CONWAY MEDICAL CENTER
POLICY

When in hard copy form, refer to Policy Manager to validate this as the most current revision.

POLICY TITLE:	Hand Hygiene Guidelines		
ISSUED BY:	Infection Control	REFERENCE #:	INF-3.10-POL
APPROVED BY:	VP Quality	EFFECTIVE DATE:	11-2003

SCOPE: Hand hygiene guidelines for all Conway Medical Center employees.

POLICY STATEMENT: Hand washing is the single most important action a health care worker can do to prevent the spread of infection in a health care facility. Conway Medical Center fully endorses the Hand-Hygiene Guidelines set forth by CDC and HICPAC. All CMC employees shall adhere to the following guidelines.

POLICY REQUIREMENTS:

I) INDICATIONS FOR HAND WASHING AND HAND ANTISEPSIS:

A) When hands are visibly dirty or contaminated with a proteinaceous material or visibly soiled with blood or other body fluids, wash hands with soap and water.
B) If hands are not visibly soiled, you may use an alcohol-based hand rub for routinely decontaminating hands or use soap and water.
C) Decontaminate hands before having direct contact with patients.
D) Decontaminate hands before donning sterile gloves when inserting a central intravascular catheter.
E) Decontaminate hands before inserting indwelling urinary catheters, peripheral vascular catheters, or other invasive devices that do not require a surgical procedure.
F) Decontaminate hands after contact with a patient's intact skin.
G) Decontaminate hands after contact with body fluids or excretions, mucous membranes, non intact skin, and wound dressings if hands are not visibly soiled.
H) Decontaminate hands if moving from a contaminated – body site to a clean body site during patient care.
I) Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient.
J) Decontaminate hands after removing gloves.
K) Before eating and after using a restroom, wash hands with soap and water.

II) HAND HYGIENE TECHNIQUE:

A) When decontaminating hands with an alcohol-based hand rub, apply product to palm of one hand and rub hands together, covering all surfaces of hands and fingers, until hands are dry.
B) When washing hands with soap and water, apply soap to hands and rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse hands with water and dry thoroughly with a disposable towel. Use towel to turn off the faucet.

III) SURGICAL HAND ANTISEPSIS:

A) Remove rings, watches, and bracelets before beginning surgical hand scrub.
B) Remove debris from underneath fingernails using a nail cleaner under running water.
C) Surgical hand antisepsis using either an antimicrobial soap or an alcohol-based hand rub before donning sterile gloves when performing surgical procedures.
D) When performing surgical hand antisepsis using an antimicrobial soap, scrub hands and forearms 5 minutes for the initial scrub.
E) When using an alcohol-based surgical hand scrub, pre-wash hands and forearms with a non-antimicrobial soap and dry hands and forearms completely. After application of the alcohol-based product, allow hands and forearms to dry thoroughly before donning sterile gloves.

IV) OTHER ASPECTS OF HAND HYGIENE:

A) Do not wear artificial fingernails or extenders when having direct contact with patients.
B) Keep natural nails less than ¼ inch long.
C) Wear gloves when contact with blood or other infectious materials, mucous membranes and non-intact skin could occur.
D) Remove gloves after caring for a patient. Do not wear the same pair of gloves between uses with different patients.
E) Change gloves during patient care if moving from a contaminated body site to a clean body site.
F) Health Care workers may use hand lotions or cream to minimize the occurrence of irritant contact dermatitis associated with hand antisepsis or hand washing.

RECORDS: None

REFERENCE/STANDARDS:

I) CDC Guidelines for Preventing Healthcare-associated Infections
II) CMS Conditions of Participation: 42 CFR §484.42(a) A-0749
III) Det Norske Veritas National Integrated Accreditation for Healthcare Organizations (NIAHO):
A) IC.1 SR.1, IC.1 SR.2

REVISION/REVIEW HISTORY:

Date	Affected Section(s)	Summary of Changes ('Reviewed' or details of change)
		Reviewed/Revised: 01/20/2005, 03/2005, 10/2006, 05/30/2007, 06/09/2008
11/01/2011		Reviewed
09/04/2012		Revised
04/11/2013		New Format
09-19-2013	Standards	Added
11-11-2013		Final Approval
6/8/2015		Reviewed-No changes
6/13/2017	Scope	Revised scope
7/26/2019	Reviewed	Reviewed-no changes

CONWAY MEDICAL CENTER
PROCEDURE

When in hard copy form, refer to Policy Manager to validate this as the most current revision.

TITLE:	Influenza Prevention and Control Program		
ISSUED BY:	Infection Control/Employee Health	REFERENCE #:	EH-3.35-PRO
APPROVED BY:	VP of Human Resources	EFFECTIVE DATE:	1981

SCOPE: Influenza immunity and exposure requirements for Conway Medical Center (CMC) patients and Staff which includes, but is not limited to Patients, Employees, Contractors, Providers, Students and Volunteers.

PROCEDURE:

I) Purpose:

A) To help protect patients, visitors, employees, employee's/patient family members, volunteers, providers, students and the general community from influenza infection through annual immunizations and following other related healthcare best practices.

II) Immunization Recommendations for Patients:

A) All inpatients and general medical office visits to locations which have the vaccination in stock and of age 18 and over will be screened for the need for influenza (flu) vaccination. Any patient found to meet these criteria will be offered the option to receive the vaccine. Patients under the age of 18 will be subject to the discretion of their attending physician and parent/guardian decision.

B) Flu vaccine for high risk patients will be determined by the attending physician.

C) The type/method of vaccination will be determined between the patient and attending physician.

III) Recommendations for positive Influenza Patients:

A) Elective admissions and surgery to be postponed if at all possible.

B) Unnecessary hospitalization of mild uncomplicated flu is discouraged.

C) Any patient presenting with flu-like symptoms will be placed on Droplet Precautions protocol.

D) Clinical Staff are educated on Droplet Precautions protocol and proper PPE.

E) Handwashing protocol should be diligently followed.

F) In the In-patient setting - the treatment team will institute curtailment of visitors including limiting hospital staff entry/contact as may be needed. Visitation protocol changes ultimately must be approved by the attending physician or Nursing Services Leader.

IV) General Recommendations for Influenza Season Patients Visitors Protocols:

A) CMC Facility access by visitors can be restricted/limited with Senior Administration approval

when case prevalence is high in the community or other concerns exist.

B) No visitor will be permitted entry with active infection and/or signs/symptoms of flu.

C) Visitors who are permitted entry are educated through signage, flyers and other means on handwashing and droplet precautions.

V) Immunization Requirements for CMC Employees:

A) Annual flu vaccinations are specifically required for all CMC employees as a condition of continued employment and are provided at no cost to the employee.

B) The Employee Health (EH) department will facilitate the employee influenza immunization program annually.

C) On an annual basis, Employee Health will determine the receipt date of influenza vaccines and will establish the "timeline" in which the required vaccinations must take place.

D) The employee is required to sign the Influenza consent form (EH-4444-FRM) before receiving the vaccination.

E) Employees may request an "accommodation" to opt out of the required vaccination only on the basis of (a) evidence based medical reasons or (b) confirmed religious objections. Employees otherwise may not opt out or elect an accommodation.

F) Employees desiring to request an "accommodation" to opt out per "V-E" above may only request to do so under two "evidence based" categories in a written request to Conway Medical Center Employee Health Office. The two evidence-based categories are:

1) Evidence Based Medical Reasons must be specific and documented/signed by the primary medical provider that has knowledge of or provided treatment for the medical condition.
   - Egg Allergy: Given supply availability, Conway Medical Center will provide an "egg-free" influenza vaccination for those with documented egg allergies.

2) Religious Beliefs: Employees requesting a "confirmed religious objection" accommodation are required to provide written confirmation/documentation from their respective clergy leadership.

G) Employee Health will review a requested accommodation on a "case by case" analysis to determine if the requested accommodations is approved.

H) If a requested accommodation is approved an appropriate alternative required protective protocol (accommodation) will be instituted.

I) Accommodations will be made based on "risk factors" associated with potential exposure to other employees, patients, guest and visitors etc. However, in all cases an approved "accommodation" to opt out of the required vaccination will require the individual to wear an Employee Health approved mask during all working hours as determined by Employee Health throughout the influenza season or until otherwise declared "over" by Employee Health.

J) Employees who fail to comply with the mask or any approved accommodation requirements will be subject to corrective action up to and including discharge from employment.

K) An employee's inability to wear the required Employee Health approved mask (or other required PPE) due to verified medical reasons, identified as an "evidence based approved accommodation", will not be allowed to work until such time the flu season ends as determined by Employee Health. Employees may (a) request a Leave of Absence during this

time which may or may not be granted per the discretion of the department leader or (b) voluntarily resign employment.

L) Employee(s) without an approved "accommodation" who refuse an influenza vaccination will be allowed to voluntarily resign in good standing or be subject to discharge from employment with Conway Medical Center.

M) Prospective final candidates for CMC hire are required to provide documentation of a current seasonal Influenza vaccination. If proof of vaccination is not provided, Employee Health will provide the influenza vaccine at no cost to the prospective employee. The documentation of flu vaccination completion during flu season is a condition of employment and these individuals are subject to the same requirements as noted in this section for "employees".

VI) General Requirements for Employees, contractors, students, affiliated Providers and other "staff" during the Influenza season

A) Required not to report to work/assignment if have a fever of 100.3 degrees or greater.

B) Required not to report to work/assignment if exhibiting flu-like symptoms such as:
   1) Body aches (muscle or joint)
   2) Cough
   3) Sore throat
   4) Acute onset of respiratory illness

C) Staff who exhibit flu-like symptoms while on CMC work/assignment are required to:
   1) Stop patient-care activities as applicable, separate from others, don a facemask.
   2) Contact the Employee Health Office for consultation at ext 8061 or 8175 during the day shift or the Nursing Supervisor at extension 7659 for all other hours not covered by Employee Health.
   3) Employees in need of medical attention as deemed necessary by either Employee Health or Administrative RN Supervisor will be referred to the appropriate entry point for testing/treatment as determined and depending on acuity of symptoms and other factors.
   4) Notify their leadership member of their status when possible.

