-79.2)</td>
<td>5.7</td>
</tr>
</tbody>
</table>

- The level of microbial contamination of room surfaces is similar regardless of how often they are touched both before and after cleaning.
- Therefore, all surfaces that are touched must be cleaned and disinfected.
ALL “TOUCHABLE” (HAND CONTACT) SURFACES SHOULD BE WIPED WITH DISINFECTANT

“High touch” objects only recently defined (no significant differences in microbial contamination of different surfaces) and “high risk” objects not epidemiologically defined. Cleaning and disinfecting is one-step with disinfectant-detergent. No pre-cleaning necessary unless spill or gross contamination.
Effective disinfection of contaminated surfaces is essential to prevent transmission of epidemiologically-important pathogens.

Efforts to improve disinfection focuses on touched surfaces.

Although floors contaminated, limited attention because not frequently touched.

Floors are a potential source of transmission because often contacted by objects that are then touched by hands (e.g., shoes, socks).

Non-slip socks contaminated with MRSA, VRE (Mahida, J Hosp Infect. 2016;94:273)
Recovery of Nonpathogenic Viruses from Surfaces and Patients on Days 1, 2, and 3 After Inoculation of Floor Near Bed
Koganti et al. ICHE 2016. 37:1374

<table>
<thead>
<tr>
<th>Variable</th>
<th>Day 1 (% Positive)</th>
<th>Day 2 (% Positive)</th>
<th>Day 3 (% Positive)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Hands</td>
<td>40</td>
<td>63</td>
<td>43</td>
</tr>
<tr>
<td>Patient Footwear</td>
<td>100</td>
<td>100</td>
<td>86</td>
</tr>
<tr>
<td>High-touch surface &lt;3ft</td>
<td>58</td>
<td>62</td>
<td>77</td>
</tr>
<tr>
<td>High-touch surface &gt;3ft</td>
<td>40</td>
<td>68</td>
<td>34</td>
</tr>
<tr>
<td>Personal items</td>
<td>50</td>
<td>44</td>
<td>50</td>
</tr>
<tr>
<td>Adjacent room floor</td>
<td>NA</td>
<td>100</td>
<td>80</td>
</tr>
<tr>
<td>Adjacent room environment</td>
<td>NA</td>
<td>40</td>
<td>11</td>
</tr>
<tr>
<td>Nursing station</td>
<td>53</td>
<td>47</td>
<td>63</td>
</tr>
<tr>
<td>Portable equipment</td>
<td>33</td>
<td>23</td>
<td>100</td>
</tr>
</tbody>
</table>

Surfaces <3ft included bedrail, call button, telephone, tray table, etc; surfaces >3ft included side table, chair, IV pole, etc; personal-cell phones, books, clothing, wheelchairs; nurses station included computer keyboard, mouse, etc
Found that a nonpathogenic virus inoculated onto floors in hospital rooms disseminated rapidly to the footwear and hands of patients and to high-touch surfaces in the room

The virus was also frequently found on high-touch surfaces in adjacent rooms and nursing stations

Contamination in adjacent rooms in the nursing station suggest HCP contributed to dissemination after acquiring the virus during contact with surfaces or patients

Studies needed to determine if floors are source of transmission
Evaluation of Hospital Floors as a Potential Source of Pathogen Dissemination
Deshpande et al. AJIC 2017. 45:336.

- 318 floors sites sampled in 159 rooms
- *C. difficile* most frequently isolated
- MRSA and VRE isolated more frequently from CDI rooms
- 41% (100) had objects (personal-clothing, phone chargers; medical-BP cuff, call button) in contact with floor
- Of 31 objects on floor, 18% MRSA, 6% VRE, 3% Cd bare/glove cultures positive
- Demonstrates potential for indirect transfer of pathogens to hands from fomites on floor
Disinfection of Noncritical Surfaces Bundle

