Defend with Profend®

Nasal Antiseptic Kit
to protect surgical and
ICU patients from
infections.

60-second application with Profend® nasal antiseptic swabs kills 99.7% of *Staphylococcus aureus (S. aureus)* at 10 minutes and 99.9% at 12 hours.[1]

PDI®

BE THE DIFFERENCE®

PROFEND PVP-IODINE NASAL ANTISEPTIC SWABS.

*Defend with **Profend** nasal antiseptic kits.*

60 SEC

Apply in nose for 60 seconds.

15 seconds per swab— up to 2.5x faster than other PVP-Iodine swabs.[2] Use all 4 swabs for one application.

99.9%

Kills 99.7% of *S. aureus*

in 10 minutes and 99.9% at 12 hours.[1]

For surgery, ICU, and other hospital areas.

Ideal for patients colonized with *S. aureus.*[3]

SIMPLY **EFFECTIVE** INFECTION PREVENTION.

Slim, compact design for patient comfort.

96.6% of patients surveyed are comfortable with nasal application of PVP-Iodine.[4]

Preferred by over 90% of clinicians.[5]

Considered faster and more efficient to use than other nasal PVP-Iodine products.

Just snap and swab.

No preparation needed: pre-saturated swabs are easy to apply, with a neat, dry design.

DEFEND AGAINST SSIs, CLABSIs, AND OTHER HAIs.

30%

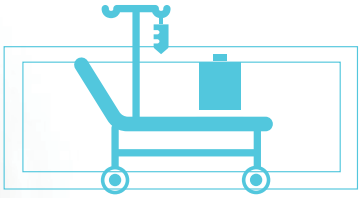
Up to 30% of healthy adults carry *S. aureus* nasally.[6]

85% of *S. aureus* SSIs* come from the patient's own nasal flora.[7]

9x the risk

Nasal colonization increases SSI risk up to 9x.[8]

77% of SSI-related deaths were directly attributable to the SSI.[9]



Patients in ICUs, long-term care and hemodialysis units are at risk.

S. aureus causes 12% of CLABSIs †[10] and 24% of VAPs.‡[11]

IDEAL FOR IN-PATIENT/AMBULATORY SURGERY AND THE ICU.

99.9%

Apply before any type of surgery.

Profend nasal antiseptic swabs kill *S. aureus* immediately and have 99.7% efficacy at 10 minutes and 99.9% at 12 hours.[1]

ICU

Administer to critical care patients per facility protocol.

Helps reduce the risk of *S. aureus* nasal re-colonization.

✓

Clinician-administered for 100% compliance.

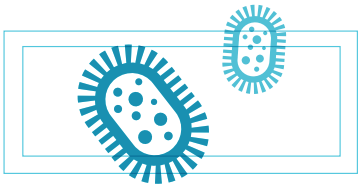
No mixing, mess or complicated steps: just use 4 swabs in nose in 60 seconds.

PROMOTE **BETTER** OUTCOMES AND REDUCE HAI RISK.

290,000

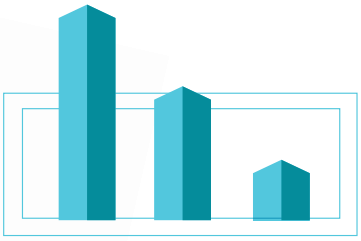
290,000 SSI events happen per year.[12]

SSIs are 20% of all HAIs[§12], and account for >90,000 readmissions annually.[13]



Surgical site infections can raise average surgical hospital costs by 82%.[14]

SSIs continue to be an expensive burden to hospital budgets.



Bacterial decolonization lowers hospital expenses.[15]

Decolonization has been shown to reduce HAIs, length of stays, and costs.

NASAL DECOLONIZATION IS PART OF A **NEW STANDARD** OF CARE.

CDC ✓

Nasal decolonization with PVP-I is now a CDC core strategy.[16]

Recommended to reduce *S. aureus* in high risk surgeries, critical care and central IV catheter patients.

60 SEC

Easy, efficient application promotes protocol compliance.

60 second **Profend** nasal antiseptic swab application is a simple part of the surgical or ICU routine.

Defend patients against antibiotic resistance.

As a PVP-Iodine antiseptic, **Profend** nasal swabs support your initiatives against antibiotic resistance.[17]

Defend with Profend nasal antiseptic swabs as part of a **layered approach** to infection prevention.

No single approach can fully eliminate the risk of HAIs. That's why healthcare institutions need multiple layers of defense to attack infections from all angles. **Profend** nasal antiseptic kits can help provide effective infection risk reduction at the innermost layer: patients themselves. It's just one of PDI Healthcare's integrated products that helps you implement an overall infection prevention strategy.