D) Staff who exhibit flu-like symptoms while at home or otherwise prior to reporting to assignment:
   1) Staff who develop a fever of 100.3 or greater should not report to assignment.
   2) Staff who develop respiratory symptoms should not report to assignment and notify their leadership member.
   3) Staff with confirmed or suspected Influenza being treated with antivirals must stay out of work/assignment for a minimum of (5) calendar days from the onset of symptoms or confirmed influenza diagnosis.
   4) Staff must be symptom and fever free for 24 hours without the use of fever-reducing medication prior to returning to assignment.
   5) Once staff have met return-to-work/assignment criteria as noted in this section the staff member is specifically required not to return to assignment until released by the Employee Health Office. That evaluation may be done by phone or in person as determined by the Employee Health Office representative.

VII) Employee Influenza Exposures and Prophylaxis Protocol:

A) Influenza Exposure Definition - a suspected infected person or a confirmed infected person coughs or sneezes within 6 feet of a staff member that has not been properly vaccinated or is otherwise unprotected (i.e., not wearing an N-95 respirator or a Powered Air Purifying Respiratory (PAPR) or other current recommendations by OSHA, CDC or DHEC).

B) Prophylaxis Definition – an action or collection of actions that prevents or treats influenza or inhibits it from spreading.

C) Staff who have presumed immunity based on documented influenza immunization:
   1) will be monitored daily during the 3-5 calendar day period after exposure for fever or symptoms suggestive of Influenza.
   2) those who become symptomatic will be tested for influenza and excluded from assignment.

D) Staff presumed to NOT have immunity based on no documented influenza immunization:
   1) are to receive vaccination as soon as possible (within 3-5 calendar days post exposure).
   2) are considered potentially infectious and will be monitored by Employee Health daily.

E) Staff who are not vaccinated and with no presumed immunity and have contraindications to the Influenza vaccine:
   1) If employee develops respiratory symptoms they will be quarantined and monitored by Employee Health for 5 calendar days.

VIII) VOLUNTEERS

A) Annual flu vaccinations are specifically required for all CMC Volunteers as a condition of continued volunteer assignment and are provided at no cost to the volunteer. All related requirements noted in section "V" above apply the same to volunteers as they do CMC employees.

IX) ROTATING STUDENTS

A) Annual flu vaccinations are specifically required for all CMC rotating students as a condition of continued presence/assignment in a CMC facility. The vast majority of educational institutions require healthcare students to receive the influenza vaccine as a condition of presence in the program. However, if that is not in effect for a particular student, the vaccination will be provided by the employee health office at "student cost" to the individual when supplies allow. All related requirements noted in section "V" above apply the same to students as they do CMC employees.

X) Long Term On-site Contractors, Temporary contractors such as "travelers", Credentialed but not employed Providers

A) CMC will intend to systematically institute contractual changes requiring these individuals as a condition of assignment with CMC to receive the annual influenza vaccination. In the meantime, these individuals are highly recommended to receive the flu vaccination.

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RECORDS:

I) Employee Health-Forms 621-622

REFERENCE/STANDARDS:

I) Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices — United States, 2020–21 Influenza Season

II) CMS Conditions of Participation: 42 CFR §484.42(a) A-0748

III) Det Norske Veritas National Integrated Accreditation for Healthcare Organizations (NIAHO):
A) IC.1 SR.3, IC.1 SR.4, IC.1 SR.5, IC.1 SR.6, IC.1 SR.7, IC.1 SR.8

IV) The Hospital Infection Control Practices Advisory Committee (HICPAC). Guideline for infection control in health care personnel, 1998.

V) CDC. MMWR Immunizations of Health-Care Personnel. Recommendations of the Advisory Committee on Immunization Practices (ACIP). November 25, 2011. https://www.cdc.gov/mmwr/pdf/rr/rr6007.pdf

REVISION/REVIEW HISTORY:

Date	Affected Section(s)	Summary of Changes ('Reviewed' or details of change)
		Reviewed/Revision Dates: September 1999; May 2001; June 2002; March 2003;
06-10-2013	All	Formatting only
07/24/2012		Reviewed…References added
09/19/2013	Standards	Added
9/1/2016	Section II A	Revised wording
3/27/2019	V and VI	Section V: added contraindications of Influenza vaccine. Section VI: added post exposure requirements
9/15/2020	All Sections	Compete policy overhaul. Essentially every section edited with a primary influence of requiring flu vac for employees, students and volunteers.

CONWAY MEDICAL CENTER
PROCEDURE

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TITLE:	Standard Precautions		
ISSUED BY:	Infection Control	REFERENCE #:	INF-3.50-PRO
APPROVED BY:	VP Quality	EFFECTIVE DATE:	03-2005

SCOPE: Standard precautions for all patient care.

PROCEDURE:

I) Purpose:

A) Standard Precautions are designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection in hospitals. Healthcare workers (HCW's) must assume that all patients are infectious. Standard Precautions apply to the following:
   1) Blood;
   2) All body fluids, secretions and excretions, except sweat, regardless of whether or not they contain blood;
   3) Non-intact skin and;
   4) Mucous membranes.

II) Clinical Procedure:

A) Standard Precautions will be used by all Healthcare workers for the care of all patients at Conway Medical Center.

B) Standard Precautions will include the following:

Hand Hygiene (Refer to Hand Hygiene Policy)

Use soap and water for visibly soiled hands. Hand hygiene is required before and after contact with patients (i.e., whether patient is or is not in patient room, in wheelchair, stretcher, etc) and their environment. This includes after touching blood, body fluids, secretions, excretions, contaminated items, immediately after removing gloves, and between patient contacts.

Personal Protective Equipment (PPE): Safe Donning and Removal of PPE refers to gloves, gown, eye protection, mask or respirator: The type of clinical interaction determines PPE use.

- **Gloves:** Wear for expected contact with blood, body fluids, secretions, excretions, contaminated items, for touching mucous membranes and non-intact skin. Gloves are to be removed immediately upon completion of the task and discarded.
- **Gown:** Wear during procedures and patient-care activities when contact of clothing/exposed skin with blood/body fluids, secretions, and excretions is anticipated. Gown is to be removed immediately after use and discarded appropriately.
- **Eye Protection (goggles, face shield, visor or glasses with solid side shields, or chin-length face shields):** Wear when there is anticipation of splash or spray of blood or body fluids to

protect the eyes, nose, and mouth (Note: regular eye glasses are NOT considered eye protection).

- **Mask or Respirator:** Wear to protect mucosa and airway from inhalation during procedures and patient-care activities likely to generate splashes or sprays of blood, body fluids, secretions, especially suctioning, endotracheal intubation, accessing spinal fluid procedures or injecting material into the spinal canal.

Work Practice Controls

- All employees who have occupational exposure to blood borne pathogens will comply with the OSHA Blood borne Pathogen rules and regulations.
- All staff should take precautions to prevent injuries caused by needles, scalpels, and other sharp instruments or devices during procedures; when cleaning used instruments; during disposal of used needles; and when handling sharp instruments after procedures.
- To prevent needle stick injuries, needles should not be recapped, purposely bent or broken by hand, removed from disposable syringes, or otherwise manipulated.
- After they are used, disposable syringes and needles, scalpel blades, and other sharp items should be placed in puncture-resistant containers for disposal.
- Safety devices should be used when provided. New safety devices will be evaluated on an ongoing basis to prevent exposures (SEE HOSPITAL BLOOD AND BODY FLUID EXPOSURE CONTROL PLAN)
- Contact Employee Health or Nursing Supervisor for any employee exposures.

Patient-care Equipment / Medical Devices

Patient-care equipment that is contaminated is handled in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and transfer of microorganisms to other patients and environments. All reusable equipment is appropriately cleaned and reprocessed prior to reuse. Single use items are properly discarded after use. Dedicate use of non-critical patient care equipment to a single patient when possible.

Environmental Control

Ensure all patient care items, bedside equipment, and frequently touched surfaces receive daily disinfection. Privacy curtains are changed when visibly soiled or as needed. Follow established procedures for routine care, cleaning, and disinfection of environmental surfaces, especially frequently touched surfaces in patient-care areas. Immediately clean spills of any blood or body fluids with approved CMC disinfectant.

Dietary Supplies

Routine meal trays: no special precautions are needed for dishes, utensils, or cups for patients on standard precautions or if transmission-based isolation precautions are added.

Linen
Handle in a manner that prevents transfer of microorganisms to others and to the environment.

Lumbar Puncture

Surgical facemasks are effective in limiting the dispersal of orophyaryngeal droplets. Wear a surgical facemask when placing a catheter or injecting material into the spinal canal or subdural space (i.e., myelograms, LPs, and spinal or epidural anesthesia).

Needles and Other Sharps

Do not recap, bend, break, or hand-manipulate used needles. If recapping is required, use a one-handed scoop technique only. Use safety features when available and place used sharps in puncture-resistant container.

Patient Placement
Prioritize for single-patient room if patient is at increased risk of transmission, is likely to contaminate the environment, does not maintain appropriate hygiene, or is at increased risk of acquiring infection or developing adverse outcome following infection. If cohorting becomes necessary, refer to transmission-based procedure in policy.

Respiratory Hygiene/Cough Etiquette (source containment of infectious respiratory secretions in symptomatic patients, beginning at initial point of encounter e.g., triage and reception areas in emergency departments and physician offices)
Instruct symptomatic persons to cover mouth/nose when sneezing/coughing; use tissues and dispose immediately after use; clean hands after contact with respiratory secretions; wear surgical mask if tolerated or maintain spatial separation, >3 feet if possible.

Safe Injection Practices

- Use a sterile, single-use, disposable needle and syringe for each injection given. Dispose of needle and syringe properly after one use. Prevent contamination of injection equipment and medication.
- Whenever possible, use of single-dose vials is preferred over multiple-dose vials, especially when medications will be administered to multiple patients.
- Do not use bags or bottles of IV solution as a common source of supply for multiple patients.

