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Evidence-based Guidelines for Selected, Candidate, and Previously Considered Hospital-Acquired Conditions

Final Report

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FINAL REPORT

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EXECUTIVE SUMMARY

The Centers for Medicare and Medicaid Services (CMS) payment provisions for preventable hospital-acquired conditions (HAC) are one of many recent CMS “value-based purchasing” initiatives through which the Medicare program is striving to tie payment to performance. Through collaboration with the Centers for Disease Control and Prevention (CDC) and extensive public input, CMS identified 11 HACs as being reasonably preventable based on the application of published, evidence-based guidelines and thus targeted these HACs for program payment reductions. Selected HACs have to be conditions that are high volume and/or high cost, be identified in the CMS grouper as a complication or comorbidity (CC) or major complication or comorbidity (MCC) for purposes of MS-DRG assignment, and be reasonably preventable using evidence-based guidelines (73 FR 48471-48491). In addition to 11 preventable HACs, there are six “previously considered conditions” and two candidate conditions under agency and public review (75 FR 50042-50677; 77 FR 53257-53750).

The purpose of this report is to identify and characterize the contemporary evidence-based guidelines available for each of the selected and previously considered HACs that provide recommendations for the prevention of the corresponding condition in the acute hospital setting. Guidelines were primarily identified using the Agency for Healthcare Research and Quality (AHRQ) National Guidelines Clearinghouse (NGC) and the CDC, along with relevant professional societies. Guidelines published in the United States were used, if available. In the absence of U.S. guidelines for a specific condition, international guidelines were included.

Evidence-based guidelines that included specific recommendations for the prevention of the condition were identified in ten of the 11 selected conditions. In the absence of evidence based guidelines, systematic reviews with specific prevention recommendations were cited. There were no U.S. guidelines for prevention of blood incompatibility. In this instance, four international guidelines citing evidence and providing specific prevention recommendations were included.

There are two candidate conditions, contrast-induced acute kidney injury, and surgical site infection following hip and knee orthopedic procedures, for which evidenced-based guidelines were identified. Six previously considered conditions are also included in the report. Evidence-based guidelines with prevention recommendations were found for each of the six previously considered HACs. For methicillin resistant *Staphylococcus aureus* (MRSA), guidelines were also included that covered strategies in the community to detect and reduce the presence of MRSA in the population served, since MRSA is commonly brought into the hospital by asymptomatic carriers. Thus, community detection and control is an important additional strategy for transmission prevention in the hospital.

Only the CDC CAUTI 2009 guidelines for urinary catheter-related infection provide estimates of the effectiveness of the recommended in actions in preventing the condition of interest. Unlike prior editions of the ICSI Health Care Protocol: Perioperative protocol, the 5th edition of these guidelines (2014) does not provide estimates of the effectiveness of the recommended in actions in preventing surgical site infections following select procedures.

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SECTION 1 INTRODUCTION

1.1 Brief Background on Hospital-Acquired Conditions (HACs) and the Importance of Obtaining the Evidence-Based Guidelines Regarding Prevention of these Conditions

The Centers for Medicare and Medicaid Services' (CMS') payment provisions for preventable hospital-acquired conditions (HACs) are one of many recent CMS "value-based purchasing" initiatives through which the Medicare program is striving to tie payment to performance. Through collaboration with the Centers for Disease Control and Prevention (CDC) and extensive public input, CMS identified 11 HACs as being reasonably preventable based on the application of published, evidence-based guidelines, and thus targeted these HACs for program payment reductions. Selected HACs must be conditions that are high volume and/or high cost, be identified in the CMS grouper as a complicating (CC) or major complicating (MCC) conditions for purposes of MS-DRG assignment, and be reasonably preventable using evidence-based guidelines (73 FR 48471-48491). In addition to 11 selected HACs, there are 6 "previously considered conditions" under agency and public review (75 FR 50042-50677) and 2 "candidate conditions" recently proposed in the CMS FY2014 and CMS FY2015 Proposed Rules.

This report represents a summary of evidence-based guidelines that can be used as a basis for hospital care that will reasonably be expected to prevent these specific HACs. Thus, this evidence-based guideline information is an essential component of the selection of conditions and the maintenance of the payment decisions for HACs.

1.2 Organization of the Report

In the following sections of this report, we present our methodological approach to identifying the HAC-related evidence-based guidelines (Section 2), the results of our review of those guidelines (Section 3), and a summary of the findings (Section 4 and [Tables 1, 2, and 3](#)). Note that, for clarity, the guidelines are referenced in the text according to the guideline developer. Tables in the appendices include identification of the guideline developer as well as commentary on the evidence level and identification of appropriate actions for HAC prevention.

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SECTION 2 METHODS

2.1 Approach Used to Identify the Appropriate Guidelines

Our search for evidence-based guidelines was based on specific inclusion and exclusion criteria. In order to be included in this report, guidelines must:

- focus on clinical recommendations for primary or secondary prevention of the specific condition of interest
- have been developed in the United States. International guidelines were accepted if no appropriate U.S. guidelines were located.

Guidelines were excluded if they had been withdrawn by guideline developers or were developed outside the US, except in the case listed above. In this report, guidelines archived by the NGC but still listed as current on the developers website have been included if no other US guideline with updated information could be identified. Relevant systematic reviews that meet the above criteria are included only when evidence based guidelines could not be identified. Documents that have a primary purpose other than provision of clinical guidance for HAC prevention (e.g., training manuals or presentations) are not considered guidelines. Please refer to Section 2.2 for further definition of “evidence-based guideline” as used in this report.

2.1.1 Search of Guidelines.gov (<http://www.guidelines.gov/>)

We began our systematic approach by searching the National Guideline Clearinghouse (NGC) website for guidelines representing each of the HACs. Alternative terms were used if we did not find the appropriate guidelines after searching for the condition as it is listed in the Federal Register. For example, for blood incompatibility, we used the terms ABO compatibility, transfusion, transfusion reaction, and administration of blood products to identify relevant guidelines. As we reviewed one guideline and it referred to another, we would investigate that guideline as well.

2.1.2 Search of CDC.gov

We also searched the CDC website for guidelines representing each HAC. The CDC did not have guidelines for foreign objects retained after surgery, pressure ulcers Stage III and IV, manifestations of poor glycemic control, deep vein thrombosis and pulmonary embolism, or other non-infection-related HACs. For this report, we included all relevant CDC guidelines, including those that have been archived by NGC but not withdrawn by CDC.

2.1.3 Search of Other Sources

In addition to the key sources listed above, we also searched the US Department of Veterans Affairs (VA/DOD) website, Medscape.com, and the Agency for Healthcare Research and Quality (AHRQ) website to locate HACs not found in the NGC. In each incident, we were referred back to the NGC. We also searched the Federal Register and used PubMed and employed a popular internet search engine to identify other guidelines as well as government and

professional clinical associations that may have relevant publications. For example, concerning the blood incompatibility HAC, we also searched the websites for the American Society of Transplantation, American Association of Blood Banks, and American Society of Clinical Pathology. For conditions with no available guidelines, we searched the Cochrane Database of Systematic Reviews in order to identify potentially applicable review articles. In addition, links attached to the guidelines for additional information were used to clarify processes for evidence evaluation and as a means to identify other relevant guidelines.

2.1.4 Limitations of the Methods Used

The method of identifying primary and secondary sources of guidelines relies on the NGC and the CDC as primary sources of guidelines relevant to selected, candidate, and previously considered HACs. RTI recognizes that most, but not all, evidence-based guidelines are contained in the NGC. We assumed that all U.S. guidelines have been developed by professional societies or governmental agencies and employed a secondary search strategy to identify these sources that may not have provided their guidelines to the NGC. It is possible that there are other *ad hoc* groups that have developed guidelines that may be missed by these techniques. For HACs for which U.S. guidelines were not identified, we did search for potentially applicable international guidelines. Because international guidelines may not be perceived to be applicable to U.S. providers, we did not perform a more extensive search and thus may have missed non-U.S. guidelines for those HACs.

2.2 Definition of Evidence-Based Guidelines Applied

Guideline-development processes have been evolving from expert panel recommendations supported by a selective literature search or based on a consensus of the panel members, to the more recent adoption of systematic processes. A comprehensive systematic review entails the *a priori* development of critical questions as well as study inclusion and exclusion criteria (I/E criteria), the use of standardized key words to search multiple databases, and step-by-step independent comparison of articles against the I/E criteria by two or more reviewers. The methods of each included study are assessed for scientific rigor using a standardized quality assessment tool. After results from included articles are compiled to form the evidence base, an explicit evidence-grading and strength-of-evidence designation is employed by subject matter experts (SMEs) based on the quality of the studies and the consistency of findings across studies. Results from high quality, well-designed clinical trials provide the strongest (most convincing, lowest risk of bias) evidence, followed by observational studies and clinical trials with poorer methodology, both of which have greater risk of biased results due to lower internal study validity. A “best evidence” approach refers to the exclusion of information from studies deemed to be of lower internal validity, which limits the confidence that can be drawn that a reported association of a treatment or other activity is causally related to the observed results. Included studies are only those studies that are most likely to demonstrate that the intervention caused the observed change in outcome and the exclusion of information from studies deemed to be of lower internal validity. The result of this process is that guideline recommendations rely only on the most scientifically sound evidence base. (Owens DK, Lohr KN, Atkins D, et al. Journal of Clinical Epidemiology. 2009. 63(5):513-523)

Despite increasing movement toward systematic evidence-based processes in guideline development, there continue to be important clinical areas for which there is no definitive

clinical trial or other relevant high-quality evidence base. SMEs typically address this issue by either making *no recommendation* when there is clinical uncertainty, or by making recommendations, *clearly specified as being expert opinion*, that are typically based on SME clinical experience and reasoning from underlying scientific principles. To account for this evolution in “evidence-based guidelines,” we developed a tiered set of criteria to categorize the type of evidence base used for each guideline.

We set Level I as the highest level of evidence-based guideline. To account for current guideline-development processes, we have subdivided this level into **Level Ia**: guidelines that used a systematic literature search, rated the quality of each individual study considered, and graded the overall strength of evidence, or demonstrated that they used a “best evidence” approach through exclusion of information from studies deemed to be of lower internal validity; and **Level Ib**: guidelines that rated the quality of each individual study considered, graded the overall strength of evidence, or demonstrated the use of a “best evidence” approach, but did not employ a systematic methodology for the review of the literature.

For those guidelines or recommendations within guidelines that did not describe a systematic methodology and only provided citations for the recommendation, we called these “evidence-cited” and designated them as **Level II**. Our lowest level, **Level III**, represented those guidelines or recommendations within guidelines, that were based only on expert opinion, or that provided no specific information to describe the basis of the recommendation. Guidelines typically present various levels of recommendation depending on the quality of evidence, and most employ expert opinion for some of the recommendations that are made when there is not sufficient evidence in the literature. The use of expert opinion may occur with Level Ia, Ib, or Level II guidelines and thus, guidelines may be rated as either Level Ia, Ib, or Level II and, **in addition**, Level III. For guidelines with recommendations arising from a more mixed evidence base (e.g., “Ib and II”), we assigned the level pertaining to the predominate methodology used in that guideline.

Level of Evidence

- **Level Ia:** Good evidence-base (e.g., highest quality, most consistent evidence). Guideline recommendations are based on a comprehensive, systematic literature search and review, AND either a) description of the quality assessment of the studies or the overall body of literature or b) a “best evidence” approach.
- **Level Ib:** Fair evidence base. Guideline recommendations are based on a non-systematic literature review, or literature review using unspecified methods, AND either a) review of the quality of the studies or the overall body of literature or b) description of a “best evidence” approach.
- **Level II:** Poor evidence base or evidence base not well characterized. Evidence is cited, but guideline authors do not describe quality or strength of evidence
- **Level III:** No evidence base. Specific guideline recommendations are based only on expert opinion, or guideline authors provide no information on how recommendations were developed.

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SECTION 3

RESULTS

In this section, we describe the evidence based guidelines found for the 11 selected HACs, the two candidate HACs, and the six previously considered HACs.

3.1 Selected HACs

In this section, we present the current guidelines identified through our searches that provide recommendations to prevent the eleven selected HACs:

- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Pressure ulcers (Stage III and IV)
- Injuries from falls & trauma (fractures, dislocations, intracranial injuries, crushing injuries, burns, other injuries)
- Deep vein thrombosis (DVT)/pulmonary embolism(PE) associated with total knee replacement or hip replacement
- Manifestations of poor glycemic control (*Diabetic ketoacidosis, Hypoglycemic coma, Nonketotic hyperosmolar coma; Secondary diabetes with ketoacidosis or hyperosmolarity*)
- Catheter-associated urinary tract infection
- Vascular catheter-associated infection
- Surgical site infection (SSI) following Coronary Artery Bypass Graft (mediastinitis), Cardiac Implantable Electronic Device (CIED), bariatric surgery (laparoscopic gastric bypass, gastroenterostomy, or laparoscopic gastric restrictive surgery), or certain orthopedic procedures (spine, neck, shoulder, or elbow).
- Iatrogenic pneumothorax with venous catheterization

Only one of the identified guidelines included a statement of the anticipated magnitude of prevention of events anticipated with use of the guideline recommendations.

A. Foreign Object Retained after Surgery

1. Guidelines identified

We found four current guidelines relating to foreign object retained after surgery:

- Statement on the Prevention of Retained Foreign Bodies after Surgery. American College of Surgeons. ACS, 2005
- Health care protocol: Prevention of unintentionally retained foreign objects during vaginal deliveries. Institute for Clinical Systems Improvement (ICSI), 2012
- Health Care Protocol: Perioperative protocol. ICSI, 2014
- Prevention of Retained Surgical Items. Association of periOperative Registered Nurses (AORN), 2015

Please refer to *Appendix A, Table A-1*, for additional commentary on each guideline and links to each reference.

2. Guidelines considered “evidence-based”

The ACS statement cites evidence and expert opinion, but does not mention quality rating of individual studies or strength of evidence. The ICSI Health Care Perioperative Protocol is based on a systematic review and provides ratings for the strength of the body of evidence; the latest edition incorporates some of the GRADE methodology. The updated ICSI protocol for prevention of unintentionally retained foreign objects contains new recommendations based on a systematic review of articles published since the issuance of the previous guidelines. Both protocols are finalized based on consensus from a panel of experts. Recommendations in the AORN Prevention of Retained Surgical Items are based on a systematic literature review with strength-of-evidence grading.

3. Identification of the appropriate actions to be taken to prevent the condition

All statements describe actions to take to prevent the retention of foreign objects. The ACS statement recommends consistent application and adherence to standardized counting procedures and use of the AHRQ Patient Safety Indicators (PSIs), which are a set of indicators for measuring in-hospital complications and adverse events. The ICSI Health Care Protocol for Prevention of Unintentionally Retained Foreign Objects During Delivery and AORN Prevention of Retained Surgical Items describe specific procedures for use in the operating room and labor and delivery, in order to provide guidance on when, how, and why counts should be performed in the delivery room. The Protocol for Prevention of Unintentionally Retained Foreign Objects during Vaginal Deliveries delineates differences in procedures between the operating arena and labor and delivery.

Common recommendations include establishing an accurate baseline count prior to surgery, minimizing distractions and interruptions during surgery, and methodical performance

of wound exploration. The ICSI Perioperative Protocol provides three different sets of recommendations for use during the perioperative, intraoperative, and postoperative periods.

B. Air Embolism

1. Guidelines identified

We identified two guidelines for the prevention of air embolism.

- Access Device Guidelines-Recommendations for Nursing Practice and Education, 3rd ed. Oncology Nursing Society (ONS), 2011
- Guidelines for performing ultrasound guided vascular cannulation: recommendations of the American Society of Echocardiography and the Society of Cardiovascular Anesthesiologists (ASE/SCA), 2011

Please refer to *Appendix A*, [*Table A-2*](#), for additional commentary on each guideline and links to each reference.

2. Guidelines considered “evidence-based”

Both guidelines cite evidence, but do not mention the quality rating of individual studies or the strength of evidence. They are therefore given a rating of Level II.

3. Identification of the appropriate actions to be taken to prevent the condition

The ONS guideline recommends an insertion technique with the patient in the Trendelenburg position to decrease the risk of air embolism, as does the ASE/SCA guideline.

C. Blood Incompatibility

1. Guidelines identified

No current U.S. guidelines and four current international guidelines were identified for blood incompatibility:

- Transfusion guidelines for neonates and older children, 2004. (2) Amendments and corrections to the transfusion guidelines for neonates and older children, 2005 and 2007. British Committee for Standards in Haematology (BCSH) Blood Transfusion Task Force
- Guideline on the Administration of Blood Components. British Committee for Standards in Haematology (BCSH) Transfusion Task Force. London (UK): 2009.
- Guidelines for Compatibility Procedures in Blood Transfusion Laboratories—Standards in Haematology. British Committee for Standards in Haematology (BCSH) Blood Transfusion Task Force, 2012

- Blood Transfusion: Indications and Administration. Finnish Medical Society Duodecim, 2012

Please refer to *Appendix A, [Table A-3](#)*, for additional commentary on each guideline and links to each reference.

2. *Guidelines considered “evidence-based”*

The Duodecim guideline is based on a systematic review with evidence grading, as well as expert opinion. The BCSH amended guidelines for transfusion of neonates and older children provide comprehensive graded recommendations for transfusion in infants younger than 4 months; these cite evidence but do not provide quality ratings of individual studies; strength of evidence is based solely on the number and type of studies. The BCSH guidelines for Administration of Blood Components were developed via a systematic literature search, classification of evidence levels based on study quality, and classification of grades of recommendations as well as expert opinion; however, only one of approximately 40 recommendations is graded. The BCSH guidelines for Compatibility Procedures in Blood Transfusion Laboratories are based on cited evidence.

3. *Identification of the appropriate actions to be taken to prevent the condition*

All of the guidelines describe actions to reduce the occurrence of blood incompatibility. The Finnish guideline recommends verification of the patient by asking the patient to state his or her own name and other identifying details, checking patient wristbands, and making sure that the blood group of the transfused patient matches the product to be transfused. The BCSH Guidelines for Compatibility Procedures in Blood Transfusion Laboratories delineate crucial patient identification information as the surname, first name in full, date of birth “(not age or year of birth),” and (in the UK) hospital number/accident, and recommends that any labels pre-printed away from the bedside should not be accepted for grouping or testing pretransfusion samples prior to transfusion. It also contains recommendations for crossmatching. The BCSH *Transfusion guidelines for neonates and older children* recommend that samples from “both mother and infant should be obtained for initial ABO and RhD group determination.” Note, however, that “an electronic cross-match may not select blood that is compatible with maternally derived ABO antibodies in the neonate's plasma. Therefore, it may not be appropriate to include neonatal samples in electronic cross-match protocols unless an appropriate algorithm has been created.” The guidelines for Administration of Blood Components recommend that “Patient identification is enhanced by using robust IT systems based on bar-code or radiofrequency identification (RFID). Level III Grade B”

D. Pressure Ulcers (Stages III and IV)

1. *Guidelines identified*

Seven current U.S. guidelines, including one written in collaboration with multiple international advisory groups, were identified relating to pressure ulcers:

- Pressure Ulcer Prevention and Treatment Following Spinal Cord Injury. Consortium for Spinal Cord Medicine, Paralyzed Veterans of America (PVA), 2001
- Early acute management in adults with spinal cord injury: a clinical practice guideline for health-care professionals. Consortium for Spinal Cord Medicine, PVA, 2008
- Guideline for prevention and management of pressure ulcers. Wound, Ostomy, and Continence Nurses Society (WOCN), 2010
- Health Care Protocol: Pressure Ulcer Prevention and Treatment Protocol. Institute for Clinical Systems Improvement (ICSI), 2012
- Preventing pressure ulcers & skin tears, In: *Evidence-based Geriatric Nursing Protocols for Best Practice*. Hartford Institute for Geriatric Nursing, 2012
- Guideline of Pressure Ulcer Guidelines. Association for the Advancement of Wound Care (AAWC), 2012.
- Prevention and Treatment of Pressure Ulcers: Clinical Practice Guidelines and Quick Reference Guide. National Pressure Ulcer Advisory Panel (NPUAP), European Pressure Ulcer Advisory Panel (EPUAP), and Pan Pacific Pressure Injury Alliance (PPPIA), 2014

Please refer to *Appendix A, [Table A-4](#)*, for additional commentary on each guideline and links to each reference.

