



## Jean Yawkey Place Policy and Procedure Manual

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### POLICY: INFECTION CONTROL

#### Isolation Precautions

**Rationale:** Every reasonable attempt will be made to prevent the spread of infection at the McInnis House Clinic. A variety of infection control measures outlined below are used for decreasing the risk of transmission of organisms at the McInnis House Clinic.

All body and blood fluids will be considered infectious regardless of the perceived status of the source individual.

**Purpose:** To control spread of infection.

#### **Procedure:**

A. **Standard Precautions** (formerly referred to as Universal Precautions): used during interaction with **all** patients regardless of their diagnosis or presumed infection status.

Hand-washing: Good hand-washing using soap and water or waterless antiseptic before and after each patient contact, after using the bathroom, after handling soiled material, and after eating is mandatory for all staff. Wash hands after touching blood, body fluids, secretions, excretions, and contaminated items **whether or not gloves are worn**. It may be necessary to wash hands between tasks and procedures on the same patient to avoid cross contamination of different body sites.

Patients are asked to use waterless antiseptic before and after restroom use and before eating meals to avoid infection.

Gloves: As mandated by the OSHA blood borne pathogens final rule:

Gloves should be worn whenever contact with any of the following is expected to occur:

- 1) blood;
- 2) any body fluids, secretions and excretions *except sweat*, regardless of whether or not they contain visible blood;
- 3) non-intact skin and/or;
- 4) mucous membranes.

In addition gloves should be worn even if not explicitly delineated above whenever:

- 1) a risk of gross contamination of the hands;
- 2) special care to avoid contamination of patients during patient-care procedures, including, but not limited to suctioning, phlebotomy, dressing changes, nail clipping, injections, and wound irrigation or ;
- 3) the possibility of transmission from one patient to another exists;
- 4) handling of contaminated items is required.

Wearing gloves and changing them between patient contacts DOES NOT replace the need for hand-washing. Failure to change gloves between patient contacts is an infection control hazard.

Protective Eyewear and nose/mouth droplet prevention masks:



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Protective eyewear and masks should be worn to protect mucous membranes of the mouth, nose and eyes whenever there is a risk of a splash or spray of blood or body fluids. This includes but is not limited to the performance of the following procedures: suctioning, nail clipping, wound irrigation and dental work.

### Gown

Non-sterile gowns should be worn when splashes, sprays, or spills of blood or bodily fluids are likely to come into contact with the caregiver's body or clothes. Remove soiled gown as promptly as possible and wash hands.

### Patient care equipment

Handle soiled patient care equipment in a manner to prevent, skin and mucous membrane exposure, contamination of clothing, and transfer of microorganisms to other patients and environments. Do not reuse patient care equipment until it has been cleaned and reprocessed appropriately (see 3e). Discard single use items properly.

### Environmental control

Please see separate policy on maintenance of clinical areas regarding cleaning and disinfecting, restocking, disposing of outdated materials, equipment maintenance/inspection, separation of clean and dirty items and medical infectious waste disposal.

### Linen

All clean linen is to be kept covered. All used linen is to be handled with gloves and deposited in the dirty linen area. Clostridium difficile – all cleaning supplies are dedicated to infected patients and supplies are disposed of in biohazard bags. No sponges are used.

### Contaminated Sharps

Never recap needles. All sharps will be discarded in puncture resistant/ leak proof containers located in the clinics. Sharps containers will be inspected daily by the house keeping staff. Full containers will be brought to biohazard room and be replaced by empty containers.

### Resuscitation

A one way mask should be used whenever possible if the need for resuscitation arises. These items are located in emergency red carts in the clinic area.

### Patient placement

When a concern about a patient's infectious status occurs the Medical Director or designee will be contacted to determine the need for a private room.

### Blood and body fluid exposures/ needle sticks

If a possible exposure due to needle stick, splash, or other accident occurs please refer to policy on "Blood and Body fluid Exposures/Needle Sticks" for course of **immediate action**.

