SILETZ COMMUNITY HEALTH CLINIC POLICY

INFECTION CONTROL

TABLE OF CONTENTS

SILETZ COMMUNITY HEALTH CLINIC	
Program	Infection Control
Policy	Infection Control Program
Date Approved	12/21/18
Date Revised	12/17/21; 08/06/22

Part 14
Infection Control Program

I. INFECTION CONTROL POLICY

It is the policy of the Siletz Community Health Clinic (SCHC) to adopt the Center for Disease Control's Infection Control Guidelines for hand hygiene and safe injection practice and precautions, to minimize communicable disease exposure to patients and staff; to ensure the SCHC Infection Control policy meets or exceeds the CDC Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care (version 2.3 – September 2016); and to use other nationally recognized guidelines, such as World Health Organization and APIC, for best practices. The Infection Control policy will be reviewed annually by the Infection Control Committee and updated as needed. See Part 18 for policies and procedures related to COVID-19.

II. INFECTION CONTROL (IC) COMMITTEE

The Safety/Infection Control Committee will serve as the IC Committee. A medical staff member will be included in the IC Committee and will serve as the Infection Control Officer. Each clinic and department will be represented on the IC Committee. IC Committee meetings will be open to all staff to discuss infection control concerns within the facility. All changes to infection control policy will be brought before the IC Committee for review and discussion before a policy is changed. The Safety/Infection Control Committee will monitor the effectiveness of the Infection Control Program outlined in the following policy and procedures.

III. INFECTION CONTROL OFFICER

Responsibilities include:

A. Keep apprised of CDC, APIC, WHO, OSAP, and OSHA infection control standards and requirements.

B. Provide technical assistance to the Safety/Infection Control Committee and staff in providing a safe workplace.

C. Maintain documentation of all reported exposures and assure that OSHA guidelines are followed.

D. Maintain employee training and health records.

E. Prepare and conduct orientation and annual infection control in-services.

F. Provide direct intervention to prevent infection, as needed.

G. Conduct an Infection Control Risk Assessment on an annual basis that is reviewed by

Safety/Infection Control Committee and presented to the Governing Board.

H. Perform facility TB risk assessment on an annual basis that is reviewed by Safety/Infection Control Committee.

I. Provide training to new staff within 30 days of hire and all staff on an annual basis. Training topics include: hand hygiene, bloodborne pathogens, sharps safety, Standard Precautions, Contact Precautions, and Airborne Precautions.

IV. INFECTION CONTROL QUALITY IMPROVEMENT

A. The Infection Control Officer and Safety/Infection Control Committee will evaluate the Infection Control Program on a continuing basis in order to identify areas needing improvement.

B. Environmental rounds and the infection control risk assessment will be used as tools to identify areas in need of quality improvement.

C. Areas identified as needing improvement will be evaluated by the Infection Control Officer and/or the Safety/Infection Control Committee as possible quality improvement projects.

D. Quality improvement projects will be documented and progress reports given to the Quality Improvement Coordinator on a regular basis.

V. INFECTION CONTROL SURVEILLANCE

A. Surveillance, as part of an infection prevention and control program in health care facilities, contributes to meeting the program's overall goals, namely:

1. Protect the patient.

2. Protect the health care worker, visitors, and others in the health care environment.

3. Accomplish the previous two goals in a timely, efficient and cost-effective manner whenever possible.

B. Infection Control Surveillance Program

1. The IC Committee, in conjunction with risk management and clinic leadership, will determine the measures that will be included in the infection control surveillance matrix. The IC Committee will also determine the method by which surveillance of each measure will be conducted.

2. The IC Committee will meet monthly in order to analyze surveillance data. This

data will then be disseminated to directors and supervisors to share with all staff.

3. Infection control quality improvement initiatives will, in part, be determined by surveillance data.

4. The IC Committee will meet on an annual basis to re-evaluate surveillance measures and make changes to those measures as determined by the committee.

5. Surveillance data will be documented on a standard form and will be stored on the shared clinic hard drive in the IC Committee folder for staff to view at any time.

6. Surveillances

    a. Safe Injection Practices Observed

    b. Environmental Cleaning

        i. Equipment and exam room cleaning

        ii. Hand hygiene compliance rate

        iii. Employee influenza vaccination rate

        iv. Employee hepatitis B immunization compliance rate

        v. Employee blood and body fluid exposures

References

Lee, Terrie B., RN, MS, MPH, CIC; Montgomery, Ona G., RN, MSHA, CIC; Marx, James, RN, MS, CIC; Olmsted, Russell N., MPH, CIC; and Scheckler, William E., MD. "Recommended practices for surveillance: Association for Professionals in Infection Control and Epidemiology (APIC), Inc." *American Journal of Infection Control*, 2007; 35: 427-440.

VI. EMPLOYEE INFECTION CONTROL ORIENTATION

A. New employees will receive orientation regarding the Infection Control policy within the first 30 days of employment.

B. Tuberculosis Screening

Initial Tuberculosis screening by intradermal PPD injection or a blood test known as the Interferon Gamma Release Assay (IGRA). If an employee has not had a documented negative test result in the prior year, and chooses the intradermal PPD injection, Two-Step Testing will be done. Employees who have had a prior positive PPD will be

evaluated to determine the need for annual chest x-rays or a Blood Assay for Mycobacterium Tuberculosis (BAMT).

C. Employee Vaccination

1. Employees of healthcare facilities are at risk for exposure to and possible transmission of vaccine-preventable diseases because of their contact with patients or infective material from patients. Employers and employees have a shared responsibility to prevent occupationally acquired infections and avoid causing harm to patients by taking reasonable precautions to prevent transmission of vaccine preventable diseases.

2. Disease for which vaccination is recommended:

   a. Hepatitis B

   b. Influenza

   c. MMR

   d. Varicella (chickenpox)

   e. Tdap (Tetanus, Diphtheria, Pertussis) or Td

   f. COVID-19

VII. HEPATITIS B VACCINATION

A. Infection Control Officer will provide training to employees about hepatitis B vaccinations, addressing safety, benefits, efficacy, methods of administration, and availability.

B. The hepatitis B vaccination series is available at no cost after initial employee training and within 10 days of initial assignment to all employees identified in the exposure determination section of this plan. Vaccination is encouraged unless:

1. documentation exists that the employee has previously received the series;

2. antibody testing reveals that the employee is immune; or

3. medical evaluation shows that vaccination is contraindicated.

C. If an employee declines the vaccination, the employee must sign a declination form. Employees who decline may request and obtain the vaccination at a later date at no cost. Documentation of refusal of the vaccination is kept at in the following location:

J:\Reports_Forms_Minutes\Forms-Schedules\Medical-Nursing\Hep B Vaccine Acceptance or Declination Form

D. Vaccination will be provided by the nursing department.

VIII. HANDWASHING AND HAND PROTECTION

A. Indications for Hand Washing

1. In the United States, patients get nearly 2 million infections each year. Some infections can be life-threatening and hard to treat. Hand hygiene is one of the most important ways to prevent the spread of infections. Healthcare providers should practice hand hygiene at key points in time to disrupt the transmission of microorganisms to patients. Hand hygiene is also discussed in Part 18, Section 18G Hand Hygiene related to COVID-19 pandemic.

2. Indications for Hand Hygiene Using Non-Antimicrobial or Antimicrobial Soap and Water. When hands are visibly dirty or contaminated with proteinaceous material or are visibly soiled with blood or other body fluids, wash hands with either a non-antimicrobial soap and water or an antimicrobial soap and water.

    a. Before eating and after using a restroom, wash hands with a non-antimicrobial soap and water or with an antimicrobial soap and water.

    b. After providing care to a patient with a diarrheal episode or with known or suspected C. difficile or Bacillus anthracis infection, wash hands with an antimicrobial soap and water.

3. Indications for Hand Hygiene Using a Hand Washing Agent or Alcohol-based Hand Rub. A hand washing agent or alcohol-based hand rub, performed for at least 20 seconds, may be used for routinely decontaminating hands in the following clinical situations:

    a. Before having direct contact with patients

    b. Before gloving

    c. After contact with a patient's intact skin (e.g., when taking a pulse or blood pressure, or lifting a patient)

    d. After contact with body fluids or excretions, mucous membranes, non-intact skin, and wound dressings, even if hands are not visibly soiled

    e. Before invasive procedures, such as venipunctures or skin punctures

f. When moving from a contaminated body site to a clean body site during patient care

g. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient

h. After removing gloves

i. Before accessing clean or sterile supplies and before stocking supplies

j. After trash or infectious waste removal

4. All hand hygiene products are utilized in accordance with manufacturer's instructions for use.

B. Procedure

1. Hand washing with soap and water (either non-antimicrobial or antimicrobial)

a. Remove jewelry and wristwatches.

b. Turn on warm sink water.

c. Wet hands and forearms with running water.

d. Apply enough hand washing agent to cover all hand surfaces.

e. Vigorously rub hands together for at least 20 seconds, covering all surfaces of hands and fingers, paying attention to under the nails.

f. Rinse hands thoroughly with water and with hands angled down in the sink, avoid splashing.

g. Pat hands with a disposable towel until they are thoroughly dry.

h. Use disposable towel to turn off the water faucet.

i. Discard the disposable towel into the appropriate container.

2. Alcohol based hand rub

a. Apply recommended amount of product to palm of one hand.

b. Rub hands together, covering all surfaces of hands and fingers and under the nails.

c. Continue to rub until hands are dry; do not rinse.

d. Repeated use of alcohol hand rubs may result in a sticky residue on the hands; wash with soap and water periodically to remove the hand rub residue.

C. Fingernail Hygiene

1. Artificial fingernails, wraps, overlays, extenders, or nail jewelry may not be worn if duties include direct contact with patients.

2. Natural nail tips shall be less than one-quarter inch long.

3. Nails must be well manicured.

D. Liquid Soap Containers

1. Disposable containers are used and are replaced by housekeeping when empty.

2. Containers are replaced when expired.

3. Soap containers are never refilled or "topped-off".

E. Soap and Water vs. Alcohol-based Hand Rub

Soap and water should be used when hands are visibly soiled (e.g. blood, body fluids) and is also preferred after caring for a patient with known or suspected C. difficile or norovirus during an outbreak. However, in the absence of the above situations alcohol-based hand rub is preferred over soap and water in the majority of clinical situations.

F. Glossary of Commonly Used Hand Hygiene Terms

1. Alcohol-based hand rub: An alcohol-containing preparation designed for application to the hands for reducing the number of viable microorganisms on the hands; in the United States, such preparations usually contain 60%–95% ethanol or isopropanol.

2. Antimicrobial soap: Soap (i.e., detergent) containing an antiseptic agent.

3. Antiseptic agent: Antimicrobial substances that are applied to the skin to reduce the number of microbial flora (e.g., alcohols, chlorhexidine, chlorine, hexachlorophene, iodine, chloroxylenol (PCMX), quaternary ammonium compounds, and triclosan).

4. Antiseptic hand rub: Applying an antiseptic hand rub product to all surfaces of the hands to reduce the number of microorganisms present.

5. Antiseptic hand wash: Washing hands with water and soap or other detergents containing an antiseptic agent.

6. Cumulative effect: A progressive decrease in the numbers of microorganisms recovered after repeated applications of a test material.

7. Decontaminate hands: To reduce bacterial counts on hands by performing antiseptic hand rub or antiseptic handwash.

8. Detergent: Detergents (i.e., surfactants) are compounds that possess a cleaning action. They are composed of both hydrophilic and lipophilic parts and can be divided into four groups: anionic, cationic, amphoteric, and nonionic detergents. Although products used for handwashing or antiseptic handwash in healthcare settings represent various types of detergents, the term "soap" is used to refer to such detergents in this policy and procedure.

9. Hand antisepsis: Refers to either antiseptic handwash or antiseptic hand rub.

10. Hand hygiene: A general term that applies to either handwashing, antiseptic handwash, antiseptic hand rub, or surgical hand antisepsis.

11. Hand washing: Washing hands with plain (i.e., non-antimicrobial) soap and water.

12. Persistent activity: Persistent activity is defined as the prolonged or extended antimicrobial activity that prevents or inhibits the proliferation or survival of microorganisms after application of the product. This activity may be demonstrated by sampling a site several minutes or hours after application and demonstrating bacterial antimicrobial effectiveness when compared with a baseline level. This property also has been referred to as "residual activity." Both substantive and non-substantive active ingredients can show a persistent effect if they substantially lower the number of bacteria during the wash period.

13. Plain soap: Plain soap refers to detergents that do not contain antimicrobial agents or contain low concentrations of antimicrobial agents that are effective solely as preservatives.

14. Substantivity: Substantivity is an attribute of certain active ingredients that adhere to the stratum corneum (i.e., remain on the skin after rinsing or drying) to provide an inhibitory effect on the growth of bacteria remaining on the skin.

15. Surgical hand antisepsis: Antiseptic handwash or antiseptic hand rub performed preoperatively by surgical personnel to eliminate transient and reduce resident hand flora; antiseptic detergent preparations often have persistent antimicrobial activity.

16. Visibly soiled hands: Hands showing visible dirt or visibly contaminated with proteinaceous material, blood, or other body fluids (e.g., fecal material or urine).

17. Waterless antiseptic agent: An antiseptic agent that does not require use of exogenous water; after applying such an agent, the hands are rubbed together until the agent has dried.

References

Boyce, J. M., & Pittet, D. (2002). Guideline for Hand Hygiene in Health-Care Settings: Recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force. Morbidity and Mortality Weekly Report, 51(RR16), 1-44. Centers for Disease Control and Prevention, Guidelines for Hand Hygiene in Healthcare Settings. http://www.cdc.gov/handhygiene/ World Health Organization. (2009). WHO Guidelines on Hand Hygiene in Health Care.

IX. PROPER ATTIRE

Clean clothes and/or uniforms shall be worn each day. As stated in the Personnel Manual, employees are expected to present a professional appearance.

A. Staff providing direct patient care are to wear scrubs.

B. All staff that use, handle, or have ongoing exposure to sharps must wear closed toed shoes.

X. RESPIRATORY HYGIENE AND COUGH ETIQUETTE

A. To prevent the transmission of all respiratory infections in healthcare settings, including influenza, the following infection control measures should be implemented at the first point of contact with a potentially infected person and is one component of Standard Precautions.

B. Visual Alerts

Visual alerts (in appropriate languages) should be posted at the entrance of the clinic instructing patients and persons who accompany them (e.g., family, friends) to inform healthcare personnel of symptoms of a respiratory infection when they first register for care and to practice Respiratory Hygiene and Cough Etiquette.

C. Respiratory Hygiene and Cough Etiquette

1. The following measures to contain respiratory secretions are recommended for all individuals with signs and symptoms of a respiratory infection.

   a. Cover your mouth and nose with a tissue when coughing or sneezing.

   b. Use in the nearest waste receptacle to dispose of the tissue after use.

c. Perform hand hygiene (e.g., hand washing with non-antimicrobial soap and water or using an alcohol-based hand rub) after having contact with respiratory secretions and contaminated objects or materials.

D. Availability of Materials

1. SCHC should ensure the availability of materials in waiting rooms, so that patients and visitors can adhere to these measures:

a. Tissues and no-touch receptacles for used tissue disposal.

b. Alcohol-based hand rub and/or hand washing supplies (soap and water, clean towels).

E. Masking or Separation of Persons with Respiratory Symptoms during Periods of Increased Community Respiratory Virus Activity (e.g., Influenza Season). (See Part 18, Section 18A Face Mask, Face Covering, Face Shield for staff, patients, and visitors related to COVID-19 pandemic.)

1. During periods of increased respiratory infection activity in the community (e.g., when there is increased absenteeism in schools and work settings and increased medical office visits by persons complaining of respiratory illness), SCHC shall offer masks to persons who are coughing.

a. Procedure masks (i.e., with ear loops) or surgical masks (i.e., with ties) may be used to contain respiratory secretions (respirators such as N-95 or above are not necessary for this purpose).

b. When space and chair availability permit, SCHC shall encourage coughing persons to sit at least three feet away from others in common waiting areas. (See Part 18, Section 18H Occupational Health for social distancing related to COVID-19 pandemic.)

F. Droplet Precautions (See Transmission Based Precautions)

1. Medical staff shall observe Droplet Precautions (i.e., wearing a surgical or procedure mask for close contact), in addition to Standard Precautions, when examining a patient with symptoms of a respiratory infection, particularly if fever is present.

2. These precautions should be maintained until it is determined that the cause of symptoms is not an infectious agent that requires Droplet Precautions.

