# CAEM November 29, 2019 Webinar Questions/Answers

1. **A Aucoin: has there been a standard set for cleaning cloths**

8.2.8

Disposable wipes/cloths should be of adequate size for the intended use and provide sufficient fluid transfer onto surfaces wiped to meet the MIFU contact time label claims.

**Note**: *Cleaning cloths can come in many forms. Cotton based cloths and some microfiber cloths can lead to binding issues if used with Quaternary ammonium compounds – 'quat binding', where the active ingredient of the cleaning agent or disinfectant is bound to the cloth. Microfiber cloths are used by many HCFs for their cleaning ability but these cloths might not work well if dry, too wet, or if MIFU are not followed.*

2. **Tanya: while reviewing standard 9.2 you mentioned that spray cleanser and disinfectants have plus and minuses. Can you please help us understand what those are?**

Spray type chemicals create aerosols into the air which can float for 1 -2 hours and travel in air currents to other parts of the room or to other rooms. The concern is that for both EVS staff or patients over time will breathe these chemicals in and there may be an occupational health hazard over prolonged exposure

https://www.ccohs.ca/oshanswers/chemicals/how_chem.html

3. **David Green: Specifically, is there any changes with these new standards for use of trigger spray bottles for either cleaning or disinfectant? reasons why or why not.**

8.6.1.2

Chemical disinfectants shall be applied on surfaces only after visible soil has been removed. Items shall not be considered disinfected if soiling is visible on any part of the surface.

The MDT shall determine which surfaces, if any, are excluded from regular disinfection.

Spraying chemicals onto surfaces in occupied rooms shall not be permitted.

13.4.6.4

Cleaning chemicals shall not be applied by aerosol or trigger sprays.

Also see rational in item #1

4. **Melissa Paquet: when it states that items purchased need to be able to withstand hospital grade disinfectants, should this require an additional water rinse after disinfection to avoid deterioration or should items stand up to the disinfection without an additional water rinse?**

Chemical disinfectants shall be used in accordance with the MIFU. This shall include

a) adherence to preparation instructions and dilution (if applicable);

b) using chemical test strips to confirm concentration;

c) following the contact time for exposure of the surface to the disinfectant and to ensure surfaces remain wet;

**d) rinsing (if applicable);**

e) adherence to required PPE;

f) the type of surfaces on which the product may be applied (e.g., floors, walls, countertops);

g) the mode of application for the product (e.g. wipe, cloth or sponge);

h) pre-cleaning instructions for heavily soiled hard surfaces as indicated; and

i) chemical disinfectant label statements including

   i) warning statements;

   ii) precautionary statements when applicable and appropriate for the potential hazard of the product;

   iii) storage instructions; and

   iv) disposal instructions.

Notes:

1) *Chemical disinfectant solutions are used to reduce the risk of their transmission from certain surfaces/objects., such as C. difficile, multi-drug resistant organisms, Norovirus or other organisms as identified by Infection Control).*

2) *Chemical disinfectants can, in principle, inactivate pathogens further than cleaning with detergents alone. Their efficacy however is dependent on several variables (concentration, dilution water quality, contact time with surfaces, types of surfaces, the types of bacteria, viruses or mould to be reduced; type of equipment used with the disinfectant (e.g., type and age of cloths, mops – cotton/microfiber.).*

3) *Chemical disinfectants come with potential toxicity issues for humans and the environment thus care shall be taken in their selection and use.*

4) *HCFs or areas that cannot ensure safe use or disposal of large amounts of disinfectant solution, may choose detergent cleaning agents as appropriate in consultation with IPAC MDT.*

5) *Aerosols can affect the health and safety of patients, HCW and visitors. (see also Clause* **Error! Reference source not found.***).*

5. **Debbie Richarz: You mention the importance of embracing new technology but our IPAC physician has indicated that there remains limited validated research to support many of the claims currently being made; in his opinion a white paper does not meet the standard that he feels is necessary to validate these claims. your thoughts? He stands by the value of old fashioned elbow grease...**

Elbow grease is very good in a traditional way for the cleaning process as by definition in the standard

Cleaning: the physical removal of foreign material (e.g., dust, soil) and organic material (e.g., blood, secretions, excretions, micro-organisms). Cleaning physically removes rather than kills micro-organisms. It is accomplished with water, detergents and mechanical action.

But elbow grease does not have any positive outcome for the disinfection process

Disinfection

the inactivation of disease-producing micro-organisms to a level previously specified as being appropriate for a defined purpose. See ***One-step cleaning agent disinfectant.***

***Notes:***

1) Disinfectants are applied on the equipment or surface after the cleaning process has been properly completed.
2) *Disinfection does not destroy all bacterial spores.*
3) *Disinfection might not destroy high numbers of bacterial spores.*
4) *Disinfectants are used on inanimate objects. Disinfection usually involves chemicals, heat or ultraviolet light.*

Summary: EVS need to clean first and a little elebow grease or mechanical action is very good but cleaning is not safe for patients. Only proper disinfection with validated standard operating procedures, education and training for staff, key performance indicators and audits under the juridiction of the C&D MDT make is safe for patients

There is considerable evidence for engineered infection reduction technologies which one must search out and make decisions at the MDT based on scientific evidence. CSA provides a valuable evaluation tool at no cost:

EXPO6 Evaluating emerging materials and technologies for infection prevention and control

https://store.csagroup.org/ccrz__ProductDetails?viewState=DetailView&cartID=&portalUser=&store=&cclcl=en_US&sku=EXP06-2015

6. Debbie Richarz: When you talked about the requirement for a resident IPAC expert in technology were you suggesting that at the facility level or at the CSA level?

9.1.4

The IPAC MDT shall appoint an IPAC Technology Leader who is responsible for evaluating, recommending, and coordinating the implementation of the available cleaning and disinfection technologies. The IPAC Technology leader should

j) provide regular input to the IPAC MDT;

k) review and evaluate cleaning and disinfection technologies for potential implementation, including review of available peer-reviewed evidence of effectiveness and other considerations such as

   i) potential risks and adverse effects;

   ii) life-cycle;

   iii) ease of use;

   iv) environmental aspects;

   v) available resources;

   vi) local issues and context;

   vii) stakeholder perspectives (e.g. clinician's perspective and experience, patient's values and perspectives); and

   viii) monitoring and evaluation;

**Note**: The quality of the evidence for technology implementation efficacy is not the sole consideration when making recommendations