**Template Infection Prevention & Control**

**Policy and Procedures Manual**

**for**

**North Carolina Licensed Adult Care Homes & Family Care Homes**

**Pursuant to Session Law 2021-189**

**Instructions for the Use of This Manual & Disclaimer**

**Instructions for the Use of this Manual**

The template policies and procedures contained in this manual were developed by the North Carolina Department of Health & Human Services and the University of North Carolina at Chapel Hill Statewide Program for Infection Control and Epidemiology (SPICE), and in consultation with the associations representing adult care home providers, in response to Session Law 2021-189. These template infection prevention and control policies and procedures are consistent with the federal Centers for Disease Control and Prevention (CDC) and address the factors listed in N.C.G.S. 131D-4.4A(b)(1).

The policies and procedures contained in this manual are intended to be a template for providers to utilize as they establish facility-specific policies and procedures for basic infection prevention and control. Since facilities differ in how they operate, the policies and procedures in this manual should be read carefully and modified to fit the individual facility’s operations. All blank spaces in the manual should be filled in with the information appropriate to the facility. Providers are able to modify these policies and procedures and should ensure that any modifications are consistent with the CDC or other accepted national standards for infection prevention and control. It is the responsibility of owners and managers of adult care homes to expand on each set of procedures with details so that facility personnel know and understand their responsibilities and how the procedures are to be carried out in the facility.

To protect residents’ health and safety and prevent the spread of disease and illness, licensed adult care homes and family care homes are required to comply with all regulations related to infection prevention and control per N.C.G.S. 131D, 10A NCAC 13F, and 10A NCAC 13G. In accordance with these laws, providers are responsible for ensuring the following:

* Policies and procedures for infection prevention and control are current, accurate and facility-specific.
* All facility staff are trained on the facility’s infection prevention and control policies and procedures within 30 days of hire and annually thereafter.
* Policies and procedures for infection prevention and control are updated as needed.

**Disclaimer**

The North Carolina Department of Health & Human Services (NCDHHS) and the University of North Carolina at Chapel Hill Statewide Program for Infection Control and Epidemiology (SPICE) have created these policies and procedures to assist facilities in developing and implementing their own infection control policies and procedures. Reliance on these policies and procedures does not guarantee compliance, and a facility may still be subject to citations, violations, penalties, or licensure actions when relying on these policies and procedures. Facilities are still responsible for maintaining compliance with all statutes and rules governing licensed adult care facilities, including adapting existing policies to emerging infectious disease threats.

**Document Change Record**

**for**

**Template Infection Prevention and Control (IPC) Policy and Procedure Manual for North Carolina Adult Care Homes and Family Care Homes**

A change log is used to provide a record of all approved changes made in the manual after initial approval and posting. Changes will be reviewed and approved by the NC Department of Health and Human Services prior to incorporating into the document. Updated revisions of this document will be made as approved changes impact the page numbers or content.

The table below is used by the Department to register all approved changes made to the template IPC policy and procedure manual.

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| --- | --- | --- | --- |
| **Published Date** | **Section Title** | **Page(s) Affected** | **Description of Revision** |
| 11/16/22 | Document Change Record | Page 3 | Document Change Record added |
| 11/16/22 | Transmission Based Precautions | Pages 43-45 | Modified to include a section on Enhanced Barrier Precautions |
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**Infection Prevention and Control Program for North Carolina Adult Care Homes (ACH) and Family Care Homes (FCH).**

**This is the policy and procedure manual for**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Facility Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (insert facility name) maintains an organized, effective facility-wide program designed to identify and reduce the risk of acquiring and transmitting infections among residents, staff, and visitors. This program is designed to meet the intent of North Carolina General Statute 131D-4.4A related to infection prevention and control for adult care homes licensed pursuant to 10A NCAC 13F and family care homes licensed pursuant to 10A NCAC 13G.

**RESPONSIBILITIES**:

***Infection Prevention Oversight:***

Ultimate responsibility for overseeing and implementing the infection prevention and control program is delegated to the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (insert title-owner, administrator, supervisor etc.,).

In accordance with NC GS 131D-4.4A, one on-site staff member \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (insert title of staff member) knowledgeable about the Center for Disease Control and Prevention (CDC) guidelines on infection prevention and control is designated to direct the facility’s infection control activities and ensure that all ACH and FCH staff are trained in the facilities infection control policy.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (insert staff member title) shall complete the NC Statewide Program for Infection Control and Epidemiology (SPICE) course “Infection Prevention and Control in Adult Care and Family Care Homes”

***Staff:***

1. Support resident safety by adhering to all policies and procedures related to infection prevention including standard and transmission-based precautions
2. Promotes enhanced use of hand hygiene, appropriate use of personal protective equipment (PPE) and adherence to respiratory hygiene/cough etiquette
3. Assist in education of residents and visitors about measures to help reduce the risk of transmission of infections (e.g., hand hygiene and respiratory hygiene/cough etiquette
4. Adheres to policies and procedures related to work restrictions, reporting of communicable disease exposures, and reporting of illnesses
5. Utilizes the expertise of the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (insert title of designated staff member) to address issues or questions related to the function of infection prevention and control

**INFECTION PREVENTION ACTIVITIES:**

1. ***Limit staff, resident and visitors unprotected exposure to infectious pathogens***
   1. Adhere to standard precautions for care of all residents
   2. Adhere to transmission-based precautions appropriate to the infectious agent and mode of transmission
   3. Adhere to universal use of personal protective equipment (e.g., wearing a face mask) when recommended by CDC or as directed by NCDHHS
   4. Post visual alerts reminding visitors not to enter the facility if ill or symptomatic with a communicable disease
   5. Encourage staff, resident, and visitor immunization to vaccine preventable diseases, including but not limited to influenza and COVID-19
   6. Staff adherence to facility’s policy and any guidance provided by NCDHHS or the local health department on work restrictions when ill
2. ***Reduce the risk of transmission of infections associated with resident care activities***
   1. Adhere to hand hygiene policy when performing hand hygiene with either soap and water OR alcohol-based hand rub
   2. Encourage residents and visitors to adhere to frequent use of hand hygiene
   3. Use PPE, per standard precautions, when there is a risk of contact with blood and/or body fluids, including wound drainage, urine, vomitus, or feces.
   4. Adhere to the policy on “Assisted Blood Glucose Monitoring and Insulin Administration” to provide safe diabetes care
   5. Clean and disinfect all shared equipment after each use
3. ***Reduce the risk of transmission of infections associated with the environment*** 
   1. Use an EPA-registered disinfectant when performing environmental cleaning
   2. Identify and report issues that impede environmental cleaning and disinfection (e.g., broken furniture, tears, or rips in surfaces)
   3. Appropriate handling and disposal of medical waste
4. ***Communicate with local health departments, residents, resident’s representatives, and staff on issues specific to infection prevention, communicable diseases, and outbreaks***
   1. Immediately report any exposure to communicable diseases (work related or community exposure)
   2. Immediately report any work-related exposure to bloodborne pathogens (i.e., needle/lancet stick, mucous membrane or non-intact skin splash or splatter with blood or body fluids)
   3. In accordance with NC public health law, report to the local public health department a suspected or confirmed reportable communicable disease or a communicable disease outbreak
   4. Inform staff, residents, and resident’s representatives (without disclosing any personally identifiable information) whenever there is a communicable disease outbreak (within 24 hours), when the outbreak has resolved and if there were any changes to facility policies as a result of the outbreak (e.g., visitor limitations)
5. ***Staff education***
   1. Provide staff education at time of hire and no less than annually. Content should include but may not be limited to:
      * Bloodborne Pathogen(s)
      * Facility’s infection prevention control activities
      * Results or findings from any monitoring activity (e.g., hand hygiene) indicating a need for performance improvement
      * Results from regulatory surveys or local health department visits indicating a need for performance improvement
      * Policy or procedural changes within the facility
6. ***Resident, and resident representatives’ education***
   1. How to help reduce the risk of transmission of infections (e.g., hand hygiene and respiratory hygiene/cough etiquette)
   2. How to help protect the resident (i.e., not visiting when sick)
   3. How to report concerns or issues related to infection prevention
   4. Importance of self-care and immunizing against vaccine preventable diseases such as COVID-19 and Influenza

**POLICIES AND PROCEDURES:**

Infection Prevention and Control policies, designed to reduce the risk of transmission of infectious organisms, have been implemented. Strategies outlined in the polices include (not limited to):

* Proper disposal of single-use equipment
* Proper disinfection of reusable equipment
* Sanitation of the environment
* Blood and body fluid precautions
* Communicable Disease reporting
* Standard and transmission-based precautions

**PROGRAM EVALUATION:**

The effectiveness of the infection prevention and control program will be reviewed no less than annually and more often, if deemed necessary, as a result of change in service(s)/policies, to maintain consistency with accepted national standards in infection prevention and control, or as the result of findings from survey or monitoring activities.

Approval by:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (insert owner, administrator etc.,) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date

Revisions/Review dates:

**Infection Prevention & Control Policy and Procedure Manual**

**for**

**FACILITY NAME**

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* Respiratory Hygiene/Cough Etiquette
* Use of Personal Protective Equipment (PPE)
* Assisted Blood Glucose Monitoring (ABGM)

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* Transmission-based Precautions
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<https://spice.unc.edu/>

**Cleaning and Disinfection**

* Cleaning and Disinfection of Reusable Resident Care Equipment
* Environmental Cleaning and Disinfection

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* NC Medical Waste
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**Facility Name**

**Infection Prevention and Control Policy Manual**

|  |  |
| --- | --- |
| **Policy and Procedure Name** | **Assisted Blood Glucose Monitoring and Insulin Administration** |
| **Policy Number** |  |
| **Date Issued:** |  |
| **Approved by:** |  |

**POLICY**:

It is the policy of (facility name) to adhere to the Centers for Disease Control and Prevention (CDC) “Infection Prevention During Blood Glucose Monitoring and Insulin Administration” to reduce the risk of transmitting hepatitis B virus (HBV) and other infectious diseases during assisted blood glucose (blood sugar) monitoring and insulin administration.

