



Owned and Operated by  
Mountain Communities Healthcare District

**2012 Annual House-wide In-Service:**

*Hand-washing, Infection Prevention, PPE Use, Seasonal and Novel Influenza, Respiratory Hygiene / Cough Etiquette, MRSA, C-diff*

**To: ALL EMPLOYEES (including exempt and non-exempt employees) and CONTRACTUAL STAFF (physicians, PT, CRNA, Registry on Contract)**

**From: Judy Nordlund, RN  
Infection Control Nurse  
February 1, 2012**

The Medical Facility Infection Control and Prevention Act, SB 1058, states:

“...all permanent and temporary hospital employees and contractual staff, ... shall be trained in hospital-specific infection prevention and control policies, including, but not limited to, hand hygiene, facility-specific isolation procedures, patient hygiene, and environmental sanitation procedures. The training shall be given [at New Employee Orientation], **annually** and when new policies have been adopted by the infection surveillance, prevention, and control committee.”

In order to full-fill these requirements, every employee and contractual staff must review the enclosed policies, Scabies information and the procedure diagrams. After reviewing all the attached material, please “Reply” email to me confirming you have read the material, understand the material and agree to abide by all Trinity Hospital Infection Control Policies. Please call me if you have any questions. **Please complete by the end of February.**

Everyone is doing an awesome job – Thank You!



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## **Annual House-wide In-Service Hand-washing, Infection Prevention, PPE Use, Seasonal and Novel Influenza, Respiratory Hygiene/Cough Etiquette**

February 2012

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## **TITLE: Aerosol Transmissible Diseases Exposure Control Plan**

**Purpose:** To protect patients, visitors and employees during possible exposure to an Aerosol Transmissible Disease (ATD), limiting the exposure to disease within the Hospital, Clinic, Home Health and Skilled Nursing Facility settings.

**Standard:**

1. The Infection Control Nurse in collaboration with the Infection Control Advisor, Infection Control Committee and Trinity County Department of Public Health is responsible for the administration of Trinity Hospital's Aerosol Transmissible Diseases Exposure Control Plan. The Infection Control Nurse will utilize proven policies and procedures recommended by the CDC, HICPAC, SHEA and APIC in administering the plan.
2. The Infection Control Nurse is responsible for all case identification, isolation monitoring, reporting and follow-up in conjunction with Risk Management and the Trinity County Department of Public Health.
3. The Infection Control Nurse will work in conjunction with the Employee Health Nurse and Risk Management for all employee exposures.
4. All employees of Trinity Hospital will be provided education regarding ATD transmission prevention, PPE indications and use, Hand Hygiene and Respiratory Hygiene / Cough Etiquette at New Employee Education, yearly and whenever policies are instituted or revised.
5. All employees are offered Tdap, varicella and MMR vaccinations in addition to Seasonal Influenza. Employees must sign a declination if the employee declines any of these vaccinations.
6. Aerosol Transmissible Diseases include "cases or suspected cases of tuberculosis (TB), measles, SARS, monkey pox, small pox, **chicken pox** (varicella), shingles and novel or unknown ATDs, such as pandemic flu strains that are not fully characterized."<sup>1</sup> See the attached "Diseases / Pathogen Requiring Airborne Infection Isolation".
7. The communicable diseases on the attached list under "Diseases / Pathogens Requiring Droplet Precautions" also require aerosol transmissible disease precautions if an aerosol-generating procedure is performed.

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<sup>1</sup> Cal/OSHA Aerosol Transmissible Disease Standard. CCR, Title 8, Section 5199. August 5, 2009.

8. Aerosol-generating Procedures include suctioning, intubation, nebulizer treatments, bronchoscopy, tracheostomy care, CPR or using a centrifuge for specimen handling.
9. Occupational Exposure: Any employee may have exposure to an ATD during the following circumstances:
  - a. Entry into a patient's room who has a suspected or confirmed ATD.
  - b. Exposure to a patient's airborne respiratory secretions in Admitting, the ED, Laboratory, Radiology, CT, SNF, Clinics either by the patient's coughing and sneezing or contact with contaminated surfaces.
  - c. Contact with a patient's environment (bed, tables, side rails, call bell, curtains, equipment in the room, etc.)
10. The following job classifications have occupational exposure:
  - a. RN, LVN, CNA, ER Technician
  - b. Environmental Services Workers
  - c. Phlebotomy Technicians
  - d. Clinical Laboratory Scientist
  - e. Radiology Technician
  - f. CRNA
  - g. Physician, Physician Assistant, Nurse Practitioner
  - h. Admitting Staff
  - i. Maintenance
  - j. BioMed
  - k. Discharge Planning
  - l. Clergy
11. The following job classifications may have exposure:
  - a. Administration
  - b. Health Information
  - c. Purchasing
  - d. Financial Services and Payroll
  - e. Pharmacy
12. Patients presenting with signs and symptoms of a respiratory infection will be required to wear a procedure mask upon presenting to the Hospital.
13. Patients will be placed in Aerosol Transmissible Disease Isolation immediately upon suspicion of an ATD. An Aerosol Transmissible Disease Isolation sign and a sign "STOP – Check with Nurse before Entering" signage will be placed outside the closed patient's room door (See 17.c.).
14. Duration of Precautions: Isolation precautions should be continued for seven (7) days from symptom onset or until the resolution of symptoms, whichever is longer.
15. The following precautions apply to ANY person entering the patient's room including nursing staff, visitors, environmental service workers, lab and x-ray personnel and clergy.

16. All Aerosol Isolation (airborne isolation) Infection Control Precautions recommended by the CDC (Center for Disease Control) and Cal/OSHA will be used: gloves, gown, a N95 Respirator and Eye Protection.
- a. Standard Precautions: Hand washing before and after ALL patient contact or contact with the patient's environment and after glove and Personal Protective Equipment (PPE) removal.
  - b. Contact Precautions
    - i. Any person entering the patient's room must don PPE before entering the patient's room.
    - ii. All PPE will be removed prior to leaving the isolation room.
    - iii. Patient designated isolation room equipment will be utilized if possible; i.e. BP cuff, temp-a-way sticks, stethoscope, bulk medications (inhaler, creams), pen etc. Once any item is taken into the room, the item stays in room until the patient is discharged and the room is terminally cleaned.
    - iv. Take into room only the supplies that are needed, trash all remaining supplies at discharge.
    - v. Disposable dishes and utensils will be utilized by dietary and disposed of in the isolation room trash receptacle.
    - vi. All PPE will be used once and then disposed of in trash receptacle in room.<sup>2</sup>
    - vii. Separate, double-bagged trash and linens – The gloved and gowned employee in the room carefully places the contaminated bag into a clean bag held by another gloved employee at the entrance to the room. (Additional linen precautions may be used per Environmental Services Policy).
  - c. Airborne Precautions
    - i. Place patient in an airborne isolation room (Room 204 with HEPA filtered air) if available. If unavailable, a private room is mandatory. The HEPA filtration unit will be monitored daily by maintenance per protocol.
    - ii. Keep patient's door closed.
    - iii. A fit-tested N95 respirator must be used when entering the room and disposed of when leaving the room.
    - iv. A disposable N95 respirator can only be reused according to the following guidelines:
      - 1) A documented severe shortage of N95 respirators exists. (see footnote #4, attached Respiratory Supply Documentation).
      - 2) "If a sufficient supply of respirators is not available during a pandemic, employers and employees may consider reuse as long as the device has not been obviously soiled or damaged (e.g., creased or torn), and it retains its ability to function properly. ***This practice is not acceptable under normal circumstances and should only be considered under the most***

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<sup>2</sup> CDC 11/09 states a N95 respirator may be reused in times of shortage, according to specific directives for the duration of one shift only, and only if it is not crushed, soiled, wet or difficult to breathe through.