Specimen/Specimen Transport

All specimens of blood and body fluids should be placed in a well-constructed CMC approved container with a secure lid to prevent leaking during transport. A clean outer container / bag must

be utilized in transport to prevent potential exposure to others. This container / bag should be labeled with a biohazard symbol for identification.

RECORDS: N/A

REFERENCE/STANDARDS:

I) CDC GUIDELINES FOR ISOLATION IN HEALTCARE FACILITIES-2007
II) CMS Conditions of Participation: 42 CFR §484.42(a) A-0749
III) Det Norske Veritas National Integrated Accreditation for Healthcare Organizations (NIAHO):
A) IC.1 SR.1, IC.1 SR.2
IV) OSHA Bloodborne pathogens:
https://www.osha.gov/lawsregs/regulations/standardnumber/1910/1910.1030#1910.1030(b)
V) OSHA Universal precautions:
https://www.osha.gov/lawsregs/regulations/standardnumber/1910/1910.1030#1910.1030(d)(1)

REVISION/REVIEW HISTORY:

Date	Affected Section(s)	Summary of Changes ('Reviewed' or details of change)
		Reviewed/Revision Dates: Replaces the Universal Precaution Policy-January 2005; March 2005; October 2006; February 2007; April 4, 2008, November 2, 2011
06-07-2013	All	Formatting only
09-20-2013	Standards	Added
11-11-2013		Final Approval
9-30-2014		Reviewed and Added Mask to lumbar puncture section and safe injection practices. Infection Control Committee approved on 9/30/2014.
7/27/2017	Reviewed	Reviewed with no revisions.
8/9/2019	Reference	Added OSHA reference for BBP and universal precautions
3/25/2020	Logo	Updated to new Logo
9/15/2020	Reviewed	No Changes

TITLE:	Transmission Based Precautions		
ISSUED BY:	Infection Control	REFERENCE #:	INF-4.10-PRO
APPROVED BY:	Infection Control Commitee Chair	EFFECTIVE DATE:	2014-09-30

SCOPE: Healthcare workers caring for patients with suspected or documented infections.

Purpose: **Transmission-based Precautions (isolation)** are designed for patients with suspected or documented infection with microorganisms that are highly transmissible and ***should be used in addition to Standard Precautions***. These four categories of additional precautions are contact, special enteric, droplet and airborne.

Transmission-based isolation precautions require specific PPE to be used and are dependent on the method of transmission of the suspected or diagnosed infection. Refer to Appendix B: Transmission-based Precautions Chart. Hand hygiene is performed before entering and as leaving patient room.

Responsible Persons:
Health Care Workers

Procedure:

Initiating Transmission-based Precautions
The RN can initiate transmission-based precautions.

Patient Placement

a. Appropriate patient placement is a significant component of transmission-based (isolation) precautions.

b. A private room is preferred because it is important to prevent direct or indirect contact transmission when the source patient has poor hygiene habits, contaminates the environment, or cannot be expected to assist in maintaining infection prevention precautions to limit transmission of microorganisms (i.e., children or patients with altered mental status).

c. When possible, a patient with highly transmissible or epidemiologically important microorganisms shall be placed in a private room with hand washing and toilet facilities, to reduce opportunities for transmission of microorganisms.

d. Patients suspected or infected with like organisms that require transmission-based (isolation) precautions may share a room. As appropriate, contact Infection Prevention for assistance with patient placement or isolation requirements. Patients requiring Airborne Precautions are to be placed in a negative airflow room and the **door is to be kept closed at all times**. If an isolation room is not available, notify Infection Prevention to assist with possible alternatives.

Signage and Isolation Supplies

a. Yellow isolation bag will be hung on the outside of the patient's room door. Hospital approved transmission-based (isolation) precautions signage is to be displayed at the entrance of the patient

room. More than one sign may be indicated. Yellow bag with signage is to remain in place until the room / area is cleaned.

b. Place isolation supplies / PPE in the yellow bag.

Gloves and Hand Hygiene

a. Performing hand hygiene, either with washing hands with soap and water or by using a waterless hand sanitizer, is the single most important component of infection prevention and control in isolation precautions. Perform hand hygiene (scrub a minimal of 15-20 seconds) as promptly and thoroughly as possible upon entering and leaving a patient's room or environment, between patient contacts and after contact with blood, bodily fluids, secretions, excretions, and contaminated equipment and/or articles. In addition to hand hygiene, gloves play an important role in reducing the risks of transmission of microorganisms (see Hand Hygiene policy).

b. Waterless hand sanitizer containers shall be available in appropriate clinical areas and in every patient room.

c. Perform hand hygiene before donning gloves (clean, non-sterile). Don gloves prior to entering the room of a patient on contact isolation.

d. Change gloves and perform hand hygiene after having contact with infective material (i.e., fecal material, urine or other body drainage).

e. Before leaving room remove gloves, sanitize hands, and discard.

f. Wash hands immediately or use waterless hand sanitizer. **Wash hands with soap and water when leaving room of a patient on Special Enteric precautions.**

g. Ensure that hands do not touch potentially contaminated surfaces or items in the room after glove removal.

h. Failure to change gloves between patient contacts is an infection prevention hazard.

Gowns

a. Gowns are worn during the care of patients suspected or infected with epidemiologically recognized microorganisms to reduce the opportunity for transmission of pathogens from patients or items in their environment to other patients or environments.

b. Wear a gown (clean, non-sterile) to enter the room of a patient on Contact Precautions and/or Special Enteric Precautions (or if the patient is not in a room, don a gown as you approach the patient's environment; refer to Appendix A: Safe Donning and Removal of PPE).

c. The gown shall be removed before leaving the patient's room or environment and disposed of in the trash. Perform hand hygiene upon leaving the patient's room or environment.

d. Gowns shall be single use. Do not reuse.

Mask, Respirator & Eye Protection (visor / face shield / goggles /N95respirator / PAPR)

a. OSHA mandates wearing of masks with eye protection or face shields when splashing or splattering of blood or body fluids is anticipated to reduce the risk of exposures to blood borne pathogens.

b. Hospital employees and personnel must wear a mask with eye protection to protect against spread of infectious large-particle droplets that are transmitted by close contact and generally travel only short distances (up to 6 feet) from infected patients who are coughing or sneezing.

c. Mask with eye protection shall be worn during bronchoscopy and endoscopy, as well as when performing lumbar punctures or any procedure where the epidural space is accessed.

d. Either Powered Air Purifying Respirator (PAPR) or fit-tested N95 respirator mask is required for healthcare workers caring for patients in Airborne Precautions for rule-out or known tuberculosis patients, etc.

Equipment / Supplies

a. Non-critical patient care equipment shall be dedicated to a single patient in isolation precautions.
b. All disposable supplies or items that cannot be cleaned, including packages of sterile supplies, shall be discarded when patient is discharged from the room.

c. All other equipment that cannot be dedicated to a single patient shall be thoroughly cleaned and disinfected immediately.

Linen

a. Although soiled linen may be contaminated with pathogenic microorganisms, the risk of disease transmission is negligible if it is handled, transported, and laundered in a manner that avoids transfer of microorganisms to patients, personnel, and environments.
b. Linen shall be placed in a single bag in the room.

Dishes, Glasses, Cups, Eating Utensils, and Medication

a. No special precautions are needed for dishes, glasses, cups, or eating utensils. Disposable meal trays are not necessary. The combination of hot water and detergents used in hospital dishwashers is sufficient to decontaminate dishes, glasses, cups, and eating utensils.

b. Any medications / IV solutions, tube feedings or baby formula taken into an isolation area that is not used shall be discarded when the patient is discharged (do not return medications / IV solutions to Pharmacy or restock baby formula).

Patient Transport or Ambulation

Limit the movement and transport of patients isolated for transmission-based precautions. Ensure that such patients leave their rooms for essential therapeutic and diagnostic purposes only. Whenever feasible, the patient's procedure shall be done in the patient's room. If the procedure cannot be done in the patient's room, then it is preferred that the patient's procedure be scheduled at the end of the day (see Appendix C: Transport of Isolation Patients). This reduces opportunities for transmission of microorganisms.

When patient transport is necessary:

a. Healthcare workers shall use PPE as outlined in Appendix C: Transport of Isolation Patients.

b. Prior to patient ambulation, the patient shall have on a clean patient gown to be used as a barrier.

c. Clean linens shall be placed over the patient on the stretcher or wheelchair to serve as a barrier.

d. Patients with draining wounds shall have on clean dressings.

e. Patients on droplet or airborne precautions shall have on a surgical mask.

f. Personnel in the receiving area shall be notified of the isolation status of the patient **prior** to transport.

g. Isolation status shall be communicated in patient care handoff, if applicable.

h. PPE is not to be worn by healthcare workers transporting the patient unless providing direct patient care during transport.

i. Transport equipment (i.e., wheelchair, stretcher) shall be thoroughly cleaned with hospital approved disinfectant after each patient transport.

Patient and Visitor Education

a. Educate the patient on the reason for precautions and how to adhere to appropriate isolation practices. Document in the medical record, education provided.

b. Educate family / visitors on appropriate isolation practices and document same in the medical record.

Visitors

a. Visitors of patients in Airborne Precautions for suspected pulmonary M. tuberculosis shall be limited to immediate adult household members who have had recent contact with the patient. Visitors shall wear a surgical tie mask while in the patient's room.

b. Visitors who cannot comply with wearing of required PPE may not visit with patient(s) on transmission-based (isolation) precautions.

c. Children less than 12 years old should be discouraged from visiting patients on transmission-based (isolation) precautions due to risk of inappropriate PPE use.

Cleaning

a. Occupied isolation rooms shall be cleaned daily and upon patient discharge (refer to EVS Cleaning and Disinfection policy).

b. Daily cleaning requires:

- Thorough cleaning and adequate disinfection of bedside equipment and environmental surfaces (i.e., bedrails, bedside tables, carts, commodes, doorknobs, faucet handles, light switches, call button, etc.).
- Use of appropriate cleaning products.

d. Upon discharge of the patient, all isolation signs shall remain on the door / entrance until room cleaning has been completed.

e. For Airborne Precautions, room remains closed 30-60 minutes after patient is discharged and leaves room to allow for adequate air exchange.

f. Upon patient discharge, all isolation rooms shall be thoroughly cleaned. Wipe all high touch surfaces in the room including the bed, bed railings, bedside table, carts, commodes, door knobs, faucet handles, telephone, IV poles, light switch, call button, etc. Wet mop / disinfect floors. Clean walls if visibly soiled. Change privacy curtains for all Contact Precaution rooms or if visibly soiled. Send curtains, linens, and other durable items to be laundered.

g. If more than one isolation class is required, the highest level shall apply.