**PROCEDURE:**

1. *Assisted Blood Glucose Monitoring (ABGM):*
   1. Whether dedicated for multi-or single resident use staff must remove gloves and perform hand hygiene **before and** **after each resident** use and after cleaning and disinfecting meters.
2. *Fingerstick Devices (lancing devices):*
   1. Fingerstick devices should be restricted to individual residents
   2. Single use lancets that permanently retract upon puncture should be used if possible
   3. Lancets should be disposed of at the point of use in an approved sharps container
   4. Lancets should NEVER be reused
   5. If reusable fingerstick devices intended for use by a single person are used they should be treated in a manner like other personal care items (e.g., razors and toothbrushes) and must never be shared
      1. Reusable fingerstick devices intended for use by a single person should be clearly labeled and stored in a manner to prevent use for the wrong resident and prevent contamination
3. *Blood Glucose Meters:*
   1. Blood glucose meters should be assigned to an individual resident whenever possible and should not be shared with other residents.
      1. Meters dedicated to a single resident use may be stored in the resident’s room if there is an order for self-administration.
      2. Meters should be clearly labeled with the resident’s name and stored in a manner that prevents contamination (e.g., contact with other meters or equipment)
      3. Meters dedicated to a single resident should be cleaned and disinfected when visibly soiled and, prior to storage**,** according to manufacturer's instructions.
      4. The disinfectant used must have a claim to inactivate (kill) hepatitis B virus (HBV), hepatitis C virus (HCV) and HIV
   2. When it is not possible to dedicate meters to an individual resident the meter must be approved for multi-patient use and cleaned and disinfected after ever use, per manufacturer’s instructions.
   3. If the manufacturer does not provide instructions on how the device should be cleaned and disinfected the meter should not be shared.
      1. The disinfectant used for cleaning must have a claim to inactivate (kill) hepatitis B (HBV), hepatitis C (HCV) and HIV
      2. Meters not dedicated to a single resident should be stored in a manner that prevents contamination from other meters and/or equipment
4. *Insulin Pens and Insulin Administration:*
   1. Insulin pens are approved and labeled only for single-resident use. Under no circumstances should they be used for more than one resident. They should be labeled with the date opened and discarded within the stability time period per manufacturer’s instructions and facility policy.
   2. Multi-dose insulin vials:
      1. Should be dedicated to a single resident
      2. Once a multi-dose vial has been opened or accessed (e.g., needle punctured the vial) the vial should be dated and discarded within the stability time period, i.e. 28 days, per manufacturer’s instructions and facility policy.

**REFERENCES:**

CDC Recommendations for Infection Prevention during Blood Glucose Monitoring and Insulin Administration

<https://www.cdc.gov/injectionsafety/blood-glucose-monitoring.html#anchor_1556215448>

CDC FAQs regarding Assisted Blood Glucose Monitoring and Insulin Administration

<https://www.cdc.gov/injectionsafety/providers/blood-glucose-monitoring_faqs.html>

CDC Guideline for Isolation Precautions: Preventing Transmission of infectious Agents in Healthcare Settings (2007)

<https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html/Isolation2007.pdf>

**Dates Reviewed and/or Revised:**

**Facility Name**

**Infection Prevention and Control Policy Manual**

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| --- | --- |
| **Policy and Procedure Name** | **Cleaning and Disinfection of Reusable Resident Care Equipment** |
| **Policy Number** |  |
| **Date Issued:** |  |
| **Approved by:** |  |

**POLICY**:

It is the policy of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (facility name) to adhere to the Centers for Disease Control and Prevention (CDC) Guidelines for Environmental Infection Control in Healthcare Settings. Shared resident equipment can be a source of healthcare-associated infections via direct or indirect contact. Appropriate cleaning and decontamination of reusable resident care equipment is essential to preventing transmission of infectious agents. Adult Care and Family Care homes primarily use noncritical equipment.

**DEFINTIONS:**

* Noncritical equipment: are those items that come in contact with intact skin but not mucous membranes. Examples of noncritical resident care items are bedpans, blood pressure cuffs, crutches.

**PROCEDURE:**

1. *Responsibility:*
   1. The \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (facility fills in with administrator, supervisor, or manager) is responsible for overseeing the process of cleaning and disinfection of non-critical equipment used for resident care, including identifying staff responsible for the cleaning and disinfection.
   2. Staff responsible for cleaning and disinfection should be trained and educated on:
      1. The correct solution to use
      2. The appropriate PPE to use as directed by the products label
      3. Complying with the product’s contact time requirement for disinfectant to sit before wiping off.
      4. How often cleaning/disinfection should be done
      5. Correct procedure for storing clean equipment-separate from dirty equipment
2. *Cleaning and Disinfection of Resident Equipment:* 
   1. All resident care equipment should be dedicated to the use of a single resident whenever possible.
   2. When equipment cannot be dedicated to a single resident and must be shared, it must be cleaned and disinfected after each use with an EPA registered disinfectant according to the product labeling or manufacturer’s instructions for use
   3. All equipment visibly soiled (presence of dirt, blood and/or body fluids for example) must be cleaned immediately
   4. Disposable equipment and supplies shall be immediately discarded after use.
   5. Equipment and supplies labeled as “single use” should be used one time only and then discarded
   6. Re-usable resident care equipment (such as nebulizer machines, CPAP machines, oxygen nasal cannulas, etc.) coming in contact with the floor or other potentially contaminated surface must be disinfected (use of a disinfectant wipe) prior to use with an appropriate disinfectant.
3. *Use of disinfectant cloths and disposable wipes:* 
   1. The entire surface of the equipment being disinfected must have direct contact with the disinfecting agent for the time indicated on the container(s) to assure effectiveness.
   2. Re-usable cloths used for cleaning must not be placed back into the disinfectant solution after using it to wipe a surface.
   3. Ensure containers of disposable wipes are kept closed, when not in use, to maintain appropriate amount of disinfectant on the wipe (not dried out)
   4. Products used for cleaning and disinfection of resident equipment should be readily available to staff but stored in areas not accessible to residents.
4. *Personal Protective Equipment*
   1. Appropriate PPE should always be available and used appropriately to reduce risk to both residents and staff (refer to policy “Use of Personal Protective Equipment”).
   2. PPE is required to prevent:
      1. Exposure to microorganisms
      2. Exposure to cleaning chemicals (e.g., disinfectants)
      3. The spread of microorganisms from one resident care area to another
   3. Follow the products label instructions, manufacturer’s instructions or SDS (Safety Data Sheets) to determine what PPE should be worn when mixing or using cleaning and disinfection products and solutions.
5. *Storage*
   1. Resident equipment that has been cleaned/disinfected should not be stored with soiled or dirty equipment.
   2. If clean and soiled equipment must be stored in the same location (due to space constraints) a spatial separation of at least 3 feet should be maintained
   3. Resident supplies and/or equipment should not be stored within 3 feet of a sink due to risk of being splashed or splattered.
   4. If a 3 feet distance cannot be maintained (due to space) splash guards can be installed on either side of the sink.

**REFERENCE(S):**

*Centers for Disease Control and Prevention. Guideline for Environmental Infection Control in Healthcare Facilities (2003).* [*https://www.cdc.gov/infectioncontrol/guidelines/environmental/index.html*](https://www.cdc.gov/infectioncontrol/guidelines/environmental/index.html)

*Centers for Disease Control and Prevention. Healthcare Associated Infections (HAIs). Preventing HAIs. Environmental Cleaning in Resource-Limited Settings.* [*https://www.cdc.gov/hai/prevent/resource-limited/cleaning-procedures.html*](https://www.cdc.gov/hai/prevent/resource-limited/cleaning-procedures.html)

**Dates Reviewed and/or Revised:**

**Facility Name**

**Infection Prevention and Control Policy Manual**

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| --- | --- |
| **Policy and Procedure Name** | **Employee Health** |
| **Policy Number** |  |
| **Date Issued:** |  |
| **Approved by:** |  |

**POLICY**:

It is the policy of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(facility name) to adhere to the Centers for Disease Control and Prevention (CDC) Guidelines for Infection Control in Healthcare Personnel and applicable NC Communicable Disease Rules and Regulations.

**PROCEDURE:**

1. *Immunization Program:* 
   1. All new staff at time of hire, including rehired staff, shall be screened for immunity to communicable diseases, in accordance with regulatory laws, including (but may not be limited to):
      1. measles,
      2. mumps,
      3. rubella,
      4. varicella, and
      5. pertussis.
   2. Other vaccines such as annual influenza and COVID-19 will be offered and given (unless exempted due to an approved religious or medical contradiction) in accordance with Public Health Rule. Influenza and COVID-19 vaccine exemptions will be evaluated on an individual basis each year and must be submitted annually or per other schedule as recommended by the CDC or Public Health Rule.
   3. Tuberculosis
      1. All new hire staff shall have a 2-step tuberculin skin test (TST), or a single Interferon Gamma release Assay (IGRA) test administered in accordance with recommendations published by the Centers for Disease Control and Prevention and in compliance with NC Communicable Disease Rule 10A NCAC 41A .0205
      2. Staff shall be required only to have a single TST or IGRA in the following situations:
         1. If they have ever had a two-step skin test; or
         2. If they have had a single skin test within the past 12 months.
      3. All staff with positive TST or positive IGRA will be counseled and advised to follow up with the NC State Health Department for further evaluation of latent TB infection (LTBI). Follow-up may include a chest x-ray to rule out active infection.
2. *Screening of Staff with Infectious Diseases or Exposure to Communicable Diseases*
   1. All staff with a potentially communicable disease (e.g., shingles, conjunctivitis, norovirus) must notify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and be seen by their primary care provider (MD, PA, FNP, etc.). Work restriction guidelines consistent with the NC Department of Health and Human Services (NCDHHS) and CDC recommendations will be followed.
   2. Staff with exudative lesions or dermatitis on hands/wrists **shall refrain from:**
      1. Handling equipment used in resident care
      2. Handling devices used for procedures where the skin is punctured
      3. Resident activities if there is a likelihood of contact with lesion
   3. Staff with non-intact skin on exposed surface may not provide direct care or have contact with equipment that is used for direct care (i.e., blood pressure cuffs, food trays) until all lesions have healed/resolved.
      1. Non-intact skin is defined as open wounds, weeping lesions and rashes, lacerations that penetrate through the dermis and are less than 48 hours old, lacerations with sutures, lacerations with steri-strips.
      2. Exposed surfaces include area below the elbow (hands and wrists) and above the neck (face and neck).
      3. Staff with skin lesions (unless a communicable disease such as varicella) that are under clothes and can be covered may provide direct resident care. Lesions should be covered with a clean, dry dressing and must also be entirely covered by clothing.
      4. Staff with active varicella may not return to work until all lesions are dry and crusted over.
   4. Bloodborne Pathogen Occupational Exposure:
      1. All staff must follow the facility’s established bloodborne pathogen exposure control plan when they have an occupational bloodborne pathogen exposure.
         1. Immediately wash exposed skin or puncture site with soap and water. If eyes or mouth are exposed rinse thoroughly with clean water
         2. Report the exposure immediately to their supervisor and the supervisor shall report it to the Administrator.
         3. The Administrator or their designee should provide staff member with an exposure evaluation (reference the facility’s Bloodborne Pathogen Exposure Control Plan. A template for this plan can be found at <https://www.osha.gov/sites/default/files/CPL_2-2_69_APPD.pdf>)
   5. Management of Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV), or Hepatitis C Virus (HCV):
      1. Staff who are infected with HIV, HBV, or HCV are not restricted from providing resident care provided they do not have another infection that places residents at risk (e.g., active pulmonary TB).
   6. Management of Upper Respiratory Infection (URI):
      1. Staff who develop respiratory symptoms ***with fever*** (>100.4°F or >38°C):