Note: The *Clinical Practice Guideline—Prediction, Prevention, Early Treatment of Pressure Ulcers in Adults* (U.S. Preventive Services Task Force) has been withdrawn by AHRQ. The Guide to the Care of the Hospitalized Patient with Ischemic Stroke (2nd Ed., 2014) by the American Association of Neuroscience Nurses is not currently available on the AANN website.

2. Guidelines considered “evidence-based”

All of the guidelines cite evidence, provide evidence grading and strength of recommendation, and use expert opinion for some recommendations. The NPUAP-EPUAP-PPPIA Clinical Guidelines and Quick Reference Guide incorporate individual study quality rating and strength of evidence using GRADE methodology. The Hartford Institute guideline uses a six-tier grading level of evidence: systematic reviews are the highest level of evidence (Level I), followed by randomized controlled trials at Level II, and on down to Level VI for expert opinions and consensus panels. The guideline recommendations for prevention of pneumonia are graded Level IV. The WOCN guideline, ICSI protocol, and PVA guidelines are based on systematic reviews with evidence grading and expert opinion.

The AAWC guideline collates and compares recommendations from previously published guidelines, including those presented here, and incorporates de-novo evidence grading and content validation. AAWC members compiled a list of 368 recommendations from other

guidelines, examined the evidence base for these recommendations using de-novo literature searches, and rated the strength of evidence based on the scale used for the Agency for Health Care Policy and Research Pressure Ulcer Guidelines (1992). Strength of evidence was graded as A, B, or C depending on the number and types of studies from which the recommendations were drawn ([Bolton, 2011](#); accessed 4/30/2015). In addition, thirty-two clinicians used an online survey to rate the relevance of each of the 368 recommendations with respect to best-practice PU care on a scale of 1 (not relevant) to 4 (very relevant and succinct). Researchers defined a valid recommendation as those with at least 75% of respondents rating the item as 3 (relevant) or 4 (very relevant).

3. Identification of the appropriate actions to be taken to prevent the condition

The Hartford Institute guideline is targeted to “older adults with identified intrinsic and/or extrinsic risk factors for pressure ulcers,” and recommends that all individuals at risk should have a systematic skin inspection at least once a day, with results documented. It also describes the use of moisturizers on dry skin as part of a very detailed protocol. The Hartford Institute guideline does not contain information specific only to stage III and IV pressure ulcers. The ICSI guidelines recommend a head-to-toe skin assessment at admission in conjunction with a reliable risk assessment tool. Both guidelines from the Consortium for Spinal Cord Medicine, PVA, provide graded recommendations for risk assessment and prevention of pressure ulcers in patients with spinal cord injuries. The NPUAP-EPUAP-PPPIA Quick Reference Guide provides a comprehensive set of recommendations including pressure ulcer risk assessment, patient skin assessment, patient positioning, support surfaces, and recommendations specific to patients in the operating room. Most guidelines contain recommendations for nutrition and/or nutrition counseling.

E. Injuries from Falls and Trauma

1. Guidelines identified

Six U.S. guidelines relating to injuries from falls and trauma were identified:

- Fall Prevention. In: *Evidence-based Geriatric Nursing Protocols for Best Practice*. Hartford Institute for Geriatric Nursing, 2012
- Reducing Adverse Drug Events. In: *Evidence-based Geriatric Nursing Protocols for Best Practice*. Hartford Institute for Geriatric Nursing, 2012
- Health Care Protocol: Prevention of Falls (Acute Care). Institute for Clinical Systems Improvement (ICSI), 2012
- Recommended practices for a safe environment of care. In: *2013 Perioperative Standards and Recommended Practices*. Association of periOperative Registered Nurses (AORN), 2012
- Practice Advisory for Prevention and Management of Operating Room Fires. American Society of Anesthesiologists Task Force (ASATF), 2013

- Health Care Protocol: Perioperative Protocol. Institute for Clinical Systems Improvement (ICSI), 2014

Please refer to *Appendix A*, [Table A-5](#), for additional commentary on each guideline and links to each reference.

2. *Guidelines considered “evidence-based”*

All six of the guidelines use level-of-evidence levels and strength of recommendations, including expert opinion, for each recommendation opinion.

The Healthcare Association of New Jersey (HCANJ) Fall Management Guideline (2007), listed in previous editions of this report, has been replaced by the HCANJ Best Practice Guideline. This Best Practice Guideline provides tools for patient assessment and quality improvement but does not contain clinical recommendations, and therefore does not meet our definition of a clinical guideline for inclusion in this report.

3. *Identification of the appropriate actions to be taken to prevent the condition*

Detailed recommendations are provided in all three fall-related guidelines: the Hartford Institute “Fall Prevention” guideline, the ICSI falls guideline (protocol with six detailed annotations), and the Hartford Institute “Reducing Adverse Events” guidelines. Recommendations include familiarizing the patient to the environment, keeping the patient’s personal possessions within patient reach, keeping floor surfaces clean and dry, setting up regular voiding schedules for patients who are bowel and/or bladder incontinent, and monitoring cognitively impaired patients on an hourly basis. Communication of patient risk among health care personnel is emphasized; both the ICSI and Hartford guidelines suggest using stickers on patients’ doors. The Hartford Institute protocol, “Reducing Adverse Events,” recommends assessing the patient for any potential drug-disease and drug-drug interactions or incorrect doses, which are the most common causes of adverse drug reactions that could lead to falls. The ICSI protocol contains a comparison of three common falls risk assessment tools, including the Morse Tool, the Hendrich II Tool, and the John Hopkins Hospital Falls Risk Tool. Periodic risk assessment is recommended regardless of the falls assessment tool selected. Identified risk factors include cognitive dysfunction, delirium, dementia, impaired mobility, medications, and physical hazards in the environs.

For burn prevention, the ASATF guideline recommends that for all procedures, surgical drapes should be configured to minimize the accumulation of oxidizers under the drapes and prevent oxidizers from flowing into the surgical site. The AORN guidelines contain recommendations related to hazard identification, communication, alarm systems, and avoidance of thermal injuries related to warming solutions, blankets, and patient linens in blanket- and solution-warming cabinets. The ICSI Perioperative Protocol contains five policy-level recommendations for prevention of fire in operating rooms; all are strong recommendations based on low evidence.

F. Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) for Total Knee Replacement or Hip Replacement

1. Guidelines identified

Six current prevention guidelines were identified for deep vein thrombosis (DVT)/pulmonary embolism (PE) for total knee replacement or hip replacement:

- Preventing Venous Thromboembolic Disease in Patients Undergoing Elective Hip or Knee Arthroplasty, American Academy of Orthopaedic Surgeons (AAOS), 2011
- Venous thromboembolism prophylaxis in hospitalized patients: a clinical practice guideline from the American College of Physicians (ACP). ACP, 2011
- Antithrombotic therapy for VTE Disease: antithrombotic therapy and prevention of thrombosis. In: *The American College of Chest Physicians Evidence-based Clinical Practice Guidelines, (9th edition)*. American College of Chest Physicians (ACCP), 2012
- Prevention of venous thromboembolism in orthopedic surgery patients: antithrombotic therapy and prevention of thrombosis. In: *The American College of Chest Physicians evidence-based clinical practice guidelines, (9th edition)*. ACCP, 2012.
- The perioperative management of antithrombotic therapy: antithrombotic therapy and prevention of thrombosis. In: *The American College of Chest Physicians Evidence-Based Clinical Practice Guidelines (9th edition)*. ACCP, 2012
- Venous Thromboembolism Prophylaxis Guideline. ICSI, 2012

Please refer to **Appendix A, Table A-6**, for additional commentary on each guideline and links to each reference.

Only two of the above guidelines, the AAOS and ACCP Prevention of Venous Thromboembolism, are specific to total knee and hip replacement surgeries. The ACCP Perioperative Management of Antithrombotic Therapy contains recommendations for bridging procedures. In contrast to the prior edition, the recently released 5th edition of the ICSI Perioperative Protocol no longer contains specific recommendations for DVT/PE prevention; instead, it refers users to the ICSI Venous Thromboembolism Prophylaxis Guideline. It has therefore been removed from the list above.

AHRQ published an online document, *Preventing Hospital-Acquired Venous Thromboembolism: A Guide for Effective Quality Improvement*, as a general guide for quality improvement. (Maynard G, Stein J. AHRQ Publication No. 08-0075, August 2008. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/qual/vtguide/>. (Accessed 4/30/2015.) While DVT-PE is used as an example preventable condition, this document provides a best practice example of guideline recommended prevention practices at

two medical centers. The ACCP guidelines referenced by the AHRQ document are included in this report.

2. Guidelines considered “evidence-based”

All of the guidelines are evidence-based, and all but the ACCP guidelines also cite expert opinion. There are quality ratings of individual studies and strength of evidence for recommendations for all of the guideline recommendations. The AAOS guideline workgroup noted, “No data specific to hip or knee arthroplasty were found addressing many potential risk factors, and in many instances where it was found, it was of very low quality and it was contradictory.” (AAOS 2011, p 15). Of the 14 recommendations listed by AAOS, one was graded “Strong” and three were graded “moderate.” All others were graded “inconclusive,” “consensus,” or “weak.” The ACP rates quality of evidence as high, moderate, low, or insufficient evidence to determine net benefits or risks, and strength of recommendations as strong or weak.

3. Identification of the appropriate actions to be taken to prevent the condition

All guidelines describe actions to take to prevent DVT/PE. The AAOS guideline recommends against routine use of duplex ultrasonography screening of patients who have undergone elective hip or knee arthroplasty. The ICSI guidelines recommend that risk factor assessment be completed pre-operatively for every patient whose surgical admission is planned. The ACCP guideline “Prevention of venous thromboembolism” contains recommendations specific to various surgical procedures, including total hip replacement, hip fracture surgery, total knee replacement, and knee arthroscopy. “The perioperative management of antithrombotic therapy” (ACCP) lists recommendations for perioperative management of patients who are receiving: Vitamin K antagonists, bridging anticoagulation, or antiplatelet therapy, as well as those who require urgent surgical or other invasive procedures. The ACP guidelines provide three major recommendations: assess “risk for thromboembolism and bleeding in medical (including stroke) patients prior to initiation of prophylaxis of venous thromboembolism (Grade: strong recommendation, moderate-quality evidence); administer pharmacologic prophylaxis with heparin or a related drug for venous thromboembolism in medical (including stroke) patients unless the assessed risk for bleeding outweighs the likely benefits (Grade: strong recommendation, moderate-quality evidence); against the use of mechanical prophylaxis with graduated compression stockings for prevention of venous thromboembolism (Grade: strong recommendation, moderate-quality evidence).”

G. Manifestations of Poor Glycemic Control

1. Guidelines identified

Six guidelines were identified that address manifestations of poor glycemic control:

- American Association of Clinical Endocrinologists Medical Guidelines for Clinical Practice for Developing a Diabetes Mellitus Comprehensive Care Plan. (AAACE), 2011

- Use of intensive insulin therapy for the management of glycemic control in hospitalized patients: a clinical practice guideline from the American College of Physicians (ACP), 2011
- Management of hyperglycemia in hospitalized patients in non-critical care setting: an endocrine society clinical practice guideline. Endocrine Society, 2012
- Heath Care Protocol: Perioperative protocol. ICSI, 2014
- Diabetes Care in the Hospital, Nursing Home, and Skilled Nursing Facility. The Standards of Medical Care in Diabetes. American Diabetes Association (ADA), 2015
- Diagnosis and Management of Type 2 Diabetes Mellitus in Adults. ICSI, 2014.

Please refer to *Appendix A, [Table A-7](#)*, for additional commentary on each guideline and links to each reference.

2. *Guidelines considered “evidence-based”*

All six guidelines are based on systematic reviews and use levels of evidence and strength of recommendation for each recommendation. The ACP, ICSI, and Endocrine Society guidelines employ GRADE methodology to assess the basis of evidence for each recommendation. Recommendations are either “strong” (level 1) or “weak” (level 2). The quality of the evidence base for each statement is graded as A (high), B (moderate), C (low), or D (very low). Some recommendations are based only on expert opinion (not graded). The AACE guideline authors reviewed the strengths and weaknesses of multiple evidence-based guideline methodologies and concluded that an “optimal...strategy might not be entirely evidence-based” because of cost, complexity, and rigidity. The AACE 2011 guideline is therefore based upon a modified evidence-based guideline approach that nonetheless assigns recommendations to one of four evidence grade levels on the basis of the quality and strength of supporting evidence. The ADA guidelines incorporate a five-level grading system developed by ADA.

3. *Identification of the appropriate actions to be taken to prevent the condition*

All of the guidelines provide comprehensive recommendations for the diagnosis and treatment of diabetes mellitus and its complications. All but the ACP guidelines include hospital-specific recommendations for appropriate monitoring and treatment of glucose levels to prevent hypoglycemia and hyperglycemia for primary and secondary causes of poor glucose control. The ADA guidelines provide a comprehensive list of recommendations for blood glucose management in the hospital setting. The guidelines from the ACP provide recommendations specifically related to blood glucose targets, use of insulin therapy among patients not in Surgical ICU or Medical ICU (SICU/MICU), and use of insulin therapy among SICU/MICU patients. The ICSI guidelines also address treatment of ketoacidosis and hyperosmolar coma after they have developed. On the basis of evidence rated as high quality, the ICSI Perioperative protocol strongly recommends that “glycemic control should be directed

at achieving blood glucose levels between 140 and 180 mg/dL and not be directed at more intensive goal targets (80-110 mg/dL).”

H. Catheter-Associated Urinary Tract Infection

1. Guidelines identified

Six guidelines were identified for catheter-associated urinary tract infection (CAUTI):

- Guideline for Hand Hygiene in Health-Care Settings. Recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force (HICPAC/SHEA/IDSA), 2002
- Guideline for Disinfection and Sterilization in Healthcare Facilities. Healthcare Infection Control Practices Advisory Committee, Centers for Disease Control and Prevention (CDC-HICPAC), 2008
- Best Practice Policy Statement on Urological Surgery Antimicrobial Prophylaxis. American Urological Association Education and Research, Inc. (AUA). 2008; reviewed and confirmed in 2010.
- Strategies to Prevent Catheter-Associated Urinary Tract Infection in Acute Care Hospitals: 2014 Update. Society for Healthcare Epidemiology of America and the Infectious Diseases Society of America (SHEA/IDSA) Compendium, 2014
- Guideline for Prevention of Catheter Associated Urinary Tract Infection 2009. Healthcare Infection Control Practices Advisory Committee (HICPAC), 2009.
- Strategies to Prevent Healthcare-Associated Infections Through Hand Hygiene. Society for Healthcare Epidemiology of America and the Infectious Diseases Society of America (SHEA/IDSA) Compendium, 2014.

Please refer to *Appendix B*, [*Table B-1*](#) and [*Table B-2*](#), for additional commentary on each guideline and links to each reference.

The HICPAC guidelines were identified through the CDC website, and the others were identified via the NGC.

2. Guidelines considered “evidence-based”

All of the guidelines cite evidence. The 2002 HICPAC/SHEA/IDSA guidelines for hand hygiene are based on a literature review with evidence grading. The HICPAC guidelines for prevention of CAUTI use systematic review with the GRADE system. The HICPAC guideline for sterilization and disinfection is also based on systematic evidence reviews. The remaining three guidelines use level-of-evidence grading for every recommendation, as well as expert opinion. Quality ratings for the evidence in the 2014 collaborative effort on strategies to prevent

transmission (SHEA/IDSA) were adapted from the Canadian Task Force on the Periodic Health Examination and GRADE. Quality of evidence is based on three tiers: the highest level (Level I, High) indicates that the recommendation is based on multiple types of studies with little between-study variation in estimate of effect and a narrow confidence interval. Level II, Moderate, indicates moderate confidence that the true effect is close to the estimated size and effect, but may be substantially different since these recommendations are based on fewer studies with increased limitations and between study variations than Level I. Level III, Low, is assigned to recommendations based on studies with significant flaws, a greater range of estimated effect sizes, or expert consensus statements

3. Identification of the appropriate actions to be taken to prevent the condition

The HICPAC 2009 guideline recommends the use of urinary catheters in operative patients only as necessary, rather than routinely. **The guideline notes that 17% to 69% of CAUTI may be preventable with recommended infection control measures.** “The strategies to prevent CAUTI in acute care recommended the insertion of urinary catheters only when necessary for patient care and leaving them in place only as long as indications persist.” The CDC-HICPAC 2008 guideline contains recommendations for catheter sterilization. The HICPAC/SHEA/IDSA Guidelines for Hand Hygiene review indications for hand hygiene, agents, techniques, and glove use for infection prevention. The IDSA-SHEA guidelines provide comprehensive recommendations for prevention of CAUTI in acute care hospitals, as well as a list of approaches that should not be included among routine CAUTI prevention practices.

I. Vascular Catheter-Associated Infection

1. Guidelines identified

Ten current guidelines were identified for vascular catheter-associated infection:

- Guideline for Hand Hygiene in Health-Care Settings. Recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force (HICPAC/SHEA/IDSA). 2002
- NKF-KDOQI clinical practice guidelines for vascular access: update 2006. (National Kidney Foundation, Kidney Disease Outcomes Quality Initiative, Vascular Access Work Group)
- Guideline for Disinfection and Sterilization in Healthcare Facilities. Healthcare Infection Control Practices Advisory Committee, Centers for Disease Control and Prevention (CDC-HICPAC), 2008
- Preservation of peripheral veins in patients with chronic kidney disease. Association for Vascular Access (AVA) and the American Society of Diagnostic and Interventional Nephrology (ASDIN), 2008

- Strategies to Prevent Central Line-Associated Bloodstream Infection in Acute Care Hospitals: 2014 Update. Society for Healthcare Epidemiology of America and the Infectious Diseases Society of America (SHEA/IDSA) Compendium, 2014.
- Guidelines for the Prevention of Intravascular Catheter-related Infections 2011. Healthcare Infection Control Practices Advisory Committee (HICPAC), 2011.
- Access Device Guidelines-Recommendations for Nursing Practice and Education, 3rd ed. Oncology Nursing Society (ONS), 2011.
- Practice Guidelines for Central Venous Access. American Society of Anesthesiologists (ASA), 2012.
- Central venous catheter care for the patient with cancer. American Society of Clinical Oncology (ASCO), 2013

Please refer to *Appendix B*, [Table B-1](#) and [Table B-3](#), for additional commentary on each guideline and links to each reference.

2. *Guidelines considered “evidence-based”*

All ten guidelines cite evidence. The ASCO and ASA guidelines use level-of-evidence and strength-of-recommendation methodology and incorporated expert opinion, as did the SHEA-IDSA guideline, which incorporates methodology developed by GRADE and the Canadian Task Force on Preventive Health Care. The ONS guidelines and AVA statement cite evidence, but do not provide level of evidence and strength of recommendation. The CDC and NKF-KDOQI guidelines use systematic review and provide for expert opinion.

