**Infection Prevention and Control Manual**

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**Definitions:**

For the purpose of this manual

* Persons referred to as “**patient(s)”** are considered any detained or incarcerated person housed in a correctional facility.
* **“Workers**” refer to any detained or incarcerated person assigned to a work detail within the facility or assigned to outside work details.
* **Infection prevention and control coordinator** is identified the healthcare employee (nurse, epidemiologist, et.al.) responsible for implementing, coordinating and monitoring all infection prevention and control responsibilities included in their job description.

The Centurion Infection Prevention and Control Manual is a resource for Centurion healthcare staff. Each facility is governed by contractual agreements that may or may not be included in this manual. The facilities should follow the contracted site-specific infection control policies and reporting as per their state or facility regulations. The Centurion Infection Prevention and Control Manual contains the Centurion Exposure Control Plan includes exposures to bloodborne pathogens and other potential infectious diseases, the respiratory control plan and hazardous communications. As the employer, Centurion is responsible for developing an Exposure Control Plan for its employees.

Each facility should review and edit for site-specific policies of their department or facility. The forms provided are to be used as appropriate unless contract-specific forms are required.

Any site-specific changes, forms, or additions to the manual are submitted to the corporate director of infection prevention and control for review. Each facility is responsible for submitting timely reports and notification to the infection prevention and control director and to the contracted entity as identified in their contract. The reports include, but not limited to infectious disease statistics, outbreaks, exposures, and vaccines administration.

In developing the Centurion Infection Prevention and Control Manual, current resources include Center for Disease Control and Prevention (CDC), t Occupational Safety and Health Administration (OSHA), Federal Bureau of Prisons (FBOP), Association for Professionals in Infection Control and Epidemiology (APIC), Society for Healthcare Epidemiology of America (SHEA)Epidemiology in America, Infectious Disease Society of America (IDSA), National Commission on Correctional Health Care (NCCHC), American Correctional Association (ACA), the U.S. Department of Health and Human Services (DHHS), and infection prevention and control consultants in correctional healthcare.

The Centurion Infection Prevention and Control Manual is reviewed annually. The infection prevention and control coordinator, medical director and responsible review the on-site manual. Healthcare authority and administration. Any site-specific revisions or additions made should be documented with date reviewed or change made on the specific policy. The complete manual review is documented with signatures of the medical direction and responsible health authority on the form *IPC-001* *Annual*

*Approval Page. C*opies of the approval is placed in the front of each manual. Copy of the manual is to be accessible by all employees. Any changes in policy or procedure is provided to the employee and the employee must acknowledge the change in writing. It the manual is electronically produced, a printed copy should available in the infection prevention and control office, and an area for access to all staff. The original copies of the manual should be kept in a secure location. Any previous manuals should be kept in according to the legal limits as required by law for medical health records.

# **Purpose**

To provide the structure to deliver healthcare in a correctional environment that is safe and recognizes the infection prevention and control issues for patients, healthcare staff, and security. Incarcerated populations are at high risk for infection and communicable diseases due to high incidence of existing, untreated medical conditions both diagnosed and undiagnosed. In addition, factors in the physical structure of facilities contribute to disease transmission (close quarters, inadequate ventilation, overcrowding, and frequent movement of patients).

# **Policy**

In a contract site where comprehensive (medical, behavior/mental health, dental) healthcare services are provided by Centurion, the site Medical Director, Program Director/Health Services Administrator (HSA, FHA), and Director of Nursing are responsible for the implementation and oversight of the Infection Prevention and Control Program. An Infection Prevention and Control Nurse/Coordinator or designated staff member oversees the day-to-day operations of the Infection Prevention and Control Program. The Infection Prevention and Control Committee or other designated committee includes representation from healthcare administration, medical, nursing, pharmacy, dental, mental health, and facility safety/sanitation or designees. The site will collaborate and consult local or state public health department, governing health authority, and corporate infection prevention and control director for providing current guidelines and treatments of infectious diseases, outbreaks, and health crisis.

In a contract site where mental/behavioral health services or some aspects of physical healthcare for patients housed on mental/behavioral health units are provided, mental/behavior health staff designee may participate on the infection prevention and control committee of the medical services department of the facility. The medical services department typically provides personal protective equipment and safety devices, but on-site mental/behavior health leadership must ensure their availability and appropriateness when staff require them and are provided at no cost to the employees.

All healthcare staff receive basic infection prevention and control information and assessment for infectious diseases most commonly seen in correctional settings, including but not limited to: tuberculosis, ectoparasites, MRSA (methicillin-resistant Staphylococcus aureus), COVID-19, and other infectious diseases at the time of employment and annually thereafter. Additionally, staff determined to be at risk for occupational exposure to bloodborne pathogens and other infectious diseases receive prevention training at the time of employment, annually thereafter, and when changes in procedures occur. Infection prevention and control needs will be coordinated at the regional office level and corporate infection prevention and control director.