* Should be instructed not to report to work, to promptly notify their supervisor and leave work.
* Are excluded from work until at least 24 hours after they no longer have a fever (without the use of anti-pyretic [fever-reducing medicines] such as acetaminophen, ibuprofen, or aspirin).
* Upon returning to work, report to their supervisor. If symptoms such as cough and sneezing are still present upon return, staff should wear a properly fitted surgical mask (nose and mouth covered) in care areas and adhere to respiratory etiquette with frequent hand hygiene.
* If unable to adequately contain their secretions with a properly fitted surgical mask staff will be excluded from work until resolution of symptoms and/or ability to contain secretions.
  + 1. Staff who develop respiratory symptoms ***without fever:***
* If symptoms such as cough and sneezing are present, they should wear a properly fitted surgical mask (nose and mouth covered) in care areas and adhere to respiratory etiquette with frequent hand hygiene.
* If unable to adequately contain their secretions with a properly fitted surgical mask they will be excluded from work until resolution of symptoms and/or ability to contain secretions.
  + 1. General Statements:
* The preceding guidance on URI symptoms and work restrictions will be followed regardless of lab testing (e.g., influenza testing).
* During an outbreak, additional work restrictions (e.g., reassignments), exclusions or laboratory evaluation may be imposed.
  1. Management of staff who handle food:
     1. Must report to their supervisor when they are sick
     2. Staff who report to work with any of the following symptoms shall be excluded from work:
        1. Vomiting
        2. Diarrhea
        3. Jaundice
        4. Sore throat with fever (100.4°F or higher)
     3. Staff who handle food must inform their supervisor if they are diagnosed with any of the following:

1. Norovirus
2. Hepatitis A
3. Shigella
4. Shiga toxin-producing *E. coli*
5. Salmonella typhi

**REFERENCE(S):**

*North Carolina Division of Public Health Communicable Disease Manual*

[*https://epi.dph.ncdhhs.gov/cd/lhds/manuals/cd/toc.html*](https://epi.dph.ncdhhs.gov/cd/lhds/manuals/cd/toc.html)

*NC TB Control Program*

[*https://epi.dph.ncdhhs.gov/cd/lhds/manuals/tb/toc.html*](https://epi.dph.ncdhhs.gov/cd/lhds/manuals/tb/toc.html)

*Centers for Disease Control and Prevention. Diphtheria, tetanus, and pertussis: Recommendations for vaccine use and other preventative measures: Recommendations of the Immunization Practices Advisory Committee (ACIP). MMWR 1991;40 (No. RR-10).* [*https://www.cdc.gov/mmwr/preview/mmwrhtml/00041645.htm*](https://www.cdc.gov/mmwr/preview/mmwrhtml/00041645.htm)

*Federal Register. Department of Labor, Occupational Exposure to Bloodborne Pathogens, Final Rule, 29CFR 1910:1030.* [*https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1030*](https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1030)

*Centers for Disease Control and Prevention. Guidelines for preventing the transmission of Mycobacterium tuberculosis in health-care facilities. MMWR 2005; 54(RR 17); 1-141.* [*https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5417a1.htm*](https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5417a1.htm)

*Centers for Disease Control and Prevention. General Recommendations for Health-Care Personnel. MMWR Recommendations and Report 2011; 60(RR-7): 1-45* [*https://www.cdc.gov/mmwr/pdf/rr/rr6007.pdf*](https://www.cdc.gov/mmwr/pdf/rr/rr6007.pdf)

*Centers for Disease Control and Prevention. Guideline for infection control in healthcare personnel, 1998. American journal of infection control; v.23, no.3, p.289-354; Infection control and hospital epidemiology; v.19, no.6, p.407-63.* [*https://stacks.cdc.gov/view/cdc/11563*](https://stacks.cdc.gov/view/cdc/11563)

*Centers for Disease Control and Prevention. Infection Control in Healthcare Personnel: Infrastructure and Routine Practices for Occupational Infection Prevention and Control Services. October 25, 2019.* [*https://www.cdc.gov/infectioncontrol/guidelines/healthcare-personnel/index.html*](https://www.cdc.gov/infectioncontrol/guidelines/healthcare-personnel/index.html)

**Dates Reviewed and/or Revised:**

**Facility Name**

**Infection Prevention and Control Policy Manual**

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| --- | --- |
| **Policy and Procedure Name** | **Environmental Cleaning** |
| **Policy Number** |  |
| **Date Issued:** |  |
| **Approved by:** |  |

**POLICY**:

It is the policy of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (facility name) to adhere to the Centers for Disease Control and Prevention (CDC) Guidelines for Environmental Infection Control in Healthcare Settings.

**DEFINITIONS:**

1. **Cleaning:** the physical removal of foreign material (e.g., dust, soil) and organic material (e.g., blood, secretions, excretions, microorganisms). Cleaning physically removes rather than kills microorganisms. It is accomplished with water, detergents, and mechanical action.
2. **Contact time**: the time that a disinfectant must be in contact with a surface or device to ensure that appropriate disinfection has occurred. For most disinfectants, the surface should remain wet for the required contact time.
3. **Disinfectant**: chemical compounds that inactivate (i.e., kill) pathogens and other microbes and fall into one of three categories based on chemical formulation: low-level, mid-level, and high-level. Disinfectants are applied only to inanimate objects. All organic material and soil must be removed by a cleaning product before application of disinfectants. Some products combine a cleaner with a disinfectant.
4. **Environmental cleaning**: cleaning and disinfection (when needed, according to risk level) of environmental surfaces (e.g., bed rails, mattresses, call buttons, chairs) and surfaces of noncritical resident care equipment (e.g., blood pressure cuffs, stethoscopes).
5. **High-touch surfaces**: surfaces, often in the resident care areas, that are frequently touched by staff, visitors and residents (e.g., bedrails, overbed table, doorknobs, phones, light switches, computers, remote controls, medication carts).
6. **Environmental cleaning services area**: a dedicated space for preparing, reprocessing, and storing clean or new environmental cleaning supplies and equipment, including cleaning products and PPE. Access is restricted to cleaning staff and authorized personnel.
7. **Personal protective equipment (PPE**): clothing or equipment worn by staff to protect themselves against hazards (e.g., blood or body fluids)
8. **Post-discharge cleaning**: cleaning and disinfection after the resident is discharged or transferred.
9. **Routine cleaning**: the regular cleaning (and disinfection, when indicated) when the room is occupied to remove organic material, reduce microbial contamination, and provide a visually clean environment. Emphasis is on surfaces within the resident zone.
10. **Scheduled cleaning**: cleaning (and disinfection, when indicated) that occurs concurrently with routine cleaning and aims to reduce dust and soiling in low-touch surfaces.
11. **Standard Precautions**: are used for all resident care, and make use of common-sense practices, PPE and other equipment that protects staff from infection and prevents the spread of infection from resident to resident.

**PROCEDURE:**

1. *Cleaning Program*
   1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (insert title of staff person) is responsible for overseeing the environmental cleaning program.
   2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (insert name of contracted agency, if used) provides environmental cleaning services for the facility. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of administrator or other person) shall review the contract and maintain a copy of their cleaning protocols and the products being utilized.
   3. Ensure that cleaning supplies and equipment are available and accessible to the appropriate personnel.
2. *Environmental Cleaning Supplies and Equipment*
   1. The selection and appropriate use of supplies and equipment is critical for effective environmental cleaning including:
      1. Surface cleaning supplies: portable containers (e.g., bottle, small buckets) for storing environmental cleaning products and surface cleaning cloths.

* Surface cleaning cloths should be cotton or microfiber (disposable cloths can be used if resources allow).
* Use a fresh clean cloth in each resident room. Change cleaning cloths when they are no longer saturated with solution, for a new, wetted cloth. Soiled cloths, if not disposable, should be stored for reprocessing.
* Never double-dip cleaning cloths (into the cleaning/disinfection solution) to avoid contamination.
  + 1. Floor cleaning supplies: mops or cleaning squeegee with floor cloths, buckets, and wet floor/caution signs.
* Mop heads or floor cloths should be cotton or microfiber.
* Change mop heads/floor cloths and buckets of cleaning and disinfectant solutions as often as needed (e.g., when visibly soiled, after cleaning an isolation room or about every 1-2 hours) and at the end of each cleaning session.
* Prepare cleaning solutions daily or as needed and replace with fresh solution according to manufacturer’s instructions on product label.
* Never shake mop heads and cleaning cloths – it disperses dust or droplets that could contain microorganisms.
  + 1. Cleaning products: liquid soap, detergents, and specialized cleaning products (e.g., bathroom/toilet cleaners, floor polishers, glass cleaners) may be needed.
    2. Disinfectants: are not substitutes for cleaning unless they are a combined detergent-disinfectant product. Before disinfecting, use a cleaning product to remove all organic material and soil.
* Select EPA-registered disinfectants and use them in accordance with the manufacturer’s instructions.
* Follow manufacturer’s instructions for cleaning and contact time.

1. *Personal protective equipment:* 
   1. Appropriate PPE should always be available and used appropriately to reduce risk to both residents and staff (refer to policy “Use of Personal Protective Equipment”).
   2. PPE is required to prevent:
      1. Exposure to microorganisms
      2. Exposure to cleaning chemicals (e.g., disinfectants)
      3. The spread of microorganisms from one resident care area to another
   3. Follow the products’ label instructions or SDS (Safety Data Sheets) to determine what PPE should be worn when mixing or using environmental cleaning products and solutions.
2. *General Environmental Cleaning Technique (Routine and Scheduled Cleaning):*
   1. Determine if the room, or what portions of the room, can be cleaned safely when the resident is present
   2. Identify any damaged or broken furniture that may need replacing and report to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (administrator or supervisor)
   3. Report any torn or ripped areas on furniture upholstery or mattresses to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (administrator or supervisor)
   4. Clean from cleaner to dirtier areas to avoid spreading dirt and microorganisms (e.g., clean resident zone before cleaning resident toilet).
   5. Clean from high to low to prevent dirt and microorganisms from dripping or falling and contaminating already cleaned areas. For example, clean the bed rails before the bed legs. Clean the floor last to allow collection of direct and microorganisms that may have fallen.
   6. Clean in a systematic manner to avoid missing anything including high touch surfaces. For example, work in a left to right or clockwise motion.
3. *Post-discharge cleaning:*
   1. Terminal cleaning occurs after the resident is discharged/transferred and includes cleaning of the entire room. The process includes:
      1. Remove soiled/used personal care items (e.g., cups, dishes) for reprocessing or disposal.
      2. Remove facility-provided linens for reprocessing or disposal.
      3. Inspect window treatments. If soiled, clean blinds and curtains
      4. Clean and disinfect all low and high touch surfaces, including those that may not be accessible when the room/areas were occupied (e.g., resident mattress, bedframe, tops of shelves, vents), and floors.
      5. Clean and disinfect handwashing sinks.

**REFERENCE(S):**

Guideline for Environmental Infection Control in Health-Care Settings (2003).

[*https://www.cdc.gov/infectioncontrol/guidelines/index.html/eic\_in\_HCF\_03.pdf*](https://www.cdc.gov/infectioncontrol/guidelines/index.html/eic_in_HCF_03.pdf)

Centers for Disease Control and Prevention. Best Practices for Environmental Cleaning in Healthcare Facilities: in Resource-Limited Settings. Version 2.