3. *Identification of the appropriate actions to be taken to prevent the condition*

The SHEA/IDSA guideline recommends use of a catheter checklist to ensure adherence to infection prevention practices at the time of CVC insertion. The Strategies to Prevent Central Line-associated Infections in Acute-care hospitals recommend the use of aseptic technique, including the use of a cap, mask, sterile gown, sterile gloves, and a large sterile sheet for the insertion of central venous catheters (CVCs), such as peripherally inserted central catheters, or guide-wire exchange. The HICPAC/SHEA/IDSA guidelines for hand hygiene reviews indications for hand hygiene, agents, techniques, and glove use for infection prevention. NKF-KDOQI recommendations also contain recommendations for vascular catheter access and cleansing of catheter sites. The HICPAC 2008 guidelines contain recommendations for catheter sterilization, while the HICPAC 2011 recommendations cover staffing and training of healthcare personnel who insert and maintain catheters, catheter and site selection, hand hygiene, patient preparation, antibiotic ointment and prophylaxis, and catheter placement and replacement. Guideline authors recommend not replacing peripheral and midline catheters more frequently than every 72-96 hours in adults, and only when necessary in children. Central lines (including PICCS and hemodialysis catheters) should not be replaced routinely in an effort to prevent infection or on the basis of fever alone. Other specific recommendations include: using “maximal sterile barrier precautions during central venous catheter insertion, using a > 0.5%

chlorhexidine skin preparation with alcohol for antisepsis, and using antiseptic/antibiotic impregnated short-term central venous catheters and chlorhexidine impregnated sponge dressings if the rate of infection is not decreasing despite adherence to other strategies.” The ASA guidelines address multiple topics related to prevention of infectious complications, including intravenous antibiotic prophylaxis, aseptic techniques, selection of coated or impregnated catheters, selection of catheter insertion site, catheter fixation method, insertion site dressings, catheter maintenance procedures, and aseptic techniques using an existing central venous catheter. The ACSO guidelines recommend the use of a catheter care bundle that incorporates general hygiene measures, skin antisepsis during catheter insertion, optimal catheter site selection, and assessment of catheter necessity. It also contains recommendations related to prophylactic use of systemic antibiotics (IV or oral) and use of antimicrobial/antiseptic-impregnated or -coated catheters (chlorhexidine and silver sulfadiazine [CH-SS] or minocycline/rifampin) and/or heparin-impregnated catheters. Guideline authors did not find sufficient evidence to recommend for or against the routine use of antibiotic-flush/antibiotic clock therapy.

These guidelines do not provide information on the likelihood of preventing vascular catheter-associated infection if the prevention strategies are followed.

J. Surgical Site Infection following Coronary Bypass Artery Graft (CABG), Bariatric Surgery for Obesity, CIED, and Certain Orthopedic Procedures

1. Guidelines identified

Eleven current guidelines were identified for surgical site infection, including general guidelines for SSI prevention applicable to all surgical categories.

- Guideline for Prevention of Surgical Site Infection. CDC, 1999
- Guideline for Hand Hygiene in Health-Care Settings. Recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force (CDC-HICPAC/SHEA/IDSA), 2002
- Guideline for Environmental Infection Control in Health-Care Facilities. Healthcare Infection Control Practices Advisory Committee, Centers for Disease Control and Prevention (CDC-HICPAC), 2003.
- Antibiotic prophylaxis in cardiac surgery, Part I: Duration. Society of Thoracic Surgeons (STS) Workforce on Evidence Based Surgery, 2007.
- Antibiotic prophylaxis in cardiac surgery, Part II: Antibiotic Choice. Society of Thoracic Surgeons (STS) Workforce on Evidence Based Surgery, 2007
- Strategies to Prevent Surgical Site Infection in Acute Care Hospitals: 2014 Update. Society for Healthcare Epidemiology of America and the Infectious Diseases Society of America (SHEA/IDSA) Compendium, 2014

- Medical Guidelines for Clinical Practice for the Perioperative Nutritional, Metabolic, and Nonsurgical Support of the Bariatric Surgery Patient. American Association of Clinical Endocrinologists, The Obesity Society, and American Society for Metabolic and Bariatric Surgery (AACE/TOS/ASMBS), 2013
- Antibiotic Prophylaxis in Spine Surgery. North American Spine Society (NASS), 2013 update. Clinical Practice Guidelines for Antimicrobial Prophylaxis in Surgery. American Society of Health-System Pharmacists (ASHP) the Surgical Infection Society (SIS), IDSA, and SHEA, 2013
- Health Care Protocol: Perioperative protocol. ICSI, 2014
- Strategies to Prevent Healthcare-Associated Infections Through Hand Hygiene. Society for Healthcare Epidemiology of America and the Infectious Diseases Society of America (SHEA/IDSA) Compendium, 2014.

Please refer to *Appendix B*, [*Table B-1*](#) and [*Table B-4*](#), for additional commentary on each guideline and links to each reference.

The CDC guideline was identified through the CDC website, and the others were identified via searches of the NGC and professional organizations.

2. *Guidelines considered “evidence-based”*

Four of the 11 guidelines report using systematic literature review methodology; all 11 guidelines use a level-of-evidence grading system and strength-of-recommendation grade in conjunction with expert opinion. Quality ratings for the evidence in the 2014 collaborative effort on strategies to prevent transmission (SHEA/IDSA) were adapted from the Canadian Task Force on the Periodic Health Examination and GRADE. Quality of evidence is based on three tiers. Level I, High, indicates that the recommendation is based on multiple types of studies with little between-study variation in estimate of effect and a narrow confidence interval. Level II, Moderate, indicates moderate confidence that the true effect is close to the estimated size and effect, but the effect may be substantially different because these recommendations are based on fewer studies with increased limitations and between-study variations than Level I. Level III, Low, is assigned to recommendations based on studies with significant flaws, a greater range of estimated effect sizes, or expert consensus statements.

3. *Identification of the appropriate actions to be taken to prevent the condition*

The SHEA/IDSA guidelines recommend clipping rather than shaving the surgical site, the timely and appropriate use of prophylactic antibiotics, and the control of blood glucose for patients undergoing coronary bypass surgery. This guideline also specifies that, whenever possible, all infections remote to the surgical site should be identified and treated before elective operation, and elective operations on patients with remote site infections should be postponed until the infection has resolved. The CDC 1999 guidelines provide comprehensive recommendations for prevention of SSI, including steps to be taken during the preoperative, intraoperative, and postoperative periods. The three CDC-HICPAC guidelines provide

recommendations for disinfection of environmental surfaces, sterilization of surgical instruments, and proper hand hygiene procedures to avoid contamination of wound sites. All other guidelines except the AACE/TOS/ASMBS guidelines consider the evidence for the most appropriate class of antibiotic for a specific surgical procedure, timeliness of administration, and duration of administration. The ASHP/SIS/IDSA/SHEA guidelines provide comprehensive recommendations for both adult and pediatric patients; guidance includes recommendations for timing of pre-operative antibiotic prophylaxis (within 60 minutes of incision), weight-based dosing, and duration of prophylaxis with respect to surgery duration. The ICSI Perioperative protocol contains recommendations for general SSI prevention. The guidelines for prevention of SSI among cardiac and bariatric patients focus on appropriate and timely preoperative prophylactic antibiotics. The revised AACE/TOS/ASMBS guidelines now contain 74 recommendations, compared with 164 original recommendations in 2008. The updated guidelines note briefly that cigarette use has been associated with increased risk of SSI and therefore recommend that all bariatric patients cease smoking before surgery.

K. Iatrogenic Pneumothorax with Venous Catheterization

1. Guidelines identified

We found three guidelines that addressed iatrogenic pneumothorax, one in the setting of thoracic needle biopsy and two with respect to venous catheterization:

- ACR Appropriateness Criteria® Radiologic Management of Thoracic Nodules and Masses. American College of Radiology (ACR), 2011
- Guidelines for performing ultrasound guided vascular cannulation: recommendations of the American Society of Echocardiography and the Society of Cardiovascular Anesthesiologists (ASE/SCA), 2011
- Practice Guidelines for Central Venous Access. American Society of Anesthesiologists (ASA), 2012

Please refer to *Appendix A*, [*Table A-8*](#), for additional commentary on each guideline and links to each reference.

2. Guidelines considered “evidence-based”

The ACR guideline is based on a literature review and expert opinion. Individual studies identified during the review were assigned “strength of evidence ratings” (quality assessment scores) from 1 to 4, with 1 defined as “The conclusions of the study are valid and strongly supported by study design, analysis and results”; 2 as “The conclusions of the study are likely valid, but study design does not permit certainty”; 3 as “The conclusions of the study may be valid but the evidence supporting the conclusions is inconclusive or equivocal”; and 4 as “The conclusions of the study may not be valid because the evidence may not be reliable given the study design or analysis.” Evidence grading for individual outcomes (e.g., pneumothorax) was not provided. The ASA and ASE/SCA guidelines used level-of-evidence and strength-of-recommendation methodology and incorporated expert opinion.

3. *Identification of the appropriate actions to be taken to prevent the condition*

The ACR guideline states that “Using a steeper angle of the biopsy needle may decrease the risk of pneumothorax,” (from a study with a quality rating of “2”). These guidelines also note that pneumothorax is most common complication of percutaneous lung biopsy requiring intervention, occurring in 10%–30% of these procedures. The ASA guidelines include recommendations for general prevention of mechanical trauma or injury associated with central venous access, including selection of catheter insertion site, patient positioning, needle insertion and catheter placement, and monitoring for placement of needles, guidewires, and catheters. With respect to pneumothorax, authors note that “Nonrandomized comparative studies report equivocal findings for arterial puncture, pneumothorax, hematoma, hemothorax, or arrhythmia when the internal jugular insertion site is compared with the subclavian insertion site (*Category C3 evidence*).” The ASE/SCA guidelines recommend that ultrasound screening of the subclavian vein in high risk patients, and notes that individual operators should not attempt cannulation more than twice, since doing so increases the risk of complications including pneumothorax.

3.2 **Candidate Conditions**

In this section, we present the current guidelines identified through our searches that provide recommendations to prevent candidate HACs:

- Contrast-induced acute kidney injury
- Surgical site infection (SSI) following hip or knee orthopedic procedures

A. **Contrast-induced acute kidney injury.**

1. *Guidelines identified*

Our search revealed two US guidelines for the candidate HAC, contrast-induced acute kidney injury (CI-AKI).

- Guideline for percutaneous coronary artery intervention. A report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines and the Society for Cardiovascular Angiography and Interventions (ACCF/AHA/SCAI), 2011
- Clinical practice guideline for acute kidney injury. Kidney Disease Improving Global Outcomes (KDIGO), 2012.

Please refer to *Appendix A, [Table A-9](#)*, for additional commentary on each guideline and links to each reference.

These guidelines were located using the National Guideline Clearinghouse and popular internet search engines.

2. Guidelines considered “evidence-based”

The ACCF/AHA/SCAI guidelines classify evidence from a systematic review based on four levels of class (I, IIa, IIb, and III), which indicate support of statement (e.g., “Procedure should be administered,” “procedure may be considered”), and three support levels (A, B, or C), which indicate the “certainty or precision” of effect.

Methods for evidence grading and strength of recommendations in the KDIGO guidelines were adapted from the GRADE approach. Recommendations are either “strong” (level 1) or “weak” (level 2). The quality of the evidence base for each statement is graded as A (high), B (moderate), C (low), or D (very low). Some recommendations are based only on expert opinion (not graded).

3. Identification of the appropriate actions to be taken to prevent the condition

The ACCF/AHA/SCI guideline recommends that patients undergoing PCI currently on dialysis for chronic kidney disease receive isosmolar contrast media in order to decrease further risk to the kidneys. The KDIGO guideline contains definitions and extensive recommendations for prevention of AKI, including a chapter on prevention of contrast-induced AKI. Recommendations include risk assessment for CI-AKI, use of alternative imaging methods or low doses of contrast medium in higher-risk patients and use of i.v. volume expansion with either isotonic sodium chloride or sodium bicarbonate solutions. Use of theophylline, fenoldopam, or oral fluids alone to prevent CI-AKI is not recommended.

B. Surgical Site Infection following hip and knee orthopedic procedures

1. Guidelines identified

Six guidelines were identified for surgical site infection following hip and knee orthopedic procedures, all of which are general guidelines for SSI prevention.

- Guideline for Prevention of Surgical Site Infection. CDC, 1999
- Guideline for Environmental Infection Control in Health-Care Facilities. Healthcare Infection Control Practices Advisory Committee, Centers for Disease Control and Prevention (CDC-HICPAC), 2003.
- Guideline for Disinfection and Sterilization in Healthcare Facilities. Healthcare Infection Control Practices Advisory Committee, Centers for Disease Control and Prevention (CDC-HICPAC), 2008.
- Clinical Practice Guidelines for Antimicrobial Prophylaxis in Surgery. American Society of Health-System Pharmacists (ASHP) the Surgical Infection Society (SIS), IDSA, and SHEA, 2013

- Strategies to Prevent Healthcare-Associated Infections Through Hand Hygiene. Society for Healthcare Epidemiology of America and the Infectious Diseases Society of America (SHEA/IDSA) Compendium, 2014
- Strategies to Prevent Surgical Site Infection in Acute Care Hospitals: 2014 Update. Society for Healthcare Epidemiology of America and the Infectious Diseases Society of America (SHEA/IDSA) Compendium, 2014.

Please refer to *Appendix B, [Table B-1](#)*, for additional commentary on each guideline and links to each reference.

The CDC guidelines were identified through the CDC website, while the others were identified via searches of the NGC. A revision of the CDC guidelines is expected by the end of 2014, according to the CDC/HICPAC website.

2. *Guidelines considered “evidence-based”*

All six guidelines use a level-of-evidence grading system and strength-of-recommendation grade for each recommendation, and also incorporate expert opinion into their level-of-evidence grading.

3. *Identification of the appropriate actions to be taken to prevent the condition*

The guidelines listed above provide recommendations to prevent infection for a broad range of surgical procedures; none focus solely on orthopedic surgeries. The SHEA/IDSA guidelines recommend clipping rather than shaving the surgical site, as well as the timely and appropriate use of prophylactic antibiotics. These guidelines also specify that, whenever possible, all infections remote to the surgical site should be identified and treated before elective operation, and elective operations on patients with remote site infections should be postponed until the infection has resolved. The CDC 1999 guidelines provide comprehensive recommendations for steps to be taken during the preoperative, intraoperative, and postoperative periods for prevention of SSI, including an evaluation of patient risk factors. The other CDC-HICPAC guidelines provide recommendations for disinfection of environmental surfaces, sterilization of surgical instruments, and proper hand hygiene procedures to avoid contamination of wound sites. The ASHP/SIS/IDSA/SHEA guidelines provide comprehensive recommendations for both adult and pediatric patients; guidance includes recommendations for timing of pre-operative antibiotic prophylaxis (within 60 minutes of incision), weight-based dosing, and duration of prophylaxis with respect to surgery duration. All guidelines consider the evidence for the most appropriate class of antibiotic for a specific surgical procedure, timeliness of administration, and duration of administration.

3.3 Previously Considered Conditions

Here, we present the current guidelines identified through our searches, for the six previously considered conditions listed below:

- Delirium
- Ventilator-associated pneumonia
- *Clostridium difficile* associated disease (CDAD)
- Legionnaires' disease
- *Staphylococcus aureus* sepsis
- Methicillin-resistant *Staphylococcus aureus*

A. Delirium

1. Guidelines identified

Three current U.S. guidelines were found that addressed the prevention, recognition, and treatment of delirium in hospitals:

- Delirium: prevention, early recognition, and treatment. In: *Evidence-based Geriatric Nursing Protocols for Best Practice*. Hartford Institute for Geriatric Nursing, 2012
- Comprehensive assessment and management of the critically ill In: *Evidence-based Geriatric Nursing Protocols for Best Practice*. Hartford Institute for Geriatric Nursing, 2012
- Clinical practice guidelines for the management of pain, agitation, and delirium in adult patients in the intensive care unit. American College of Critical Care Medicine (ACCM), 2013.

Please refer to **Appendix A, Table A-10**, for additional commentary on each guideline and links to each reference.

The Hartford Institute developed their guidelines in 2012 as an update to their 2008 guidelines; expert nurses from across the country developed the guideline's recommendations. The guideline, *Prevention of Delirium in Older Hospitalized Patients*, In: *Making Health Care Safer: A Critical Analysis of Patient Safety Practices, 2001* (AHRQ), has been withdrawn by the developer. The 2009 University of Iowa Gerontological Nursing Interventions Research Center, *Research Translation and Dissemination Core Evidence-based Practice Guideline: Acute Confusion/Delirium* is no longer available on the developer website. Also considered out of date is Levels Ib and III *Practice Guideline for the Treatment of Patients With Delirium, 1999*, American Psychiatric Association
(http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/delirium.pdf)

[accessed 4/30/2015]), though an informal “Guideline Watch” from 2004 may be found at http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/delirium-watch.pdf. (Accessed 4/30/2015.)

2. Guidelines considered “evidence-based”

All three guidelines incorporate strength of evidence ratings. The Hartford Institute protocols use a six-tier grading level of evidence. Systematic reviews are the highest level of evidence (Level I), followed by randomized controlled trials at Level II, and on down to Level VI for expert opinions and consensus panels. The ACCM guideline uses GRADE methodology to rate the evidence base. Recommendations are either “strong” (level 1) or “weak” (level 2). The quality of the evidence base for each statement is graded as A (high), B (moderate), C (low), or D (very low). Some recommendations are based only on expert opinion (not graded).

3. Identification of the appropriate actions to be taken to prevent the condition

The ACCM guidelines recommend that adult patients be mobilized as soon as feasible in order to prevent or reduce the duration of delirium. The Hartford Institute protocols provide parameters for assessment, nursing care strategies to eliminate or minimize risk factors, and instructions for establishing a therapeutic environment and providing follow-up measures of quality care. For example, the protocols’ specific recommendations for eliminating or minimizing risk factors include the following:

- Administer medications judiciously; avoid high-risk medications
- Prevent/promptly and appropriately treat infections
- Prevent/promptly treat dehydration and electrolyte disturbances
- Provide adequate pain control
- Maximize oxygen delivery (supplemental oxygen, blood, and blood pressure support as needed)
- Use sensory aids as appropriate
- Regulate bowel/bladder function
- Provide adequate nutrition.

B. Ventilator-Associated Pneumonia

1. Guidelines identified

Five guidelines were identified for ventilator-associated pneumonia:

- AARC Evidence-Based Clinical Practice Guidelines: Care of the Ventilator Circuit and Its Relation to Ventilator-Associated Pneumonia. American Association of Respiratory Care (AARC), 2003
- Guidelines for Preventing Health-Care–Associated Pneumonia. CDC, 2003
- Guidelines for the Management of Adults with Hospital-acquired, Ventilator-associated, and Healthcare-associated Pneumonia. American Thoracic Society (ATS) and Infectious Diseases Society of America (IDSA), 2005
- Comprehensive assessment and management of the critically ill. In: *Evidence-based Geriatric Nursing Protocols for Best Practice*. Hartford Institute for Geriatric Nursing, 2012
- Strategies to prevent ventilator-associated pneumonia in acute care hospitals: 2014 Update. Society for Healthcare Epidemiology of America and the Infectious Diseases Society of America (SHEA/IDSA) Compendium, 2014.

Please refer to [*Appendix B, Table B-1 and Table B-5*](#), for additional commentary on each guideline and links to each reference.

The ATS/IDSA guidelines were published in 2005, on the management of adults with hospital acquired, ventilator-associated, and healthcare-associated pneumonia. The SHEA/IDSA guidelines for VAP prevention were published in 2014 and were developed using the same process as other SHEA/IDSA guidelines. Expert nurses from across the country developed The Hartford Institute guidelines in 2012 as an update to their 2008 guidelines. The AARC guidelines for the care of the Ventilator Circuit was published in 2003 and provides specific recommendations for identifying risk factors and for management of the ventilator circuit to prevent ventilator-associated pneumonia.