- Develop policies and procedures
  - Standardize C/D patient rooms and pieces of equipment throughout the hospital
  - All touchable hand contact surfaces wiped with disinfection daily, when spills occur and when the surfaces are visibly soiled.
  - All noncritical medical devices should be disinfected daily and when soiled
  - Clean and disinfectant sink and toilet
  - Damp mop floor with disinfectant-detergent
  - If disinfectant prepared on-site, document correct concentration
  - Address treatment time/contact time for wipes and liquid disinfectants (e.g., treatment time for wipes is the kill time and includes a wet time via wiping as well as the undisturbed time).
Disinfection of Noncritical Surfaces Bundle

NL Havill AJIC 2013;41:S26-30

- Develop policies and procedures
- Select cleaning and disinfecting products
- Educate staff to environmental services and nursing
- Monitor compliance (thoroughness of cleaning, product use) and feedback
- Implement “no touch” room decontamination technology and monitor compliance
Effective Surface Decontamination

Product and Practice = Perfection
# LOW-LEVEL DISINFECTION FOR NONCRITICAL EQUIPMENT AND SURFACES


<table>
<thead>
<tr>
<th>Germicide</th>
<th>Use Concentration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethyl or isopropyl alcohol</td>
<td>70-90%</td>
</tr>
<tr>
<td>Chlorine</td>
<td>100ppm (1:500 dilution)</td>
</tr>
<tr>
<td>Phenolic</td>
<td>UD</td>
</tr>
<tr>
<td>Iodophor</td>
<td>UD</td>
</tr>
<tr>
<td>Quaternary ammonium (QUAT)</td>
<td>UD</td>
</tr>
<tr>
<td>QUAT with alcohol</td>
<td>RTU</td>
</tr>
<tr>
<td>Improved hydrogen peroxide (HP)</td>
<td>0.5%, 1.4%</td>
</tr>
<tr>
<td>PA with HP, 4% HP, chlorine (C. difficile)</td>
<td>UD</td>
</tr>
</tbody>
</table>

UD=Manufacturer’s recommended use dilution; others in development/testing-electrolyzed water; polymeric guanidine; cold-air atmospheric pressure plasma (Boyce Antimicrob Res IC 2016. 5:10)
PROPERTIES OF AN IDEAL DISINFECTANT

- Broad spectrum-wide antimicrobial spectrum
- Fast acting—should produce a rapid kill
- Remains Wet—meet listed kill/contact times with a single application
- Not affected by environmental factors—active in the presence of organic matter
- Nontoxic—not irritating to user
- Surface compatibility—should not corrode instruments and metallic surfaces
- Persistence—should have sustained antimicrobial activity
- Easy to use
- Acceptable odor
- Economical—cost should not be prohibitively high
- Soluble (in water) and stable (in concentrate and use dilution)
- Cleaner (good cleaning properties) and nonflammable
Microbiological Disinfectant Hierarchy
Rutala WA, Weber DJ, HICPAC. www.cdc.gov

Most Resistant

Spores (C. difficile)
Mycobacteria (M. tuberculosis)
Non-Enveloped Viruses (norovirus, HAV, polio) LLD
Fungi (Candida, Trichophyton)
Bacteria (MRSA, VRE, Acinetobacter)

Enveloped Viruses (HIV, HSV, Flu)

Most Susceptible
MOST PREVALENT PATHOGENS CAUSING HAI


- Most prevent pathogens causing HAI (easy to kill)
  - *E. coli* (15.4%)
  - *S. aureus* (11.8%)
  - *Klebsiella* (7.7%)
  - Coag neg Staph (7.7%)
  - *E. faecalis* (7.4%)
  - *P. aeruginosa* (7.3%)
  - *C. albicans* (6.7%)
  - *Enterobacter* sp. (4.2%)
  - *E. faecium* (3.7%)
  - *C. difficile* (now common)

- Common causes of outbreaks and ward closures (relatively hard to kill)
  - *C. difficile* spores
  - Norovirus
  - Rotavirus
  - Adenovirus
Disinfection of Noncritical Surfaces Bundle