Isolation in Special Procedure Areas

a. Special procedure areas (i.e., PACU, Endoscopy, etc.) shall utilize isolation requirements in the patient's immediate environment.

b. Operating Rooms (OR):

   i. All ORs shall notify recovery areas of precaution status to allow for appropriate placement and handling of patients.

   ii. OR cleaning is not different for patients on transmission-based (isolation) precautions.

   iii. When patient is on Contact Precautions, OR staff shall wear gloves and gown when it is anticipated that staff member's hands and clothing shall have contact with patient or patient's environment. Patient environment is defined as, but not limited to tubes, drains, EKG wires, bed, linens, lines, ventilator, etc.

   iv. OR staff shall wear a mask with eye protection if within six feet of a patient who is on Droplet Precautions or an N95 respirator for Airborne Precautions.

Discontinuing Isolation

a. Isolation of patients with known or suspected organisms with durations as delineated in Appendix D. Discontinuing Transmission-based (Isolation) Precautions for Certain Identified Pathogen/Disease Guideline; CDC Guidelines for Duration of Isolation, may be discontinued after meeting specified requirements.

b. Call Infection Prevention with questions regarding the removal of isolation precautions or if precautions are discontinued against policy guidelines.

Contact Precautions (green sign)

Contact Precautions are used for patients who are suspected or known to be infected with organisms that can be transmitted by direct contact with the patient (hand or skin-to-skin contact that occurs when performing patient care activities that require touching the patient's dry skin) or indirect contact with environmental surfaces or patient-care items in the patient's environment.

This isolation category requires the use of gloves and gown to enter the room regardless of patient contact.

Patients should be placed in a private room whenever possible.

If a private room is unavailable, the patient must be placed in a room with another patient who has active infection or colonization of the same microorganism but with no other organisms requiring isolation (cohorting).Consult with Infection Prevention when considering cohorting patients.

Special Enteric Precautions (brown sign)

Special Enteric Precautions are designed to reduce transmission of Clostridium difficile (C-diff) or other GI organisms (example: norovirus) transmitted by direct contact with the patient and/or the environment.

Contact Precautions are used with Special Enteric Precautions with hand hygiene by **soap and water only**.

Hand hygiene with soap and water must be used when leaving the patient's room / environment in order to remove the spores.

(**REMINDER: Although not on Standardized signage A 1:10 bleach solution shall be used to disinfect environmental surfaces and equipment. (i.e. Clorox Bleach Wipes)**

Droplet Precautions (orange sign)

Droplet Precautions are used for a patient known or suspected to be infected with microorganisms transmitted by droplets (large-particle droplets larger than 5 µm in size) that can be generated by the patient during coughing, sneezing, talking, or the performance of procedures involving the respiratory tract.

Microorganisms can be acquired by contact with droplets over distances of 3-6 feet, as well as by contact with objects recently contaminated with respiratory secretions.

Universal masking is recommended during Respiratory Syncytial Virus (RSV) and influenza seasons for select immunosuppressed populations.

Patients should be placed in a private room.

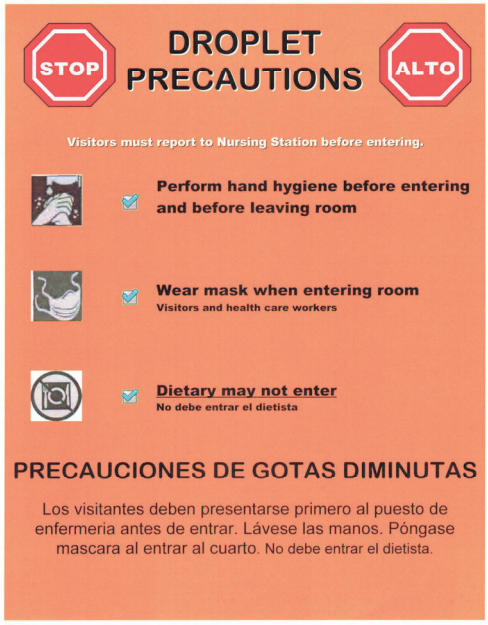
When a private room is not available, the patient must be placed in a room with a patient(s) who has active infection with the same microorganism but with no other infection (cohorting).

Consult with Infection Prevention when considering cohorting patients. When a private room is not available and cohorting is not achievable, maintain spatial separation of at least 3-6 feet between the infected patient and other patients and visitors.

Special air handling and ventilation are not necessary, and the door may remain open.

Curtains should be in place between patients on Droplet Precautions when cohorting is required.

In addition to wearing a mask as outlined under Standard Precautions, a surgical mask shall be worn when working within 3 feet of the patient.



Airborne Precautions (pink sign)

Airborne Precautions are used for patients known or suspected to be infected with microorganisms transmitted by airborne droplet nuclei (small particle residue of 5 µm or smaller in size) of evaporated droplets containing microorganisms that remain suspended in the air and that can be dispersed widely by air currents within a room or over a long distance.

Place the patient in a private room that has:
1) monitored negative air pressure in relation to the surrounding areas;
2) a minimum of 6-12 air changes per hour; and
3) appropriate discharge of air outdoors or monitored high-efficiency purified air filtration (HEPA) of room air before the air is circulated to other areas in the facility.

Portable HEPA filter units should remain in use in the room for 30-40 minutes after patient discharge and before admitting another patient (CDC TB Guideline, 2005).

Keep the room door closed and the patient in the room.

This isolation category requires the use of either a Positive Air Purifying Respirator (PAPR) that is obtained on the unit (additional ones can be obtained by calling Infection Prevention) or a N95 mask that has been fit-tested on the user for entry into the patient's room.

Seal Check - should be performed to ensure that proper respirator fit can be achieved. To perform a seal check on a 3M N95 cup shaped disposable respirator, place both hands completely over the respirator and exhale. The respirator should bulge slightly. If air leaks between the face and the face seal of the respirator, reposition it and readjust the nose clip for a more secure seal. If air leaks around the respirator edges, adjust the position on the face and the straps along the sides of the head and recheck fit.

If a proper fit cannot be achieved, do NOT enter the area requiring respiratory protection.) In the case of varicella or measles, the individual does not require a PAPR/N95 if immunity is documented.

Airborne Isolation Rooms are as follows:

Medical: **Room Numbers 240 & 241**	**E.R.:** Room Number 7
Telemetry Unit: **Room Numbers 308 & 309**	2-Surgical Unit: Room Numbers 207 & 208; 209 & 210; 217 & 218; 225 & 226
CCU: **Room Numbers 9 & 10; 17 & 18; 25 & 26** **COU:** **Room Numbers 5 & 6**	Pediatrics: Room Numbers 266 & 267

Contact and Droplet Precautions – Guidance below reflects CDC Guidance Dated April 13, 2020. Revisions to the guidance below will be updated as CDC and or DHEC guidance changes.

Contact/Droplet Precautions will be implemented on patients known or suspected of COVID 19.

Patient Placement:

- Patient must be in a negative pressure room if performing aerosol generating procedures (AGP).
- Patient can be placed in private room with door shut if not performing AGP.

PPE Requirements:

- If AGP (N-95, face shield, gown and gloves)
- If NO AGP (surgical mask, face shield, gown and gloves)

Appendix A: Safe Donning and Removal of Personal Protective Equipment (PPE)

SEQUENCE FOR DONNING PERSONAL PROTECTIVE EQUIPMENT (PPE)

The type of PPE used will vary based on the level of precautions required; e.g., Standard and Contact, Droplet or Airborne Infection Isolation.

1. GOWN
- Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back
- Fasten in back of neck and waist

2. MASK OR RESPIRATOR
- Secure ties or elastic bands at middle of head and neck
- Fit flexible band to nose bridge
- Fit snug to face and below chin
- Fit-check respirator

3. GOGGLES OR FACE SHIELD
- Place over face and eyes and adjust to fit

4. GLOVES
- Extend to cover wrist of isolation gown

SECUENCIA PARA PONERSE EL EQUIPO DE PROTECCIÓN PERSONAL (PPE)

El tipo de PPE que se debe utilizar depende del nivel de precaución que sea necesario; por ejemplo, equipo Estándar y de Contacto o de Aislamiento de Infecciones transportadas por gotas o por aire.

1. BATA
- Cubra con la bata todo el torso desde el cuello hasta las rodillas, los brazos hasta la muñeca y dóblela alrededor de la espalda
- Átesela por detrás a la altura del cuello y la cintura

2. MÁSCARA O RESPIRADOR
- Asegúrese los cordones o la banda elástica en la mitad de la cabeza y en el cuello
- Ajústese la banda flexible en el puente de la nariz
- Acomódesela en la cara y por debajo del mentón
- Verifique el ajuste del respirador

3. GAFAS PROTECTORAS O CARETAS
- Colóquesela sobre la cara y los ojos y ajústela

4. GUANTES
- Extienda los guantes para que cubran la parte del puño en la bata de aislamiento

USE SAFE WORK PRACTICES TO PROTECT YOURSELF AND LIMIT THE SPREAD OF CONTAMINATION
- Keep hands away from face
- Limit surfaces touched
- Change gloves when torn or heavily contaminated
- Perform hand hygiene

UTILICE PRÁCTICAS DE TRABAJO SEGURAS PARA PROTEGERSE USTED MISMO Y LIMITAR LA PROPAGACIÓN DE LA CONTAMINACIÓN
- Mantenga las manos alejadas de la cara
- Limite el contacto con superficies
- Cambie los guantes si se rompen o están demasiado contaminados
- Realice la higiene de las manos

SEQUENCE FOR REMOVING PERSONAL PROTECTIVE EQUIPMENT (PPE)

Except for respirator, remove PPE at doorway or in anteroom. Remove respirator after leaving patient room and closing door.

