

DEPARTMENT OF THE ARMY
RAYMOND W. BLISS ARMY HEALTH CENTER
FORT HUACHUCA, ARIZONA 85613-7079

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Medical Services
INFECTION PREVENTION AND CONTROL MANUAL

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1. HISTORY: This is a revision of this publication.

2. PURPOSE:

2.1 This Infection Prevention and Control Manual establishes the policies and procedures for the Infection Prevention and Control Program at Raymond W. Bliss Army Health Center and its outlying clinics. (Here after referred to as RWBAHC or Health Center). These policies and procedures are in place to prevent and control clinically acquired infections and to ensure a safe occupational environment for our staff.

2.2 This guide constitutes the standard of practice in Infection Prevention and Control and is approved by the Infection Prevention and Control Service and Functional Management Team (FMT). The use of trade names is for identification purposes and does not constitute endorsement by the RWBAHC Infection Prevention and Control Service.

2.3 Statement of Authority: see Appendix A

3. SCOPE: This publication applies to all personnel assigned, attached, or employed by RWBAHC. RWBAHC is an Ambulatory Care practice setting.

4. REFERENCES.

4.1 Friedman, C., Petersen, K.H., Infection Control in Ambulatory Care. (current edition). Jones and Bartlett Publishers, 40 Tall Pine Drive, Studbury, MA 01776.

4.2 Joint Commission on Accreditation of Healthcare Organizations Standards for Ambulatory Care (current edition). Joint Commission Resources, One Renaissance Blvd. Oakbrook Terrace, IL 60181.

4.3 Center for Disease Control. www.cdc.gov.

4.4 AORN Inc.,(current edition) Recommended Practices and Guidelines: Care and Cleaning of Instruments and Powered Equipment., Denver, Co., AORN, Inc.

4.5 MEDDAC Memo 15-1, COMMITTEE MANAGEMENT

4.6 MEDDAC Memo 40- 5, EMPLOYEE HEALTH

4.7 MEDDAC Memo 40-38, COMMUNICABLE AND PREVENTABLE DISEASE REPORTING

4.8 MEDDAC Memo 40-145, TUBERCULOSIS PREVENTION PROGRAM

4.9 MEDDAC Memo 40-131, Management of Regulated Medical Waste (RMW).

4.10 MEDDAC Pam 750-5, Medical Bulk Refrigerator Automated Alarm System

4.11 40 Code of Federal Regulations

4.12 Operating Room SOP for Infection Control

5. GENERAL.

5.1 Infection Prevention and Control Service mission: The Infection Prevention and Control Program at RWBAHC is designed to support the mission of the Health Center and optimize the health and wellness of the Fort Huachuca community. The community served by RWBAHC consists of active duty soldiers, their dependents, and retired personnel. The overwhelming majority of health care provided at RWBAHC is primary in nature with approximately 30-50 general and orthopedic ambulatory same day surgery procedures performed per month.

5.2 Rationale: The Infection Prevention and Control process is based on sound, current epidemiologic principles and nosocomial/health care acquired (HCA) infection research.

5.4 Evolving scope: Many patients who once required hospitalization are now managed entirely as outpatients in the Ambulatory Care practice setting. Ambulatory care now comprises of various practices in highly diverse sites caring for an even greater diversity of patients in various stages of wellness. The different types of invasive procedures performed are also growing in variety as the Ambulatory Care setting expands. In the past surgery was only performed in the Operating Room and is now preformed in examination rooms, procedure rooms, as well as Ambulatory Surgery Centers. Infection Prevention and Control has evolved to meet the new challenges in this increasingly complex Ambulatory Care setting. In contrast to traditional Inpatient Health Care Acquired (HCA) Infections, infections transmitted in the Ambulatory Care

setting are difficult to systematically monitor and detect by traditional surveillance methods, therefore prevention is of the utmost importance in our Infection Prevention and Control Program.

5.5 Host resistance: Many conditions compromise a patient's ability to fight infection. These include pre-existing underlying diseases, immunosuppressive drugs, antibiotic therapy, treatments which provide a portal of entry for microorganisms (e.g. surgery, IV therapy, and urinary catheters), reusable equipment, and our Health Center's microbial population. Infection Prevention and Control service aims to reduce the impact of these conditions by practicing stringent aseptic technique, sanitation of the Health Care setting, as well as separating and transferring patients with infectious diseases requiring hospitalization. The Infection Prevention and Control service will implement the program by various means to include: administrative controls, work practice controls, and personal protective equipment.

6. INFECTION CONTROL PROGRAM GOALS:

6.1 The following goals of the RWBAHC Infection Prevention and Control program have been approved by the Infection Prevention and Control FMT. The goals listed below are evolving and adapted based on the most recent surveillance as well as the most current references.

6.1.1 Conduct routine surveillance of clinical areas for compliance or non compliance to the policies and procedures outlined in the pamphlet.

6.1.2 Provide Infection Prevention and Control feedback to all the clinic and patient care areas based on objective data collection.

6.1.3 Annual review and IPC Pamphlet 40-160, staff IPC annual training requirements (Blood borne Pathogens, Hand washing guidelines PowerPoint slides) as well as other educational IC information ensuring it is relevant, appropriate, and congruent with current practices.

6.1.4 Ensure that preparation for The Joint Commission survey is a continuous, on-going process.

6.1.5 Continue to develop relationship within the Health Center sections ensuring complete and full understanding of the IPC mission and strive to amend any knowledge deficits among our staff members.

6.1.6 Provide on-going feedback to the IPC Functional Management Team (FMT) Champion.

6.2 Structure and Function: The Infection Prevention and Control Program at RWBAHC is managed by the Infection Prevention and Control Functional Management Team (FMT) and the Infection Control Officer. To accomplish these goals, the program performs the following essential functions:

6.2.1 Coordinates and collaborates in the development and with any changes to the Medical Emergency Management Plan (MEMP). See RWBAHC MEMP.

6.2.2 Formulation of policies and procedures to prevent and control infections.

6.2.3 Design, develop and monitor education programs to increase awareness of the prevalence of disease and infections, disseminate prevention techniques, and reduce the overall transmission rate of disease and infections.

6.2.4 Epidemiological surveillance for the occurrence of infections in patients and staff within the Health Center.

6.2.5 Formulate and coordinate timely intervention activities based on epidemiologically sound surveillance.

6.2.6 Provide standardized definitions of HCA Infections for surveillance and reporting of pertinent infection rates.

6.2.7 Maintain a system for reporting, evaluating, and maintaining records of infections among patients and staff. This includes assignment of responsibility for the ongoing collection and analytical review of such data, as well as for required follow-up action.

6.2.8 Review and evaluate all aseptic, isolation, and sanitation techniques employed at RWBAHC. Techniques and standards will be defined and established in written policies and procedures.

6.2.9 Define the specific indications for isolation requirements relevant to the medical condition.

6.2.10 Provide preventive, surveillance, and control procedures relating to the inanimate Health Center environment, to include: sterilization, disinfection practices, Central Material Service, housekeeping, laundry, engineering and maintenance, food sanitation, and waste management. Such procedures shall be evaluated on a continuing basis and revised as necessary.

6.2.11 Provide for all necessary laboratory support, particularly microbiological and serological.

6.2.12 Provide input into the scope and content of RWBAHC Memorandum 40-5 Employee Health.

6.2.13 Provide documented orientation education for new employees and annual training for current employees on the Infection Prevention and Control program, Blood borne Pathogens, and Hand Hygiene education.

6.2.14 Coordinate with the medical staff on actions relative to the findings from the Antibiotic susceptibility report and the antibiotic utilization review. The ongoing monitoring and appropriateness of antibiotic usage in the Health Center is a medical staff responsibility documented through the Pharmacy and Therapeutics Committee.

6.2.15 Develop and/or revise all forms used for the collection and collation of surveillance data for the Infection Prevention and Control program.

6.2.16 A mechanism for the initiation, approval, and review of results of all special studies conducted by the Infection Prevention and Control service.

6.2.17 Institute antibiotic susceptibility/resistance trend studies as appropriate.

6.2.18 Consultation relative to the purchase of all equipment and supplies used for sterilization, disinfection, and decontamination purposes.

6.2.19 Evaluation of Health Center disposal systems, for all liquid and solid wastes.

6.2.20 Periodic review of cleaning procedures, agents, and schedules in use throughout the Health Center. Consultation relative to major changes in cleaning products or techniques will be done annually.

6.2.21 Employee Health and Staff Awareness: The Infection Prevention and Control Program includes promoting the health and protection of RWBAHC personnel, as well as patients. It is imperative that personnel be cognizant and understand sources of infection, adhere to and anticipate the need for personal protective equipment, and understand immediate procedures for blood or body fluid exposure (See paragraph 32 for further instructions). The exams and screening programs provided by Occupational Health and Community Health Nursing are a further means of protection, and require the full cooperation and participation of all employees. Personnel must be aware of infections in themselves and act responsibly to prevent cross-infection to patients and co-workers. Consultation and coordination with Infection Prevention and Control and Occupational Health will take place in the event of an employee illness or infection for guidance on patient contact. Details concerning employee health may be found in RWBAHC Memo 40-5 Employee Health.

6.3 Special Studies:

6.3.1 When a problem or question is brought to the attention of the Infection Prevention and Control Officer or any FMT member, a special study may be requested and/or initiated.

6.3.2 The Infection Prevention and Control FMT will determine the need and vote for initiating the study.

6.3.3 Any problem or hazard that poses an immediate threat falls under the purview of the Statement of Authority and immediate action will be taken.

6.3.4 The study may be performed by the Infection Prevention and Control Officer, Infection Prevention and Control FMT or the person/clinic area that identified the problem.

6.3.5 The Infection Prevention and Control FMT will review the results of the study and distribute the findings to the appropriate medical and nursing staff.

6.4 Infection Prevention and Control FMT: Covered in MEDDAC Memo 15-1 Committees and Minutes

6.5 Appendix B - Performance Standards / Job Description of Infection Prevention Control Officer.

6.6 Outbreak Plan: Appendix C outlines procedures to follow in the event of an outbreak

7. DEFINITIONS FOR SURVEILLANCE OF INFECTIONS

7.1 INFECTION: Infection is the presence of an organism(s) in body tissues or fluids, accompanied by a clinically adverse effect, either locally or systemically.

7.2 COLONIZATION: Colonization is the persistence of organisms on the skin, or mucosal surfaces without a clinically adverse effect being present.

7.3 NOSOCOMIAL INFECTION: Healthcare Associated Infections (HAIs) are infections patients acquire during the course of receiving treatment for other conditions within a healthcare setting. Appearance of infection at a new, different site, even with the same organism as the original infection will also be classified as a HAI.

7.4 SURGICAL WOUND CLASSIFICATIONS. The Centers for Disease Control and Prevention (CDC) recommends routine surveillance for surgical site infections; accrediting agencies such as The Joint Commission require it. Surveillance

identifies clusters of infection, establishes baseline risks for infection, provides comparisons between institutions or surgical specialties, identifies risk factors, and permits evaluation of control measures. Achieving these goals requires health-care systems to have access to different information types. Wound classification assists in determining the extent of wound contamination during surgery, and thereby provides a tool for determining whether an infection is HCA or community-acquired. The following classification is recommended by the American College of Surgeons Committee on Control of Surgical Infections of the Pre- and Postoperative Care Committee.

7.4.1 Clean (Class I) - has the least potential for contamination at the time of surgery.

- A nontraumatic, primary incision in which no inflammation or infection was encountered, no breaks in sterility occurred, was elective and primarily closed, and the respiratory, alimentary, and genitourinary tracts were not entered.

- Examples of common procedures include (but not limited to):

 - Repair of Inguinal Hernia/Varicose Vein stripping

 - Mastectomy/Breast Biopsy

 - Operations on Muscles, Tendons, Fascia, and Bursa

 - Abdominal surgeries not entering the digestive tract

 - Arthroscopy

7.4.2 Clean-contaminated (Class II) - clean, but systems with endogenous flora are involved.

- A nontraumatic wound in which a minor break in sterility occurred or in which gastrointestinal, genitourinary, or respiratory tracts were entered without significant spillage. No inflammation is encountered.

- Examples of common procedures include (but not limited to):

 - Appendectomy (incidental, not ruptured)

 - Cholecystectomy without inflammation or infection (Open or Laparoscopic)

 - Hemorrhoidectomy

 - Resection of Small Intestine or Colon (without infection or gross spillage)

 - Episiotomy/Circumcision/Vasectomy

7.4.3 Contaminated (Class III).

- Any fresh traumatic wound (less than 8 hours) from a relatively clean source, or an operative wound in which there is a major break in sterility, gross spillage from the digestive, biliary, or genitourary tracts. Includes incisions encountering acute, nonpurulent inflammation.

- Examples include (but not limited to):

Burn Debridement (immediate)

Pilonidal Cystectomy

Appendectomy (acute, not ruptured)

Cholecystectomy with inflammation

7.4.4 Dirty (Class IV).

- Traumatic wound with delayed treatment (more than eight hours), fecal contamination, foreign body (bullet), or retained devitalized tissue. Includes operative wounds in which acute bacterial inflammation or a perforated viscus is encountered, or in which clean tissue is transected to gain access to pus.

- Examples include (but not limited to):

Perianal Fistulas

Rectal Abscess

Ruptured Appendix

Any abdominal procedure in presence of peritonitis

7.4.5 Examples of minor breaks in sterility include glove punctures and wet sterile fields without barriers.

7.4.6 Examples of major breaks in sterility include use of unsterile instruments, drapes, or supplies, perspiration in the wound, unsterile foreign bodies in the wound, and insects in the operating suite.

7.4.7 For multiple procedures, classify case according to the dirtiest rating, i.e. hernia repair and tonsillectomy = Class III.

7.4.8 Documentation. The OR nurse will document the classification on the Register of Operations as well as document the classification in the Surgical Scheduling System (S3).

8. STANDARD PRECAUTIONS:

8.1 Applicability: All RWBAHC Health Care Worker's (HCW) will use appropriate standard precautions in the care of all patients when contact (or potential contact) with blood or body fluids, non-intact skin, and mucous membranes is anticipated.