2. Guidelines considered “evidence-based”

The ATS-IDSA guidelines use the same grading system for evidence-based recommendations previously used for the ATS Community-Acquired Pneumonia statement. Using three tiers of evidence levels, the guidelines’ highest level consists of randomized controlled trials. Well designed, non-randomized controlled trials (e.g., large case series, cohort studies, case-controlled studies) are considered Level II, with case studies and expert opinion at the lowest level, Level III.

The CDC levels of evidence are based on two levels/categories. Level 1, the higher level consists of three categories: a) well-designed experimental, clinical, or epidemiologic studies, b) “certain” clinical or epidemiologic studies and by strong theoretical rationale, and c) mandated by federal or state regulation or standard. Category II evidence is suggestive clinical or epidemiologic studies or strong theoretical rationale. Insufficient evidence or no consensus is rated as “No recommendation” or “Unresolved Issue.”

The Hartford Institute protocols use a six-tier grading level of evidence. Systematic reviews are the highest level of evidence (Level I), followed by randomized controlled trials (RCTs) at Level II, and on down to Level VI for expert opinions and consensus panels. The guideline recommendations for prevention of pneumonia are graded Level IV.

The AARC guidelines use a systematic review of the literature, grading of the evidence, and expert opinion.

Quality ratings for the evidence in the 2014 collaborative effort on strategies to prevent transmission (SHEA/IDSA) were adapted from the Canadian Task Force on the Periodic Health Examination and GRADE. Quality of evidence is based on three tiers: the highest level (Level I, High) indicates that the recommendation is based on multiple types of studies with little between-study variation in estimate of effect and a narrow confidence interval. Level II, Moderate,, indicates moderate confidence that the true effect is close to the estimated size and effect, but may be substantially different since these recommendations are based on fewer studies with increased limitations and between study variations than Level I. Level III, Low, is assigned to recommendations based on studies with significant flaws, a greater range of estimated effect sizes, or expert consensus statements.

3. Identification of the appropriate actions to be taken to prevent the condition

The ATS guidelines cover the major points and recommendations for modifiable risk factors, general prophylaxis, diagnosis, clinical strategy, comparing diagnostic strategies, initial antibiotic therapy, optimal antibiotic therapy, selected multi-drug resistant pathogens, assessing response to therapy and performance indicators. Specific performance indicators include:

- Circulate hospital-acquired infection prevention guidelines to appropriate medical staff (administrators for quality and safety, physicians, and nurses) for review.
- Provide epidemiologic data on the prevalence and types of multi-drug resistant pathogens in intensive care unit patients and current antibiograms to select appropriate initial antibiotic therapy.
- Select specific parts of the guideline for implementation by the medical and surgical services, including the intensive care units, and monitor compliance with the guidelines in relation to patient outcomes.
- Identify modifiable risk factors and develop programs to reduce the risk of pneumonia through changing these risk factors.

The SHEA/IDSA guidelines include special approaches for prevention of ventilator-associated pneumonia in hospitals with unacceptably high ventilator-associated pneumonia rates after following basic prevention procedures, such as “using an endotracheal tube with in-line, subglottic suctioning for all eligible patients, and ensure that all intensive care unit beds used for patients undergoing ventilation have a built-in tool to provide continuous monitoring of the angle of incline.” The guidelines also provide guidance on approaches that should not be considered a routine part of ventilator-associated pneumonia prevention, such as the following:

- Do not routinely administer intravenous immunoglobulin, white-cell–stimulating factors (filgrastim or sargramostim), enteral glutamine, or chest physiotherapy
- Do not routinely use rotational therapy with kinetic or continuous lateral rotational therapy beds
- Do not routinely administer prophylactic aerosolized or systemic antimicrobials or actions that are not consistently supported one way or another by evidence (referred to as unresolved issues)
- Avoidance of H2 antagonist or proton pump inhibitors for patients who are not at high risk for developing gastrointestinal bleeding
- Selective digestive tract decontamination for all patients undergoing ventilation
- Use of antiseptic-impregnated endotracheal tubes
- Intensive glycemic control.

The AARC guidelines make specific recommendations for the changing of ventilator circuits, suction procedures, and the use of humidifiers.

The Hartford guidelines recommend standard ventilator-associated pneumonia (VAP) precautions, including elevation of the head of the bed to more than 30 degrees, frequent oral care, assessment of the need for stress ulcer prophylaxis, turning of the patient, and maintenance of general hygiene practices.

The 2003 CDC recommendations were the combined effort of the CDC and HICPAC. This effort provided no new recommendations for ventilator-associated pneumonia as compared to their 1994 guidelines, but the new guidelines did note that there were unresolved issues with respect to oral decontamination. The CDC guidelines address the specifics on the type, care and monitoring of the equipment used. Use of certain medications is not covered, but education, surveillance, prevention of transmission, monitoring host risk for infection and performance indicators is addressed.

The SHEA/IDSA guidelines include recommendations for education, surveillance, practices for disinfection and sterilization of equipment, and assignment of accountability, as well as special approaches for prevention in hospitals with high rates of VAP. They also distinguish approaches that should not be routine in VAP prevention practices.

C. *Clostridium difficile*—Associated Disease

1. Guidelines identified

Eight U.S. guidelines were identified that address strategies to prevent *Clostridium difficile* infections (CDI) in acute care hospitals:

- Guideline for Hand Hygiene in Health-Care Settings. Recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force (CDC-HICPAC/SHEA/IDSA), 2002
- Guideline for Environmental Infection Control in Health-Care Facilities. Healthcare Infection Control Practices Advisory Committee, Centers for Disease Control and Prevention (CDC-HICPAC), 2003.
- Multidrug Resistant Organisms in Health Care Settings, 2006 (CDC)
- Guideline for Disinfection and Sterilization in Healthcare Facilities. Healthcare Infection Control Practices Advisory Committee, Centers for Disease Control and Prevention (CDC-HICPAC), 2008.
- Clinical Practice Guidelines for *Clostridium difficile* Infection in Adults: 2010 Update. SHEA/IDSA, 2010
- Guidelines for diagnosis, treatment, and prevention of *Clostridium difficile* infections. American College of Gastroenterology (ACG), 2013
- Strategies to Prevent *Clostridium difficile* Infections in Acute Care Hospitals: 2014 Update. Society for Healthcare Epidemiology of America and the Infectious Diseases Society of America (SHEA/IDSA) Compendium, 2014.
- Strategies to Prevent Healthcare-Associated Infections Through Hand Hygiene. Society for Healthcare Epidemiology of America and the Infectious Diseases Society of America (SHEA/IDSA) Compendium, 2014.

Please refer to **Appendix B**, [Table B-1](#) and [Table B-6](#), for additional commentary on each guideline and links to each reference.

The SHEA/IDSA Compendium recommendations are based on previously published guidelines from the HIPAC and the CDC, SHEA, ISDA, and the Association for Professionals in Infection Control and Epidemiology, as well as from other relevant literature recently published after the prior guidelines were released.

2. Guidelines considered “evidence-based”

Quality ratings for the evidence in the 2014 collaborative effort on strategies to prevent transmission (SHEA/IDSA) were adapted from the Canadian Task Force on the Periodic Health Examination and GRADE. Quality of evidence is based on three tiers: the highest level (Level I, High) indicates that the recommendation is based on multiple types of studies with little between-study variation in estimate of effect and a narrow confidence interval. Level II, Moderate, indicates moderate confidence that the true effect is close to the estimated size and effect, but may be substantially different since these recommendations are based on fewer studies with increased limitations and between study variations than Level I. Level III, Low, is assigned

to recommendations based on studies with significant flaws, a greater range of estimated effect sizes, or expert consensus statements.

The CDC guidelines use a bi-level approach with specific categories. Level I, the highest level, consists of three categories: a) well-designed experimental, clinical, or epidemiologic studies, b) “certain” clinical or epidemiologic studies and by strong theoretical rationale, and c) mandated by federal or state regulation or standard. Category II evidence is suggestive clinical or epidemiologic studies or strong theoretical rationale. Insufficient evidence or no consensus is rated as “No recommendation” or “Unresolved Issue.”

The ACG guidelines rate strength of evidence according to the GRADE system. Recommendations are either “strong” (level 1) or “weak” (level 2). The quality of the evidence base for each statement is graded as A (high), B (moderate), C (low), or D (very low). Some recommendations are based only on expert opinion (not graded).

3. Identification of the appropriate actions to be taken to prevent the condition

Recommendations include components of a CDI prevention program, performing a CDI risk assessment; employment of routine prevention approaches, as well as approaches that should *not* be used for routine prevention; and a discussion of unresolved issues. Specifically, the components of a CDI prevention program should include the following:

- Use contact precautions for infected patients, with a single-patient room preferred
- Ensure cleaning and disinfection of equipment and the environment
- Implement a laboratory-based alert system to provide immediate notification to infection prevention and control personnel and clinical personnel about patients with newly diagnosed CDI
- Conduct CDI surveillance, and analyze and report CDI data
- Educate healthcare personnel, housekeeping personnel, and hospital administration about CDI
- Educate patients and their families about CDI, as appropriate
- Measure compliance with CDC or World Health Organization hand-hygiene and contact precaution recommendations.

The ACG recommendations encompass many of the recommendations already listed above. Strong recommendations with high-quality evidence include those for implementation of antibiotic stewardship, contact precautions and isolation for patients with CDI, and disinfection of environmental surfaces an Environmental Protective Agency (EPA)-registered disinfectant with *C. difficile*-sporicidal label claim or 5000 p.p.m. chlorine-containing cleaning agents.

The Clinical Practice Guidelines for *Clostridium difficile* Infection in Adults: 2010 (SHEA/IDSA) contain recommendations for the prevention of horizontal transmission of *C. difficile* in the hospital setting, including:

- Use of gloves and gowns by healthcare workers and visitors
- Compliance with good hand hygiene practices
- Private rooms or, at the least, dedicated commodes for patients with CDI
- Duration of control measure implementation
- Routine identification of asymptomatic carriers is not recommended.

The CDC-HIPAC guideline describes practices for inactivation of *C. difficile* spores, including the use of diluted hypochlorite solutions to disinfect rooms of patients with CDI. Contaminated medical devices should be cleaned with two percent glutaraldehyde, peracetic acid, or *ortho*-Phthalaldehyde. For routine disinfection of the environment, use of an EPA-registered germicidal agent is recommended.

D. Legionnaires' Disease

1. Guidelines identified

We found two guidelines that addresses Legionnaires' disease:

- Guidelines for Preventing Health Care–Associated Pneumonia. CDC-HICPAC, 2003
- Guidelines for Environmental Infection Control in Health-Care Facilities, CDC-HICPAC, 2003

Please refer to **Appendix B, [Table B-1](#)**, for additional commentary on each guideline and links to each reference.

2. Guidelines considered “evidence-based”

Recommendations in the CDC-HICPAC guidelines are predominantly based on literature reviews of the evidence base. Only the newest guideline employed systematic literature search methodology. The levels of evidence used are based on two levels, one with categories. Level 1, the higher level, consists of three categories: a) well-designed experimental, clinical, or epidemiologic studies, b) “certain” clinical or epidemiologic studies and by strong theoretical rationale, and c) mandated by federal or state regulation or standard. Category II evidence is suggestive clinical or epidemiologic studies or strong theoretical rationale. Insufficient evidence or no consensus is rated as “No recommendation” or “Unresolved Issue.”

3. *Identification of the appropriate actions to be taken to prevent the condition*

Recommended actions include proper maintenance and testing of potable water and the water system and initiating investigations into sources of legionella; primary prevention efforts such as education, surveillance, and proper use and care of medical devices, equipment and environment; and many secondary prevention efforts. The guidelines note that chlorine disinfection (via hyperchlorination or chlorine dioxide of hospital water supplies), disinfection of municipal water supplies using monochloramine, and use of Chloramine T and hypochlorites have been used to control the spread of *Legionella* in hospital settings.

E. ***Staphylococcus aureus* Sepsis**

1. *Guidelines identified*

We identified seven guidelines that addressed *Staphylococcus aureus* sepsis, either in the context of prevention of general blood stream infections or general infection control. Most identified references from the searches were for methicillin-resistant staphylococcus (MRSA), which is another previously considered HAC.

- Guideline for Hand Hygiene in Health-Care Settings. Recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force, 2002
- Multidrug Resistant Organisms in Health Care Settings. CDC, 2006
- Guideline for Disinfection and Sterilization in Healthcare Facilities. Healthcare Infection Control Practices Advisory Committee, Centers for Disease Control and Prevention (CDC-HICPAC), 2008
- Guidelines for the Prevention of Intravascular Catheter-related Infections. Healthcare Infection Control Practices Advisory Committee (CDC-HICPAC), 2011
- Practice Guidelines for Central Venous Access. American Society of Anesthesiologists (ASA), 2012.
- Clinical Practice Guidelines for Antimicrobial Prophylaxis in Surgery. American Society of Health-System Pharmacists (ASHP) the Surgical Infection Society (SIS), IDSA, and SHEA, 2013
- Strategies to Prevent Surgical Site Infections in Acute Care Hospitals: 2014 Update. Society for Healthcare Epidemiology of America and the Infectious Diseases Society of America (SHEA/IDSA) Compendium, 2014.

Please refer to **Appendix B, [Table B-1](#)**, for additional commentary on each guideline and links to each reference.

2. *Guidelines considered “evidence-based”*

Quality ratings for the evidence in the 2014 collaborative effort on strategies to prevent transmission (SHEA/IDSA) were adapted from the Canadian Task Force on the Periodic Health Examination and GRADE. Quality of evidence is based on three tiers. Level I, High, indicates that the recommendation is based on multiple types of studies with little between-study variation in estimate of effect and a narrow confidence interval. Level II, Moderate, indicates moderate confidence that the true effect is close to the estimated size and effect, but the effect may be substantially different because these recommendations are based on fewer studies with increased limitations and between-study variations than Level I. Level III, Low, is assigned to recommendations based on studies with significant flaws, a greater range of estimated effect sizes, or expert consensus statements. The CDC guidelines use a bi-level approach with specific categories. Level I, the highest level, consists of three categories: (a) well-designed experimental, clinical, or epidemiologic studies; (b) “certain” clinical or epidemiologic studies and by strong theoretical rationale; and (c) practices mandated by federal or state regulation or standard. Category II evidence is suggestive clinical or epidemiologic studies or strong theoretical rationale. Insufficient evidence or no consensus is rated as “no recommendation” or “unresolved issue.” The ASA guidelines used level-of-evidence and strength-of-recommendation methodology and incorporated expert opinion, and the ASHP/SIS/IDSA/SHEA guidelines relied on a seven-level evidence grading system in conjunction with expert opinion.

3. *Identification of the appropriate actions to be taken to prevent the condition*

The 2011 HICPAC guidelines for prevention of intravascular catheter-related infection recommend the use of aseptic technique including the use of a cap, mask, sterile gown, sterile gloves, and a large sterile sheet for the insertion of CVCs. The 2002, 2006, and 2008 CDC-HICPAC guidelines contain recommendation for the sterilization of hands, medical and surgical devices, and environmental surfaces to prevent transmission of a broad range of pathogens. The ASA guidelines provide a range of recommendations for infection prevention but mention sepsis only briefly: “Randomized controlled trials indicate that catheter-related infections and sepsis are reduced when prophylactic intravenous antibiotics are administered to high-risk immunosuppressed cancer patients or neonates. (*Category A2 evidence*).” The SHEA/IDSA guidelines recommend screening for *S. aureus* and decolonizing surgical patients with an antistaphylococcal agent in the preoperative setting for high-risk procedures.

F. ***Methicillin Resistant Staphylococcus aureus (MRSA)***

1. *Guidelines identified*

Eight U.S. guidelines were identified that address MRSA:

- Guideline for Environmental Infection Control in Health-Care Facilities. Healthcare Infection Control Practices Advisory Committee, Centers for Disease Control and Prevention (CDC-HICPAC), 2003.

- SHEA Guideline for Preventing Nosocomial Transmission of Multidrug Resistant Strains of *Staphylococcus aureus* and Enterococcus, Society for Healthcare Epidemiology of America (SHEA), 2003
- Multidrug Resistant Organisms in Health Care Settings. CDC, 2006
- Guideline for Disinfection and Sterilization in Healthcare Facilities. Healthcare Infection Control Practices Advisory Committee, Centers for Disease Control and Prevention (CDC-HICPAC), 2008
- Community Associated Methicillin-resistant *Staphylococcus aureus*: Guidelines for Clinical Management and Control of Transmission. Wisconsin Division of Public Health (WDPH), 2011
- Clinical Practice Guidelines for Antimicrobial Prophylaxis in Surgery. American Society of Health-System Pharmacists (ASHP) the Surgical Infection Society (SIS), IDSA, and SHEA, 2013
- Strategies to Prevent Transmission of Methicillin-Resistant *Staphylococcus aureus* in Acute Care Hospitals: 2014 Update. Society for Healthcare Epidemiology of America and the Infectious Diseases Society of America (SHEA/IDSA) Compendium, 2014
- Strategies to Prevent Healthcare-Associated Infections Through Hand Hygiene. Society for Healthcare Epidemiology of America and the Infectious Diseases Society of America (SHEA/IDSA) Compendium, 2014

Please refer to *Appendix B*, [Table B-1](#) and [Table B-7](#), for additional commentary on each guideline and links to each reference.

Because the transmission of MRSA in the hospital is significantly impacted by the level of asymptomatic carriers in the community, the WDPH guideline, which addresses community control and prevention, was also included.

2. Guidelines considered “evidence-based”

Quality ratings for the evidence in the 2014 collaborative effort on strategies to prevent transmission (SHEA/IDSA) were adapted from the Canadian Task Force on the Periodic Health Examination and GRADE. Quality of evidence is based on three tiers: the highest level (Level I, High) indicates that the recommendation is based on multiple types of studies with little between-study variation in estimate of effect and a narrow confidence interval. Level II, Moderate, indicates moderate confidence that the true effect is close to the estimated size and effect, but may be substantially different since these recommendations are based on fewer studies with increased limitations and between study variations than Level I. Level III, Low, is assigned to recommendations based on studies with significant flaws, a greater range of estimated effect sizes, or expert consensus statements. The SHEA and ASHP/SIS/IDSA/SHEA guidelines for

preventing transmission used also used a systematic review strategy with evidence ratings. The ASHP/SIS/IDSA/SHEA rating system is based on methods previously used by AHRQ.

The CDC guideline used a bi-level approach with specific categories. Level 1, the higher level consists of three categories: a) well-designed experimental, clinical, or epidemiologic studies, b) “certain” clinical or epidemiologic studies and by strong theoretical rationale, c) mandated by federal or state regulation or standard. Category II evidence is suggestive clinical or epidemiologic studies or strong theoretical rationale. Insufficient evidence or no consensus is rated as “No recommendation” or “Unresolved Issue.” The WDPH guidelines cite references, but do not provide the search strategy or an evidence rating strategy.

3. Identification of the appropriate actions to be taken to prevent the condition

Each practice recommendation is associated with both strength of recommendation and quality of evidence grade. Components of a MRSA Transmission Prevention Program include risk assessment, monitoring, compliance with CDC and World Health Organization hand hygiene recommendations, use of contact precautions, cleaning and disinfection of equipment and environment, education, personnel, alert systems, special approaches, and unresolved issues. The SHEA/IDSA guidelines, updated in 2014, cover strategies to prevent transmission of MRSA in acute care hospitals. The 2008 CDC-HICPAC guidelines address measures for the inactivation of antibiotic resistant bacteria. The 2003 guidelines address measures for general infection prevention through environmental control. For patients undergoing surgery, the ASHP/SIS/IDSA/SHEA guidelines recommend that mupirocin be given intranasally to all patients with documented *S. aureus* colonization. (Strength of evidence for prophylaxis = A.) Authors note in a footnote that “it is reasonable to add a single preoperative dose of vancomycin to the recommended [surgery-specific antimicrobial] agent(s)” for patients known to be colonized with MRSA. The CDC 2006 Multi-Drug Resistant Organism (MDRO) guidelines focus more specifically on multi-drug resistant organisms, including MRSA, and cover recommendations ranging from administrative support and education through use of antimicrobial agents, surveillance techniques, and infection control precautions.