<https://www.cdc.gov/hai/pdfs/resource-limited/environmental-cleaning-RLS-H.pdf>

Centers for Disease Control and Prevention. Healthcare Associated Infections. Preventing HAIs. Environmental Cleaning in Resource Limited Settings. (4) Environmental Cleaning Procedures. Updated April 21, 2020. Accessed October 8, 2021. <https://www.cdc.gov/hai/prevent/resource-limited/cleaning-procedures.html>

**Dates Reviewed and/or Revised:**

**Facility Name**

**Infection Prevention and Control Policy Manual**

|  |  |
| --- | --- |
| **Policy and Procedure Name** | **Linen and Laundry Service** |
| **Policy Number** |  |
| **Date Issued:** |  |
| **Approved by:** |  |

**POLICY**:

It is the policy of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (facility name) to adhere to the recommendations for handling, storing, processing, and transporting linens outlined in the “Guidelines for Environmental Infection Control in Health-Care Facilities, 2003, NC Rules for Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions“ and rules governing licensed adult care homes (10A NCAC 13F)/family care homes (10A NCAC 13G).

**PROCEDURE:**

1. *Linen*
   1. Linen shall be kept clean and in good repair
   2. Clean bed linen shall be provided for each resident and shall be changed as often as necessary but at least once per week.
2. *Routine Handling of Soiled Linen*
   1. All soiled linen, including linen from isolation rooms, must be treated as potentially infectious using Standard Precautions.
   2. To avoid contaminating clothing, linen should be carried away from the body when it is removed and placed in a laundry bag.
   3. Soiled linens should be bagged at the location of use and not sorted or rinsed in the location of use.
   4. Soiled laundry will be bagged in linen bags that prevent soak-through and/or leakage of fluids to the exterior. If the outside bag becomes ripped, wet, or soiled it must be double bagged into a second linen bag.
   5. Linen should be removed with a minimum of agitation to prevent gross airborne microbial contamination of air, surfaces, residents, or staff.
3. *Transporting Soiled Linen*
   1. Containers, carts, or bags used for soiled laundry shall be covered and labeled for soiled laundry use only
4. *Processing Laundry*
   1. The facility must have a process for cleaning linen/laundry.
   2. Gloves and waterproof aprons should be available to staff processing soiled linen.
   3. Laundering facilities, when located in the facility should be separate from the clean-linen processing area, from resident rooms, from areas of food preparation and storage, and from areas in which clean material and equipment are stored.
   4. Handwashing facilities should be available to those who sort linen.
   5. In the laundry, soiled linen should move from the dirtiest to cleanest areas as it is being processed to avoid contamination.
5. *Linen Storage*
   1. Clean linen should always be kept separate from contaminated linen.
   2. Clean linen should be handled as little as possible before use.
   3. Store clean linen in clean, covered linen carts, or behind closed doors in a designated linen room, or within a closed cabinet to protect it from accidental contamination.
   4. Once taken into a resident’s room, linen does not need to be covered and should not be returned to the linen cart or shelf until after it has been laundered.
6. *Other Laundry Services*
   1. If linen is sent off site to a professional laundry, the facility administrator and/or their designee should be knowledgeable in how the service will be provided, including how the linen is processed and handled to prevent contamination from dust and dirt during the loading and transfer.

**REFERENCES:**

Guidelines for Environmental Infection Control in Health-Care Facilities, 2003

Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions\_*15A NCAC 18A.1319 furnishings and patient contact items*

<https://ehs.ncpublichealth.com/docs/rules/294306-2-1300.pdf>

OSHA- Occupational Safety and Health Administration: Standards for handling contaminated laundry, [www.ohsa.gov](http://www.ohsa.gov) section 1910.1030 (d)(4)(iv)

**Dates Reviewed and/or Revised:**

**Facility Name**

**Infection Prevention and Control Policy Manual**

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| --- | --- |
| **Policy and Procedure Name** | **Management of Outbreak(s)** |
| **Policy Number** |  |
| **Date Issued:** |  |
| **Approved by:** |  |

**POLICY**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Facility Name) shall adhere to guidance from the federal Centers for Disease Control and Prevention (CDC), the NC Department of Health and Human Services (NCDHHS) and local health department when evaluating a potential or confirmed outbreak.

**PROCEDURE:**

1. *Definition:* 
   1. An outbreak is defined as more cases of disease (or infection) than would be expected (often with the increased number(s) happening suddenly) within a specific group of people in the same place and over a specific time. However, **one case** of an unusual disease (e.g., COVID-19) may constitute an outbreak.
2. *Conducting an outbreak investigation:*
   1. The reason for conducting an outbreak investigation is to identify the source early and stop transmission.
   2. Outbreaks can start with ill residents, staff and/or visitors
3. *Components of initial outbreak investigation:*
   1. Confirm that an outbreak may be happening by reviewing signs and symptoms of the illness and laboratory data if available.
   2. Communicate with administrator, supervisor and individual responsible for the facility’s infection prevention and control program.
   3. Notify the local health department immediately
   4. Begin documenting **early** (using a log or line listing) what is going on, who is involved and where they are in the facility. Items to include:
      1. Resident/staff members name
      2. Unit (area) they are located on
      3. Onset date of symptoms
      4. What the symptoms include (i.e., cough, fever, diarrhea etc.,)
      5. Any diagnostic test (labs or x-rays)
      6. How long did the symptoms last?
   5. **Follow guidance and instructions from the local health department in determining what infection prevention measures or other actions need to be taken. Potential measures/actions may include but not be limited to the following:**
      1. Use of transmission-based precautions for residents that are suspected of or confirmed to be infected or exposed to the infectious agent
      2. Consider whether communal activities and/or group activities should be limited and/or suspended
      3. Consider limiting or restricting visitation under the guidance of NCDHHS or the local health department and in accordance with current state law.
      4. Screening everyone (e.g., staff, residents, non-staff, visitors, volunteers) prior to entry into the facility for signs and/or symptoms of illness
      5. Posting visual alerts instructing any one with signs/symptoms of illness not to enter the facility
      6. Use source control appropriate for the way the infection is transmitted.
4. *Continuing Surveillance* 
   1. Evaluate effectiveness of your interventions
   2. Continue to conduct surveillance for additional cases based on health department guidance.
   3. Record all actions and communicate to administrator, supervisor or management and staff about what is happening, why the outbreak may have occurred and how it can be stopped and prevented from recurring.
5. *Reporting to residents and their representatives*
   1. The \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (facility insert- administrator, supervisor, or manager) of the facility shall inform residents and their representatives within 24 hours following confirmation by the local health department of a communicable disease outbreak or one on more confirmed cases of COVID-19 among any resident or staff person
   2. The facility in its notification to residents and their representative(s) shall:
      1. Not disclose any personally identifiable information of the residents or staff
      2. Provide information on the measures the facility is taking to prevent or reduce the risk of transmission, including whether normal operations of the facility will change.
      3. Provide weekly updates until the communicable illness within the facility has resolved, as determined by the local health department; and
      4. Provide education to the resident(s) concerning measures they can take to reduce the risk of spread or transmission of infection
6. *Addressing potential staffing issues during a communicable disease outbreak*

**Key Points include:**

*Maintaining staffing is essential to provide a safe work environment for staff and for resident care*

*Maximize interventions to protect staff, residents and visitors when considering strategies to address staffing shortages*

* 1. Understand normal staffing needs and the minimum number of staff needed to provide a safe environment and safe resident care under normal circumstances
  2. Understand and stay current with the community rate of transmission of the infectious agent (e.g., community transmission rate of COVID-19)
  3. Communicate with NC Department of Health and Human Services (NCDHHS), local public health departments, public health emergency preparedness and response staff to identify potential staffing resources and/or volunteers.
  4. Cancel all non-essential activities
  5. Request staff delay elective time off from work (vacation)-when feasible
  6. Cross-train staff to perform activities not normally assigned to them (e.g., feeding, cleaning) – when feasible
  7. Develop plans to identify ACHs/FCHs with adequate staffing to temporarily transfer care of the resident
  8. Follow CDC recommendations for “return to work “criteria for staff infected with the pathogen (e.g., COVID-19, influenza)

**REFERENCE(S):**

*NC Communicable Disease Manual-Outbreak Investigations*

[*https://epi.dph.ncdhhs.gov/cd/lhds/manuals/cd/outbreak.html*](https://epi.dph.ncdhhs.gov/cd/lhds/manuals/cd/outbreak.html)

*Adult Care Home and Family Care Home Rules*

<https://info.ncdhhs.gov/dhsr/rules/2020/adult-family-carehomerules/>

<https://info.ncdhhs.gov/dhsr/rules/2020/adult-family-carehomerules/AP-10A-NCAC-13G-1702.pdf>

*CDC’s “Strategies to Mitigate Healthcare Personnel Staffing Shortages” \_12\_23\_21*

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html>

**Dates Reviewed and/or Revised:**

**Facility Name**

**Infection Prevention and Control Policy Manual**

|  |  |
| --- | --- |
| **Policy and Procedure Name** | **NC Medical Waste Rules** |
| **Policy Number** |  |
| **Date Issued:** |  |
| **Approved by:** |  |

**POLICY**:

It is the policy of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to dispose of medical waste in accordance with the NC Medical Waste Management (Rules) 15A NCAC 13B .1201-.1204.