8.2 General: Standard Precautions are based on the principle that all blood, body fluids, secretions, excretions except sweat, non-intact skin, and mucous membranes may contain transmittable infectious agents. Standard Precautions include a group of infection prevention practices that apply to all patients, regardless of suspected or confirmed infection status, in any setting in which healthcare is delivered. These prevention practices include: hand hygiene; use of gloves, gown, mask, eye protection, or face shield, depending on the anticipated exposure; providing appropriate supplies for resp hygiene and cough etiquette, and safe injection practices. The application of Standard Precautions during patient care is determined by the nature of the HCW-patient interaction and the extent of anticipated blood, body fluid, or pathogen exposure. 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.

8.3 Definitions:

8.3.1 HCW - all Health Center employees (active or reserve military, civilian or contract), students, and volunteers whose work may involve direct contact with human blood and body fluids.

8.3.2 Blood borne pathogens - microorganisms which cause disease in humans that are present in human blood, human blood components, products made from human blood

8.4 Standards:

8.4.1 Used with all patients.

8.4.2 Hand hygiene should occur before and after each patient contact and before and after glove use.

8.4.3 Hand washing should occur if contaminated with blood or body fluids or visibly soiled.

8.4.4 Gloves should be used for contact with blood, all body fluids, non-intact skin, mucous membranes, and contaminated items or surfaces. They must be worn when performing venipuncture and other vascular access procedures.

8.4.5 Protective eyewear (masks, goggles, face shields) must be used if the face is likely to be splashed; for example, during procedures likely to generate droplets of blood or body fluids.

8.4.6 Fluid-resistant gowns or aprons must be used during procedures likely to splatter clothing with blood or body fluids.

8.4.7 Sharp items must be handled safely and in a cautious manner. Needles should never be recapped, bent, broken, or manipulated by hand. Place sharp items in puncture-resistant containers for disposal. Ensure that disposal containers are out of the reach of children; however, make sure they are available at points of use. Sharps with engineered safety devices will be utilized whenever possible.

8.4.8 Reusable sharp items should be placed in puncture-resistant containers for transport to a reprocessing area.

8.4.9 If an environmental surface or piece of equipment is visibly contaminated with blood or body fluid, it should be cleaned according to manufacturer's recommendations with a facility approved disinfectant. After all visible blood or body fluid is removed disinfectant should be reapplied with a fresh disinfectant cloth or paper towel.

8.4.10 There should be easy access to resuscitation equipment so that direct mouth-to-mouth resuscitation without a barrier may be avoided.

8.5 Respiratory Hygiene/Cough Etiquette: The strategy is targeted at patients and accompanying family members and/or friends with undiagnosed transmittable respiratory infections, and applies to any person with signs of illness including cough, congestion, rhinorrhea, or increased production of respiratory secretions when entering the Healthcare Center.

8.5.1 Elements of Respiratory Hygiene/Cough Etiquette include:

8.5.1.1 Education of healthcare facility staff, patients, and visitors

8.5.1.2 Posted signs, in language(s) appropriate to the population served, with instructions to patients and accompanying family members or friends

8.5.2 Source control measures e.g., covering the mouth/nose with a tissue when coughing and prompt disposal of used tissues, using surgical masks on the coughing person when tolerated. Covering sneezes and coughs and placing masks on coughing patients are proven means of source containment that prevent infected persons from dispersing respiratory secretions into the air

8.5.3 Hand hygiene after contact with respiratory secretions

8.5.4 Spatial separation in waiting areas is ideally >3 feet away from persons with respiratory symptoms.

8.6 Safe injection practices

8.6.1 Sterile, single-use, disposable needle and syringes will be used for each injection.

8.6.2 Whenever possible and feasible, single-dose vials will be used over multiple-dose vials, especially in areas where medications and or vaccines will be administered to multiple patients.

9. TRANSMISSION BASED PRECAUTIONS: There are three categories of Transmission-Based Precautions: Contact Precautions, Droplet Precautions, and Airborne Precautions. Transmission-Based Precautions are used when the route(s) of transmission is not completely interrupted using Standard Precautions alone. When Transmission-Based Precautions are indicated, efforts must be made to counteract possible adverse effects on patients i.e., anxiety, depression and other mood disturbances, perceptions of stigma, and reduced contact with clinical staff, in order to improve acceptance and compliance by the patients.

9.1 Contact Precautions:

9.1.1 Are intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the patient or the patient's environment.

9.1.2 Standards:

9.1.2.1 If the diagnosis is suspected prior to arrival, place the patient in a private/precaution room as soon as he or she arrives.

9.1.2.2 Wear gloves for any patient contact and for contact with any item that touched the patient. Remove gloves and perform hand hygiene before leaving the room.

9.1.2.3 Wear fluid-resistant gowns when entering the room if clothing will come in contact with the patient or if working close to the patient.

9.1.2.4 Wipe down all equipment that had patient contact or that is potentially contaminated with blood or body fluid with a disinfectant cleaner prior to removal from the room.

9.1.2.5 Post a sign on the examination, procedure, isolation, or precaution room door to notify staff of required Standard precautions and appropriate protective measures. See APPENDIX D for Contact Precaution sign.

9.1.2.6 The specific agents and circumstance for which Contact Precautions are indicated in paragraph 9.4.6.

9.2 Droplet Precautions

9.2.1 Droplet Precautions are intended to prevent transmission of pathogens spread through close (within 3 feet) respiratory or mucous membrane contact with respiratory secretions.

9.2.2 These pathogens do not remain infectious over long distances in a healthcare facility, special air handling and ventilation are not required to prevent droplet transmission

9.2.3 Standards

9.2.3.1 A single patient room is preferred for patients who require Droplet Precautions verses placing patients with like illness in the same exam room.

9.2.3.2 Spatial separation of greater than 3 feet is considered adequate space separation. Direct patient care or movement within 3 feet of patient necessitates the need for a staff to utilize Droplet Precautions.

9.2.3.3 HCW will wear a simple surgical mask (a respirator (>N95) is not necessary) for close contact (within 3 feet) with infectious patient; the mask is generally donned upon room entry.

9.2.3.4 Patients on Droplet Precautions who must be transported outside of the room should wear a mask if tolerated and follow Respiratory Hygiene/Cough Etiquette.

9.2.3.5 Post a sign on the examination or procedure room door to notify staff of required Droplet Precautions and appropriate protective measures. See APPENDIX D for Droplet Precaution sign.

9.2.3.6 The specific agents and circumstance for which Droplet Precautions are indicated in paragraph 9.4.6.

9.3 Airborne Precautions

9.3.1 Airborne Precautions prevent transmission of infectious agents that remain infectious over long distances when suspended in the air.

9.3.2. Standards

9.3.2.1 The preferred placement for patients who require Airborne Precautions is in an airborne infection isolation room (AIIR). RWBAHC's only AIIR is in FCC B, Rm 101-10.

9.3.3.2 HCW caring for patients on Airborne Precautions must wear a properly fitted respirator (N95 or greater) that is donned prior to room entry.

9.3.3.3 Provide patient with tissues and instructions to cover his/her nose and mouth when sneezing or coughing.

9.3.3.4 Post a sign on the examination or procedure room door to notify staff of required Airborne Precautions and appropriate protective measures. The door to the exam room must remain closed to maintain negative pressure. See APPENDIX D for Airborne Precaution sign.

9.3.3.5 Patients on Airborne Precautions who must be transported outside of the room will wear a respirator if tolerated and follow all guidelines for Respiratory Hygiene/Cough Etiquette except the simple surgical mask requirement, instead of the simple surgery mask the patient will don a respirator. If a respirator is not tolerated the simple surgical mask can be worn. If neither can be tolerated tissues and instructions for use when coughing or sneezing must be provided.

9.4 Implementing transmission based precautions

9.4.1 Infectious diseases account for about approximately 20% to 30% of health care visits. Exposure can occur in waiting areas or any area where many people congregate. Avoiding overcrowding and triage patients with obvious communicable illness as soon as possible and having them wait in pre-designated isolation or precaution room rather than in the waiting room with other patients. At the main pharmacy antibiotic prescriptions will be prioritized as a first fill prescription to reduce exposure to other waiting beneficiaries.

9.4.2 Proactive prevention practices include segregating patients with visible respiratory illness. In addition, when a patient is scheduled for an appointment and they are known to require transmission based precaution, every effort must be made to coordinate with the receptionist and screening staff to place the patient directly into an isolation or precaution exam room upon arrival for the appointment.

9.4.3 The charge nurse of the clinic is responsible for initiating isolation precautions based on sound judgment, pending notification of the Licensed Independent Practitioner (LIP). The Charge nurse will also notify the Infection Control Officer with any questions regarding standards of implementation.

9.4.4 The patients' LIP is responsible for the written order to place the patient (s) on the specific transmission based precaution (s).

9.4.5 Educating, informing, answering questions, and maintaining confidentiality for our patients is essential. Patiently educating the indications for transmission based precautions will sometimes alleviate patient's potential perceptions of stigma, anxiety and/or mood disturbances. Inform the patient a door sign will be placed to inform and communicate to the staff the particular precaution being utilized.

9.4.6 Communicable Diseases and their corresponding transmission based precaution:
C-contact precautions D-droplet precautions A-airborne precautions S-standard precautions ** C if diapered or incontinent)

Acquired immune deficiency syndrome (AIDS)	S
Adenovirus infection in infants and young children	D, C
Anthrax	S
Antibiotic-resistant microorganisms (MRSA, VRE, C Diff)	C
Chicken pox	A, C
Conjunctivitis	S
Cytomegalovirus infection, neonatal or immunosuppressed	S
Diphtheria	
Cutaneous	C
Pharyngeal	D
Gastroenteritis	
E. coli	S
Giardia lamblia	S
Rotavirus	S
Salmonella	S
Shigella	S
Gonorrhea	S
Hepatitis	
A	S
B	S
other viral	S
Herpes Zoster	
Disseminated	A, C
Localized	S
Human immunodeficiency virus (HIV)	S
Influenza	D
Lice	C
Measles (rubeola)	A
Meningitis	
Viral	S
H. influenzae	D
N. meningitidis	D
Mumps	D
Parvovirus B 19 (Fifth disease)	D

Respiratory disease, infants and young children	C	
Rubella	D	
Scabies	C	
Streptococcus, Group A (e.g., strep throat)		
Adults	S	
Infants and children	D	
Syphilis		S
Tuberculosis, pulmonary	A	
West Nile Virus	S	
Whooping cough (pertussis)	D	

10. TUBERCULOSIS (TB) PREVENTION PROGRAM: General. The risk of exposure to Mycobacterium Tuberculosis at RWBAHC has been assessed as low. Infection is most likely to occur in the Health Center when a patient has unsuspected pulmonary or laryngeal TB, has bacilli-laden sputum or respiratory secretions, and is coughing or sneezing into air that remains in circulation. The best way to protect others from a patient with TB are to maintain a high index of suspicion for TB and to institute Airborne Precautions (FCC B Room 101-10) when a patient comes into the Health Center, with suspected or confirmed TB. The Tuberculosis Prevention Plan is outlined in MEDDAC Memo 40-145. The Tuberculosis Risk Assessment will be conducted annually with the overall Proactive Risk Assessment.

10.1 As a precautionary measure each clinic has identified a licensed independent provider and a medic or nurse to maintain a N95 mask fit testing annually in the event of a TB patient or other Airborne precaution illness presents for care.

11. REPORTABLE DISEASES (See MEDDAC MEMO 40-38 Communicable Disease and Preventable Disease Reporting)

12. EMPLOYEE SCREENING PROGRAM: For additional information see MEDDAC Memo 40-5.

12.1 Employees with confirmed Methicillin Resistant Staphylococcus Aureus that provide direct patient care must be screened by Occupational Health who will collaborate with the Infection Prevention and Control Service. A decolonization regime may be indicated for employees providing direct patient care. Collaboration between Occupational Health, Infection Prevention and Control, and the Infectious Disease Service, William Beaumont Army Medical Center will determine on a case by case basis the indication for decolonization. If decolonization is indicated, the decolonization medication regime will also be included in the collaborative efforts.

13. HAND HYGIENE PROGRAM

13.1 Hand Hygiene Techniques:

13.1.1 Hand hygiene is considered the most important single procedure for preventing Health Care Acquired (HCA) infections and occupation acquired infections. Health Care personnel are believed to be the mode of transmission for most preventable HCA infections, and, in many outbreaks, hand hygiene has been shown to eliminate or markedly reduce hand carriage of pathogenic organisms, most of which are transient flora. Hand Hygiene techniques are listed below:

13.1.2 Handwashing

- Traditional handwash: A 15-20 second hand wash with plain soap and warm water. (15 seconds is approximately the time it takes to slowly count to 20).
- Antiseptic handwash: A 15 -20 second hand wash with antiseptic/antimicrobial soap and warm water. (15 seconds is approximately the time it takes to slowly count to 20).

13.1.3 Indications: Thorough hand washing with soap and running water must be accomplished in the following circumstances:

- Hands are visibly soiled
- Whenever hands come in contact with blood or bodily fluids such as during glove removal hands get soiled with blood or bodily fluids.
- Following personal hygiene
- Before handling or serving food.

- The primary means of hand hygiene when caring for a patient with a suspected or confirmed infection of spore forming bacteria such as: Clostridium difficile, Bacillus Anthracis (Anthrax). Alcohol based hand sanitizers are ineffective against spore forming bacteria.

13.1.4 Technique:

- Moisten hands with warm water.
- Apply soap. Use the amount recommended by the manufacturer.
- Vigorously rub all surfaces for at least 15 seconds, paying particular attention to areas around the finger-nails and between the fingers.
- Rinse hands thoroughly under running water to completely remove soap.
- Pat hand dry thoroughly with a disposable paper towel.
- Use a fresh dry paper towel to turn off the faucet.

13.1.5 Alcohol based hand rub: One application from the dispenser of Alcohol based hand sanitizer applied to entire hand surface until dry.