NL Havill AJIC 2013;41:S26-30

- Develop policies and procedures
- Select cleaning and disinfecting products
- Educate staff to environmental services and nursing
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- Implement “no touch” room decontamination technology and monitor compliance
### EFFECTIVENESS OF DISINFECTANTS AGAINST MRSA AND VRE


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#### TABLE 2
**Disinfectant Activity Against Antibiotic-Susceptible and Antibiotic-Resistant Bacteria**

<table>
<thead>
<tr>
<th>Product</th>
<th>0.5 min</th>
<th>5 min</th>
<th>0.5 min</th>
<th>5 min</th>
<th>0.5 min</th>
<th>5 min</th>
<th>0.5 min</th>
<th>5 min</th>
</tr>
</thead>
<tbody>
<tr>
<td>VSE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vesphene IIse</td>
<td>&gt;4.3</td>
<td>&gt;4.3</td>
<td>&gt;4.8</td>
<td>&gt;4.8</td>
<td>&gt;5.1</td>
<td>&gt;5.1</td>
<td>&gt;4.6</td>
<td>&gt;4.6</td>
</tr>
<tr>
<td>Clorox</td>
<td>&gt;5.4</td>
<td>&gt;5.4</td>
<td>&gt;4.9</td>
<td>&gt;4.9</td>
<td>&gt;5.0</td>
<td>&gt;5.0</td>
<td>&gt;4.6</td>
<td>&gt;4.6</td>
</tr>
<tr>
<td>Lysol Disinfectant</td>
<td>&gt;4.3</td>
<td>&gt;4.3</td>
<td>&gt;4.8</td>
<td>&gt;4.8</td>
<td>&gt;5.1</td>
<td>&gt;5.1</td>
<td>&gt;4.6</td>
<td>&gt;4.6</td>
</tr>
<tr>
<td>Lysol Antibacterial</td>
<td>&gt;5.5</td>
<td>&gt;5.5</td>
<td>&gt;5.5</td>
<td>&gt;5.5</td>
<td>&gt;5.1</td>
<td>&gt;5.1</td>
<td>&gt;4.6</td>
<td>&gt;4.6</td>
</tr>
<tr>
<td>Vinegar</td>
<td>0.1</td>
<td>5.3</td>
<td>1.0</td>
<td>3.7</td>
<td>+1.1</td>
<td>+0.9</td>
<td>+0.6</td>
<td>2.3</td>
</tr>
</tbody>
</table>

**Log_{10} Reductions**

**Abbreviations:** MRSA, methicillin-resistant *Staphylococcus aureus*; MSSA, methicillin-susceptible *S. aureus*; VRE, vancomycin-resistant *Enterococcus*; VSE, vancomycin-susceptible *Enterococcus*.

Data represent mean of two trials (n=2). Values preceded by “>” represent the limit of detection of the assay. Assays were conducted at a temperature of 20°C and a relative humidity of 45%. Results were calculated as the log of Nd/No, where Nd is the titer of bacteria surviving after exposure and No is the titer of the control.
Bactericidal (S. aureus) Efficacy of EPA-Registered Towelettes
West, Teska, Oliver, AJIC, 2018

- Drying time curve based on surface wetness; bold-contact time (180s); dashed-dry (~260s)
- Wet time is not crucial for complete disinfection (wet or dry ~4.5 log_{10} reduction); 30s for log_{10} reduction
# Risk Assessment Worksheet

## Justifies to TJC/CMS Off-Label Use for Surface Disinfection

[www.disinfectionandsterilization.org](http://www.disinfectionandsterilization.org)

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### Risk-Assessment Worksheet

**Issue:** Off-label use for undisturbed time after environmental disinfection

**Assessment Date:** March 5, 2018

**Scoring:**
- Low = 1
- Moderate = 3
- High = 5

**Team Members:**

**Meeting Actions:** Team members evaluated the evidence and determined that off-label use of undisturbed time was sufficient to disinfect noncritical environmental surfaces and noncritical patient care equipment in a healthcare environment.