References

Bennett, G. & Kassai, M. (2011). Infection Prevention Manual for Ambulatory Surgery Centers. ICP Associates: Rome, Georgia. Siegel, J. D., Rhinehart, E., Jackson, M., Chiarello, L., & the

Healthcare Infection Control Practices Advisory Committee. (2007). 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. Atlanta, Georgia: Centers for Disease Control and Prevention. Respiratory Hygiene/Cough Etiquette in Healthcare Settings http://www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm

XI. STANDARD PRECAUTIONS

A. Definitions

1. Doffing: To take off

2. Donning: To put on

3. HCW: Health Care Worker

4. OPIM: Other potentially infectious materials

5. Standard Precautions:

   a. Practices to reduce healthcare associated infections.

   b. Used with all patients regardless of diagnosis or isolation status.

   c. Applies to interactions with blood, all body fluids, secretions, and excretions except sweat, regardless of whether they contain visible blood, non-intact skin, or mucous membranes.

   d. Are sufficient to interrupt the spread of most infectious agents and include:

      i. Hand hygiene

      ii. Personal Protective Equipment (PPE): Use of PPE (e.g., gloves, gowns, facemasks, shoe covers), depending on the anticipated exposure

      iii. Respiratory hygiene and cough etiquette

      iv. Safe injection practices

      v. Sharps precautions

      vi. Safe handling of potentially contaminated equipment or surfaces in the patient environment

      vii. General infection control practices

B. Standard Precautions

Standard Precautions apply to all patients and all situations, regardless of diagnosis or presumed infection status. Because all patients can serve as reservoirs for infectious agents, adhering to Standard Precautions during the care of all patients is essential to interrupting the transmission of microorganisms. Standard Precautions represent the minimum infection prevention measures that apply to all patient care, regardless of suspected or confirmed infection status of the patient, in any setting where healthcare is delivered. These evidence-based practices are designed to protect healthcare personnel and prevent the spread of infections among patients.

C. Hand Hygiene (See Handwashing and Hand Protection and/or Part 18, Section 18G Hand Hygiene related to COVID-19 pandemic)

Hand hygiene procedures include the use of alcohol-based hand rubs (containing 60-95% alcohol) and handwashing with soap and water. Alcohol-based hand rub is the preferred method for decontaminating hands, except when hands are visibly soiled (e.g., dirt, blood, body fluids), or after caring for patients with known or suspected infectious diarrhea (e.g., Clostridium difficile, norovirus), in which case soap and water should be used.

D. Personal Protective Equipment (PPE) (See Part 18, Section 18B COVID-19 Personal Protective Equipment (PPE))

1. PPE is provided free of charge to all employees. OSHA's Bloodborne Pathogens Standard (29 CFR 1910.1030) requires employers to protect workers who are occupationally or can reasonably be anticipated to come into contact with blood and other potentially infectious materials (OPIM). Each employee is responsible for knowing where the equipment is kept in their department. The type of PPE used should be appropriate for the procedure being performed and the type of exposure anticipated.

2. Gloves

Gloves should be worn whenever contact with blood, blood products, body fluids, excretions, secretions, mucous membranes, or non-intact skin is anticipated. Gloves should also be worn when touching dressings or drainage tubes or when performing venipuncture or invasive procedures.

a. Changing Gloves

i. Between each patient contact

ii. Between tasks and procedures on the same patient after contact with material that may be contaminated

iii. When holes or tears are noted or when the glove's ability to function as a barrier is compromised

b. Removing Gloves

i. After each use

ii. Before touching non-contaminated items and environmental surfaces

iii. Before going to another patient

c. Reusing Gloves

i. Single use gloves are not to be reused

ii. Utility gloves may be decontaminated for re-use with an approved EPA-registered disinfectant if the integrity of the glove is not compromised

iii. An approved hospital disinfectant is suitable for decontaminating utility gloves

iv. Utility gloves must be discarded if they are cracked, peeling, torn, punctured, or exhibit any signs of deterioration

d. Selecting Gloves

i. Gloves should be chosen to fit hand size

ii. Gloves should provide flexibility and tactile sensitivity needed during the procedure

iii. The following should be considered when selecting gloves:

A) Need to follow the Sterile Procedure (sterile versus non-sterile)

B) Potential for exposure to blood and body fluids during the procedure both in terms of the amount and the length of time exposed

C) Exposure to other substances that break down glove material, such as disinfectants and solvents

D) The amount of stress placed on the glove during the

procedure

3. Protective Face and Eyewear

   a. Masks, goggles, or face shields must be worn to provide protection of the mucous membranes of the eyes, nose, and mouth during procedures and patient care activities that are likely to generate droplets or splashing of blood, body fluids, secretions, or excretions.

   b. Prescription glasses alone do not provide protection from splatter and splashes. Removable side shields are needed to adequately protect healthcare workers from blood and body fluid exposures when they wear prescription glasses.

   c. Selecting Masks

      i. Check the mask box for the mask's filtering efficiency.

      ii. Make sure the mask will filter to the level of protection that is needed. For example, if the mask is intended to protect a HCW from TB, a NIOSH-approved respirator must be selected. See Respiratory Protection Program in this policy.

      iii. Do not use adult masks on small children and infants.

   d. Wearing Masks

      i. Adjust the mask so it fits snugly against the face, is secured along the sides of the face, and molded over the bridge of the nose; air should not enter around the mask edges.

      ii. Keep beards groomed so the mask fits as closely to the face as possible.

      iii. Change the mask between patients.

      iv. Change the mask if it gets wet.

      v. Remove the mask as soon as treatment is over.

      vi. Do not leave the mask dangling around your neck.

4. Gowns, Lab Coats, and Protective Apparel

   a. Gowns are worn to prevent contamination of clothing and to protect the skin from blood and body fluid exposures. Gowns and other appropriate

protective apparel must be worn when there is potential that an exposure (splashing with blood or body fluids) will occur. Various types of gowns and protective apparel are worn to provide barrier protection and reduce opportunities for transmission of microorganisms. Uniforms and scrubs do not provide adequate protection from blood and body fluid exposure.

b. Selecting gowns and protective apparel

i. Protective garments should fit the HCW.

ii. Choose garments that prevent blood or other potentially infectious materials from passing through or reaching the HCW's clothes or body.

iii. Select protective garments that are appropriate for the activity and amount of fluid likely to be encountered.

iv. Do not wear the same gown for the care of more than one patient.

v. Remove gown and perform hand hygiene before leaving the patient's environment (e.g., exam room).

c. If the uniforms or scrubs become soiled with blood or body fluids:

i. Glove and remove clothing immediately; handle clothing as little as possible.

ii. Do not rinse clothing.

iii. Wash contaminated skin with soap and water prior to changing into replacement scrubs.

E. Respiratory Hygiene and Cough Etiquette (See Respiratory Hygiene and Cough Etiquette in this policy)

F. Safe Injection Practices (See Safe Injection Practices in this policy)

G. Sharps Precautions

1. Staff who use sharps and safety equipment will be oriented to safe practices to prevent injury to patients and themselves during orientation and annually or as needed.

2. Safer sharps devices will be used whenever commercially available as a substitute for a non-safety engineered device.

3. The safety device should be engaged before the device is placed into the sharps container.

4. Used needles will not be recapped, purposely bent or broken by hand, removed from disposable syringes, or otherwise manipulated by hand.

5. Used sharps should be placed directly into impervious, rigid, leak-proof, and puncture-resistant containers to eliminate the hazard of physical injury.

6. The sharps containers will be appropriately marked with the bio-hazard symbol.

7. Sharps containers will be placed in appropriate patient care areas, (ex. exam rooms, dental, laboratory drawing station) which are locked and secure from tampering.

8. Containers should be emptied when they are three-fourths full or are level with the containers line marked "full".

9. Accidental Needle Stick "Sharps" Exposure

   If an accidental needle stick "sharps" exposure occurs, the employee should notify his or her supervisor immediately.

H. Safe Handling of Patient-Care Equipment and Articles

1. Patient care equipment and articles that have become soiled or contaminated with infective material should be handled by employees wearing appropriate PPE.

2. The handling of patient care equipment and articles depends upon the type of item being handled.

   a. Any disposable item that has become soiled or contaminated with infectious material should be disposed of in the appropriate biohazard container.

   b. Reusable patient care equipment and articles that have been grossly soiled or contaminated with infectious material should be covered, handled, and decontaminated or sterilized according to the transmission-based isolation precautions, cleaning/disinfection, and sterilization policies.

I. General Infection Control Practices

1. Ventilation Devices

   Resuscitation equipment mouthpieces or other ventilation devices are available in the procedure room on the code cart as alternatives for mouth to mouth resuscitation.

2. Linen and Laundry

   a. Linen that is soiled or contaminated with infective material should be handled by employees wearing appropriate PPE.

      i. Soiled or contaminated linen should be placed directly into the impervious linen bags that line the linen hampers.

      ii. Soiled linen should be handled as little as possible to prevent gross contamination of the environment and exposure of personnel handling the linen to organisms within the linen.

   b. Soiled laundry and linen should be picked up by an authorized laundry service.

3. Routine and Terminal Cleaning

   Routine and thorough cleaning, and adequate disinfection of rooms and shared patient equipment, will be accomplished according to the cleaning, disinfection, sterilization, and environmental cleaning sections of this policy. Special attention should be given to items that have been in direct contact with the patient or in contact with the patient's body fluids.

4. Regulated Medical Waste

   a. All medical waste should be handled by employees wearing appropriate PPE based on potential exposure risks.

      i. Waste should be bagged in impervious bags or containers.

      ii. Regulated medical waste shall be placed in an appropriately labeled or color coded bag according to state and local regulations.

      iii. An authorized waste disposal service should pick up biohazardous waste on a weekly basis.

5. Lab Specimens

a. At the time of collection, all specimens must be placed in a labeled container which prevents leakage during collection, handling, processing, storage, transport, or shipping.

b. All specimens must be contained in a plastic biohazard lab specimen bag before leaving the collection area.

c. Some specimens may require special handling procedures. Contact your state and/or local health department or CDC to determine the proper category for shipment of specimens based on clinical history and risk assessment to obtain detailed shipping guidance and shipping documents.

6. Blood Spills

a. Gloves should be worn during cleaning and decontamination.

b. Spills of blood or other body fluids should be removed and the area decontaminated using an OSHA approved blood spill kit.

i. OSHA approved blood spill kits are located on all three floors of SCHC in a labeled cupboards.

ii. The manufacturer's directions should be followed for use of the product in cleaning and decontaminating spills.

iii. The disinfectant should be EPA registered and have kill data against Hepatitis B, HIV, Noroviruses, non-enveloped viruses, and tuberculosis.

7. Food and Drink

a. In patient care areas, staff can designate specific locations where drinks with lids are allowed.

i. The pre-approved locations must be separate from areas where lab specimens or contaminated equipment are handled.

ii. Eating from utensils or drinking from open containers or coffee cups are prohibited at laboratory workstations or in areas where patient care occurs.

References

United States Department of Labor, Occupational Safety and Health Administration. Occupational Safety and Health Standards, Toxic and Hazardous Substances, Bloodborne Pathogens. 29 CFR, 1910.1030. Basic Infection Control and Prevention Plan for Outpatient Oncology Settings http://www.cdc.gov/HAI/settings/outpatient/basic-infection-control-prevention-plan-2011/fundamental-of-infection-prevention.html Siegel, J. D., Rhinehart, E., Jackson, M., Chiarello, L., & the Healthcare Infection Control Practices Advisory Committee. (2007). 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. Atlanta, Georgia: Centers for Disease Control and Prevention. Guide to Infection Prevention in Outpatient Settings http://www.cdc.gov/HAI/settings/outpatient/outpatient-care-gl-standard-precautions.html

XII. TRANSMISSION BASED PRECAUTIONS (See Part 18 for additional COVID-19 related precautions)

A. To reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection.

B. Contact Precautions

1. Contact precautions apply to patients with any of the following conditions or diseases:

   a. The presence of stool incontinence (may include patients with norovirus, rotavirus, Ebola (EBV), or Clostridium difficile), draining wounds, uncontrolled secretions, pressure ulcers, or presence of ostomy tubes and/or bags draining body fluid.

   b. Precautions also apply to any patient with the presence of a generalized rash or exanthemas.

2. Prioritize placement of patients in an exam room if they have stool incontinence, draining wounds and/or skin lesions that cannot be covered.

3. Perform hand hygiene before touching patient and prior to wearing gloves.

4. Use PPE that is appropriate for the type of exposure anticipated. Gown and gloves are minimum.

5. Perform hand hygiene after removal of PPE. Use soap and water when hands are visibly soiled (e.g., blood, body fluids), or after caring for patients with known or suspected infectious diarrhea (e.g., Clostridium difficile, norovirus).

6. Clean and disinfect the exam room accordingly.

7. Instruct patients with known or suspected infectious diarrhea to use a separate bathroom, if available; clean and disinfect the bathroom before it can be used

again.

C. Droplet Precautions

1. Droplet precautions apply to patients known or suspected to be infected with a pathogen that can be transmitted by droplet route. These include, but are not limited to:
   a. Respiratory viruses (e.g., influenza, parainfluenza virus, adenovirus, respiratory syncytial virus, human metapneumovirus, SARS-COV-2 (COVID-19))

   b. Bordetella pertussis

   c. Neisseria meningitides and Group A streptococcus (for first 24 hours of therapy)

2. The patient should be provided a facemask and placed in a separate area as far from other patients as possible while awaiting care.

3. PPE Use

   a. Wear a facemask, such as a procedure or surgical mask, for close contact with the patient; the facemask should be donned upon entering the exam room.

   b. If substantial spraying of respiratory fluids is anticipated, gloves and gown as well as goggles (or face shield in place of goggles) should be worn.

4. Perform hand hygiene before and after touching the patient and after contact with respiratory secretions and contaminated objects or materials. Use soap and water when hands are visibly soiled (e.g., blood, body fluids)

5. Instruct patient to wear a facemask when exiting the exam room, avoid coming into close contact with other patients, and practice respiratory hygiene and cough etiquette.

6. Clean and disinfect the exam room accordingly following the cleaning, disinfection, and sterilization sections of this policy.

D. Airborne Precautions (See Part 18, Section 18F Testing for COVID-19 Virus)

1. Airborne precautions apply to patients known or suspected to be infected with a pathogen that can be transmitted by an airborne route. These include, but are not limited to:
   a. Tuberculosis

b. Measles

c. Chickenpox (until lesions are crusted over)

d. Localized (in immunocompromised patient) or disseminated herpes zoster (until lesions are crusted over)

e. COVID-19 when performing aerosol generating procedure

2. Have patient enter through the ambulance entrance to the facility, if available, to avoid the reception and registration area.

3. Provide a facemask (e.g., procedure or surgical mask) to the patient and place the patient immediately in a designated exam room, Procedure Room 150, with the door closed and turn on the negative air flow switch located on the wall behind the code cart. Turn on negative pressure before bringing patient to room. If negative pressure room is not available, use exam room farthest away from other patients, keeping door closed as much as possible.

4. Instruct the patient to keep the facemask on while in the building and to change the mask if it becomes wet.

5. Initiate protocol to transfer patient to a healthcare facility that has the recommended infection control capacity to properly manage the patient if indicated. See the Isolation Management of Patients with Transmissible Disease section of this policy.

6. PPE Use

   a. Wear a fit-tested N-95 or higher level disposable respirator when caring for the patient. The respirator should be donned prior to room entry and removed after exiting room. See the N95 Respirator Fit Testing section of this policy.

   b. If substantial spraying of respiratory fluids is anticipated, gloves and gown as well as goggles or face shield should be worn. See the Respiratory Protection Program section of this policy.

7. Perform hand hygiene before and after touching the patient and after contact with respiratory secretions or body fluids and contaminated objects or materials. Use soap and water when hands are visibly soiled (e.g., blood, body fluids).

8. Instruct patient to wear a facemask when exiting the exam room, avoid coming into close contact with other patients, and practice respiratory hygiene and cough etiquette.

a. When the patient leaves, the exam room should remain vacant for one hour with negative pressure one before anyone enters. This increases to two hours when a patient with suspected or confirmed COVID-19 has been in an exam room that is not an airborne isolation room.

b. If the patient was in the airborne isolation room (procedure room 150) then 6-14 minutes should elapse prior to staff wearing appropriate PPE entering the room to clean and disinfect.

c.. If staff must enter the room during the wait time, they are required to use respiratory protection. See the Respiratory Protection Program section of this policy.

d. Ventilation of airborne isolation room should be maintained for 30 minutes after prior patient departure before occupying with a subsequent patient.

References

United States Department of Labor, Occupational Safety and Health Administration. Occupational Safety and Health Standards, Toxic and Hazardous Substances, Bloodborne Pathogens. 29 CFR, 1910.1030. Healthcare Associated Infections, Transmission Based Precautions http://www.cdc.gov/HAI/settings/outpatient/basic-infection-control-prevention-plan 2011/transmission-based-precautions.html Siegel, J. D., Rhinehart, E., Jackson, M., Chiarello, L., & the Healthcare Infection Control Practices Advisory Committee. (2007). 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. Atlanta, Georgia: Centers for Disease Control and Prevention. Guide to Infection Prevention in Outpatient Settings http://www.cdc.gov/HAI/settings/outpatient/outpatient-care-gl-standared-precautions.html

XIII. SAFE INJECTION PRACTICES

Siletz Community Health Clinic follows the CDC "One and Only" campaign for safe injection practices.

A. A Single Needle and Single Syringe Are Used For a Single Patient

1. It shall be the policy for licensed staff to give immunizations in accordance with current standing orders and recommendations set forth by the World Health Organization (WHO) best practices for injections.

2. Perform hand hygiene prior to accessing medications and solutions and immediately before drawing up or administering the medication.

3. Check expiration dates prior to administration.

4. Use aseptic technique to avoid contamination of sterile injection equipment; the stopper on vials shall be scrubbed with alcohol (or other products if appropriate) prior to each entry.

5. Medication vials are always entered into with a new needle and new syringe regardless of whether that medication vial is dedicated for that patient only and is being used for the same procedure.

6. Needles, cannula, and syringes are sterile, single-use items; they will not be reused for another patient or to access a medication or solution that might be used for a subsequent patient.