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SECTION 4 SUMMARY

Summaries of the numbers of guidelines found for each selected, candidate and previously considered condition are provided in [Tables 1, 2, and 3](#), respectively. The number of guidelines with Level Ia: Systematic Reviews; Level Ib: Evidence-grading system Level II: Evidence Cited; Level III: Expert Opinion are also summarized by condition. Note that guidelines may employ Level III: Expert Opinion **in addition** to Level Ia, Level Ib or Level II.

4.1 Selected Conditions

Table 1
Summary of the number and ratings of available guidelines for selected HACs

Condition	Guidelines with recommendations for prevention of the condition	Guidelines with Level Ia: Systematic review and evidence grading	Guidelines with Level Ib: evidence grading	Guidelines with Level II: evidence cited only	Guidelines with Level III: expert opinion
Foreign object retained after surgery	4	2	1	0	4
Air embolus	2	0	0	2	0
Blood incompatibility	4	2	1	1	2
Pressure ulcers (Stages III and IV)	7	7	0	0	7
Injuries from falls & trauma	6	4	1	1	6
Deep vein thrombosis pulmonary embolism for total knee or hip replacement	6	6	0	0	3
Manifestations of poor glycemic control	6	6	0	0	6
Catheter-associated urinary tract infection	6	2	4	0	6
Vascular catheter associated infection	10	4	4	1	8
Surgical site infection following selected cardiac, bariatric, or orthopedic surgeries	11	4	7	0	11
Iatrogenic pneumothorax with venous catheterization	3	1	2	0	3

4.2 Candidate Conditions

Table 2
Summary of the number and ratings of available guidelines for candidate HACs

Condition	Guidelines with recommendations for prevention of the condition	Guidelines with Level Ia: systematic review and evidence grading,	Guidelines with Level Ib: evidence grading	Guidelines with Level II: evidence cited only	Guidelines with Level III: expert opinion
Contrast-induced acute kidney injury	2	2	0	0	2
SSI following hip and knee orthopedic procedures	6	2	4	0	6

4.3 Previously Considered Conditions

Table 3
Summary of the number and ratings of available guidelines for previously considered HACs

Condition	Guidelines with recommendations for prevention of the condition	Guidelines with Level Ia: systematic review and evidence grading,	Guidelines with Level Ib: evidence grading	Guidelines with Level II: evidence cited only	Guidelines with Level III: expert opinion
Delirium	3	3	0	0	2
Ventilator-associated pneumonia	5	2	3	0	5
<i>Clostridium difficile</i> -associated disease	8	2	6	0	8
Legionnaires disease	2	0	2	0	2
<i>Staphylococcus aureus</i> septicemia	7	3	4	0	7
Methicillin-resistant <i>Staphylococcus aureus</i>	8	3	4	1	7

APPENDIX A

GUIDELINES FOR NON-INFECTION RELATED HACs

A.1 Guidelines for Selected HACs

In [Tables A-1](#) through [A-8](#) below, we present the current guidelines identified through our searches that provide recommendations to prevent the eight selected HACs not related to infection:

- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Pressure ulcers (Stage III and IV)
- Injuries from falls & trauma (fractures, dislocations, intracranial injuries, crushing injuries, burns, other injuries)
- Deep vein thrombosis (DVT)/pulmonary embolism(PE) associated with total knee replacement or hip replacement
- Manifestations of poor glycemic control (*Diabetic ketoacidosis, Hypoglycemic coma, Nonketotic hyperosmolar coma; Secondary diabetes with ketoacidosis or hyperosmolarity*)
- Iatrogenic pneumothorax with venous catheterization

Table A-1
Identified guidelines for foreign object retained after surgery

Evidence-based guideline and publishing organization	Location	Evidence level	Comments	Prevention recommendations
Foreign object retained after surgery				
AORN. "Prevention of retained surgical items." In: Guidelines for Perioperative Practices. Denver, CO: AORN, Inc.; 2015. Association of periOperative Registered Nurses (AORN).	http://www.aorn.org/Books_and_Publications/Perioperative_Standards_and_Recommended_Practices.aspx (Book available for purchase) (accessed 4/30/2015)	Levels Ia and III: Systematic review, evidence rating and expert opinion	First, the references of an AORN evidence rating is a two-step process involving appraisal of guideline references using the Johns Hopkins nursing evidence appraisal tools, followed by rating of practice recommendations using the Oncology Nursing Society model (accessed 4/30/2015) Additional information on AORN Evidence Rating processes is here: http://www.aorn.org/EvidenceRating/ (accessed 4/30/2015)	Contains comprehensive recommendations for incorporating a multidisciplinary approach to retention of surgical items, item counts, and locating and retrieving missing items.
Institute for Clinical Systems Improvement (ICSI). Health Care Protocol: Prevention of Unintentionally Retained Foreign Objects During Vaginal Deliveries. January 2012.	http://www.ngc.gov/content.aspx?id=36060 (accessed 4/30/2015) https://www.icsi.org/_asset/3xvmi8/RF_OSoFC.pdf (accessed 4/30/2015)	Levels Ib and III: Literature search, evidence rating and expert opinion	A list of changes from the previous version is here: https://www.icsi.org/_asset/zqjguy/RF_OSoFC.pdf (accessed 4/30/2015)	"The recommendations for prevention of unintentionally retained foreign objects during vaginal deliveries are presented in the form of a protocol and an algorithm with 12 components, accompanied by detailed annotations."

(continued)

Table A-1 (Continued)
Identified guidelines for foreign object retained after surgery

Evidence-based guideline and publishing organization	Location	Evidence level	Comments	Prevention recommendations
American College of Surgeons (ACS) and the Council of Surgical and periOperative Safety. Statement on the Prevention of Retained Foreign Bodies after Surgery, 2005; <i>Bulletin of the American College of Surgeons</i> Vol. 90, No. 10, October 2005.	http://www.facs.org/fellows_info/statements/st-51.html (accessed 4/30/2015)	Level III: Expert opinion	1 page statement available here: https://www.facs.org/about-acsc/statements (accessed 4/30/2015)	“Consistent application and adherence to standardized counting procedures”
Institute for Clinical Systems Improvement (ICSI) Perioperative protocol. Health care protocol, 2014. 5 th edition.	NGC guideline summary. http://www.guideline.gov/content.aspx?id=48408 (accessed 4/29/2015) https://www.icsi.org/guidelines_more/catalog_guidelines_and_more/catalog_guidelines/catalog_patient_safetyreliability_guidelines/perioperative/ (accessed 4/29/2015)	Levels Ia and III: Systematic review, evidence rating and expert opinion	The 2014 update is in transition to GRADE methodology. A summary of changes from the previous version is here: https://www.icsi.org/asset/5h7ypw/PeriopSoC.pdf (accessed 4/29/2015)	Contains detailed annotations for prevention of retained foreign bodies, including comprehensive descriptions of counting processes and recommendations for implementation.

Table A-2
Identified guidelines for air embolism

Evidence-based guideline and publishing organization	Location	Evidence level	Comments	Prevention recommendations
Air embolism				
Access Device Guidelines-Recommendations for Nursing Practice and Education, 3 rd ed. Oncology Nursing Society (ONS), 2011	http://www.ons.org/products/access-device-guidelines-recommendations-nursing-practice-and-education-third-edition (accessed 4/30/2015) Available for purchase	Level II: Evidence cited	Comprehensive guideline covering all types of vascular access devices	Includes recommendations for patient positioning during insertion to decrease risk of air embolism.
Guidelines for performing ultrasound guided vascular cannulation: recommendations of the American Society of Echocardiography and the Society of Cardiovascular Anesthesiologists (ASE/SCA), 2011	http://www.onlinejase.com/article/S0894-7317%2811%2900727-9/fulltext (accessed 4/30/2015)	Level II: Evidence cited	Although the major recommendations in this guideline are based on Levels Ia and III , systematic review, evidence rating, and expert opinion, the instructions for patient positioning are ungraded and only cite supporting literature. This “recommendation” is therefore rated as Level II.	“Patients should be placed in Trendelenburg position to increase the diameter of the jugular veins and reduce the risk for air embolism when cannulating the SC vein, unless this maneuver is contraindicated.”

Table A-3
Identified guidelines for blood incompatibility

Evidence-based guideline and publishing organization	Location	Evidence level	Comments	Prevention recommendations
Blood incompatibility				
British Committee for Standards in Haematology (BCSH) Blood Transfusion Task Force. Guidelines for Pre-Transfusion Compatibility Procedures in Blood Transfusion Laboratories, 2012	http://www.bcsghguidelines.com/documents/Compat_Guideline_for_submission_to_TTF_011012.pdf (accessed 4/30/2015) (Redirects to PDF document)	Level II: Evidence cited	Included British and Finnish work due to lack of standards from USA.	"Errors in patient identification and sample labeling may lead to ABO incompatible transfusions."
British Committee for Standards in Haematology (BCSH). (1) Transfusion guidelines for neonates and older children, 2004. (2) Amendments and corrections to the transfusion guidelines for neonates and older children, 2007.	http://www.ncbi.nlm.nih.gov/pubmed/14984493 (accessed 4/30/2015) 2004 guidelines: http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2141.2004.04815.x/pdf (accessed 4/30/2015)	Levels Ib and III: Literature review and expert opinion	British Guidelines	Blood and Blood Component Specification General Recommendations (Fetuses, Neonates, Infants and Children) Table: Choice of ABO Group for Blood Products for Administration to Children
Boulton F, BCSH Transfusion Task Force. Amendments and corrections to the 'transfusion guidelines for neonates and older children'. London (UK): 2005 Dec 7.	2005 amendment: http://www.bcsghguidelines.com/documents/transfusion_neonates_amendments_bcsgh_091205.pdf (accessed 4/30/2015)			
	2007 amendment: http://www.bcsghguidelines.com/documents/FFP_neonate_Amendment_1_17_Oct_2007.pdf (accessed 4/30/2015)			

(continued)

Table A-3 (continued)
Identified guidelines for blood incompatibility

Evidence-based guideline and publishing organization	Location	Evidence level	Comments	Prevention recommendations
British Committee for Standards in Haematology (BCSH). Guideline on the Administration of Blood Components. BCSH Transfusion Task Force. London (UK): 2009.	http://www.bcsghguidelines.com/documents/Admin_blood_components_bcsgh_05012010.pdf (accessed 4/30/2015)	Levels Ia and III: Systematic review, evidence rating and expert opinion	British Guidelines	Provides suggestions and one graded recommendation related to positive patient identification, including use of information technology (IT), as well as staff education and documentation requirements. The formally graded recommendation is: "Patient identification is enhanced by using robust IT systems based on bar-code or radiofrequency identification (RFID). Level III Grade B"
Finnish Medical Society Duodecim. Blood transfusion: indications, administration, and adverse reactions. In: EBM Guidelines. Evidence-Based Medicine. Helsinki, Finland: Wiley Interscience, John Wiley & Sons; 2011 Aug 15	http://www.guideline.gov/content.aspx?id=34955 (accessed 4/30/2015)	Level Ia: Systematic review and evidence rating	Finnish Guidelines	"Verify the identity of the patient. Ask the patient to state his/her own identification details. If necessary, check them against the patient's identity wrist band. The blood group of the product to be transfused must correspond with the patient's blood group."

Table A-4
Identified guidelines for pressure ulcers (Stage III and IV)

Evidence-based guideline and publishing organization	Location	Evidence level	Comments	Prevention recommendations
Pressure ulcers (Stage III and IV)				
Hartford Institute for Geriatric Nursing. Ayello EA, Sibbald RG. Pressure Ulcer Prevention. In: Boltz M, Capezuti E, Fulmer T, Zwicker D, editor(s). Evidence-based geriatric nursing protocols for best practice. 4 th ed. New York (NY): Springer Publishing Company; 2012 Nov. p. 298-323.	http://www.guideline.gov/content.aspx?id=43935 (accessed 4/30/2015) Chapter available for purchase; corresponding protocol available here: http://consultgerirn.org/topics/pressure_ulcers_and_skin_tears/want_to_know_more (accessed 4/30/2015)	Level Ia and III: Systematic review, evidence rating, and expert opinion	Not specific to stage III and IV pressure ulcer.	“Assess skin daily, use moisturizers on dry skin.”
Wound, Ostomy, and Continence Nurses Society (WOCN). Guideline for prevention and management of pressure ulcers. Mount Laurel (NJ): Wound, Ostomy, and Continence Nurses Society (WOCN); 2010 Jun 1.	http://www.guideline.gov/content.aspx?id=23868 (accessed 4/30/2015) http://www.wocn.org/store/VIEWProduct.aspx?ID=692610 (available for purchase) (accessed 4/30/2015)	Level Ia and III: Systematic review, evidence rating, and expert opinion	Covers assessment, prevention, and treatment of pressure ulcers.	“Pressure redistribution surfaces should be used in the operating room for individuals assessed to be at high risk for pressure ulcer development. <i>Level of Evidence = B</i> ”
Institute for Clinical Systems Improvement (ICSI). Health care protocol. Pressure ulcer prevention and treatment protocol, January 2012.	http://www.guideline.gov/content.aspx?id=36059 (accessed 4/30/2015) https://www.icsi.org/_asset/6t7kxy/PressureUlcer.pdf (accessed 4/30/2015) (Redirects to PDF document)	Level Ia and III: Systematic review, evidence rating, and expert opinion	None.	“Avoid prolonged positional immobilization whenever possible.” “Full risk assessment includes determining a person’s risk for pressure ulcers.”

(continued)

Table A-4 (continued)
Identified guidelines for pressure ulcers (Stage III and IV)

Evidence-based guideline and publishing organization	Location	Evidence level	Comments	Prevention recommendations
Consortium for Spinal Cord Medicine, Paralyzed Veterans of America: Early acute management in adults with spinal cord injury: a clinical practice guideline for health-care professionals. J Spinal Cord Med 2008;31(4):403-79.	http://www.ncbi.nlm.nih.gov/pubmed/18959359 (accessed 4/30/2015) Available for download (accessed 4/30/2015)	Levels Ia and III: Systematic review, evidence rating, and expert opinion	Not specific to Stage III and Stage IV pressure ulcer.	“Place the patient on a pressure reduction mattress or a mattress overlay, depending on the patient's condition. Use a pressure reducing cushion when the patient is mobilized out of bed to a sitting position. (<i>Scientific evidence–III; Grade of recommendation–C; Strength of panel opinion–5</i>)”
Association for the Advancement of Wound Care (AAWC). Association for the Advancement of Wound Care guideline of pressure ulcer guidelines. Malvern (PA): Association for the Advancement of Wound Care (AAWC); 2010.	http://www.guideline.gov/content.aspx?id=24361 (accessed 4/30/2015) http://aawconline.org/wp-content/uploads/2011/08/AAWCPressureUlcerGuidelineofGuidelinesAug11.pdf (accessed 4/30/2015)	Level Ia and III: Systematic review, evidence rating, and expert opinion	Includes evidence from original studies as well as previously published guidelines; incorporates de-novo evidence grading and content validation. Strength of evidence rating was based on the scale used for Agency for Health Care Policy and Research Pressure Ulcer Guidelines (1992). Evidence tables are available here: http://aawconline.org/professional-resources/resources/ (accessed 4/30/2015)	Comprehensive guidelines include recommendations for patient assessment, risk factor assessment, and preventive care, including positioning, hydration, and nutrition.

(continued)

Table A-4 (continued)
Identified guidelines for pressure ulcers (Stage III and IV)

Evidence-based guideline and publishing organization	Location	Evidence level	Comments	Prevention recommendations
Consortium for Spinal Cord Medicine, Paralyzed Veterans of America (PVA): Pressure ulcer prevention and treatment following spinal cord injury: a clinical practice guideline for health-care professionals. J Spinal Cord Med 2001 Spring;24(Suppl 1):S40-101.	http://www.ncbi.nlm.nih.gov/pubmed/11958176 (accessed 4/30/2015) Available for download (accessed 4/30/2015)	Level Ia and III: Systematic review, evidence rating, and expert opinion	Not specific to Stage III and Stage IV pressure ulcer. Recommendations are graded on a group level.	Contains recommendations for risk assessment, risk assessment tools, and prevention strategies
National Pressure Ulcer Advisory Panel (NPUAP), European Pressure Ulcer Advisory Panel (EPUAP), and Pan Pacific Pressure Injury Alliance (PPPIA). Prevention and Treatment of Pressure Ulcers: Clinical Practice Guidelines and Quick Reference Guide. 2014.	Full guideline available for purchase, http://www.npuap.org/resources/educational-and-clinical-resources/prevention-and-treatment-of-pressure-ulcers-clinical-practice-guideline/ ; (accessed 4/30/2015) Quick reference guide available free of charge, http://www.npuap.org/wp-content/uploads/2014/08/Updated-10-16-14-Quick-Reference-Guide-DIGITAL-NPUAP-EPUAP-PPPIA-16Oct2014.pdf (accessed 4/30/2015) (Redirects to PDF document)	Levels Ia and III: Systematic review evidence rating, and expert opinion	Jointly developed by NPUAP (USA), EPUAP (European), and PPPIA (Asia); evidence is assessed according to GRADE methodology. Only the Quick Reference guide is available free of charge. The authors note that it contains only excerpts and should be used in conjunction with the Clinical Practice Guidelines. Guideline support materials, including a methodology addendum, evidence, and abstraction tables, are available here: http://www.internationalguideline.com/guideline (accessed 4/30/2015)	Provides recommendations for risk assessment policy and practice, skin assessment, patient nutrition, patient repositioning techniques and practices, support surfaces. Includes some recommendations specific to patients in the operating room.

Table A-5
Identified guidelines for injuries from falls and trauma

Evidence-based guideline and publishing organization	Location	Evidence level	Comments	Prevention recommendations
Injuries from falls & trauma (fractures, dislocations, intracranial injuries, crushing injuries, burns, other injuries)				
Degelau J, Belz M, Bungum L, Flavin PL, Harper C, Leys K, Lundquist L, Webb B. Institute for Clinical Systems Improvement (ICSI). Prevention of Falls (Acute Care). Health care protocol, 23 rd April 2012.	http://www.guideline.gov/content.aspx?id=36906 (accessed 4/30/2015) https://www.icsi.org/_asset/dcn15z/Falls-Interactive0412.pdf (accessed 4/30/2015) (Redirects to PDF document)	Levels Ia and III: Systematic review evidence rating and expert opinion	None.	Protocol with 6 detailed annotations for fall reduction
Hartford Institute for Geriatric Nursing. Gray-Micelli D, Quigley PA. Fall Prevention. In: Boltz M, Capezuti E, Fulmer T, Zwicker D, editor(s). Evidence-based geriatric nursing protocols for best practice. 4 th ed. New York (NY): Springer Publishing Company; 2012 Nov. p. 268-97.	http://www.guideline.gov/content.aspx?id=43933 (accessed 4/30/2015) Chapter available for purchase; corresponding protocol available here: http://consultgerirn.org/topics/falls/want_to_know_more (accessed 4/30/2015)	Level Ia and III: Systematic review, evidence rating, and expert opinion	None	Includes recommendations for risk assessment and prevention of falls in older patients.