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<table>
<thead>
<tr>
<th>Suggested Questions</th>
<th>Benefit</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the truth about disinfectant contact time?</td>
<td>Most manufacturers suggest the user maintain wetness for the duration of the contact time. The method used to assess efficacy of disinfectant wipes by the EPA is the Disinfectant Towelette Test. The procedure involves using one towelette to wipe ten carriers/slides. The area of the towelette used for wiping is folded and rotated so as to expose a new surface of the towelette for each carrier. To generate test cultures, carriers are inoculated using pathogens <em>Staphylococcus aureus, Pseudomonas aeruginosa, and Salmonella enteric</em>. The test procedure involves wiping the slide back and forth for a total of six passes across the inocula for ±5 seconds of</td>
<td>There is no risk to utilizing a treatment time instead of a wet time for the given contact time of a disinfectant. Score = 1</td>
</tr>
</tbody>
</table>
Disinfection of Noncritical Surfaces Bundle

- Develop policies and procedures
  - Standardize C/D patient rooms and pieces of equipment throughout the hospital
  - All touchable hand contact surfaces wiped with disinfection daily, when spills occur and when the surfaces are visibly soiled.
  - All noncritical medical devices should be disinfected daily and when soiled
  - Clean and disinfectant sink and toilet
  - Damp mop floor with disinfectant-detergent
  - If disinfectant prepared on-site, document correct concentration
  - Address treatment time/contact time for wipes and liquid disinfectants (e.g., treatment time for wipes is the kill time and includes a wet time via wiping as well as the undisturbed time).
Effective Surface Decontamination

Product and Practice = Perfection
Disinfection of Noncritical Surfaces Bundle

- Develop policies and procedures
  - Environmental cleaning and disinfection is an integral part of preventing transmission of pathogens
  - In addition to identifying products and procedures, ensure standardization of cleaning throughout the hospital
    - Some units utilize ES to clean pieces of equipment (e.g., vital sign machines, IV pumps); some units use patient equipment, and some units utilize nursing staff.
    - Multidisciplinary group to create a standardized plan for cleaning patient rooms and pieces of patient equipment throughout the hospital
Disinfection of Noncritical Surfaces Bundle

- Develop policies and procedures
- Select cleaning and disinfecting products
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- Monitor compliance (thoroughness of cleaning, product use) and feedback
- Implement “no touch” room decontamination technology and monitor compliance
Thoroughness of Environmental Cleaning
Carling et al. ECCMID, Milan, Italy, May 2011

Mean = 32%

>110,000 Objects

14 Sites 16 Sites 7 Sites 7 Sites 4 Sites 4 Sites 9 Sites 4 Sites
HEHS G HOSP OTHER HOSP OPERATING ROOMS NICU EMS VEHICLES ICU DAILY AMB CHEMO MD CLINIC LONG TERM DIALYSIS

= 95% CI
MONITORING THE EFFECTIVENESS OF CLEANING
Cooper et al. AJIC 2007;35:338

- Visual assessment-not a reliable indicator of surface cleanliness
- ATP bioluminescence-measures organic debris (each unit has own reading scale, <250-500 RLU)
- Microbiological methods-<2.5CFUs/cm²-pass; can be costly and pathogen specific
- Fluorescent marker-transparent, easily cleaned, environmentally stable marking solution that fluoresces when exposed to an ultraviolet light (applied by IP unbeknown to EVS, after EVS cleaning, markings are reassessed)
Thoroughness of Environmental Cleaning

Hospitals can improve their thoroughness of terminal room disinfection through fluorescent monitoring.