7. The Dental Clinic uses sterile aspirating syringes that are sterilized between patients.

8. Do not administer medications from a syringe to multiple patients, even if the needle or cannula on the syringe is changed.

9. Sharps will be disposed of in a puncture-resistant sharps container.

B. Use of Single-Dose or Single Patient Use Vials for Medications

1. Do not administer medications from single-dose vials or ampules to multiple patients or combine leftover contents for later use.

2. Discard vials or solutions labeled with "single patient use" or "single use" or "preservative free" after use on single patient.

3. Manufactured pre-filled syringes that may have enough medication for more than one patient must still only be used for one patient and discarded at the end of the procedure.

C. Use of Multi-Dose Injectable Vials

1. Multi-dose injectable vials are only used for one patient, whenever possible.

2. If multi-dose vials must be used, both the needle or cannula and syringe used to access the multi-dose vial must be sterile.

3. Multi-dose containers (e.g., vials, eye drops) are formulated for removal of portions on multiple occasions because they contain antimicrobial preservatives. The beyond-use date after initially entering or opening (e.g., needle-punctured) multi-dose containers is 28 days, unless a shorter timeframe is otherwise specified by the manufacturer.

4. Do not keep multi-dose vials in the immediate patient treatment area; store in accordance with the manufacturer's recommendations and discard if sterility is compromised or questionable.

D. Medicine Preparation

1. Draw up medication, using aseptic technique, just prior to the procedure.

2. Do not draw up for multiple patients.

3. Pre-drawn medications must be labeled properly with the time of the draw, initials of the person drawing up the medication, name of the medication, strength of medication, and expiration date if the manufacturer has not printed it on the vial. Sharps should be disposed of in a puncture-resistant sharps container.

4. Never store or carry medications in personal clothing or pockets.

E. Eye Ointments and Eye Drops

1. Use eye ointments and eye drops in single-dose or smaller sized containers whenever possible.

2. Use only single unit sterile fluorescein strips.

3. If using multi-dose eye drops the bottle tip should not come into direct contact with the patient's tears or conjunctiva; if the tip does touch the patient, the bottle must be discarded.

4. Pharmaceutical dispenser tips should never touch tears or tissues. If they do, discard.

5. Discard the bottle when used on patient with an infectious eye process.

6. Store all eye ointments and eye drops in accordance with the manufacturer's recommendations and discard if sterility is compromised or questionable.

References

American Society of Cataract and Refractive Surgery and the American Society of Ophthalmic Registered Nurses. Recommended Practices for Cleaning and Sterilizing Intraocular Surgical Instruments. February 16, 2007. Dolan, S.A., Felizardo, G., Barnes, S., Cox, T.R., Patrick, M., Ward, K.S., & Arias, K.M. (2010). APIC Position Paper: Safe Injection, Infusion, and Medication Vial Practices in Healthcare. American Journal of Infection Control, 38(3), 167-72. Siegel, J.D., Rhinehart, E., Jackson, M., Chiarello, L., & the Healthcare Infection Control Practices Advisory. (2007). 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. Atlanta, Georgia: Centers for Disease Control & Prevention. One Needle,

One Syringe, Only One Time. Centers for Disease Control & Prevention, Safe Injection Practices Coalition. WHO best practices for injections and related procedures http://whqlibdoc.who.int/publications/2010/9789241599252_eng.pdf?ua=1

XIV. BLOOD/BODY FLUID SPILLS

All spills of blood or other body fluids will be cleaned in the following manner:

A. Blood spills will be cleaned using an OSHA approved blood spill kit. Manufacturer's recommendations for cleaning and decontaminating the spill will be followed. Spill kits can be found in the following areas.

1. Ground Floor: Maintenance office and Behavioral Health

2. First Floor: Laboratory, under the sink in Procedure Room 150, and under the sink in Pod B

3. Second Floor- Dental Clinic

B. If a blood spill kit is used, the disinfectant should be EPA registered and have kill data against Hepatitis B and HIV or should be tuberculocidal. Blood spill kits have expiration dates that must be monitored.

C. If a blood spill kit is not available, as an alternative, a fresh 1:10 dilution of bleach may be used.

D. Gloves and other appropriate personal protective equipment (PPE) will be worn. PPE should be selected based on the specific situation.

E. Post-appropriate signage to alert other staff of the wet area.

XV. ENVIRONMENTAL CLEANING (See Part 18, Section 18E Cleaning, Decontamination, High-Level Disinfection and Sterilization for COVID-19 specific instructions)

A. General Principles

1. Personal protective equipment (PPE) must be worn according to the OSHA Bloodborne Pathogen Standard when disposing of waste that could result in exposure to bloodborne or other potentially infectious microorganisms and hazardous material. Attention to frequently touched surfaces (e.g., light switches, door handles) is essential.

2. EPA registered disinfectants or facility approved cleaning agents shall be used as directed following manufacturer recommendations. Cleaning agents are only effective when they remain wet for the appropriate contact time. Refer to the cleaning agent label for organism kill times.

3. Thorough scrubbing with mechanical friction (back and forth motion) will be used for all environmental surfaces.

4. Mop heads, cleaning cloths, and cleaning solutions will be changed frequently.

5. HEPA-filtered vacuums shall be used in patient care areas. Carpeting will be vacuumed regularly, cleaned promptly if spills occur, and shampooed regularly or when indicated by appearance or after contaminated with body fluids.

6. In patient care areas, cleaning of non-carpeted floors and other horizontal surfaces will be done daily and more frequently if spillage or visible soiling occurs using an Environmental Protection Agency (EPA)-registered disinfectant or facility-approved cleaning agent.

B. Cleaning of Patient Exam Rooms

1. Patient exam rooms should be cleaned at the beginning of the day (if terminal cleaning was not done the night before), using a facility-approved, EPA-registered disinfectant or wipe and visually inspected for cleanliness before the patient is brought into the room.

2. Cleaning of the patient exam room between patients must be done with a facility-approved, EPA-registered disinfectant or wipes.

   a. Clean hands and put on gloves.

   b. Collect and remove all soiled linen and place in the designated laundry hamper.

   c. Collect and remove trash. All waste will be disposed of in the proper biohazard container. Remove gloves and wash hands.

   d. Clean hands and put on gloves. Use facility approved disinfectant wipes to clean and disinfect surfaces that have come in contact with a patient or body fluids, including blood pressure cuffs.

   e. Clean and disinfect horizontal surfaces, exam tables, counters, prep tables, chairs, etc. When cleaning is complete, remove gloves and wash hands.

   f. Call maintenance to damp mop floor only if visibly soiled; allow to air dry.

3. Terminal cleaning of each patient exam room will be performed daily when the scheduled appointments are completed for the day. A facility approved EPA-registered cleaning agent will be used to clean the patient rooms.

C. Laboratory Responsibilities

1. The phlebotomy room should be cleaned at the beginning of the day, using a facility-approved, EPA-registered disinfectant or wipe and visually inspected for cleanliness before the patient is brought into the area for a blood draw.

2. Cleaning of the phlebotomy chair between patients must be done with a facility-approved, EPA-registered disinfectant or wipes.

3. Terminal cleaning of the laboratory will be performed daily when the scheduled appointments are completed for the day. A facility approved EPA-registered cleaning agent will be used to clean the laboratory.

D. Dental Responsibilities

1. Dental exam areas and chairs should be cleaned at the beginning of the day, using a facility-approved, EPA-registered disinfectant or wipe and visually inspected for cleanliness before the patient is brought into the exam area.

2. Cleaning of the dental exam area and chairs between patients must be done with a facility-approved, EPA-registered disinfectant or wipes.

   a. Clean hands and put on gloves. Use facility-approved disinfectant wipes to clean and disinfect surfaces that have come in contact with a patient or body fluids.

   b. Clean and disinfect horizontal surfaces, counters, prep tables, chairs, etc. When cleaning is complete, remove gloves and wash hands.

   c. Call maintenance to damp mop floor only if visibly soiled; allow to air dry.

3. Terminal cleaning of dental exam areas and chairs will be performed daily when the scheduled appointments are completed for the day. A facility approved EPA-registered cleaning agent will be used to clean the dental areas and chairs.

E. Cleaning of Optometry Exam Areas

1. Optometry exam areas should be cleaned at the beginning of the day, using a facility-approved, EPA-registered disinfectant or wipe and visually inspected for cleanliness before the patient is brought into the exam area.

2. Cleaning of the optometry exam area between patients must be done with a facility-approved, EPA-registered disinfectant or wipes.

3. Terminal cleaning of optometry exam areas will be performed daily when the scheduled appointments are completed for the day. A facility approved EPA-

registered cleaning agent will be used to clean the optometry exam areas.

F. Cleaning of Nursing Stations and Staff Lounges

All nursing stations and staff lounges will be cleaned on a daily basis and as needed if they become soiled using a facility approved EPA-registered cleaning agent.

G. Pharmacy

Pharmacy staff will do all cleaning before the end of the workday. Waste will be bagged appropriately and left outside the door to be collected by the night maintenance staff.

1. The floors shall be vacuumed weekly by pharmacy staff.

2. All horizontal surfaces will be cleaned by pharmacy staff daily with a facility-approved EPA-registered cleaning agent.

H. Maintenance Responsibilities

1. All high touch surfaces will be cleaned daily at a minimum.

2. All bathrooms will be cleaned by maintenance staff on a daily basis and as needed if they become soiled using a facility- approved, EPA-registered cleaning agent.

3. Non patient care areas, waiting rooms, and other clinic areas not listed above will be cleaned on a daily basis and as needed if they become soiled using a facility-approved, EPA-registered cleaning agent.

4. Walls, ceiling, and ceiling vents will be cleaned every six months or more often if needed.

5. Light fixtures will be checked weekly for bugs.

6. Maintenance is responsible for emptying all waste containers daily or more often as needed.

XVI. MEDICAL EQUIPMENT AND SUPPLIES

A. Soiled supplies and equipment may not be stored near clean supplies and equipment. Sterile and non-sterile supplies will be stored in separate areas or on separate shelves. All sterile supplies and equipment will be checked for sterility prior to use by examining the expiration date and the condition of the packaging. Supplies will be dated and rotated in a timely manner.

B. SCHC follows all manufacturer's guidelines and instructions for use regarding

maintenance and cleaning of reusable medical equipment.

C. Product recalls are forwarded to the Clinical Services Director (CSD) or designee via mail or email through a supplier. Those lot numbers are verified by the CSD or designee with the current stock and removed if found on hand and returned to supplier. A list of patients who may have received products in question are contacted by phone or mail to recover the product. Product recall notices are kept by the CSD. .

XVII. POINT OF CARE DEVICE SAFE HANDLING AND DISINFECTION

A. Use of Point of Care Devices (including glucometers and INR ratio testing devices)

1. Laboratory and nursing staff will be properly trained and educated on the use of point of care testing devices. Competency will be documented before these devices are used on patients. Annual competency will be demonstrated. Training checklists will be on file in the Clinical Services Director's office.

2. Perform hand hygiene prior to performing fingersticks on patients.

3. Always wear gloves during fingerstick glucose monitoring and during any other procedure that involves potential exposure to blood or body fluids.

4. A disposable, single-use, auto-disabling lancet is the only type of device that should be used when performing fingersticks. When performing a finger puncture, direct the blood away from the face. Squeezing a puncture site to obtain an adequate amount of blood can cause a blood splash onto the face or mucous membranes.

5. Dispose of the used lancet in an approved sharps container.

6. Never reuse lancets.

7. Do not recap, bend, or break used lancets because these practices are potential causes of needle stick injury.

8. Change gloves between patient contacts; change gloves that have touched potentially blood-contaminated objects or fingerstick wounds before touching clean surfaces.

9. Remove and discard gloves in appropriate receptacles after every procedure that involves potential exposure to blood or body fluids, including fingerstick blood sampling.

10. Perform hand hygiene immediately after removal of gloves and before touching other medical supplies intended for use on other patients.

11. Wash hands immediately with soap and water if they become contaminated with

blood or body fluids.

B. Disinfection After Using Point of Care Testing Devices

1. The SCHC uses point of care testing devices (such as glucose meters and INR ratio testing devices) that are designed for use on multiple patients, as indicated by the manufacturer's indications and instructions. Refer to the manufacturer instructions regarding how the device should be cleaned and disinfected.

2. Special precautions apply for testing devices used on multiple patients and that require the lanced finger to be brought to the surface of the device. Continue to wear gloves while cleaning the device thoroughly after each use and disinfecting it according to manufacturer's recommendations with an EPA-approved disinfectant or wipe.

3. Immediately and thoroughly clean any countertops and surfaces that have become contaminated with blood or body fluids and disinfect with an EPA-approved, germicidal solution.

C. Accidental Needle Sticks

Report and manage accidental needle sticks and mucous membrane exposure following the Employee Exposure to a Bloodborne Pathogen instructions.

References

ASC Quality Collaboration; Centers for Disease Control and Prevention. Infection Prevention during Blood Glucose Monitoring and Insulin Administration. Atlanta, Georgia.

XVIII. INFECTIOUS DISEASES

A. If a patient is diagnosed or suspected of having a communicable disease of extreme health significance, the Medical Director and the nursing staff will be notified immediately to coordinate terminal cleaning and disinfection of the contaminated area. Nursing staff will notify the Patient Care Coordinators to ensure future scheduling considerations.

B. Some infectious diseases are required by law to be reported to the local health department.

1. The registered nurses shall report all cases or suspected cases of the diseases, infections, microorganisms, and conditions specified below. Reports should be made to the patient's local health department.

2. Reports on out-of-state residents can be made to the provider's local health department or (preferably) directly to the Oregon Health Authority's (OHA) Public Health Division (phone 971-673-1222; fax 971-673-1100). The timing of

healthcare provider reports is specified to reflect the severity of the illness or condition and the potential value of rapid intervention by public health agencies.

3. When local public health authorities cannot be reached within the specified time limits, reports shall be made directly to OHA, which shall maintain an around-the-clock public health consultation service.

4. Report immediately, day or night:

   a. Bacillus anthracis (anthrax)

   b. Clostridium botulinum (botulism)

   c. Corynebacterium diphtheriae (diphtheria)

   d. Severe Acute Respiratory Syndrome (SARS) and infection by SARS-coronavirus

   e. Yersinia pestis (plague)

   f. Intoxication caused by marine microorganisms or their byproducts (for example, paralytic shellfish poisoning, domoic acid intoxication, ciguatera, scombroid); any known or suspected common-source outbreaks

   g. Any uncommon illness of potential public health significance

   h. Ebola Virus Disease (EBV)

5. Report within 24 hours (including weekends and holidays):

   a. Haemophilus influenzae (any invasive disease; for laboratories, any isolation or identification from a normally sterile site)

   b. Measles (rubeola)

   c. Neisseria meningitidis (any invasive disease; for laboratories, any isolation or identification from a normally sterile site)

   d. Pesticide poisoning

   e. Poliomyelitis

   f. Rabies (human or animal)

   g. Rubella

h. Vibrio (all species)

i. SARS-COV-2 (COVID-19)

6. Report within one local public health authority working day:

a. Bordetella pertussis (pertussis)

b. Borrelia (relapsing fever, Lyme disease)

c. Brucella (brucellosis)

d. Campylobacter (campylobacteriosis)

e. Chlamydophila (Chlamydia) psittaci (psittacosis)

f. Chlamydia trachomatis (chlamydiosis, lymphogranuloma venereum)

g. Clostridium tetani (tetanus)

h. Coxiella burnetii (Q fever)

i. Creutzfeldt-Jakob disease and other transmissible spongiform encephalopathies

j. Cryptosporidium (cryptosporidiosis)

k. Cyclospora cayetanensis (cyclosporidiosis)

l. Escherichia coli (Shiga-toxigenic, including E. coli O157 and other serogroups)

m. Francisella tularensis (tularemia)

n. Giardia (giardiasis)

o. Haemophilus ducreyi (chancroid)

p. Hantavirus

q. Hepatitis A

r. Hepatitis B (acute or chronic infection)

s. Hepatitis C

t. Hepatitis D (delta)

u. HIV infection (does not apply to anonymous testing) and AIDS

v. Legionella (legionellosis)

w. Leptospira (leptospirosis)

x. Listeria monocytogenes (listeriosis)

y. Mumps

z. Mycobacterium tuberculosis and M. bovis (tuberculosis)

aa. Neisseria gonorrhoeae (gonococcal infections)

bb. Pelvic inflammatory disease (acute, non-gonococcal)

cc. Plasmodium (malaria)

dd. Rickettsia (all species: Rocky Mountain spotted fever, typhus, others)

ee. Salmonella (salmonellosis, including typhoid)

ff. Shigella (shigellosis)

gg. Taenia solium (including cysticercosis and other undifferentiated Taenia infections)

hh. Treponema pallidum (syphilis)

ii. Trichinella (trichinosis)

jj. Yersinia (other than pestis)

kk. Any infection that is typically arthropod vector-borne (e.g., Western equine encephalitis, Eastern equine encephalitis, St. Louis encephalitis, dengue, West Nile fever, yellow fever, California encephalitis, ehrlichiosis, babesiosis, Kyasanur Forest disease, Colorado tick fever, etc.)

ll. Human bites by any other mammal

mm. CD4 cell count <200/ml (mm3) or CD4 proportion of total lymphocytes <14%

nn. Hemolytic uremic syndrome

7. Report within 7 days:

   Suspected lead poisoning (for laboratories, this includes all blood lead tests performed on persons with suspected lead poisoning). SCHC submits all blood lead screening tests to Oregon Health Authority regardless of results. See Part 7 Nursing Procedures, Lead Screening.