13.1.6 Indications: Alcohol based hand rub may be used for hand hygiene before and after patient contact, before and after glove use, and before medications are prepared or handled.

13.1.7 Exceptions: A traditional/antiseptic hand wash must be conducted instead of an alcohol based hand rub in the following instances:

- If at any time hands become contaminated with blood or bodily fluids
- At the beginning of a shift, before and after preparing or handling food, and after using the restroom
- If hands are visibly soiled
- If a build up of alcohol based hand sanitizer is felt on hands

13.1.8 Surgical Hand Hygiene / Antisepsis:

- Traditional/Antiseptic hand wash with nail cleaning device followed by an approved surgical alcohol based hand scrub.
- Traditional Surgical Hand scrub using impregnated Providone Iodine sponge or Chlorhexidine Gluconate, brush and nail cleaner

13.1.9 Indications: Utilized in the Operating Room preoperatively just prior to donning sterile gloves for performing a procedure utilizing sterile technique.

13.1.10 Technique: See Operating Room SOP for further guidance.

13.2 Frequent use of facility approved hand lotion to maintain healthy intact skin is an integral part of the Hand Hygiene program.

14. APPROVED DISINFECTANTS: The following is the list of facility approved disinfectants at RWBAHC.

Action D Disinfectant
 Acute Kare
 Alcare (foam alcohol scrub)
 Alcohol, 70% Ethyl (solution or pads)
 Aqua Satin Stainless Steel Cleaner
 Asepticare Aerosol
 Base Shooter Stripper
 Betadine (scrub, solution)
 Bleach (Sodium Hypochlorite)
 Carex Antiseptic Soap
 Carpet Rinse Extraction Neutralizer
 Cavicide
 Chemtrol Bowldozer Non Acid Toilet Bowl Cleaner
 Chemtrol Dazzle Neutral Floor Maintainer
 Chemtrol Film Free Glass Cleaner
 Dispatch Hospital Cleaner Disinfectant with Bleach
 CIDEX OPA
 Crew Cream Cleaner
 Crew Neutral NA Bowl Cleaner
 D Foam Suds Buster

D-STROY
DynaHex (Hibiclens)
Expose II 256
First Time Floor Stripper
Formula 409
Glance HC
Gum Solv Gum and Label Remover
Hydrogen Peroxide
Innovation Extreme Durability UHS Floor Finish
IShine
Kindest Care
Klenzme
LPH
New Look Spray Buff
Oxivir TB
Peracetic Acid Steris System
PhisoHex
Premium Lotion Soap
Pre Spray Traffic Lane Cleaner
Purcell Hand Sanitizer
Rebound UHS Restorer
Sonic Detergent
Staphene Aerosol
Stride Citrus HC
S State Hand Sanitizer w/Aloe
Tannin Spotter Plus
Taski TR 163
Tile Brite Cleaner
Ultra Lime-a-Way
Urinal-Ade
Virex II 256
Vortex Non Acid Disinfectant Bowl and Restroom Cleaner
Wex-cide

15. STERILE SUPPLIES:

15.1 General: In order to provide sterile processing of medical/surgical instruments, this section establishes guidelines for all departments/clinics requiring the services provided by Central Materiel Services (CMS).

15.2 Responsibilities:

15.2.1 CMS Services: Will provide sterilization services to all Clinics requiring sterile instrumentation processing.

15.2.2 Department Chief/OIC/NCOIC of clinics will: Request needed services; ensure that all instruments turned in to CMS for sterile processing have been decontaminated and are free of debris; ensure that instruments are brought to CMS in a closed/covered container; be accountable for instruments and supplies; and ensure that rotation of sterile supplies is accomplished routinely to prevent outdates.

15.2.3 Prepackaged sterile items or items received sterile from a manufacture are considered sterile until opened, damaged, or until outdated. Packaging shall be inspected prior to use to ensure package integrity. If a supply does not have an outdate it will be considered sterile based on the condition of the packaging. Damage to the packaging occurs whenever the item is handled. A close inspection of the packaging to ensure the integrity is intact and the overall sterility of the product has been maintained must occur prior to patient care use. If uncertain as to the sterility or suitability of a sterile product, consult the Infection Control Officer, or CMS for guidance.

15.3 CMS personnel will not accept any instruments or supplies that contain blood, body fluids, or tissue. Instruments must be cleaned and decontaminated prior to turn in. Cleaning includes physical removal of soil, blood, tissue, or other organic matter with instrument detergent, mechanical action (brushing), and rinsing. Cleaning removes the debris, reduces the quantity of microorganisms, and is the initial step in the sterilization process.

15.3.1 CMS provides STEAM, STERIS, and STERRAD sterilization services. Ethylene Oxide is not used at this facility. The Specialty Clinic conducts endoscopic services and processes all endoscopes within the clinic area.

15.3.2 Storage of Sterile Supplies: All supplies and instruments issued by CMS will be wrapped or peel packed. These items must be kept in an enclosed area to ensure the package remains clean, dry, and dust and/or lint free such as in an enclosed cabinet or drawer. If the integrity of the seal or wrapper is compromised, the item shall be returned to CMS for reprocessing. All sterile items should be rotated on the shelf. The most recently sterilized items should be placed behind the items that have been on the shelf. Clean supplies and sterile supplies should always be stored separately to avoid soiling the packaging of sterile items. Clinic supervisors must ensure that sterile supplies are rotated and stored appropriately to maintain and prevent damage to the wrapping or integrity of the seal.

15.3.3 All items submitted for sterile processing in CMS will be sterilized using a 3M Biological Indicator on each day the autoclave is in use. Additionally, a biological indicator will be run with all implantable items. Parametric release of sterile instrument will not be authorized. No sterile supplies or instruments will be released from CMS for use until the biological indicator results are read (minimum time for read out is 3 hours).

15.3.4 A monthly CMS Sterilizer Quality Assurance log is maintained to ensure appropriate sterilization procedures are being followed.

15.4 WRAPPING PROCEDURE: All items-used in sterile procedures are to be wrapped using one of the following methods.

15.4.1 Peel Pak Wrappers.

- Supplies placed in peel packs and sealed are considered sterile unless the integrity of the packaging has been compromised (i.e., torn, wet, etc.).
- Double peel packs are not required, but may be used for convenience in handling. Both will be sealed. A chemical indicator will be placed inside the inner wrapper.
- All sharp tipped or delicate items must be protected from damage when being wrapped with this method.

15.4.2 Non-woven paper, plastic paper laminate. Supplies double wrapped in paper (non-woven) are considered to have event related shelf life (sterility).

16. CLEANING OF INSTRUMENTS: Instruments cleaning begins at the point of use and will be thoroughly clean before being sterilized. Cleaning includes physical removal of soil, blood, tissue, or other organic matter with an instrument detergent, mechanical action, and rinsing. Cleaning removes the debris, reduces the quantity of microorganisms, and is the initial step in the sterilization process. An enzymatic instrument detergent, diluted according to label instructions, will be used for initial cleaning. Enzymatic detergents do not contain germicides, therefore instruments are still infectious after cleaning is complete. Instruments transported to CMS will be transported in a hardened, sealable, biohazard container.

17. REUSE OF DISPOSABLE SINGLE USE DEVICES: Single Use Devices (SUDs). Disposable equipment and supplies that are designated for single patient use are to be used once and discarded according to the manufacturer's directions. SUDs will not be reprocessed in this facility.

18. ELECTRONIC EQUIPMENT: All electronic equipment used for patient care should be cleaned and disinfected at the point of use between patient uses in accordance with manufactures recommendations with a facility approved disinfectant. If the manufacturer's recommendations are unavailable a recognized, documented standard of practice for routine cleanings is acceptable.

19. ICE MACHINES/REFRIGERATORS

19.1 General: Proper cleaning and use of ice machines, ice scoops and refrigerators is instrumental in decreasing bacterial contamination and overall transmission of bacteria to patients and staff.

19.2 Ice Machines are located in the Laboratory (belongs to the coffee shop), Post Anesthesia Care Unit (PACU), and the Physical Therapy (PT) clinic. The ice machines in the Laboratory and PACU are bin type ice machines. The ice machine in the PT clinic is a dispenser type machine.

19.2.1 Scoops: Scoops are cleaned on a daily basis (in the PACU on surgical days) with Dispatch Hospital Cleaner Disinfectant with Bleach as directed. Place the scoop in a basin that was cleaned in the same manner as the scoop. Place a sticker on the basin noting the current date to annotate the daily cleaning.

19.2.2 Cleaning of bin-type ice machines. On a weekly basis, ice machines will be externally cleaned with Cavicide or an equivalent facility approved disinfectant. On a monthly basis, disconnect machine, empty the bin and let it thaw. Using a disposable cloth, clean and sanitize with Dispatch Hospital Cleaner Disinfectant with Bleach as directed giving special attention to cracks, crevices, and recesses. Allow to dry and reconnect machine. Documentation of external weekly and internal monthly cleanings will be maintained with the ice machine.

19.2.3 Cleaning of dispenser-type ice machines. On a weekly basis, clean and sanitized with Dispatch Hospital Cleaner Disinfectant with Bleach as directed. Every three months the machine will be disassembled, cleaned and disinfected by the medical maintenance section. Documentation of daily and quarterly cleaning will be maintained with the ice machine.

19.3 Refrigerators

19.3.1 Clinical Refrigerators for medications and specimens: Temperatures will be maintained between 36-46 degrees Fahrenheit or 2-8 degrees Celsius and will be recorded daily. Medication / Clinical Refrigerators will require monthly cleanings and be sanitized with Dispatch Hospital Cleaner Disinfectant with Bleach as directed.

19.3.2 Staff Food Refrigerators: Do not need daily temperature recordings or prescribed periodic cleanings, however they must be maintained in a reasonably clean manner at all time. Staff food refrigerators will be cleaned and sanitized with Dispatch Hospital Cleaner Disinfectant with Bleach as directed.

19.3.3 Follow procedures in MEDDAC Pam 750-5, Medical Bulk Refrigerator Automated Alarm System for any medical refrigerator out of temperature range noted above.

20. CLEANING OF PATIENT CARE AREAS:

20.1 Designated housekeeping staff is responsible for cleaning during duty hours. If a clinic does not have a designated housekeeper or a housekeeper is not available, the clinic staff will perform the required cleaning task (s).

20.2 Hasty cleaning: Exam room cleanings between patient clinic visits.

20.2.1 Staff are responsible for ensuring the exam is clean room between each patient. Surfaces touched with intact skin to include but not limited to the table/gurney(s)/beds, stands, blood pressure cuffs, thermometer and all other equipment that have been touched by the patient should be cleaned when visibly soiled and at a minimum on a daily basis. All exam table paper and linen will be changed or removed between patients. Exam rooms will be cleaned with Cavicide or equivalent approved disinfectant and mechanical friction to remove any environmental soilage. Disinfectant contact time for should be at least 3 minutes for routine cleanings. For Tuberculocidal effects contact time will increase to at least 5 minutes.

20.3 Terminal Cleanings: Complete, thorough cleanings of patient care areas to include all equipment and surfaces in the exam room are required between patients requiring transmission based precautions and daily. A terminal cleaning may be conducted by housekeeping or may be required to be cleaned by clinic staff members. Cleanings will be accomplished in a systematic top to bottom fashion, on all equipment and surfaces. Equipment and furniture that can be moved will be moved to ensure under the equipment and furniture is clean. Disinfectant contact time for should be at least 3 minutes for routine cleanings. For Tuberculocidal effects contact time will increase to at least 5 minutes.

20.4 Housekeeping personnel are responsible for cleaning floors and bathrooms daily. Walls, windowsills, air vents, lamps, and lockers will be cleaned as necessary.

20.5 All clean equipment and supplies will be stored in a "clean" utility room; and dirty equipment and supplies will be stored in a "dirty/soiled" utility room.

20.6 Remove linen/paper from the bed by folding it upon itself making sure that non-linen items are not included in the linen bundle. If any of the linen is wet, ensure that the wet portion is located in the center of the bundle. Handle all soiled linen with gloves, as little as possible, while minimizing contact between soiled linen and uniform.

20.7 Isolation or Precaution Room – If patient is present, transmission based precautions are still in effect, and cleaning can't wait until patient has departed. Cleaning staff will don the appropriate PPE and proceed with cleaning.

20.6.1 If Airborne Precautions have been utilized for a patient with known or suspected Tuberculosis wait at least 30 minutes prior to cleaning to ensure adequate air exchanges. For Tuberculocidal effects contact time will increase to at least 5 minutes. . Wipe surface dry using a towel or allow to air dry.

21. CLEANING UP BODY FLUIDS

21.1 General: Cleaning up spills of any fluid must be done in a timely manner to prevent not only exposure to contagious bodily fluids but also to prevent falls. Wet floor signs should be used in the immediate area of a spill on the floor until the floor is dry. If the origin of the spill is unknown, clean up must be done as described in the following procedure for cleaning blood and body fluids from all surfaces. Exam gloves should be worn for all clean ups.

21.2 Simple/small spill (no sharp material in fluid): Using a disposable absorbent material (paper towels, paper wash cloths, chux) wipe up the spill. Place the wipe material in a red trash bag. Flood area with LPH. Ensure that the spill area remains wet with the disinfectant for a minimum of (10) ten minutes.

21.3 Simple/large spill (no sharp material in fluid): If the spill area is too large to soak up with paper products, a mop may be used. Take care not to extend the edges of the spill any further than necessary. The mop head must be disposed of in a red trash bag. Flood the entire area with LPH. Ensure that the spill area remains wet with the disinfectant a minimum of (10) minutes.