**Figure 4.** A comparison of the results of the 3 previously published multisite studies compared with results from the Iowa project. White bars represent the average baseline TDCs and black bars represent the average final TDCs for sites that completed each study.
Disinfection of Noncritical Surfaces Bundle

NL Havill AJIC 2013;41:S26-30

- Develop policies and procedures
- Select cleaning and disinfecting products
- Educate staff to environmental services and nursing
- Monitor compliance (thoroughness of cleaning, product use) and feedback
- Implement “no touch” room decontamination technology and monitor compliance
These interventions (effective surface disinfection, thoroughness indicators) not enough to achieve consistent and high rates of cleaning/disinfection

No Touch
(supplements but do not replace surface cleaning/disinfection)
“NO TOUCH” APPROACHES TO ROOM DECONTAMINATION
(UV/VHP~20 microbicidal studies, 12 HAI reduction studies; will not discuss technology with limited data)
Enhanced Disinfection Leading to Reduction of Microbial Contamination and a Decrease in Patient Col/Infection


All enhanced disinfection technologies were significantly superior to Quat alone in reducing EIPs. Comparing the best strategy with the worst strategy (i.e., Quat vs Quat/UV) revealed that a reduction of 94% in EIP (60.8 vs 3.4) led to a 35% decrease in colonization/infection (2.3% vs 1.5%). Our data demonstrated that a decrease in room contamination was associated with a decrease in patient colonization/infection. First study which quantitatively described the entire pathway whereby improved disinfection decreases microbial contamination which in-turn reduced patient colonization/infection.
This technology ("no touch"-microbicidal and ideally, HAI reduction per peer-reviewed literature) should be used (capital equipment budget) for terminal room disinfection (e.g., after discharge of patients on Contact Precautions).
Disinfection of Noncritical Surfaces Bundle
NL Havill AJIC 2013;41:S26-30

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- Educate staff to environmental services and nursing
- Monitor compliance (thoroughness of cleaning, product use) and feedback
- Implement “no touch” room decontamination technology and monitor compliance
How Will We Prevent Infections Associated with the Environment?

- Implement evidence-based practices for surface disinfection
  - Evidence-based policies
  - Ensure use of safe and effective (against emerging pathogens such as *C. auris* and CRE) low-level disinfectants
  - Ensure thoroughness of cleaning (new thoroughness technology)
- Use “no touch” room decontamination technology proven to reduce microbial contamination on surfaces and reduction of HAIs at terminal/discharge cleaning
- Use new continuous room decontamination technology that continuously reduces microbial contamination
LECTURE OBJECTIVES

- Review the CDC Guideline for Disinfection and Sterilization: Focus on role of environmental surfaces
- Review “best” practices for environmental cleaning and disinfection
- Review the use of low-level disinfectants and the activity of disinfectants on key hospital pathogens
- Review medical waste management
Medical Waste Problem

- Perceived threat of AIDS via medical waste
- Beach wash-ups of “medical waste”
- Overly restrictive medical waste rules and increase in volume of regulated medical waste
- Options for medical waste treatment and disposal diminishing
Definitions

Hospital waste (solid waste) refers to all waste (biological or nonbiological) which are discarded and not intended for further use (e.g., administrative waste, dietary waste).

Medical waste refers to materials generated as a result of patient diagnosis, treatment, or immunization (e.g., soiled dressing, intravenous tubing).

Regulated medical waste (“infectious” waste) refers to that portion of medical waste which could transmit an infectious disease (e.g., microbiological waste, sharps).
## Total Hospital Waste Generated per Patient by Bed Size

Rutala, Odette, Samsa. JAMA. 1989; 262:1635-1640

<table>
<thead>
<tr>
<th>Hospital Beds</th>
<th>Nb/Bed/Day</th>
<th>N</th>
<th>Total</th>
<th>Nb/Patient/Day</th>
<th>N</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;100</td>
<td></td>
<td>90</td>
<td>5.72</td>
<td></td>
<td>69</td>
<td>11.30</td>
</tr>
<tr>
<td>100-299</td>
<td></td>
<td>108</td>
<td>10.36</td>
<td></td>
<td>84</td>
<td>15.79</td>
</tr>
<tr>
<td>300-499</td>
<td></td>
<td>40</td>
<td>12.51</td>
<td></td>
<td>32</td>
<td>18.47</td>
</tr>
<tr>
<td>&gt;500</td>
<td></td>
<td>27</td>
<td>12.86</td>
<td></td>
<td>23</td>
<td>16.95</td>
</tr>
<tr>
<td>Combined</td>
<td></td>
<td>265</td>
<td>9.21</td>
<td></td>
<td>208</td>
<td>15.28</td>
</tr>
</tbody>
</table>
Regulated Medical Waste