# **Procedures**

1. Surveillance for infectious diseases of special concern for transmission in the correctional environment include but are not limited to: COVID-19, ectoparasites (pediculosis -lice and scabies, respiratory infections (*N. meningitides, S. pneumonia, influenza, tuberculosis,COVID-19, legionaires*), sexually transmitted infections, bloodborne diseases (HIV, HBV, HCV, syphilis, gonorrhea), hepatitis A virus (HAV), GI infections (i.e. by diarrhea caused by organisms such as norovirus, and foodborne diseases), and emerging and reemerging infectious diseases identified by increase in infections. A high index of suspicion for tuberculosis and CA-MRSA (community-associated methicillin-resistant staph aureus and other infectious diseases) in correctional settings is surveilled. Infection prevention and control measures in this environment are similar to other ambulatory care settings. Standard Precautions, Universal Precautions, and, when indicated, Transmission-based Precautions are followed.
2. The Infection Prevention and Control Manual is provided as a guideline to staff for compliance with generally accepted infection control practices of the Centers for Disease Control and Prevention (CDC), the Occupational Safety and Health Administration (OSHA), the Association for Professionals in Infection Control and Epidemiology, Inc. (ACIP), the Department of Health and Human Services, the Federal Bureau of Prisons, other specialty organization and applicable standards of care in a correctional facility.
3. The model infection prevention and control manual is to be reviewed by the sites to provide site specific infection control processes in collaboration with the facilities’ standard operation policies and procedures. An annual review of the infection prevention and control manual is conducted and approved by the site or regional medical director, program director/ health services administrator, and director of nursing. Signature of the medical director and medical administrator with dates of review and note of any changes in the year are recorded on IPC-001 *Annual Approval Page* form inserted before the Table of Contents. When changes in the model or corporate of individual policies and procedures will be signed on the date of update, and changes noted and documentation of sharing changes with the site staff. A copy of any previous policies or manuals need to be kept in accordance with the health care records of the state or site policy ( if longer.
4. The infection prevention and control program focuses on accurate and consistent identification, reporting, and treatment of infectious diseases within the patient population. Surveillance activities monitor and evaluate infections with high occurrence or high risk of morbidity and mortality in the correctional environment. The infection prevention and control program provides staff education and exposure prevention/control for communicable diseases.
5. The infection prevention and control program recognizes the importance of local and state health departments and establishes collaborative relationships to improve the treatment of patients in the facility and after release from the facility. Local and state health departments, in addition to the CDC, are consulted to assist the healthcare staff in providing current infection control practices and treatment guidelines for infectious diseases.
6. The infection prevention and control program provides ongoing review and evaluation of aseptic, isolation, and sanitation techniques utilized in the health care setting. The review and evaluation on site includes participation as requested by correctional administration and the analysis of data. Analysis of data determines the need for further surveillance or the need for changes in any preventive and control policies and procedures related to patient healthcare or the facility environment.
7. The Infection Prevention and Control program Nurse/coordinator or designee is responsible for and coordinates with the medical director and infection prevention and control program, in the following:
8. Surveillance, tracking, and reporting of all communicable diseases and infections
9. Reporting communicable diseases as required by law
10. Ensuring staff compliance with Standard Precautions and other infection prevention and control practices
11. Evaluating the vaccination program and infectious disease screening of staff and patients, including tuberculosis screening
12. Identifying infectious diseases and, in consult with the provider, appropriateness of therapy for the patient population
13. Providing educational information and programs on infectious disease/infection prevention and control for staff, patient population, and correctional staff per policy and contract
14. Investigating and reporting occupational exposures including bloodborne pathogens and communicable diseases including tuberculosis
15. Reviewing and making proposals for site-specific updates or changes of infection prevention and control policies and procedures no less than annually
16. Ensuring that reports from nursing, dental, and pharmacy regarding infectious waste disposal, sterilization and disinfection practices, etc. are accurate and current
17. Reviewing reports and participating in regular inspections of the healthcare unit and isolation rooms including airborne infectious isolation rooms (if on site), and any areas as per contract
18. Reviewing reports of inspections of the facility when requested
19. Preparing infection control and infectious disease reports required by contract
20. Overseeing safer medical devices, personal protective equipment and other related products’ evaluation, selection and education
21. Overseeing the exposure control program including, but not limited to, bloodborne pathogen training, respiratory protection program, hazardous communications, monitoring exposure incidents, and evaluation of incidents.
22. Completing all infection control reports as required by contract and corporate requirements
23. Participating and reporting infection control statistics and information at meetings (infection control committee, continuous quality improvement, medical administration-MAC, and any contract required meetings)
24. Providing resources for infection prevention and control issues in the facility
25. Any and all requirements as outlined in their job description
26. Infection prevention and control Committee membership will include at least the following:
    * 1. Infection prevention and control nurse/coordinator or designee, chairperson
      2. Physician
      3. Nursing, mental health, dental, pharmacy, and appropriate ancillary department representatives
      4. Institutional safety and sanitation officer or designee assigned by institutional administration.
27. The infection prevention and control committee meets no less than quarterly and provides written reports to the continuous quality improvement (CQI) committee. These meetings may be held in conjunction with CQI committee meetings. Issues related to the security of the facility will be discussed in institutional administration meetings.
28. A review of the infection prevention and control program is conducted annually to evaluate problem identification and resolution, trends, evaluate education programs presented to staff and patients, and to ensure compliance with the bloodborne pathogen exposure control and other staff programs including tuberculosis screening for employees and the incarcerated population.
29. The CQI committee is committed to evaluating, monitoring and improving all aspects of infection prevention and control in the healthcare unit and collaborating with facility administration and other departments within the facility to support infection control in the facility.
30. Monthly and annual reports and additional reports as identified will be submitted to the corporate infection prevention and control director.

## Referenced Forms:

IPC-001 Annual Approval Page

## Staff Training:

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## Attachments/Resources:

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## Clinical Operations Revision Dates:

Originated 2016

Revised June 2019

Revised December 2021

# **Purpose**

To provide relevant infection prevention and control information education for the promotion of healthy lifestyles for healthcare staff, patients, workers, and correctional staff.

# **Policy**

Education is important in identifying and preventing the transmission in infectious/communicable disease. It is important that all parties have knowledge of and participate in the infection prevention and control program. Infection prevention and control is taught to the level and need of each category of participants.

Education includes but is not limited to: cough etiquette, basic hand washing, appropriate locations for eating and drinking, basic infection prevention and control information, the importance of reporting illnesses, exposure control plan, procedure for reporting exposures, use and testing for personal protective equipment, infectious disease precautions, immunizations, the importance of reporting illnesses, individual patient education for diagnosis treatment, with follow up directions, and additional information in the event of increased incidence of a specific disease

The Program Director/Health Services Administrator or designee is responsible for ensuring that each category of employee is provided education.

# **Procedures**

* 1. Healthcare Staff:

The Program Director/Health Services Administrator is responsible for ensuring that each healthcare staff member who has been identified as at risk for occupational exposure due to job duties receives training in infection control and the Bloodborne Pathogen Exposure Control Plan at the time of hire prior to duty assignment, annually thereafter, and when procedures change.