**DEFINITION(S):**

1. **“Blood and body fluids”** means liquid blood, serum, plasma, other blood products, emulsified human tissue, spinal fluids, and pleural and peritoneal fluids
2. **“Medical waste”** means any solid waste which is generated in the diagnosis, treatment, or immunization of human beings or animals
3. **“Microbiological waste”** means cultures of specimens from laboratories
4. **“Pathological waste”** means waste removed during surgery or autopsies
5. **“Regulated medical waste”** means blood and body fluids in individual containers in volumes greater than 20 ml, microbiological waste and pathological waste that have not been treated
6. **“Sharps”** means needles, syringes, and scalpel blades
7. **“Treatment”** means any process, including steam sterilization, chemical treatment, incineration-which changes the character or composition of medical waste so as to render it noninfectious

**PROCEDURE:**

1. Sharps and other safety objects such as syringes with attached needles, insulin pen needles, lancets, auto injectors and objects that can penetrate the skin shall:
   1. Be placed in a rigid, leak-proof when in an upright position, and puncture-resistant properly labeled biohazard container
   2. Shall not be compacted (crushed) prior to off-site transportation
2. Medical waste treatment and disposal:
3. Blood and body fluids in individual containers in volumes greater than 20 ml shall be disposed of by sanitary sewer or treated by incineration or steam sterilization (transported from the facility by a medical waste management company)
4. Blood and body fluids in individual container in volumes of 20 ml or less may be disposed of in a municipal solid waste landfill or disposed of in a sanitary sewer system

**REFERENCE(S):**

15A NCAC 13B .1202 GENERAL REQUIREMENTS FOR MEDICAL WASTE

[*https://deq.nc.gov/about/divisions/waste-management/solid-waste-section/medical-waste*](https://deq.nc.gov/about/divisions/waste-management/solid-waste-section/medical-waste)

SUBCHAPTER 13B - SOLID WASTE MANAGEMENT SECTION .0100 - GENERAL PROVISIONS 15A NCAC 13B .0101 DEFINITIONS

**Dates Reviewed and/or Revised:**

**Facility Name**

**Infection Prevention and Control Policy Manual**

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| --- | --- |
| **Policy and Procedure Name** | **OSHA Regulated Waste** |
| **Policy Number** |  |
| **Date Issued:** |  |
| **Approved by:** |  |

**POLICY**:

It is the policy of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to manage regulated waste in accordance with the Occupational Safety and Health Administration (OSHA)s Bloodborne pathogens standard 1910.1030

**DEFINITION(S):**

1. **“Blood”** means human blood, human blood components and products made from human blood
2. **“Bloodborne pathogens”** means pathogenic microorganisms that are present in human blood and can cause disease in humans. They include but are not limited to hepatitis B virus (HBV) and HIV
3. **“Contaminated”** means the presence or the reasonably anticipated presence of blood or other potentially infectious materials on an item or surface
4. **“Contaminated sharps”** means any contaminated object that can penetrate the skin including but not limited to needles, scalpels, and broken glass
5. **“Other Potentially Infectious Materials”** means the following human body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids
6. **“Regulated waste”** means liquid or semi-liquid blood or other potentially infectious materials; contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid state if compressed; items that are caked with dried blood or other potentially infectious materials and can release these materials during handling; contaminated sharps; and pathological and microbiological wastes containing blood or other potentially infectious materials.

**PROCEDURE:**

1. Contaminated needles and other sharps shall:
   1. Not be bent or recapped
   2. Immediately or as soon as possible after use be placed in appropriate containers that are:
      1. Closable
      2. Puncture resistant
      3. Labeled with a bio-hazard symbol or be red in color
      4. Leakproof on the sides and bottom
      5. Accessible to staff and located as close as feasible to the immediate area where sharps are used or can be anticipated to be found (e.g., laundry room)
      6. Maintained upright throughout use
      7. Routinely replaced and not allowed to overfill
2. Other regulated waste shall be placed in containers which are:
   1. Closable
   2. Constructed to contain contents and prevent leakage of fluids
   3. Labeled with a biohazard symbol or be red in color
3. Disposal of all regulated waste shall be in accordance with applicable NC regulations

**REFERENCE(S):**

Occupational Safety and Health Standards: 1910.1030-Bloodborne Pathogens

<https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1030>

**Dates Reviewed and/or Revised:**

**Facility Name**

**Infection Prevention and Control Policy Manual**

|  |  |
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| **Policy and Procedure Name** | **Post Exposure to Bloodborne Pathogen(s)** |
| **Policy Number** |  |
| **Date Issued:** |  |
| **Approved by:** |  |

**POLICY**:

It is the policy of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (facility name) to adhere to the Occupational Safety and Health Administration (OSHA) standard 1910.1030-Bloodborne Pathogens and applicable NC Communicable Disease Rules and Regulations when a staff member has had an occupational (work related) exposure to bloodborne pathogens.

**DEFINITIONS:**

1. **“Exposure Incident”** means a specific eye, mouth, other mucous membrane, non-intact skin or parenteral (needle or lancet stick) contact with blood, or other potentially infectious material that results from the performance of an employee’s duties
2. **“Occupational Exposure”** means 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
3. **“Licensed Healthcare Professional”** is a person whose legally permitted scope of practice allows him or her to independently perform the activities required by paragraph (f) Hepatitis B Vaccination and Post-exposure Evaluation and Follow-up

**PROCEDURE:**

1. *Bloodborne Pathogen Occupational Exposure*
   1. All staff must follow the facility’s established bloodborne pathogen exposure control plan when they have had an occupational exposure. (A template for this plan can be found at <https://www.osha.gov/sites/default/files/CPL_2-2_69_APPD.pdf>.)
   2. Staff should immediately wash exposed skin or puncture site with soap and water. If eyes or mouth are exposed rinse thoroughly with clean water
   3. Report the exposure **immediately** to the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (administrator, supervisor, or manager)
2. *Post-exposure Evaluation and Follow-up:*
   1. Following a report of an exposure incident the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (administrator, supervisor, manager, staff person responsible for the facility’s infection prevention and control program, etc.,) shall make immediately available to the exposed staff a confidential medical evaluation and follow-up, including at least the following elements:
      1. Document the route of exposure and how it happened
      2. Identify and document the source person unless unknown (e.g., sharp from the trash and/or laundry)
      3. Test the source person’s blood as soon as feasible to determine HIV, HBV, and HCV infectivity unless the status is already known
      4. Offer baseline testing to the exposed staff person
      5. Offer post-exposure prophylaxis, when medically indicated, as recommended by U.S. Public Health Service and in consultation with the NCDHHS
      6. Offer the exposed staff member counseling if indicated
   2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (administrator/supervisor /manager) shall ensure that all medical evaluations and procedures, including HBV vaccination and post-exposure evaluation and follow up are made available at no cost to the staff, made available at a reasonable time and place and performed by or under the supervision of a licensed physician or by or under the supervision of another licensed healthcare professional.
   3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (administrator/supervisor/manager) must maintain and keep confidential an accurate record (for at least the duration of employment plus 30 years) for each staff with occupational exposure which contains:
      1. Name and SS #
      2. HBV status
      3. Copy of results of post-exposure follow up
      4. Copy of the healthcare professional’s written opinion

***References:***

Occupational Safety and Health Administration Bloodborne Pathogen Standard: 1910.1030

[*https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1030*](https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1030)

NC Department of Labor Bloodborne Pathogen Standard

NC General statutes: Communicable Disease Control and Reporting

<https://epi.dph.ncdhhs.gov/cd/laws.html#cds>

**Dates Reviewed and/or Revised:**

**Facility Name**

**Infection Prevention and Control Policy Manual**

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| --- | --- |
| **Policy and Procedure Name** | **Reporting Communicable Diseases** |
| **Policy Number** |  |
| **Date Issued:** |  |
| **Approved by:** |  |

**POLICY**:

It is the policy of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (facility name) to adhere to the NC Public Health law (N.C.G.S. section 130A-135; 10A NCAC 41A.0101) regarding reportable diseases and conditions in North Carolina.

**PROCEDURE:**

1. *Communicable Disease Reporting to NCDHHS*
   1. A treating physician who has reason to suspect that a person reasonable suspected of having a reportable communicable disease shall report the information to the local health director of the county in which the facility is located.
   2. When a resident is reasonably suspected of having a reportable communicable disease the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_( administrator, supervisor, staff person responsible for the infection prevention and control program) may report the information to the local health director of the county in which the facility is located.
   3. A list of reportable communicable disease can be found at:

<http://reports.oah.state.nc.us/ncac/title%2010a%20-20health%20and%20human%20services/chapter%2041%20-%20epidemiology%20health/subchapter%20a/10a%20ncac%2041a%20.0101.pdf>

* 1. Depending on the specific reportable condition, time frames for reporting vary and include:
     1. immediately by telephone
     2. within 24 hours by telephone
     3. within 7 days by mailing or faxing the form
  2. Reporting communicable diseases to the health department is not a breach of resident confidentiality. It is specifically allowed pursuant to the Privacy Rule (HIPPA)and N.C. law.

1. *Communicable Disease Report Form*
   1. Upon making or suspecting any of the diagnoses listed on the CD Report form, the physician/facility will obtain and complete the form.
   2. The form should be mailed or faxed to the local health department in the county in which the resident resides.

Report form (copy attached) can be obtained from local health departments and online at: [NC DPH: Communicable Disease Surveillance & Reporting (ncdhhs.gov)](https://epi.dph.ncdhhs.gov/cd/report.html)

1. *Reporting to residents and their representatives*
   1. The \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (administrator, supervisor, or staff person responsible for the infection prevention and control program) of the facility shall inform residents and their representatives within 24 hours following confirmation by the local health department of a communicable disease outbreak or one on more confirmed cases of COVID-19 among any resident or staff person
   2. The facility in its notification to residents and their representative(s) shall:
      1. Not disclose any personally identifiable information of the residents or staff
      2. Provide information on the measures the facility is taking to prevent or reduce the risk of transmission, including whether normal operations of the facility will change.
      3. Provide weekly updates until the communicable illness within the facility has resolved, as determined by the local health department; and
      4. Provide education to the resident(s) concerning measures they can take to reduce the risk of spread or transmission of infection