1. GLOVES
- Outside of gloves is contaminated!
- Grasp outside of glove with opposite gloved hand; peel off
- Hold removed glove in gloved hand
- Slide fingers of ungloved hand under remaining glove at wrist
- Peel glove off over first glove
- Discard gloves in waste container

2. GOGGLES OR FACE SHIELD
- Outside of goggles or face shield is contaminated!
- To remove, handle by head band or ear pieces
- Place in designated receptacle for reprocessing or in waste container

3. GOWN
- Gown front and sleeves are contaminated!
- Unfasten ties
- Pull away from neck and shoulders, touching inside of gown only
- Turn gown inside out
- Fold or roll into a bundle and discard

4. MASK OR RESPIRATOR
- Front of mask/respirator is contaminated — DO NOT TOUCH!
- Grasp bottom, then top ties or elastics and remove
- Discard in waste container

SECUENCIA PARA QUITARSE EL EQUIPO DE PROTECCIÓN PERSONAL (PPE)

Con la excepción del respirador, quítese el PPE en la entrada de la puerta o en la antesala. Quítese el respirador después de salir de la habitación del paciente y de cerrar la puerta.

1. GUANTES
- ¡El exterior de los guantes está contaminado!
- Agarre la parte exterior del guante con la mano opuesta en la que todavía tiene puesto el guante y quítesela
- Sostenga el guante que se quitó con la mano enguantada
- Deslice los dedos de la mano sin guante por debajo del otro guante que no se ha quitado todavía a la altura de la muñeca
- Quítese el guante de manera que acabe cubriendo al primer guante
- Arroje los guantes en el recipiente de desechos

2. GAFAS PROTECTORAS O CARETA
- ¡El exterior de las gafas protectoras o de la careta está contaminado!
- Para quitárselas, tómelas por la parte de la banda de la cabeza o de las piezas de las orejas
- Colóquelas en el recipiente designado para reprocesar materiales o de materiales de desecho

3. BATA
- ¡La parte delantera de la bata y las mangas están contaminadas!
- Desate los cordones
- Tocando solamente el interior de la bata, páseláa por encima del cuello y de los hombros
- Voltee la bata al revés
- Dóblela o enróllela y desáchela

4. MÁSCARA O RESPIRADOR
- La parte delantera de la máscara o respirador está contaminada — ¡NO LA TOQUE!
- Primero agarre la parte de abajo, luego los cordones o banda elástica de arriba y por último quítese la máscara o respirador
- Arrójela en el recipiente de desechos

PERFORM HAND HYGIENE IMMEDIATELY AFTER REMOVING ALL PPE

EFECTÚE LA HIGIENE DE LAS MANOS INMEDIATAMENTE DESPUÉS DE QUITARSE CUALQUIER EQUIPO DE PROTECCIÓN PERSONAL

Appendix B: Transmission Based Precautions Chart

Standard Precautions ALWAYS applies: All employees must follow Standard Precautions for all patients. Standard Precautions are designed to reduce the risk of transmission of microorganisms for both recognized and unrecognized sources of infections.

Standard Precautions consist of the following elements:

- Routine handwashing
- Appropriate use of masks, eye protection and face shields (i.e. suctioning)
- Routine cleaning or disposal of patient-care equipment
- Bag linen at point of use
- Face mask for lumbar punctures
- Safe injection practices
- Consistent and correct use of gloves
- Appropriate use of gowns to prevent contamination of uniform/clothing
- Regular cleaning of environmental surfaces
- Strict adherence of occupational safety requirements
- Respiratory hygiene/cough etiquette

Isolation Type	Contact Precautions	Contact Precautions-Special Enteric	Droplet Precautions	Airborne Precautions	Contact/Droplet Precautions (COVID 19)
Private Room	Yes	Yes	Yes	Yes	Yes
Door Closed	No	No	No	Yes	Yes
Mask/Eye Protections	No	No	If within 6 feet of patient	Yes	Yes
Gown	Yes-To enter room	Yes-To enter room	No	No	Yes
Gloves	Yes-To enter room	Yes-To enter room	Yes-To enter room	No	Yes
Dedicated thermometer	Yes	Yes	Yes	No	Yes
Dedicated BP apparatus	Yes	Yes	Yes	No	Yes
Transport	Patient in clean linens	Patient in clean linens	Patient in face mask and clean linens	Patient in face mask	Refrain from patient leaving room. If patient must leave room, patient wears surgical mask
Disposable Meal Tray	No	No	No	No	No
Procedures not done in room should be done at the end of day	Preferred	Preferred	Preferred	Preferred	Yes

All equipment is to be cleaned between patient use regardless of isolation status.

Appendix C: Transport of Isolation Patients

Standard Precautions ALWAYS Apply

Isolation Type	One or Two Person Transport*
Airborne Precautions (pink sign)	1. Healthcare worker shall put on PAPR/N95 respirator prior to entering the patient room. 2. Isolation / surgical mask is put on patient (**NOT** N95 respirator). 3. Healthcare workers are not required to wear PAPR/N95 respirator once mask is on patient or worker is out of patient room. 4. Prior to taking the patient's mask off, all staff must have on PAPR/N95 respirators.
Contact Precautions (green sign) **Or** **Special Enteric Precautions (brown sign)**	1. When direct patient contact is needed during the transport, then healthcare workers shall wear gown and gloves. 2. Another healthcare worker is "clean" and shall not wear gown and gloves and shall proceed ahead of patient and transport staff to open doors, press elevator buttons,etc. 3. Clean linens shall be placed over the patient on the stretcher or wheelchair. 4. PPE is not to be worn by healthcare workers transporting the patient unless providing direct patient care during transport. In addition, with **Special Enteric Precautions, wash hands with soap and water** immediately after patient contact.
Droplet Precautions (orange sign)	1. Healthcare worker shall put on a surgical mask prior to entering the patient room. 2. Isolation / surgical mask is put on patient. 3. Healthcare workers are not required to wear surgical mask once mask is on patient or worker is out of patient room. 4. Prior to taking the patient's mask off, all staff must have on a surgical mask.
Contact/Droplet (COVID 19)	1. Healthcare worker must don mask, face shield, gown and gloves 2. Patient MUST wear surgical mask

*Utilize strategies to not contaminate the environment such as ask for assistance, use elbow to push elevator buttons or utilize inside of gown.

Appendix D

Discontinuing Transmission-based (Isolation) Precautions for Certain Identified Pathogen/Disease Guideline

This guideline is intended to give additional guidance at CMC for selected pathogens and is not all-inclusive. Clinicians can refer to the CDC table, *Type and Duration of Precautions Recommended for Selected Infections and Conditions* at this website http://www.cdc.gov/hicpac/2007IP/2007ip_appendA.html to search by condition/infection for initiation and duration of precautions. Always notify Infection Prevention for clarification if in doubt prior to discontinuing isolation.

Pathogen/Disease	New Diagnosis	Arrived with
Clostridium Difficile Infection (CDI)	Contact isolation along with special enteric precautions should be continued in all hospitalized patients with known CDI until the time of hospital discharge. Patients hospitalized longer than 2 weeks following resolution of symptoms and treatment of CDI may be removed from contact isolation and special enteric precautions with Infection Prevention approval when there are no signs and symptoms of CDI. The patient's room is then terminally cleaned with bleach solution per Environmental Services.	Contact isolation along with special enteric precautions should be continued in all hospitalized patients with known CDI until the time of hospital discharge. Patients hospitalized longer than 2 weeks following resolution of symptoms and treatment of CDI may be removed from contact isolation and special enteric precautions with Infection Prevention approval when the patient has no signs and symptoms of CDI. The patient's room is terminally cleaned with bleach solution per Environmental Services.
Influenza	Adult patients with confirmed influenza are to remain on droplet precautions for at least 7 days after illness onset or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer, while the patient is in a healthcare facility. If a patient is receiving	Patients should remain on droplet precautions for **7 days** from symptom onset or until 24 hours after resolution of influenza-like illness symptoms, whichever is longer. If a patient is receiving mechanical ventilation, the patient should remain on droplet precautions until symptoms can be assessed (i.e., the patient should be

Pathogen/Disease	New Diagnosis	Arrived with
	mechanical ventilation the patient should remain on droplet precautions until symptoms can be assessed (i.e., the patient should be reassessed after off of mechanical ventilation). Pediatric patients should also be on droplet and contact precautions for remainder of hospitalization.	reassessed after off of mechanical ventilation). Pediatric patients should also be on droplet and contact precautions for remainder of hospitalization.
Meningococcal disease: sepsis, pneumonia, meningitis	Droplet precautions for 24 hours after initiation of effective therapy	Droplet precautions for 24 hours after initiation of effective therapy.
Multi-Drug Resistant Gram Negative Organisms (MDRO): may include but not limited to ESBL (extended spectrum beta lactum) producers, MRSA, VRE, CRE, Pseudomonas aeruginaos, Acinetobacter baumanii, and Strenotrophomonas	Patients with a **new** (+) positive culture should remain on contact precautions until they are discharged, **OR** have completed an adequate course of therapy for their infection and have clinically improved. NOTE: It is not necessary to send a microbiological sample as a "test of cure" to confirm eradication of the organism. In addition these patients do **NOT** require automatic contact isolation upon readmission to the hospital unless the infection persists.	These patients do **NOT** require automatic contact isolation upon readmission to the hospital unless the infection persists.
Klebsiella pneumonia-carbapenemases (KPC)(also known as carbapenem-resistant enterobacteriaciae (CRE)	Contact isolation for duration of hospitalization	Contact isolation for duration of hospitalization

Pathogen/Disease	New Diagnosis	Arrived with
Tuberculosis: A. Pulmonary or laryngeal, confirmed B. Pulmonary or laryngeal, suspected. C. Other: open or draining soft tissue lesion Refer to TB Control Plan	Discontinue airborne precautions only when: A. Patient is on effective therapy for at least two (2) weeks, is improving clinically and has three (3) consecutive sputum smears negative for acid- fast bacilli (AFB) collected 8-24 hours apart with one being an early morning specimen. B. When a diagnosis other than pulmonary tuberculosis is confirmed and tuberculosis is no longer considered in the differential diagnosis or the patient has three (3) consecutive sputum smears negative for acid fast bacilli collected 8-24 hours apart with one being an early morning specimen. C. The patient is on effective therapy is improving clinically and when smears obtained from wound drainage are negative for AFB, or when in the opinion of the hospital Infection Preventionist there is little or no significant risk of transmission.	Patients with previously diagnosed TB readmitted before confirmation of complete cure are placed on airborne infection isolation pending assessment of their infectiousness. Discontinue Airborne precautions only when: A. Patient is on effective therapy for at least two (2) weeks, is clinically improving and has three (3) consecutive sputum smears negative for acid- fast bacilli (AFB) collected 8-24 hours apart with one being an early morning specimen. B. When a diagnosis other than pulmonary mycobacterium tuberculosis is confirmed and tuberculosis is no longer considered in the differential diagnosis or the patients has three (3) consecutive sputum smears negative for acid fast bacilli collected 8-24 hours apart with one being an early morning specimen. C. The patient is on effective therapy is improving clinically and when smears obtained from wound drainage are negative for AFB, or when in the opinion of the hospital Infection Preventionist there is little or no significant risk of transmission.