The CDC, EPA, and states define medical waste as regulated ("infectious")

When it is suspected to contain potentially hazardous levels of microorganisms
Factors Necessary for Induction of Disease

- Dose
- Resistance of host
- Portal of entry
- Presence of a pathogen
- Virulence
Medical Waste
Plausible Transmission Routes

• Virtually nonexistent - respiratory, urinary or gastrointestinal tract or mucous membrane of the mouth, eyes, nose.
• Why? Waste must contain pathogens -> person must come in direct contact -> inject, ingest, or injury must follow the contact thereby creating portal of entry -> an infectious dose must enter susceptible host via portal of entry -> agent causes infection.
• Rare - "Sharps" have an intrinsic capability to disrupt the skin's integrity and introduce infectious agents.
Epidemiologic Evidence

• Only medical waste associated with infectious disease transmission is contaminated sharps.
• All reports of transmission of infectious agents by sharps occurred in health care setting.
• No evidence that a member of the public or a waste industry worker has ever acquired infection from medical waste (one exception).
• No infectious risks associated with any type of medical waste treatment method to include sanitary landfill disposal.
Microbiologic Quality

- Household waste contains on average 100x more microorganisms with pathogenic potential for humans than medical waste.
- Common nosocomial pathogens (i.e. *P. aeruginosa*, *Klebsiella* spp, *Enterobacter* spp, *Proteus* spp) were detected more frequently from household waste than from hospital waste.
Regulated Medical Waste

The CDC, EPA, and states define medical waste as regulated ("infectious")

When it is suspected to contain potentially hazardous levels of microorganisms
Medical Waste Regulations

- State - designation, transportation, storage and treatment
- Federal (OSHA) - education, labeling, use of PPE
# Types of Solid Waste Designated as Infectious and Recommended Disposal Methods


<table>
<thead>
<tr>
<th>Source/Type</th>
<th>Infectious Waste</th>
<th>Disposal Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Microbiological</td>
<td>Yes</td>
<td>S,I</td>
</tr>
<tr>
<td>Blood and blood products</td>
<td>Yes</td>
<td>S,I, Sew</td>
</tr>
<tr>
<td>Pathological</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Sharps (especially needles)</td>
<td>Yes</td>
<td>S,I</td>
</tr>
<tr>
<td>Contaminated animal carcasses (carcasses)</td>
<td>Yes</td>
<td>S,I</td>
</tr>
<tr>
<td>Isolation</td>
<td>No</td>
<td>---</td>
</tr>
<tr>
<td>Other (surgical waste, dialysis,</td>
<td></td>
<td>---</td>
</tr>
<tr>
<td>contaminated lab waste)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abbreviations: S-steam; I-incineration; Sew-s sanitary sewer.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
North Carolina Medical Waste Rules

Regulated Medical Waste Definitions

Microbiological - cultures and stocks of infectious agents

Pathological - human tissues, organs and body parts; carcasses and body parts of animals exposed to pathogens

Blood - liquid blood, serum, plasma, other blood products, emulsified human tissue, spinal fluids, and pleural and peritoneal fluids; in individual containers in volumes greater than 20 ml (bloody gauze, used gloves, tubing and dressings are not regulated medical waste).
Regulated Waste: OSHA

- Contaminated sharps
- Pathological and microbiological wastes containing blood or OPIM
- Liquid or semi-liquid blood or OPIM
- Contaminated items that would release blood or OPIM in a liquid or semi-liquid state if compressed
- Items caked with dried blood or OPIM that are capable of releasing these materials during handling
Regulated Waste: OSHA

Can OSHA and states adopt uniform definitions of RMW?

