

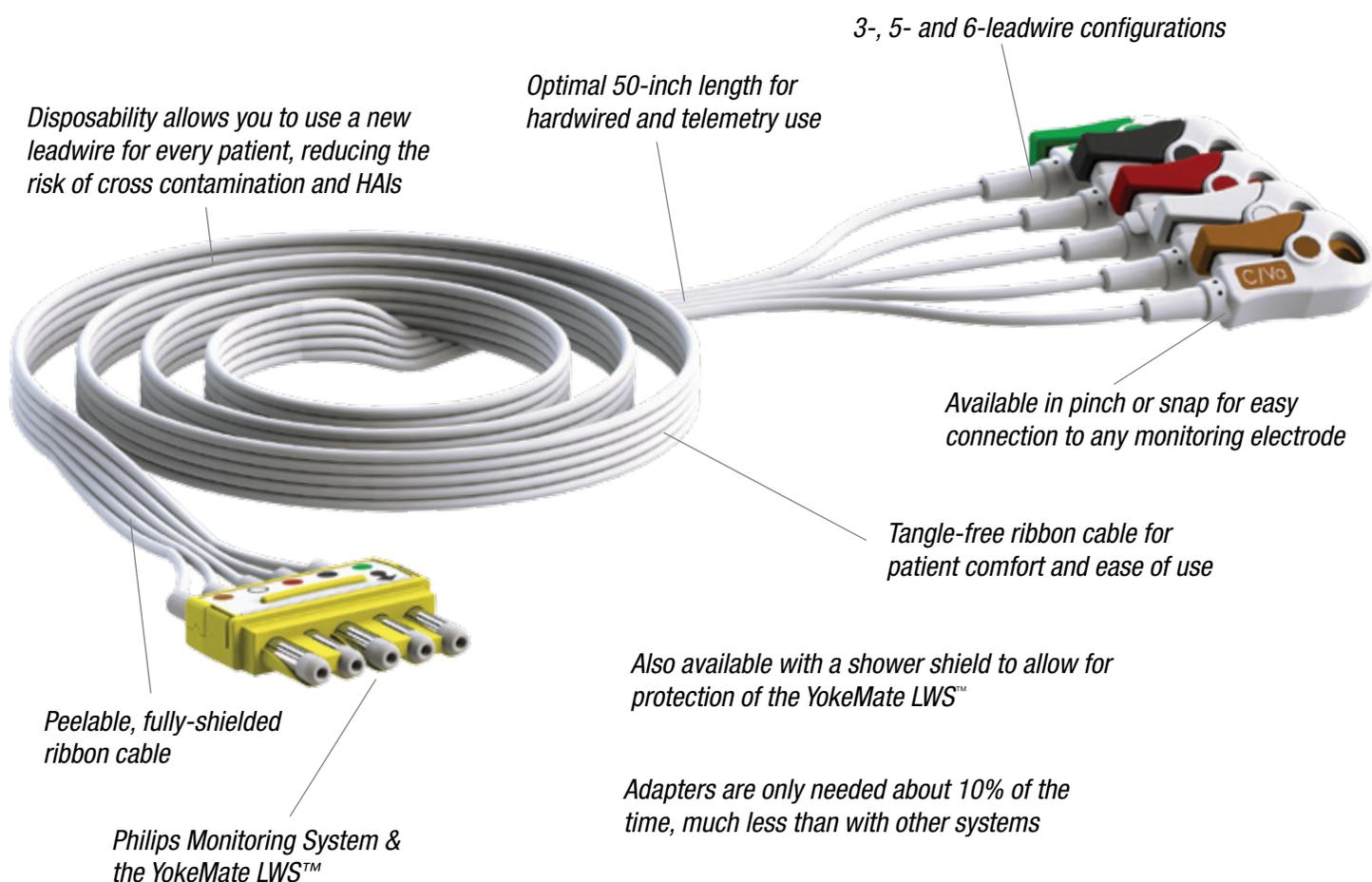
Minimize risk. Standardize inventory. Utilize one source.

3M has been a global leader in ECG technology for several decades. And now we are partnering with Advantage Medical Cables & Electrodes to bring you a wide variety of disposable leadwire solutions. These solutions enable you to connect to almost any make of monitoring equipment on the market today. In addition, they help make it possible to reduce the risk of cross contamination, improve efficiency, and improve patient comfort and outcomes.

One set of leadwires can be used for each patient throughout their stay

Improve hospital efficiency through “unplug and plug” capabilities

Reduce the risk of cross contamination



Reusable ECG leadwires can, and do, cause infections.



Antibiotic-Resistant Pathogens Found on 77% of ECG Lead Wires¹

“Cultured 100 randomly selected ECG telemetry leads after they had been reprocessed and immediately before their planned attachment to new ICU patients.”

“77% of the ECG leads were contaminated with one or more antibiotic-resistant nosocomial pathogens.”