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| NC Electronic Disease Surveillance System | | | | | | | | | | | NC EDSS EVENT ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| **A close up of a logo  Description automatically generated NC Department of Health and Human Services**  **Division of Public Health • Epidemiology Section**  **Communicable Disease Branch** | | | | | | | | | | | **ATTENTION HEALTH CARE PROVIDERS:**  Please report relevant clinical findings about this  disease event to the local health department. | | | | | | | | |
| **CONFIDENTIAL COMMUNICABLE DISEASE REPORT – PART 1** | | | | | | | | | | |  | | | | | | | | |
|  | | | **NAME OF DISEASE/CONDITION** | | | | | |  | |
|  | | | | | | | | | | |  | | | | | | | | |
| Patient’s Last Name First Middle Suffix Maiden/Other Alias | | | | | | | | | | | | | | | | | | | |
| Birthdate (mm/dd/yyyy)  **/    /** | | | | | | Sex  M  F  Trans. | | | | | Parent or Guardian *(of minors)* | | | | | Medical Record Number | | | |
| Patients Street Address | | | | | | | | | | City | | | State | ZIP | | County | | | Phone  **(****)     -** |
| Age | | Age Type  Years  Months  Weeks  Days | | | Race (check all that apply): Ethnic Origin  White  Asian  Hispanic  Black/African American  Other  Non-Hispanic  American Indian/Alaska Native  Unknown  Native Hawaiian or Pacific Islander | | | | | | | | Was patient hospitalized for this disease? (>24 hours)  Yes  No  Date **/    /** | | | Did patient die from this disease?  Yes  No | | Is the patient pregnant?  Yes  No | |
| Patient is associated with (check all that apply): | | | | | | | | | | | In what geographic location was the patient MOST LIKELY exposed?  In patient’s county of residence  Outside county, but within NC - County:  Out of state - State/Territory:  Out of USA - Country:  Unknown | | | | | | | | |
| Child Care (child, household contact, or worker in child care)  School (student or worker)  College/University (student or worker)  Food Service (food worker)  Health Care (health care worker)  Migrant Worker Camp | | | | | | | Correctional Facility (inmate or worker)  Long Term Care Facility (resident or worker)  Military (active military,  dependent, or recent retiree)  Travel (outside continental  United States in last 30 days)  Other | | | |
| **CLINICAL INFORMATION** | | | | | | | | | | | | | | | | | | | |
| Is/was patient symptomatic for this disease?  Yes  No  Unknown  If yes, symptom onset date (mm/dd/yyyy):  **/    /**  SPECIFY SYMPTOMS: | | | | | | | | If a sexually transmitted disease, give specific treatment details | | | | | | | | | | | |
| 1. Date patient treated:(mm/dd/yyyy) **/    /**  Medication:  Dosage:  Duration: | | | | | | | 2. Date patient treated:(mm/dd/yyyy) **/    /**  Medication:  Dosage:  Duration: | | | | |
| **DIAGNOSTIC TESTING** | | | | | | | | | | | | | | | | | | | |
| Provide lab information below and fax copy of lab results and other pertinent records to local health department. | | | | | | | | | | | | | | | | | | | |
| Specimen  Date | | | | Specimen # | | Specimen  Source | | Type of Test | | | Test  Result(s) | | Description (comments) | | | Result Date | | Lab Name –City/State | |
| **/    /** | | | |  | |  | |  | | |  | |  | | | **/    /** | |  | |
| **/    /** | | | |  | |  | |  | | |  | |  | | | **/    /** | |  | |
| **/    /** | | | |  | |  | |  | | |  | |  | | | **/    /** | |  | |
| **LOCAL HEALTH DEPARTMENT USE ONLY** | | | | | | | | | | | | | | | | | | | |
| Initial Date of Report to Public Health:  **/    /**  Initial Source of Report to Public Health:  Health Care Provider (specify):  Hospital  Private clinic/practice  Health Department  Correctional facility  Laboratory  Other | | | | | | | | Is the patient part of an outbreak of this disease?  Yes  No | | | | | | | | | | | |
| Outbreak setting:  Household/Community (specify index case):  Restaurant/Retail  Child Care  Long term care  Healthcare setting  Migrant Worker Camp | | | | | | | | | Adult care home  Assisted living facility  Adult day care  School  Prison  Other | | |
| Name of facility:  Address of facility: | | | | | | | | | | | |
| DHHS 2124 (Revised July 2020) EPIDEMIOLOGY | | | | | | | | | | | | | | | | | | | |
| **DISEASES AND CONDITIONS REPORTABLE IN NORTH CAROLINA** | | | | | | | | | | | | | | | | | | | |
| Physicians must report these diseases and conditions to the county local health department, according to the **North Carolina Administrative Code: 10A NCAC 41A.0101 Reportable Diseases and Conditions** (see below). Contact information for local health departments can be accessed at **www.ncalhd.org/directors**. If you are unable to contact your local health department, call the 24/7 pager for NCDHHS, Communicable Disease Branch **(919) 733-3419**.  For diseases and conditions required to be reported within 24 hours, the initial report shall be made by telephone to the local health department, and the written disease report be made within 7 days. The reporting rules and disease report forms can be accessed at: **http://epi.publichealth.nc.gov/cd/report.html** | | | | | | | | | | | | | | | | | | |
| **Disease/Condition Reportable to Local Health Department Within a Specific Timeframe** | | | | | | | | | | | | | | | | | | |
| Acquired immune deficiency syndrome (AIDS) – 24 hours  Acute flaccid myelitis – 7 days  Anaplasmosis – 7 days  Anthrax – immediately  Arboviral infection, neuroinvasive (WNV, LAC, EEE, other, unspecified) – 7 days  Babesiosis – 7 days  Botulism – immediately  Brucellosis – 7 days  Campylobacter infection – 24 hours  Candida auris – 24 hours  Carbapenem-Resistant Enterobacteriaceae (CRE) – 24 hours  Chancroid – 24 hours  Chikungunya virus infection – 24 hours  Chlamydial infection (laboratory confirmed) – 7 days  Cholera – 24 hours  COVID-19: see Novel coronavirus  Creutzfeldt-Jakob disease – 7 days  Cryptosporidiosis – 24 hours  Cyclosporiasis – 24 hours  Dengue – 7 days  Diphtheria – 24 hours  Escherichia coli, shiga toxin-producing infection – 24 hours  Ehrlichiosis – 7 days  Foodborne disease, including Clostridium perfringens, staphylococcal,  Bacillus cereus, and other and unknown causes – 24 hours  Gonorrhea – 24 hours  Granuloma inguinale – 24 hours  Haemophilus influenzae, invasive disease – 24 hours  Hantavirus infection – 7 days  Hemolytic-uremic syndrome (HUS) – 24 hours  Hemorrhagic fever virus infection – immediately  Hepatitis A – 24 hours  Hepatitis B – 24 hours  Hepatitis B carriage or perinatally acquired – 7 days  Hepatitis C, acute – 7 days  Human immunodeficiency virus (HIV) infection confirmed – 24 hours  Influenza virus infection causing death – 24 hours  Interferon-gamma release assay (IGRA), all results – 7 days  Legionellosis – 7 days  Leprosy – 7 days  Leptospirosis – 7 days  Listeriosis – 24 hours  Lyme disease – 7 days  Lymphogranuloma venereum – 7 days | | | | | | | | | | | Malaria – 7 days  Measles (rubeola) – immediately  Meningitis, pneumococcal – 7 days  Meningococcal disease, invasive – 24 hours  Middle East respiratory syndrome (MERS) – 24 hours  Monkeypox – 24 hours  Mumps – 7 days  Nongonococcal urethritis – 7 days  Novel coronavirus infection causing death – 24 hours  Novel coronavirus infection – immediately  Novel influenza virus infection – immediately  Ophthalmia neonatorum – 24 hours  Plague – immediately  Paralytic poliomyelitis – 24 hours  Pelvic inflammatory disease – 7 days  Pertussis (whooping cough) – 24 hours  Psittacosis – 7 days  Q fever – 7 days  Rabies, human – 24 hours  Rubella – 24 hours  Rubella congenital syndrome – 7 days  Salmonellosis – 24 hours  Severe acute respiratory syndrome (SARS) – 24 hours  Shigellosis – 24 hours  Smallpox – immediately  Spotted fever rickettsiosis (including RMSF)– 7 days  Staphylococcus aureus with reduced susceptibility to vancomycin – 24 hours  Streptococcal infection, Group A, invasive disease – 7 days  Syphilis, primary, secondary, early latent, late latent, late with clinical manifestations, congenital – 24 hours  Tetanus – 7 days  Toxic shock syndrome, non-streptococcal or streptococcal – 7 days  Trichinosis – 7 day  Tuberculosis – 24 hours  Tularemia – immediately  Typhoid fever, acute (Salmonella typhi) – 24 hours  Typhoid carriage (Salmonella typhi) – 7 days  Typhus, epidemic (louse-borne) – 7 days  Vaccinia – 24 hours;  Varicella (chickenpox) – 24 hours  Vibrio infection (other than cholera & vulnificus) – 24 hours  Vibrio vulnificus – 24 hours  Yellow fever – 7 days  Zika virus – 24 hours | | | | | | | |
| You may be contacted by the local health department for additional information about this case. Medical record information relevant to the investigation and/or control of a communicable disease is exempt from the HIPAA Privacy Rule (see 45 CFR 164.512(a) ) and is permitted as an exception to confidentiality of records in NC State Law GS § 130 A-130.  **North Carolina General Statute: §130A-135. Physicians to report.** A physician licensed to practice medicine who has reason to suspect that a person about whom the physician has been consulted professionally has a communicable disease or communicable condition declared by the Commission to be reported, shall report information required by the Commission to the local health director of the county or district in which the physician is consulted.  **North Carolina Administrative Code: 10A NCAC 41A.0101 Reportable Diseases and Conditions** (a) The following named diseases and conditions are declared to be dangerous to the public health and are hereby made reportable within the time period specified after the disease or condition is reasonably suspected to exist: | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| DHHS 2124 (Revised July 2020) EPIDEMIOLOGY | | | | | | | | | | | | | | | | | | | |

**REFERENCES:**

*Laws and rules governing communicable disease control and reporting N.C. Statute130A.*

<https://epi.dph.ncdhhs.gov/cd/laws.html>

*Reportable diseases and Conditions*

<https://epi.dph.ncdhhs.gov/cd/lhds/manuals/cd/reportable_diseases.html>

*Adult Care Home and Family Care Home Rules*

<https://info.ncdhhs.gov/dhsr/rules/2020/adult-family-carehomerules/>

<https://info.ncdhhs.gov/dhsr/rules/2020/adult-family-carehomerules/AP-10A-NCAC-13G-1702.pdf>

**ATTACHMENTS:**

*Confidential Communicable Disease Report July 2020*

**Dates Reviewed and/or Revised:**

**Facility Name**

**Infection Prevention and Control Policy Manual**

|  |  |
| --- | --- |
| **Policy and Procedure Name** | **Respiratory Hygiene and Cough Etiquette** |
| **Policy Number** |  |
| **Date Issued:** |  |
| **Approved by:** |  |

**POLICY**:

To reduce the transmission of respiratory infections, it is the policy of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (facility name) to adhere to the Centers for Disease Control and Prevention (CDC) recommendations for Respiratory Hygiene and Cough Etiquette in healthcare facilities.

**PROCEDURE:**

1. *Visual Alerts*
   1. Post visual alerts (e.g., signage, posters) at facility entrances and other strategic places within the facility (e.g., common areas, dining hall) instructing residents and those who accompany/visit them to:
      1. inform staff if they have symptoms of respiratory infection
      2. practice respiratory hygiene and cough etiquette
   2. Post alerts in appropriate languages.
2. *Containment of respiratory secretions for people with signs and symptoms of a respiratory infection*
   1. Anyone (staff, residents, visitors, volunteers etc.,) with respiratory signs and symptoms such as coughing, sneezing, congestion, rhinorrhea, and/or increased secretions should:
      1. Cover the nose and mouth when coughing/sneezing with ideally a tissue or sleeve of clothing
      2. After use, dispose of tissues in the nearest no touch waste receptacle.
      3. Perform hand hygiene (use soap and water **OR** an alcohol-based hand rub-ABHR) after having contact with respiratory secretions or any contaminated objects/surfaces. If visible soiled use soap and water.
   2. Facility shall ensure the availability of the following materials, at entrances and common areas within the facility (e.g., common areas, dining hall), so residents, staff and visitors can adhere to these measures.
      1. Disposable tissues
      2. No-touch receptacles for disposal of tissues
      3. Hand hygiene products conveniently located and available for use (e.g., dispensers of alcohol-based hand rub, soap and disposable towels if sink available)
3. *Masking and Separation of people with respiratory secretions* 
   1. Visitors with respiratory infection should not enter the facility without a face covering
   2. Provide surgical masks to residents/visitors with symptoms of a respiratory illness.
   3. Provide instructions on the proper use and disposal of masks.
   4. For symptomatic residents who cannot wear a surgical mask, provide tissues and instructions on when to use them (i.e., when coughing, sneezing, or controlling nasal secretions), how and where to dispose of them, and the importance of hand hygiene after handling this material.
4. *Droplet Precautions*
   1. Advise staff caring for residents, who have symptoms of a respiratory infection (particularly if fever is present), to observe Droplet Precautions, in addition to Standard Precautions (i.e., wearing a surgical or procedure mask and eye protection for close contact with the resident).
   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:**

CDC Guideline for Isolation Precautions: Preventing Transmission of infectious Agents in Healthcare Settings (2007)

<https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html/Isolation2007.pdf>

CDC Respiratory Hygiene and Cough Etiquette in Healthcare Settings

<https://www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm>

Printable Posters

<https://www.cdc.gov/flu/prevent/actions-prevent-flu.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fflu%2Fprotect%2Fhabits%2Findex.htm>

**Dates Reviewed and/or Revised**

**Facility Name**

**Infection Prevention and Control Policy Manual**

|  |  |
| --- | --- |
| **Policy and Procedure Name** | **Standard Precautions** |
| **Policy Number** |  |
| **Date Issued:** |  |
| **Approved by:** |  |

**POLICY**:

It is the policy of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(facility name) to adhere to the Centers for Disease Control and Prevention (CDC) Standard Precaution recommendations outlined in the “Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007)”.