RECORDS: Medical Record

REFERENCE STANDARDS:

CDC Guidelines for Isolation Precautions: Preventing transmission of infectious agents in Healthcare Settings. HICPAC 2007.http://www.cdc.gov/hicpac/pdf/isolation/isolation2007.pdf

CDC Guidelines for Environmental Infection control in Health-Care Facilities MMWR 2003 http://www.cdc.gov/hicpac/pdf/guidelines/eic_in_HCF_03.pdf

CDC Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Healthcare Settings 2005 MMWR. http://www.cdc.gov/mmwr/pdf/rr/rr5417.pdf

REVISION/REVIEW HISTORY:

Date	Affected Section(s)	Summary of Changes ('Reviewed' or details of change)
9/30/2014		New procedure-approved per ICC 9/30/2014
7/30/2015		Reviewed-no changes
8/31/2016	Signage and Isolation supplies	Revised wording in the signage and isolation supplies section to reflect the yellow isolation bags.
2/10/2017		Revised/deleted section regarding MRSA colonization/isolation, flagging of MRSA on re-admission.
3/14/2018	Reviewed	Reviewed, no changes
3/15/2019	Reviewed	No changes
3/25/2020	Logo	Updated to new Logo
5/29/2020	Revised	Added Contact/Droplet Precautions (COVID 19)

CONWAY MEDICAL CENTER
PROCEDURE

When in hard copy form, refer to Policy Manager to validate this as the most current revision.

TITLE:	Guidelines for Cleaning Equipment		
ISSUED BY:	Infection Control Committee	REFERENCE #:	INF-54323.2-PRO
APPROVED BY:	Infection Control Committee	EFFECTIVE DATE:	11/30/2012

SCOPE: To delineate guidelines and standards for cleaning, disinfection and sterilization within Conway Medical Center. Cleaning is a shared responsibility between all CMC departments.

PROCEDURE: In accordance with existing infection prevention and control policies and procedures, Conway Medical Center will implement and maintain processes to ensure all patient-care equipment, critical and non-critical, as well as the environment, is cleaned, disinfected, and/or sterilized as appropriate per Federal and State guidelines.

Guidelines for Equipment Cleaning			
Item to be Cleaned	**When to Clean**	**How to Clean**	**Responsible Party**
Crash Cart	Weekly	Hospital approved disinfectant	Housekeeping
Walker (Surgical Unit)	After each use	Hospital approved disinfectant	Housekeeping
Copiers	Monthly	Hospital approved disinfectant	Housekeeping
Otoscope/Ophthalmoscope (Wall Mount)	Daily	Wipe with 70% alcohol	Housekeeping
Pedestal Fan	After each use	Hospital approved disinfectant	Housekeeping
IV pump	At discharge & between patients	Hospital approved disinfectant	Housekeeping & User
TV/VCR/DVD Cart	After each use and weekly	Hospital approved disinfectant	Housekeeping & User
Free standing radiant warmer	After each use and weekly	Hospital approved disinfectant	Housekeeping & User
Seizure Pads	After each use	Hospital approved disinfectant	Housekeeping & User
Shower Chair	After each use	Hospital approved disinfectant	Housekeeping/Nursing
Bedside Commode	After each use	Hospital approved disinfectant	Housekeeping/Nursing
Cardiac/Resp. Monitors	At discharge & between patients	Hospital approved disinfectant	Housekeeping/Nursing
Workstation on wheels-cart/computer/keyboard	Quarterly or as needed	Hospital approved disinfectant	IT
Desktop Computers/ Keyboards (Patient care areas)	Quarterly or as needed	Hospital approved disinfectant	IT
Printers	Quarterly or as needed	Hospital approved disinfectant	IT
Mobi-lab Devices	After each use	Hospital approved disinfectant	Lab

Phlebotomy Chairs	After each use	Hospital approved disinfectant	Lab
Optiflex Machines	Monthly	Hospital approved disinfectant	Materials Mgmt.
Omnicell Machines	Monthly	Hospital approved disinfectant	Pharmacy
Walker (PT)	After each use	Hospital approved disinfectant	PT
Free Weights	After each use	Hospital approved disinfectant	PT
Gait Belt	After each use	Hospital approved disinfectant	PT
CPM Machine	After pt. discharge	Hospital approved disinfectant	PT
Imagery Cassette	After each use	Hospital approved disinfectant	Radiology
Radiology Portable Units	Every shift	Hospital approved disinfectant	Radiology
Radiology Tables/Pads	After each use	Hospital approved disinfectant	Radiology
Respiratory care equipment	After each use	Hospital approved disinfectant	Respiratory Therapy
SCD/IPC machine	After each use	Hospital approved disinfectant	Sterile Supply
PCA pump	After each use	Hospital approved disinfectant	Sterile Supply & User
Thermometer (Mounted)	Daily	Wipe with 70% alcohol	User
Breast Pump (electric)	After each use	Hospital approved disinfectant	User
Walker (ODSU,Tele,CCU,Med)	After each use	Hospital approved disinfectant	User
Glucometer	After each use	Wipe machine with 70% alcohol	User
Pulse Oximeter	Probe after each use, machine every shift	Wipe machine with 70% alcohol	User
Stretcher	After each use	Hospital approved disinfectant	User
Wheelchair	After each use	Hospital approved disinfectant	User
Apnea Monitor	After each use	Hospital approved disinfectant	User
Patient lift equipment including non-disposable sling	After each use	Hospital approved disinfectant	User
Vena Scan	After each use	Hospital approved disinfectant	User
Ascom phone	Between users	Wipe with 70% alcohol	User
Isolette	After each use	Hospital approved disinfectant	User
Bassinets	After each use	Hospital approved disinfectant	User
Geri-Chair	After each use	Hospital approved disinfectant	User
Bear Hugger	After each use	Hospital approved disinfectant	User
Portable Electronic Devices (example: Ipad)	After each use	Hospital approved disinfectant	User

Cooling Blanket	After each use	Hospital approved disinfectant	User
Transvenous pacer	After each use	Wipe with 70% alcohol	User
Glide Scope	After each use	Hospital approved disinfectant	User
Balloon Pump	After each use	Hospital approved disinfectant	User
Defibrillator	After each use and weekly	Hospital approved disinfectant	User
Crash Cart	After each use	Hospital approved disinfectant	User
High Chair	After each use	Hospital approved disinfectant	User
Bili-Blanket	After each use	Hospital approved disinfectant	User
Bili-Check	After each use	Wipe with 70% alcohol	User
Nursery/Pediatric Scale	After each use	Hospital approved disinfectant	User
Transfer/Slider Board	After each use	Hospital approved disinfectant	User
Vital Signs Machine	After each use	Hospital approved disinfectant	User
Cyracom Phone	After each use	Hospital approved disinfectant	User
Doppler	After each use	Hospital approved disinfectant	User
Otoscope/Ophthalmoscope (Hand held)	After each use	Wipe with 70% alcohol	User
Fetascope	After each use	Hospital approved disinfectant	User
Stethoscope	After each use	Wipe with 70% alcohol	User
Percussion Hammer	After each use	Wipe with 70% alcohol	User
Syringe Pump	After each use	Hospital approved disinfectant	User
Thermometer (Hand held)	After each use	Wipe with 70% alcohol	User
Bladder Scanner	After each use	Wipe with 70% alcohol	User
Clipper Handle	After each use	Hospital approved disinfectant	User
Reusable Blood Pressure Cuff	After each use	Hospital approved disinfectant	User
Traction Equipment	After each use	Hospital approved disinfectant	User
Patient room keyboards	Daily	Hospital approved disinfectant	User
WOW- keyboards	Daily	Hospital approved disinfectant	User
Desktop keyboards	Daily	Hospital approved disinfectant	User
Fax machines	Monthly	Hospital approved disinfectant	User
TCOM Machine	After each use	Wipe with 70% alcohol	Wound Care staff

RECORDS: N/A

REFERENCE STANDARDS:

I) Medicare Conditions of Participation
  A) 42 CFR § 482.42(a)(1)

II) Det Norske Veritas NIAHO Standards
  A) IC.1 SR.1

III) Centers for Disease Control
  A) Guideline for Disinfection and Sterilization in Healthcare and Sterilization in Health-Care Facilities, 2008

IV) Association for Professionals in Infection Control and Epidemiology (APIC)
  A) APIC Text of Infection Control and Epidemiology, Revised 2002

REVISION/REVIEW HISTORY:

Date	Affected Section(s)	Summary of Changes ('Reviewed' or details of change)
02/11/2013	Created new procedure	
9/30/2014		Added "non-disposable sling" to equipment table. Infection Control Committee approved on 9/30/2014.
7/27/2017	Cleaning table	Added "Portable Electronic Devices" to cleaning table
6/25/2018	Table	Revised following items to be cleaned to quarterly and as needed- workstation on wheels, desktop computers, printers.