The Not-So-Hidden Cost of Surgical Site Infections²

“In an effort to reduce sternal wound infections, three separate hospitals began using disposable ECG lead wires in their ICUs. In all three hospitals, the frequency of sternal wound infections decreased by more than 90%, a result that hospital administrators largely attributed to the use of disposable ECG lead wires.”

“The decrease in the total number of infections and the corresponding costs that were avoided as a result of implementing this new... disposable system paid for the system in the first two months of use.”

“One medical center near Richmond, VA, began using a disposable ECG lead wire set ... and subsequently experienced a 40% decrease in SSIs.”

ABSTRACT

SURGICAL SITE INFECTIONS (SSIs) adversely affect approximately 500,000 patients annually, causing immense human suffering and taking a huge financial toll on patients, hospitals, insurance companies, and the government.

NATIONAL ORGANIZATIONS have made recommendations for reducing SSIs, and many advances have been made in evidence-based practice recommendations that result in fewer SSIs.

REUSABLE ELECTROCARDIOGRAM (ECG) lead wires can be a significant source of infection. One medical center near Richmond, VA, began using a disposable ECG lead wire set and wireless transmitter system and subsequently experienced a 40% decrease in SSIs. *AORN J* 86 (August 2007) 249-258. © AORN, Inc, 2007.

OUTBREAK OF VANCOMYCIN-RESISTANT ENTEROCOCCI IN A BURN UNIT

Patricia S. Falk, MPH, Janice Winnike, BSN, Carla Woodmansee, MT(ASCP), M. Desai, MD, C. Glen Mayhall, MD

ABSTRACT

OBJECTIVE: To investigate and control an outbreak of colonization and infection caused by vancomycin-resistant enterococci (VRE) in a burn intensive care unit (ICU).

DESIGN: Epidemiologic investigation, including multiple point-prevalence culture surveys of patients and environment, cultures from hands of healthcare workers (HCWs), and ecological (epidemiologic) typing of patient and environmental isolates, case-control study, and isolation and monitoring of control measures.

SETTING: ICU in an 800-bed university medical center in Galveston, Texas.

RESULTS: Between June 6, 1996, and July 14, 1997, 21 patients were colonized by VRE, and 4 of these patients developed bacteremia. Of 248 environmental cultures, 121 (49%) were positive, but all hand cultures from HCWs were negative. PFGE typing indicated that the outbreak was clonal, with VRE isolates from patients differing by <4 bands from the index case. The trees of 14 environmental isolates worked by <4 bands from the pattern of the index case. A case-control study analyzed by exact logistic regression identified diarrhea (OR, 4.13; 95% confidence interval [CI], 1.5-11.4; P=0.01) and administration of an antacid (OR, 3.14; 95% CI, 1.0-10.0; P=0.04) as independent risk factors for acquisition of VRE. During a 5-week period in October and November 1996, all patient and 517 environmental cultures were negative for VRE. The outbreak recurred from a contaminated electrocardiogram lead that had not been identified during the prior 5 weeks. VRE were finally eradicated from the ICU in July 1997, using barrier isolation and a very aggressive environmental decontamination program.

CONCLUSIONS: A VRE outbreak in a ICU over 13 months was caused by a single clone. After apparent eradication of VRE from a ICU, reoccurrence of the outbreak occurred, evidently from a small, unsuspected source of environmental contamination: single-point environmental (E) tract function (quality) and administration of medications, other than antibiotics, that have an effect on the GI tract may increase the risk of GI tract colonization by VRE in burn patients. Application of barrier isolation and an aggressive environmental decontamination program can eradicate VRE from a burn population. *Infect Control Hosp Epidemiol* 2002;27:582-587.

The first outbreak due to vancomycin-resistant enterococci (VRE) was reported from England more than 10 years ago.¹ In the United States, data from the National Nosocomial Infection Surveillance System of the Centers

Outbreak of Vancomycin-Resistant *Enterococci* in a Burn Unit³

“The outbreak was restarted from a contaminated EKG lead that had been contaminated by the last patient with a culture positive for VRE in that room, 38 days earlier.”



3M Health Care
Infection Prevention Division
 3M Center, Building 275-4E-01
 St. Paul, MN 55144-1000
 USA
 1-800-228-3957
www.3m.com/patientmonitoring

YokeMate LWS is a registered trademark of Advantage Medical Electronics, Inc. Philips is a trademark of Koninklijke Philips Electronics N.V. Limited Liability Company. 3M and Red Dot are trademarks of 3M. Please recycle. Printed in U.S.A. © 3M 2013. All rights reserved. 70-2010-9173-6

1. Jancin, Bruce. “Antibiotic-Resistant Pathogens Found on 77% of ECG Lead Wires.” *Cardiology News*. 2(3) (2004):14.
2. Barnett, RN, MBA, Todd E. “The Not-So-Hidden Costs of Surgical Site Infections.” *AORN Journal*. 2000; 86(2):249-258.
3. Falk PS, Winnike J, Woodmansee C, Desai M, Mayhall CG. “Outbreak of Vancomycin-Resistant Enterococci in a Burn Unit.” *Infect Control and Hospital Epidemiology*. 2000;21(9):575-582.