**PROCEDURE:**

1. *Standard Precautions*
   1. Standard Precautions are used for all residents regardless of known or unknown infectious status.
   2. Standard Precautions apply to
      1. blood,
      2. all body fluids, secretions, and excretions except sweat, regardless of whether they contain visible blood,
      3. non-intact skin and
      4. mucus membranes.
2. *Components of Standard Precautions:*
   1. *Hand Hygiene -****reference “Use of Hand Hygiene Policy”***
      1. Perform hand hygiene before touching a resident.
      2. Perform hand hygiene after touching blood, body fluids, secretions, excretions, and contaminated items even if gloves are worn.
      3. Perform hand hygiene immediately after gloves are removed, between resident contacts, and after touching the resident’s environment.
   2. *Personal Protective Equipment-****reference “Use of PPE Policy”***
      1. Gloves
         1. Wear gloves for all residents when contact with blood, body fluids, secretions, excretions, nonintact skin, rashes, mucus membranes and contaminated items (environment or equipment) is anticipated.
         2. Remove gloves promptly after use with a resident and perform hand hygiene immediately.
         3. Change gloves whenever they are visibly soiled or torn.
      2. Mask, eye protection, face shields
         1. Wear a mask and eye protection (goggles or a face shield) to protect mucous membranes of the eyes, nose, and mouth during procedures and resident-care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, and excretions.
         2. Implement use of surgical masks and eye protection by staff during the evaluation of resident with respiratory symptoms.
      3. Gown
         1. Wear a gown to protect skin and to prevent soiling of clothing during procedures and activities that are likely to generate splashes or sprays of blood, body fluids, secretions, or excretions.
         2. Carefully remove the soiled gown in manner that clothing does not become contaminated and dispose of appropriately.
         3. Gowns should be changed right away if the gown gets wet, soiled or tears.
         4. Gowns should not be used more than once.
   3. *Respiratory Hygiene and Cough Etiquette-reference* ***“Respiratory Hygiene and Cough Etiquette Policy”*** 
      1. All individuals with signs and symptoms of a respiratory infection should follow measures to contain respiratory secretions.
      2. Cover your mouth and nose with a tissue when coughing or sneezing. Use the nearest waste receptacle to dispose of the tissue after use.
      3. Perform hand hygiene after having contact with respiratory secretions or contaminated objects or materials.
   4. *Resident Placement*
      1. Residents should be placed in a private room, when available, if:
         1. Incontinent **OR** has secretions or excretions that cannot be contained/covered,
         2. Does not (or cannot be expected to) assist in maintaining appropriate hygiene especially hand hygiene

(*Example: a resident with uncontrollable diarrhea or a wound with a lot of drainage that cannot be contained, and the resident cannot or will not perform hand hygiene)*

* + 1. Patient placement also depends on Transmission-based Precautions.
    2. When a private room is unavailable:
       1. Determine patient placement based on the following principles:
          1. Route(s) of transmission of the known or suspected infectious agent
          2. Risk factors for transmission in the infected resident
          3. Risk factors for adverse outcomes resulting from a Healthcare Acquired Infection (HAI) in other residents in the area or room being considered for resident-placement
          4. Resident options for room-sharing (e.g., cohorting residents with the same infection)
  1. *Resident Care Equipment -reference* ***“Cleaning and Disinfection of Resident Equipment Policy”***
     1. Handle used equipment in a manner that prevents skin and mucus membranes exposures and contamination of clothing.
     2. Ensure that reusable equipment is not used for the care of another resident until it has been cleaned and disinfected appropriately.
  2. *Linens/Trash*
     1. Manage all linen and trash as potentially contaminated. Handle, transport, and process in a manner that prevents skin and mucous membrane exposures and contamination of clothing.
     2. When possible, bag linen and trash in the resident room. Double bagging is not necessary unless the outside of bag is visibly contaminated.
  3. *Follow Safe Injection Practices-reference* ***“Assisted Blood Glucose Monitoring Policy”***
     1. Do not use needles or syringes for more than one resident, this includes prefilled syringes and insulin pens. *One needle, one syringe, one time*.
     2. Use aseptic (clean) technique when preparing and administering medications.
     3. Prepare medications in a clean designated area.
     4. Disinfect the rubber septum on a medication vial with alcohol before accessing.
     5. Single dose vials should be accessed one time only and for one resident only. Remaining contents of the vial should be discarded.
     6. Never recap needles and dispose of immediately after use in a designated and appropriate sharps disposal container

**REFERENCES:**

CDC Guideline for Isolation Precautions: Preventing Transmission of infectious Agents in Healthcare Settings (2007)

<https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html/Isolation2007.pdf>

CDC Standard Precautions for All Patient Care

<https://www.cdc.gov/infectioncontrol/basics/standard-precautions.html>

**Dates Reviewed and/or Revised:**

**Facility Name**

**Infection Prevention and Control Policy Manual**

|  |  |
| --- | --- |
| **Policy and Procedure Name** | **Transmission Based Precautions** |
| **Policy Number** |  |
| **Date Issued:** |  |
| **Approved by:** |  |

**POLICY**:

It is the policy of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(facility name) to adhere to the Centers for Disease Control and Prevention (CDC) Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007) for Transmission-based Precautions

**PROCEDURE:**

1. *Transmission-Based Precautions (TBP)*
   1. TBPs are the second level of basic infection control and are used in **addition to Standard Precautions.**
   2. *The type of TBP* ***needed or required*** *depends on how the spread of infection occurs (i.e., direct, or indirect contact,* respiratory droplets, or airborne route).
   3. Educate staff on type of precautions needed and appropriate personal protective equipment (PPE) to use when caring for residents on TBPs.
2. *Contact Precautions-*use for residents with a **multidrug- resistant organism** (MDRO) when there is acute diarrhea, draining wounds or other sites of secretions/excretions that cannot be contained or covered
   1. Use private room if indicated based on room placement decisions balancing risks to other residents-room restriction except for medically necessary care.
   2. Put on gown and gloves prior to entering the room.
   3. Perform hand hygiene after PPE (gown and glove) removal with alcohol-based hand rub or soap and water.
   4. Dedicate equipment needed for the resident when feasible (BP cuff for example).
   5. Equipment that is shared with other residents must be cleaned and disinfected prior to use.
3. *Enhanced Barrier Precautions*- use when recommended by local health department and/or North Carolina Division of Public Health.
   1. Wear gown and gloves for high-contact care activities (e.g., bathing, toileting, changing linens, device care or use, wound care).
   2. Remove and discard gown and gloves after care activity completed, do not wear for the care of more than one person, perform hand hygiene.
   3. Private room not required.
   4. Residents do not need to be restricted to their room.
   5. Residents do not need to be restricted from participation in group events.
4. *Droplet Precautions-*use for residents known or suspected to be infected with an organism transmitted by respiratory droplets generated by a resident when coughing, sneezing, or talking (e.g., influenza)
   1. Place the resident in a private room if feasible. Make decisions regarding resident placement on a case-by-case basis considering infection risks to other residents in the room and available alternatives.
   2. Put on a surgical mask upon entry into the resident’s room.
   3. Limit movement of residents outside of the room. If transport or movement outside the room is necessary, instruct the resident to wear a mask and practice Respiratory Hygiene/Cough Etiquette.
5. ***Special*** *Droplet and Contact Precautions* use for residents known or suspected to be infected with an organism spread by both the contact AND droplet route **AND require use of a NIOSH certified respirator for personal protective equipment (e.g., SARs, COVID-19)**
   1. Place in private room with door closed unless closing the door poses a safety risk/concern (e.g., risk of fall, memory care resident).
   2. Put on a NIOSH approved N95 or higher-level respirator, eye protection (goggles or face shield) gown and gloves prior to entry into the resident’s room
   3. Limit movement of residents outside of the room. If transport or movement outside the room is necessary, instruct the resident to wear a mask and practice Respiratory Hygiene/Cough Etiquette.
6. *Airborne Precautions*- use for residents known or suspected to be infected with an organism spread by the airborne route (e.g., tuberculosis, chicken pox, disseminated shingles)
   1. Place in a private room with the door closed.
   2. Transfer the resident as soon as feasible to a facility with an airborne infection isolation room (AIIR).
   3. Instruct the resident to wear a surgical mask, if possible, when being transported out of the facility.
   4. Staff entering the room must wear a fit-tested NISOH-approved N95 or higher-level respirator.
   5. **Residents with localized shingles do not require Airborne Precautions and transfer.**
7. *Contact and Droplet Precautions*-use for residents known or suspected to be infected with an organism spread by both the contact AND droplet route (**e.g., rhinovirus, RSV, invasive group A strep)**
   1. Place in a private room when available. When a private room is not available make decisions regarding resident placement on a case-by-case basis considering infection risks to other residents in the room and available alternatives.
   2. Put on a surgical mask, gown, and gloves upon entry into the resident’s room.
   3. Limit movement of residents outside of the room. If transport or movement outside the room is necessary, instruct the resident to wear a mask and practice Respiratory Hygiene/Cough Etiquette.
8. *Enteric Precautions*-use for residents known or suspected to be infected with an organism that can be spread by contact route (e.g., *C. difficile* and norovirus)
   1. Place in a private room.
   2. Put on a gown and gloves prior to entry into the resident’s room
   3. Limit movement of residents outside of the room. If transport or movement outside the room is necessary, instruct the resident to wear clean clothing and practice hand hygiene.
   4. If the facility is experiencing an outbreak, consider using **soap and water** instead of ABHRs for hand hygiene after glove removal.
   5. Use a bleach wipe or bleach solution to clean the room

**REFERENCES:**

CDC Guideline for Isolation Precautions: Preventing Transmission of infectious Agents in Healthcare Settings (2007)

<https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html/Isolation2007.pdf>

CDC Transmission-Based Precautions

<https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html>

Implementation of PPE Use in Nursing Homes to Prevent the Spread of Multidrug-resistant Organisms (MDRO)

<https://www.cdc.gov/hai/containment/PPE-Nursing-Homes.html>

North Carolina Standardized Isolation Signs From SPICE

[**https://spice.unc.edu/resources/signage/**](https://spice.unc.edu/resources/signage/)

**Dates Reviewed and/or Revised**

**Facility Name**

**Infection Prevention and Control Policy Manual**

|  |  |
| --- | --- |
| **Policy and Procedure Name** | **Use of Hand Hygiene** |
| **Policy Number** |  |
| **Date Issued:** |  |
| **Approved by:** |  |

**POLICY**:

It is the policy of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (facility name) to adhere to the Centers for Disease Control and Prevention (CDC) Guidelines for Hand Hygiene in Healthcare Settings.