*dire*<sup>3</sup> of conditions. Data on decontamination and/or reuse of respirators for infectious diseases are not available. Reuse may increase the potential for contamination; however, this risk must be balanced against the need to provide respiratory protection...<sup>4</sup>

- 3) The respirator should be carefully stored between uses in a single-use, name labeled paper bag;
- 4) The wearer should wash his or her hands before and after handling the respirator and the device used to shield it and
- 5) The wearer should store the respirator in such a way as to prevent the inside of the respirator from being contaminated<sup>5</sup>
- 6) **These steps are intended for reuse of a respirator by a single person.**  
The paper bag must be replaced each time the N95 is stored.  
The N95 must not be used by more than one employee.<sup>6</sup>  
The N95 respirator must be replaced if damp, creased or torn.

17. N95 Use Guidelines:

- a. The N95 respirator should always be removed and discarded if (1) it becomes damaged or deformed, (2) it no longer forms an effective seal to the employee's face, (3) it becomes contaminated with hazardous substances, (4) it becomes wet or visibly dirty, or (5) breathing through it becomes more difficult. In addition, the respirator should always be discarded if it becomes contaminated with blood, respiratory or nasal secretions, or other bodily fluids from patients.<sup>7</sup>
- b. Surgical masks should not be placed over the respirator, as they may unseat or deform the respirator and may make it more difficult to breathe through.<sup>8</sup>

18. PPE is available to employees at all times.

- a. N95 Respirators: Every employee is fit-tested at hire and annually thereafter. Replacement N95 respirators are available from the ED, M/S, SNF, Clinic,

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<sup>3</sup> Cal/OSHA interprets this phrase to mean that the employer has ordered a supply of respirators sufficient to assure that a respirator may be disposed of each time it is taken off, and that despite efforts to procure such a supply, there is less than a sixty day supply available.

<sup>4</sup> Cal/OSHA Interim Enforcement Policy on H1N1 and Section 5199 (Aerosol Transmissible Diseases, 09-08-09.

<sup>5</sup> Flu.gov: Institute of Medicine. Reusability of facemasks during an influenza pandemic: facing the flu. Report of the Committee on the Development of Reusable Facemasks for Use During an Influenza Pandemic. Washington, D.C.: The National Academies Press, 2006.

<sup>6</sup> Cal/OSHA Aerosol Transmissible Disease Standard. Effective August 5, 2009

<sup>7</sup> Cal/OSHA Interim Enforcement Policy on H1N1 and Section 5199 (Aerosol Transmissible Diseases, 09-08-09.

<sup>8</sup> Cal/OSHA Interim Enforcement Policy on H1N1 and Section 5199 (Aerosol Transmissible Diseases, 09-08-09.

laboratory and purchasing stores. In event of low supply, additional N95 respirators are available from the County Emergency Management supply. See “PPE”.

- b. Gloves are stocked in every patient care department.
  - c. Gowns, shoe protection, eye protection and face shields are stocked in the ED, M/S and SNF units. They are also available from Purchasing.
19. Employees are required to use appropriate PPE when indicated.
20. Respiratory Precautions to be used by Patient
- a. Cover the nose/mouth when coughing or sneezing.
  - b. Use tissues to contain respiratory secretions and dispose of them in the nearest waste receptacle after use.
  - c. Hand washing with soap and water or alcohol-based hand rub after having contact with respiratory secretions and contaminated objects or materials.
  - d. The patient must wear a surgical / procedure mask at all times if transport to another department is necessary (ex. x-ray, CT).
21. Patient Transfer
- a. The receiving facility must be informed of all suspected or confirmed H1N1 infections prior to receiving facility acceptance and transfer.
  - b. All transporting personnel (staff, ambulance and air transport personnel) must be informed of all suspected or confirmed aerosol transmissible infections prior to transfer.
  - c. The patient must wear a procedure mask at all times.
22. Visitation Limitations
- a. For the protection of visitors, all patients and Hospital staff, visiting of the patient in Aerosol Transmissible Isolation will be limited to one, 2 hour visit per shift, in which time the visitor must remain in the patient’s room.
  - b. All visitors will be required to report to the nurses’ station for hand washing and PPE instruction prior to entering the patient’s room.
  - c. The patient’s room will have notification on the door to instruct the visitor to report to the nurses’ station before entering.
  - d. All visitors will be required to abide by all isolation hand washing and PPE requirements.
23. Wearing a surgical mask or respirator incorrectly, or removing or disposing of it improperly, could allow contamination of the hands or mucous membranes of the wearer or others, possibly resulting in disease transmission.
- a. All employees will be educated regarding the appropriate use and disposal of Personal Protective Equipment (PPE) at New Employee Orientation, yearly thereafter or when new guidelines become available.

24. Durable Medical Equipment
  - a. Disposable equipment will be used as possible.
  - b. All equipment that enters the isolation room will be thoroughly disinfected before removing from the room, including any wheels and cords.
  - c. Once equipment enters the isolation room, it remains in the room until the patient is discharged and the room is terminally cleaned.
  
25. Skilled Nursing Facility
  - a. Suspected and confirmed cases of a ATD should be placed in a single room or cohorted, with the door closed, unless closing of the door would jeopardize patient safety or patient's rights.
  - b. Employees who enter rooms where suspected or confirmed ATD cases are located or who otherwise are exposed to those patients must be protected with an N95 respirator (or higher level of respiratory protection).
  - c. Signs must be posted on the patient's door to communicate that isolation precautions are to be followed in the room.
  
26. See the Tuberculosis Exposure Plan, PPE, Isolation Precautions and DME policies for additional guidance.
  
27. **CCR, Title 8, Section 5199.**

**CCR, Title 8, Section 5199, August 5, 2009.**

**Appendix A – Aerosol Transmissible Diseases/Pathogens (Mandatory)**

This appendix contains a list of diseases and pathogens which are to be considered aerosol transmissible pathogens or diseases for the purpose of Section 5199. Employers are required to provide the protections required by Section 5199 according to whether the disease or pathogen requires airborne infection isolation or droplet precautions as indicated by the two lists below.

**Diseases/Pathogens Requiring Airborne Infection Isolation**

Aerosolizable spore-containing powder or other substance that is capable of causing serious human disease, e.g.

*Anthrax/Bacillus anthracis*

Avian influenza/Avian influenza A viruses (strains capable of causing serious disease in humans)

Varicella disease (chickenpox, shingles)/Varicella zoster and Herpes zoster viruses, disseminated disease in any patient.