1. Educational programs relating to the Infection Prevention and Control Program and the Bloodborne Pathogens Exposure Control Plan are provided to healthcare staff during working hours when possible at no cost to the staff.
2. The staff have the opportunity to ask questions and have answers provided by knowledgeable staff.
3. Initial orientation includes but is not limited to the following:
4. Review and location of the Infection Prevention and Control Manual and the Centurion Exposure Control Plan including exposure to bloodborne pathogens
5. Standard precautions
6. Universal blood and body fluid precautions
7. Transmission-based precautions
8. Isolation precautions
9. Personal protective equipment location and use, proper donning and doffing
10. N95 fit testing (including initial medical evaluation)
11. Use of safety devices
12. Bloodborne pathogens information as outlined in the Bloodborne Pathogens Exposure Control Plan
13. Respiratory protection plan
14. Hazard Communication
15. Tuberculosis management
16. Communicable diseases overview (including ectoparasites, MRSA, influenza, and common communicable diseases seen in corrections)
17. Definitions and disposal of regulated/biohazardous waste
18. Disinfection/sterilization procedures
19. Staff health programs: hepatitis B vaccination and post-vaccination antibody testing; tuberculosis screening and skin testing; and post-exposure to communicable diseases procedures including bloodborne pathogen post-exposure
20. Annual infection control education the review of infection control program and additional updates on policy, procedure, or supplies:
    * Additional education for: Any changes in infection control policies and procedures
    * Implementation of and use of new PPE or safety devices
    * Review of exposure control plan including bloodborne pathogens exposure
    * Review of tuberculosis and the respiratory protection plan
21. Other important or emerging issues (MRSA, influenza, outbreaks, epidemics and pandemics)
22. Education is provided at the time of changes in policies, procedures and equipment and when safety devices are implemented.
23. Training records are completed for each educational session and are maintained for three years from the date of training. Training records include:
24. Date of the training sessions
25. Content or summary of the training sessions
26. Name and qualifications of person(s) conducting the training
27. Names and job titles of all staff attending the training sessions
28. Healthcare staff are given the opportunity to provide input on infection-related issues including but not limited to bloodborne pathogens, tuberculosis, safety devices, and personal protective equipment at each staff meeting. Bloodborne pathogen exposures, tuberculosis exposures, and other communicable disease exposures are discussed. The staff have the opportunity to try and evaluate safety devices. Notes from staff input and discussions and infection prevention and control education are maintained in staff meeting minutes.
    1. Patient and worker education/training may include:
    2. Individual health education and self-care for their health conditions
    3. Common infections and diseases as appropriate
    4. Infection prevention, including personal hygiene, immunizations, and reporting of possible infectious diseases
    5. Workers: Worker Infection Prevention and Control Training
29. Healthcare staff will provide training as required by the contract.
30. Training will include:
31. Basic infection control practices
    * Bloodborne pathogens training
    * Protecting against exposure and response in event of an exposure
    * Safe handling of linens and trash
    * Environmental cleaning
    1. The training process will include:
32. Handout for each participant will be provided by printing PowerPoint presentation formatted 6 slides to a page
33. Attendance list will be maintained
34. Each participant of the training will complete IPC-015 Worker Infection Prevention and Control/Bloodborne Pathogen Training Checklist
35. Original attendance list and checklist documentation will be submitted to the facility’s training department
36. Copy of the documentation will be placed in the worker’s health record
37. Training will be reported to the Infection Prevention and Control Coordinator or designee
38. Hepatitis B vaccine series will be offered to worker working in environmental cleaning and laundry handling if the worker is not immune.
    1. Correctional staff training per contract
    2. Bloodborne pathogens
    3. Infection prevention and control
    4. Tuberculosis

## Forms:

IPC-015 Worker Infection Prevention and Control Monitoring Checklist

IPC-025 Staff Training Verification - Tuberculosis Skin Testing Procedure

## Trainings on Central or Centurion University:

Bloodborne Pathogens and Infection Control Annual Self Study:

Tuberculosis Annual Training

Needle and Sharp Safety–l

Inmate Workers training *How to Protect Yourself*

Correctional Officer training

## Clinical Operations Revision Dates:

Originated 2016

Revised June 2019

Revised December 2021

# **Purpose**

To eliminate or minimize occupational exposure to bloodborne pathogens and other infectious diseases for the health and safety of Centurion healthcare staff determined to be at risk for exposure. This policy is to outline and comply with the all infection prevention guidelines and the revised OSHA Title 29 Code of Federal Regulations 1910:1030 and Compliance Document for Bloodborne Pathogens, Respiratory Protection and Hazard Communications.

# **Policy**

The Exposure Control Plan includes the Bloodborne Pathogens Exposure Control Plan, Respiratory Protection and Hazard Communication. The standards apply to all work operations in which a healthcare staff member may be exposed to blood, bloodborne pathogens or other potentially infectious diseases during normal working conditions or during emergency situations. Healthcare staff have been identified by their job responsibilities. Identification of healthcare staff as at risk for exposure is indicated on their job description. The staff is informed of the contents of the plan; definitions of blood and bloodborne pathogens; personal protective equipment; safe practices and handling procedures; measures to protect all healthcare staff; and procedures if an exposure occurs.

Centurion considers exposed healthcare staff to be covered by this plan and site management will be held accountable for the implementation of the exposure control plan.

# **Procedures**

**Bloodborne Pathogens and Infectious Disease Exposure**

**Exposure Determination**

1. Centurion has made a determination of which healthcare staff are in the category as at risk for exposure based upon their job description and the tasks they are performing.
2. All at risk for exposure healthcare staff are covered under this plan.
3. Centurion management is responsible for ensuring compliance with the plan by healthcare staff at risk for exposure.
4. Training of healthcare staff at risk for exposure is outlined later in this document and is in accordance with the OSHA and CDC standards.
5. As new job positions are added to the organization, an evaluation is performed to determine if a job description includes tasks that may place the employee at risk for exposure.

**Precautions**

***All precautions are defined in IPC-06M Infection Control Precautions*.**

1. **Standard Precautions** are the minimum infection prevention practices that apply to all patient care, regardless of suspected or confirmed infection status or diagnosis in any setting where health care is delivered Standard precautions include universal precautions and are supplemented by transmission based precautions. ; Caution, handling and protection for exposure to blood borne pathogens, biohazards: and other infectious organism. These practices are designed to both protect the employee and prevent healthcare staff from spreading infections among patients
2. **Universal precautions** (considers blood or OPIM (other potentially infectious material) that may contain blood, or suspected to contain blood that can transmit blood borne pathogens),
3. Engineering and work practice controls are used to eliminate or minimize healthcare staff employee exposure whenever possible. Where the possibility of occupational exposure remains after implementation of the controls, personal protective equipment is used.