References

Oregon Department of Human Services, Office of Disease Prevention and Epidemiology. (2010). Oregon Public Health Division Reporting for Clinicians (poster). DHS 8577; Oregon Health Authority, Public Health Division. Communicable Disease Reporting Phone Numbers by County; Centers for Medicare and Medicaid Services (CMS), Point of Care Devices and Infections in Nursing Homes http://www.cms.gov/site-search/search-results.html?q=point%20of%20care%20 testing Rutala, W.A., Weber, D.J., and the Healthcare Infection Control Practices Advisory Committee. (2008). Guideline for Disinfection and Sterilization in Healthcare Facilities. Atlanta, Georgia: Centers for Disease Control & Prevention; American Association of Diabetes Educators. Position Statement: Educating Providers and Persons with Diabetes to Prevent the Transmission of Bloodborne Infections and Avoid Injuries from Sharps. Chicago, Illinois.

XIX. Employee Health and Occupational Exposure Risk Mitigation (See Part 18, Section 18H Occupational Health related to COVID-19 pandemic)

A. Employee Health

1. Employee, for the purposes of this policy is defined as: "Anyone whose employment is primarily based at the Siletz Community Health Clinic." Employees of the SCHC who work outside of the Siletz area are not included in the scope of this policy.

2. Employees who are ill with an acute infection (including respiratory, gastrointestinal, and skin) may require evaluation by a health care provider, at their supervisor's discretion, for clearance to remain on duty or to return to work. Symptoms that may indicate an acute infection include fever (>100.4), chills, diarrhea, vomiting, persistent cough, or draining skin lesions.

B. Occupational Exposure Risk Mitigation

1. SCHC is committed to providing a safe and healthful work environment for the entire staff. In pursuit of this goal, the following exposure control plan (ECP) is provided to eliminate or minimize occupational exposure to bloodborne pathogens in accordance with OSHA standard 29 CFR 1910.1030, "Occupational Exposure to Bloodborne Pathogens."

2. The ECP is a key document to assist in implementing and ensuring compliance with the standard, thereby protecting the employees. The ECP includes:

a. Determination of employee exposure

b. Implementation of various methods of exposure control, including: standard precautions, transmission based precaution, engineering and work practice controls, personal protective equipment, and housekeeping. All of these are addressed in the Exposure Control Plan section of this policy.

c. Hepatitis B vaccination- addressed earlier in this document

d. Post-exposure evaluation and follow-up

e. Communication of hazards to employees and training

f. Recordkeeping

g. Procedures for evaluating circumstances surrounding exposure incidents

C. Program Administration

1. The Safety/Infection Control Committee is responsible for implementation of the ECP. The Infection Control Officer will maintain, review, and update the ICP/ECP at least annually, and whenever necessary to include new or modified tasks and procedures. Contact location/phone number: Clinical Services Director/Infection Control Officer at 541-444-9610 or X1610.

2. Employees who are determined to have occupational exposure to blood or other potentially infectious materials (OPIM) must comply with the procedures and work practices outlined in this policy.

3. Nursing, dental, and maintenance supervisors will provide and maintain all necessary personal protective equipment (PPE), engineering controls (e.g., sharps containers), labels, and red bags as required by the standard. The supervisors will ensure that adequate supplies of the aforementioned equipment are available in the appropriate sizes. Contact location/phone number: 541-444-1030 and ask for department you are trying to reach.

4. Infection Control Officer will be responsible for ensuring that all medical actions required by the standard are performed and that appropriate employee health and OSHA records are maintained. Contact location/phone number: Infection Control Officer at 541-444-9610 or x1610.

5. QI Coordinator will be responsible for training, documentation of training, and making the written ECP available to employees, OSHA, and NIOSH representatives. Contact location/phone number: QI Coordinator at 541-444-9633 or x 1663.

D. Employee Exposure Determination

1. The following is a list of job titles for employees who have potential occupational exposure:

Job Title	Department/Location
Clinicians	Medical, Dental, Optometry
Registered Nurse	Medical
Medical Assistant	Medical
Dental Hygienist	Dental
Dental Assistant	Dental
Laboratory Staff	Lab
Maintenance	Maintenance

2. The following is a list of job classifications for some employees who have occupational exposure. Included is a list of tasks and procedures, or groups of closely related tasks and procedures, in which occupational exposure may occur:

Job Title	Department/Location	Task/Procedure
A&D Counselor	Behavioral Health	Collecting UA's
Behavioral Health Program Administrator	Behavioral Health	Collecting UA's
Data Coordinator	Behavioral Health	Collecting UA's
Peer Recovery Mentor	Behavioral Health	Collecting UA's
Prevention Coordinator	Behavioral Health	Collecting UA's
TLC Aide	Behavioral Health	Collecting UA's
TLC Coordinator	Behavioral Health	Collecting UA's
Youth Development Program Coordinator	Behavioral Health	Collecting UA's

NOTE: Part-time, temporary, contract and per diem employees are covered by the bloodborne pathogens standard.

E. Post-Exposure Evaluation and Follow-Up

1. All employees who have an occupational exposure to blood or body fluids are to seek evaluation and document the exposure accordingly. It is the responsibility of the supervisor to relieve the employees from their current assignment to allow for prompt post-exposure assessment and treatment

2. Definitions

a. Blood or Body Exposure: For transmission of blood borne pathogens (Human Immunodeficiency Virus (HIV), Hepatitis BVirus (HBV), Hepatitis C Virus (HCV)) to occur, an exposure must include one or more of the given factors. If one or more are not present, there is no risk of transmission and further evaluation is not required.

i. Infectious body fluid: Blood, semen, vaginal fluids, amniotic fluids, breast milk, cerebrospinal fluid, pericardial fluid, peritoneal fluid, pleural fluid, and synovial flood can transmit HIV, HBV, and HCV. Note that saliva, vomitus, urine, feces, sweat, tears, and respiratory secretions do not transmit bloodborne pathogens (unless visibly bloody).

ii. A portal of entry (percutaneous, mucous membrane, cutaneous)

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

c. PEP Exposure Protocol: A guide to assist with early intervention and urgent decision-making for occupational exposures to HIV and Hepatitis B and C.

d. Post-Exposure Prophylaxis (PEP): Any preventive medical treatment started immediately after exposure to a pathogen (such as a disease-causing virus), in order to prevent infection by the pathogen and the development of disease.

F. Prevention

1. Avoiding occupational blood exposures is the primary way to prevent transmission of hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV) in health-care settings, followed by vaccination of hepatitis B virus (Centers for Disease Control and Prevention [CDC], 2001)

2. Standard Precautions

a. Wash hands frequently and thoroughly before and after patient care

b. Use appropriate Personal Protective Equipment (PPE) -- gloves, gowns, boots, shoe covers, eyewear, and masks

c. Gloves must be worn when any kind of venous or arterial access is being performed

d. Use sharps with caution:

i. Plan ahead – use sharps in a safe environment with a sharps container nearby

ii. Dispose of used sharps in puncture proof receptacles immediately after use

iii. Do not recap needles

e. Use safety devices if available

G. Risk of Exposure

1. The risk of exposure to blood and bloodborne pathogens is slightly greater for healthcare employees than for people who do not work around blood.

2. An exposure to infected blood, tissue, or other potentially infectious body fluids can occur by:

a. Percutaneous injury (e.g. a needle stick or cut with a sharp object)

b. Contact with mucous membrane or non-intact skin (e.g. skin that is chapped, abraded, or affected by dermatitis)

3. After percutaneous injury, the risk of infection varies for specific bloodborne pathogens:

4. The risk of infection appears to be higher with:

a. Exposure to a larger quantity of blood or other infectious fluid

b. Prolonged or extensive exposure of non-intact skin or mucous membrane to blood or other infectious fluid or concentrated virus in a laboratory setting

c. Exposure to the blood of a patient in an advanced disease stage or with a high viral load

d. A deep percutaneous injury

e. An injury with a hollow-bore, blood-filled needle

H. PEP Exposure Protocol

1. Step 1: Treat Exposure Site

a. Use soap and water to wash areas exposed to potentially infectious fluids as soon as possible after exposure

b. Flush exposed mucous membranes with water
c. Flush exposed eyes with water or saline solution

d. Do not apply caustic agents, or inject antiseptics or disinfectants into the wound

2. Step 2: Report and Document

Report occupational exposures immediately; circumstances of the exposure and post exposure prophylaxis (PEP) management should be recorded in the exposed employee's confidential medical record. Include the following:

a. Date and time of exposure

b. Details of the incident:

i. Where and how the exposure occurred

ii. Exposure site(s) on the employee's body

iii. If related to sharp device, the type and brand of device

c. Details of the exposure:

i. Type and amount of fluid or material

ii. Severity of exposure

d. Details about the exposure source:

i. Whether the source material contained HIV, HBV or HCV

ii. If the source patient is HIV-infected, determine stage of disease, CD4 cell count, HIV viral load, history of antiretroviral therapy, and antiretroviral resistance information.

e. Details about the exposed employee:

Hepatitis B vaccination and vaccine-response status

3. Step 3: Evaluate the Exposure

a. The exposure should be evaluated for potential to transmit HBV, HCV, or HIV based on the type of body substance involved, the route, and severity of exposure.

b. Significant exposures to any of the following may pose a risk for bloodborne pathogen transmission and require further evaluation:

i. Blood

ii. Semen

iii. Vaginal secretions

iv. Breast milk

v. Cerebrospinal fluid

vi. Synovial fluid

vii. Pleural fluid

viii. Peritoneal fluid

ix. Pericardial fluid

x. Amniotic fluid

c. Body fluids that do not pose a risk of bloodborne pathogen transmission unless visibly contaminated with blood include:

i. Urine

ii. Saliva

iii. Vomitus

iv. Respiratory secretions

v. Feces

vi. Tears

vii. Sweat

d. Factors to consider in assessing the need for follow-up:

i. Type of exposure

A) Percutaneous injury

B) Mucous membrane exposure

C) Non-intact skin exposure

D) Bites resulting in blood exposure to either person involved

ii. Type and amount of fluid/tissue

A) Blood

B) Fluids containing blood

C) Potentially infectious fluid or tissue

D) Direct contact with concentrated virus

e. Infection status of source patient

i. If positive for HBsAg, consider testing for presence of HBeAg

ii. If positive for HCV antibody, consider measuring HCV viral load

iii. If positive for HIV antibody, consider obtaining HIV viral load, resistance testing, and evaluating clinical status of patient

iv. Susceptibility of exposed employee

A) Hepatitis B vaccine and vaccine response status

B) HBV, HCV, and HIV status—baseline testing for HBsAb, anti-HCV, and HIV antibody should be completed as early as possible (preferably within 72 hours)

4. Step 4: Evaluate the Exposure Source

a. When source patient is known

i. Test patient for HBsAg, HCV antibody, and HIV antibody

A) HIV viral load assessments for routine screening of source patients are not recommended

B) Use a rapid HIV-antibody test

C) If the source person is not infected with a bloodborne pathogen, baseline testing or further follow-up of employee is not necessary

D) Follow state regulations related to informed consent and confidentiality

ii. For patients who cannot be tested, consider medical diagnoses, clinical symptoms, and history of risk behaviors

b. When source patient is not known

i. Evaluate the likelihood of high risk exposure

Consider the likelihood of bloodborne pathogen infection among patients in the exposure setting, e.g. what is the community infection rate? Does the clinic for a large number of HIV-, HBV- or HCV-infected or at-risk patients?

ii. Do not test discarded needles for bloodborne pathogens; the reliability of these findings is not known

5. Step 5: PEP Management

a. After performing steps above, provider will call the Clinicians' Post Exposure Prophylaxis Hotline (PEP line) at 1-888-448-4911 or go to the following link for access to current up to date standards on post exposure management.

b. https://nccc.ucsf.edu/clinical-resources/pep-resources/pep-quick-guide/

c. Provider will discuss recommended treatment options with employee.

6. Step 6: Follow-up

a. Hepatitis-exposed employee

i. HBV exposure follow-up testing and counseling:

A) Test for anti-HBs 1-2 months after last dose of vaccine; Anti-HBs cannot be ascertained if HBIG is given within 6-8 weeks

B) Advise exposed employee to refrain from donating blood, plasma, organs, tissue, or semen and use risk reduction methods including latex barriers during sex, not sharing

injection equipment, and abstaining from risk behaviors

C) Offer mental health counseling as needed

b. HCV exposure follow-up testing and counseling

i. Repeat test for anti-HCV and ALT at least 4-6 months post exposure; confirm repeatedly positive anti-HCV EIA results with supplemental tests

ii. Test for HCV RNA at 4-6 weeks for earlier diagnosis. (Caution must be used due to occurrence of false positive results)

iii. During follow-up period, refrain from donating blood, plasma, organs, tissue, or semen

iv. Guidelines do not recommend changes in sexual activity, pregnancy, breastfeeding, or professional activities

v. Offer mental health counseling as needed

vi. HIV-exposed employee

c. HIV exposure follow-up testing

i. Repeat HIV-antibody testing at 6 weeks, 3 months, and 6 months post exposure, or as recommended from Clinicians' Post Exposure Prophylaxis Hotline

ii. If illness compatible with acute retroviral syndrome occurs, perform HIV viral load

iii. Extended follow-up (12 months) is recommended for employees who become infected with HCV following an exposure to a source co-infected with HIV and HCV

iv. If PEP is given, employee should be monitored for drug toxicity. CBC, creatinine, and liver enzyme tests (AST, ALT, alkaline phosphatase, total bilirubin) should be repeated at 2 weeks.

A) For those receiving a protease inhibitor, monitor for hyperglycemia

B) If receiving indinavir(IDV) ortenofovir(TDF), tests should include urinalysis

v. Counseling after HIV exposure

A) Advise exposed employee to refrain from donating blood, plasma, organs, tissue, or semen; to avoid breastfeeding; to use methods to prevent pregnancy; and to use risk reduction methods including latex barriers during sex, not sharing injection equipment, and abstaining from risk behaviors.

B) Offer mental health counseling as needed.

C) Counsel employee about the signs and symptoms of acute retroviral syndrome (flu-like syndrome), and the need to come in for additional testing at the onset of symptoms.

D) If PEP is given, advise regarding the importance of adherence and potential side effects and how to minimize these. Inform regarding any possible drug interactions or toxicities and the importance of monitoring for these.

I. Employee Training

1. All employees who have occupational exposure to bloodborne pathogens receive initial and annual training conducted by the Infection Control Officer or delegate.

2. All employees who have occupational exposure to bloodborne pathogens receive training on the epidemiology, symptoms, and transmission of bloodborne pathogen diseases. The training program covers, at a minimum, the following elements:

   a. OSHA bloodborne pathogen standard (copy distributed)

   b. Infection Control Policy and Exposure Control Plan (copy distributed during clinic orientation)

   c. Methods to recognize tasks and other activities that may involve exposure to blood and OPIM, including what constitutes an exposure incident

   d. Use and limitations of engineering controls, work practices, and PPE

   e. Types, uses, location, removal, handling, decontamination, and disposal of PPE

   f. Basis for PPE selection

g. Hepatitis B vaccine, including information on its efficacy, safety, method of administration, the benefits of being vaccinated, and that the vaccine will be offered free of charge

h. Appropriate actions to take and persons to contact in an emergency involving blood or OPIM

i. Procedure to follow if an exposure incident occurs, including the method of reporting the incident and the medical follow-up that will be made available

j. Post-exposure evaluation and follow-up that the employer is required to provide for the employee following an exposure incident

k. Signs and labels and/or color coding required by the standard and used at this facility

l. an opportunity for interactive questions and answers with the person conducting the training session

3. Training materials are available in the quality improvement office.

J. Recordkeeping

1. Training Records

a. Training records are completed for each employee upon completion of training. These documents will be kept for at least three years by the QI Coordinator.

b. The training records include:

i. the dates of the training sessions

ii. the contents or a summary of the training sessions

iii. the names and qualifications of persons conducting the training

iv. the names and job titles of all persons attending the training sessions

c. Employee training records are provided upon request to the employee or the employee's authorized representative within 15 working days. Such requests should be addressed to QI Coordinator.

2. Medical Records

   a. Medical records are maintained for each employee with occupational exposure in accordance with 29 CFR 1910.1020, "Access to Employee Exposure and Medical Records."

   b. Infection Control Officer or delegate is responsible for maintenance of the required medical records. These confidential records are kept in the employee health file cabinet in the Clinical Services Director's office for the duration of employment. Records for previous employees are sent to Human Resources to be kept in the permanent file plus 30 years.

   c. Employee medical records are provided upon request of the employee or to anyone having written consent of the employee within 15 working days. Such requests should be sent to Human Resources.

3. OSHA Recordkeeping

   An exposure incident is evaluated to determine if the case meets OSHA's recordkeeping requirements (29 CFR 1904). This determination and the recording activities are done by Infection Control Officer.