## **B. Transmission-based Precautions:**

Transmission based precautions are designed for patients documented or suspected to be infected with highly transmissible or epidemiologically important pathogens for which additional precautions beyond standard/universal precautions are



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needed to interrupt transmission. Precautions are determined based on the mode of transmission of the disease/pathogen involved. There are three types of transmission-based precautions: Airborne, Droplet, and Contact.

### 1. **Airborne Precautions:** See Policy titled "Protocol for Airborne Transmissions Precautions"

Airborne precautions require special air handling and ventilation specifications that are not possible at the McInnis House Clinic. Therefore anyone with a high suspicion of being an infectious carrier of an airborne pathogen cannot be admitted to McInnis House Clinic program. Airborne pathogens include pathogens that can be transmitted by "droplet nuclei" (residue from evaporated droplets 5um or smaller in size) or dust particles. Diseases that require airborne precautions include: measles, disseminated Varicella zoster (including primary infection), Varicella pneumonia, and pulmonary tuberculosis. Patients with the above diagnoses cannot be admitted to the McInnis House Clinic until they are considered non-infectious and the medical director or his/her designee has reviewed their case.

### 2. **Droplet Precautions:** Droplet transmission of diseases involves the contact of eyes, or the mucous membranes of the nose or mouth of a susceptible person with "large particle droplets" (larger than 5 um in size) containing microorganisms generated from who is infected by or a carrier of that pathogen. Droplets are generally formed during coughing, sneezing, talking, suctioning and other similar activities. Droplet Transmission requires close contact between source and recipient because droplets generally remain suspended in air for 3 ft or less. Special air handling and ventilation is not required. Diseases that require droplet precautions include, but are not limited to, MRSA pneumonia.

In addition to standard precautions patients known or suspected to be infected with microorganisms transmitted by droplets (see attachment) should be treated with the following precautions:

- a) Place patient in private room if available. If no private room is available, place patient in a room with a patient(s) with the same infection, but no other infection that is not shared (cohorting). However cohorted roommates should not be immunocompromised.
- b) A mask should be worn within 3ft of the patient. Mask patient when he/she leaves the room. Minimize travel of patient from his/her room.

### 3. **Contact Precautions:** Transmission of disease can occur through direct and indirect contact. Direct contact transmission involves direct skin-to-skin contact and physical transfer of microorganisms from a source person to a susceptible host. Indirect-contact transmission involves contact of a susceptible host with a contaminated intermediate object.

In addition to standard precautions patients known to be infected or colonized with an epidemiologically important pathogen that can be transmitted by direct or indirect contact (see attached list) should be treated with the following precautions.

- a) Place patient in a private room if possible. Private room needed for patients with large wound, copious drainage, drainage or body fluids not well contained, patients not able to manage their own hygiene sufficiently. When a private



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room is not available place patient in a room with a patient(s) who has similar infection and/or colonization. However cohorted roommates should not be immunocompromised.

- b) Wear gloves when coming in direct contact with patient. Dispose of gloves **before** leaving the room. Change gloves after contact with material that may have a high microorganism count (fecal material, wound drainage etc.). Wash hands immediately after removing **or use waterless antiseptic**.
- c) Wear a gown when entering the room if you anticipate substantial contact with the patient, environmental surfaces or items in the patient's room or if the patient has diarrhea, an ileostomy, a colostomy, or wound drainage not contained by a dressing. Remove gown **before** leaving the patients room. After gown removal ensure that clothing does not contact potentially contaminated surfaces.
- d) Parameters of patient movement will be decided based on the organism in question and the likelihood of environmental contamination by the patient.
- e) When indicated, dedicate the use of patient care equipment (e.g. stethoscope, BP cuff, and thermometer) to the cohort of patients with a single pathogen. Adequately clean and disinfect it between uses with 60% isopropyl alcohol or with disinfectant spray.
- f) A red Biohazard trash bag should be placed in the patient's room for disposal of contaminated material (gloves, masks, etc) A special laundry bag, marked appropriately should be used to bag bed linens and gowns. The room should be completely sanitized with disinfectant detergent surface cleaner followed by germicidal detergent when patient is discharged. Used red biohazard bags are moved to the biohazard waste room.