CONWAY MEDICAL CENTER
POLICY

POLICY TITLE:	Infection Control Guidelines for All CMC Employees		
ISSUED BY:	Infection Control	REFERENCE #:	INF-54322-POL
APPROVED BY:	Infection Control Committee	EFFECTIVE DATE:	10/01/2012

SCOPE: Conway Medical Center Non-Patient Care Units

POLICY STATEMENT: Insure safety of personnel through active participation in the infection control process. To prevent and control the transmission, dissemination, or acquisition of infectious or communicable disease.

POLICY REQUIREMENTS: All units will provide a safe environment through the utilization of effective infection control measures and guidelines as follows:

1) Strict hand-hygiene guidelines shall be followed by all personnel. (Refer to Hand-Hygiene Policy)
2) All personnel shall adhere to Standard and Transmission-Based precautions as outlined in the Standard Precautions and Transmission Based Procedure.
3) All newly hired personnel shall be required to received documented orientation on infection prevention and control practices.
4) All personnel shall participate in annual in-service programs relating to infection prevention and control practices.
5) All personnel shall restrict any eating or drinking to designated areas.
6) All personnel shall conform to CMC infection Control and Employee Health policies.
7) The Employee Health Dept. /Infection Control Dept. shall be notified promptly of any employee who is absent from work due to a communicable illness or possible communicable illness. In the absence of either the Employee Health nurse or Infection Control Practitioner, emergency employee problems will be dealt with on an individual basis by the Nursing Shift Coordinator on duty.

RECORDS: N/A

REFERENCE STANDARDS:

1. **CDC ISOLATION GUIDELINES FOR HEALTHCARE WORKERS-2008**
2. **OSHA FEDERAL REGISTER-54242 1994**

REVISION/REVIEW HISTORY:

Date	Affected Section(s)	Summary of Changes ('Reviewed' or details of change)
9/17/2012	New policy created.	
10/15/2012	Approved -CJ	Name of policy changed
1/20/2016	Reviewed	No changes-Reviewed
9/24/2018	Reviewed	No changes

CONWAY MEDICAL CENTER
PROCEDURE

When in hard copy form, refer to Policy Manager to validate this as the most current revision.

TITLE:	Measles, Mumps, Rubella (MMR) Immunity and Exposure		
ISSUED BY:	Infection Control/Employee Health	REFERENCE #:	EH-8.70-PRO
APPROVED BY:	VP of Human Resources	EFFECTIVE DATE:	09-1982

SCOPE: MMR immunity and exposure requirements for Health Care Personnel (HCP).

PROCEDURE:

HCP who work at Conway Medical Center (CMC) will be required to be immune to MMR prior to starting work at CMC unless otherwise contraindicated.

I. Vaccine Effectiveness

a. MMR vaccine is highly effective in preventing measles with 1-dose vaccine effectiveness of 95% when administered on or after age 12 months and a 2-dose vaccine effectiveness of 99%.
b. Two doses of measles vaccines are considered to provide long-lasting immunity.

I) Clinical Procedure:

A) Evidence of Immunity to MMR: In addition to the items listed below, CMC will draw MMR titers to verify immunity, if HCP does not provide.

1) Written documentation of vaccination with 2 doses of live measles or MMR vaccine administered at least 28 days apart.
2) Laboratory evidence of immunity to MMR.
3) Documented physician diagnosed disease.
4) Birth before 1957.

B) Immunization schedule for HCP who lack presumptive evidence of immunity:

1) Administer MMR vaccine in 2 doses subcutaneous per Employee Health Nurse or designee.
2) Doses are to be administered $\geq$ 28 days apart.
   (a) Repeat MMR titers after 30 days of 2nd dose to check for immunity.

C) Major Precautions and Contraindications to MMR Vaccine:

1) Anaphylaxis to previous administration
2) Immunosuppression (cancer, HIV).
3) HCP on prednisone >20 mg for > 2 weeks; avoid immunization for 1 month.
4) Pregnancy or plans to become pregnant.
5) Allergy to eggs or egg products.
6) Allergy to neomycin (or other aminoglycosides).
7) Active infection (febrile).

NOTE: Individuals refusing the vaccine shall sign form (RSK-604-FRM).

II) Declination of MMR Vaccine

A) Employees desiring to request an "accommodation" to opt out of the MMR vaccination,

may only request to do so under two "evidence based" categories in a written request to Conway Medical Center Employee Health Office. The two evidence-based categories are:

1) Evidence Based Medical Reasons must be specific and documented/signed by the primary medical provider that has knowledge of or provided treatment for the medical condition.
2) Religious Beliefs: Employees requesting a "confirmed religious objection" accommodation are required to provide written confirmation/documentation from their respective clergy leadership.

III) Post-Exposure Prophylaxis/Work Restrictions: Definition of Exposure: Cohabiting confined air space or face to face contact in an open area. NOTE: HCP who are wearing mask (surgical mask or N-95 respirator) are not considered exposed.

A) **Measles Prophylaxis/Work Restrictions**:
1) Susceptible personnel should receive immune globulin 0.25/mL/kg (maximum 15mL) IM within 6 days of exposure OR measles vaccine.
2) Susceptible persons should be furloughed from days 5-21 post exposure or for 7 days after rash appears.

B) **Mumps Work Restriction**:
1) HCP with active mumps, exclude from duty 5 days after onset of parotitis.
2) HCP without evidence of immunity should be offered the first dose of MMR vaccine as soon as possible. Exclude from duty 12 days after first exposure through 25 days after last exposure of 5 days after onset of parotitis.

C) **Rubella Work Restriction**:
1) HCP with active rubella, exclude from duty 7 days after rash appears.
2) HCP without evidence of immunity, exclude from duty 7 days after exposure through 23 days after last exposure and/or 7 days after rash appears.
3) If exposure to rubella does not cause infection, post exposure vaccination with MMR vaccine should induce protection. If exposure results in infection, no evidence indicates the need to administer MMR vaccine.

RECORDS: n/a

REFERENCE STANDARDS:

I) CMS Conditions of Participation: 42 CFR §484.42(a) A-0748

II) Det Norske Veritas National Integrated Accreditation for Healthcare Organizations (NIAHO):
A) IC.1 SR.3, IC.1 SR.4, IC.1 SR.5, IC.1 SR.6, IC.1 SR.7, IC.1 SR.8

III) CDC. MMWR Immunizations of Health-Care Personnel. Recommendations of the Advisory Committee on Immunization Practices (ACIP). November 25, 2011. https://www.cdc.gov/mmwr/pdf/rr/rr6007.pdf

REVISION/REVIEW HISTORY:

Date	Affected Section(s)	Summary of Changes ('Reviewed' or details of change)
		Reviewed/Revision Dates: March 1, 1996; Sept. 1999; June 2002; March 2003; March 2005; May 2005; Oct. 2006; May 2007; June 12, 2008; December 29, 2011

06-12-2013	All	Formatting only
09-19-2013	Standards	Added
3/22/2019	Entire Procedure	Title and content revised to include measles, mumps and rubella immunization requirements. Previous procedure only detailed rubella vaccination requirements.
9/14/2020	**II)** A)1) & 2), header	Added MMR declination process. Changed approval to VP of HR

CONWAY MEDICAL CENTER
PROCEDURE

When in hard copy form, refer to Policy Manager to validate this as the most current revision.

TITLE:	Varicella Immunity and Exposure Requirements		
ISSUED BY:	Infection Control/Employee Health	REFERENCE #:	EH-8.80-PRO
APPROVED BY:	VP of Quality Medical Director Infection Control	EFFECTIVE DATE:	03-1997

SCOPE: Varicella immunity and exposure requirements for health care personnel (HCP).

PROCEDURE:

I) Purpose:

A) To protect patients and employees from exposure to the varicella virus by providing immunization to each employee who is susceptible and to outline the process to report exposures to varicella virus of non-immune employees.

II) Procedure Statement:

A) Varicella vaccine will be given to all employees that cannot provide written documentation of a positive titer, unless contraindicated.

III) Screening:

A) A varicella titer is drawn at the time of pre-employment, unless documentation of positive immunity is provided.

B) The employee is to be notified of the varicella titer results.
HCP will be required to be immune to varicella prior to starting work at CMC, unless otherwise contraindicated (see section V). **NOTE:** Immunity is not considered to be confirmed until the second injection of vaccine has been administered OR a positive titer or 2 varicella vaccines previously documented.

IV) Administration of Varicella Vaccine:

A) The Employee Health Nurse is to contact the employee and to arrange for the first dose of the vaccine. A second dose is to be administered 4-8 weeks after the first dose. A pregnancy test may be necessary prior to administering either dose.

B) The employee is to sign a consent form (INF-621-FRM) outlining the following instructions:

1) Avoid close contact with immune compromised persons, newborns, and pregnant women for 2-3 weeks after each dose.
2) Avoid salicylate (aspirin or ibuprofen) for 6 weeks.
3) Take extra birth control precautions for 3 months after each injection.

C) Vaccinated persons may develop modified varicella disease with atypical presentation and are to be considered infectious and contagious.

V) Contraindications to varicella vaccine:

- **A)** Previous anaphylactic reaction to this vaccine or any of its components.
- **B)** Pregnancy or possible pregnancy within 4 weeks.
- **C)** Active infection (febrile).
- **D)** Immunocompromised HCP.

VI) Exposure Prevention

- **A)** Patients with suspected or confirmed Varicella should be admitted to the ED with limited exposure to the general public and non-immune and pregnant healthcare personnel.
- **B)** A surgical mask should be applied to a patient who is suspected of having the Varicella virus in common areas.
- **C)** Patients suspected of having the varicella virus are to be placed in an Airoborne Isolation room until diagnosis is confirmed or lesions are dry and crusted. A negative pressure room should be used with a minimum of 12 air exchanges per hour through a High Efficiency Particulate Air (HEPA) filter directly to the outside air.
  1) If an Airborne isolation room is not available, apply a face mask on the patient and place patient in a private room with door closed.
  2) Instruct the patient to keep the facemask on while in the exam room, if possible, and to change the mask if it becomes wet
- **D)** Only staff who have a known immunity to the Varicella Virus may work with patients suspected of being infected.
- **E)** Pregnant women should not have contact with patients with known or suspected Varicella.