4. Sharps Injury Log

   a. In addition to the 1904 Recordkeeping Requirements, all percutaneous injuries from contaminated sharps are also recorded in a Sharps Injury Log. All incidences must include at least:

      i. date of the injury

      ii. type and brand of the device involved (syringe, suture needle)

      iii. department or work area where the incident occurred

      iv. explanation of how the incident occurred.

   b. This log is reviewed as part of the annual program evaluation and maintained for at least five years following the end of the calendar year covered. If a copy is requested by anyone, it must have any personal identifiers removed from the report.

K. Respiratory Protection Program

1. All employees who are expected to wear respiratory protection must comply with the Occupational Safety and Health Administration (OSHA) Respiratory Protection Standard, 29 CFR 1910.134 and the most current CDC guidelines.

2. Program Scope and Application

The Respiratory Protection Program applies to all employees who could potentially be exposed to airborne contaminants with harmful particles including dusts, fumes, mists, and microbial agents in the form of droplet nuclei such as, but not limited to, tuberculosis bacteria, influenza, Ebola Virus Disease (EVD), Severe Acute Respiratory Syndrome (SARS), measles, and smallpox. Depending on job responsibilities, N95 respirators are considered personal protective equipment and will be worn during tasks such as entering isolation rooms and other activities involving close contact with potentially infected persons.

3. Program Elements

The Respiratory Protection Program will cover the following basic elements:

a. Program administration

b. Program scope and application

c. Identifying work hazards

d. Selecting respirators for use in the workplace

e. Medical evaluations of employees required to use respirators

f. Fit testing for respirators

g. Respirator training

h. Proper respirator use

i. Cleaning and disinfecting

j. Inspection, maintenance and care

k. Documentation and record-keeping

l. Regular evaluation of the effectiveness of the program

4. Program Administration

The Infection Control Officer will assume responsibility for supervising the program administration. The Infection Control Officer or delegate will monitor the ongoing and changing respiratory protection needs of the facility while ensuring consistent coordination and direction of the respiratory program including:

a. Identifying work areas, processes, or tasks that require respiratory protection

b. Ensuring that employees receive appropriate training, medical evaluation, and fit testing

c. Arranging and conducting training and fit testing

d. Selecting and ensuring the availability of appropriate respirator supplies

e. Monitoring respirator use to ensure that respirators are used in accordance with certification

f. Ensuring proper storage and maintenance of respiratory protection equipment

g. Conducting evaluations of the Respiratory Protection Program as necessary and updating the written policy as needed to comply with OSHA and applicable state and federal regulations

h. Evaluating any feedback information or surveys

i. Maintaining records required by Standard 29 CFR 1910.134

5. Supervisor Duties

The supervisors of employees expected to use respirators must be knowledgeable about the program requirements and must also ensure that the program is understood and followed by employees under their charge. The Supervisors duties include:

a. Knowing the hazards and types of respirators used in the area in which they work

b. Ensuring the respirator program and worksite procedures are followed

c. Enforcing and encouraging staff to use appropriate respirators

d. Ensuring employees receive training and medical evaluations

e. Coordinating annual retraining and fit testing

f. Notifying the Infection Control Officer of any problems with respirator use or changes in work processes that would impact airborne contaminant levels

g. Ensuring proper storage and maintenance of all respirators

6. Employee Responsibilities

a. Participate in all trainings

b. Wear respirator when indicated

c. Maintain equipment

d. Report malfunctions or concerns to supervisor or Infection Control Officer

7. Respirator Selection

a. The Infection Control Officer or delegate will make respirators available to each employee who is assigned a job that requires respiratory protection once the medical evaluation, training, and fit testing are completed. Various sizes of respirators will be stored in the laboratory.

b. All respirators selected must be certified by the National Institute for Occupational Safety and Health (NIOSH) and must be used in accordance with the terms of the certification which appears on the NIOSH certification label.

c. N95 Particulate Respirator masks are provided to persons with assigned tasks that require respiratory protection. N95 Particulate Respirators are air-purifying respirators certified to have filter efficiency levels of 95% or greater against particulate aerosols free of oil and greater than 0.3 microns in size.

8. Medical Evaluation

a. Employees assigned to tasks that require the use of a respirator must be physically able to perform the work while using a respirator. The medical evaluation is designed to identify medical conditions that place employees who use respirators at risk of serious medical consequences.

b. All employees requiring respiratory protection will complete the most up to date OSHA Respiratory Medical Evaluation Questionnaire, Sec. 1910.134 at the time of hire and as warranted by changes in job or health condition.

i. Upon completion of the questionnaire the Medical Director will review the document to determine individual medical clearance.

ii. Once medical clearance has been granted the employee will be

scheduled for fit testing and basic respirator training.

c. After review of the OSHA Respiratory Medical Evaluation Questionnaire by the Medical Director, employees found to have issues that might make wearing a N95 respirator difficult or cause exacerbation of current medical conditions must be medically evaluated by a physician or other licensed healthcare professional and found eligible to wear the respirator selected for their use prior to fit testing and first-time use of the respirator in the workplace.

   i. Employees refusing a medical evaluation will not be allowed to work in conditions requiring respirator use.

d. Re-evaluation will be conducted if:

   i. Employee reports physical symptoms that are related to the ability to use a respirator including wheezing, shortness of breath, chest pain, etc.

   ii. Employee is having a medical problem during respirator use

   iii. The Medical Director determines an employee needs to be re-evaluated

   iv. A change occurs in the workplace conditions that may result in an increase physiological burden on the employees

   v. Employee facial size, shape, and structure has changed significantly

e. All examinations and questionnaires are to remain confidential between the employee and health care provider. A hard copy will be kept in the employee health file.

9. Fit Testing

a. The primary purpose of fit testing is to identify the specific make, model, style, and size of respirator best suited for each employee.

b. Fit tests are conducted to determine that the respirator fits the user adequately and that a good seal can be obtained. Respirators that do not seal do not offer adequate protection.

c. Fit testing also reinforces respirator training by having wearers review the proper method of donning and wearing the respirator.

d. Fit testing will occur upon hire and at least annually thereafter for employee's assigned tasks that require respiratory protection.

e. Fit tests will be conducted:

i. Prior to being allowed to wear any respirator

ii. If the clinic changes respirator product

iii. If an employee changes weight by 10% or more

iv. If an employee has changes in facial hair or scarring

v. As OSHA standards require

f. See the N95 Respirator Fit Testing section of this policy, which outlines the policy and procedure used to perform the OSHA-accepted Qualitative Fit Testing including donning instructions, sensitivity test, fit test, and required documentation.

10. Respiratory Training

a. During initial fit testing and annually thereafter, employees will receive training on:

i. OSHA Respiratory Protection Standard (29 CFR 1910.134)

ii. When and why respirators are necessary including identification of hazards, potential exposures to these hazards, and health effects of hazards

iii. Proper selection of respirators

iv. Procedure for inspecting the respirator, donning and removing it, checking the fit and seal, how to wear the mask, and troubleshooting

v. Consequences of improper fit, usage, and maintenance

vi. Limitations and capabilities of respirators

vii. How to use the respirator in emergency situations

viii. Proper procedure for maintenance and storage

ix. Recognition of medical signs and symptoms that limit or prevent

the usage of respirators

b. Circumstances which would require retraining include changes in the type of respirator used or if the employee has not retained the requisite understanding or skill to use the respirator properly.

11. Proper Respirator Use

a. Employees must use their respirators under conditions specified by the Respiratory Protection Program and in accordance with the training received during fit testing and annually thereafter.

b. The respirator must not be used in a manner for which it is not certified by NIOSH or by its manufacturer.

c. All employees shall conduct positive and negative pressure user seal checks each time they wear a respirator before entering an area of concern.

d. All employees shall leave a potentially contaminated work area immediately to change or remove their (N95-Disposable) respirator if the respirator is impeding their ability to work. Only remove the respirator when you are no longer exposed to the potential airborne hazard. This includes, but is not limited to, the respirator becoming damaged, soiled, or you experience problems with using the respirator (breathing becomes difficult, dizziness, irritation).

e. N95 respirators only filter out particulate contaminants and do not protect you from chemical vapors, gasses, asbestos, and high-risk aerosol-generating procedures.

f. Only use the respirator model, size, and manufacturer for which you have been fit-tested.

g. Do not use N95 respirators with beards or other facial hair that interferes with the direct contact between your face and the sealing surface of the respirator.

12. Cleaning and Storage and Inspection of Respirators

a. Cleaning

N95 Particulate Respiratory masks are disposable and should be discarded at the end of the work day or if they become dirty, damaged, or difficult to breathe through. Discard respirator as contaminated waste.

b. Storage

i. All respirators will be stored in the clean linen room so that they are protected against damage, contamination, dust, sunlight, extreme temperatures, excessive moisture, and damaging chemicals.

ii. Each respirator should be positioned in the box that it came in so that it retains its natural configuration.

c. Inspection

All respirators must be inspected before each use. Respirators that fail to pass inspection or are otherwise found to be defective must be discarded.

13. Documentation and Recordkeeping

a. The Infection Control Officer must maintain a copy of the OSHA Respiratory Medical Evaluation Questionnaire in the employee health file (and annually thereafter), and the Fit Test Record that includes:

i. Name of the person tested

ii. Type of fit test performed

iii. Make, model, and size of the respirator fitted

iv. Date of fit test

v. Pass or fail results

b. Fit test records must be maintained to determine whether annual fit testing has been completed and to assure employees are issued the correct replacement respirators. The completed medical forms, documented medical recommendations, and fit test records are confidential and will be maintained for the duration of the employment of the individual plus thirty years as required under Standard 29 CFR 1910.134.

14. Program Evaluation

The Infection Control Officer will conduct evaluations of the Respiratory Protection Program as necessary to ensure that the provisions of the current written respirator program are being properly implemented for all employees required to use respirators. Evaluations must be conducted to ensure the continued effectiveness of the training program and to determine if the respirator

is being worn accurately under the correct conditions.

References

Product Insert, Kimberly Clark Professional Qualitative Fit Test Kit, www.kcprofessional.com. Product Insert, MOLDEX N95 Particulate Respirator and Surgical Mask, Moldex-Metric, Inc. 10111 W. Jefferson Blvd, Culver City, CA 90232; NIOSH Respiratory Protection Program (http://www.cdc.gov/niosh/topics/respirators/); U.S. Department of Labor, Occupational Safety and Health Administration. Standard 29 CFR 1910.134, Respiratory Protection Standard. Directive Number: CPL 2-2.54A; US Department of Health and Human Services, 1999, OSHA Technical Manual: Respiratory Protection 29 CFR 1910.134; (http://www.osha.gov/SLTC/etools/ respiratory/ osha files/otherdocs.html); Yakima Indian Health Service Policy and Procedure, Respiratory Protection Program, Jackie Follansbee RN-BSN MBA, Infection Prevention Officer YSU

XX. N95 Respirator Fit Testing

A. The Occupational and Safety Health Administration (OSHA) requires that wearers be fit tested with respirator masks before use according to the Respiratory Protection Standard, 29CFR1910.134. Depending on job description, N95 Particulate Respirators are considered personal protective equipment and will be worn during tasks such as entering isolation rooms and other activities involving close contact with potentially infected persons. A medical evaluation is required before fit testing health care workers with the respirator mask and employee will follow the policies and procedure.

B. Background

1. The N95 Particulate Respirator and Surgical Mask used at SCHC have been tested and certified by NIOSH to have filter efficiency level of 95% or greater against particulate aerosols free of oil. It is fluid resistant and meets CDC guidelines for TB exposure control. As a respirator, it is intended to minimize wearer exposure to airborne particles in a size range of 0.1 to >10.0 microns. It also provides >99% Bacterial Filtration Efficiency (BFE) against wearer-generated microorganisms.

2. This respirator does not supply oxygen and must not be used in atmospheres containing less than 19.5% oxygen

C. Donning Instructions for the N95 Particulate Respirator and Surgical Mask

1. Cup the respirator in your hand with the molded nose contour nosepiece (narrow end) at fingertips, allowing the headbands to hang freely below hands.

2. Position the respirator under your chin with the nosepiece (narrow end) up. (Nose cushion must not be creased inside respirator).

3. Pull the top strap over your head so it rests high on the back of head.

4. Pull the shorter bottom strap over your head and position it around neck below ears. Do not wear with only one strap because it may affect the fit.

5. Adjust respirator for comfortable fit. Using two hands mold the nosepiece to the shape of your nose by pushing inward while moving fingertips down both sides of the nosepiece. Continue to adjust the respirator and secure the edges until you feel you have achieved a good facial fit. (Note: Pinching the nosepiece using one hand may result in less effective respirator performance).

D. Directions for User Seal Checking (Face Fit)

1. User Seal Checking is intended to help the wearer verify that he or she has properly donned the respirator. The respirator should be checked before each use. User seal checking is not a substitute for fit testing. To check fit:

   a. The wearer should place both hands completely over the respirator; inhale and exhale sharply several times. The respirator should collapse slightly when inhaling and bulge out slightly upon exhaling. A negative pressure should be felt inside the respirator. The wearer should not feel any air leaking between his or her face and the respirator.

   b. If air leaks around your nose, adjust the nosepiece. If air leaks at respirator edges, adjust the straps back along the sides of your head and recheck.

   c. Repeat until sealed properly, otherwise see your supervisor. Entry into a contaminated area with an improper fit may result in sickness or death.

2. If the wearer is having a problem successfully "User Seal Checking" the respirator, he or she should try the following:

   a. Use a mirror while adjusting the respirator

   b. Ask someone to look for hair or earrings that might be caught in the seal

   c. Make sure the headbands are positioned properly

3. To remove mask, cup the respirator in your hand to maintain position on face. Pull bottom strap over the head, then pull top strap over the head.

E. Qualitative Fit Testing of the N95 Particulate Respirator and Surgical Mask

1. The 3M FT-10 Qualitative Fit Test Apparatus (saccharin-based and BITREX) is being used to test N95 Particulate Respirators. The kit meets the performance

criteria for fit testing respirators under the current OSHA Standard for Respiratory Protection 29 CFR 1910.134. Qualitative Fit Testing consists of two parts: A Threshold/Sensitivity Test and a Fit Test.

2. Manufacture instructions for use will be followed and used as step by step instructions by the Infection Control Officer or delegate when performing Qualitative Fit Testing of N95 Particulate Respirator and Surgical Masks.

References

Product Insert, Kimberly Clark Professional Qualitative Fit Test Kit, www.kcprofessional.com. Product Insert, MOLDEX N95 Particulate Respirator and Surgical Mask, Moldex-Metric, Inc. 10111 W. Jefferson Blvd, Culver City, CA 90232. Occupational Safety and Health Administration (OSHA) Standard for Respiratory Protection: 29 CFR 1910.134. https://www.osha.gov/ National Institute for Occupational Safety and Health (NIOSH) Standard for Respiratory Protection: NIOSH 42 CFR 84, www.cdc.gov/niosh Yakama Indian Health Service Policy and Procedure, Respiratory Protection Program, Jackie Follansbee RN-BSN MBA, Infection Prevention Officer YSU

XXI. Hazard Communication Standard

A. Policy

1. To ensure that information about the dangers of all hazardous chemicals used by SCHC are known by all affected employees, the following hazardous information program has been established. Under this program, the employees will be informed of the contents of the OSHA Hazard Communications standard, the hazardous properties of chemicals with which they work, safe handling procedures, and measures to take to protect themselves from these chemicals.

2. This program applies to all work operations where an employee may be exposed to hazardous chemicals under normal working conditions or during an emergency situation. All work units will participate in the Hazard Communication Program. Copies of the Hazard Communication Program are available in the Human Resources Department for review by any interested employee.

3. Human Resources Manager is the program coordinator, with overall responsibility for the program, including reviewing and updating this plan as necessary.

B. Container Labeling

1. Receiving staff will verify that all containers received for use include the following:

   a. Label that describes the contents

   b. Appropriate hazard warning

c. Manufacturer's name and address

2. The maintenance in each section will ensure that all secondary containers are labeled with either an extra copy of the original manufacturer's label or with labels marked with the identity and the appropriate hazard warning. For help with labeling, see lead maintenance staff.

C. Safety Data Sheets (SDSs)

1. The QI Coordinator is responsible for establishing and monitoring the SDS program to include:

   a. Ensuring that procedures are developed to obtain the necessary SDSs.

   b. Reviewing incoming SDSs for new or significant health and safety information.

   c. Communicating new information to affected employees

2. When an SDS is not received at the time of initial shipment search for the SDS online.

3. Copies of SDSs for all hazardous chemicals to which employees are exposed or are potentially exposed will be kept in the laboratory, dental, medication room, and maintenance.

4. SDSs will be readily available to all employees during each work shift. If an SDS is not available, contact the QI Coordinator.

5. SDSs will be readily available to employees in each work area using the following format: SDS books – paper copies.

6. When revised SDSs are received, the following procedures will be followed to replace old SDSs: remove old SDS and replace with current SDS. Staff in each area that are responsible for receiving and unpacking inventory are responsible for updating SDS book in their respective area.

D. Employee Training and Information

1. Human Resources is responsible for the Hazard Communication Program and will ensure that all program elements are carried out.