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### List of Infections that require precautions in addition to Standard Precautions:

Organism/illness:	Patients should remain on precautions until/for:
<b>Infections that require droplet precautions:</b>	
Pharyngeal Diphtheria	Off antibiotics 2 cultures taken 24 hours apart are negative
Influenza	Duration of symptoms or seven days, whichever is longer, avoid room sharing with high risk patients, cohort when possible
Haemophilus influenzae, known or suspected	24 hrs after initiation of effective therapy
Neisseria meningitidis (meningococcal), known or suspected	24 hrs after initiation of effective therapy
Meningococcal pneumonia	24 hrs after initiation of effective therapy
Meningococcemia	24 hrs after initiation of effective therapy
Mumps (infectious parotitis)	For 9 days after onset of swelling
Mycoplasma pneumonia	Duration of illness
Pertussis (whooping cough)	5 days after initiation of effective therapy
Pneumonic plague	72 hrs after initiation of effective therapy
Adenovirus pneumonia	Duration of illness
Rubella	7 days after onset of rash
MRSA – respiratory infections	Resolution of cough
<b>Infections that require comprehensive contact precautions:</b>	
Methicillin/oxacillin resistant <i>Staph aureus</i> (MRSA) – skin infections	See separate protocol
Vancomycin resistant enterococcus (VRE)	See separate protocol
Cutaneous Diphtheria	Off antibiotic 2 cultures 24 hrs apart are negative
Ebola viral hemorrhagic fever	Call State Health Dept. and CDC for specific advice
Lassa fever	Call State Health Dept. and CDC for specific advice
Marburg Virus disease	Call State Health Dept. and CDC for specific advice
E coli 0157:h7 in a diapered or incontinent patient	Duration of illness
Rotavirus in a diapered or incontinent patient	Duration of illness
Shigella in a diapered or incontinent patient	Duration of illness
Hepatitis A in a diapered or incontinent patient	Duration of illness
Disseminated or severe primary mucocutaneous <i>Herpes simplex</i>	Duration of illness
Impetigo	24 hrs after initiation of effective therapy
Adenovirus pneumonia	Duration of illness
Clostridium difficile in a diapered or incontinent patient	Stool culture negative 1 week after last dose of treatment medication (flagyl or vancomycin)



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<b><i>Conditions that require Modified Contact Precautions (Precaution parameter orders to be written on a case by case basis and approved by medical director or designee):</i></b>	
Lice (pediculosis)	
Scabies	
<i>Clostridium difficile</i>	
Acute viral (acute hemorrhagic) conjunctivitis	
Body Surface Infections that are not contained by a dressing including: major draining abscess, significant weeping cellulitis, decubitus ulcer with major infection and major wound infections	

**NOTE:** Precautions that apply to infants and children only ARE NOT included in this list



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### **POLICY: INFECTIONS THAT REQUIRE AIRBORNE TRANSMISSION PRECAUTIONS**

#### **Varicella Zoster (Chicken Pox and Herpes Zoster)**

Primary (Chicken Pox): Patients with known or suspected chicken pox can be admitted to McInnis House Clinic negative pressure room. This must be approved by the Respite Medical Director or Designee. Infected employees, visitors, and volunteers are not allowed on the premises until they are not infectious. A person can be considered not infectious when all lesions are crusted.

Disseminated Herpes Zoster or Herpes Zoster affecting more than one dermatome should be treated as above. (Dissemination implies there is a viremia and therefore potential for transmission via respiratory droplets. This requires Airborne Precautions, negative pressure isolation, and intravenous antiviral treatment, which should occur in an acute inpatient facility.)

Localized Herpes Zoster (one dermatome) in immunocompetent patients should be treated with Standard Precautions only. If it is possible for a non-susceptible caregiver to give care to the affected patient that is preferable, but not required.

Localized Herpes Zoster (one dermatome) in immunocompromised patients should be discussed with the Medical Director on a case-by-case basis since they may or may not be considered viremic, based on their clinical picture. The Medical Director will decide whether Airborne Precautions or Standard Precautions will apply in these cases.