Localized disease in immunocompromised patient until disseminated infection ruled out

Measles (rubeola)/Measles virus

Monkeypox/Monkeypox virus

Novel or unknown pathogens

Severe acute respiratory syndrome (SARS)

Smallpox (variola)/Variola virus

Tuberculosis (TB)/*Mycobacterium tuberculosis* -- Extrapulmonary, draining lesion; Pulmonary or laryngeal disease, confirmed; Pulmonary or laryngeal disease, suspected

Any other disease for which public health guidelines recommend airborne infection isolation

**Diseases/Pathogens Requiring Droplet Precautions**

Diphtheria pharyngeal



Epiglottitis, due to *Haemophilus influenzae* type b

*Haemophilus influenzae* Serotype b (Hib) disease/*Haemophilus influenzae* serotype b -- Infants and children

Influenza, human (typical seasonal variations)/influenza viruses

Meningitis

*Haemophilus influenzae*, type b known or suspected

*Neisseria meningitidis* (meningococcal) known or suspected

Meningococcal disease sepsis, pneumonia (see also meningitis)

Mumps (infectious parotitis)/Mumps virus

Mycoplasmal pneumonia

Parvovirus B19 infection (erythema infectiosum)

### **Diseases/Pathogens Requiring Droplet Precautions Continued**

Pertussis (whooping cough)

Pharyngitis in infants and young children/Adenovirus, Orthomyxoviridae, Epstein-Barr virus, Herpes simplex virus,

Pneumonia

Adenovirus

*Haemophilus influenzae* Serotype b, infants and children

Meningococcal

*Mycoplasma, primary atypical*

*Streptococcus Group A*

Pneumonic plague/*Yersinia pestis*

Rubella virus infection (German measles)/Rubella virus

Severe acute respiratory syndrome (SARS)

Streptococcal disease (group A streptococcus)

Skin, wound or burn, Major

Pharyngitis in infants and young children

Pneumonia

Scarlet fever in infants and young children

Serious invasive disease

Viral hemorrhagic fevers due to Lassa, Ebola, Marburg, Crimean-Congo fever viruses (airborne infection isolation and respirator use may be required for aerosol-generating procedures)

Any other disease for which public health guidelines recommend droplet precautions

**TITLE: CLOSTRIDIUM DIFFICILE (C-Diff)**

**PURPOSE:** To prevent the occurrence and spread of Clostridium Difficile (C-Diff) within Trinity Hospital.

**STANDARD:**

1. Definition: Clostridium difficile is a bacterium commonly found in the intestinal tract but which, under the right circumstances such as after or during antibiotics therapy, can be the cause of enterocolitis. C. difficile bacteria are everywhere — in soil, air, water, human and animal feces, and on most surfaces. The bacteria don't create problems until they grow in abnormally large numbers in the intestinal tract of people taking antibiotics or other antimicrobial drugs. Then, C. difficile can cause symptoms ranging from diarrhea to life-threatening inflammations of the colon. C. difficile isn't confined exclusively to hospitals. It's also a growing problem among otherwise healthy people. And although the infection can usually be controlled with oral antibiotics, virulent strains of C. difficile are now appearing that resist treatment with common medications. Most people develop C. difficile infection during or shortly after a course of antibiotics, but signs and symptoms may not appear for weeks or even months after treatment has stopped. Almost any antibiotic can cause harmful bacteria to proliferate in the intestine, but **ampicillin, amoxicillin, clindamycin, fluoroquinolones and cephalosporins are most often implicated in C. difficile infections.** C. difficile can produce two virulent toxins that attack the lining of the intestine. There is an emergence of new, aggressive strains of C. difficile that produce far more deadly toxins than ordinary strains do. The new strains are more resistant to treatment with certain medications, and increasingly are showing up in people who haven't been in the hospital or taken antibiotics.

**Table 1. Antibiotics and Risk for *C difficile* Colitis<sup>9</sup>**

High Risk	Medium Risk	Low or No Risk
Cephalosporins -- third generation	Betalactams -- narrow spectrum	Sulfonamides

<sup>9</sup> The New York Course 2007: Developments in Infectious Diseases — *Clostridium difficile*. July 24, 2007.

Fluoroquinolones	Carbapenems	Vancomycin IV
Clindamycin	Trimethoprim-Sulfamethoxazole	Metronidazole
Penicillins -- broad spectrum	Tetracyclines	Linezolid
	Macrolides	Nitrofurantoin

2. Signs and symptoms:
  - a. Some people who are infected with *C. difficile* never become sick, though they can still spread the infection.
  - b. Profuse, watery diarrhea — 10 or more bowel movements a day
  - c. Fever, often greater than 101 F
  - d. Abdominal pain, which may be severe
  - e. Blood or pus in the stool
  - f. Nausea
  - g. Dehydration
  - h. Weight loss
  - i. *C. Difficile* Colonization
    - i. NO clinical symptoms
    - ii. Patient tests positive for *C. difficile* organism and/or its toxin
    - iii. More common than *C. difficile*-associated disease
  - j. *C. difficile*-associated Disease
    - i. Patient exhibits clinical symptoms
    - ii. Patient tests positive for the *C. difficile* organism and/or its toxin<sup>10</sup>
3. Risk factors:
  - a. Recent use of antibiotics.
  - b. 65 years of age or older.
  - c. A serious underlying illness or weakened immune system.
  - d. Have recently been hospitalized, especially for an extended period.
  - e. Live in a nursing home or long-term care facility.
  - f. Have had abdominal surgery.
  - g. Have a chronic colon disease such as inflammatory bowel disease or colorectal cancer.
  - h. Over-the-counter antacid or Proton-pump Inhibitor use.
  - i. Have had a previous *C. difficile* infection.
4. Treatment:

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<sup>10</sup> CDC: Information for Healthcare Providers *Clostridium difficile* (*C. Difficile*). Released August 2004; Updated 07/22/2005

- a. If possible, stopping the antibiotic that triggered the infection is the first step in treating *C. difficile*. For some people, this may be enough to relieve symptoms. But most people require further treatment.
  - b. Antibiotics: **Oral** metronidazole or vancomycin.
  - c. Probiotics: *Saccharomyces boulardii*, a natural yeast.
  - d. Surgery: For people with severe pain, organ failure or inflammation of the lining of the abdominal wall, surgery to remove the diseased portion of the bowel may be the only option
5. Infection control
- a. Transmission:
    - i. Environmental sources play a major role in transmission since *C difficile* has a hardy spore that may persist for many months. These spores have been found on bedding, toilets, bedpans, sinks, floors curtains and medical devices as well as on hands.
    - ii. Person-to-person transmission **via the hands of healthcare workers** or contact with contaminated environmental surfaces is the main route of transmission in hospitals.
    - iii. The incubation period is usually 1 to 10 days.
    - iv. *Clostridium difficile* can be carried asymptotomatically by up to 46% of hospitalized adults.
  - b. **CONTACT PRECAUTIONS:**
    - i. Disposable gloves and disposable gowns.
    - ii. Wash hands thoroughly with soap and warm water before and after treating each patient, after removing gloves, and after touching surfaces that might be contaminated. Alcohol-based hand gels, which are commonly used in health care institutions, are not effective in destroying *C. difficile* spores.
    - iii. Visitors must wash their hands with soap and warm water before entering and after leaving the room of a patient with a *C. difficile* infection. Visitors must also wear a gown.
    - iv. Dedicated equipment.
    - v. Private room or share a room with someone who has the same illness.
    - vi. All room surfaces are carefully disinfected daily and upon discharge or transfer with a 1:10 chlorine bleach solution.<sup>11</sup>
    - vii. **CONTINUE THESE PRECAUTIONS UNTIL DIARRHEA CEASES**<sup>12</sup>
6. Patient Education

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11 AFL 10-21, CDPH, August 19, 2010.