Learn more at ***www.DefendwithProfend.com***

	NDC	REORDER NO.	COUNT	CASE PACK	TI/HI	CASE WEIGHT	CASE CUBE
Profend® Nasal Antiseptic Kit							
Patient Kit	#10819-3888	X12048	48 patient units/case	4 swabs/patient pack, 12 patient packs/shelf unit, 4 shelf units/case	35/5	2.7 lbs	0.263 ft³

References: 1. PDI Study PDI-0113-CTEV01. **2.** Instructions for use. **3.** PDI Study PDI-0113-KT1. **4.** Maslow J, Hutzler L, Cuff G, Rosenberg A, Phillips M, Bosco J. Patient experience with mupirocin or povidone-iodine nasal decolonization. *Orthopedics*. 2014;37(6):e576–e581. **5.** PDI user acceptance study. **6.** VandenBergh MF, Yzerman EP, van Belkum A, Boelens HA, Sijmons M, Verbrugh HA. Follow-up of *Staphylococcus aureus* nasal carriage after 8 years: redefining the persistent carrier state. *J Clin Microbiol*. 1999;37:3133–3140. **7.** Septimus EJ. Nasal Decolonization: What antimicrobials are more effective prior to surgery? *Am J Infect Control* 2019;47S:A53-A57. doi: 10.1016/j.ajic.2019.02.028. **8.** Kalmeijer MD, van Nieuwland-Bollen E, Bogaers-Hofman D, de Baere GA. Nasal carriage of *Staphylococcus aureus* is a major risk factor for surgical-site infections in orthopedic surgery. *Infect Control Hosp Epidemiol*. 2000;21(15)319-323. **9.** Awad SS. Adherence to surgical care improvement project measures and post-operative surgical site infections. *Surg Infect (Larchmt)*. 2012;13(4):234–237. **10.** Burton DC, Edwards JR, Horan TC, Jernigan JA, Fridkin SK. Methicillin-resistant *Staphylococcus aureus* central line-associated bloodstream infections in US intensive care units, 1997-2007. *JAMA*. 2009;301(7):727–736. doi:10.1001/jama.2009.153. **11.** Greene LR, Sposato K. Guide to the elimination of ventilator-associated pneumonia. Washington, DC: Association for Professionals in Infection Control and Epidemiology (APIC); 2009. http://www.apic.org/Resource_/EliminationGuideForm/18e326ad-b484-471c-9c35-6822a53ee4a2/File/VAP_09.pdf. Accessed January 23, 2018. **12.** Klevens RM, Edwards JR, Richards CL, et al. Estimating healthcare-associated infections and deaths in U.S. hospitals, 2002. *Public Health Rep*. 2007;122(2):160–166. **13.** Ban KA, Minei JP, Laronga C, et al. American College of Surgeons and Surgical Infection Society: Surgical Site Infection Guidelines, 2016 Update. *J Am Coll Surg*. 2017;224(1):59–74. **14.** Engemann JJ, Carmeli Y, Cosgrove SE, et al. Adverse clinical and economic outcomes attributable to methicillin resistance among patients with *Staphylococcus aureus* surgical site infection. *Clin Infect Dis*. 2003;36(5)5:592–598. **15.** Nelson R, Samore M, Smith K, et al. Cost-effectiveness of adding decolonization to a surveillance strategy of screening and isolation for methicillin-resistant *Staphylococcus aureus* carriers. *Clin Microbiol Infect*. 2010;16(12):1740–1746. **16.** Centers for Disease Control and Prevention. Strategies to Prevent Hospital-onset *Staphylococcus aureus* Bloodstream Infections in Acute Care Facilities. https://www.cdc.gov/hai/prevent/staph-prevention-strategies.html. Published December 2019. Accessed December 10, 2020. **17.** Sievert D, Ricks P, Edwards JR, et al. Antimicrobial-resistant pathogens associated with healthcare-associated infections: summary of data reported to the National Healthcare Safety Network at the Centers for Disease Control and Prevention, 2009-2010. *Infect Control Hosp Epidemiol*. 2013;34(1):1–14.

* Surgical site infections
† Central line-associated bloodstream infections
‡ Ventilator-associated pneumonia
§ Healthcare-associated infections

400 Chestnut Ridge Road, Woodcliff Lake, NJ 07677
T: 800.999.6423 W: pdihc.com

PDI®
BE THE DIFFERENCE