(continued)

Table A-5 (continued)
Identified guidelines for injuries from falls and trauma

Evidence-based guideline and publishing organization	Location	Evidence level	Comments	Prevention recommendations
American Society of Anesthesiologists (ASATF). Apfelbaum JL, Task Force on Operating Room Fires. Practice advisory for the prevention and management of operating room fires: an updated report by the American Society of Anesthesiologists Task Force on Operating Room Fires. <i>Anesthesiology</i> . 2013 Feb;118(2):271-90.	http://www.guideline.gov/content.aspx?id=43895 (accessed 4/29/2015) http://anesthesiology.pubs.asahq.org/Article.aspx?articleid=1918685 (accessed 4/29/2015)	Levels Ib and III: Literature review, evidence rating, and expert opinion	None	Comprehensive list of recommendations for fire prevention in the OR setting, including specific recommendations for “minimizing or avoiding an oxidizer-enriched atmosphere near the surgical site, safely managing ignition sources, and safely managing fuels.”
Hartford Institute for Geriatric Nursing. Zwicker D, Fulmer T. Reducing Adverse Drug Events in Older Adults. In: Boltz M, Capezuti E, Fulmer T, Zwicker D, editor(s). Evidence-based geriatric nursing protocols for best practice. 4 th ed. New York (NY): Springer Publishing Company; 2012 Nov. p 324-62.	http://www.guideline.gov/content.aspx?id=43938 (accessed 4/29/2015) Chapter available for purchase; corresponding protocol available here: http://consultgerirn.org/topics/medication/want_to_know_more (accessed 4/29/2015)	Level Ia and III: Systematic review, evidence rating, and expert opinion	None	“Initiation of a new medication— Assess for potential drug-disease and drug-drug interactions and correct doses—the most common causes of adverse drug reactions” that might lead to falls.

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Table A-5 (continued)
Identified guidelines for injuries from falls and trauma

Evidence-based guideline and publishing organization	Location	Evidence level	Comments	Prevention recommendations
AORN. Recommended practices for a safe environment of care. In: 2013 perioperative standards and recommended practices. Denver (CO): Association of periOperative Registered Nurses (AORN); 2012 Dec. p. E37-61.	http://www.guideline.gov/content.aspx?id=43790 (accessed 4/29/2015) (Guideline available for purchase)	Level Ia and III: Systematic review, evidence rating, and expert opinion	None	<p>Recommendations include:</p> <ul style="list-style-type: none"> • “Potential hazards associated with fire safety in the practice setting should be identified, and safe practices for communication, prevention, suppression, and evacuation should be established and followed. • Precautions should be taken to mitigate the risk of injury associated with the use of electrical equipment. • Precautions should be taken to mitigate hazards associated with non-functioning clinical and alert alarms or with personnel failing to hear or failing to act on alarms. • Precautions should be taken to avoid thermal injuries related to warming solutions, blankets, and patient linens in blanket- and solution-warming cabinets. • Precautions should be taken to mitigate risks associated with handling, storage, and use of compressed medical gas cylinders and liquid oxygen containers. • Precautions should be taken to mitigate hazards related to waste anesthesia gases.”

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Table A-5 (continued)
Identified guidelines for injuries from falls and trauma

Evidence-based guideline and publishing organization	Location	Evidence level	Comments	Prevention recommendations
Institute for Clinical Systems Improvement (ICSI) Perioperative Protocol. Health care protocol, 2014. 5 th edition.	NGC guideline summary. http://www.guideline.gov/content.aspx?id=48408 (accessed 4/29/2015) https://www.icsi.org/guidelines_more/catalog_guidelines_and_more/catalog_guidelines/catalog_patient_safetyreliability_guidelines/perioperative/ (accessed 4/29/2015)	Levels Ia and III: Systematic review, evidence rating and expert opinion	The 2014 update is in transition to GRADE methodology. A summary of changes from the previous version is here: https://www.icsi.org/assets/5h7ypw/PeriopSoC.pdf (accessed 4/29/2015)	Contains recommendations for policies related to prevention of operating room fires.

Table A-6
Identified guidelines for deep vein thrombosis/pulmonary embolism for total knee or hip replacement

Evidence-based guideline and publishing organization	Location	Evidence level	Comments	Prevention recommendations
Deep vein thrombosis (DVT)/pulmonary embolism(PE) for total knee replacement or hip replacement				
American Academy of Orthopaedic Surgeons (AAOS). Preventing Venous Thromboembolic Disease in Patients Undergoing Elective Hip or Knee Arthroplasty, 2011.	http://www.guideline.gov/content.aspx?id=35173 (accessed 4/29/2015) (Redirects to PDF document)	Levels Ia and III: Systematic review, evidence rating, and expert opinion	Links to supplemental information including responses to peer reviews and a quality of studies report can be found here: http://www.aaos.org/Research/guidelines/VTE/VTE_guideline.asp (accessed 4/29/2015)	Provides 14 specific recommendations in ten statements for determining risk classification, screening, and prevention therapy, including a recommendation against routine post-operative duplex ultrasonography screening of patients who undergo elective hip or knee arthroplasty. (Grade of Recommendation: Strong)
Institute for Clinical Systems Improvement (ICSI). Venous Thromboembolism Prophylaxis Guideline, Tenth edition, 2012.	http://www.guideline.gov/content.aspx?id=39350 (accessed 4/29/2015) https://www.icsi.org/_asset/ht2bhd/VTEProphy-Interactive1112.pdf (accessed 4/29/2015)	Level Ia and III: Systematic review, evidence rating and expert opinion	List of changes in the updated version is provided here: https://www.icsi.org/_asset/2cb7ug/VTEProphySoC1112.pdf (accessed 4/29/2015) (Redirects to PDF document)	Specific recommendations for prevention in patients undergoing hip replacement or knee replacement

(continued)

Table A-6 (continued)
Identified guidelines for deep vein thrombosis/pulmonary embolism for total knee or hip replacement

Evidence-based guideline and publishing organization	Location	Evidence level	Comments	Prevention recommendations
Kearon C, Akl EA, Comerota AJ, Prandoni P, Bounameaux H, Goldhaber SZ, Nelson ME, Wells PS, Gould MK, Dentali F, Crowther M, Kahn SR. Antithrombotic therapy for VTE disease: antithrombotic therapy and prevention of thrombosis, 9th ed. American College of Chest Physicians Evidence-Based Clinical Practice Guidelines. Chest 2012 Feb;141(2 Suppl):e419S-94S.	http://www.guideline.gov/content.aspx?id=35268 (accessed 4/29/2015) http://journal.publications.chestnet.org/article.aspx?articleid=1159520 (accessed 4/29/2015)	Level Ia: Systematic review and evidence rating	None	Addresses treatment of DVT to prevent PE
Falck-Ytter Y, Francis CW, Johanson NA, Curley C, Dahl OE, Schulman S, Ortel TL, Pauker SG, Colwell CW Jr. Prevention of venous thromboembolism in orthopedic surgery patients: antithrombotic therapy and prevention of thrombosis. American College of Chest Physicians Evidence-Based Clinical Practice Guidelines. Chest 2012 Feb;141(2 Suppl):e278S-325S.	http://www.guidelines.gov/content.aspx?id=35265 (accessed 4/29/2015)	Level Ia: Systematic review and evidence rating	None	Anticoagulant prophylaxis during Elective Hip Replacement and elective Knee Replacement, in patients with and without a high risk of bleeding

(continued)

Table A-6 (continued)
Identified guidelines for deep vein thrombosis/pulmonary embolism for total knee or hip replacement

Evidence-based guideline and publishing organization	Location	Evidence level	Comments	Prevention recommendations
Douketis JD, Spyropoulos AC, Spencer FA, Mayr M, Jaffer AK, Eckman MH, Dunn AS, Kunz R. The perioperative management of antithrombotic therapy: antithrombotic therapy and prevention of thrombosis, 9 th ed.: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines. Chest 2012 Feb;141(2 Supple):2326S-50S.	http://www.guideline.gov/content.aspx?id=35266 (accessed 4/29/2015) http://journal.publications.chestnet.org/article.aspx?articleid=1159479 (accessed 4/29/2015)	Level Ia: Systematic review and evidence rating	None	Recommended procedures for bridging of anticoagulation therapy
Qaseem A, Chou R, Humphrey LL, Starkey M, Shekelle P, for the Clinical Guidelines Committee of the American College of Physicians. Venous thromboembolism prophylaxis in hospitalized patients: a clinical practice guideline from the American College of Physicians. Ann Intern Med. 2011 Nov 1;155(9):625-32.	http://www.guideline.gov/content.aspx?id=34969 (accessed 4/29/2015) http://annals.org/article.aspx?articleid=1033137 (accessed 4/29/2015)	Level Ia and III: Systematic review, evidence rating, and expert opinion	None.	ACP provides three major recommendations related to risk assessment prior to prophylaxis, prophylaxis with heparin or a related drug in some circumstances, and against the use of graduated compression stockings.

Table A-7
Identified guidelines for manifestations of poor glycemic control

Evidence-based guideline and publishing organization	Location	Evidence level	Comments	Prevention recommendations
Manifestations of poor glycemic control <i>Diabetic ketoacidosis, Hypoglycemic coma, Nonketotic hyperosmolar coma; Secondary diabetes with ketoacidosis or hyperosmolarity</i> American Association of Clinical Endocrinologists medical guidelines for clinical practice for developing a diabetes mellitus comprehensive care plan. 2011.	http://www.ngc.gov/content.aspx?id=34038 (accessed 4/29/2015) https://www.aace.com/files/dm-guidelines-ccp.pdf (accessed 4/29/2015)	Levels Ia and III: Systematic review, evidence rating, and expert opinion	This guideline replaces the 2007 “Medical Guidelines for Clinical Practice for the Management of Diabetes Mellitus. Diabetes management in the hospital setting.”	Recommendations for the routine glucose monitoring and a plan for treatment of hospitalized patients with diabetes designed to maintain glucose control and prevent hyperglycemic or hypoglycemic episodes and resultant complications. Recommendations also provide for special circumstances, including the use of concomitant medication that may worsen glucose control. Recommendation 32 is focused on control of hyperglycemia in hospitalized patients. Responses to question 7.5 and 9 provide justification and also recommendations for prevention of hypoglycemia, respectively. Response to question 11.1 summarized findings related to glycemic control in cardiovascular patients.

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Table A-7 (continued)
Identified guidelines for manifestations of poor glycemic control

Evidence-based guideline and publishing organization	Location	Evidence level	Comments	Prevention recommendations
Institute for Clinical Systems Improvement (ICSI) Perioperative protocol. Health care protocol, 2014. 5 th edition.	NGC guideline summary. http://www.guideline.gov/content.aspx?id=48408 (accessed 4/29/2015) https://www.icsi.org/guidelines_more/catalog_guidelines_and_more/catalog_guidelines/catalog_patient_safetyreliability_guidelines/perioperative/ (accessed 4/29/2015)	Levels Ia and III: Systematic review, evidence rating and expert opinion	The 2014 update is in transition to GRADE methodology. A summary of changes from the previous version is here: https://www.icsi.org/_asset/5h7ypw/PeriopSoC.pdf (accessed 4/29/2015)	“Glycemic control should be directed at achieving blood glucose levels between 140-180 mg/dL and not be directed at more intensive goal targets (80-110 mg/dL) (<i>Strong Recommendation, High Quality Evidence</i>).”
Qaseem A, Humphrey LL, Chou R, Snow V, Shekelle P, Clinical Guidelines Committee of the American College of Physicians. Use of intensive insulin therapy for the management of glycemic control in hospitalized patients: a clinical practice guideline from the American College of Physicians. Ann Intern Med 2011 Feb 15;154(4):260-7.	http://www.ngc.gov/content.aspx?id=34168 (accessed 4/29/2015) http://annals.org/article.aspx?articleid=746815 (accessed 4/29/2015)	Levels Ia and III: Systematic review, evidence rating and expert opinion	Uses GRADE methodology	ACP recommends against the use of intensive insulin therapy to strictly control blood glucose in certain hospital settings and patient groups. Contains a discussion of target blood glucose levels if insulin therapy is used in SICU/MICU patients

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Table A-7 (continued)
Identified guidelines for manifestations of poor glycemic control

Evidence-based guideline and publishing organization	Location	Evidence level	Comments	Prevention recommendations
American Diabetes Association. Diabetes Care in the Hospital, Nursing Home, and Skilled Nursing Facility. In: Standards of Medical Care in Diabetes, 2015. Diabetes Care. 2015;38(Suppl 1):S80-85.	http://care.diabetesjournals.org/content/37/Supplement_1/S14.full.pdf http://care.diabetesjournals.org/content/38/Supplement_1/S80.full.pdf (accessed 4/29/2015) http://professional.diabetes.org/ResourcesForProfessionals.aspx?cid=84160&loc=rp-slabnav (accessed 4/29/2015)	Levels Ia and III: Systematic review, evidence rating and expert opinion	Summary of revisions from 2014 version is available here: http://care.diabetesjournals.org/content/38/Supplement_1/S4.full (accessed 4/29/2015) Updated summary of changes evidence table is available here: http://professional.diabetes.org/admin/UserFiles/0%20-%20Sean/Documents/Evidence%20Table%20for%202015%20ADA%20SoC.pdf (accessed 4/29/2015)	Recommendations for the monitoring and treatment of patients to prevent and treat manifestations of hypoglycemia and hyperglycemia. Section 13 presents recommendations specific to patients in the hospital setting.
Redmon B, Caccamo D, Flavin P, Michels R, Myers C, O'Connor P, Roberts J, Setterlund L, Smith S, Sperl-Hillen J. Institute for Clinical Systems Improvement. Diagnosis and Management of Type 2 Diabetes Mellitus in Adults. Updated July 2014.	https://www.icsi.org/guidelines-more/catalog_guidelines_and_more/catalog_guidelines/catalog_endocrine_guidelines/diabetes/ (accessed 4/29/2015) NGC summary: http://www.guideline.gov/content.aspx?id=48544 (accessed 4/29/2015)	Levels Ia and III: Systematic review, evidence rating, and expert opinion	Although the recommendations in this document were developed using GRADE methodology, there are no formal recommendations specific to management of inpatient diabetes. The provided algorithm provides citations in support of the suggested steps.	Suggestions for the monitoring, treatment of glucose to prevent and treat manifestations of hypoglycemia and hyperglycemia in diabetic inpatients.

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Table A-7 (continued)
Identified guidelines for manifestations of poor glycemic control

Evidence-based guideline and publishing organization	Location	Evidence level	Comments	Prevention recommendations
Endocrine Society. Management of hyperglycemia in hospitalized patients in non-critical care setting: an Endocrine Society clinical practice guideline. Umpierrez GE, Hellman R, Korytkowski MT, Kosiborod M, Maynard GA, Montori VM, Seley JJ, Van den Berghe G. J Clin Endocrinol Metab. 2012 Jan;97(1):16-38.	http://jcem.endojournals.org/content/97/1/16.full.pdf+html (accessed 4/29/2015) NGC link: http://www.guideline.gov/content.aspx?id=35255 (accessed 4/29/2015)	Levels Ia and III: Systematic review, evidence rating, and expert opinion	Uses GRADE methodology.	“Implementing a standardized sc insulin order set promoting the use of scheduled basal and nutritional insulin therapy is a key intervention in the inpatient management of diabetes. We provide recommendations for practical, achievable, and safe glycemic targets and describe protocols, procedures, and system improvements required to facilitate the achievement of glycemic goals in patients with hyperglycemia and diabetes admitted in non-critical care settings.”

Table A-8
Identified guidelines for iatrogenic pneumothorax with venous catheterization

Evidence-based guideline and publishing organization	Location	Evidence level	Comments	Prevention recommendations
Iatrogenic pneumothorax with venous catheterization				
Ray CE Jr, English B, Funaki BS, Burke CT, Fidelman N, Ginsburg ME, Kinney TB, Kostelic JK, Kouri BE, Lorenz JM, Nair AV, Nemcek AA Jr, Owens CA, Saleh AG, Vatakencherry G, Mohammed TH, Expert Panel on Interventional Radiology. ACR Appropriateness Criteria® Radiologic Management of Thoracic Nodules and Masses. Reston (VA): American College of Radiology (ACR); 2011.	http://www.ngc.gov/content.aspx?id=32616 (accessed 4/29/2015)	Levels Ib and III: Literature search and expert opinion	Individual studies were assigned “strength of evidence” quality scores, but no ratings of evidence strength across studies were provided.	“Using a steeper angle of the biopsy needle may decrease the risk of pneumothorax.” “The most common complication requiring intervention is pneumothorax (10% to 30%).”
Practice guidelines for central venous access: a report by the American Society of Anesthesiologists Task Force on Central Venous Access. Anesthesiology. 2012 Mar;116(3):539-73	https://acsearch.acr.org/docs/69343/Narrative (accessed 4/29/2015) (redirects to PDF)			
	http://www.guideline.gov/content.aspx?id=36196 (accessed 4/29/2015)	Levels Ib and III: Literature search, evidence rating and expert opinion	Evidence grading is based on the number and type of studies.	Recommendations focus on preparation of the surgical environment and intravenous antibiotic prophylaxis, but include recommendations for patient positioning.
	http://www.asahq.org/~media/Sites/ASAHQ/Files/Public/Resources/standards-guidelines/practice-guidelines-for-central-venous-access.pdf (accessed 4/29/2015) (redirects to PDF)			

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Table A-8 (continued)
Identified guidelines for iatrogenic pneumothorax with venous catheterization

Evidence-based guideline and publishing organization	Location	Evidence level	Comments	Prevention recommendations
Guidelines for performing ultrasound guided vascular cannulation: recommendations of the American Society of Echocardiography and the Society of Cardiovascular Anesthesiologists, 2011.	http://journals.lww.com/anesthesia-analgesia/pages/articleviewer.aspx?year=2012&issue=01000&article=00007&type=Fulltext (accessed 4/29/2015)	Levels Ia and III: Systematic review, evidence rating, and expert opinion	None.	“Individual operators should not attempt cannulation more than twice, as the incidence of complication, particularly pneumothorax, rises significantly with additional attempts. High-risk patients may benefit from ultrasound screening of the SC vein before attempted cannulation to identify vessel location and patency and to specifically identify thrombus before attempted cannulation. The recommendation for ultrasound guidance during SC vein cannulation is based on category A (supportive), level 3 evidence.”