12 CDC: Information for Healthcare Providers *Clostridium difficile (C. Difficile)*. Released August 2004; Updated 07/22/2005

- a. Patient will need to stay in their room.
  - b. Healthcare workers will wear gowns and gloves to prevent them from picking up the *Clostridium difficile* and from taking it to other patients.
  - c. It is very important for all staff and visitors to wash their hands when they come in and when they leave your room.
  - d. Signs will be placed outside the room to remind everyone about the special precautions.
  - e. If the patient needs to go to another part of the hospital for tests or treatments, they must wash your hands before they leave their room.
  - f. Patient instructed to please wash their hands carefully after going to the bathroom and frequently during the day.
  - g. *C. difficile* lives on objects in the room, so the room will be cleaned very well using a 1:10 chlorine bleach solution.
7. Classification:
- a. **Recurrent:** An episode that meets the case criteria and that occurs within 8 weeks of onset of a previous episode, provided that there was a symptom-free period with or without therapy. This definition may be augmented by a specimen positive by the above criteria collected 2-8 weeks after the last positive specimen. A specimen that was collected more than 8 weeks after the last specimen was positive represents a "new case."
  - b. **Severe case:** Any of the following criteria within 30 days of onset of symptoms: admission to an intensive care unit for this complication; colectomy for toxic megacolon; perforation or refractory colitis; and death caused within 30 days of symptom onset as listed on the death certificate or recorded in the medical record.
  - c. **Healthcare facility (HCF)-onset:** The patient has the onset of symptoms more than 48 hours after admission.
  - d. **Community-onset HCF-associated disease:** Onset of symptoms within 48 hours of admission to a HCF, provided that symptom onset was less than 4 weeks after discharge from a prior admission.
  - e. **Community-associated disease:** Onset of symptoms in the community or less than 48 hours after admission, provided that symptom onset was over 12 weeks from the last discharge.
  - f. **Indeterminate disease:** A case that does not fit the prior definition, primarily those who are discharged from a HCF 4-12 weeks prior to symptom onset.
8. SNF Specific
- a. Potential residents to the Skilled Nursing Facility will not be denied admission based on a previous *C. diff* infection if the resident is asymptomatic; i.e. no longer has diarrhea.
  - b. Three consecutive negative *C. diff* cultures are not required prior to admission to the SNF.
  - c. Asymptomatic nursing home residents may be colonized with *C. difficile* and may be shedding the organism in their stool. Good resident and healthcare worker hygiene is important to prevent transmission, even from asymptomatic residents.<sup>13</sup>

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13 AFL 10-21, CDPH, August 19, 2010.

Resources:

Centers for Disease Control and Prevention, Information for Healthcare Providers. Clostridium Difficile. Released August 2004; Updated 07/22/2005

The New York Course 2007: Developments in Infectious Diseases — *Clostridium difficile*. July 24, 2007.

<http://www.mayoclinic.com/health/c-difficile/DS00736/DSECTION=9>

**TITLE: CONTROL OF INFECTIONS**

**PURPOSE:** To insure that all personnel, patients/residents and visitors understand and employ good hygienic practices.

**STANDARD:** Control of Infections

I. General Principles

- a. The prevention and control of infections require that all hospital personnel, patients/residents and visitors understand and employ good hygienic practices on an every day basis. Good hygienic practices primarily include hand washing, personal hygiene, proper handling of soiled equipment and patient/resident laundry.
- b. The primary and single most important good practice to preventing infection is hand washing. All personnel should use good hand washing before and after contact with each patient/resident and before serving meals and after toileting. Good personal hygiene, including frequent bathing, hair, mouth and nail care and clean clothing should additionally be emphasized to all personnel as well as incorporated in daily patient/resident care.
- c. A hygienic environment will be maintained through standards for cleaning patient/resident care equipment, handling patient/resident linens; cleaning the tubs, showers, toilets and kitchen equipment; pest control; handling of infectious wastes, etc.

II. Activities are conducted to prevent and control infections in patients and personnel include but may not be limited to the following:

- a. Written standard that defines the indications for special precautions to prevent transmission of infection.

- b. A blood and body fluid precautions plan, following OSHA guidelines, has been developed to assure that staff and physicians are protected against exposure to blood or body fluid.
- c. For the protection of the patient and employee:
  - 1. Standards are contained in the Infection Control Manual in all departments.
  - 2. Adequate supplies of personal protective equipment are available to staff to comply with universal precaution guidelines.
  - 3. Gloves, pocket masks and sharps containers are available in all patient rooms and patient care areas. Other protective equipment is kept in clean utility rooms.
  - 4. Engineered safety devices are utilized, complying with our Sharps Injury Prevention Program.
- d. A TB Control Plan has been written to protect patients and employees from exposure to Tuberculosis.
- e. Filled infectious waste containers are disposed of in a timely manner in accordance with the hospital medical waste policy.
- f. The Infection Control Nurse and Environmental Services conduct rounds of all hospital departments for the purpose of spot inspections and consultation.
- g. The Infection Control Nurse is consulted regarding equipment changes or purchases in products and/or techniques.
- h. Standard Precautions as well as Transmission Based Precautions are applied in the care of patients, in addition to Universal Precautions.

**TITLE: DURABLE MEDICAL EQUIPMENT (DME)**

**PURPOSE:** To outline the Infection Control cleaning measures to be used for DME by nursing staff in order to prevent the spread of infectious disease within Trinity Hospital.

## STANDARD:

1. DME includes any non-disposable equipment used for patient care, including but not limited to:
  - BP cuffs
  - Roll-a-Rounds including BP cuffs, oximetry cables, EKG cables EKG machines and all attachments
  - IV pumps
  - Thermometers
  - Cardiac monitors and lead wires
  - Accucheck machine
  - Oxygen concentrators
  - Nebulizer machines
  - Suction machines
  - Gurneys
  - Wheelchairs
2. Super Sani-Wipes or HDQ will be used to clean all DME.
  - a. HDQ is a quaternary disinfectant.
  - b. Enough disinfectant will be applied in order to have a 10 minute dry time to kill all germs, wet but not so wet it drips.
3. BP Cuffs:
  - a. A clean, disposable patient “sleeve” will be worn by the patient when blood pressures are taken in the clinic unless the BP cuff is cleaned between each patient use. These are available from Purchasing.
  - b. BP cuffs will be cleaned after every patient use and whenever visibly soiled as directed in 2.b.
  - c. A clean, patient-designated BP cuff will be used for all M/S and Out-patient Surgery patients throughout the admission.
    - i. The BP cuff will be cleaned upon any visible soiling
    - ii. The BP cuff will be thoroughly cleaned by nursing staff upon patient discharge
    - iii. The BP cuff will be cleaned according to 2. a. and b.; then placed in the “Clean” BP cuff receptacle in the patient’s room.
    - iv. Additional sized cuffs will be available in the M/S clean utility room. Whenever these are used, they will be cleaned in the patient room according to 2a. and b.; then placed in a zip-lock bag and kept in the clean utility room for future use.
4. Stethoscopes
  - a. The flat part of the stethoscope will be swiped with alcohol before placing on the patient and after any patient contact.
5. Roll-a-Rounds will be cleaned nightly on all units.



6. EKG machines:
  - a. Cleaned after every patient use with special attention to the patient attachments.
  - b. Cleaned weekly, every Wednesday night, on M/S.
  - c. Cleaned nightly in the ER.
7. IV pumps, cardiac monitors, oxygen concentrators, nebulizer and suction machines, Accucheck machine, gurneys and wheelchairs will be cleaned after every patient use before storage.
8. Gurneys will be cleaned after every patient use, with special attention to the rails, supports and storage areas.
  - a. This is especially important for gurneys entering the surgical suite and those used for endoscopic procedures.
  - b. All gurneys will be cleaned nightly in the ER.
9. All other equipment will be thoroughly cleaned after every patient use including but not limited to infant isolette, cribs, humidifiers, blood warmer, fetal heart monitor, Bair Hugger.
10. DME used in Isolation
  - a. All equipment will be cleaned, including all wheels, before removing from patient room for storage.
  - b. Additional cleaning may be required for terminal cleaning (See environmental services policy).
11. Other equipment used daily by nursing staff will also be cleaned every shift. This includes telephones, keyboards, computer mouse and the nursing station desk. Medication preparation surfaces will be wiped down with HDQ or Super sani-wipes before any medication preparation.
12. A DME cleaning CQI will be placed on all units to monitor DME cleaning, amended according to department's needs.