**Personal Protective Equipment and Use**

1. Personal protective equipment is available for all healthcare workers who may have occupational exposure. The equipment is located in each examination room, in emergency response bags, and in other areas where exposure to bloodborne pathogens or other potentially infectious diseases may occur. Masks and gloves in various sizes and types are located in all rooms where healthcare is provided.
2. Personal protective equipment is provided at no cost to healthcare staff at risk for exposure.
3. All aspects of personal protective equipment and use are addressed in policy and procedure *IPC-06M Infection Control Precautions,* of the Infection Prevention and Control Manual and additional information under Respiratory Protection Program on pages 38-47 of this policy.
4. In the event that an employee’s clothing becomes contaminated:
5. Centurion healthcare staff HealthCare staff are not to wear contaminated articles of clothing outside the facility.
6. If blood or other potentially infectious material splashes or soaks through to work clothes, street clothes, undergarments, shoes, etc., the clothing are to be removed, laundered, or decontaminated at the facility, or other arrangements per site protocol, at no cost to the healthcare staff.
7. The site Responsible Health Authority (Program Director/Health Services Administrator or designee) will provide replacement pairs of scrubs for use while contaminated clothing is being cleaned.
8. Replacement scrubs are maintained in a readily accessible location.

**Work Practice and Engineering Controls**

1. **Hand Hygiene** policies are located in policy and procedure *IPC-06M Infection Prevention Precautions*, section #10, of the Infection Prevention and Control Manual. It is expected that healthcare staff will comply with all aspects of the policy. Hand washing supplies, including appropriate alcohol-based waterless hand washing products, are provided.
2. **Respiratory Hygiene- Cover Your Cough;** policies are located in policy and procedure *IPC-06M Infection Prevention Precautions* of the Infection Prevention and Control Manual. It is expected that healthcare staff will comply with all aspects of the policy.
3. **Needle Puncture Prevention and Safer Medical Devices**
4. Contaminated sharps will not be bent, sheared, purposely broken, recapped, or removed by hand. Broken glassware, which may be contaminated, is picked up using mechanical means, such as a broom and dustpan, it should never be picked up by hand.
5. When recapping or needle removal is required, it is performed using a mechanical device (forceps, recapping device, etc.) or a one-handed “scoop” technique. Recapping is only used in the dental department in specific instances of administering local anesthetic. Dental services maintain specific policies and procedures related to this practice in the *Dental Provider Procedure Manual*.
6. Contaminated/used sharps are discarded in labeled, puncture-resistant; color-coded, and leak-proof containers that are placed as near as feasible to the area of use. Sharps containers are located or transported to the point of injection/sharp use. Since security concerns may limit the locations of sharps containers, healthcare staff are provided with small portable sharps containers when necessary. These containers must never be overfilled (not more than 2/3 full) and are removed, sealed, and stored in the biohazard secure storage area. Full containers are replaced immediately. The containers must be kept upright and closed immediately prior to removal or replacement to prevent spills.
7. All aspects of sharps handling are addressed in *policy IPC-06 Sharp and Needle Safety of the Infection Control Manual.*
8. **Laboratory policies** are covered in the policy and procedure *IPC-06 Sharp and Needle Safety,* of the Infection Prevention and Control Manual.
9. **Contaminated Medical Equipment** procedures are covered in policy and procedure *IPC-06M,* *Infection Control Precautions: Equipment Disposal and Cleaning*, and IPC—18M Cleaning, Disinfecting, Sterilization in the Infection Prevention and Control Manual. Mechanical cleaning and disinfecting of articles such as stethoscopes, electrodes, blood pressure cuffs, and tables that are soiled with blood or body fluids must be completed on a routine basis and, at a minimum, when visibly soiled. All such items are cleaned and disinfected when visibly soiled, and at least twice weekly.
10. Paper on exam tables is changed between patients.
11. Any non-disposable equipment is cleaned according to device cleaning recommendation.
12. Non-disposable equipment used on a patient in isolation for an infectious disease should be assigned to that patient and decontaminated once isolation discontinued.
13. A detergent disinfectant that is effective on multiple viruses, fungi, bacteria, tuberculosis, and effective against non-enveloped viruses is mixed, used, and stored following manufacturer’s directions.
14. **Laundry** policies are covered in policy and procedure IPC-11M, *Standard Precautions: Laundry and Linen Safe Handling,* of the Infection Prevention and Control Manual.
15. All soiled laundry from the healthcare unit will be placed in plastic leak-proof bags. Soiled laundry is handled as little as possible with a minimum of agitation.
16. Standard Precautions are used when handling all soiled linen.
17. If blood or body fluids are leaking, or if leaking is possible through the original bag, the container is double-bagged in a red bag.
18. All soiled laundry is washed according to the manufacturer’s recommendation detergent used.
19. Laundered items are to be dried on the highest possible temperature until completely dried to prevent transmission of microorganisms
20. Special handling for contaminated linens includes, but is not limited to, placing in a water-soluble biohazard laundry bag or separate red bag and labeled . Contaminated laundry is to be washed separate from other soiled laundry.
21. **Housekeeping** policies are covered in policy and procedure *IPC-18 Cleaning, Disinfecting and Sterilization* of the infection prevention and control manual.
    * 1. Healthcare units are maintained in a clean and sanitary condition.
      2. Blood or infectious spills are cleaned up promptly using Standard Precautions/Universal Precautions. Appropriate personal protective equipment is used to prevent exposures.
      3. Contaminated or biohazardous waste is placed in red bags or containers that are closable, constructed to contain all contents and prevent leaking, and closed before removal to prevent spilling or protrusion of contents during handling. Containers are labeled with the universal biohazard sign. Biohazardous waste is kept separate from ordinary trash.
22. **Kitchen sanitation** is governed by facility standard operational procedures.
23. Any kitchen work with an infectious/communicable disease should be reported to medical department
24. **Work Area Guidelines**
25. Eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses are prohibited in work areas where there is a reasonable likelihood of occupational exposure to blood or body fluids.
26. Healthcare staff are to eat, drink, or smoke only in areas designated for this purpose.
27. Food and drink are not to be kept in refrigerators, freezers, shelves, or bench tops where medications, blood or other potentially infectious materials are kept.
28. Any specimen handling area must be disinfected at the end of each shift or when visibly soiled.
29. **Biohazardous/Infectious Waste** is handled according to policy and procedure *IPC-04M Biohazardous Waste Management: Handling, Labeling and Sharps Disposal,* of the Infection Prevention and Control Manual.
30. **Safer Medical Devices** are used to reduce the risk of microbial transmission to patients and the likelihood of transmission by following sharp safety and safe injection practices addressed in *IPC-06M Sharp and Needle Safety in the infection control manual.* The RHA, HSA, infection control coordinator, healthcare staff, and the Infection Prevention and Control Committee guides the review and evaluation of appropriate, commercially available sharps and safer medical devices designed to eliminate or minimize occupational exposures to bloodborne pathogen no less than annually.