Pregnant women who are already immune to varicella infection (either because of prior infection or vaccination) are not at risk of infection. Therefore, if a pregnant woman has already had varicella or vaccination, her fetus is not at risk. If a pregnant woman is not immune to varicella infection, she should not be involved in the care of patients with either primary infection (chicken pox) or Herpes Zoster.

#### **Rubeola (Measles)**

Patients with know or suspected measles (Rubeola) cannot be admitted to McInnis House Clinic. See Policy on Isolation of Potentially Infectious Patients .

#### **Tuberculosis (TB)**

See separate TB policy and policy on Isolation of Potentially Infectious Patients.





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### **POLICY: PROTOCOL FOR AIRBORNE TRANSMISSION PRECAUTIONS**

A. Airborne Infection Isolation Rooms will be used to isolate patients suspected of having a pathogen spread by airborne transmission. The pathogens that require airborne transmission precautions include Tuberculosis, Varicella and Measles. (See policy: Infections that Require Airborne Transmission Precaution).

#### **B. Admission criteria**

1. Patients suspected of having TB because of positive PPD status and clinical symptoms, and suspected of having Varicella and Measles.
2. Patients must be willing to comply with Isolation policy (see section D), and must be physically and mentally capable of complying with Isolation policy.
3. Patients with active TB or clinically suspected TB, defined as: 'a condition in which the individual has acid fast bacilli in the sputum or other bodily fluid or tissue as evidenced by a laboratory smear; or has chest x-ray findings interpreted as probable Tuberculosis by a qualified medical authority' can not be admitted.
4. TB suspected patients need to be evaluated by a clinician and have a CXR prior to admission (if one has not been done in the past 1 month) to ensure that the patient doesn't have 'clinically suspected TB'.
5. TB suspected patients should be able to produce sputum for laboratory evaluation
6. If one AFB sputum sample is found to be positive for an airborne bacilli, the patient will be transferred to an inpatient medical facility (See Section D for transporting patient).

#### **C. Admitting Protocol**

1. Medical Director and Director of Nursing of BMH, or their designees must be notified of all pending admissions.
2. Airborne Infection Isolation Rooms will be checked by Nurse Supervisor or designee prior to patient arrival to assure negative pressure. The result will be documented in the Check Log (See section E, under Negative Pressure Monitoring).
3. Upon initial encounter in JYP:
  - a. The patient will be met by security or BMH staff member at the lobby.
  - b. The patient will wear a N-95 mask upon entry into JYP
  - c. The patient will be escorted directly to the designated Airborne Infection Isolation Room



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4. Admission and Benefits staff will see patient in Airborne Infection Isolation Room to complete admission.
5. AIRBORNE PRECAUTIONS sign will be posted on patient's door.

### **D. Isolation Policy**

1. Patients will be encouraged to remain in Isolation Room until their TB status has been confirmed.
2. All meals will be served in the Isolation Room.
3. All lab draws will be done in the Isolation Room; however labs will only be ordered if there is a strong clinical indication.
4. Patients will not be permitted to leave the room for non-medical appointments.
5. Transporting patient
  - a. If a patient needs to leave the Airborne Infection Isolation Room, the clinical provider must be notified.
  - b. The patient must be accompanied by a patient escort
  - c. The patient escort must wear a personal respirator to enter room. He/she should ensure that patient wears a N-95 mask prior to leaving room. The mask is to remain in place for the duration of the trip.
  - d. Once the patient is out of the room and masked, the escort's respirator can be removed.
  - e. BMH staff and other patients are not required to wear a mask while patient is being transported.
6. Leaving the Isolation Room in order to smoke will be strongly discouraged.
7. Visitors are not allowed while patient requires an Airborne Infection Isolation Room unless approved by Medical Director of BMH or designee

### **E. Maintaining Airborne Precautions**

1. BMH employees will not enter Airborne Infection Isolation Rooms without being protected by a N-95 filtered respirator (see Policy: Respiratory Protection Program)
2. Negative Pressure Monitoring
  - a. A green light on the Digital Pressure Monitor indicates that the room is negatively pressurized; a red light indicates that the room is not negatively pressurized. If the room is negatively pressurized, the readout will display a negative value (e.g. -0.001). If a negative value is not displayed, the room cannot be used for Airborne Precautions.
  - b. While in use the Airborne Infection Isolation Room will be checked for negative pressure on every nursing shift by the nurse supervisor or designee. The results will be documented in the Check Log.
  - c. Once isolation is complete, the Check Log will be placed in the patient's medical record.