**TITLE:** HAND HYGIENE

**PURPOSE:** To define the indications and procedure for hand hygiene.

**STANDARD:**

1. **Handwashing** is the single most effective technique to prevent the spread of infection.
2. HAND WASHING is required:
  - a. Before and after eating, drinking and smoking
  - b. Before and after shift change
  - c. After using the restroom
  - d. After covering a sneeze, cough or blowing your nose
  - e. Before and after any patient contact
  - f. After any contact with a patient’s environment.
  - g. After removing gloves
  - h. After removing PPE
  - i. After handling specimen containers
3. Alcohol based hand sanitizers may be used except when hands are visibly contaminated.
4. Alcohol based hand sanitizers may not be effective against spores such as C-difficile.<sup>14</sup>
5. Hand hygiene compliance will be monitored and tabulated monthly by the Infection Control Nurse based on the observations of HCW’s in the ER, M/S Unit, Environmental Services Department and the Skilled Nursing Unit in addition to direct observations by the Infection Control Nurse. Hand hygiene compliance is mandatory for all Healthcare Workers who perform direct patient care or have contact with a patient’s environment. Those workers include but are not limited to nursing, physicians, laboratory, radiology and environmental services.

**PROCEDURE:**

1. Equipment:
  - a. Soap
  - b. Warm running water
  - c. Paper towels
  - d. Alcohol-based hand sanitizer if appropriate

<b>STEPS</b>	<b>KEY POINTS</b>
1. File nails short. Artificial nails are not recommended.	1. Short nails are less likely to harbor microorganisms or scratch a patient Long Nails are hard to clean. Artificial nails can harbor fungal organisms but there is not data available indicating that nail polish does. Nail polish, however, may chip, flake or drop into clean areas.
2. Remove jewelry from the arms and hands.	2. Microorganisms can lodge in the settings of jewelry. Removal

14 CDC: Information for Healthcare Providers *Clostridium difficile* (C. diff). Released August 2004; Updated 2005.

<ol style="list-style-type: none"> <li>3. Check hands for breaks in the skin such as hangnails or cuts. Use lotions to prevent hangnails and cracked dry skin or open areas.</li> <li>4. Turn on the water and adjust the flow so that water is warm.</li> <li>5. Wet hands thoroughly by holding them under the running water. Hold hands lower than elbows so water flows downward.</li> <li>6. Apply soap to hands. If the soap is liquid apply 2-3 ml. If bar soap rub firmly between hands and rinse the bar before returning back to the dish.</li> <li>7. Use firm rubbing circular movements to wash the palm, back and wrist of each hand. Interlace the fingers and thumbs and move the hands back and forth. Continue this for 10-15 seconds.</li> <li>8. Rinse hands</li> <li>9. Dry hands and arms thoroughly with a paper towel. Discard it in the appropriate container.</li> <li>10. Turn off the water, using a paper towel.</li> <li>11. Apply hand lotion.</li> </ol>	<p>facilitates proper cleaning of the hands and arms.</p> <ol style="list-style-type: none"> <li>3. Report cuts to the nurse in charge before beginning work.</li> <li>4. Warm water removes less of the protective oil of the skin than hot water.        . Water should flow from the least to the most contaminated area. NOTE: for sterile procedures hold hands higher than elbows        .</li> <li>6. Rinsing the bar removes the microorganisms.</li> <li>7. The circular action helps remove microorganisms. Interlacing the fingers and thumbs cleans the interdigital spaces.</li> <li>9. Moist skin becomes chapped readily; chapping produces cracking.</li> <li>10. This prevents picking up microorganisms from the faucet handles.</li> <li>11. Prevents drying and cracking of skin.</li> </ol>
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## **TITLE: HEALTHCARE ASSOCIATED INFECTION (HAI) PREVENTION**

### **PURPOSE:**

1. A Healthcare Associated Infection (HAI) is defined as a localized or systemic condition resulting from an adverse reaction to the presence of an infectious agent(s) or its toxin(s) that:
  - a. occurs in a patient in a hospital **and**
  - b. was not found to be present or incubating at the time of admission unless the infection was related to a previous admission to the same setting.
2. Summarization of Trinity Hospital's policies which have been developed in order to prevent Healthcare Associated Infections.

### **STANDARD:**

1. **Infection Prevention:**
  - a. Standard precautions for all patients with staff surveillance for compliance.
    - i. Gloves will be used for any patient contact.
  - b. Respiratory Hygiene and Cough Protocol
    - i. Practiced by patients, staff and visitors.
    - ii. Notices placed at Hospital entrances.
    - ii. Place visitors and patients presenting to the Admitting or ED with respiratory symptoms 3 feet away from others.
  - c. Hand hygiene and hand hygiene compliance
    - i. Alcohol based hand sanitizers readily available.
    - ii. When hands become visibly soiled or there is possible contact with spores (like *C difficile*), they should be carefully washed with soap and water. Otherwise, alcohol-based hand gels are the preferred method for hand decontamination between patients.<sup>15</sup> Decontamination should be performed after contact with a patient as well as after contact with medical equipment.
  - d. Contact Precautions:
    - i. Personal PE will be readily available.

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<sup>15</sup> <http://www.cdc.gov/ncidod/dhqp/pdf/isolation2007.pdf>

- ii. PPE include gloves for touching blood, body fluids, secretions, excretions, contaminated items, mucous membranes, and nonintact skin
  - iii. Gown during patient procedures and activities involving contact of clothing or exposed skin with blood or body fluids, secretions, and excretions.
  - iv. Mask, eye protection (goggles), and face shield should be worn during procedures such as suctioning or endotracheal intubation that are associated with splashes or sprays of blood, body fluids, secretions.
- e. Droplet Precautions:
- i. Mask use by staff for all pneumonia patients infected.
  - ii. Patient wears mask when out of room.
  - iii. Gown during patient procedures and activities involving contact of clothing or exposed skin with secretions.
- f. Airborne Precautions:
- i. In conjunction with droplet for suspected influenza, TB.
  - ii. Annually fit-tested N95 respirator use by staff.
- g. Designated Isolation rooms.
- h. Designated “clean” Reverse Isolation Room 207 on M/S.
- i. No cohorting of possibly infectious patient with post-surgical or other non-infectious patient.
- j. Cleaning of DME (Durable Medical Equipment) between patients.
- k. Terminal cleaning of all isolation rooms per Environmental Policy.
- l. Sharps containers readily available
- i. Used needles will not be recapped, bent, broken, or manipulated by hand.
- m. Annual Influenza vaccination
- i. All employees at no cost
  - ii. Offered to patients over 65 years of age if vaccine available.
- n. Rapid Influenza Test available October - February
- o. Post-Exposure Prophylaxis Program

- p. Use urinary catheters only when necessary, insert using proper technique and remove as soon as possible.
- q. Insert venous catheters according to policy, observing for any signs or symptoms of phlebitis or infection.

2. **Effective Diagnosis and Treatment**

- a. Appropriate cultures will be obtained prior to initiation of antibiotics.
- b. Culture reports will be reviewed for appropriateness of antibiotic therapy.
- c. Non-susceptible antibiotics will be discontinued.
- d. Antibiotics will be prescribed based on current local antibiograms.
- e. Blood, Urine and Sputum will be cultured; not the skin, catheter or tracheal aspirate.
- f. Antibiotic treatment will be stopped when:
  - i. Infection is cured.
  - ii. Cultures are negative and infection is unlikely
  - iii. Infection is not diagnosed.

3. **Chain of Contagion**

- a. Employees should stay home when sick.
- b. Sick slips monitored by the ICN (Infection Control Nurse) for trends and possible communicable diseases.

4. **Surgical Site Infection Prevention**

- a. Appropriate use of antibiotics
- b. Measures to prevent Pneumonia
- c. Appropriate preparation of surgical site
- d. Appropriate care of catheters and drains
- e. Normal glycemia and normothermia will be maintained.
- f. See policy.