a. The review and evaluation include but are not limited to the following:

1. Changes in technology that eliminate or reduce exposure to bloodborne pathogens
2. Occupational exposure data and trends identified by injuries
3. Input from non-managerial healthcare staff responsible for direct patient care who are potentially exposed to injuries from contaminated sharps
4. Methods of product evaluation, selection, and implementation including solicitation from direct care healthcare staff will be documented.
5. Devices that may be evaluated and implemented for engineered sharps protection include devices for:
6. The collection of bodily fluids or withdrawal of bodily fluids after initial venous or arterial access is established
7. The administration of medication or fluids
8. Any other procedure involving the potential for occupational exposure to bloodborne pathogens due to percutaneous injuries from contaminated sharps
9. The safer medical devices selected for implementation may include, but are not limited to:
10. IV safety catheters
11. IV safety administration sets
12. Safety lancets
13. Butterfly safety devices
14. Vacutainer safety devices
15. Safety syringes
16. Hemodialysis access safety devices
17. Dental safety devices and syringes
18. Safety or blunt scalpels
19. Safer medical device evaluation includes healthcare staff education, training with hands-on return demonstration, and pilot testing of proposed new or replacement devices. The *Safer Medical Device Evaluation & Recommendation Form* is completed and analyzed.
20. The on-site RHA or designee is responsible for soliciting healthcare staff evaluation of safer medical devices and ensuring that devices are selected based on ease of use, the likelihood of a successful reduction of risk of exposure, and the ability to perform the task without a major change in current procedure or technique. Documentation of the selection process for safer medical devices is reflected in Infection Prevention and Control Committee minutes.
21. Unsafe sharps medical devices are not used. If an unsafe device is found in stock, it should not be used and will be placed in a sharps container. The Program Manager or designee will be notified.
22. An up-to-date listing of all safety devices is maintained. The *Safer Medical Devices Utilized* form is available for this documentation.

**Hepatitis B Vaccination**

1. Hepatitis B vaccine is available, free of charge, to all healthcare staff who are at risk of occupational exposure to blood or other potentially infectious materials. A list of the job classifications of healthcare staff likely to have such occupational exposure is outlined in the *At-Risk Healthcare Positions* attachment.
2. Hepatitis B vaccine is offered to all healthcare staff at risk for exposure. This vaccine is offered to newly hired healthcare staff within 10 days of initial hiring. Any healthcare staff member who refuses vaccination at the time of hire for any reason must sign a declination statement. If the healthcare staff member elects not to take the vaccine at the time of initial hire, it is available to him/her at any time upon request.
3. The healthcare staff member is given educational information on the Hepatitis B vaccine including its efficacy, safety, method of administration, and the benefits of being vaccinated.
4. Healthcare staff are expected to follow all infection control policies and Standard Precautions regardless of the decision to receive or decline the Hepatitis B vaccine.
5. The Hepatitis B vaccine series is composed of three injections given into the deltoid (shoulder) muscle with a 1 to 1.5-inch-long needle at 0, 1, and 6 months.
6. The consent/declination form becomes part of the healthcare staff member’s confidential Health and Safety file.
   1. When healthcare staff requests the series, the administration of the three injections is documented on the consent form when administered by a licensed professional employed by Centurion. Should healthcare staff employee end employment with Centurion prior to completion of the series, the company-provided injections will also end. A record of immunization dates will be given to healthcare staff members upon request.
   2. When the Hepatitis B vaccine series is administered by a healthcare provider other than Centurion, the healthcare staff member is required to present documentation at the completion of the series. Tracking of the completion of the vaccine series when not administered by Centurion will consist of contacting the employee at the time the series is to be completed, six months after the initial signing of the consent for the series.
   3. Healthcare staff who delay the second or third vaccine doses or who do not wish to continue with the series must sign a Hepatitis B vaccine declination statement.
7. Second and third vaccine injections are administered at the recommended intervals from the first injection of the vaccine without interruption. However, if the vaccination series is interrupted after the first dose, the second dose will be administered as soon as possible. The second and third doses should be separated by an interval of at least two months. If only the third dose is delayed, it should be administered as soon as convenient.
8. Healthcare staff completing the third vaccine dose given by Centurion are offered a Hepatitis B surface antibody level (HBsAb). The level is drawn one to two months after the third dose. If the antibody is not detected (>10 MIU/mL is considered a positive serum titer), a second three-dose vaccine series is recommended. The vast majority of individuals receiving three doses of the vaccine on schedule develop detectable antibodies. If at the completion of the second series, the antibody is still not detected, the healthcare staff member should be considered a non-responder. Additional vaccine doses are not likely to be successful. Subsequent exposure to Hepatitis B infected blood/body fluid should be handled as an occupational exposure according to the post-exposure evaluation and follow-up guidelines. Non-responders working in chronic dialysis centers should have Hepatitis B vaccine antigen and antibody levels drawn every six months. Healthcare staff who refuse the Hepatitis B surface antibody level test must sign the refusal that is contained on the consent/declination form. This testing is performed at a laboratory designated by Centurion. In all instances, costs associated with the testing of post-Centurion provided vaccine series and any post-exposure testing due to job exposure are the responsibility of Centurion.
9. If a person who has received the series in >22 years, and they provide a copy of a titer (HBsAG) that is <10mIU/mL, it is recommended they receive an additional one-time Hepatitis B vaccination, followed by a titer.
10. If at any time during the employment of healthcare staff identified as at risk for exposure they decide to be vaccinated, he/she should contact the HSA/Program Manager or designee.

**Bloodborne Pathogen or Infectious Disease Exposure Evaluation and Follow-Up**

Healthcare staff Exposed employee must immediately report all exposures to their immediate supervisor or administrator on call. The employee should follow the procedure below. Prompt reporting of exposure incidents permits timely medical evaluation and follow-up. If evaluation of the circumstances indicates post-exposure treatment, the exposed employee will benefit from the prompt initiation of treatment. All healthcare staff are immediately provided follow-up for all occupational exposures. This includes exposure to infectious diseases and possible blood borne pathogens through contact with blood or body fluids from needle sticks, other sharps injury, mucous membrane exposure, percutaneous exposure, and non-intact skin exposure (cuts, wounds, abraded, chapped, or human bite which breaks the skin). Immediate care to evaluate, treat, provide prophylaxis, and follow-up is confidential.