21.4 Spill with glass or other sharp materials: UNDER NO CIRCUMSTANCES should a spill with glass be cleaned up in either of the first two methods of this procedure. Use an Emergency Spill kit for blood and body fluids. Follow the instructions inside the kit. Do not use a spill kit for chemicals. If a spill kit is not available do not use hands to pick up sharp objects. Use a pair of forceps or utilize cardboard or a like rigid material to scoop the sharp objects into a dustpan. The cardboard is disposed of in a red trash bag. Forceps will be disinfected and sent to CMS for sterilization. Place the sharp material into an approved sharps container. When all of the sharp material is removed, soak up the fluid portion with a disposable but absorbent material, dispose of this in a red trash bag, and flood the area with LPH. Ensure that the spill area remains wet with the disinfectant a minimum of (10) minutes.

22. DISPOSAL OF WASTE

22.1 General: Special care must be taken in the methods of disposal to ensure that contamination of personnel, patients, and the immediate environment do not occur. Waste will be processed as follows:

22.2 Administrative Area: No special handling required.

22.3 Service Areas: Waste from these areas include; cartons, packing materials, glass bottles, cans, and rags. These items can create a hazard in the form of physical injury. Containerize and transport to prevent personnel injury.

22.4 Patient-Care Areas: Waste should be containerized at the point of generation. Waste generated in the exam rooms, with the exception of needles, syringes, and other sharp objects should be placed in a durable plastic bag, sealed, and transported to the dirty utility room. Needles, syringes, and sharp objects will be placed in an approved sharps container, sealed with tape when $\frac{3}{4}$ full, dated, initialed, and identified with place of origin prior to removal from work area. Waste that has been saturated with blood or bodily fluids shall be considered contaminated and will be disposed of as regulated medical waste. All contaminated waste will be disposed of in accordance with MEDDAC Memorandum 40-131, Management of Regulated Medical Waste (RMW).

23. MULTI-DOSE VIALS:

23.1 General: Standard Precautions dictate that multi-dose vial usage should be minimized. Single dose vials are preferred and should be utilized when possible to mitigate accidental contamination.

23.2 Unopened multi-dose vials will expire on the manufacturer's expiration date, or when obvious contamination occurs, i.e. cloudiness or floating particles are detected. Opened vials must be marked with open date, plus 28 days or less and initialed by the person opening the vial. Opened vials should be disposed of in 28 days or sooner or when the medication becomes obviously contaminated.

23.3 Oral medications will be considered to be expired upon reaching the manufacturer's labeled expiration date. If an oral solution is known to have been inadvertently contaminated, appears contaminated on visual inspection or the medication has not been stored according to manufacturer's recommendations this solution is considered expired and must be discarded.

23.4 Containers of medications labeled "single dose" or single dose vial or those packaged in break tip ampules are not multi-dose vials. Once they have been opened and a dose removed they will not be used for subsequent doses.

23.5 Sterile solutions used for wound irrigation (e.g. normal saline, sterile water in surgical irrigations) will not be recapped and reused as recapping renders the solution unsterile.

24. VISITATION POLICY

24.1 Any person (adult or child) demonstrating signs of upper respiratory illness or other communicable disease upon entering the facility shall be placed in a Droplet precaution room. Clinics may provide masks as necessary to these patients if no precaution room is available. There will be no co habitation of patients. Each patient requiring transmission based precautions will have their own exam room, with the exception of operations being conducted under the Medical Emergency Management Policy.

24.2 Special areas:

24.2.1 Recovery Room (PACU) and Operating Room (OR): The doors to these units must be closed at all times. Personnel may not proceed beyond the Red Line of the Operating Room without proper "scrub" attire to include scrub cap, and shoe covers (if wearing outside shoes). See Operating Room SOP for Infection Control measures.

24.2.2 Parents of pediatric patients, when indicated, may be permitted to remain in the recovery room area with the child.

25. VENDING MACHINES and VENDORS

25.1 All food items placed in the vending machines in RWBAHC will be individually packaged.

25.2 No hot food(s) or potentially hazardous food (s) (e.g. dairy products) will be placed in the vending machines. All refrigerated items must be kept refrigerated.

25.3 The vendor will remove outdated items during restocking.

25.4 Quarterly, the vendor will wash the dispensing portions of the machine with soap and water.

25.5 Food vendors must remove gloves and wash their hands between handling money, talking on the phone, or conducting any unsanitary activity and preparing food or drink for patrons. Ideally a designated cashier will complete all payment transactions and a designated person will prepare the food/drinks.

25.6 Food vendors will clean all ice and refrigerators on a regular schedule according to the manufacturer's recommendations.

26. COLLECTION AND HANDLING OF LINEN

26.1 General: Although linen has not been linked to the acquisition of infection (with the exception of lice and scabies), it still needs to be handled in such a manner that clean linen remains clean and soiled or potentially contaminated linen does not add to the microbial load in the environment.

26.2 Clean linen includes all linen which has been processed by the laundry using approved methods and has been through the transfer/receiving process in a manner to minimize contamination by the environment/personnel. Clean linen will:

26.2.1 Be handled as little as possible.

26.2.2 Be stored in an enclosed room, in a covered receptacle, on a covered cart, on covered shelves, in covered bins, drawers, or linen closets. The covered protective receptacle must remain closed at all times. All linen storage carts must have a solid bottom for the protection of clean linen.

26.2.3 Be stored away from direct patient care areas.

26.2.4 Always be transported in clean linen receptacles.

26.3 Dirty/Soiled linen will be placed in a clear plastic bag except as noted below.

26.4 Infectious linen includes linen, which is contaminated with the patient's body fluids, blood, secretions, or excretions. The following areas will utilize the yellow linen bags: PACU, OR, and the Specialty Clinic. All other clinics will use a clear bag to store dirty/soiled linen. However, if a clinic does generate infectious linen then it will utilize the yellow linen bag. All infectious linen will:

26.4.1 Be collected in yellow bags at the point of generation.

26.4.2 Be stored in a covered bag/container.

26.4.3 Be held and carried away from the body.

26.4.4 Not be sorted, counted or presoaked.

26.5 Personnel will wash their hands prior to and following contact with all linen. Exam gloves will be worn when handling linen.

26.6 If any leakage occurs from the linen bag, place the bag and its contents into another bag.

27. ELECTRIC RAZORS. No common use razors will be utilized at RWBAHC. Disposable razors or clippers are the only acceptable shaving instruments that will be used in this facility.

28. TOYS

28.1 Soft toys will not be provided. Toys will be restricted to those with hard surfaces and that are easily cleaned. Toys that are to be maintained in clinic areas will be cleaned in accordance with the following guidelines: Used toys must be separated for cleaning utilizing a "dirty" bin separate from play area. Dirty bin should be placed in area inaccessible to children. Toys will be cleaned and sanitized with Dispatch Hospital Cleaner Disinfectant with Bleach as directed.

28.2 Stationary toys must be cleaned and sanitized at least once week with Dispatch Hospital Cleaner Disinfectant with Bleach as directed.

29. SAFETY NEEDLES AND ANGIOCATHETERS

29.1 General: In order to provide safety for our staff and patients, safety needles and safety angiocatheter systems will be utilized in all clinical areas at RWBAHC.

29.2 If it is impossible to utilize a safety needle or sharp system to perform the procedure or if the safety needle or sharp doesn't come in the proper gauge, length, or size an exception to policy may be granted. Logistics will notify the IPCO and Safety Officer of the request for a non safety needle system, the IPCO and Safety Officer will conduct a collaborative needs assessment and notify the Logistics section with authorization to order non safety needles or sharps.

29.3 All staff will be trained on the correct utilization of the safety needle systems during their newcomers and unit orientation.

29.4 After use, all sharps or potential sharps will be discarded in a facility approved sharps container.

30. ASEPTIC TECHNIQUE/STERILE TECHNIQUE

30.1 General: Asepsis is the absence of disease-producing organisms. Aseptic techniques are those practices which help to minimize or reduce the transmission of pathogenic organisms from one person or place to another. Aseptic techniques are necessary to prevent contamination of wounds, to isolate the site to be worked on from the rest of the body, and to protect staff, patients, and visitors from the needless risk of infection.

30.2 Keep patient care areas clean. Staff will not consume food of any kind in patient care areas.

30.3 Keep all contaminated material (e.g., soiled linen, dirty dressings, or excretions) away from one's own body. Always conduct hand hygiene after coming in contact with such items.

30.4 Conduct thorough hand hygiene prior to any contact with any sterile items. Keep hands in sight and above waist level.

30.5 Put on sterile gloves (gown as required by procedure) in an aseptic manner maintaining outer sterility of gloves.

30.6 Sterile equipment should be handled as little as possible, only with sterile gloves or with other sterile equipment.

30.7 Establish a sterile field when doing procedures (e.g., suturing of lacerations, dressing changes, wound irrigations), which require asepsis. All trays and sets should have an inner wrapper, sterile towel, or drapes that can be used for this purpose; if not, use disposable sterile towels (available in CMS).

30.8 Prepare the sterile field as close to time to be used as possible. Long exposure to air increases the possibility of contamination.

30.9 Keep the sterile field, and sterile supplies, in view at all times. This helps prevent accidental contamination from an outside source. Never turn your back to the sterile field.

30.10 Keep sterile items separated from non-sterile items. Establish a receptacle away from the sterile field to dispose of waste.

30.11 When opening sterile items, both wrappers are opened. The inside of the package must not be touched by any unsterile object; otherwise the sterile object is contaminated.

30.12 The edges of the inside wrappers of sterile supplies are not sterile once a package has been opened.

30.13 Only the top of the sterile field is considered sterile. DO NOT reach across the sterile field. Never pass an unsterile item across a sterile field. Keep the area dry. Moisture will contaminate the field.

30.14 Avoid excessive movement around or near a sterile field, as this increases air movement and contamination.

30.15 Stay at least one foot away from a sterile field.

30.16 If there is any doubt as to the sterility of an item, DO NOT use it. The following are reasons for rejecting an item.

30.16.1 If it has fallen on the floor (even if still in the original packaging).

30.16.2 It is, or shows signs of having been wet or is damp/wet.

30.16.3 If there are holes, tears, or any breaks in the wrapper, or if the seal on the packaging permits outside air into the package.

30.16.4 If the sterilization expiration date has passed (always check the expiration date on a sterile item before opening).

30.16.5 If either the external sterilizing tape or the internal indicator have not changed to the appropriate color.

31. COLLECTION OF URINE SAMPLES.

31.1 General: Proper collection and handling of urine samples are essential in obtaining accurate laboratory results. Improper technique and delay in transport of the specimen to the laboratory could alter vital diagnostic information. If a culture is ordered by a provider, be sure the urine sample is collected in a sterile container.

31.2 Clean Catch or Midstream Urine Specimens:

31.2.1 MALES: Recent studies have indicated some contamination of urine specimens by males who had not cleansed the urethral meatus. Therefore, in obtaining a clean catch urine specimen the male should be instructed to:

31.2.1.1 Not touch the inside of the cap or container with anything other than urine.

31.2.1.2 Hold foreskin back with one hand, cleanse the urethral meatus, begin to urinate and place the sterile cup under the stream after the flow of urine has commenced.

31.2.1.3 After at least one fourth of the cup has been filled, the cup should be secured and any spilled urine on the outside of the container cleaned.

31.2.2 FEMALES: Females should be instructed to wash the urethral meatus prior to obtaining a midstream specimen. Provide the patient with two prepackaged cleansing wipes (i.e., "Castile Soap Towelettes") and instruct her to do the following:

31.2.2.1 With 2 fingers hold the outer folds of her vagina away from the opening through which she urinates.

31.2.2.2 Wipe the opening from front to back with the cleansing wipe(s) twice, begin to urinate and place the sterile cup under the stream after the flow has commenced.

31.2.2.3 After at least one fourth of the cup has been filled, the cap should be secured and any spilled urine on the outside of the container cleaned.

31.2.2.4 If no prepackaged cleansing wipe is available, soap and water should be used to clean the urethral meatus. Provide the patient with four sterile gauzes, a sterile specimen cup and liquid soap. Instruct the patient to prepare the sterile gauze as follows: 1 gauze with soap and water, 2 gauze with water, 1 dry gauze.

31.2.2.5 Using the technique described previously have the patient wipe the urethral meatus with the soapy gauze, dispose of the gauze in the waste basket, then wipe once with each of the moistened gauzes. Last of all, dry the area with the dry gauze. Instruct the patient to always wipe from front to back.

31.3 Catheterization Urine Sample: In and Out Cath – (This Procedure is performed only on Pediatric patients) This specimen should be obtained using strict aseptic technique. The following procedure is recommended:

31.3.1 Orient patient/parent to procedure.

31.3.2 Prepare sterile field with a #5 or #8 Feeding Tube, specimen cup and betadine swabs. Also have a container available for the excess urine.

31.3.3 Position patient – Male or Female, supine with hips flexed and outwardly rotated, knees flexed, and feet together.

31.3.4 Wipe urethral meatus with 3 betadine swabs. (Females from front to back).

31.3.5 Insert the appropriate Feeding Tube, ensuring it does not become contaminated.

31.3.6 Collect the urine in the sterile specimen cup to at least one fourth of the way and allow the rest of the urine to flow in a separate container.

31.3.7 Gently remove the feeding tube when the urine has stopped flowing and give the patient/parent a moistened gauze to wipe off the betadine.

31.3.8 Place the cap securely on the container

31.4 Once the urine sample is obtained it should be transported to the laboratory immediately. Only in extreme cases of staff shortage should the specimen be allowed to remain in the area of collection. If there must be a delay in transport to the laboratory, the urine sample should be refrigerated.

32. ACCIDENTAL NEEDLE STICK/SHARPS, INJURY, OR BODY FLUIDS SPLASHING

32.1 SELF AID: The injured employee with an accidental parental (e.g., needle stick or cut) or mucous membrane (e.g., splash to the eye or mouth) exposure to blood or other body fluid will complete the self aid process immediately following the injury and prior to any other activity.

32.1.1 Bleed the area, if skin is broken to flush the wound of any contamination. Wash the area with an approved bactericidal solution, such as antiseptic soap, betadine or chlorohexidine gluconate. For splashing into the eyes, flush with water only. Each clinical area where there is the possibility for splashing to occur will have an eye wash station available.