2. Everyone who works with or is potentially exposed to hazardous chemicals will receive initial training on the hazard communication standard and this plan before starting work. Each new employee will attend a health and safety orientation that includes the following information and training:

a. An overview of the OSHA hazard communication standard

b. The hazardous chemicals present at his or her work area

c. The physical and health risks of the hazardous chemicals

d. Symptoms of overexposure

e. How to determine the presence or release of hazardous chemicals in the work area

f. How to reduce or prevent exposure to hazardous chemicals through use of control procedures, work practices, and personal protective equipment

g. Steps the employer has taken to reduce or prevent exposure to hazardous chemicals

h. Procedures to follow if employees are overexposed to hazardous chemicals

i. How to read labels and SDSs to obtain hazard information

j. Location of the SDS file and written Hazard Communication program

3. Prior to introducing a new chemical hazard into any section of this company, each employee in that section will be given information and training as outlined above for the new chemical hazard. The training format will be as follows: in-service for all staff using new chemical prior to use.

E. Information for Contractors

1. It is the responsibility of the Lead Maintenance Worker to provide contractors with information about hazardous chemicals their employees may be exposed to on a job site and suggested precautions for employees. It is the responsibility of the Lead Maintenance Worker to obtain information about hazardous chemicals used by other contract employers to which employees of the clinic may be exposed.

2. Contractors will be provided with SDSs for hazardous chemicals generated by this company's operations in the following manner: Notified of location of SDS book.

F. List of Hazard Chemicals

1. A list of all known hazardous chemicals used by the employees is kept in the form of SDS books kept in locations hazardous chemicals are used.

2. When new chemicals are received, the SDS book is updated (including date the chemicals were introduced) within 30 days.

XXII. Medical Instrument Sterilization

A. Purpose

The purpose of this policy is to provide current recommendations from the Centers for Disease Control and Prevention (CDC) regarding cleaning, disinfecting, and sterilization of patient care equipment, instruments, and the patient care environment. It provides reference to websites where the most up-to-date information should be available.

B. Policy

It is the policy of the Siletz Community Health Clinic (SCHC) that all reusable instruments, equipment, and environmental surfaces will be decontaminated, disinfected, and sterilized prior to use on patients.

C. Definitions

1. Biological Indicator: A sterilization process monitoring device consisting of standardized, viable population of micro-organisms (usually bacterial spores) known to be resistant to the mode of sterilization being monitored. Biological indicators are intended to demonstrate whether the conditions were adequate to achieve sterilization.

2. Chemical Indicator: A system that reveals change in one or more predefined process variables based on a chemical or physical change resulting from exposure to a process.

3. Cleaning: The removal of all soil from surfaces. This can be accomplished by using water with detergents. Thorough cleaning is necessary before proceeding to high-level disinfection and sterilization. This includes pre-cleaning, manual/ultrasonic, washer/sterilizers, decontaminators, or point of use cleaning/disinfection processes.

4. Disinfection: A process that kills or destroys many or all disease-producing microorganisms on the inanimate object. It usually does not kill spores.

5. High Level Disinfection: A process that destroys all vegetative microorganisms, tubercle bacilli, fungi, non-lipid and small viruses and medium-sized viruses with the exception of high numbers of bacterial spores through a chemical process.

6. MDRO: Multi-Drug Resistant Organism.

7. Sterilization: The complete elimination and destruction of all forms of microbial life by physical or chemical procedures.

D. Introduction

Department supervisors are responsible for the overview of the sterilization program and the assignment of appropriately trained staff to perform sterilization duties.

E. Determine the Appropriate Category for the Article to be Cleaned and Disinfected and the Level of Disinfection that is Indicated

1. CLASS I – CRITICAL

Sterility is the standard for any instrument which can be introduced into the bloodstream or through the patient's skin or into other normally sterile areas.

2. CLASS II - SEMI-CRITICAL

Items requiring high-level disinfection include instruments which come into contact with intact mucous membranes but do not penetrate body surfaces.

3. CLASS III - NON-CRITICAL

Items which do not touch patients or touches only intact skin and rarely, if ever, transmits infection. These items include countertops, crutches, blood pressure cuffs, stethoscopes, and chin and forehead rests. Routine cleaning with soap and water is sufficient. Alcohol or a facility approved disinfectant will be used to clean the surface of these items between patients if they are not visibly soiled.

4. SINGLE-USE (SUDS)

SUDS are labeled by the manufacturer for a single use and do not have reprocessing instructions. They may not be reprocessed for reuse except by entities which have complied with FDA regulatory requirements and have received FDA clearance to reprocess specific SUDs.

F. Disinfection

1. Destruction of pathogenic and other kinds of microorganisms by physical or chemical means. Disinfection is less lethal than sterilization, because it destroys most recognized pathogenic microorganisms, but not necessarily all microbial forms, such as bacterial spores. Disinfection does not ensure the margin of safety associated with sterilization processes.

2. The Environmental Protection Agency (EPA) classifies sterilization products sporicidal as sterilizing agents. Defined levels of disinfection are based upon (1)

the biocidal activity of an agent against bacterial spores, tubercle bacilli, vegetative bacteria, and viruses and (2) the contact time of the solution.

a. Sterilization. The use of a physical or chemical procedure to destroy all microorganisms including large numbers of resistant bacterial spores.

b. High-Level Disinfectants (Sterilizing Agents). A disinfection process that inactivates vegetative bacteria, mycobacteria, fungi, and viruses but not necessarily high numbers of bacterial spores. The FDA further defines a high-level disinfectant as a sterilant used under the same contact conditions except for a shorter contact time.

c. Intermediate-Level Disinfectants. A liquid chemical germicide registered by the EPA as hospital disinfectant and with a label claim of potency as a tuberculocidal.

d. Low-Level Disinfectants. A liquid chemical germicide registered by the EPA as a hospital disinfectant. OSHA requires low-level disinfectants also to have a label claim for potency against HIV and HBV if used for disinfecting clinical contact surfaces.

e. Sanitization. A process which removes gross debris and reduces the number of microorganisms on nonliving material.

G. Personal Protective Equipment (PPE)

1. Use PPE when cleaning an item for protection against exposure to the chemicals as directed by the Safety Data Sheets (SDS).

2. Traffic between the decontamination, preparation, and assembly areas should be minimized and employees should wash their hands upon leaving the area. See the Standard Precautions section of this policy.

H. Cleaning

1. The manufacturer's specifications for the quality of water used for cleaning should be followed (i.e., sterile, distilled, de-ionized).

2. Safely transport contaminated items to the sterilization room.

3. Following manufacturer's directions, immediately immerse contaminated items in an enzymatic disinfectant, or place immediately in an ultra-sonic cleaner.

4. Cleaning solutions and detergents should be used and discarded appropriately according to the manufacturer's directions.

5. Cleaning solutions and detergents should be compatible with the instruments and equipment for which they are used.

6. Appropriate sharps which are contaminated with blood or other potentially infectious materials should be placed in drainage type baskets prior to submerging in cleaning solutions. Sharps should not be stored or processed in a manner which requires employees to reach by hand into the container where these sharps have been placed.

I. Sterilization

1. Select the appropriate method of sterilization according to the instrument or equipment manufacturer's instructions. The sterilization process, including critical parameters (time, pressure, temperature) and chemical indicators, must be identified and followed accordingly. Refer to Operator's Manual.

2. Assure adequate drying time for instruments and equipment prior to packaging for sterilization.

3. Follow manufacturer's recommendations for the following items:

   a. Lubricants

   b. Type of wrap or container that may be used

   c. Shelf life and storage recommendations

   d. Wrapping of delicate instruments and sharp points

J. Monitoring

1. Mechanical (physical), chemical, and biological monitors must be used to assure that the sterilization process has been effective. In the event of a failed biological monitor, follow the Management of Positive Biological Indicator in a Steam Sterilizer section of this policy.

2. Monitors include time, temperature, pressure gauges, and displays. At the end of each cycle, the operator will examine the monitors to verify that all cycle parameters have been met.

3. Check steam integrators for adequacy of sterilization process.

4. Biological indicators are performed weekly when using autoclaves. Chemical indicators are placed in every package.

K. Loading of Sterilizer

1. Arrange on rack or carriage so as to present least possible resistance to the passage of steam.

2. Do not overload sterilizer; items should never touch sterilizer chamber walls.

3. When possible, sterilize like materials together.

4. Basins and trays must be set on edge or upside down so air will flow out freely as steam flows in.

L. Removing Load from Sterilizer

1. Load should be dry and cool when removed.

2. If packs are wet when removed, they must be re-sterilized.

3. Check the chemical and process biological monitor to ensure proper temperature and exposure time has been met.

M. Documentation

Package identification should include which sterilizer was used, date of sterilization, and initials of processor. In addition, generalized contents should be labeled on wrapped packaging.

N. Supply and Equipment Management

1. Integrity of clean and sterile equipment and supplies shall be assessed prior to use.

2. Packaging will be considered non-sterile (compromised) when the following events occur and will not be used:

   a. Holes or tears

   b. Broken or no seal

   c. Dropped

   d. Moisture

   e. Unsealed dust cover

   f. Broken tape

g. Lids improperly applied

3. Store items in a manner that prevents crushing or binding together

4. Place lighter items on heavier ones

5. Store items in closed cabinets; if this is not possible, store items on wire shelves in a restricted storage area with the bottom shelf being solid

6. Store materials at least 18" below the ceiling and sprinkler head

7. Do not store sterile items under plumbing values and traps

O. Cleaning Non-Critical Patient Care Items

1. All non-disposable patient care equipment shall be cleaned the same regardless of the patient's infection status

2. In the exam rooms of patients with MDROs, the amount of non-disposable equipment taken into the room shall be limited as much as feasible.

P. Safe Handling of Medical Devices

1. Medical devices that need to be sent to an external vendor for reprocessing, inspection, or repair must first be decontaminated to ensure the safety of all who come into contact with the device. Documentation of pre-cleaning to return the device to a non-infectious state is required prior to transport and handling or packaging of the device.

2. Follow the manufacturer's recommendations for disinfection, as different devices will have separate pre-cleaning requirements. A log should be kept to track the vendor, type of disinfection, and date of return to service of the device.

Q. Proper Storage of Sterile Items

1. Sterile items and disposable (single-use) items should be stored in an enclosed storage area (e.g., cabinet or drawer). Dental and medical supplies and instruments should not be stored under sinks, on windowsills, or adjacent to air vents. Conditions in these areas can compromise the sterility of the packages and instruments

2. Clean and sterile materials should be stored at a height of 8 to 10 inches high from the floor and 18 inches under the ceiling

R. Shelf Life of Sterilized Instruments

1. Sterilized instruments should be stored in a manner that preserves the integrity of the packaging material. Storage practices can be either date or event related. Date every sterilized package and use shelf-life practices (first in, first out). This approach recognizes that the product should remain sterile until some event causes the item to become contaminated (e.g., a package becomes torn or wet).

2. The quality of the packaging material, the conditions under which items are stored and transported, and the amount that they are handled all affect the chances that the package and its contents will remain sterile.

3. All packages containing sterile items should be inspected before use to verify barrier integrity and dryness. Any package that is wet, torn, dropped on the floor, or damaged in any way should not be used. The instruments should be re-cleaned, packaged in new wrap, and sterilized again.

4. Sterile packages should not be handled unnecessarily so that contamination can be avoided.

References

Appendix C: Methods for Sterilizing and Disinfecting Patient-Care Items and Environmental Surfaces (http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5217a4.htm); Association for the Advancement of Medical Instrumentation. (2010). ANSI/AAMI ST79 Comprehensive Guide to Steam Sterilization and Sterility Assurance in Health Care Facilities. Washington, D.C. Block, S.S. "Chemical and Physical Sterilization," Disinfection, Sterilization and Preservation, 3rd edition, Lea & Febinger, Philadelphia, 1983; OSHA Quick Facts- Laboratory Safety Autoclaves/Sterilizers https://www.osha.gov/Publications/laboratory/OSHAquickfacts-lab-safety-autoclaves-sterilizers.pdf OSHA's Personal Protective Equipment standard (29 CFR 1910.132); Rutala W.A., Weber D.J., and the Hospital Infection Control Practices Advisory Committee. (2008). Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008. Centers for Disease Control and Prevention: Atlanta, Georgia; Rutala W.A., and Weber D.J., "Disinfection and Sterilization in Healthcare Facilities: What Clinicians Need to Know", Clinical Infectious Diseases (2004);39:702-9; Owner's Manual, M11 Autoclave and Biosonic UC125 ultrasonic Cleaning System Guidelines for Infection Control in Dental Health-Care settings, 2003, MMWR, December 19, 2003:52 (RR-17)

XXIII. Management of a Positive Biological Indicator in a Steam Sterilizer

A. Purpose

To monitor the adequacy of sterilization of all reusable instruments and equipment and to ensure the proper corrective action is taken when a "Positive Biological Indicator" occurs.

B. Definitions

1. Biological Indicator (BI): A sterilization process monitoring device consisting of standardized, viable population of microorganisms (usually bacterial spores) known to be resistant to the mode of sterilization being monitored. Biological indicators are intended to demonstrate whether the conditions were adequate to achieve sterilization.

2. Positive Biological Indicator: Failure of a load to be properly sterilized as indicated by the lack of a color change in the "Accept" window of the chemical integrator

C. Biological Indicators

1. Biological indicators (BI) provide direct evidence that the sterilization process conditions are able to kill spores.

2. A negative BI result indicates conditions were adequate to achieve sterilization.

3. A positive BI result indicates a failure of the sterilization process.

D. Procedure

1. When Biological Indicators are Positive

a. Take the sterilizer out of service.

b. Notify Nursing Supervisor and Infection Control Officer.

c. Repeat biological indicator test in three consecutive sterilizer cycles. If additional spore tests remain positive, the items should be considered non-sterile, and supplies processed since the last acceptable (negative) biological indicator must be recalled. The items from the suspect loads will be recalled and reprocessed.

d. Check to ensure the sterilizer was used correctly (i.e., verify correct time and temperature setting, refer to department procedure manual). If not, repeat using appropriate settings and recall and reprocess all inadequately processed items.

e. Check with maintenance for irregularities (e.g., electrical) or changes in the clinic steam supply (i.e., from standard ≥ 97% steam, < 3% moisture). Any abnormalities should be reported.

f. Check to ensure the biological indicator was used and interpreted appropriately. If not, repeat using appropriate settings.

g. If all three repeat biological indicators from three consecutive sterilizer cycles are negative, put the sterilizer back in service.

h. If one or more repeat biological indicators from the three consecutive sterilizer cycles are positive, do the following:

i. Request an inspection of the equipment by the Biomed Field Technician

ii. Discuss the abnormalities with the sterilizer manufacturer

iii. Repeat the biological indicator using a different manufacturer's indicator

REFERENCES

Bennett, G. & Kassai, M. (2011). Infection Prevention Manual for Ambulatory Surgery Centers. Rome, Georgia: ICP Associates.

Rutala, W.A., Weber, D. J., and the Healthcare Infection Control Practices Advisory Committee. (2008). Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008. Atlanta Georgia: Centers for Disease Control and Prevention.

XXIV. Isolation and/or Transfer of Patient (See Part 18, Section 18F Testing for COVID-19 Virus)

A. Policy

It is the policy of the Siletz Community Health Clinic (SCHC) to evaluate individuals known or suspected of having a communicable disease which can be transmitted via the airborne route; to have in place procedures to minimize the exposure to other patients and staff; and to implement preventive strategies to minimize the risk of transmission of infections when potential transmissible illnesses spread by contact, droplet, or airborne routes are suspected following CDC Guidelines for Isolation Precautions.

B. Definitions

1. Airborne Precautions: Apply to patients known or suspected to be infected with a pathogen that can be transmitted by airborne route

2. Contact Precautions: Apply to patients with the presence of stool incontinence, draining wounds, uncontrolled secretions, pressure ulcers, or presence of ostomy tubes and/or bags draining body fluids

3. Droplet Precautions: Apply to patients known or suspected to be infected with a pathogen that can be transmitted by coughs or sneezes causing droplets

4. MDRO = Multi-Drug Resistant Organism

5. MRSA = Methicillin Resistant Staph aureus

C. Assignment of Responsibility

1. It is the responsibility of the Medical Director and the Infection Control Officer to ascertain that resources and staff are available to implement Isolation and/or Transfer Plan (I&T Plan).

2. It is the responsibility of the Infection Control Officer, or designee, to implement the I&T Plan and to educate staff.

3. It is the responsibility of each staff member to understand the information in the I&T Plan and to follow the outlined procedures.

D. Isolation Management of Patients with Transmissable Disease

1. Patient Scheduling and Triage

a. Reception room staff should be alert to patients presenting with symptoms of active infection such as fever, generalized rash, respiratory symptoms, draining wounds, skin lesions, lice, or new onset of diarrheal illness.

b. Patients will be asked if they have a history of Methicillin Resistant Staph Aureus (MRSA) or another type of Multi-drug Resistant Organism (MDRO)

c. Patients who report to the Dental Clinic with a contagious disease (i.e., Group A Strep, etc.,) in conjunction with their dental problem, will receive only emergency dental care. The Dentist will take the necessary steps to protect himself or herself, the dental staff, and other patients when treating these patients.

d. Reception staff should notify the clinical staff of their observations of active infections to enable rapid placement into designated Procedure Room 150 for isolation until the physician or clinical staff can further evaluate the situation. Multiple patients with potential transmissible illnesses spread by airborne, contact, or droplet routes will be segregated, at least three feet away in the waiting area, or placed in another exam room if available.

i. Patients suspected of having any of the following diseases will be given a mask, instructed to perform hand hygiene using an alcohol based hand rub, and placed in Procedure Room 150 for isolation with the door closed until transfer for additional treatment at a receiving facility or discharge to home can be done:

A) Ebola Virus Disease (EBV): Contact and Droplet Precautions. Refer to the CDC website for the most current guidance and recommendations.

http://www.cdc.gov/vhf/ebolahcp/ index.html

B) Tuberculosis: Airborne Precautions. Wait an hour after the patient has left the room before reusing the room.