If the exposure involves body fluids that can transmit bloodborne pathogens including blood, blood products, cerebrospinal fluid, synovial fluid, pleural fluid, peritoneal fluid, pericardial fluid, amniotic fluid, semen, vaginal secretions, or other body fluids contaminated with visible blood or fluids that are suspected to blood. Complete the follow up procedure for blood borne pathogens. If the exposure to other potentially infectious disease, the staff should report the exposure as in paragraph 1 and reporting of the exposure below

**Procedure for Post-Exposure Follow-Up**

Bloodborne pathogen exposure immediate response, the healthcare staff is to:

Immediately perform first aid on the injury site

Needle stick and sharps injuries or non-intact skin:

The area is allowed to bleed freely for 30 seconds

The area is washed with soap and water or scrub solution

Pressure is applied to stop the bleeding, and a bandage applied if necessary.

Eye, nose, and mouth contact:

The affected area is flushed with water for 2 minutes

Mouth contamination: spit out any fluid, rinse with fluid, and spit out again.

For all exposures

Notify immediate supervisor or administrator

Contact the Worker’s Compensation Insurance Consult Line by telephone:

GB CareTM ZURICH Phone: 1-855-700-0905 (available 24/7/3650

Identify your name, your position and your site

GB representative will take information for first report and file the first report of injury

Give complete information of the incident and answer all questions

The GB representative will provide you with a claim number and will fax a copy for you to use at the provider’s (ER, Urgent Care, or provider, and pharmacy for treatment and medications

If known exposure is from a known source (person), they need to be tested as soon as possible

If known source administrator is to contact on site provider to order exposure labs on the source (HIV, Hep C, Hep B) if unknown status,

If any test is positive, a viral load should be obtained on the positive test.

If source is a known positive for any of the labs (HIV, Hepatitis C, Hepatitis B), a viral load should be ordered

Test results are to be given to the worker’s compensation provider, for discussion with patient. Access to the test results or not to be accessed by or for the employee

All records are confidential and should be placed in the employee’s file

The employee and supervisor are to complete the Centurion Exposure packet and all forms including a detailed description of the incident, the purpose is to evaluate the root cause of the incident, and provide education on injuries. This is an education and not a punitive action.

If the incident is caused by a malfunction of a device, the administration is to conduct an investigation of the device and determine the cause of malfunction. A complete description of the device, the manufacturer and lot number are to be included on the report.

Complete report of incident and findings are to be summarized and sent to the Corporate Director of Infection Prevention and Control

Post-exposure follow-up is provided following the information and directions detailed in Exposure Follow-up Packet. The most current packet is available on Centurion Central (Departments>Human Resources>Benefits>Worker’s Compensation and in the Exposure Control binder, and on-site packets are available to all healthcare staff.

All expenses related to a determined injury or exposure will be covered at no cost to the employee.

In the event the employee has questions or needs additional assistance in filing a workers' compensation claim, please contact the Leave Administrator at LeaveAdministrator@TeamCenturion.com or call 800-416-3649

In the event of an exposure, the employee has access to the Employee Assistance Program. Information is available in the employee exposure packet.

**Post Exposure Record Keeping**

The following are medical records and are maintained in the Employee Medical File (EMF) in accordance with 5 CFR 293, Subpart E:

Copies of all results of examinations, medical testing, and follow-up procedures received from the outside provider.

A copy of the following forms located in the exposure packets and available on the Central in the Human Resources department, workers compensation folder and list for bloodborne pathogen exposure packet. The forms to be included in the file should be referral form from the Nurse Consultant line, It should also include forms from Centurion’s exposure packet: Document 4 *Exposure Report Form*,Document 5 *First Report of Injury,* Document 8 *Source Evaluation Form* Document 3 *Post Exposure Summary Checklist*; and any additional documentation completed for the incident, including any refusal of treatment. Employee medical records must be kept confidential and are not to be disclosed or reported without the employee’s express written consent to any person within or outside the BOP, except as required by law. These records are maintained for the duration of employment plus 30 years, in accordance with 29 CFR 1910.1020.

Work-related needle stick injuries and cuts from sharps that are contaminated with another person’s blood or other potentially infectious material must be entered on the OSHA 300 Log as an injury. To protect the employee’s privacy, his/her name is not entered on the log. Instead, “Privacy Case” is written in place of employee’s name (29 CFR 1904.8 and 29 CFR 1904.29).

Work-related needle stick injuries and cuts from sharps not contaminated with blood or other infectious material, or when contamination is not known, are only recorded on the OSHA 300 Log if the case meets the recording criteria of 29 CFR 1904.7.

Respiratory Protection Program

* 1. **Hygiene- Cover Your Cough;** policies are located in *IPC-06M Infection Prevention Precautions* of the Infection Prevention and Control Manual. It is expected that all healthcare staff will comply with all aspects of the policy.
  2. **Mask and disposable respirator (N95 mask) use:**
     1. All healthcare staff are required to wear appropriate masks as per recommendations of CDC guidelines and per facility requirements
     2. Healthcare staff will be instructed on the use of and types of masks (surgical/procedural, N95 Respirators) used in the clinical setting
     3. Healthcare staff with direct patient contact at risk for exposure to known airborne diseases are recommended to wear an N95 masks or highest level of mask protection available during encounter
     4. Staff recommended to wear N95 respirator will be required to have fit testing done at time of hire, and at least annually. Additional testing will be done in event of the employee’s change of facial contour weight change, facial surgery, dental change, etc.), or if masks type is changed. N95 respirators are not recommended for staff that do not have face to face contact with patients unless special circumstances are identified as a health care emergency or crisis. Additional recommendations will be made through emergency policies.
     5. Fit testing includes:
        + - An initial medical evaluation to determine the person’s ability to wear the N95 mask (additional medical evaluation only if complications or changes in medical condition.
          - Instructions and practice of donning and doffing, storage and use of N95 mask
          - A qualitative fit testing procedure performed by a trained IPCN, DON, or nurse educator consists of procedure for fit testing

Initial medical evaluation to determine safety of fit testing

Education of purpose of fit testing, limitations for respirator

Evaluation of size and adjustments of NIOSH approved N95 respirator

Purpose of testing

Fit test procedure

Post documentation

* + - * 1. Documented the fit testing on the certification form and placed in the employee’s personnel file with date, type of masks, and solution used.
        2. On site log to track all employee’s and tests done with date of testing and reported to the RHA . Report of fit testing information Corporate Director of Infection Prevention and Control or designee on IPC-003 Infection Prevention and Control Monthly Report

**Hazard Communications**

In order to fulfill its obligation to protect the health and safety of healthcare staff, **Centurion** has developed the following hazard communication standard (HCS) program to comply with Occupational Safety and Health Administration (OSHA) standards 29 CFR 1910.1200 and 29 CFR 1926.59.