32.2 REPORTING: Anyone receiving a needle stick, other sharps injury or body fluid exposure will: Notify their immediate supervisor and then do the following:

32.2.1 During normal duty hours – report to the Occupational Health Clinic (OHC). Evaluation must be accomplished immediately so that prophylaxis, if indicated, can be initiated within 1-2 hours.

32.2.2 After duty hours – report to the Emergency Room at Sierra Vista Regional Health Center and then report to the OHC first thing the next duty day.

32.2.3 Contract employees – follow the guidelines provided by the contracting agency outlining care for BBP exposure. Occupational Health may be consulted to provide the current treatment guidelines recommended and followed at RWBAHC, but not to provide treatment. All treatment for BBP exposure is the responsibility of the contract agency.

32.3 SOURCE PATIENT: Should be identified and his/her name sent to the physician treating the exposed person or to Occupational Health as soon as possible. The source patient should be evaluated to assess the degree of risk for HIV, and hepatitis A, B, and C. The physician treating the exposed will also order the appropriate labs for the source patient

32.4 See MM 40-5, Employee Health for complete guidance on evaluation and treatment of occupational blood and body fluid exposures.

32.5 The following forms will be completed: Military: MEDCOM Form 754-R and DA 4106, and documented in medical records. Civilian: MEDCOM Form 754-R, CA-1, and a DA Form 4106 and documented in civilian medical records.

32.5.4 Occupational Health and the treating provider will determine the need for follow up.

The proponent agency of this publication is the Deputy Commander for Clinical Services. Users are invited to send comments and/or suggested improvements to Commander, USAMEDDAC, ATTN: MCXJ-DCCS, Fort Huachuca, AZ 85613-7079.

FOR THE COMMANDER

OFFICIAL:

GREGORY A. SWANSON
LTC, MS
Deputy Commander for
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APPENDIX A: STATEMENT OF AUTHORITY

MCXJ-CDR

DATE

STATEMENT OF AUTHORITY

The Infection Prevention and Control Functional Management Team (FMT), the Chairman of the Infection Prevention and Control (FMT)/Infection Prevention and Control Officer have the authority to institute any appropriate infection control measures deemed necessary to protect patients and/or personnel from communicable disease.

Deputy Commander Clinical Services
SIGNATURE BLOCK

COMMANDER'S
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APPENDIX B
INFECTION PREVENTION AND OFFICER PERFORMANCE STANDARDS/JOB
DESCRIPTION

1. PURPOSE: To establish guidelines for the role of the Infection Prevention and Officer at RWBAHC, Ft. Huachuca, AZ and to delineate areas of responsibility and major functional duties.
2. SCOPE: This clinical guideline applies to the Infection Prevention and Officer assigned to the RWBAHC, FT. Huachuca, AZ.
3. RESPONSIBILITY: The Infection Prevention and Officer is responsible to the Deputy Commander for Health Services (DCHS); Deputy Commander for Clinical Services; and the Health Center Commander
4. REFERENCES:
 - 4.1 Friedman, C., Petersen, K.H., Infection Control in Ambulatory Care. (2004). Jones and Bartlett Publishers, 40 Tall Pine Drive, Sturbridge, MA 01776.
 - 4.2 The Joint Commission, Standards for Ambulatory Care (2007). Joint Commission Resources, One Renaissance Blvd. Oakbrook Terrace, IL 60181.
 - 4.3 Center for Disease Control. www.cdc.gov
 - 4.4 Association for Professionals in Infection prevention and Control (APIC) www.apic.org
5. GENERAL: The position of Infection Prevention and Officer involves multiple roles and duties:
 - 5.1 An Infection Control Professional with the specialized training assists in preventing the occurrence or transmission of infectious diseases in patients' and staff through education, consultation, surveillance and research. The ICP meets certain minimum qualifications to enter the profession.
 - 5.2 Performs surveillance for infections:
 - 5.2.1 Infection and control practice that is specific to the practice setting, population served, and the continuum of care.
 - 5.2.2 Epidemiology: Institutes, maintains and evaluates records and data pertinent to all surveillance and monitoring programs. This method includes principles and statistical methods, including risk stratification, to identify target populations, analyze trends and risk factors, and design and evaluate prevention and control strategies.

5.3 Provides education for infection prevention and control and healthcare epidemiology.

5.3.1 Provides orientation and annual training in Infection Prevention and for Health Center employees to include active duty, civilians, contractors, reserves and volunteers.

5.3.2 Provides resource information and/or materials to units, departments or services requesting infection control prevention education.

5.3.3 Provides education for the prevention of infections as required through the results of surveillance activities and/or federal/state/local requirements.

5.3.4 Attends infection control conferences concerning surveillance, prevention and control in ambulatory care and disseminates pertinent information.

5.3.5 Reviews the current periodic literature for substantiation to recommendations concerning the prevention and control of ambulatory care acquired infections.

5.4 Provides consultation and expert knowledge and guidance in epidemiology and infection prevention and control-related issues.

5.4.1 Serves as an active participant on various committees to suggest revisions of RWBAHC procedures and techniques concerning infection prevention and control (substantiating recommendations): Infection Prevention and Control FMT; Patient Safety Committee, Safety Committee, and Environment of Care FMT.

5.4.2 Advises and supervises personnel on Health Center isolation policies. Implements the appropriate management of problems, which may be of an infectious nature.

5.4.3 Maintains close communications with all supervisors, head nurses, nurse clinicians and health care providers through meetings or rounds. This will ensure that the Infection Prevention and Control Officer is the primary focal point to which information will accumulate in regard to patients being treated in the Health Center with possible communicable diseases and to those who may have HCA infections.

5.4.4 Reviews environmental cleanliness through routine observation.

5.4.5 Serves as consultant on infection prevention and control problems related to all clinical areas. Detects evidence of cross infection and assists in the development and/or implementation of improved infection control measures.

5.4.6 Conducts a periodic review of cleaning procedures, agents and schedules in use throughout RWBAHC.

5.4.7 Serves as a consultant to USA DENTAC.

5.5 Performance improvement is an integral component of the plan for improvement of practice and patient outcomes.

5.6 Accomplishment of the Infection Prevention and Control Officer's responsibilities; he/she must establish a working rapport with head nurses, health care providers and administrators in the Health Center, keep open lines of communication with all members of the health care team, both professional and nonprofessional, is essential for the circulation of pertinent data. The Infection Prevention and Control Officer incorporates the principles of fiscal responsibility, evaluates the quality and effectiveness of the IC plan appropriate to the practice setting.

5.7 Review Infection Prevention and Control policies and procedures at least every 18 months. Present the revised policies to the Infection Control FMT for approval. Upon approval submits reviewed policy for approval from DCHS, ECOPS, and EXCOM committees. Relevant research findings relating to infection prevention and control practice shall be reviewed.

5.8 If an additional duty the Infection Prevention and Control Officer will be allocated at least 20 hours per week for the performance of the duties and responsibilities of Infection Prevention and Control.

6. QUALIFICATION REQUIREMENTS:

6.1 Experience with knowledge of epidemiological principles, infectious diseases, sterilization, sanitation and disinfection practices.

6.2 Attend formal course of instruction in the control of hospital/ambulatory infections.

6.3 Provide documentation of formal instruction.

7. SCOPE OF DUTIES AND RESPONSIBILITIES: The Infection Prevention and Control Officer at RWBAHC, Ft. Huachuca, AZ has responsibility for the day-to-day management of the Infection Prevention and Control Program which is directed and monitored by the Infection Prevention and Control FMT.

INFECTION PREVENTION AND CONTROL OFFICER
SIGNATURE BLOCK

APPENDIX C OUTBREAK INVESTIGATION PLAN

Refer to RWBAHC Emergency Management Plan

Step 1: Confirm an outbreak exists

- Who: The RWBAHC patient population subset that has been determined to have an unusual infection based on historic infection data.
- When: When there is an unusual occurrence of microorganisms isolated in the health clinic, on the installation, or in the local civilian community.
- Where: The place or clinic involved i.e. where cases may have been exposed to an infectious agent.

Step 2: Once an Outbreak has been confirmed:

Implement control measures –

-Ensure basic Infection Prevention and Control practices such as Hand hygiene, standard and transmission based precautions, proper PPE use, and Aseptic technique are being conducted appropriately.

-Dedication of equipment such as vital sign machine for suspected infectious patients

-Geographically separate suspected infectious patients from other patients and/or provide separate staff dedicated to caring for suspect cases.

Step 3: Formulate hypothesis of likely cause of the outbreak further data collection may be indicated to narrow source of infection such as:

-cultures, environmental or HCWs.

-Direct observation of patient care practices

Step 4: Test Hypothesis by conducting a cohort or case control study

-This step may or may not be necessary base on outbreak resolution

Step 5: implement appropriate control measures. Control measures may be:

-directed against the reservoir of the infection

-measures that interrupt transmission

-measures that reduce host susceptibility (immunization, prophylaxis, antibiotics)

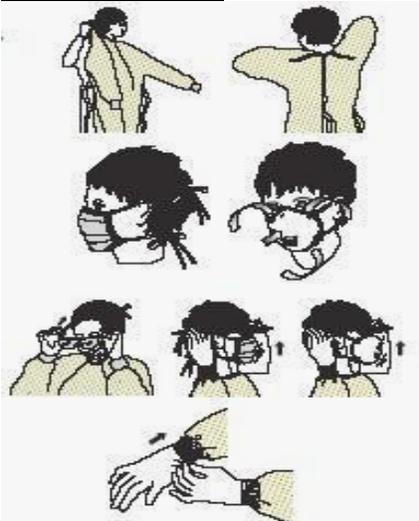
Step 6: Evaluate control measures:

-once control measures are effective, outbreak should cease or infections should return to pre-outbreak levels.

-surveillance should continue to determine that no new cases develop or that pre-outbreak levels are not being exceeded.

Step 7. Summary/Report of findings

- description of circumstances leading to outbreak
- summary of outbreak investigation
- outline of control measures
- plan for continued surveillance and ongoing maintenance and infection prevention and control measures

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 before and after putting on or taking off PPE.

Remove PPE at doorway before leaving patient room or in anteroom**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 designated receptacle for reprocessing or 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 or linen 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!

APPENDIX D – Transmission Based Precautions

CONTACT PRECAUTIONS

**IN ADDITION TO STANDARD
PRECAUTIONS**

**To prevent the spread of infection,
ANYONE ENTERING THIS ROOM MUST
WEAR:**



**Hand Washing or Gel
Before Entering & Upon Leaving**

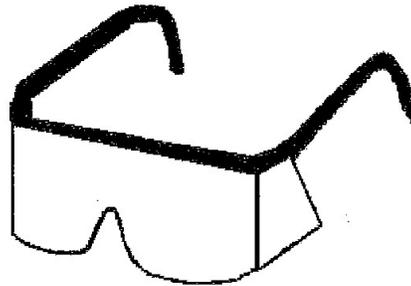
**Questions? Please Call Infection Prevention &
Control at 3-9011 or 3-5667.**

DROPLET PRECAUTIONS

IN ADDITION TO STANDARD
PRECAUTIONS
ANYONE ENTERING THIS ROOM MUST
WEAR:



**SURGICAL
MASK**



**EYE
PROTECTION**

**Hand Washing or Gel
Before Entering & Upon Leaving**

**Questions? Please Call Infection Prevention &
Control at 3-9011 or 3-5667.**

AIRBORNE PRECAUTIONS

IN ADDITION TO STANDARD
PRECAUTIONS

To prevent the spread of infection,
ANYONE ENTERING THIS ROOM MUST
WEAR:



N-95 RESPIRATOR

Hand Washing or Gel
Before Entering & Upon Leaving

**Questions? Please Call Infection Prevention &
Control at 3-9011 or 3-5667.**

APPENDIX E
GLOSSARY OF TERMS

PURPOSE: To standardize case findings, terms, and identification of demographically important HCA infections provide surveillance data.

REFERENCES:

Friedman, C., Petersen, K.H., *Infection Control in Ambulatory Care*.(2004). Jones and Bartlett Publishers, 40 Tall Pine Drive, Sturbury, MA 01776.

Benenson, Abram S.(ed) = Control of communicable Diseases in Man, 15th Edition, American Public Health Association, Washington, D.C., 1990

Dorland's Illustrated Medical Dictionary, 25th Edition. W.B. Saunders. Philadelphia, 1974.

Stein, Jess (ed), The Random House; college Dictionary, Revised Edition, Random House: Inc., New York, 1982.

Federal Register, "Occupational Exposure of Blood borne Pathogens," 29 CFR, Part 1910.1030,6 Dec 1991.

Federal Register, "Draft Guidelines for Preventing the Transmission of Tuberculosis in Healthcare Facilities," October 12, 1993.

GENERAL: There is considerable variation in definitions of terms among the various sources of medical literature. To provide uniformity, the definitions presented in this Guideline have, where possible, been adapted from standard authoritative sources.

Accidental Exposure - A specific eye, mouth, other mucous membrane, non-intact skin or parenteral contact with blood or other body fluids that results from the performance of an employee's duties.

Acid-Fast Bacilli - Bacteria that retain certain dyes even when washed with an acid solution. Most acid-fast organisms are mycobacteria. When seen on a stained smear of sputum or other clinical specimen, a diagnosis of TB should be considered; however, the diagnosis is not confirmed until a culture is grown and identified as *M. tuberculosis*.

Acquired Drug Resistance - Resistance to one or more antituberculosis drugs which develops while a patient is on therapy, usually the result of nonadherence on the part of the patient or inadequate therapy prescribed by a health care provider.

Aerosol, Aerosolization - In TB, it refers to the infectious droplet nuclei that are expelled from a person which can be transmitted to other people.

Air Exchanges - Air flow quantity to a space measured in terms of the room volume, i.e., volume of air delivered + room volume. Usually expressed as number of air changes per hour.

Anergy - The inability of a person to react to skin-test antigens because of defects in the immune system, even if the person is infected with the organisms tested.

Antisepsis - The prevention of sepsis by the inhibition or destruction of the causative organism. Usually refers to substances used on human tissue.