C) Chickenpox: Airborne and Contact Precautions. Use Contact Precautions if contact with active lesions is anticipated or to handle used linens.

D) Measles: Airborne Precautions. Do not place another patient in the room for two hours after the patient has left the area.

E) Mumps: Droplet Precautions

F) Rubella: Droplet Precautions

G) Bacterial meningitis: Droplet Precautions

H) Sars-COV-2 (COVID-19): Contact, Droplet, and Airborne Precautions. Refer to the CDC website for the most current guidance and recommendations.

https://www.cdc.gov/coronavirus/2019CoV/hcp/index.html

ii. Refer to the CDC's Guideline for Isolation Precautions: 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings for further information on isolation category requirements.

http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf

e. Staff will notify any receiving facility of the potential infectious disease so that appropriate precautions may be implemented.

f. Staff will implement appropriate barriers specific to the situation prior to transport (e.g., mask on patient, wound covered) and advise the persons doing the transport of these precautions.

g. Staff shall follow the Respiratory Hygiene and Cough Etiquette section of this policy as recommended by the CDC.

h. Supplies for respiratory hygiene (tissues, hand sanitizers, masks) shall be kept on a stand located near the reception desks and will be available for patient use as recommended by the CDC.

i. All patients will have any open wounds covered with an impermeable dressing that is clean and dry.

2. Providers shall be notified of positive laboratory results or concerns regarding appropriate treatment. Referring or receiving facilities should be notified of positive patient laboratory results.

E. Management of Patients with MRSA or Other MDROs

1. MRSA is usually spread by direct contact with an infected wound or from contaminated hands, usually those of healthcare providers. Also, people who carry MRSA but do not have signs of infection can spread the bacteria to others and potentially cause an infection.

2. Patients identified as having active or recent infections with MRSA or other MDROs will have such noted in the patient's electronic medical record.

3. Use Standard Precautions at all times for patients known to be infected or colonized with MRSA or target MDROs, making sure that gloves and gowns are used for contact with uncontrolled secretions, pressure ulcers, draining wounds, stool incontinence, and ostomy tubes and bags

4. If possible, the care provider should consider a private room or spatial separation of patients with potentially active MRSA or MDROs.

5. Shared patient care equipment and surfaces (e.g., exam tables, BP cuffs, and oximeters) should be cleaned and disinfected with an EPA and facility approved agent before reuse.

6. A hypochlorite-based germicidal agent should be used to disinfect items used by incontinent patients with known or suspected C. difficile infections.

7. Before use, care should be taken to assure disinfected equipment is compatible with the bleach solution.

8. Patients and families of patients with MRSA and MDROs shall be provided with written educational materials to inform them about the MDRO and control measures

References

Siegel, J. D., Rhinehart, E., Jackson, M., Chiarello, L. & the Healthcare Infection Control Practices Advisory Committee. (2006). Management of Multidrug-Resistant Organisms in

Healthcare Settings, 2006. Atlanta, Georgia: Centers for Disease Control and Prevention; Washington, D.C.: U.S. Department of Health & Human Services. Siegel, J. D., Rhinehart, E., Jackson, M., Chiarello, L., & the Healthcare Infection Control Practices Advisory Committee. (2007). 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. Atlanta, Georgia: Centers for Disease Control and Prevention. http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf
General Information About MRSA in Healthcare Settings, http://www.cdc.gov/mrsa/healthcare/index.html
Muto, C. A., Jernigan, J. A., Ostrowsky, B. E., Richet, H. M., Jarvis, W. R., Boyce, J. M., Farr, B. M. (2003). SHEA Guideline for Preventing Nosocomial Transmission of Multidrug-Resistant Strains of Staphylococcus aureus and Enterococcus. Infection Prevention & Hospital Epidemiology, 24, 362–386. Guide to Infection Prevention in Outpatient Settings http://www.cdc.gov/HAI/settings/outpatient/outpatient-care-gl-standared-precautions.html
Ebola Virus Disease (EVD), http://www.cdc.gov/vhf/ebola/hcp/index.html

XXV. Influx of Patients (See Part 18 COVID-19 for various pandemic related policies and procedures)

A. Policy

It is the policy of the Siletz Community Health Clinic (SCHC) that in an emergent outbreak situation the clinic will appropriately triage patients to an alternate level of care in the community when the need is greater than what the ambulatory clinic can provide. SCHC will receive patients in accordance with any outlined instructions per the Centers for Disease Control (CDC).

B. Identification of patients

Features that should alert the staff to the possibility of an influx of patients and potential outbreak include:

1. A rapid increase in disease incidence in a normally healthy population.

2. An unusual increase in the number of people seeking care, especially with fever, respiratory, or GI complaints.

3. Lower attack rates among people who have been indoors compared to those being outdoors.

4. Cluster of patients arriving from a single location.

5. Large numbers of rapidly fatal cases.

6. Any patient presenting with a disease that is relatively uncommon and has bioterrorism potential. (ie. anthrax, plague)

C. Procedure

1. When a staff member feels as though there is an influx of infectious patients based on the criteria list above they should bring this information to the Infection Control Officer and clinic leadership immediately.

2. To the extent possible, management of the influx of infectious patients will be conducted in accordance with the organization's emergency operations plan.

3. Clinic leadership will establish initial and ongoing contact with Lincoln County Public Health and IHS resources as appropriate to determine the specific nature and extent of the infectious issue:

    a. Community hospitals, clinics, and urgent care centers for Lincoln County Health Department (Lincoln County 541-265-4947)

    b. Emergency management systems for Lincoln County (541-265-4199)

    c. Center for Disease Control and Prevention (CDC) www.cdc.gov/nors

    d. Portland Area IHS epidemiologist (503) 416-3298

4. Based on information and recommendations from these agencies, the scope and depth of the planned response will be determined and appropriate measures will be implemented including:

    a. Designation of a location where infectious patients will be received and treated (on-site or off-site).

    b. Relocation of non-infectious patients from areas anticipated to receive incoming infectious patients. An area should be cleared of non-infectious patients and designated as the admission unit for the patients presenting to the clinic.

    c. Designation of providers and staff to see and treat infectious patients.

    d. A determination of supplies and equipment needed.

5. Elective procedures or screenings may be cancelled

    a. Consideration should be given to the impact of the infectious processes in the community where the patient will be discharged to determine if additional precautions are warranted.

    b. The need to maintain appropriate infection control precautions will be paramount during this type of emergency. Staff should be informed of

the following by clinic leadership before assuming care during the emergency:

i. The specific nature of the infectious process

ii. The mode of transmission

iii. What precautions need to be implemented to prevent cross contamination

iv. PPE required when in contact with infectious patients

v. The procedure for use and disposal of appropriate protective equipment

6. All waterborne, foodborne, and enteric disease outbreaks need to be reported to the CDC @ www.cdc.gov/nors

7. Daily and weekly briefings shall be conducted by leadership as appropriate until the situation is resolved.

8. Planning for influx of patients with potential infectious epidemic is monitored by:

a. Rapid response notification data received by CDC. This information will be obtained from the Portland area IHS epidemiologist.

b. Review urgent visits including symptoms and diagnosis.

c. Review of microbiology results.

XXVI. Post-Exposure Evaluation and Follow-Up Procedure to Communicable Disease

A. Employee Exposure to Meningitis

1. High-risk continual contact with a patient's respiratory secretions when the patient was potentially infectious.

2. Occurs when staff do not wear a mask while caring for a patient with meningococcal disease and has direct exposure to a patient's respiratory secretions. The infectious period starts seven days before onset of the patient's signs and symptoms, and ends 24 hours after the onset of effective antimicrobial therapy.

3. Procedure for Meningococcal Exposure

a. If an employee has a possible meningococcal exposure, the employee will

contact the supervisor for referral to appropriate evaluation and counseling.

b. Post-exposure prophylaxis should be received within 24 hours of exposure to the diagnosed of suspected case.

c. High-risk contact which requires post-exposure chemoprophylaxis includes:

i. Unprotected mouth-to-mouth resuscitation

ii. Unprotected suctioning or intubation

iii. Unprotected close inspection of the oropharynx, including obtaining nasopharyngeal or throat swab specimens

iv. Close, face-to-face contact with patient for more than four hours total

B. Employee Exposure to Pertussis (Whooping Cough)

1. Direct contact with respiratory secretions from an infectious patient with pertussis, face-to face exposure within three feet of a symptomatic patient, or sharing a confined space (within six feet) with an infectious patient for more than one hour while unmasked

2. Pertussis is highly contagious; the most infectious period begins two weeks prior to cough onset, and ends approximately two weeks after cough onset, or after five days of appropriate antimicrobial therapy

3. Procedure for Pertussis Exposure

a. Employees who believe they have been exposed to pertussis will contact their supervisor for referral to appropriate evaluation and counseling.

b. Laboratory testing or post-exposure chemoprophylaxis may be recommended if a high-risk exposure has occurred within 42 days (two maximum incubation periods).

C. Employee Exposure to Scabies

1. Defined as prolonged direct contact with infested skin. Transfer from garments and linens occur only if these have been contaminated by an infested patient immediately beforehand.

2. Scabies can be transmitted as long as the patient remains infested and

untreated.

3. Employees who may have been exposed to scabies will contact their supervisor for referral to appropriate evaluation and counseling. Transmission usually requires prolonged, close, personal contact with the infested patient. Only in unusual circumstances will prophylactic treatment be recommended.

4. Procedure for Scabies Exposure

   a. Employees with possible exposure to scabies must be watchful for symptoms and report to their supervisor if symptoms occur.

   b. The incubation period in people without previous exposure usually is four to six weeks.

   c. People with a previous history of infestation are sensitized and develop symptoms one to four days after re-exposure.

D. Employee Exposure to Varicella (Chickenpox)

1. Defined as face-to-face contact with a patient who has chickenpox during the infectious period, unprotected contact with articles freshly soiled by mucous membrane secretions from a patient with chickenpox or shingles (zoster), or unprotected contact with open vesicles of a patient with chickenpox or shingles. Patients with chickenpox are most contagious from two days before to shortly after the onset of rash. The infectious period persists until crusting of all lesions.

2. Employees who have followed isolation requirements for the patient with chickenpox or zoster are considered protected and do not require follow up.

3. Employees who have a clinical history of chickenpox or laboratory evidence of immunity to varicella are considered protected and do not require follow up.

4. Procedure for Varicella Exposure

   a. If an employee has a possible exposure to varicella and is unsure of his or her disease history, the employee will contact the supervisor for evaluation on the same or next business day to determine if an exposure has occurred and if laboratory evaluation is indicated.

   b. If an employee has no evidence of immunity, the employee will be provided with counseling regarding the potential for disease and possible work restriction.

   c. Susceptible employees will be vaccinated within three days of exposure. Varicella-zoster immune globulin (VZIG) will be considered if employee is

immunocompromised.

5. Procedure for COVID-19 Exposure

   a. If an employee experiences COVID-like symptoms while at work, they will be directed to isolate from staff/patients, be tested, then sent home pending results.

   b. Exposures to COVID-19 positive patients will be addressed using current OHA and CDC recommendations for healthcare workers exposed to COVID-19.

   c. See Part 18, Section 18H Occupational Health for further information.

E. Procedure for Employee Exposure to Other Communicable Diseases

1. If an employee is exposed to a communicable disease in the workplace, the employee is responsible to notify the supervisor and to document the exposure on an incident report form.

2. Consultation regarding exposure management and recommendations regarding possible work restriction is available from the local health department.

References

Bolyard, E.A., Tablan, O.C., Williams, W.W., Pearson, M.L., Shapiro, C.N., Deitchman, S.D. & the Hospital Infection Control Practices Advisory Committee. (1998). Guidelines for Infection Control in Health Care Personnel, 1998. *American Journal of Infection Control*, 26, 289-354; Centers for Disease Control & Prevention. (1997). Immunization of Health Care Workers: Recommendations of the Advisory Committee on Immunization Practices (ACIP) and the Hospital Infection Control Practices Advisory Committee (HICPAC). *Morbidity and Mortality Weekly Report*, 46(RR-18), 1-42; Centers for Disease Control & Prevention. (2005). Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005. Morbidity and Mortality Weekly Report, 54(RR-17); Oregon Patient Safety Commission Infection Prevention and Control Toolkit. oregonpatientsafety.org; Panlilio, A.L., Cardo, D.M., Grohskopf, L.A., Heneine, W., & Ross, C.S. (2005). Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Postexposure Prophylaxis. Morbidity and Mortality Weekly Report, 54(RR09), 1-17.

XXVII. Outbreak Identification and Management Policy

A. Purpose

To standardize the action steps needed if an outbreak of healthcare-associated infections (HAIs) or adverse events occur or when an unusual microbe or adverse event is recognized. The goal of any outbreak investigation is to identify probable contributing factors and to stop or reduce the risk for future occurrences following the most recent APIC Guidelines.

http://www.apic.org/

B. Procedure

1. Healthcare-Associated Outbreaks

a. Healthcare-associated outbreaks are often multifactorial and may be associated with:

i. Lapses in infection prevention or clinical practices

ii. Contaminated or defective products or devices

iii. Colonized or infected healthcare personnel

iv. Patients or visitors who have, or are harboring an infectious disease

2. Recognition of a Suspected Outbreak and Notification

a. Any employee who becomes aware of a possible outbreak or cluster of infections should immediately report this to the supervisor and the Infection Control Officer.

b. The Medical Director and Nursing Supervisor should also be notified.

c. An outbreak investigation team and team leader should be identified.

3. Initial Investigation

Outbreaks generally do not unfold in a linear or orderly manner. Thus, not all of the actions described below will be applicable to all situations and many of the steps may occur simultaneously. Each outbreak shall be handled on a case by case basis. It is recommended that the infection control officer do the following:

a. Confirm the presence of an outbreak, which might include laboratory confirmation.

b. Alert key partners about the investigation, which might include the notification of appropriate state and local entities.

c. Determine if immediate control measures are needed and implement accordingly.

d. Establish a preliminary working case definition using a PDSA report. This may be refined during the investigation.

e. Review charts, laboratory results, and information obtained from medical providers and involved patients or families.

f. Survey for additional cases linked to the outbreak and for the onset of new cases.

g. Gather data

i. Provide patient name and medical record number

ii. Room number patient was in

iii. Date and time of appointment

iv. Date of infection onset

v. Site culture results

vi. Identify physicians, nurses, and other staff who had contact with the patient

vii. Provide any other pertinent information

h. Observe and review potentially implicated patient care activities, such as hand hygiene, standard precautions, etc.

i. Consider whether environmental sampling or additional facility testing (e.g., disinfection) should be performed.

j. The presumptive hypotheses for the mode of transmission of the organism and other circumstances will be developed by the team. Procedures for testing the hypotheses will be outlined.

k. If necessary, refine the case definition, continue case finding and surveillance, and refine control and prevention measures to prevent further or future illness.

l. If the cause of the infection is not evident as a result of the above investigation, seek expert consultation.

4. Communication During and After an Outbreak

a. The Infection Control Officer will ensure that the Medical Director, providers, administration management, healthcare personnel, and others as needed will be kept abreast of developments and findings and should be queried regularly on any additional thoughts or insight they might

have.

b. Decisions about whether to notify patients about an outbreak will be made on a case-by-case basis.

c. Decisions regarding personnel cultures, work restrictions, or the impounding or quarantine of patient care items will be carefully communicated.

5. Conclusion of the Investigation

a. The investigation will continue as long as there are cases of the infection occurring above the endemic level.

b. A final written report of the investigation that outlines findings and recommendations should be prepared by the Infection Control Officer.

c. The report should be presented to the committee charged with overseeing the infection control program, all attending providers, and healthcare team. Notify the area epidemiologist.

References

Association for Professionals in Infection Control and Epidemiology, Inc. (2009). APIC Text of Infection Control and Epidemiology, 3rd Edition; APIC Guidelines. http://www.apic.org

XXVIII.TB Exposure Control Plan

A. Policy

It is the policy of the Siletz Community Health Clinic (SCHC) that all employees will be screened for tuberculosis at hire and upon known or suspected exposure. The need for serial or additional screening will be based upon findings from the risk assessments. Additionally, the SCHC may evaluate individuals known or suspected of having communicable disease transmitted via the airborne route, including Tuberculosis (TB), and, therefore, will have in place procedures to minimize the exposure of other patients and staff. Employees will receive training to assure they have a baseline understanding of the nature of control and prevention of tuberculosis in a low risk clinic setting.

B. Employee Training

1. All employees will receive training on TB exposure and control procedures. Such training will occur at the time of initial employment and annually thereafter.

2. The Infection Control Officer will conduct the training.

C. Assignment of Responsibility

1. It is the responsibility of the Medical Director and the Infection Control Officer to ascertain that resources and personnel are available to implement the TB Exposure Control Plan (TB/ECP).

2. It is the responsibility of the Infection Control Officer, or designee, to implement the TB/ECP and to educate staff.

3. It is the responsibility of each staff member to understand the information in the TB/ECP and to follow outlined procedures.

4. The TB/ECP will be kept in the Infection Control Policy and Procedure Manual. Copies are in the office of the Infection Control Officer and QI Coordinator and will be available to employees at all times.