VII) Postexposure Management of HCP: Defines as close contact with an infectious person, such as close in door contact (e.g., in the same room) or face to face without an N95 respirator mask or Powered Air-Purifying Respiratory (PAPR).

- **A) HCP who are immune to varicella:**
  1) HCP will be monitored daily during days 8-21 after exposure for fever, skin lesions, and systemic symptoms suggestive of varicella.
  2) HCP will be required to report any symptoms to employee health, infection control and or designee daily during days 8-21 after exposure.
  3) HCP will be excluded from work immediately if symptoms occur.
- **B) HCP who have received 1 dose of varicella vaccine:**
  1) HCP are to receive the second dose within 3-5 days after exposure to rash (provided 4 weeks have elapsed after the first dose).
     - **(a)** HCP will be monitored daily during days 8-21 after exposure for fever, skin lesions, and systemic symptoms suggestive of varicella.
     - **(b)** HCP will be required to report any symptoms to employee health, infection control or designee daily during days 8-21 after exposure.
  2) HCP who did not receive a second dose or who received the second dose > 5 days after exposure will be excluded from work for 8-21 days after exposure.

C) Unvaccinated HCP with no immunity to varicella:
1) HCP are to receive vaccination as soon as possible (within 3-5 days post exposure).
2) HCP are considered potentially infectious and will be furloughed from days 8-21 after exposure.

D) Unvaccinated HCP with no immunity and contraindications to varicella vaccine: (see section V)
1) HCP are to receive the varicella-zoster immune globulin (VariZIG). HCP are to report to employee health during regular business hours or Emergency Department after hours for administration of (VariZIG).
2) HCP are considered potentially infectious and will be furloughed from days 8-21 after exposure.

E) Exposure Conversion:
1) The incubation period after exposure is 14-16 days but can extend up to 21 days.
2) The period of contagiousness of infected persons is estimated to begin 1--2 days before the onset of rash and to end when all lesions are crusted, typically 4-7 days assuming there are no newly developed lesions.

F) Treatment:
1) Employees who convert to active varicella illness are to report to the ED. The ED is to be notified of the employee's condition before arrival to ensure proper isolation guidelines are followed.
2) In-Patient intravenous Acyclovir may be warranted. Varicella vaccination is not recommended.

RECORDS:

I) Employee Health-Forms 621-622 and Form 637

REFERENCE/STANDARDS:

I) CDC Guidelines Prevention of Varicella-Advisory Committee on Immunization of Practices-MMRW 1996

II) CMS Conditions of Participation: 42 CFR §484.42(a) A-0748

III) Det Norske Veritas National Integrated Accreditation for Healthcare Organizations (NIAHO):
A) IC.1 SR.3, IC.1 SR.4, IC.1 SR.5, IC.1 SR.6, IC.1 SR.7, IC.1 SR.8

IV) The Hospital Infection Control Practices Advisory Committee (HICPAC). Guideline for infection control in health care personnel, 1998.

V) CDC. MMWR Immunizations of Health-Care Personnel. Recommendations of the Advisory Committee on Immunization Practices (ACIP). June 22, 2007
https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5604a1.htm

VI) CDC. MMWR Immunizations of Health-Care Personnel. Recommendations of the Advisory Committee on Immunization Practices (ACIP). November 25, 2011. https://www.cdc.gov/mmwr/pdf/rr/rr6007.pdf

REVISION/REVIEW HISTORY:

Date	Affected Section(s)	Summary of Changes ('Reviewed' or details of change)
		Reviewed/Revision Dates: September 1999; May 2001; June 2002; March 2003;

		March 2005; May 2005; October 2006; May 30, 2007; June 12, 2008; Dec. 13, 2011
06-10-2013	All	Formatting only
07/24/2012		Reviewed…References added
09/19/2013	Standards	Added
9/1/2016	Section II A	Revised wording
3/27/2019	V and VI	Section V: added contraindications of varicella vaccine. Section VI: added post exposure requirements
8/7/2020	Added VI, VII (e), VII (f)	Section VI: Exposure Prevention Added Section VII (E): Exposure Conversion added Section VII (F): Treatment added

CONWAY MEDICAL CENTER
PROCEDURE

TITLE:	Pertussis Immunity and Exposure		
ISSUED BY:	Infection Control	REFERENCE #:	EH-9.6-PRO
APPROVED BY:	VP Quality	EFFECTIVE DATE:	5/30/2018

SCOPE: Provide guidelines for health care workers exposed to pertussis.

Purpose:
To provide guidelines for post-exposure prophylaxis following exposure to Pertussis. HCP exposure is defined as being within 3 feet of the patient without appropriate personal protective equipment (PPE). As soon as it is concluded that the HCP has had an exposure to place her/him at risk, the following steps must be taken to determine the need for post exposure prophylaxis. The HCP is referred to the Occupational Health Clinic during routine business hours (M-F) and Emergency Department after hours and weekends. Follow up will be through the Occupational Health Clinic as deemed necessary.

I. **Pertussis Vaccination:**
   a. Regardless of age, HCP will be required, unless contraindicated, to receive a single dose of Tdap if they have not previously received Tdap and regardless of the time since their most recent Tdap vaccination.
   b. Tdap coverage is suboptimal among HCP, and the duration of protection afforded by Tdap is unknown. Vaccination status does not change the approach to evaluate for necessity of post exposure antibiotic for the exposed HCP.
   c. Tdap might not preclude the need for antibiotic post exposure prophylaxis. Therefore, post exposure antibiotic prophylaxis is indicated for all HCP (unvaccinated and vaccinated) in contact with persons at risk for severe disease (e.g. hospitalized neonates, immunocompromised patients and pregnant women).
   d. Pre-vaccination serologic testing is not recommended.
      i. Contraindications for Tdap vaccine:
         1. Encephalopathy within 7 days of a previous dose of pertussis containing vaccine not attributable to another identifiable source.
         2. Progressive neurological disorder, controlled epilepsy, or progressive encephalopathy.
         3. Active infection (febrile)
         4. Severe latex allergy.

II. **Post Exposure Antibiotic Prophylaxis:** NOTE-HCP either should receive post exposure antibiotic prophylaxis or be monitored for 21 days after pertussis exposure and treated at the onset of signs and symptoms of pertussis.

Age Group	**Primary Agents**			**Alternative Agent**
	Azithromycin	**Erythromycin**	**Clarithromycin**	**TMP-SMX**
<1 month	Recommended agent: 10mg/kg	Not preferred; erythromycin is	Not recommended	Contraindicated for infants aged

	per day in a single dose for 5 days	associated with infantile hypertrophic pyloric stenosis; use of azithromycin is unavailable; 40mg/kg per day in four divided doses for 14 days		<2 months (risk for kernicterus)
1 to 5 months	10mg/kg per day in a single dose for 5 days	40mg/kg per day in four divided doses for 14 days	15mg/kg per day in two divided doses for 7 days	Contraindicated at age <2 months: for infants >2 months, TMP 8mg/kg per day, SMX 40 mg/kg per day in two divided doses for 14 days
Infants (aged > 6 months) and children	10mg/kg in a single dose on day 1 (maximum: 500 mg); then 5mg/kg per day (maximum: 250mg) on days 2 through 5	40mg/kg per day in four divided doses for 7 to 14 days (maximum: 2 g per day)	15mg/kg per day in two divided doses for 7 days (maximum: 1 g per day)	TMP 8mg/kg per day, SMX 40mg/kg per day in two divided doses for 14 days (maximum TMP 320mg, SMX 1600mg per day)
Adults	500mg in a single dose on day 1 then 250mg per day on days 2 through 5	2 g (base) per day in four divided doses for 7 to 14 days	1 g per day in two divided doses for 7 days	TMP 320mg per day, SMX 1600mg per day in 2 divided doses for 14 days.

III. HCP Work Restrictions:

Pertussis	Work Restriction	Duration
Active	Exclude from duty	Beginning of catarrhal stage through third week after onset of paroxysms or until 5 days after start of effective antimicrobial therapy
Post exposure		
Symptomatic personnel	Exclude from duty	5 days after start of effective antimicrobial therapy

Asymptomatic personnel HCP likely to expose a patient at risk for severe pertussis	No restriction from duty; on antimicrobial prophylactic therapy	
Asymptomatic personnel-other HCP	No restriction from duty; can receive post exposure prophylaxis or be monitored for 21 days after pertussis exposure and treated at the onset of signs and symptoms of pertussis	

Note: The length of any paid leave and the use of PTO (Paid Time Off) versus Short Term Disability shall be determined by, and is subject to approval by, the VP-Human Resources.

RECORDS: Occupational Health Record; Medical Record

REFERENCE STANDARDS:

1. CDC. Immunization of health-care personnel: recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR Recomm Rep. 2011 Nov 25; 60(RR-7): 1-45. http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6007a1.htm
2. "Updated Recommendations for Use of Tetanus Toxoid, Reduced Diphtheria Toxoid, and Acellular Pertussis (Tdap) Vaccine in Adults Aged 65 Years and Older — Advisory Committee on Immunization Practices (ACIP), 2012 MMWR June 29, 2012; 61(25): 468-470 http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6125a4.htm?s_cid=mm6125a4_x
3. http://www.apic.org/Resource_/TinyMceFileManager/Practice_Guidance/Pertussis_Talking_Points_8-14-2012.pdf
4. https://www.cdc.gov/pertussis/outbreaks/pep.html

REVISION/REVIEW HISTORY:

Date	Affected Section(s)	Summary of Changes ('Reviewed' or details of change)
5/31/2018	New procedure	New procedure. ICC approved on 5/31/2018
3/22/2019	Added section di	Added contraindications of Tdap vaccine
5/30/2019	Section 1A and 1D	Approved per IC committee
8/7/2019	Approved by	Changed to VP Quality
3/10/2020	Log, Reference #	Updated to new Logo; Changed Reference # from INF-9.6 to EH-9.6-PRO to match Reference # in MCN
6/11/2020	All	No Changes