Antiseptic - A substance that will inhibit the growth and development of microorganisms without necessarily destroying them usually refers to substances used on human tissue.

Asepsis - Freedom from infection: The prevention of contact with microorganisms.

Asymptomatic - Showing or causing no symptoms.

Bacteremia - The presence of bacteria in the blood. Bactericidal - Capable of killing bacteria.

Bacteriostatic - Capable of preventing bacterial growth but not necessarily capable of killing bacteria.

BCG - (Bacillus of Calmette and Guerin) - A TB vaccine widely used in some parts of the world.

Biohazard - A danger/peril to health of a human being due to living microorganisms.

Blood - The fluid that circulates through the heart, arteries, capillaries, and veins, carrying nutrients and oxygen to the body cells. Includes blood components and products made from human blood.

Bloodborne Pathogen - Pathogenic microorganisms that are present in human blood and can cause disease in humans. These include, but are not limited to, Hepatitis B virus (HBV) and Human Immunodeficiency Virus (HIV).

Body Fluids - All tissues and fluids in the human body that may potentially harbor contagious microorganisms. Body fluids include, but are not limited to, body tissues, cerebrospinal fluid, feces, nasal or respiratory secretions, non-intact skin, pericardial fluid, peritoneal fluid, pleural fluid, saliva, semen, sputum, synovial fluid, urine, vaginal secretions, vomitus, breast milk or amniotic fluid.

Booster Phenomenon - Seen when an individual with infection does not react to tuberculin because his/her body's cell responses to tuberculin have gradually waned over the years. An initial tuberculin test may stimulate (boost) the immune system so that the next test will be positive. This phenomenon is important in infection control in order to distinguish between converters and people who have been infected for a long time, and determine if in fact transmission is taking place. Although the booster phenomenon may occur at any age, it is most frequent among persons over 55.

Cavity - A hole in the lung resulting from destruction of pulmonary tissue. May be caused by TB, but also by other pulmonary infections and diseases. TB patients with cavities in their lungs are said to have "cavity disease" and are often more infectious than patients without cavities.

Communicable - Capable of being transmitted from one person to another.

Community-acquired infection - Infection resulting from the acquisition of the responsible infectious agent before hospitalization. The infection may become manifest before hospitalization, or be in the incubation period at the time of admission to the hospital.

Contact - An individual who has shared the same air as a person with infectious TB for a sufficient amount of time so that there is a probability that transmission of TB has occurred.

Contamination - The presence of a microorganism on a body surface or on /in an inanimate article or substance including water or food. Contamination on a surface does not imply a carrier state. The presence or the reasonably anticipated presence of blood or other potentially infectious material on an item or surface contamination - The use of physical or chemical means to remove, inactivate, or destroy microorganisms on a surface or item to the point where they are no longer capable of transmitting infectious particles and the surface is rendered safe for handling, use, or disposal.

Detergent - Any of a large number of synthetic water-soluble or liquid organic surface-active agents for use in washing. Resembles soaps in the ability to emulsify oils and hold dirt in suspension.

Directly Observed Therapy - (D.O.T.) - An adherence-enhancing strategy in which each dose of medication is ingested by the patient under the supervision of a health care worker.

Disinfect - To free from pathogenic organisms, or to render them inert.

Disinfectant - An agent that frees pathogenic organisms or renders them inert from inanimate objects/surfaces.

Disinfection - The act of removing or rendering microorganisms inert from inanimate objects or surfaces.

Droplet Nuclei - Microscopic particles (1 to 5 microns in diameter) produced when a person coughs, sneezes, shouts, or sings. The droplets can carry tubercle bacilli and remain in the air by normal air currents in the room.

Engineering Controls - Controls (e.g. sharps disposal containers, self-sheathing needles, splashguards) that isolate or remove the bloodborne pathogens hazard from the workplace.

Exposure - The condition of being subjected to something, such as an infectious agents, which may have a harmful effect.

Exposure Incident - A specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that results from the performance of an employee's duties.

Fomite (fomes) - An object, such as a book, wooden object, or an article of clothing that is not in itself harmful, but is able to harbor pathogenic microorganisms and thus serve as an agent of transmission of an infection.

Germicide- An agent that kills pathogenic microorganisms.

Hand washing Facilities - A facility providing an adequate supply of running potable water, soap and single use towels or hot air drying machines. Dispenser- alcohol based hand rub.

HBV - Hepatitis B virus

HEPA (High-Efficiency Particulate Air) Filter - Specialized filter that is capable of removing 99.97% of particles 0.3 microns in diameter. It may be of assistance in control of TB transmission. Requires expertise in installation and maintenance.

HIV - Human Immunodeficiency virus

HAI (Hospital-acquired infection) - An infection that originates in the hospital. Synonymous with Nosocomial.

Immunity - That resistance usually associated with the presence of antibodies or cells having a specific action on the microorganism concerned with a particular infectious disease or its toxin.

Induced Sputum - Sputum obtained from a patient unable to cough up a spontaneous specimen. The patient inhales a mist of saline (salt water), which stimulates a cough deep within the lungs.

Induration - The area of swelling that surrounds the site of injection of tuberculin. The diameter of the indurated area is measured (in millimeters) 48-72 hours after the injection and is recorded as the result of the PPD test.

Infection - An invasion and multiplication of microorganisms in body tissues, resulting in local cellular injury due to competitive metabolism, toxins, intracellular replication, or antigen-antibody response. The immunological response may be transient or prolonged and consists of a cellular response (hypersensitivity) or the production of specific antibody (immunoglobulin) to the components of the infecting organism or its toxins.

Infectious - Caused by or capable of being communicated by infection.

Infectious Agent - An organism (virus, rickettsia, bacteria, fungus, protozoa or helminth) that is capable of producing infection or infectious disease.

Infectious Disease - A clinically manifest disease of man or animal resulting from an infection.

Infectious Waste - See Regulated Medical Waste.

Intermittent Therapy - Therapy given on a twice weekly or three times weekly basis under direct supervision of a health worker.

Intradermal - Within the layers of the skin.

Isoniazid (INH) - An oral drug either used alone to treat TB infection or in combination with one or more other drugs to treat TB disease.

Mantoux Test - A tuberculin test given by injecting a measured amount of liquid tuberculin into the dermis (second layer of the skin) with a needle and syringe. It is the most reliable and best-standardized technique for tuberculin testing.

Mycobacterium Tuberculosis Complex - The complex of mycobacterium species that causes TB; it includes *M. tuberculosis*, *M. bovis*, and *M. africanum*.

Negative Pressure - A term used to describe the relative air pressure difference between two areas of the health-care facility. Air will flow from the higher pressure area into the lower pressure area.

Nosocomial Infection - An infection that originates in the hospital, ambulatory Health Center, or surgery center. The infection was not present or incubating at the time of admission. The infection may not become clinically manifest until after the patient is discharged. It may also be the residual of an infection acquired during a previous admission.

Occupational Exposure - Reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee's duties.

Opportunistic - Capable of adapting to a tissue or a host other than the normal one, usually said of microorganisms.

Parametric release – Declaring a product to be sterile on the basis of physical and/or chemical process data, rather than on the basis of sample testing or biological indicator results.

Parenteral - Piercing mucous membranes or the skin barrier through such events as needlesticks, human bites, cuts, and abrasions.

Pathogen - Any disease-producing microorganism or material.

Personal Protective Equipment - Specialized clothing or equipment worn by an employee for protection against a hazard. General work clothes (e.g. uniforms, pants, shirts, or blouses) not intended to function as protection against a hazard are not considered to be personal protective equipment. Protective equipment includes, but is not limited to, gowns, masks, head covers, shoe covers, gloves, or resuscitation devices.

Positive PPD Reaction - A reaction to the purified protein derivative (PPD) test that suggests the individual tested is infected with tubercle bacilli. Determination of the reaction is largely dependant on interpretation by the person evaluating the test, given the patient's or HCW's medical history and risk factors.

Preventive Therapy - Chemotherapy of TB infection, primarily used to prevent progression of infection to clinically active disease.

Primary Drug Resistance - Resistance of bacteria to drugs which exists before beginning of treatment.

Purified Protein Derivative (PPD) - A type of purified tuberculin preparation derived from old tuberculin (OT) and developed in the 1930's. The standard Mantoux test uses 5 TU (tuberculin units) of PPD.

Purified Protein Derivative (PPD) Test - see Mantoux test.

Purified Protein Derivative (PPD) Test Conversion - Growth in induration within a two-year period after an initial negative reaction with a difference of 10 or more millimeters of induration. Such "conversion" may represent new infection which is associated with a high risk of developing disease, or may occur as a result of the Booster Phenomenon.

Pyrazinamide (PZA) - An oral antituberculosis drug. It is important as a primary drug in short-course treatment regimens.

Regulated Medical Waste (RMW1) - Liquid or semi-liquid blood or other potentially infectious materials; contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid state if compressed; items that are caked with dried blood or other potentially infectious materials and are capable of releasing these materials during handling; contaminated sharps; and pathological and microbiological wastes containing blood or other potentially infectious materials. (F)

Resistance - The ability of some strains of bacteria (including M. tuberculosis) to grow and multiply even in the presence of certain drugs which normally kill them. Such strains are referred to as "drug resistant strains."

Rifampin - An oral antituberculosis drug which when used along with isoniazid provides the basis for short-course therapy. (T)

Sanitize - a cleaning procedure that reduces microbial count on an object, but doesn't render it free of microbes

Sepsis - The presence in the blood or other tissues of pathogenic microorganisms or their toxins; the condition associated with such presence.

Septicemia - Systemic disease associated with the presence and persistence of pathogenic microorganisms or their toxins in the blood

Soap - A substance used for washing and cleansing purposes usually made by treating a fat with an alkali.

Source individual - Any individual, living or dead, whose blood or other potentially infectious materials may be a source of occupational exposure to the employee. Examples include, but are not limited to, hospital and clinic patients, trauma victims, clients of drug and alcohol treatment facilities human remains, and individuals who donate or sell blood or blood components.

Standard Precautions - An approach to infection control in which all human blood and certain human body fluids are treated as if known to be infectious for HIV, HBV, and other bloodborne pathogens.

Sterile - Aseptic; not producing microorganisms; free from living organisms.

Sterility - The state of being free from living microorganisms.

Sterilization - The complete elimination of microbial viability.

Sterilize - To render sterile, to free from microorganisms.

Surgical Site Infections (SSI) – Infection occurring at the surgical site within 30 days of invasive procedure and within 1 year of infection at the site of an implant. Further definitions of SSIs can be obtained utilizing the CDC Definitions of Nosocomial Infections.

Treatment Failures - Refers to individuals who fail to improve even after a course of chemotherapy is begun, and to individuals whose disease worsens after having initially improved. (T)

Tuberculosis (TB) - A clinically apparent active disease process caused by *Mycobacterium tuberculosis* complex.

Tuberculin Skin Test - see Mantoux test

Tuberculosis Case - A particular instance of clinically active TB. It is sometimes used incorrectly to designate the individual with the disease.

Tuberculosis Infection - A condition in which living tubercle bacilli are present in the body, without producing clinically active disease. Although the infected individual has a positive tuberculin reaction, he/she has no symptoms related to the infection and is not infectious. However, the infected individual remains at lifelong risk of developing disease unless preventive therapy is given.

Tuberculosis (TB) Isolation Precautions - Infection control procedures that should be applied when persons with known or suspected infectious TB are hospitalized or residing in other inpatient facilities. These precautions include the use of a precaution room with negative pressure in relation to surrounding air and removal of air from the room directly outside. Not the same as "respiratory isolation" which calls for a precaution room, but does not require negative pressure and exhaust of room air to the outside.

Work Practice Controls - Policies and procedures that reduce the likelihood of exposure by altering the manner in which a task is performed (e.g. prohibiting recapping of needles by a two-handed technique).

APPENDIX F
Housekeeping, Clinical Engineering Branch

1. **PURPOSE.** To establish guidelines and procedures for an effective and efficient housekeeping program for RW BAHC. These guidelines will also define techniques and practices utilized by housekeeping personnel in the Health Center infection control program.

2. **GENERAL.** The prime objective of the housekeeping department is to maintain the highest order of aseptic cleanliness throughout the entire Health Center. The degree, to which this objective is achieved, while maintaining attractive surroundings, has a positive effect on the comfort and morale of patients, visitors and the Health Center staff.

3. **ADMINISTRATIVE.**

a. **Hours of work:** A clean, sanitary clinic is a very important aspect of the healing process. Therefore, housekeeping employees must work days, evenings, weekends to provide the housekeeping service required. The normal work period consists of five days a week. The determination of daily and weekly work schedules is the responsibility of the Housekeeping Supervisor. It is expected that all employees will comply with the schedule as established by the Housekeeping Supervisor.

b. **Confidential Information:** When a patient enters the Health Center, the Health Center assumes an obligation to keep in confidence all that pertains to the patient and his affairs. Whether on or off duty, employees will not discuss a patient or give any information about the patient to those not immediately concerned.

4. **RESPONSIBILITIES**

a. The House Keeping Supervisor will:

1) Secure approval from the Infection Prevention and Control FMT for the techniques, procedures and supplies utilized by the housekeeping personnel.

2) Continually reevaluate approved techniques, procedures and supplies to improve the quality of housekeeping service in the Health Center. Approval must be secured from Infection Prevention and Control FMT for any changes.

3) Continually monitor the quality of housekeeping services through regular inspections.

4) Coordinate with the medical staff to ensure proper procedures are being followed and the proper supplies are being used.

5) Establish an orientation program for all new housekeeping personnel to introduce them to basic Health Center housekeeping considerations and procedures.

6) Establish an ongoing education program for all housekeeping personnel to include both formal and informal training.

b. Housekeeping personnel will:

1) Thoroughly familiarize themselves with this MEDDAC PAM and ensure they follow the techniques, procedures and cleaning schedules established herein.

2) Verify that all cleaning supplies have been approved for use within their work areas.

3) Ensure proper aseptic techniques are used and appropriate protective clothing worn when working in contaminated areas or disposing of contaminated wastes.