- OSHA rules and state rules address two different concerns
- OSHA rule addresses waste management in the workplace to ensure worker safety
- State waste management rules ensure storage, shipping, and treatment/disposal practices that protect the environment and public health
Segregation of Medical Waste by US Hospitals

95% segregate regulated medical waste from non-regulated medical waste

96% use labeled or color-coded bags
Collection and Containment of US Hospital Waste

Collection

Housekeeping (82%), maintenance (4%)
or both (7%) transfer wastes to on-site
storage or processing site (at least daily) 92%

Container

Leakproof wastebaskets 95%
Plastic bags as wastebasket liners 99%
## Transporting Waste Within US Hospitals

<table>
<thead>
<tr>
<th>Method</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transfer Carts - used to transport waste within the hospital</td>
<td>95%</td>
</tr>
<tr>
<td>Gravity Chutes - allows for vertical transfer</td>
<td>13%</td>
</tr>
<tr>
<td>Pneumatic chutes - vacuum source to propel wastes</td>
<td>2%</td>
</tr>
</tbody>
</table>
Storage

- No single requirement for storage of infectious waste in terms of time and temperature but most states do have regulations.

- NC - if not shipped within seven days of generation, medical waste must be refrigerated.
Compaction

- **Advantages**
  - Decreases the volume of waste 4-5 times
  - Decreases size of storage facilities
  - Decreases cost of transporting waste

- **Disadvantage**
  - May interfere with the effectiveness of certain treatment processes
Medical Waste Management: Environmentally Responsible Healthcare

- Treatment of regulated medical waste (RMW)
  - Properly define RMW
  - Rational definition could save millions in treatment costs
  - Reduce waste now treated as RMW (e.g., incineration)
    - Know what happens to facility’s wastes and how treated
    - Locate “red bags” strategically to capture RMW
  - Encourage segregation of properly defined RMW
### Treatment of Medical Waste by US Hospitals


<table>
<thead>
<tr>
<th>Waste Category</th>
<th>Infectious (%)</th>
<th>Treatment/Disposal Methods (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Microbiological</td>
<td>99</td>
<td>1</td>
</tr>
<tr>
<td>Human blood</td>
<td>94</td>
<td>6</td>
</tr>
<tr>
<td>Pathological</td>
<td>96</td>
<td>4</td>
</tr>
<tr>
<td>Isolation</td>
<td>94</td>
<td>6</td>
</tr>
<tr>
<td>Sharps</td>
<td>99</td>
<td>1</td>
</tr>
</tbody>
</table>
Incineration

Ash Residue: Controlled-air incinerators produce a sterile ash

Air Emissions: No difference between bacteria in stack emissions and ambient air. Chemicals (CO, metals, acid gases, dioxins, furans) emitted from hospital or municipal incinerators.
EPA’s Proposed Incineration Emission Limits

- New set of medical waste incineration regulations
- Regulates Hosp/Med/Inf Waste Incinerators
- Mandated by the Clean Air Act Amendments of 1990
- Regulations substantially reduced emissions (dioxins, CO, Pb, Hg)
- EPA estimates regulations would close 50-80% of existing medical waste incinerators.
North Carolina Medical Waste Rules

Steam Sterilization

- 250°F for 45 min or other effective combination.
- Unit should have time-temperature recorder and pressure gauge.
- Biological monitoring at least weekly; log maintained and shall include type of indicator used, date, time and result of test.
Sanitary Landfill

- Untreated medical waste could be discarded in sanitary landfills provided workers do not have contact.
- Studies demonstrate:
  - Bacteria and viruses are reduced by thermal inactivation, antimicrobial characteristics of leachate and absorption to organic material.
  - Household waste is more microbially contaminated and it is discarded in sanitary landfills.
- Unavailable, reaching capacity, or restricted to untreated medical waste.
North Carolina Medical Waste Rules

Regulated Medical Waste Definitions

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“Needles should not be recapped, purposely bent or broken by hand, removed from disposal syringes, or otherwise manipulated by hand. After they are used, disposable syringes and needles, scalpel blades, and other sharp items should be placed in puncture-resistant containers for disposal; the puncture-resistant containers should be located as close as practical to the use area.”