D. Epidemiology, Transmission, and Pathogenesis of Tuberculosis

1. TB is a communicable disease caused by the microorganism *Mycobacterium tuberculosis*. With medical treatments for TB introduced in the 1940's there was a steady decline in cases in the US from 1953 through 1984. However, from 1985 through 1994, the number of cases of TB rose by 20%. Since 1993, the numbers have again declined. TB affects racial/ethnic minorities disproportionately; Native Americans are 5 times more likely to have TB (CDC August 1999). TB is reported in all 50 states, with a concentration of cases in urban areas. Resistance to anti-TB drugs is a public health concern. An estimated 10-15 million people in the US are infected with TB.

2. TB is spread primarily by tiny airborne particles (droplet nuclei) that are expelled by a person with infectious TB. This can occur when a person with pulmonary TB coughs, sneezes, speaks, or sings. The droplet nuclei can remain airborne for up to several hours. If another person inhales air containing these droplet nuclei, transmission may occur. The probability that TB will be transmitted depends on the infectiousness of the person with TB, the environment in which the exposure took place, the duration of the exposure, the virulence of the organism, and the susceptibility of the exposed individual.

3. Infection begins when the bacilli become lodged in the lower respiratory tract (lung alveoli) and multiply. Once in the lung, the organism can be spread throughout the body. The incubation period from time of infection to the point when a TB test will show a positive reaction is generally 4-12 weeks. Within 2-10 weeks after infection, the immune system is usually able to prevent further spread.

4. Persons who are infected but do not have TB disease are asymptomatic and not infectious. They are not designated as "TB case" but may be referred to as

having latent TB infection. In the US about 5% of infected persons who are untreated will develop TB disease within the first two years; another 5% will develop TB disease at some time in life. Risk is higher for immunocompromised people (i.e. those with HIV infection). The majority of TB cases are pulmonary, but TB can occur nearly anywhere in the body or as disseminated disease. The period of communicability of TB is, theoretically, as long as bacilli are being expelled in the sputum. Inadequately or poorly treated individuals can remain communicable for years.

5. Signs and symptoms of TB may include productive prolonged cough (duration >3 weeks), bloody sputum, fever, weakness, weight loss, fatigue, loss of appetite, and night sweats.

6. Persons at higher risk for exposure to or infection with TB include close contacts of people with known or suspected TB (i.e. same household or shared enclosed environments), foreign-born persons from areas with high TB rates (i.e. Asia, Africa, Latin America, Eastern Europe), residents or employees of high risk institutions (i.e. correctional facilities, nursing homes, homeless shelters), and health care workers who serve high-risk clients.

E. Risk Assessment

1. All staff is included in a comprehensive TB control program that includes employee screening, TB testing, and education. Baseline testing with TST or IGRA blood test for M. tuberculosis infection will be administered for all newly hired employees, regardless of the facility risk classification. Two-step TST testing will be the primary testing method used by SCHC. Those who have had a prior positive PPD will be evaluated to determine the need for annual chest x-rays.

2. The annual facility TB risk assessment is completed by the Infection Control Officer and submitted to the Infection Control Committee. The risk assessment is maintained in the QI Coordinator's office. A facility is rated as minimal, very low, low, intermediate, or high-risk area based on the criteria listed below:

   a. Minimal Risk Areas

      i. Facility does not admit TB patients to inpatient or outpatient.

      ii. Facility is located in a community or county in which no TB cases have been reported in the past year.

         A) **Required Action:** Annual risk assessment.

b. Very Low Risk Areas

i. Facility does not admit TB patients to inpatient areas, but may initially assess, evaluate, or manage TB patients in the outpatient setting.

ii. Patients who are known or suspected to have active TB and need inpatient care are promptly referred to a collaborating facility.

iii. Appropriate for outpatient facilities that do not do initial assessment for TB, but do screen patients.

A) **Required Action:** Annual risk assessment and TB ECP guidelines.

c. Low Risk Areas

i. PPD conversion rate in employees is no greater than in areas without occupational exposure.

ii. There are no clusters of TB test conversions (two positive PPDs within a three-month period).

iii. There are less than three TB cases seen per year.

A) **Required Action:** Annual risk assessment, TB ECP guidelines, annual PPD testing of moderate to high-risk employees.

d. Intermediate Risk Areas

i. PPD conversion rate in employees is not greater than in areas without occupational exposure.

ii. There are no clusters of TB test conversions.

iii. Three or more TB cases are seen per year.

A) **Required Action:** Risk assessment and PPD testing of employees every six months.

e. High Risk Areas

i. PPD conversion of employees is higher than that of groups without occupational risk.

ii. Clusters of TB test conversions have occurred.

A) **Required Action:** Risk assessment and PPD testing every three months.

Note: No cough inducing or aerosol-generating procedures are performed on patients.

F. Tuberculosis Screening

1. Baseline Testing

a. Baseline test results provide a basis for comparison in the event of a potential or known exposure to M. tuberculosis and facilitate the detection and treatment of LTBI or TB disease in employees before employment begins and reduces the risk to patients and other employees

b. Baseline testing with TST or BAMT for M. tuberculosis infection will be administered for all newly hired employees, regardless of the facility risk classification.

c. Two-step TST testing will be the primary testing method. All employees will complete a symptom screening:

i. At hire

ii. Known exposure

iii. Potential exposure

d. All results of TST testing will be interpreted using the recommended diagnostic cut points listed in this document.

e. Two-step TST testing will be done for employees whose initial TST results are negative.

f. The second-step TST should be administered 1–3 weeks after the first TST result was read as negative.

SCHC employees have the option to consent to an Interferon Gamma Release Assay (IGRA) blood test in lieu of the 2 step skin test. Cost of this test will be covered by SCHC. Employee will have to complete SCHC patient registration packet in order to have blood test processed by reference lab.

g. If either the baseline first-step TST or the second-step TST result is positive, TB disease should be excluded, and if it is excluded, then the

employee should be evaluated for treatment of LTBI.

h. If the first and second-step TST results are both negative, the person is classified as not infected with M. tuberculosis.

i. If the second test result of a two-step TST is not read within 48–72 hours, administer a TST as soon as possible (even if several months have elapsed) and ensure that the result is read within 48–72 hours.

j. A positive TST test result for M. tuberculosis infection in an employee with previous BCG vaccination should be interpreted as representing infection with M. tuberculosis (BCV vaccination wanes after 5 years). Test results for M. tuberculosis infection for employees with a history of BCG should be interpreted by using the same diagnostic cut points used for those without a history of BCG vaccination.

k. A single TST test can be administered when the employee has a documented negative TST within the past 12 months. This additional TST represents the second stage of two-step testing.

l. Additional tests for M. tuberculosis infection do not need to be performed for an employee with a documented history of TB disease, documented previously positive test result for M. tuberculosis infection, or documented completion of treatment for LTBI or TB disease.

m. If previous positive result is not documented, employees should undergo baseline testing for M. tuberculosis infection to ensure that the test result has been performed and measured using the recommended diagnostic procedures.

n. Completion of testing will be documented within 30 days of first patient contact.

2. Serial Testing

a. The need for serial follow-up screening for groups of employees with negative test results for M. tuberculosis infection is an institutional decision that is based on the setting's risk classification.

b. If a serial follow-up screening program is required, the risk assessment for the setting will determine which employees should be included in the program and the frequency of screening.

c. Two-step TST testing should not be performed for serial or follow-up testing.

d. If possible, stagger follow-up screening (rather than testing all employees at the same time each year) so that all employees who work in the same area or profession are not tested in the same month.

3. Workplace Restrictions

a. Employees with confirmed infectious pulmonary, laryngeal, endobronchial, or tracheal TB disease, or a draining TB skin lesion pose a risk to patients, employees, and others. Such employees should be excluded from the workplace and should be allowed to return to work when the following criteria have been met (obtained through employee's primary care provider):

i. Three consecutive sputum samples collected in 8–24 hour intervals that are negative, with at least one sample from an early morning specimen (because respiratory secretions pool overnight).

ii. The person has responded to anti-tuberculosis treatment that will probably be effective (can be based on susceptibility results).

iii. The person is determined to be noninfectious by a physician knowledgeable and experienced in managing TB disease.

b. Employees with extra-pulmonary TB disease usually do not need to be excluded from the workplace as long as no involvement of the respiratory track has occurred. They can be confirmed as noninfectious and can continue to work if documented evidence is available that indicates that concurrent pulmonary TB disease has been excluded.

c. Employees receiving treatment for LTBI can return to work immediately. Employees with LTBI who cannot take or do not accept or complete a full course of treatment for LTBI should not be excluded from the workplace. They should be counseled regarding the risk for developing TB disease and instructed to report any TB symptoms immediately to the occupational health unit.

d. Employees who have a documented positive TST or BAMT result and who leave employment should be counseled again, if possible, regarding the risk for developing TB disease and instructed to seek prompt evaluation with the local health department or their primary care physician if symptoms of TB disease develop.

e. Asymptomatic employees with a baseline positive or newly positive TST or BAMT result do not need to be excluded from the workplace. Treatment for LTBI should be considered in accordance with CDC

guidelines.

i. Promptly evaluating the employee for TB disease, including performing a chest radiograph, if the symptom screen or the initial or 8–10-week follow-up TST result is positive.

ii. Providing additional medical and diagnostic evaluation for LTBI, including determining the extent of exposure, if TB disease is excluded.

iii. Exposed persons with documented previously positive test results for M. tuberculosis infection do not require either repeat testing for M. tuberculosis infection or a chest radiograph (unless they are immunocompromised or otherwise at high risk for TB disease), but they should receive a symptom screen.

4. Problem Evaluation

a. Contact investigations might be initiated in response to:

i. Conversions in test results in employees for M. tuberculosis infection

ii. Diagnosis of TB disease in an employee

iii. Suspected person-to-person transmission of M. tuberculosis

iv. Lapses in TB infection-control practices that expose employees and patients to M. tuberculosis

v. Possible TB outbreaks identified using automated laboratory systems

b. The objectives of a contact investigation might be to:

i. Determine the likelihood that transmission of M. tuberculosis has occurred

ii. Determine the extent of M. tuberculosis transmission

iii. Identify persons who were exposed, and, if possible, the sources of potential transmission

iv. Identify factors that could have contributed to transmission, including failure of environmental infection-control measures, failure to follow infection-control procedures, or inadequacy of

current measures or procedures

v. Implement recommended interventions

vi. Evaluate the effectiveness of the interventions

vii. Ensure that exposure to M. tuberculosis has been terminated and that the conditions leading to exposure have been eliminated

5. Contact Investigation

a. A contact investigation should be initiated when:

i. A person with TB disease has been examined at a healthcare setting

ii. TB disease was not diagnosed and reported quickly, resulting in failure to apply recommended TB infection controls

iii. Environmental controls or other infection control measures have malfunctioned while a person with TB disease was in the setting

iv. An employee develops TB disease and exposes other persons in the setting

b. The following activities should be implemented in collaboration with or by the local or state health department:

i. Interview the index case and all persons who might have been exposed

ii. Review the medical records of the index case

iii. Determine the exposure sites (i.e., where the index case lived, worked, visited, or was hospitalized)

iv. Determine the infectious period of the index case, which is the period during which a person with TB disease is considered contagious and most capable of transmitting M. tuberculosis to others

v. The most intensely exposed employees and patients should be screened as soon as possible after exposure to M. tuberculosis has occurred and 8–10 weeks after the end of exposure if the initial TST result is negative

vi. Close contacts should be the highest priority for screening

6. Newly Recognized Positive Test Result or Signs and Symptoms of TB

   a. Any employee with a newly recognized positive test result for M. tuberculosis infection, test conversion, or symptoms or signs of TB disease should be promptly evaluated.

   b. Employees with a baseline positive or newly positive TST or BAMT result should receive one chest radiograph to exclude a diagnosis of TB disease (or an interpretable copy within a reasonable time frame, such as 6 months).

   c. After this baseline chest radiograph is performed and the result is documented, repeat radiographs are not needed unless symptoms or signs of TB disease develop or a clinician recommends a repeat chest radiograph.

   d. Instead of participating in serial testing for M. tuberculosis infection, employees with a positive test result for M. tuberculosis infection should complete a symptom screening form. The frequency of this assessment should be determined by the risk classification for the setting.

   e. Serial follow-up chest radiographs are not recommended for employees with documentation of a previously positive test result for M. tuberculosis infection, treatment for LTBI or TB disease, or for asymptomatic employees with negative test results for M. tuberculosis infection.

   f. If the employee has signs or symptoms of TB disease:

      i. Record the symptoms in the employee's health record

      ii. Perform a chest radiograph

      iii. Employee will need full medical evaluation by their Primary Care Provider (PCP)

7. General Recommendations for Investigating Conversions in Test Results

   a. If an employee experiences a conversion in a test result for M. tuberculosis infection, evaluate the employee for a history of suspected or known exposure to M. tuberculosis to determine the potential source.

   b. If a test conversion in an employee is detected as a result of serial screening and the source is not apparent, conduct a source case investigation to determine the probable source and the likelihood that

transmission occurred in the health-care setting.

c. Report to the local and state health department, who will perform investigation, assessment, and provide treatment if necessary.

d. Conduct problem evaluation.

e. Any lapses in TB infection control should be corrected.

8. Investigating a Case of TB Disease

Immediately notify the Medical Director and Infection Control Officer if an employee is diagnosed with TB disease. They will notify the local health department who will take over the investigation, testing recommendations, and treatment recommendations.

References

Centers for Disease Control and Prevention. (2005, December 30). *Guidelines for preventing the transmission of Mycobacterium tuberculosis in health-care settings*. MMWR. *Morbidity and Mortality Weekly Report,* 54(No.RR-1) 1-141. Retrieved from http://www.cdc.gov/mmwr/pdf/rr/ rr5417.pdf; Centers for Disease Control and Prevention. (2013). *Latent tuberculosis infection: A guide for primary health care providers*. Retrieved from http://www.cdc.gov/tb/publications/ LTBI/pdf/ TargetedLTBI.pdf; Oregon Health Authority, Public Health Division. (2013). *Facilities required to test new employees for tuberculosis upon hire*; https://public.health.oregon.gov/ Diseases Conditions/ Communicable Disease/Tuberculosis/Documents/tbtestrecs.pdf; Oregon Health Authority, Public Health Division. (2013). *Guidance and clarification on healthcare worker TB screening requirements in Oregon*; https://public.health.oregon.gov/DiseasesConditions/ CommunicableDisease/Tuberculosis/Documents/UpdatedGuidanceHCPTBScreening.pdf

XXIX. TB Containment in the Clinic Setting

A. The following precautions shall be followed when a patient is known to have infectious TB or has the following constellation of symptoms: prolonged cough, coughing up blood, fever, night sweats, weakness, and weight loss:

1. The patient will be moved promptly to an area away from other patients and given a diagnostic evaluation. Procedure Room 150A and 150B.

a. The procedure room should be converted to a negative pressure airflow room by turning on the vent (switch located in the middle of the east wall) and keeping the exam room doors closed. Use the 'ball-in-the-wall' for visual confirmation of negative pressure at all times. The control panel next to on/off switch will also document amount of negative pressure. The negative air pressure should be maintained for 30 minutes following the patient's departure before any staff go in to clean room.

2. Patients known or suspected of having TB will be given a surgical mask and instructed to keep it on at all times while in the clinic.

3. Trained employees who will be coming into close contact with the potentially infectious person should use National Institute for Occupational Safety and Health (NIOSH/CDC) approved respirator masks. These are kept in the clean linen room directly across from the procedure room. Keep the number of individuals providing care to exposed patient to a minimum.

4. Most patients with infectious TB can be treated as outpatients.

5. The Infection Control Nurse at Lincoln County Health Department will obtain sputum specimens needed for diagnosis and monitoring of TB status. Directly observed therapy (DOT) will be also be coordinated through the Health Department. DOT will occur outside of the clinic building until the patient is confirmed as noninfectious by sputum sample.

6. If the patient is in need of inpatient care and isolation, he or she will be transported by EMS to Pacific Communities Hospital. EMS and receiving facility will be notified of need for isolation.

7. Following the patient's departure and 30 minute room ventilation, maintenance will be notified to disinfect the room according to the evening shift's cleaning guidelines. A sign will be placed on the contaminated exam room door to serve as notice to staff.

XXX. Eye and Face Wash Stations

A. All staff members that work with hazardous materials must be instructed on the location and proper use of emergency eye and face wash stations.

B. Eye and face wash stations must have a high and visible sign.

1. Emergency eye and face wash stations must be placed within 10 seconds of hazard areas with a clear pathway.

2. The valve actuator should be large enough to be easily located and operated by user.

3. The "Hands Free" valve will stay open and activate in one second or less.

4. The connected unit must have an uninterruptible water supply with 30 PSI flow pressure.

5. The unit must be capable of delivering 3.0 gallons (11.4 liters) of water per minute for 15 minutes.

6. The water temperature must be tepid (lukewarm) so no scalding occurs to eyes and face.

7. The water pressure has to be controlled and low velocity flow completely rinses eyes and face and is not injurious to user.

8. Outlet heads should be positioned between 33" and 45" from the floor and at least 6" from the wall or nearest obstruction.

9. Protect outlet heads from airborne contaminants.

C. Maintenance

Eye and face wash stations must be tested weekly.