**TITLE:** INFLUENZA ISOLATION PLAN

**PURPOSE:** To provide a method for influenza patient isolation in order to provide patient, staff and community protection from influenza exposure; curtailing a possible epidemic.

- STANDARD:**
1. Any patient presenting with signs or symptoms of a possible influenza infection will be placed in Droplet Isolation (see policy), in addition to Standard Precautions. Precautions will continue for 5 days after the onset of symptoms.
  2. Patients with symptoms of influenza will be placed in a private room, utilizing Droplet Precautions. If a private room is not available, suspected influenza patients may be cohorted (placed with other patients suspected of having influenza).
  3. The patient in isolation will be informed of the isolation precaution plan and its rationale.
  4. A notification sign will be placed outside the patient's room, informing all staff and visitors that a respiratory mask must be donned before entering the patient's room and removed prior to leaving the patient's room.
  5. A surgical or procedure mask will be worn when entering the patient's room and when working within 3 feet of the patient. The mask will be removed and discarded in the waste container before leaving the patient's room.
  6. Hands will be washed or alcohol-based hand sanitizer will be used before and after any patient contact or contact with the patient's environment and after removing PPE.
  7. All staff performing direct patient care will also use Contact Precautions (see policy).
  8. If patient movement or transport is necessary, the patient will wear a surgical or procedure mask. All receiving departments will be notified prior to patient transfer.

# **TITLE: METHICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS (MRSA) NASAL SWAB PROCEDURE**

## **PURPOSE:**

1. The Medical Facility Infection Control and Prevention Act, SB 1058: Section 1255.8 was added to the California Health and Safety Code on September 25, 2008.<sup>16</sup> It mandates MRSA Active Surveillance cultures be performed on selected admissions to all general acute care hospitals and skilled nursing facilities (SNF) in California<sup>17</sup> in order to identify patients in designated high risk groups who may be colonized with Methicillin Resistant Staph aureus (MRSA).
2. Active Surveillance Cultures (ASC) for MRSA in Trinity Hospital's patient population may be an important pathway to prevent healthcare associated transmission of MRSA from one patient to another.
3. An ASC for MRSA is a process to document Present on Admission (POA) patient MRSA exposure.
4. An ASC for MRSA carrier identification is a method to track community MRSA prevalence and trends.
5. Identify the procedure for obtaining a nasal swab culture sample for laboratory identification of MRSA.

## **STANDARD:**

1. Definitions:
  - a. **Colonization**-- The presence of organisms in or on a host with growth and multiplication of the organism but without tissue invasion (no signs or symptoms of infection). Colonization may become infection when changes in the host occur. A patient colonized with MRSA may spread this organism to other patients.
  - b. **Infection**--The presence of organisms in or on a host with growth and multiplication of the organism producing tissue damage, which results in signs and symptoms.
  - c. **CA** – Community Acquired
  - d. **HA** – Healthcare Associated

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16 Medical Facility Infection Control and Prevention Act. SB 1058, Chapter 296, Section 1255.8; 9/25/08.

17 California Health and Safety Code Section 1240.



2. Each patient who is admitted to Trinity Hospital or the Trinity Hospital SNF will be tested for MRSA.
3. Every surgical patient will have a MRSA nasal screening test performed at the least 24 hours prior to surgery.
  - a. Facilitate results to surgeon so patient may be treated if indicated.
  - b. Facilitates appropriate prophylactic antibiotic choice.
4. Each patient/resident or their representative will be informed of the MRSA nasal culture procedure and the reasons for obtaining the culture. They will be given the informational handout “MRSA Screening” (attached).
5. If a patient/resident tests positive for MRSA, the attending physician shall inform the patient or the patient’s representative immediately or as soon as practically possible.
6. A patient who tests positive for MRSA **infection** shall, prior to discharge, receive oral and written instruction regarding aftercare and precautions to prevent the spread of the infection to others. (See attached “Patient and Family MRSA Information Sheet).
7. A MRSA nasal swab may be used to determine that a previously documented MRSA positive patient is no longer a MRSA carrier.
  - a. (3) Three negative tests are required to determine that a previously MRSA positive patient is no longer a carrier.<sup>18</sup>
8. Antibiotic treatment is generally not recommended for colonized patients; however, decolonization may be done on a case-by-case basis.
9. A MRSA screening nasal culture is recommended for all new residents prior to admission to Trinity Hospital’s SNF.
10. Precautions:
  - a. Patients with a positive MRSA nasal swab, indicating a **CARRIER** state, may be cohorted together (only HA-MRSA with HA-MRSA, or CA-MRSA with CA-MRSA, **not** HA-MRSA with CA-MRSA).
    - a.i. See “MRSA Patient Placement”
  - b. Private room is recommended.
  - c. Standard Precautions

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18 CDC. MDRO Guideline 2006, pg. 25.

- i. Hand washing before and after any patient care or contact with the patient's environment.
  - ii. Glove use for any possible contact with the patient's secretions or excretions. Remove gloves before leaving the room and wash hands or use of alcohol-based hand sanitizer after glove removal.
- d. Contact Precautions:
- d.i. Glove and gown use for contact with uncontrolled secretions, pressure ulcers, draining wounds, stool incontinence, and ostomy tubes/bags. Mask use for patients unable to contain respiratory secretions or for procedures that may generate an aerosol spray (See "Draining Wounds" and "Pressure Ulcers").
- e. CDC MDRO Guidelines for SNF:
- e.i. "Least restrictive environment possible which isolates the organism.
  - e.ii. For ill residents who are generally independent, follow Standard Precautions, making sure that gloves and gowns are used by all HCWs for contact with uncontrolled secretions, pressure ulcers, draining wounds, stool incontinence, and ostomy tubes/bags.
  - e.iii. For ill residents who are totally dependent upon healthcare personnel for healthcare and activities of daily living and for those residents whose infected secretions or drainage cannot be contained, use Contact Precautions (Contact Isolation) in addition to Standard Precautions.
  - e.iv. For MDRO colonized or infected patients without draining wounds, diarrhea, or uncontrolled secretions, establish ranges of permitted ambulation, socialization, and use of common areas based on their risk to other patients and on the ability of the colonized or infected patients to observe proper hand hygiene and other recommended precautions to contain secretions and excretions."<sup>19</sup>

11. **Procedure:**

- a. A standard 2- swab culture tube may be used.
- b. Culture specimen will be obtained from the anterior nare<sup>20</sup>, rotating the swabs to collect the specimen.
- c. An addressograph label will be placed on the specimen and the accompanying lab requisition form will be addressograph stamped.

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19 CDC, HICPAC. Management of Drug-Resistant Organisms in Healthcare Settings, 2006.

20 CDC. MDRO Guideline 2006, pg. 44.

- d. A standard lab slip will be used, noting “MRSA nasal Swab” culture.
- e. Culture results will be monitored by the nursing staff, the Infection Control Nurse and the Attending Physician.

**TITLE: PERSONAL PROTECTIVE EQUIPMENT (PPE)**

**PURPOSE:** Personal Protective Equipment is part of Trinity Hospital’s Infection Control Plan to protect employees, patients and visitors from potential exposure to an infectious organism.

**STANDARD:**

- 1. PPE includes glove use, gowns, procedure masks, N95 respirators, shoe protectors, hair caps, face shields and eye protection goggles/glasses.
- 2. PPE is provided by Trinity Hospital for employee, patient and visitor use.
- 3. All employees are instructed on the proper use and removal of PPE and the indications for PPE use at New Employee Orientation, yearly and whenever new guidance on PPE use becomes available.
- 4. All employees, visitors and patients are required to use PPE as indicated.
- 5. Appropriate use guidelines are attached.
- 6. Guidelines for the appropriate donning and removal of PPE are attached.
- 7. The use of PPE does not negate the need for hand hygiene before and after any patient contact or contact with their environment and after glove and PPE removal.
- 8. See Lab Precautions.