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3. Patients should be instructed to cover nose and mouth with a tissue when coughing and sneezing, even when they are in the Isolation Room.
4. Airborne Infection Isolation Room doors must remain closed at all times. When entering the room, the inner anteroom door must not be opened until the outer door is closed. When leaving the room, the inner door must be closed before opening the outer door.
5. Respirators must be removed and hands washed when staff exiting the room.
6. Pressure Failure
  - a. When the pressure monitor indicates that the room is not negatively pressurized, the nursing supervisor or designee will notify the Director of Facilities or designee.
  - b. Patient immediately wears N-95 mask.
  - c. Director of Facilities will investigate the failure, including both negative pressure rooms, and notify the DON or designee of required actions.
  - d. If negative pressure cannot be restored, the patient must be moved to another functioning Airborne Infection Isolation Room, which may require transfer to another facility as determined by the Medical Director.
7. Codes and Code Team
  - a. In the event of an emergency requiring the code team to enter the room, the risk of transmission of TB to other patients and staff must be included in the decision making process
  - b. Airborne Precautions procedures must be used throughout the rescue and transfer of patient when ever possible.
8. Patient leaving AMA and/or uncooperative
  - a. The public health risk will be taken into account by the Medical Director when making decisions about disposition of such patients.
9. Discontinuation of Airborne Precautions
  - a. Precautions can be discontinued once there is laboratory evidence of three sputum cultures negative for acid fast bacillus, for TB suspected patients (See section F), or when the patient is considered no longer infectious from a clinical standpoint, in the case of Varicella and Measles.
  - b. Following the discharge of an Airborne Precautions patient, the Isolation Room will remain vacant for 1 hour.
10. Preventive maintenance and rebalancing of Airborne Infection Isolation Rooms will be performed annually, in accordance with CDC Guidelines by Facilities.

### **F. Sputum Specimen**

1. 3 consecutive sputum specimens, taken at least 24 hours apart will be collected in a sterile container.



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2. Specimen will be collected in Airborne Precaution Room and placed into a plastic bag before being removed from the room.
3. All specimens will be sent to Boston Medical Center for evaluation.
4. If patient is unable to produce sputum, Medical Director or designee will be notified and patient will be transferred to an acute-care facility.



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### **POLICY: RESPIRATORY PROTECTION PROGRAM**

1. All employees must wear a N95 respirator when entering an Airborne Transmission room with a patient requiring airborne precaution.
2. Prior to wearing a N95 respirator, all employees must be fit-tested for the appropriate respirator size.
3. In compliance with OSHA employees who need to wear a N-95 respirator must complete the OSHA Medical Clearance Questionnaire.
4. The completed questionnaire will be evaluated by the Department of Occupational & Environmental Medicine (OEM) at Boston Medical Center.
5. The Department of OEM will determine if the employee is medically cleared for fit testing and will notify Human Resources. If the employee is not medically clearance through the questionnaire, the Department of OEM will contact the employee and arrange for a more detailed evaluation.
6. The employees' supervisor will arrange for the fit testing after medical clearance.
7. All employees must be fit tested annually in compliance with OSHA.
8. If an employee is ultimately not medically cleared for fit testing, or if the employee fails the fit testing process, he/she cannot entering an Airborne Transmission room with a patient requiring airborne precaution except in the case of a code (see Policy: Isolation of Potentially Infectious Patients).



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### **POLICY: MULTI-DRUG RESISTANT ORGANISM**

#### **Vancomycin Resistant Enterococcus (VRE)**

In addition to Standard Precautions and Contact Precautions the following procedures will be followed for any patients with VRE infection or colonization:

Obtain cultures of stool or rectal swabs of roommates of patients newly diagnosed with VRE to determine their colonization status and apply isolation precautions as necessary.