Will provide Hazard communication training

All sites will maintain a list of hazardous material used in the medical areas

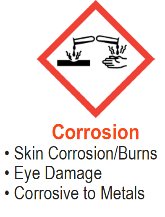
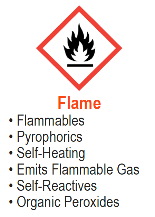
All hazardous materials will have a Safety Data sheet on File

**Labeling**

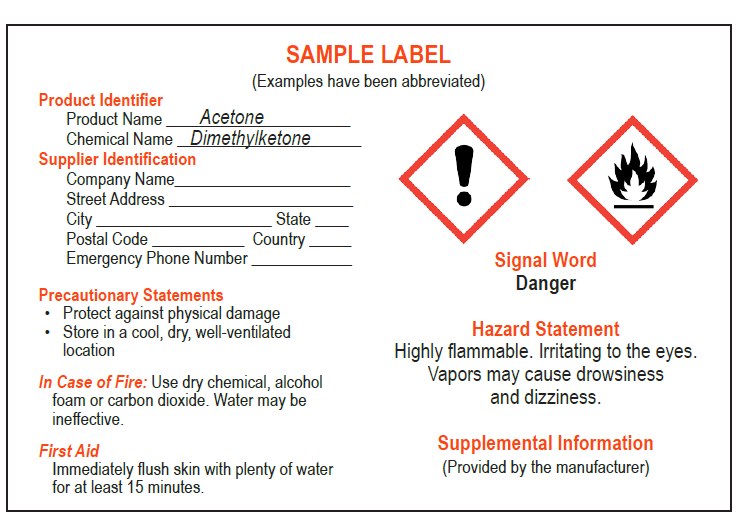
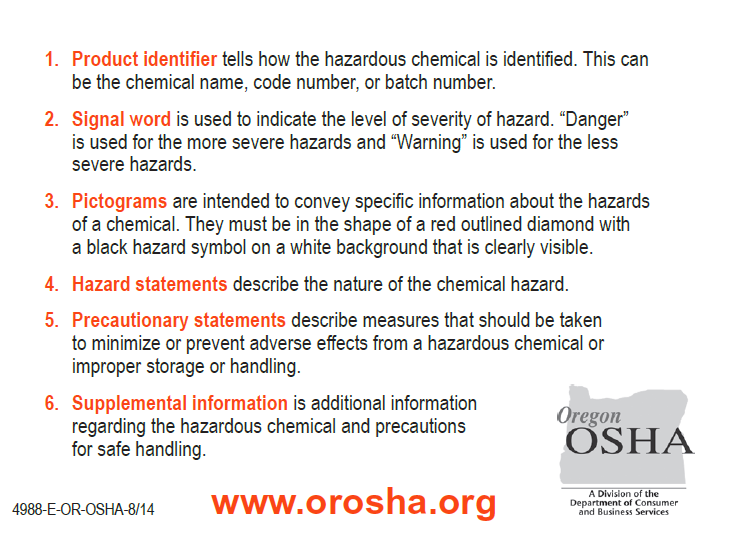
1. Labeling of biohazardous materials is handled according to policy and procedure *IPC-04M,* *Biohazardous Waste Management* of the Infection Prevention and Control Manual.
2. The locations of the items requiring biohazard labeling follows. The labeling is the universal biohazard label and coloring approved by OSHA.

|  |
| --- |
| **ITEM, MATERIAL, LOCATION** |
| Laboratory specimen refrigerator - Laboratory processing room |
| Regulated waste (awaiting removal) - Regulated waste room |
| Red-lined receptacles (for contaminated waste) - Each medical and dental room in which patient care is provided |
| Approved sharps containers - Point of care for sharps used by medical, mental health and dental healthcare staff |
| Medical: Oxygen tanks stored securely and labels indicating location, and when in use |
| Facility: all chemicals used in the facility should have a Safety Data Sheet located in are where chemicals are used |

The universal symbols of Hazardous waste pictograms of the Globally Harmonized System Pictograms (GHS) system include:



**Sample Label**

Safety Data Sheets (previously identified as Material Safety Data Sheets)

Provide a clear description of the data used to identify the hazards.

Minimum information on SDS’s below (may include several pages of information

Identification

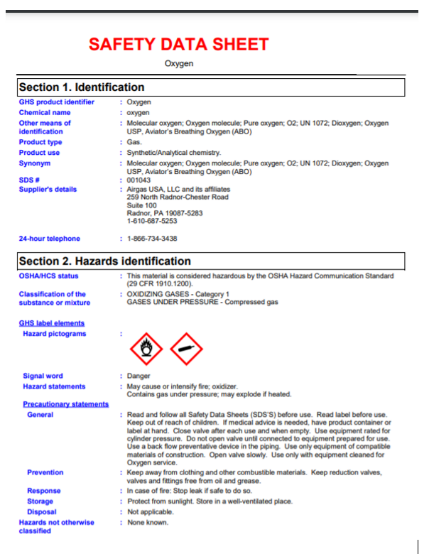
Hazard(s) identification

Composition/information on ingredients

First-aid measures

Fire-fighting measures

Accidental release measures

Handling and Storage

Exposure controls/personal protection

Physical and chemical properties

Stability and reactivity

Toxicological information

Ecological information

Disposal considerations

Transport information

Regulatory information

Other information

**Evaluation and Enforcement**

1. Supervisory healthcare staff monitor employee compliance with the Exposure Control Plan for Bloodborne Pathogens Exposure, Respiratory Protection Program and Hazard Communication)
2. Healthcare staff who consistently violate these regulations including but not limited to the Hepatitis B vaccination or declination statement process; use of safer medical devices; and failure to notify supervisor of the presence or use of unsafe medical devices, or timely reporting of an exposure are subject to corrective action through the performance management process.