**TITLE: PRECAUTIONS**

**PURPOSE:** To define the precautions to be used by all healthcare workers when providing patient care at Trinity Hospital in order to prevent the spread of infectious disease within the Hospital.

**STANDARD:**

- 1. **Standard Precautions**
  - a. Originally developed to protect healthcare workers from Hepatitis B, Hepatitis C and HIV blood borne pathogen exposure.

- b. Used for all patient care, regardless of the patient's diagnosis or infection status, in any setting in which healthcare is delivered.
- c. Standard Precautions are based on the principle that all blood, body fluids, secretions, excretions may contain transmissible infectious agents.
- d. Combines universal precautions and body substance precautions.
- e. The specific application of Standard Precautions during patient care is determined by the nature of the healthcare worker-patient interaction and the extent of anticipated blood, body fluid, or pathogen exposure.
- f. Standard Precautions are also intended to protect patients by ensuring that healthcare personnel do not carry infectious agents to patients on their hands or via equipment used during patient care.
- g. Standard Precautions include the following:
  - i. Respiratory Hygiene and Cough Etiquette: (See Policy).
  - ii. Hand Washing: Hands are to be washed after any contact with the patient or the patient's environment before leaving the patient's room, before and after applying gloves, between tasks or procedures on the same patient. (See policy).
  - iii. Gloves:
    - 1. Gloves will be worn when providing all direct patient care.
    - 2. Gloves will be removed of and disposed of in the trash before leaving the patient's room.
  - iv. Mask:
    - 1. Used within 3 feet of any patient exhibiting signs or symptoms of a respiratory infection.
    - 2. Used during central venous catheter and Port-a-Cath insertion.
    - 3. Used during central line dressing changes.
    - 4. Used as part of full contact precautions for patients in isolation.
    - 5. Used during any procedure that may generate a splash of blood, body fluids, secretions or excretions.
    - 6. Used by any patient exhibiting respiratory symptoms while out of their room for ambulation, showering or transportation to another hospital department for testing.
    - 7. N-95 respirator use: (See Policy).

- v. Eye Protection and Face Shields:
  - 1. Used when performing any procedures that may generate a splash of blood, body fluids, secretions or excretions.
  - 2. Select masks, goggles, face shields, and combinations of each according to the need anticipated by the task performed.
  - 3. Indicated during endotracheal intubation, respiratory suctioning, wound irrigation and any other procedure that may generate a splash of any body fluid.
- vi. Gowns:
  - 1. Wear a gown, that is appropriate to the task, to protect skin and prevent soiling or contamination of clothing during procedures and patient-care activities when contact with blood, body fluids, secretions, or excretions is anticipated.
  - 2. Wear a gown for direct patient contact if the patient has uncontained secretions or excretions.
  - 3. Remove gown and perform hand hygiene before leaving the patient's environment.
  - 4. Do not reuse gowns, even for repeated contacts with the same patient.
- vii. Patient Care Equipment: (See DME Policy).
  - 1. All patient care equipment that is soiled with blood, body fluids, secretions or excretions will be cleaned according to the DME policy.
  - 2. Any equipment contaminated with blood on the inside of the machine's mechanism (IV pumps) must be tagged as contaminated, placed in a red bag and sent to Biomed for cleaning before re-use.
- viii. Personal Protective Equipment (PPE): (See PPE Policy)
  - 1. Wear PPE (e.g., gloves, gown, mask, eye protection, booties), according to the level of anticipated contamination, when handling patient-care equipment and instruments/devices that is visibly soiled or may have been in contact with blood or body fluids.
- ix. Environmental Cleaning
  - 1. Surfaces that are likely to be contaminated with pathogens, including those that are in close proximity to the patient (e.g., bed rails, over bed tables) and frequently-touched surfaces in the patient care environment (e.g., door knobs, surfaces in and surrounding toilets in patients' rooms) will be

- cleaned according to Trinity Hospital's environmental cleaning policies.
2. EPA-registered disinfectants that have microbicidal (i.e., killing) activity against the pathogens most likely to contaminate the patient-care environment will be used in accordance with manufacturer's instructions.
  3. Nursing counters, keyboards, phones will be cleared every shift and as needed per the DME Policy.
  4. Patient equipment will be cleaned between each patient use. (See DME policy).
- x. Safe Injection Practices: The following recommendations apply to the use of needles, cannulas that replace needles, and, where applicable, intravenous delivery systems.
1. Use aseptic technique to avoid contamination of sterile injection equipment.
  2. Do not administer medications from a syringe to multiple patients, even if the needle or cannula on the syringe is changed. Needles, cannulae and syringes are sterile, single-use items; they should be reused for another patient nor to access a medication or solution that might be used for a subsequent patient.
  3. Use fluid infusion and administration sets (i.e., intravenous bags, tubing and connectors) for one patient only and dispose appropriately after use. Consider a syringe or needle/cannula contaminated once it has been used to enter or connect to a patient's intravenous infusion bag or administration set.
  4. Use single-dose vials for parenteral medications whenever possible.
  5. Do not administer medications from single-dose vials or ampules to multiple patients or combine leftover contents for later use.
  6. If multidose vials must be used, both the needle or cannula and syringe used to access the multidose vial must be sterile.
  7. Do not keep multidose vials in the immediate patient treatment area and store in accordance with the manufacturer's recommendations; discard if sterility is compromised or questionable.
- xi. Linen
1. Used linen will be handled, transported and processed in a way that prevents skin and mucous membrane exposure, contamination of clothing and

- the transfer of microorganisms to another patient or the environment.
- 2. Each patient's room will have a linen disposal bag. The bag will be secured before removing from the patient's room.
- xii. Occupational Health and Blood Borne Pathogens:
  - 1. Use resuscitation bags or pocket masks when the need for resuscitation is anticipated.
- xiv. Patient Placement
  - 1. Ensure that patients who are infectious are placed in the appropriate room under the appropriate isolation precautions.
  - 2. Ensure that patients who may contaminate the environment or who do not or cannot be expected to assist in maintaining appropriate hygiene or adhere to Respiratory Hygiene and Cough Etiquette protocols are placed in private room.

2. **Transmission Based Precautions:**

- a. Standard Precautions are always used in addition to Transmission Based Precautions.
- b. The CDC has identified three types of disease transmission and appropriate precautions for each mode of transmission.
- c. **Airborne**
  - i. The infecting organism is transported through the air.
  - ii. Usually <5 microns in size.
  - iii. Contracted via nasal passages, mouth or eyes.
  - iv. Spread by coughing, sneezing, talking
  - v. Examples: Tuberculosis, Novel Influenza Virus, SARS.
  - vi. Full isolation precautions (Respiratory and Contact).
  - vii. HEPA filtration unit needed (Room 204).
- d. **Droplet**
  - i. The infecting organism is transported through the air.
  - ii. Usually >5 microns in size.
  - iii. Contracted via the nasal passages, mouth or eyes.
  - iv. Spread by coughing, sneezing, talking
  - v. Examples: organisms that cause the common cold, flu, pneumonias.
  - vi. Respiratory Isolation: Mask use within 3 feet of the infected person.
  - vii. Contact precautions if patient is unwilling or unable to control their own secretions or abide by the Respiratory Hygiene and Cough Etiquette protocol.

- e. **Contact**
  - i. Contact precautions apply to specified patients known or suspected to be infected with infectious organisms that can be transmitted by either direct or indirect contact with the organism.
  - ii. Direct Contact: the infected person touches the uninfected person and spreads the infection (person-to-person).
  - iii. Indirect Contact: the infected person touches an object and the uninfected person touches the same object which is now infected (person-to-object-to-person: bed rails, bedside tables, linen, IV pumps).