A.2 Guidelines for Candidate Conditions

In [Table A-9](#), we present the current guidelines identified through our searches that provide recommendations to prevent candidate HACs:

- Contrast-induced acute kidney injury

Table A-9
Identified guidelines for contrast-induced acute kidney injury

Evidence-based guideline and publishing organization	Location	Evidence level	Comments	Prevention recommendations
Contrast-Induced Acute Kidney Injury				
2011 ACCF/AHA/SCAI guideline for percutaneous coronary artery intervention. A report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines and the Society for Cardiovascular Angiography and Interventions. J Am Coll Cardiol 2011 Dec 6;58(24):e44–122. [879]	http://www.ngc.gov/content.aspx?id=34980 (accessed 4/30/2015)	Levels Ia and III: Systematic review, evidence rating, and expert opinion	This is the full update to the previous 2007 guidelines.	“In chronic kidney disease patients undergoing angiography, isosmolar contrast agents are indicated and are preferred.” (Class I, Level A)
Kidney Disease Improving Global Outcomes: KDIGO clinical practice guideline for acute kidney injury. Kidney Int Suppl 2012 Mar;2(1):1-138.	http://circ.ahajournals.org/content/124/23/e574.full (accessed 4/30/2015) http://www.ngc.gov/content.aspx?id=38024 (accessed 4/30/2015) http://www.kdigo.org/clinical_practice_guidelines/AKI.php (accessed 4/30/2015)		Supplementary tables are available here: http://www.kdigo.org/clinical_practice_guidelines/pdf/KDIGO-AKI-Suppl-Online-Tables_March2012.pdf (accessed 4/30/2015)(redirects to PDF)	Contains recommendations for risk assessment, non-pharmacological prevention strategies, and pharmacological prevention strategies
			Supplementary appendices are here: http://www.kdigo.org/clinical_practice_guidelines/pdf/KDIGO-AKI-Suppl-Appendices-A-F_March2012.pdf (accessed 4/30/2015)(redirects to PDF)	

A.3 Guidelines for Previously Considered Conditions

In **Table A-10**, we present the current guidelines identified through our searches, for the previously considered condition listed below:

- Delirium

Table A-10
Identified guidelines for delirium

Evidence-based guideline and publishing organization	Location	Evidence level	Comments	Prevention recommendations
Delirium				
Hartford Institute for Geriatric Nursing. Tullmann DF, Mion LC, Fletcher K, Foreman MD. Delirium: Prevention, early recognition, and treatment, In: Boltz M, Capezuti E, Fulmer T, Zwicker D, editor(s). Evidence-based geriatric nursing protocols for best practice. 4 th ed. New York (NY): Springer Publishing Company; 2012 Nov. p. 186-99.	http://www.guideline.gov/content.aspx?id=43920 (accessed 4/30/2015) Chapter available for purchase; corresponding protocol available here: http://consultgerim.org/topics/delirium/want_to_know_more (accessed 4/30/2015)	Levels Ia and III: Systematic review, evidence rating, and expert opinion	Guidelines developed by nursing experts from across the country; update of 2008 guidelines	Addresses assessment and mitigation of risk factors for delirium, as well as monitoring of delirium
Barr J, Fraser GL, Puntillo K, Ely EW, Gélinas C, Dasta JF, Davidson JE, Devlin JW, Kress JP, Joffe AM, Coursin DB, Herr DL, Tung A, Robinson BRH, Fontaine DK, Ramsay MA, Riker RR, Sessler CN, Pun B, Skrobik Y, Jaeschke R, American College of Critical Care Medicine. Clinical practice guidelines for the management of pain, agitation, and delirium in adult patients in the intensive care unit. Crit Care Med. 2013 Jan;41(1):263-306.	http://www.guideline.gov/content.aspx?id=43903 (accessed 4/30/2015) http://www.learnicu.org/SiteCollectionDocuments/Clinical%20Practice%20Guidelines%20for%20the%20Management%20of%20Pain.%20Agitation.%20and%20Delirium%20in%20Adult%20Patients%20in%20the%20Intensive%20Care%20Un.pdf (accessed 4/30/2015) (redirects to pdf)	Level Ia: Systematic review and evidence rating	Uses GRADE methodology to rate evidence base.	“We recommend performing early mobilization of adult ICU patients whenever feasible to reduce the incidence and duration of delirium (+1B).”

(continued)

Table A-10 (continued)
Identified guidelines for delirium

Evidence-based guideline and publishing organization	Location	Evidence level	Comments	Prevention recommendations
University of Iowa Gerontological Nursing Interventions Research Center, Research Translation and Dissemination Core. Evidence-based practice guideline: Acute confusion/delirium. <i>J Gerontol Nurs.</i> 2009 Nov;35(11):11-8.				
Hartford Institute for Geriatric Nursing. Balas MC, Casey CM, Happ MB. Comprehensive assessment and management of the critically ill. In: Boltz M, Capezuti E, Fulmer T, Zwicker D, editor(s). Evidence-based geriatric nursing protocols for best practice. 4 th ed. New York (NY): Springer Publishing Company; 2012 Nov. p. 600-27.	http://www.guideline.gov/content.aspx?id=43919 (accessed 4/30/2015) Chapter available for purchase; corresponding protocol available here: http://consultgerirn.org/topics/critical_care/want_to_know_more (accessed 4/30/2015)	Levels Ia and III: Systematic review, evidence rating, and expert opinion	None	“Closely monitor the older adult’s neurologic/mental status. Screen for delirium and sedation level at least once per shift. Implement interventions to reduce delirium.”

APPENDIX B

GUIDELINES FOR INFECTION-RELATED HACs

B.1 Guidelines with recommendations for prevention of multiple infection-related HACs

In [Table B-1](#) below, we present the current guidelines identified through our searches that provide recommendations to prevent multiple infection-related HACs:

- Catheter-associated urinary tract infection (CAUTI)
- Vascular catheter-associated infection (CLABSI)
- Selected surgical site infections (S-SSI) following Coronary Artery Bypass Graft (mediastinitis), Cardiac Implantable Electronic Device (CIED), bariatric surgery (laparoscopic gastric bypass, gastroenterostomy, or laparoscopic gastric restrictive surgery), or certain orthopedic procedures (spine, neck, shoulder, or elbow).
- Candidate surgical site infections (C-SSI) following
- Ventilator-associated pneumonia
- *Clostridium difficile* associated disease (CDAD)
- Legionnaires' disease
- *Staphylococcus aureus* sepsis
- Methicillin-resistant *Staphylococcus aureus*

Table B-1
Identified guidelines for multiple infection-related conditions

Evidence-based guideline and publishing organization	Location	Relevant HACs	Evidence level	Comments	HAC-Specific Recommendations
Multiple HACs HICPAC, CDC. Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008.	http://www.cdc.gov/hicpac/Disinfection_Sterilization/acknowledgment.html (accessed 4/30/2015) http://www.cdc.gov/hicpac/pdf/guidelines/Disinfection_Nov_2008.pdf (accessed 4/30/2015) (Redirects to PDF document)	CAUTI CDAD CLABSI C-SSI MRSA Staph sepsis	Level Ia and III: Systematic review, evidence rating and expert opinion	Addresses sterilization for a broad range of pathogens	<p>CAUTI and CLABSI: Describes disinfection and sterilization techniques for surgical and medical devices, including catheters.</p> <p>CDAD: Describes specific inactivation techniques for <i>C. difficile</i></p> <p>C-SSI: Describes disinfection and sterilization techniques for surgical and medical devices, including endoscopes and implantable surgical devices.</p> <p>MRSA and Staph Sepsis: “Use standard sterilization and disinfection procedures for patient-care equipment (as recommended in this guideline), because these procedures are adequate to sterilize or disinfect instruments or devices contaminated with blood or other body fluids from persons infected with bloodborne pathogens or emerging pathogens, with the exception of prions. No changes in these procedures for cleaning, disinfecting, or sterilizing are necessary for removing bloodborne and emerging pathogens other than prions. <i>Category IA.</i>”</p>

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Table B-1 (continued)
Identified guidelines for multiple infection-related conditions

Evidence-based guideline and publishing organization	Location	Relevant HACs	Evidence level	Comments	HAC-Specific Recommendations
Guideline for Hand Hygiene in Health-Care Settings. Recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force. MMWR Recomm Rep 2002 Oct; 51(RR16):1-44.	http://www.cdc.gov/hicpac/pubs.html (accessed 4/30/2015) http://www.cdc.gov/mmwr/PDF/rr/rr5116.pdf (redirects to PDF) (accessed 4/30/2015)	CAUTI CDAD CLABSI S-SSI Staph sepsis	Levels Ib and III: Literature review, evidence rating, and expert opinion	Although the recommendations are graded, this report received a grade of Ib because the literature review was not described as systematic. Authors of this report could not locate a historic description of CDC/HICPAC guideline development methods in use at that time.	CAUTI and CLABSI: “Decontaminate hands before donning sterile gloves when inserting a central intravascular catheter (IB). Decontaminate hands before inserting indwelling urinary catheters, peripheral vascular catheters, or other invasive devices that do not require a surgical procedure (IB).” CDAD: Decontaminate hands after contact with a patient’s intact skin (e.g., when taking a pulse or blood pressure, and lifting a patient) (IB) Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient (II) C-SSI, S-SSI, and Staph sepsis: The guideline contains graded recommendations for hand hygiene during procedures included in both the selected and candidate surgical site infection HACs.

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Table B-1 (continued)
Identified guidelines for multiple infection-related conditions

Evidence-based guideline and publishing organization	Location	Relevant HACs	Evidence level	Comments	HAC-Specific Recommendations
IDSA/SHEA. Strategies to Prevent Healthcare-Associated Infections Through Hand Hygiene. <i>Infect Control Hosp Epidemiol</i> 2014; 35(8):937-960	http://www.jstor.org/stable/10.1086/677145 (accessed 4/30/2015)	CAUTI CDAD CLABSI C-SSI S-SSI	Levels Ib and III: Literature search, evidence rating and expert opinion	From: SHEA/IDSA Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals, http://www.shea-online.org/PriorityTopics/CompendiumofStrategiestoPreventHAIs.aspx (accessed 4/30/2015) Evidence grading is based on Grades of Recommendation, Assessment, Development, and Evaluation (GRADE) and the Canadian Task Force on Preventive Health Care	CAUTI, CLABSI, C-SSI, and S-SSI: Contains recommendations for basic hand hygiene for all acute-care hospitals, including timing of hand hygiene performance and selection of cleansing agents, as well as recommendations for approaches that should not be considered part of routine hand hygiene: “Perform hand hygiene with an ABHR or, alternatively, an antimicrobial or nonantimicrobial soap for the following indications (quality of evidence: II). a. Before direct patient contact. c. Before inserting an invasive device d. Before and after handling an invasive device, including before accessing intravenous devices for medication administration.” CDAD: In addition to general recommendations for hand hygiene, contains one recommendation specific to <i>C. difficile</i> : “During <i>C. difficile</i> outbreaks or in settings with hyper-endemic CDI, in addition to contact precautions requiring the use of gloves, consider preferential use of soap and water after caring for patients with known or suspected CDI (quality of evidence: III)”

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Table B-1 (continued)
Identified guidelines for multiple infection-related conditions

Evidence-based guideline and publishing organization	Location	Relevant HACs	Evidence level	Comments	HAC-Specific Recommendations
Practice guidelines for central venous access: a report by the American Society of Anesthesiologists Task Force on Central Venous Access. <i>Anesthesiology</i> . 2012 Mar;116(3):539-73	http://www.guideline.gov/content.aspx?id=36196 (accessed 4/30/2015) http://www.asahq.org/~media/Sites/ASAHQ/Files/Public/Resources/standards-guidelines/practice-guidelines-for-central-venous-access.pdf (accessed 4/30/2015) (redirects to PDF)	CLABSI Staph sepsis	Levels Ib and III: Literature search, evidence rating and expert opinion	Evidence grading is based on the number and type of studies.	CLABSI: Recommendations cover preparation of the surgical environment, intravenous antibiotic prophylaxis, aseptic preparation and selection of antiseptic solution, and selection of catheter insertion sites. Staph sepsis: “Randomized controlled trials indicate that catheter-related infections and sepsis are reduced when prophylactic intravenous antibiotics are administered to high-risk immunosuppressed cancer patients or neonates. (<i>Category A2 evidence</i>).”
CDC. Guidelines for the Prevention of Intravascular Catheter-related Infections, 2011.	http://www.cdc.gov/hicpac/BSI/BSI-guidelines-2011.html (accessed 4/30/2015) http://cid.oxfordjournals.org/content/early/2011/03/30/cid.cir257.full.pdf+html (accessed 4/30/2015)	CLABSI Staph sepsis	Levels Ia and III: Systematic review, evidence rating, and expert opinion	Work on the <i>Guidelines for the Prevention of Intravascular Catheter-Related Infections</i> was initiated prior to implementation of CDC’s revised methodology for guideline development. Therefore, this guideline reflects the development methods that were used for guidelines produced prior to 2009.	CLABSI: Detailed recommendations for prevention of infection during central venous line and vascular access catheter insertion and maintenance in adults and children. Staph Sepsis: Addresses central venous line and vascular access catheters insertion and maintenance in adults and children. Use of 10% povidone iodine at site of catheter insertion may decrease “colonization, exit-site infection, or bloodstream infection” among patients undergoing hemodialysis, especially those with nasal colonization of <i>S. aureus</i> .

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Table B-1 (continued)
Identified guidelines for multiple infection-related conditions

Evidence-based guideline and publishing organization	Location	Relevant HACs	Evidence level	Comments	HAC-Specific Recommendations
Guidelines for Environmental Infection Control in Health-Care Facilities, 2003; CDC and the Healthcare Infection Control Practices Advisory Committee MMWR Recomm Rep. 2003 June 6; 52(RR10);1-42	http://www.cdc.gov/hicpac/pdf/guidelines/eic_in_HCF_03.pdf (accessed 4/30/2015)	CDAD C-SSI Leg. MRSA S-SSI	Levels Ib and III: Literature review and expert opinion.	Errata here: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5242a9.htm (accessed 4/30/2015)	CDAD: "... for inactivating <i>Clostridium difficile</i> spores, use hypochlorite-based products for disinfection of environmental surfaces in accordance with guidance from the scientific literature in those patient-care areas where surveillance and epidemiology indicate ongoing transmission of <i>C. difficile</i> (274,319,334). Category II" C-SSI and S-SSI: Contains recommendations for general prevention of surgical site infection through surgical and disinfection procedures. C-SSI: "No recommendation is offered for performing orthopedic implant operations in rooms supplied with laminar airflow. <i>Unresolved issue</i> " Legionnaires': Contains extensive recommendations for Controlling Waterborne, Health-Care–Associated Legionnaires Disease as well as General Infection-Control Strategies for Preventing Legionnaires Disease MRSA: "Use standard cleaning and disinfection protocols to control environmental contamination with antibiotic-resistant, gram-positive cocci (e.g., methicillin-resistant <i>Staphylococcus aureus</i> , vancomycin intermediate sensitive <i>Staphylococcus aureus</i> , or vancomycin-resistant <i>Enterococcus</i> [VRE]) (318,320--322). Category IB" (accessed 4/20/2014) S-SSI: Remove bird roosts and nests near air intakes to prevent mites and fungal spores from entering the ventilation system. <i>Category IB</i>

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Table B-1 (continued)
Identified guidelines for multiple infection-related conditions

Evidence-based guideline and publishing organization	Location	Relevant HACs	Evidence level	Comments	HAC-Specific Recommendations
Bratzler DW, Dellinger EP, Olsen KM, Perl TM, Auwaerter PG, Bolon MK, Fish DN, Napolitano LM, Sawyer RG, Slain D, Steinberg JP, Weinstein RA. Clinical practice guidelines for antimicrobial prophylaxis in surgery. Am J Health Syst Pharm. 2013 Feb 1;70(3):195-283.	http://www.guideline.gov/content.aspx?id=39533 (accessed 4/30/2015) http://www.ashp.org/DocLibrary/BestPractices/TGSurgery.aspx (accessed 4/30/2015) (Redirects to PDF)	C-SSI MRSA S-SSI Staph Sepsis	Levels Ia and III: Systematic review, evidence rating and expert opinion	Guideline authors note that the system of evidence grading used in this guideline is the same as that used by AHRQ, ASHP, IDSA, SIS, and SHEA. The authors state that “the strength of evidence represents only support for or against prophylaxis and does not apply to the antimicrobial choice, dose, or dosage regimen.”	C-SSI and S-SSI: Includes recommendations for preoperative-dose timing, selection and dosing, duration of prophylaxis, and principles common across various types of surgical procedures, including cardiac and cardiac device insertion, certain orthopedic procedures, and total joint replacements. MRSA and Staph sepsis: For patients undergoing cardiac procedures...mupirocin should be given intranasally to all patients with documented <i>S. aureus</i> colonization. (Strength of evidence for prophylaxis = A.)
Management of Multidrug-resistant Organisms in Healthcare Settings, 2006; CDC-HICPAC	http://www.cdc.gov/hicpac/mdro/mdro_toc.html . (accessed 4/30/2015)	CDAD MRSA Staph sepsis	Levels Ib and III: Evidence rating and expert opinion	None.	Strategies to detect and prevent the spread and treat infections with multidrug resistant organisms, including C. difficile , MRSA , and Staph-related sepsis are recommended.
Guidelines for Preventing Health-Care–Associated Pneumonia, 2003; CDC	http://www.cdc.gov/hicpac/pdf/guidelines/CDcpneumo_guideline_s.pdf (accessed 4/30/2015)	Leg. VAP	Levels Ib and III: Evidence rating and expert opinion	None	Legionnaires’ : Separate section contains recommendations related to prevention of Legionnaires’ disease. VAP: Recommendations for general infection control and specific measures for ventilator circuits for prevention of VAP.

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Table B-1 (continued)
Identified guidelines for multiple infection-related conditions

Evidence-based guideline and publishing organization	Location	Relevant HACs	Evidence level	Comments	HAC-Specific Recommendations
Guideline for Prevention of Surgical Site Infection, 1999; CDC Infect Control Hosp Epidemiol. 1999 Apr;20(4):250-78	http://www.cdc.gov/hicpac/pdf/guidelines/SI_1999.pdf (accessed 4/30/2015)	C-SSI S-SSI	Levels Ib and III: Evidence rating and expert opinion	Detailed recommendations for infection prevention before, during, and after all surgical procedures. Update in progress. Draft guidelines are available at http://www.regulations.gov/#!documentDetail;D=CD-C-2014-0003-0002 (accessed 4/30/2015)	Comprehensive recommendations for prevention of surgical site infections , including antimicrobial prophylaxis for total joint replacements (C-SSI) and cardiac surgeries and certain orthopedic surgeries (S-SSI).
IDSA/SHEA. Strategies to Prevent Surgical Site Infections in Acute Care Hospitals: 2014 Update. 2014. <i>Infect Control Hosp Epidemiol</i> 2014, 35(6):605-627.	http://www.jstor.org/stable/pdfplus/10.1086/591064.pdf?acceptTC=true (accessed 4/30/2015)	C-SSI MRSA S-SSI Staph Sepsis	Levels Ib and III: Literature search, evidence rating and expert opinion	From: SHEA/IDSA Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals, http://www.shea-online.org/PriorityTopics/CompendiumofStrategiestoPreventHAIs.aspx (accessed 4/30/2015) Evidence grading is based on Grades of Recommendation, Assessment, Development, and Evaluation (GRADE) and the Canadian Task Force on Preventive Health Care	General recommendations for prevention of surgical site infection. C-SSI, MRSA, Staph sepsis, S-SSI: Screen for <i>S. aureus</i> and decolonize surgical patients with an antistaphylococcal agent in the preoperative setting for high-risk procedures, including some orthopedic and cardiothoracic procedures (quality of evidence: II). S-SSI: Includes some recommendations related to cardiac surgery: "Stop prophylaxis within 24 hours after the procedure for all procedures except cardiac surgery; for cardiac surgery, antimicrobial prophylaxis should be stopped within 48 hours" as well as total joint replacement

B.2 Guidelines for Selected Infection-related HACs

In **Tables B-2** through **B-4** below, we present the current guidelines identified through our searches that provide recommendations to prevent specific selected infection-related HACs:

- Catheter-associated urinary tract infection (CAUTI)
- Vascular catheter-associated infection (CLABSI)
- Surgical site infection (SSI) following Coronary Artery Bypass Graft (mediastinitis), Cardiac Implantable Electronic Device (CIED), bariatric surgery (laparoscopic gastric bypass, gastroenterostomy, or laparoscopic gastric restrictive surgery), or certain orthopedic procedures (spine, neck, shoulder, or elbow). (S-SSI)

Table B-2
Identified guidelines for catheter-associated urinary tract infection

Evidence-based guideline and publishing organization	Location	Relevant HACs	Evidence level	Comments	HAC-Specific Recommendations
Catheter-associated urinary tract infection					
HICPAC, CDC. Guideline for Prevention of Catheter Associated Urinary Tract Infection (CAUTI), 2009.	http://www.cdc.gov/hicpac/pdf/CAUTI/CAUTIguideline2009final.pdf (accessed 4/30/2015) (Redirects to PDF document)	CAUTI	Level Ia and III: Systematic review, evidence rating, and expert opinion	Appendices here: http://www.cdc.gov/hicpac/pdf/CAUTI/CAUTI_GuidelineAppendices2009final.pdf (accessed 4/30/2015) (Redirects to PDF document)	Recommendation for the appropriate use and procedures for insertion and maintenance of urinary catheters to minimize the occurrence of urinary tract infection
Infectious Diseases Society of America and the Society for Healthcare Epidemiology of America (IDSA/SHEA). Strategies to Prevent CAUTI in Acute Care Hospitals. Infect Control Hosp Epidemiol 2014 35(5):464-479.	http://www.jstor.org/stable/10.1086/675718 (accessed 4/30/2015)	CAUTI	Levels Ib and III: Literature search, evidence rating and expert opinion	From: SHEA/IDSA Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals, http://www.shea-online.org/PriorityTopics/CompendiumofStrategiestoPreventHAIs.aspx (accessed 4/30/2015) Evidence grading is based on Grades of Recommendation, Assessment, Development, and Evaluation (GRADE) and the Canadian Task Force on Preventive Health Care	Recommendations for preventing and monitoring catheter-associated urinary tract infection