4) Ensure rubber gloves and eye protection are worn whenever liquid cleaners are being utilized.

5) Promptly inform the supervisor of any illness, infection or exposure to contamination.

6) Bring to the attention of their supervisor any conditions or procedures observed which they feel are contrary to good housekeeping or aseptic cleanliness.

7) Questions or doubts concerning any of the foregoing must be resolved with the supervisor before any action is taken.

5. DEFINITIONS:

a. Asepsis: The condition of being free from pathogenic organisms to prevent infection.

b. Pathogenic Organism: Organisms which are capable of causing illness.

c. Infection Prevention and Control FMT: A committee of professional medical and support personnel responsible for the overall Infection Control Program within RWBAHC.

d. Infection Control Program: A formal program designed to reduce infection within RWBAHC. Housekeeping personnel make a significant contribution through strict adherence to the procedures/techniques herein; through these procedures/techniques, the presence of micro-organisms are reduced and cross-contamination and potential infection of patients as well as visitors and staff is minimized.

6. TRAINING OF PERSONNEL:

a. Newly assigned housekeeping personnel are required to attend ten hours orientation training prior to being assigned to a designated area in RWBAHC. The training schedule is as follows:

1) Orientation:

(a) Organization of RWBAHC

(b) Role of Housekeeping

(c) Employee information (annual leave, sick leave, pay scale, promotion, tours of duty).

2) Basic principles of sanitation and disinfection:

(a) Basic bacteriology

(b) Types of disinfectants used in RWBAHC and examples of their use.

3) Safety

4) The care and use of housekeeping equipment

5) Basic housekeeping techniques:

(a) Dusting

(b) Washing

(c) Organization of housekeeping carts

6) Cleaning Procedures:

(a) Floors – swept with treated dust cloth or treated mop, wet-mopping, scrubbing, finishing

(b) Carpeting – vacuuming, shampooing

(c) Exam rooms and bathrooms

(d) Isolation and contaminated areas

- 7) Waste disposal:
 - (a) Identification, handling and disposing of trash and waste
 - (b) Handling and disposing of contaminated trash and waste
- 8) EE/EO Program
- 9) Housekeeping Inspections: Quantitative and qualitative standards

b. A continuing education program will be established for all housekeeping personnel to include both formal and informal training.

STANDARDS FOR CLINIC CLEANING

The following cleaning procedures will be utilized in administrative AND outpatient areas of the Health Center.

1. Carpet care:

a. Equipment needed:

- 1) Shampooer with cold water and carpet cleaner
- 2) Spot cleaner for carpets
- 3) Extractor
- 4) Vacuum cleaner

b. Procedures:

- 1) All furniture will be removed from the area to be cleaned. Upon removal of the furniture, the area will be thoroughly vacuumed.
- 2) Spot remover will be used to pre-clean excessively soiled areas and spots. An upright shampooer will be utilized to clean the entire carpet. Particular attention will be given to corners and edges of the area being cleaned.
- 3) An extractor will be used to remove shampoo and water from the carpet.
- 4) The entire carpet will be vacuumed after it has been allowed to dry.

5) When furniture is returned to the original locations, cardboard will be placed under metal legs.

2. Walls:

a. Equipment needed:

- 1) Wall-washing machine
- 2) Disinfectant or wall-washing compound
- 3) Ladder
- 4) Rags or disposable cleaning cloth
- 5) Bucket

b. Procedure:

1) Before using the wall washing machine, treated dust brooms will be used to remove loose surface dust. This dry cleaning will begin at the floor and work toward the ceiling in long, smooth strokes. A minimum of pressure will be applied to avoid grinding dust into the surface.

2) Using an approved wall cleaner and the wall washing machine, housekeeping personnel will clean the wall working from the top down. Rags or cloth will be used to dislodge stubborn soil not removed by the machine.

3) When one section of the wall has been cleaned, the area will be dried using rags.

3. Windows and glass doors:

a. Equipment needed:

- 1) Window squeegee – 12"
- 2) Cleaning cloth
- 3) Bucket – 10 quart
- 4) Chamois
- 5) Razor-blade scraper

b. Procedure:

1) Cleaning solution will be applied with a cloth, using as little as possible. A razor-blade scraper will be used to remove spots. The window will then be scrubbed vigorously with a wet cloth.

2) Starting at a top corner of the window, a squeegee will be used to remove the cleaning solution from the window. Any remaining solution will be drawn to the bottom of the window with the squeegee and collected with a cloth.

c. Special Instructions: The squeegee will be wiped dry with a chamois after each stroke. Large windows will be cleaned one half at a time to prevent the solution from drying on the window.

4. Scrubbing and refinishing floors:

a. Equipment needed:

- 1) One automatic scrubbing machine
- 2) One bucket, wringer and mop (for removal of excess water)
- 3) One bucket, wringer and mop (for applying finish)
- 4) A minimum of two caution signs

b. Procedures for scrubbing and finishing floors:

- 1) A minimum of two people are required for this operation.
- 2) When working in corridor, a caution sign "FLOOR IS WET" will be posted to the front and to the rear of the work area. When working area is a room, a caution sign will be placed at the entrance.
- 3) One person will use the automatic scrubbing machine to scrub the floor and remove the water. Excess water will be removed using the regular mop, wringer and water bucket.
- 4) The second person will apply the finish so that one half of the corridor remains clear for through traffic.

5. Stripping floors:

a. Equipment needed:

- 1) Automatic floor machine
- 2) Four buckets of water (1 hot, 1 cold)
- 3) Two water mops
- 4) Approximately three packages of green pads
- 5) One large plastic bag of rags
- 6) A minimum of two caution signs

b. Procedures used in floor stripping:

- 1) A minimum of two people are required for this operation.
- 2) When working in corridors, a caution sign "FLOOR IS WET" will be posted to the front and to the rear of the work area. Additional signs will be posted at intersections entering the work area. When work area is a room, a caution sign will be placed at the entrance.
- 3) One person will begin to lay stripper solution lengthwise, on one half of the corridor permitting normal traffic flow on the other side. The stripper solution will be left on the floor approximately 10 minutes, after which the automatic floor machine will be used to remove all the old finish and sealer from the floor.
- 4) A second person will use hot rinse water to remove the stripper solution. This rinse will be followed by three more rinses using cold water.
- 5) Housekeeping personnel will spot clean baseboards and the lower section of walls to remove any spots from the stripping or finishing process.

CLEANING PROCEDURES FOR OUTPATIENT AND ADMINISTRATIVE AREAS

The following cleaning procedures will be utilized in administrative and outpatient areas of the Health Center.

1. Administrative offices, outpatient clinic's and open areas (lobbies and waiting room).
 - a. Equipment needed:
 - 1) Glass cleaner

- 2) Furniture polish
- 3) Disinfectant
- 4) Spray spot cleaner
- 5) Disposable washcloths
- 6) Cleaning rags
- 7) Treated dust mop
- 8) Rubber gloves
- 9) Waste basket liners
- 10) Vacuum cleaner

b. Procedures for offices and outpatient clinics:

- 1) Fill paper towel dispensers in all physician offices, examination rooms and bathrooms.
- 2) Empty all wastebaskets and replace liners. The inside of wastebaskets in clinics will be cleaned with disinfectant.
- 3) Wipe light fixtures with a disposable washcloth and disinfectant, when needed.
- 4) Damp dust picture and bulletin board frames using a disposable washcloth and approved Health Center disinfectant.
- 5) Spot clean walls as required, particularly around door jams and light switches.
- 6) Dust all furniture, counters and ledges. All wooden furniture will be polished to a high luster.
- 7) All rugs and overstuffed furniture will be vacuumed.
- 8) All chrome and brass will be polished.

c. Procedures for open areas:

- 1) Wipe light fixtures with a disposable washcloth and disinfectant, when needed.
- 2) Damp dust picture and bulleting board frames, and doors leading into offices using a disposable washcloth and approved Health Center disinfectant.
- 3) Clean windows with glass cleaner and wipe dry.
- 4) Spot clean walls as required, particularly around door jams and light switches.
- 5) Dust all furniture, counters and ledges. All wooden furniture will be polished to a high luster.
- 6) All rugs and overstuffed furniture will be vacuumed. Particular attention should be given to corners and under furniture.
- 7) Tile floors will be mopped daily. Personnel must ensure that care is taken along mop boards and at door jams to prevent dirt from accumulating.
- 8) All furniture will be arranged neatly.

2. Restrooms for outpatient use:

a. Equipment and supplies needed (ensure the cart contains sufficient supplies for the entire shift):

- 1) Hand soap
- 2) Paper towels
- 3) Waste basket liners
- 4) Toilet paper
- 5) Mop, broom, wringer bucket, dustpan, rags
- 6) Porcelain cleaner (cleanser)
- 7) Disinfectants
- 8) Toilet bowl brush

9) Rubber gloves

b. Procedures: Janitors tasked with cleaning restrooms are required to perform the following daily:

1) All doorknobs, hinges, door jams, closets and room partitions will be damp dusted before cleaning the rest of the room. All soil and writing must be removed from surfaces to present a neat, clean appearance.

2) Toilet bowl cleaner will be put in the bowl and allowed to stand while the housekeeper uses a germicidal detergent to clean fixtures, toilet seat and the outside of the bowl from the top down. When the outside is thoroughly clean, a toilet bowl brush will be directed to under the rim where calcium deposits can develop. The brush will be rinsed by flushing the toilet.

3) A cloth and disinfectant will be used to clean light fixtures and mirrors. The cleaning will begin at the top of the mirror and start down. The mirror will be dried with clean paper towels to prevent water spots on the surface.

4) A disposable washcloth and disinfectant will be used to clean the fixtures of the sink, all porcelain, and plumbing servicing the basin. The paper towel holder and soap dispensers will be similarly cleaned.

5) Paper towel and toilet paper will be refilled as needed.

6) The walls will be spot cleaned as needed. Particular emphasis must be given to areas around switches, behind the toilet and above sinks.

7) Wastebaskets will be emptied by tying off the liner in each. Before a new liner is inserted in the wastebasket, the interior and exterior surfaces will be cleaned with a Health Center approved disinfectant.

8) Floors will be wet mopped with disinfectant solution after all the above steps have been completed.

HANDLING AND DISPOSING OF CONTAMINATED WASTE

1. PURPOSE: To prevent infection by maintaining a clean Health Center environment.

2. PROCEDURE:

a. The following procedures, will be used whenever trash or waste is removed from clinical areas.

1) All waste from patient care areas is considered contaminated

2) Trash Bags should be labeled with clinic name and date.

b. Disposable needles and syringes will be placed in impervious, red plastic containers. When the box becomes $\frac{3}{4}$ full, it will be taken to the contaminated waste shed.

c. Non-combustible infectious material such as glass culture plates from the laboratory should be double wrapped in red plastic bags and handled as contaminated waste for disposal.

CLEANING SCHEDULES

General:

a. The following procedures will be completed daily at a minimum during the workweek in all areas of the Health Center.

1) Wastebaskets will be emptied and the liners replaced.

2) Restrooms will be cleaned.

3) All hard surface floors in offices, corridors and elevators will be dusted and damp mopped.

4) All drinking fountains will be cleaned.

5) All paper towel dispensers will be filled.

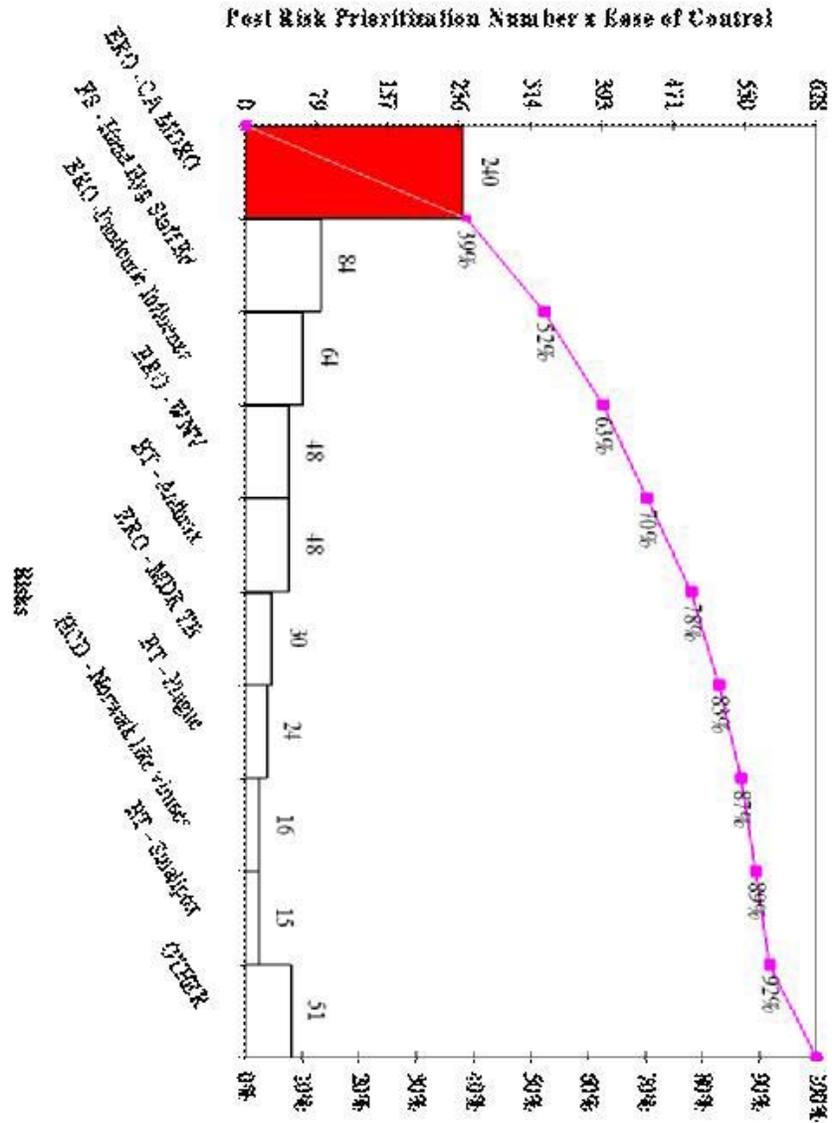
b. The Family Care Clinics, main lobby and elevators will be serviced by both shifts.