**Reference:** CDC. Guideline for Isolation Precautions: Preventing the Transmission of Infectious Agents in Healthcare Settings. 2007.

**TITLE:                    Respiratory Hygiene / Cough Etiquette**

**PURPOSE:**            To prevent the transmission of all respiratory infections in healthcare settings, including influenza.

**STANDARD:**

- 1. Incoming Patients and Visitors:
  - a. Postings at the entrances to Trinity Hospital instructing patients and persons accompanying them to practice Respiratory Hygiene / Cough Protocols, emphasizing covering coughs and sneezes and cleaning hands.
  - b. Notification of healthcare personnel of symptoms of a respiratory infection.
  - c. Alcohol-based hand sanitizers at Hospital entrances and throughout the Hospital care areas.
  - d. Visitor education and demonstration regarding the use and disposal of personal protective equipment (PPE).
- 2. **Respiratory Hygiene / Cough Etiquette:**
  - a. The following measures to contain respiratory secretions are recommended for all individuals with signs and symptoms of a respiratory infection:



- Cover the nose/mouth when coughing or sneezing;
  - Use tissues to contain respiratory secretions and dispose of them in the nearest waste receptacle after use;
  - Perform hand hygiene (e.g., hand washing with non-antimicrobial soap and water, alcohol-based hand rub, or antiseptic handwash) after having contact with respiratory secretions and contaminated objects/materials.
- b. Materials will be available in all patient care areas and waiting rooms for adhering to the Respiratory Hygiene / Cough Etiquette policy: tissues and no-touch receptacles for used tissue disposal and conveniently located dispensers of alcohol-based hand rub will be provided; where sinks are available, supplies for hand washing (i.e., soap, disposable towels) will be consistently available.
3. **Masking and Separation of Persons with Respiratory Symptoms**
- a. During periods of increased respiratory infection activity in the community offer masks to persons who are coughing. Either procedure masks (i.e., with ear loops) or surgical masks (i.e., with ties) may be used to contain respiratory secretions (respirators such as N-95 or above are not necessary for this purpose).
- b. When space and chair availability permit, encourage coughing persons to sit at least three feet away from others in common waiting areas.
4. **Droplet Precautions:**
- a. Healthcare personnel will observe Droplet Precautions (i.e., wearing a surgical or procedure mask for close contact), in addition to Standard Precautions, when examining a patient with symptoms of a respiratory infection, particularly if fever is present.
- b. These precautions will be maintained until it is determined that the cause of symptoms is not an infectious agent that requires Droplet Precautions.

Reference: *Preventing Transmission of Infectious Agents in Healthcare Settings*, (HICPAC), CDC. December, 2003.

## ***Healthcare Worker Medical Glove Checklist***

### **When to wear gloves**

- When touching patient mucous membranes or nonintact skin.
- While performing phlebotomy and other vascular access procedures.
- When processing body fluid specimens.
- When performing fingersticks or heelsticks.
- When touching items contaminated with blood or body fluids.
- While treating lacerations, abrasions, and compound fractures.
- During patient care when the healthcare worker has hangnails, chapped hands, or other abrasions on the hands.

### **How to wear gloves**

- Wear gloves that fit properly. Place them to fit over your sleeve cuff.
- Before putting on gloves, check for tiny punctures, discoloration, and other physical defects. Do not use defective gloves.
- Remove gloves before handling noncontaminated items such as telephones and when leaving the area.
- Change gloves between patient contacts. Never wash or disinfect latex or vinyl gloves for reuse.

### **How to remove gloves without contamination**

- Grasp the outside of the glove with opposite hand; peel off.
- Hold removed glove in glove hand.
- Slide fingers of ungloved hand under remaining glove at wrist.
- Peel gloves over first hand.
- Discard gloves in a waste container.
- Perform hand hygiene immediately after removing gloves.

#### **Do's and Don'ts of Glove Use**

- » Work from clean to dirty—this will help prevent contamination
- » Don't touch your face or adjust PPE with contaminated gloves
- » Don't touch environmental surfaces – doorknobs, keyboards, computer mouse. This means when leaving the laboratory TAKE OFF YOUR GLOVES. If you need to wear a glove in the hallway to carry a sample, make sure that the gloved hand is carrying the sample and the non gloved hand is operating door handles, elevator buttons, etc.
- » Change gloves when heavily soiled or if they are torn.
- » Discard gloves after use, never wash or reuse disposable gloves.

<http://www.cdc.gov/ncidod/hip/ppe/PPEslides6-29-04.pdf>

## **DONNING PPE**

### **GOWN**

- Fully cover torso from neck to knees, arms to end of wrist, and wrap around the back
- Fasten in back at neck and waist

### **MASK OR RESPIRATOR**

- Secure ties or elastic band at middle of head and neck
- Fit flexible band to nose bridge
- Fit snug to face and below chin
- Fit-check respirator

### **GOGGLES/FACE SHIELD**

- Put on face and adjust to fit

### **GLOVES**

- Use non-sterile for isolation
- Select according to hand size
- Extend to cover wrist of isolation gown

### **SAFE WORK PRACTICES**

- Keep hands away from face
- Work from clean to dirty
- Limit surfaces touched
- Change when torn or heavily contaminated
- Perform hand hygiene

*2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, June 2007*

## **REMOVING PPE**

**Remove PPE at doorway before leaving patient room**

### **GLOVES**

- Outside of gloves are contaminated
- Grasp outside of glove with opposite gloved hand; peel off
- Hold removed glove in gloved hand
- Slide fingers of ungloved hand under remaining glove at wrist

### **GOGGLES/FACE SHIELD**

- Outside of goggles or face shield are contaminated!
- To remove, handle by “clean” head band or ear pieces
  - Place in waste container

### **GOWN**

- Gown front and sleeves are contaminated!
- Unfasten neck, then waist ties
- Remove gown using a peeling motion; pull gown from each shoulder toward the same hand
- Gown will turn inside out
- Hold removed gown away from body, roll into a bundle and discard into waste receptacle

### **MASK OR RESPIRATOR**

- Front of mask/respirator is contaminated – **DO NOT TOUCH!**
- Grasp **ONLY** bottom then top ties/elastics and remove
- Discard in waste container

### **HAND HYGIENE**

**Perform hand hygiene immediately after removing all PPE!**

*2007 Guideline for Isolation Precautions: Preventing  
Transmission of Infectious Agents in Healthcare Settings, June 2007*  
PERSONAL PROTECTIVE EQUIPMENT

	NON-STERILE GLOVES	PROCEDURE MASK	GOWN	N95 RESPIRATOR	EYE PROTECTION AND/OR FACE SHIELD	SHOE PROTECTION	HAIR PROTECTION
<b>All patient exposure or exposure to the patient's environment</b>	X						
<b>Pneumonia or patient difficulty controlling own secretions</b>	X	X	consider		consider	consider	
<b>Novel or Pandemic Influenza</b>	X		X	X	Within 6 feet	consider	
<b>Seasonal Influenza</b>	X	X	consider		Within 3 feet	consider	
<b>Draining Wound</b>	X	During wound irrigation/dressing change	X		During wound irrigation/dressing change	X	
<b>ATD</b> (tuberculosis (TB), measles, mumps, rubella, pertussis, SARS, monkey pox, small pox, <b>chicken pox</b> (varicella), and novel or unknown ATDs, such as pandemic flu strains that are not fully characterized)	X		X	X	X	consider	
<b>Scabies / Lice</b>	X		X			X	X
<b>C-diff, Gastroenteritis</b>	X		X			X	