Patients should remain on VRE precautions until VRE-negative results are found on three consecutive occasions at least 3 days apart from multiple body sites including: stool or rectal swab, perineal area, axilla or umbilicus, wound, Foley catheter and/or ostomy sites if applicable.

All patients colonized or infected with VRE will have access to a private bathroom or a bathroom shared with patients with the same organism when appropriate. Patients are expected use only that bathroom while at Barbara McInnis House Clinic.

Charts of VRE colonized patients will be recorded in the BHCHP electronic medical record.

#### **Methicillin/oxacillin Resistant Staph Aureus (MRSA)**

In addition to following Standard and Contact Precautions for all patients known to have MRSA skin infections or colonizations, MRSA status will be recorded in the BHCHP electronic medical record.

Patients with MRSA respiratory infections will be treated with Droplet Precautions.

Mattresses are wiped with bacteriocidal cleanser, air dried, and linens are replaced.



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### POLICY: BLOOD AND BODY FLUID EXPOSURES/NEEDLESTICKS

**Rationale:** To protect employees from infection from blood borne pathogens and to assure appropriate follow up care for any employee who has an exposure incident

#### Procedures:

- Standard precautions are to be used at all times unless specific precautions are ordered (i.e. airborne, contact, etc)
- All patients should be considered potentially infected with bloodborne pathogens.
- All sharps and instruments should be considered potentially infected with bloodborne pathogens.
- Exposure to potentially infectious materials should be minimized.
- The Post Exposure Prophylaxis following Occupational Exposure to HIV policy of Boston Medical Center (Addendum) will be adopted with the following changes:
  - Upon exposure, immediately clean the area with antiseptic solution and notify immediate supervisor
  - Supervisor will await instruction from OHS ED regarding the necessity for testing patient for HIV, Hepatitis. Supervisor in consultation with Director of Nursing or designee will confirm that appropriate testing is done
  - Supervisor should check the patient's chart to determine his/her HIV, hepatitis, and RPR status while employee is getting ready to go to BMC Occupational Health Service or their choice of provider.
- If the above status is unknown, obtain the patient's written consent and draw an RPR, HIV, HCV and HbsAG (see attached at Informed Consent Policy). However, this should not delay the employee going to BMC's OHS.

On **the same day as the exposure**, if it occurs during daytime hours, the Boston Medical Center Occupational Health Service (OHS) will be contacted, Mon-Fri 8:00am-4:00pm, 414-4632 or 638-8400 (or provider of choice).