Centers for Disease Control, MMWR August 21, 1987
Suctioned Fluids Disposal Treatment

Sanitary sewer - suctioned fluids may be carefully poured down a drain connected to a sanitary sewer (CDC, 1985)

Incineration - suction canister may be tightly capped, bagged (coded) and incinerated.

Sanitary landfill - suction canister fluid may be treated with liquid treatment system and sent to sanitary landfill (2/3 states)

Sanitary landfill - suction canisters may be tightly capped, bagged and sent to a sanitary landfill (a few states).
Medical Waste Management: Treatment

- Goal of treatment is to reduce microbial load
- Changes that impact treatment of RMW
  - Incineration (new emission standards)
  - Alternative treatment technologies
    - Some states allow alternatives, other states not
  - Autoclave
Medical Waste Regulations

- State - designation, transportation, storage and treatment
- Federal (OSHA) - education, labeling, use of PPE
North Carolina Medical Waste Rules

- **Definition** - “sharps” means and includes needles, syringes with attached needles, capillary tubes, slides, cover slips and scalpel blades.
- **Requirement** - sharps will be placed in a container which is rigid, leakproof when in an upright position and puncture-resistant. Contained sharps shall not be compacted prior to off-site transportation.
- **Treatment** - none required. The package may be disposed with general solid waste.
North Carolina Medical Waste Rules

Regulated Medical Waste Treatment*

Microbiological - incineration, steam sterilization or chemical treatment

Pathological - incineration

Blood and body fluids in individual containers in volumes greater than 20 ml - incineration or sanitary sewage systems, provided the sewage treatment authority is notified.

*Other methods of treatment shall require approval by the Division of Solid Waste Management
Medical Waste Minimization

Recycling/Reuse/Reduction

- Corrugated boxes and paper products
- Aluminum, glass, and plastic from defined areas
- Recovery/redistillation of laboratory solvents (e.g., alcohol, xylene, toluene)
- Source reduction-replace single use items with reusable items
Infectious Risks Associated with Recycling Hospital Waste

- No infectious risks associated with recycling hospital waste
- Presently, recycling efforts have generally focused on nonpatient contact sources of waste such as glass, scrap metal, aluminum cans, cardboard and packaging material
- From an infectious disease perspective, only a few items generated in the health-care setting are not likely candidates for recycling (e.g. sharps)
Waste Management:
How to be Friendly to the Environment

- Recycling in healthcare
  - Internal forces: employee requests, environment, public image, proactive posture
  - External forces: state/national solid waste laws, local government regulations, air quality regulations
  - Example: NC
    - 1989-GS established recycling goal of 25% by 1993
    - 1991-Amended to waste reduction and 40% by 2001
    - 1995-Amended so County government selects own goal
    - Orange county selected a reduction goal of 45%
LECTURE OBJECTIVES

- Review the CDC Guideline for Disinfection and Sterilization: Focus on role of environmental surfaces
- Review “best” practices for environmental cleaning and disinfection
- Review the use of low-level disinfectants and the activity of disinfectants on key hospital pathogens
- Review medical waste management
The contaminated surface environment in hospital rooms is important in the transmission of healthcare-associated pathogens (MRSA, VRE, *C. difficile*, *Acinetobacter*).

Disinfection of noncritical environmental surfaces/equipment is an essential component of Infection prevention.

Disinfection should render surfaces and equipment free of pathogens in sufficient numbers to cause human disease. Follow CDC D/S guideline.

When determining the optimal disinfecting product, consider the 5 components (kill claims/time, safety, ease of use, others).

Comply with federal (OSHA) and state medical waste regulations.
THANK YOU!
www.disinfectionandsterilization.org