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Table B-2 (continued)
Identified guidelines for catheter-associated urinary tract infection

Evidence-based guideline and publishing organization	Location	Relevant HACs	Evidence level	Comments	HAC-Specific Recommendations
American Urologic Association Education and Research, Inc. Best Practice Policy Statement on Urological Surgery Antimicrobial Prophylaxis. 2008. (Reviewed and validity confirmed 2010; updated February 2012).	http://www.guideline.gov/content.aspx?id=12210 (accessed 4/30/2015) http://www.auanet.org/education/guidelines/antimicrobial-prophylaxis.cfm (accessed 4/30/2015)	CAUTI	Levels Ib and III: Literature search, evidence rating and expert opinion	None.	Prophylactic antibiotic recommendations for urologic instrumentation. Including catheters to prevent systemic infections in select patients

Table B-3
Identified guidelines for vascular catheter-associated infection

Evidence-based guideline and publishing organization	Location	Relevant HACs	Evidence level	Comments	HAC-Specific Recommendations
Vascular catheter-associated infection Association for Vascular Access (AVA), American Society of Diagnostic and Interventional Nephrology (ASDIN). Preservation of peripheral veins in patients with chronic kidney disease. 2008.	http://www.avainfo.org/website/download.asp?id=193195 (accessed 4/30/2015) (Redirects to PDF document)	CLABSI	Level II: Evidence cited	Association website: http://www.avainfo.org/website/article.asp?id=1441 (accessed 4/30/2015)	Recommendations address the need for specialized venous access care in patients with chronic kidney disease.
Clinical Practice Guidelines for Vascular Access, Update 2006. National Kidney Foundation, Kidney Disease Outcomes Quality Initiative Vascular Access Work Group (NFK-DOQI), 2006 Am J Kidney Dis 2006 Jul;48 Suppl 1:S248-73	https://www.kidney.org/sites/default/files/docs/12-50-0210_jag_dcp_guide_lines-va_oct06_section_0fc.pdf (accessed 4/30/2015) (redirects to PDF)	CLABSI	Levels Ia and III: Systematic review, evidence rating, and expert opinion	Detailed guidelines. NFK-DOQI clinical guidelines are here: https://www.kidney.org/professionals/KDOQI/guidelines_commentaries (accessed 4/30/2015)	Includes recommendations for “Infection-control measures that should be used for all HD catheters and port catheter systems”

(continued)

Table B-3 (continued)
Identified guidelines for vascular catheter-associated infection

Evidence-based guideline and publishing organization	Location	Relevant HACs	Evidence level	Comments	HAC-Specific Recommendations
IDSA/SHEA. Strategies to Prevent Central Line-Associated Bloodstream Infection in Acute Care Hospitals, 2014 Update. <i>Infect Control Hosp Epidemiol</i> 2014, 35(7):753-771.	http://www.jstor.org/stable/10.1086/676533 (accessed 4/30/2015)	CLABSI	Level Ib and III: Systematic review, evidence rating and expert opinion	From: SHEA/IDSA Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals, http://www.shea-online.org/PriorityTopics/CompendiumofStrategiesToPreventHAIs.aspx (accessed 4/30/2015) Evidence grading is based on Grades of Recommendation, Assessment, Development, and Evaluation (GRADE) and the Canadian Task Force on Preventive Health Care	CLABSI: Comprehensive recommendations for the insertion and maintenance of central line catheters

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Table B-3 (continued)
Identified guidelines for vascular catheter-associated infection

Evidence-based guideline and publishing organization	Location	Relevant HACs	Evidence level	Comments	HAC-Specific Recommendations
Oncology Nursing Society. Access Device Guidelines- Recommendations for Nursing Practice and Education, 3 rd ed. 2011	http://www.ons.org/products/access-device-guidelines-recommendations-nursing-practice-and-education-third-edition (accessed 4/30/2015) (Available for purchase)	CLABSI	Level II: Evidence cited	Evidence not specific to each recommendation	CLABSI: Addresses peripheral and central lines for administration of chemotherapy.
Schiffer, C. A., P. B. Mangu, et al. (2013). "Central venous catheter care for the patient with cancer: American Society of Clinical Oncology clinical practice guideline." <i>J Clin Oncol</i> 31 (10): 1357-1370	http://www.asco.org/quality-guidelines/central-venous-catheter-care-patient-cancer-american-society-clinical-oncology (accessed 4/30/2015)	CLABSI	Levels Ia and III: Systematic review, evidence rating, and expert opinion	Supplemental materials including an evidence table are available at http://www.asco.org/sites/www.asco.org/files/cvc_ds_3.4.13_0.pdf (Redirects to PDF) (accessed 4/30/2015)	Contains recommendations for use of central venous catheter clinical care bundles and use of use of antimicrobial/antiseptic-impregnated or -coated CVCs (CH-SS or minocycline/rifampin) and/or heparin-impregnated Catheters; recommends against prophylactic use of systemic antibiotics (IV or oral) before insertion of long-term catheters.

Table B-4
Identified guidelines for selected surgical site infections

Evidence-based guideline and publishing organization	Location	Relevant HACs	Evidence level	Comments	HAC-Specific Recommendations
Surgical site infection (S-SSI)					
<i>Following CABG (mediastinitis), CIED, bariatric surgery (laparoscopic gastric bypass, gastroenterostomy, or laparoscopic gastric restrictive surgery), or certain orthopedic procedures (spine, neck, shoulder, or elbow).</i>					
North American Spine Society (NASS). Antibiotic Prophylaxis in Spine Surgery, 2013 update.	https://www.spine.org/Documents/ResearchClinicalCare/Guidelines/AntibioticProphylaxis.pdf (accessed 4/30/2015) (Redirects to PDF document)	S-SSI	Levels Ia and III: Literature search, evidence rating and expert opinion	Supplemental technical material is here: https://www.spine.org/Documents/ResearchClinicalCare/Guidelines/AntibioticProphylaxisTechReport.pdf (accessed 4/30/2015) (Redirects to PDF document)	“Patients undergoing spine surgery should receive preoperative prophylactic antibiotics.”

(continued)

Table B-4 (continued)
Identified guidelines for selected surgical site infections

Evidence-based guideline and publishing organization	Location	Relevant HACs	Evidence level	Comments	HAC-Specific Recommendations
Society of Thoracic Surgeons Workforce on Evidence Based Surgery. Antibiotic prophylaxis in cardiac surgery, Part I: Duration. 2005.	http://www.sts.org/sites/default/files/documents/pdf/guidelines/AntibioticProphylaxisinCardiacSurgeryPartIDuration.pdf (accessed 4/30/2015) (Redirects to PDF)	S-SSI	Levels Ib and III: Literature search, evidence rating and expert opinion.	The type of evidence is identified and graded for major recommendations. Antibiotic guidelines are available here: http://www.sts.org/resources-publications/clinical-practice-credentialing-guidelines/antibiotic-guidelines (accessed 4/30/2015)	Contains recommendations with respect to antibiotic duration and catheterization, single dose prophylaxis, and duration of administration.
Society of Thoracic Surgeons Workforce on Evidence Based Surgery. Antibiotic prophylaxis in cardiac surgery, Part II: Antibiotic Choice. 2007.	http://www.guideline.gov/content.aspx?id=10411 (accessed 4/30/2015) http://www.sts.org/sites/default/files/documents/pdf/guidelines/AntibioticProphylaxisinCardiacSurgeryPartIIAntibiotic_Choice.pdf (accessed 4/30/2015) (redirects to pdf)	S-SSI	Levels Ib and III: Literature search, evidence rating and expert opinion.	The type of evidence is identified and graded for major recommendations. Guideline developers reaffirmed the currency of this guideline in 2011.	Major recommendations for prevention of surgical site infections following cardiac surgery—soft tissue sterna infections and suppurative mediastinitis—include those application of topical antibiotics, choice of primary prophylactic antibiotic, and appropriate dosing.

(continued)

Table B-4 (continued)
Identified guidelines for selected surgical site infections

Evidence-based guideline and publishing organization	Location	Relevant HACs	Evidence level	Comments	HAC-Specific Recommendations
American Association of Clinical Endocrinologists, The Obesity Society, and American Society for Metabolic and Bariatric Surgery. Medical Guidelines for Clinical Practice for the Perioperative Nutritional, Metabolic, and Nonsurgical Support of the Bariatric Surgery Patient. 2013 update. <i>Endocr Pract</i> 19 (2): 337-372.	http://www.ncbi.nlm.nih.gov/pubmed/23529351 (accessed 4/30/2015) http://s3.amazonaws.com/publicASMBS/GuidelinesStatement/s/Guidelines/AACE_TOS_ASMBS_Clinical_Practice_Guidlines_3.2013.pdf (redirects to PDF) (accessed 4/30/2015)	S-SSI	Levels Ia and III: Literature search, evidence rating and expert opinion	Minimal mention of surgical site infection.	“Tobacco use should be avoided at all times by all patients. In particular, patients who smoke cigarettes should stop, preferably at least 6 weeks before bariatric surgery (<i>Grade A; BEL 2, upgraded by consensus</i>). Also, tobacco use should be avoided after bariatric surgery given the increased risk for of poor wound healing, anastomotic ulcer, and overall impaired health (<i>Grade A; BEL 1</i>).” Authors note that, “The relative risk conferred by cigarette smoking on the incidence of infections in post-bariatric surgery patients undergoing body contouring abdominoplasty is 14, with a cutoff of 8.5 pack-years (185 [EL 3, SS]).”
Institute for Clinical Systems Improvement (ICSI) Perioperative protocol. Health care protocol, 2014. 5 th edition.	https://www.icsi.org/guidelines_more/catalog_guidelines_and_more/catalog_guidelines/catalog_patient_safetyreliability_guidelines/perioperative/ (accessed 4/30/2015)	S-SSI	Levels Ia and III: Systematic review, evidence rating and expert opinion	The 2014 update is in transition to GRADE methodology. A summary of changes from the previous version is here: https://www.icsi.org/asset/5h7ypw/PeriopSoC.pdf (accessed 4/29/2015)	S-SSI: “Prophylactic antibiotic should be discontinued within 48 hours after surgery end-time for all coronary artery bypass graft (CABG)/cardiac procedures.”

B.3 Guidelines for Candidate Infection-related HACs

No guidelines were located that focused solely on Surgical site infection (SSI) following hip or knee orthopedic procedures (C-SSI); therefore, tables for this candidate HAC are not included in this section of the Appendix. For guidelines related to C-SSI, please refer instead to [Table B-1](#).

B.4 Guidelines for Previously Considered Infection-related HACs

In [Tables B-5](#) through [B-7](#) below, we present the guidelines identified through our searches that provide recommendations to prevent specific candidate infection-related HACs:

- Ventilator-associated pneumonia (VAP)
- *Clostridium difficile* associated disease (CDAD)
- Legionnaires' disease (Leg.)

No guidelines were located that focused solely on Legionnaires' disease or *Staphylococcus aureus* sepsis (Staph sepsis); therefore, tables for these two HACs are not included in this section of the Appendix. For guidelines related to these HACs, please refer instead to [Table B-1](#).

Table B-5
Identified guidelines for ventilator-associated pneumonia

Evidence-based guideline and publishing organization	Location	Relevant HACs	Evidence level	Comments	Prevention recommendations
Ventilator-associated pneumonia					
American Thoracic Society, Infectious Diseases Society of America. Guidelines for the Management of Adults with Hospital-acquired, Ventilator-associated, and Healthcare-associated Pneumonia. <i>American Journal of Respiratory and Critical Care Medicine</i> , 2005; Vol. 171. pp. 388-416	https://www.thoracic.org/statements/resources/mtpi/guide1-29.pdf (accessed 4/30/2015)	VAP	Levels Ib and III: Literature search, evidence rating and expert opinion	Listed on the ATA website as under revision. (https://www.thoracic.org/professionals/clinical-resources/disease-related-resources/pneumonia.php , accessed 4/30/2015)	Recommendation for assessment and reduction of risk factors and treatment of Ventilator-associated pneumonia
Hartford Institute for Geriatric Nursing. Balas MC, Casey CM, Happ MB. Comprehensive assessment and management of the critically ill. In: Boltz M, Capezuti E, Fulmer T, Zwicker D, editor(s). Evidence-based geriatric nursing protocols for best practice. 4 th ed. New York (NY): Springer Publishing Company; 2012 Nov. p. 600-27.	http://www.guideline.gov/content.aspx?id=43919 (accessed 4/30/2015) Chapter available for purchase; corresponding protocol available here: http://consultgerirn.org/topics/critical_care/want_to_know_more (accessed 4/30/2015)	VAP	Levels Ia and III: Systematic review, evidence rating, and expert opinion	None	“Exercise standard ventilator-associated pneumonia (VAP) precautions. Keep the head of the bed elevated to more than 30 degrees. Provide frequent oral care. Assess the need for stress ulcer prophylaxis. Turn the patient as tolerated Maintain general hygiene practices”

(continued)

Table B-5 (continued)
Identified guidelines for ventilator-associated pneumonia

Evidence-based guideline and publishing organization	Location	Relevant HACs	Evidence level	Comments	Prevention recommendations
AARC Clinical Practice Guidelines: Care of the Ventilator Circuit and Its Relation to Ventilator-Associated Pneumonia. <i>Respir Care</i> . 2003;48:869–879.	http://www.rcjournal.com/cpgs/pdf/09.03.0869.pdf (accessed 4/30/2015) (Redirects to PDF document)	VAP	Levels Ia and III: Systematic review, evidence rating, and expert opinion	AARC clinical practice guidelines are available here: http://www.rcjournal.com/cpgs/index.cfm (accessed 4/30/2015)	Identifies risk factors and recommends practices for management of the ventilator circuit to prevent ventilator-associated pneumonia
IDSA/SHEA. Strategies to prevent ventilator-associated pneumonia in acute care hospitals: 2014 Update. <i>Infect Control Hosp Epidemiol</i> . 2014 35(8):915-936.	http://www.jstor.org/stable/10.1086/677144 (accessed 4/30/2015)	VAP	Level Ib and III: Literature search and evidence rating	From: SHEA/IDSA Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals, http://www.shea-online.org/PriorityTopics/CompendiumofStrategiestoPreventHAIs.aspx (accessed 4/30/2015) Evidence grading is based on Grades of Recommendation, Assessment, Development, and Evaluation (GRADE) and the Canadian Task Force on Preventive Health Care	Includes special approaches for the prevention of VAP for use in locations and/or populations within the hospital; also approaches that should not be considered a routine part of VAP prevention. Each recommendation includes a ranking for the quality of evidence supporting it.

Table B-6
Identified guidelines for CDAD

Evidence-based guideline and publishing organization	Location	HACs	Evidence level	Comments	Prevention recommendations
<i>Clostridium difficile</i> disease IDSA/SHEA. Strategies to Prevent <i>Clostridium difficile</i> Infections in Acute Care Hospitals: 2014 Update. <i>Infect Control Hosp Epidemiol</i> 2014; 35(6):628-645.	http://www.jstor.org/stable/10.1086/676023 (accessed 04/30/2015)	CDAD	Levels Ib and III: Literature search, evidence rating and expert opinion	From: SHEA/IDSA Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals, http://www.shea-online.org/PriorityTopics/CompendiumofStrategiesToPreventHAIs.aspx (accessed 04/30/2015) Evidence grading is based on Grades of Recommendation, Assessment, Development, and Evaluation (GRADE) and the Canadian Task Force on Preventive Health Care	Comprehensive recommendations for prevention of <i>C. difficile</i> transmission and implementation of prevention and monitoring strategies.
IDSA/SHEA. Clinical Practice Guidelines for <i>Clostridium difficile</i> Infection in Adults: 2010 Update. <i>Infect Control Hosp Epidemiol</i> . 2010 May;31(5):431-55.	http://www.journals.uchicago.edu/doi/full/10.1086/651706 (accessed 04/30/2015)	CDAD	Levels Ia and III: Systematic review, evidence rating, and expert opinion	None	Lists prevention and control measures including recommendations for hospital staff and visitors, environmental disinfection, antimicrobial use restrictions, and probiotics.

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Table B-6 (continued)
Identified guidelines for CDAD

Evidence-based guideline and publishing organization	Location	HACs	Evidence level	Comments	Prevention recommendations
American College of Gastroenterology. Surawicz CM, Brandt LJ, Binion DG, Ananthakrishnan AN, Curry SR, Gilligan PH, McFarland LV, Mellow M, Zuckerbraun BS. Guidelines for diagnosis, treatment, and prevention of Clostridium difficile infections. Am J Gastroenterol. 2013 Apr;108(4):478-98.	http://www.guideline.gov/content.aspx?id=45139 (accessed 04/30/2015) http://gi.org/guideline/diagnosis-and-management-of-c-difficile-associated-diarrhea-and-colitis/ (accessed 04/30/2015)	CDAD	Levels Ia and III: Systematic review, evidence rating, and expert opinion	Evidence was evaluated according to the GRADE system	Presents recommendations for prevention (environmental disinfection); diagnosis; management of mild, moderate, severe, recurrent, and complicated CDI; and management of patients with CDI and comorbidities.

Table B-7
Identified guidelines for MRSA

Evidence-based guideline and publishing organization	Location	HACs	Evidence level	Comments	Prevention recommendations
Methicillin-resistant <i>Staphylococcus aureus</i> IDSA/SHEA. Strategies to Prevent Transmission of Methicillin-Resistant <i>Staphylococcus aureus</i> in Acute Care Hospitals: 2014 Update. <i>Infect Control Hosp Epidemiol.</i> 2014; 35(7).	http://www.jstor.org/stable/10.1086/676534 (accessed 04/30/2015)	MRSA	Levels Ib and III: Literature search, evidence rating and expert opinion	From: SHEA/IDSA Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals, http://www.shea-online.org/PriorityTopics/CompendiumofStrategiestoPreventHAIs.aspx (accessed 04/30/2015) Evidence grading is based on Grades of Recommendation, Assessment, Development, and Evaluation (GRADE) and the Canadian Task Force on Preventive Health Care	Strategies to detect MRSA colonization, prevent its spread and treat infections are recommended
SHEA. Guideline for Preventing Nosocomial Transmission of Multidrug Resistant Strains of <i>Staphylococcus aureus</i> and Enterococcus. <i>Infect Control Hosp Epidemiol.</i> 2003 May; 24(5):362-86.	http://www.shea-online.org/Assets/files/position_papers/SH_EA_MRSA_VRE.pdf (accessed 04/30/2015)	MRSA	Level Ia: Systematic Review and evidence rating	Not listed in the National Guideline Clearinghouse	Recommends strategies to detect and prevent the spread of MRSA in the community and the hospital setting

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Table B-7 (continued)
Identified guidelines for MRSA

Evidence-based guideline and publishing organization	Location	HACs	Evidence level	Comments	Prevention recommendations
Wisconsin Division of Public Health. Community Associated Methicillin-resistant <i>Staphylococcus Aureus</i> : Guidelines for Clinical Management and Control of Transmission, 2011.	http://www.dhs.wisconsin.gov/publications/P4/P42160.pdf (accessed 04/30/2015)	MRSA	Levels II and III: Evidence cited and expert opinion	None	Guidelines for the detection of colonization, prevention of transmission and treatment of MRSA