NOTE: Operating Room Cleaning guidelines are covered under OR SOP 404 Monitoring and Cleaning of the Operating Room.

APPENDIX G: RISK ASSESSMENT
Infection Prevention and Control Program Goals / Plan for 2008

1. Conduct routine surveillance of clinical areas for compliance or non compliance to the policies and procedures outlined in the pamphlet.
2. Continue to development Hand hygiene surveillance program to monitor our compliance with the CDC/WHO Hand hygiene guidelines and improve overall numbers.
3. Provide Infection Prevention and Control feedback to all the clinic and patient care areas based on objective data collection.
4. Annual review and IPC pamphlet, staff IPC annual training requirements (Bloodborne Pathogens, Hand washing guidelines powerpoint slides) as well as other educational IC information ensuring it is relevant, appropriate, and congruent with current practices.
5. Ensure that preparation for The Joint Commission survey is a continuous, on-going process.
6. Continue to develop relationship within the Health Center sections ensuring complete and full understanding of the IPC mission and strive to amend any knowledge deficits among our staff members.
7. Provide on-going feedback to the IPC Functional Management Team (FMT) Champion.

Infection Prevention and Control - Prioritized Risk Assessment



HIGHLY COMMUNICABLE DISEASES

Risk	Potential Failure Effects	Potential Causes	S	O	D	RPN	Current Controls	E	EOC x RPN	P	P	P	P	EOC x PRPN
			E	C	E			O		S	O	D	R	
			V	C	T			C		E	C	E	P	
Meningococcal disease (Neisseria meningitides)	Outbreak in training population	Noncompliance with vaccination	8	4	2	64	Vaccination	1	64	4	2	1	8	8
Norwalk Virus (Stomach Flu)	Increase stomach flu	Poor hand hygiene and disinfection procedures	4	8	3	96	Staff education, Standard and Transmission based precautions, Proper disinfection procedures.	1	96	2	4	2	1	16
Legionella	Opportunistic illness present in the HVAC system	Improper monitoring, cleaning and servicing of HVAC system and water systems	6	3	3	54	Facilities quality controls	2	108	1	1	1	1	2

BIOTERRORISM

BIOTERRORISM

Risk	Potential Failure Effects	Potential Causes	SEV	OCC	DET	RPN	Current Controls	EOC	EOC x RPN	PSEV	FOCC
Smallpox	Highly infectious	Mutation of bird flu, Global travel opportunities, poor compliance c restricted activity	9	2	5	90	Reso Hygiene and Cough Etiquette program, MEM/P	1	90	5	1
Anthrax	High mortality rate	Bioterrorism, Unknown infection in livestock	8	3	5	120	Staff education, Standard and transmission based precautions, MEM/P	2	240	4	2
Bubonic/Pneumonic Plague	Epidemic	Public unaware of contributing risk factors	6	1	8	48	Public education, community awareness	2	96	3	1

EMERGING RESISTANT ORGANISMS

Risk	Potential Failure Effects	Potential Causes	SEV	OCC	DET	RPN	Current Controls	EOC	EOC x RPN	PSEV	POCC	PDET	PRPN	EOC x PRPN
Pandemic Influenza	Global economic disruption, Generational population effects	Mutation of bird flu, Global travel opportunities, poor compliance c restricted activity	9	2	4	72	Resp Hygiene and Cough Etiquette program, Pan Flu plan - treatment plan, public educ, segregation plan	4	432	4	2	2	16	64
CA MDRO	Chronic opportunistic infection risk, Increase in UTIs, VAPs, Nosocomials, and Surgical Site Infections	Poor compliance c Standard and Transmission based precautions in HC settings, unknowning transmission at home, work, environment	6	8	4	192	Staff education, Standard and Transmission based precautions implementation	5	960	4	6	2	48	240
West Nile Virus	Epidemic,	Public unaware of contributing risk factors	6	4	5	120	Public education, community awareness and mitigation of risk factors	4	480	3	2	2	12	48
SARS Co virus	Global pandemic of SARS CoV illness	Global travel, poor compliance c restricted activity,	7	2	6	84	Staff, public education, Resp Hygiene and Cough Etiquette program,	3	252	4	1	1	4	12
MDR TB	Reversal of declining TB infection rates	Global travel, poor compliance c restricted activity,	8	1	10	80	TB Screening for employees, AD parents, and dependant children enrolled in child services	1	80	1	3	10	30	30

EMERGING RESISTANT ORGANISMS

FACILITY SERVICES AND INTERNAL CONTROLS

Risk	Potential Failure Effects	Potential Causes	SEV	OCC	DET	RPN	Current Controls	EOC	EOC x RPN	PSEV	POCC	PDET	PRPN	EOC x PRPN
Improper Sterilization and Distraction	Increase in SSSs and potentially death	Improper training/ improper quality controls	7	1	2	14	Competency based orientation, SOPs, Multiple sterilization verification indicators	2	50	4	1	1	4	8
Construction & Renovation Projects - Aspergillus Outbreak	Aspergillus outbreak or other mold outbreak resulting in illness and facility contamination	Inadequate quality assurance in Facility checks for aspergillus	6	2	2	24	Infection Control Risk Assessment prior to all Health Center construction projects	2	70	3	1	1	3	6
Poor Hand Hygiene compliance	Increased HAIs, SSSs, nosocomial infections	Too busy, Inconsistent hand hygiene products, knowledge deficit for specific times required to conduct hand hygiene	6	4	4	96	Email reminders, Briefed on at Newcomers and Annual training, Facility mandated training in APECS	7	125	3	2	2	12	84
Availability and proper utilization of isolation rooms	Increased HAIs	Knowledge deficit on appropriate usages for transmission based precautions	6	2	1	12	Isolation rooms identified in each clinic, AIIR location communicated to the staff at Newcomers and Annual training	4	175	3	1	1	3	12
Availability and appropriate use of PPE equipment	Increase HAIs for patients and staff	Knowledge deficit on appropriate usages for PPE	6	2	1	12	Inspectable item on the IPC, EOC, and Safety rounds	1	490	3	1	1	3	3

FACILITY SERVICES AND INTERNAL CONTROLS

APPENDIX H
DIAPHRAM RING SETS

PROCEDURE
FOR DISINFECTING OF ORTHO DIAPHRAGM FITTING SET

1. PURPOSE : This Standard Operating Procedure establishes the guidelines for the disinfecting of diaphragm fitting set(s) in this facility.

2. SCOPE : This Standard Operating Procedure is applicable to all personnel performing the disinfecting of diaphragm fitting set(s).

3. REFERENCES :

- a. OSHA Standards, Personal Protective Equipment.
- b. APIC Text of Infection Control & Epidemiology, 2nd Edition, Chapter 21.
- c. Ortho Diaphragm Fitting Set Cleaning Options, Ortho-McNeil

4. BACKGROUND:

a. Patient care equipment is divided into Spaulding's three general categories (critical, semi-critical, non-critical).

(1) Semi-critical items. Instruments and objects that will contact mucous membrane. These require high-level disinfecting. Diaphragm fitting rings are in this category.

b. High-Level Disinfecting.

(1) Used for items that will come in contact with mucous membranes, but will not enter tissue or vascular system.

(2) PPE to include gloves, gowns and face shields must be worn when using these disinfectants. All instruments/equipment will be rinsed thoroughly with water.

5. PROCEDURE :

- a. Wipe off any foreign substances from the ring(s) using a cloth towel or paper towel.
- b. Using a liquid detergent and water thoroughly scrub the ring(s). Rinse well with running tap water. Inspect to ensure all foreign material has been removed.
- c. Soak in 1:10 dilution of chlorine bleach (e.g. Chlorox 10%) for 30 minutes at room temperature. PPE to include gloves, gowns and face shields must be worn when using bleach.
- d. Rinse thoroughly in running tap water.
- e. Soak in 70% ethyl or isopropyl alcohol for 15 minutes.
- f. Allow to air dry on clean towel or chux.
- g. Store in original container.

FOR THE COMMANDER:

Signature Block Commander

APPENDIX I
Infection Control
Guidelines for Service or Working Animals

1. **PURPOSE.** The purpose of this policy is to provide infection control guidance for service/working animals within RWBAHC while maintaining compliance with the Americans with Disabilities Act (ADA) of 1990.

2. **SCOPE.** The infection control guidance is applicable to Raymond W. Bliss Army Health Center, including outlying medical clinics that provide care for working animals or may receive persons, i.e., patients, employees, or visitors that require the use of service animals.

3. **RESPONSIBILITY.** The supervisor of each area is responsible to ensure that all employees within their areas adhere to infection control and Americans with Disabilities Act (ADA) guidelines for service/working animals.

4. **DEFINITIONS.**

a. Service animal is a legal term defined in the ADA. A service animal is any animal individually trained to do work or perform tasks for the benefit of a person with a disability under the ADA. Examples of service animals include guide dogs, hearing or signal dogs, seizure alert cats, mobility dogs, and emotional support cats. A service animal is trained to not pose a danger to the health and safety of the general public and is not categorized as a "pet" because it is specially trained to help a person overcome the limitations caused by his or her disability.

b. A working animal is an animal that is used by a law enforcement agency, that is specifically trained for law enforcement work and that is under the control of a handler.

c. Handler means a law enforcement officer or any other person who has successfully completed a course of training prescribed by the person's agency or the service animal owner and who used a specially trained animal under the direction of the person's agency or the service animal owner.

d. Hand hygiene is the use of soap and running water or alcohol-based hand gel to remove disease-causing organisms from the hands. Hand hygiene is an essential activity in the health care setting because it is the number one method of preventing the transmission (spread) of disease.

5. **ADA GUIDELINES.**

a. Title III of the ADA requires that places of public accommodation (hospitals, clinics, doctors and dentists offices, laboratories, imaging services) permit the use of a service animal by a person with a disability, unless doing so would create a fundamental alteration or a direct threat to the safety of others or to the facility.

b. The ADA prohibits public accommodations from requiring “certification” or proof of an animal’s training or proof of a person’s disability, for the purpose of access, but does allow employees to question whether or not the animal is a service animal.

c. The service animal will be clean and well groomed. The handler is liable for any damage caused by the service animal.

6. GENERAL.

a. Allow service/working animals access to the facility, unless the presence of the animal(s) creates a direct threat to other persons. The presence of more than one dog in the facility (service or working) at a time can potentially pose a risk. For example, if a working dog is ever sent into the facility, make sure that they do not encounter service dogs, as there would probably be a display of aggression or the military working dog might be distracted from his or her olfactory tasks.

b. If the animal exhibits a condition that presents a threat to others, then the animal may be removed, restricted or denied access to the area. Additional information may be required about the animal if it is necessary to protect public health and safety.

c. If a patient must be separated from his or her service animal while in the health-care facility:

(1) ascertain from the person what arrangements have been made for supervision or care of the animal during this period of separation;

(2) make appropriate arrangements to address the patient’s disabilities while care is administered without the aid of the service animal.

7. Infection Control Measures:

a. If a service animal is epidemiologically linked to an infection or outbreak, the animal must be examined by a veterinarian.

b. Wash hands with alcohol-based hand gel after contact with the service animal, the animal’s equipment, or other items if hands are not visibly soiled.

c. Wash hands with soap and warm water (a minimum of 15 seconds), if hands are visibly soiled or contaminated with proteinaceous material from the service animal.

d. When a decision must be made regarding a service animal's access to any particular area of the health-care facility, evaluate the service animal, the patient, and the health-care situation on a case-by-case basis to determine whether significant risk of harm exists and whether reasonable modifications in policies and procedures will mitigate this risk.

e. Animals are not permitted in any areas where sanitary precautions are necessary, i.e., food preparation areas, medication storage and preparation areas, operating rooms, central sterile supply, or the recovery room.

f. Handlers are responsible for the animal and will identify someone for all care of the animal to include feeding, exercising, hygiene and clean-up of any accidents in his/her absence. Any animal urine, feces, vomit, or blood, must be removed using appropriate PPE (gloves minimum PPE), followed by cleaning with a hospital approved disinfectant.

g. A private exam room is recommended for any patient that requires the use of a service animal. Animals should not be allowed in isolation rooms particularly contact isolation rooms. The animal is not allowed to come in contact with any patient's non-intact skin (surgical sites, drainage tubes, wounds, etc.).

9. RERERENCES.

a. Duncan, Susan L. APIC State-of-the-Art Report: The Implications of Service Animals in Health Care Settings, 1999.

CDC Guidelines for Environmental Infection Control, 2003.

c. "Epidemiology and Prevention of Nosocomial Infections Associated with Animals" is published in Mayhall's Infection Control and Hospital Epidemiology, 1996.

d. APIC TEXT of Infection Control and Epidemiology, 2nd Edition, 2005 – Service Animals.

e. American with Disabilities Act, Title III regulations, 28 CFR Part 36, 1990, revised July 1994.

f. Duncan SL. APIC state-of-the-art report: the implications of service animals in health care settings. Am J Infection Control 2000; 28: 170-80.

g. Sehulster L., Chinn, R., Arduino, M., et al. Guidelines for environmental infection control in health care facilities: recommendations of CDC and the Healthcare Infection Control Practices Advisory Committee (HICPAC). Chicago, IL: MMWR 2003; 52 (No. RR-10): 1-48.
http://www.cdc.gov/ncidod/hip/enviro/Enviro_guide_03.pdf

- h. Arizona Revised Statutes Title 13, Chapter 29.
http://tarlton.law.utexas.edu/dawson/cruelty/az_cruel.htm
- i. Arizona Revised Statutes, Title 13, Chapter 11.
<http://www.know-the-ada.com/serviceanimal1.html>

The proponent for this publication is the Infection Prevention and Control Officer.

FOR THE COMMANDER:

Commander Signature Block