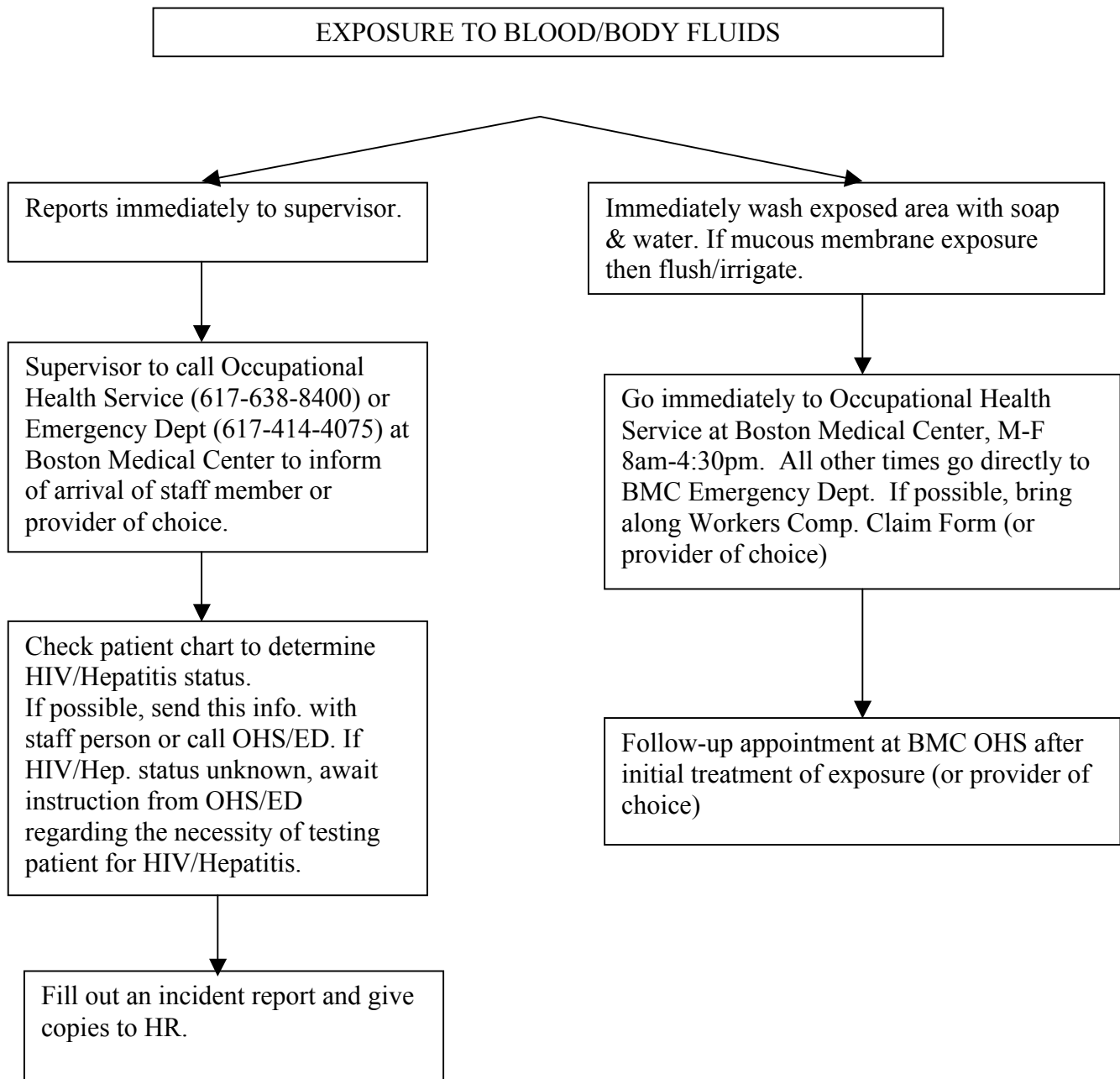
- The staff member will be instructed to proceed directly to OHS. If possible, the Worker's Comp. Claim form must accompany the employee to OHS.
- On **the same day as the exposure**, if it occurs after 4pm, the employee should go to the BMC Emergency Department (or provider of choice). The BMC ED knows the procedures followed by BMC OHS and can arrange for follow-up there as soon as possible. **Employee should be seen at OHS or ED within an hour of exposure.**
- Report to Medical Director or, if s/he is not available, page the on-call physician.
- **ALL INSTANCES OF EXPOSURE MUST BE REPORTED TO OHS.**
- An incident report should be filled out. Copies need to go to HR, Director of Nursing or designee and appropriate supervisor.
- Clinical care committee will review all exposure incidents and monitor for trends, equipment evaluation and make recommendation for staff education.
- Follow-up after the initial exposure evaluation is mandatory in all cases, and particularly important for exposures from HIV-positive patients or for persons starting prophylaxis. Follow-up should be done at BMC OHS (or provider of choice) as soon as is possible.



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### Blood and Body Fluid Exposure Flow Chart

(Exposures include; cuts with dirty needle or other sharp objects, human bites, blood on open cuts or other breaks in the skin, splashes to the eyes or mucous membranes)







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### PATIENT LAB DRAW CONSENT FORM AFTER CRITICAL EXPOSURE

I \_\_\_\_\_ **CONSENT / DO NOT CONSENT** to have blood drawn for the purpose of  
determining:

HIV status \_\_\_\_\_

Hepatitis status \_\_\_\_\_

RPR status \_\_\_\_\_

And for staff, as appropriate, to know the results and provide results to the Occupational Health Service of Boston Medical Center if necessary.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date