**PROCEDURE:**

1. *Indications for handwashing and hand antisepsis:*
   1. When hands are visibly dirty or contaminated 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.
   2. If hands are not visibly soiled, use an alcohol-based hand rub (containing 60%-95% alcohol) for routinely cleaning hands in all other situations described below:
      1. Perform hand hygiene before touching a resident.
      2. Perform hand hygiene after contact with a resident’s intact skin (e.g., taking a pulse, taking a blood pressure, assisting with ambulation).
      3. Perform hand hygiene after contact with body fluids or excretions, mucous membranes, nonintact skin, or wound dressings, if hands are not visibly soiled (if soiled use soap and water)
      4. Perform hand hygiene if moving from a contaminated body site to a clean body site during resident care.
      5. Perform hand hygiene after contact with inanimate objects (including medical equipment) within the resident environment
      6. Perform hand hygiene after removing gloves
   3. Before eating and after using a restroom, wash hands with a non-antimicrobial soap and water or with an antimicrobial soap and water
   4. Antimicrobial wipes (i.e., towelettes) should not be used for staff in clinical areas
2. *Availability of Hand Hygiene Products*
   1. Replace liquid soap dispensers when empty. Dispensers must not be “topped off” since this can lead to bacterial contamination of the soap
   2. Staff should have easy and readily available access to alcohol-based hand rubs (ABHRs) (i.e. hand sanitizer). Examples include wall mounted dispensers, pump dispensers and in areas such as Dementia Memory Care Units individual pocket size portable alcohol hand sanitizers
   3. If feasible, make ABHRs available in common areas of the facility to promote hand hygiene among visitors and residents
   4. Nonalcohol-based hand rubs are not recommended.
   5. Supplies of ABHR should be stored in cabinets or areas approved for flammable materials and that are not accessible to residents. ABHR should be stored in a lockable space when used in a licensed special care unit.
3. *Hand Hygiene Technique*
   1. When washing hands with a non-antimicrobial or antimicrobial soap, wet hands first with warm water, apply 3 to 5 mL of detergent to hands, and rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers to include the nail beds and between the fingers. Rinse hands with warm water and dry thoroughly with a disposable towel. Use towel to turn off the faucet
   2. When decontaminating hands with an ABHR, apply product to palm of one hand and rub hands together, covering all surfaces of hands and fingers, until hands are dry. Follow the manufacturer’s recommendations on the volume of product to use. If an adequate volume is used it should take 15-25 seconds to dry
4. *Other Aspects of Hand Hygiene*
   1. Gloves
      1. Use hand hygiene before putting on and after removing gloves
      2. Remove gloves after caring for the resident
      3. Do not use the same pair of gloves for caring for more than one resident
      4. Do not wash gloves or use an ABHR on gloves.
   2. Artificial Nails
      1. Long nails are known to promote bacterial growth and yeast. Nails should be less than ¼ inch long
      2. Traditional nail polish, if used, must be intact. Chipped nail polish is a potential infection risk and should be removed immediately
   3. Jewelry
      1. Rings can make donning gloves more difficult and may cause tears more easily
      2. Wrist jewelry and rings may make cleaning of hands more difficult
5. *Skin Care and Lotion*
   1. Staff should use hand lotion to minimize the occurrence of irritant contact dermatitis
   2. Staff should not bring hand lotions and creams from home. They may not be compatible with the glove and the hand cleaning agent (may interfere with effectiveness of the antimicrobial handwashing agent)
6. *Staff educational and motivational programs*
   1. Staff should be educated regarding the types of resident care activities that may result in hand contamination
   2. Staff should be provided with education related to the advantages and disadvantages of the different methods to clean their hands (e.g., use of soap and water versus use of ABHR)
   3. Observe staff’s adherence to recommended hand hygiene practices and provide them with information regarding their performance
   4. Encourage residents and visitors to use hand hygiene

**REFERENCE(S):**

*Guideline for Hand Hygiene in Health-Care Setting: Recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force: MMWR; October 25, 2002/Vol.51/No.RR-16*

[*https://www.cdc.gov/mmwr/pdf/rr/rr5116.pdf*](https://www.cdc.gov/mmwr/pdf/rr/rr5116.pdf)

**Dates Reviewed and/or Revised:**

**Facility Name**

**Infection Prevention and Control Policy Manual**

|  |  |
| --- | --- |
| **Policy and Procedure Name** | **Use of Personal Protective Equipment (PPE)** |
| **Policy Number** |  |
| **Date Issued:** |  |
| **Approved by:** |  |

**POLICY**:

It is the policy of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (facility name) to adhere to the Centers for Disease Control and Prevention (CDC) Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007) for use of PPE.

**PROCEDURE:**

1. *Protect Yourselves with the use of PPE*
   1. Use appropriate PPE when performing tasks to improve personal safety in your facility. PPE is specialized clothing/equipment worn by staff (e.g., gloves, masks/respirators, gowns, eye protection) for protection against infectious agents (germs).
   2. Wear PPE when the nature of the anticipated resident interaction indicates that contact with blood or body fluids or non-intact skin may occur.
   3. Wear PPE based on type of Transmission-based Precaution utilized.
2. *Selection of appropriate PPE* 
   1. Gloves
      1. Wear gloves when contact with a resident’s blood or body fluids is anticipated, and when the resident requires Contact Precautions.
      2. When wearing gloves, 1) work from clean to dirty, 2) limit opportunities for touch contamination to protect yourselves, others, and the environment, 3) don’t touch your face or PPE with contaminated gloves, and 4) Don’t touch environmental surfaces except as necessary when providing care.
      3. Change gloves after each resident. Do not wash and reuse gloves.
   2. Gowns
      1. Wear a disposable gown when splash or spray of a resident’s blood or body fluid is anticipated and when the resident requires Contact Precautions.
      2. Remove the gown and dispose of after use. Gowns should not be used more than one time.
   3. Masks
      1. Wear a surgical mask to protect nose and mouth from spray or splash of blood and body fluids or for protection from respiratory secretions and when resident is on Droplet Precautions.
   4. Respirators
      1. Wear a fit-tested, NIOSH approved N-95 respirator or higher-level respirator when working with a resident requiring Airborne Precautions or if recommended by the CDC (COVID-19 (SARS-CoV-2) for example).
      2. Place the respirator over the nose, mouth and fit the flexible nose piece over the nose bridge.
      3. Secure on the head with the elastic bands and adjust to fit.
      4. Perform a fit-check: inhale-the respirator should collapse and exhale- checking for leakage around the face.
      5. The respirator should be removed immediately after exiting the room, discard and perform hand hygiene.
   5. Goggles
      1. Wear goggles to protect the eyes from splash or spray of blood or body fluids. Goggles should fit snuggly over and around the eyes.
      2. Personal glasses are not a substitute for protective eyewear.
   6. Face Shields
      1. Wear a face shield to protect face, mouth, nose and eyes from splash or spray of blood or body fluids.
      2. Assure the face shield completely covers the face around to sides and below the chin.
3. *Putting on PPE (donning)-put on in the following order*
   1. Gown first
      1. Select appropriate size
      2. Fully cover torso from neck to knees, arms to end of wrists and wrap around the back
      3. Fasten behind neck and waist-never tie gown in the front
   2. Mask or respirator
      1. Secure ties or ear loops
      2. Fit flexible band to nose bridge
      3. Fit snug to face and below chin (make sure nose, mouth and chin are covered)
      4. Fit-check respirator
   3. Goggles or face shield
      1. Place over face and eyes
      2. Adjust to fit
   4. Gloves
      1. Select appropriate size
      2. Extend to cover wrist of gown
4. *Removal of PPE (doffing)-remove in the following order*
   1. Gloves
      1. Outside of gloves are contaminated
      2. Use a gloved hand, grasp the palm area of the other gloved hand and peel off the first glove
      3. Hold removed glove in gloved hand
      4. Slide fingers of ungloved hand under remaining glove at wrist and peel off second glove over first glove
      5. Discard in an appropriate container
   2. Goggles or face shield
      1. Outside of goggles or face shield are contaminated
      2. Remove goggles or face shield from the back by lifting head band or earpieces
      3. If reusable disinfect, if disposable discard in an appropriate container
   3. Gown
      1. Gown front and sleeves are contaminated
      2. Unfasten gown ties, taking care that sleeves don’t contact your body when reaching for ties
      3. Pull gown away from neck and shoulders, touching inside of gown only
      4. Turn gown inside out
      5. Fold or roll into a bundle and discard in an appropriate container
   4. Mask or respirator
      1. Front of mask or respirator is contaminated
      2. Grasp bottom ties or elastics of the mask or respirator, then the ones at the top and remove without touching the front
      3. Discard in an appropriate container

***WASH HANDS OR USE AN ALCOHOL BASED HAND RUB IMMEDIATELY AFTER REMOVING ALL PPE***

1. *Accessibility of PPE*
   1. Appropriate PPE should be readily accessible to staff
   2. PPE shall be available in appropriate sizes
2. *Key Points of PPE usage*
   1. Keep hands away from your face when wearing PPE.
   2. Perform tasks from clean to dirty.
   3. Limit the surfaces you touch.
   4. Change PPE when torn or heavily contaminated.
   5. Remove PPE in a manner to avoid contaminating your skin or clothing
   6. Perform hand hygiene following removal of PPE.
3. *Staff Training and Competencies*
   1. Staff should be trained at time of hire and at least annually in use of PPE. Training should include:
      1. How to recognize the different type of PPE available
      2. How to select appropriate PPE based on the activity
      3. How to put on and remove PPE
      4. How to discard PPE appropriately
      5. Risk of staff contaminating themselves if PPE is not removed and discarded appropriately
      6. Use of hand hygiene after removal of PPE
      7. Return demonstration of how to safely put on and take off PPE

**REFERENCES:**

CDC Guideline for Isolation Precautions: Preventing Transmission of infectious Agents in Healthcare Settings (2007)

<https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html/Isolation2007.pdf>

Guidelines for selection and Use of Personal Protective Equipment in Healthcare Setting

<https://www.cdc.gov/hai/pdfs/ppe/ppeslides6-29-04.pdf>

Personal Protective Equipment Competency Validation

<https://spice.unc.edu/wp-content/uploads/2020/02/PPE-Competency-SPICErev-1-EC02272020.pdf>

Poster-Sequence for putting on and removing PPE

<https://www.cdc.gov/hai/pdfs/ppe/ppeposter148.pdf>

**Dates Reviewed and/or Revised**

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