**Accessibility**

1. Copies of the Exposure Control Plan and a copy of the regulatory text are available to all healthcare staff in the Infection Prevention and Control Manual.
2. The Infection Prevention and Control Manual including the Exposure Control Plan is located on Centurion Central, and a hard copy is located in areas that are available to all healthcare staff. Additional copies are to be available to all healthcare staff and maintained in the administration office, the medical, mental health, dental areas, and other areas including but not limited to the Program Administrative offices may include the Responsible Health Authority (i.e. Health Services Administrator’s (HSA), Facility Health Administrator (FHA), and the infection prevention and control office, healthcare staff

**Training and Education**

1. In order to provide a safe working environment, training, and education of all healthcare staff at risk for exposure to bloodborne pathogens and infectious diseases will be conducted by or under the direct supervision of the management team. The management team will have access to the Corporate Director of Infection Prevention and Control or designee to answer specific employee questions or to provide consultation as needed.
2. The Program Director/Health Services Administrator/Facility Health Administrator ensures that healthcare staff at risk for exposure to bloodborne pathogens and other infectious disease receive training at the time of hire (before assignment), annually and whenever changes in policy, procedure, or implementation of new devices occurs.
3. Training will cover, at a minimum, the following elements:
4. An explanation of the OSHA standard and location of a copy of the standard
5. An explanation of the Centurion Exposure Control Plan and how to obtain a copy
6. An explanation of methods to recognize tasks and other activities that may involve exposure to blood and other potentially infectious diseases
7. An explanation of what constitutes an exposure incident
8. An explanation of the use and limitations of engineering controls, work practices, and personal protective equipment
9. An explanation of the types, uses, location, removal, handling, decontamination, and disposal of personal protective equipment
10. An explanation of the basis for personal protective equipment selection, types provided and locations of personal protective equipment
11. Information on the Hepatitis B vaccine series, including information on its efficacy, safety, method of administration, benefits of vaccination, the vaccine will be offered free of charge, and that HBsAb testing will be offered one 1 to two months after the third does in the vaccine administration by Centurion
12. Information on the appropriate actions to take and who to contact in an emergency involving blood or other potentially infectious disease exposure
13. An explanation of the procedure to follow if an exposure incident occurs including the method of reporting the incident and the medical follow-up that will be made available
14. Information on the post-exposure evaluation and follow-up that Centurion is required to provide for healthcare staff following an exposure incident
15. An explanation of the signs, labels, and color coding required by the standard and used at the facility
16. Respiratory protection program purpose and requirements
17. Hazard Communication and Biohazardous Waste handling and disposal, location of hazardous materials in facilities, location of SDS sheets and response to a hazardous incident
18. An opportunity for interactive questions and answers with trainer or facilitator

**Record Keeping**

1. The Sharps Injury Log contains the type and brand of device involved in the exposure incident; the department or work area where the exposure incident occurred; and an explanation of how the incident occurred. The name of the potentially exposed healthcare staff member is NOT to be recorded on the log. The log will be maintained by the Program Director/Health Services Administrator or designee and will be kept for at least three years. The Sharps Injury Log is maintained in addition to the OSHA 300 Log of Work-Related Injuries and Illnesses or other required documentation. These logs are readily available from the Corporate Worker’s Compensation Department.
2. Training records are completed for each healthcare staff member upon completion of training. These documents will be kept for at least three years by the Program Director/Health Services Administrator or designee. The training records include:
   * 1. Dates of the training sessions
     2. Contents or summary of the training sessions
     3. Names and qualifications of persons conducting the training
     4. Names and job titles of all persons attending the training sessions
3. Healthcare staff training records are provided upon request to healthcare staff employee or the healthcare staff’s authorized representative within 15 working days of the request. Such requests should be addressed to the Program Director/Health Services Administrator.
4. Confidential records of an exposure incident are included in the healthcare staff’s Confidential Health & Safety file and maintained for each healthcare staff with occupational exposure in accordance with 29 CFR 1910.20, “Access to Employee Exposure and Medical Records.” The Program Director/Health Services Administrator is responsible for updating the confidential Health & Safety files.
5. If the healthcare staff ends employment or the healthcare contract is terminated, healthcare staff’s confidential Health & Safety file is available from the Centurion Corporate Office. These confidential records are maintained for at least the duration of employment plus 30 years.
6. The healthcare staff confidential Health & Safety file is provided upon request to the healthcare staff or the healthcare staff authorized representative within 15 working days of the request. Such requests will be processed by the RHA or designee.

## Referenced Forms:

IPC-005 BBP Post Exposure Prophylaxis Patient Counseling and Consent to Treat

IPC-006 Inmate Exposure to BBP: Exposure Report Form - Patient

IPC-007 BBP Post Exposure Prophylaxis Source Testing/Information Release

IPC-008 Sharps Injury Log

IPC-009 Needle Stick/Sharps Injury Checklist

IPC-010 Safer Medical Device Evaluation and Recommendations

IPC-011 Safer Medical Devices Utilized

IPC-012 HIV Log

IPC-033 or IPC-004 Hepatitis B Vaccine Consent or Decline Form

## Staff Training:

Infection Prevention and Control

Respiratory Protection

Tuberculosis

Bloodborne Pathogen

Hazardous Communication

## Attachments/Resources:

Exposure Control Plan at Risk Healthcare Positions

Exposure Control Plan at Risk Tasks/Procedures

Exposure Control Plan Definitions

Exposure Follow-up Packet

Hazardous Communication

Available on Central

Human Resources/Benefits/Workers Compensation

Complete instructions for claims and information on Employee Assistance Program

# *Keep copies on hand for exposure incidents*

OSHA Standard Bloodborne Pathogens - 1910.1030 (available in Exposure Control Binder and on line at <https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1030> )

<https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051>

# CDC **(**Center for Disease Control and Prevention):

# Infection Control in Healthcare Personnel;

<https://www.cdc.gov/infectioncontrol/guidelines/healthcare-personnel/index.html>

Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>

Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities; <https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html>

Standard Precautions for All Patient Care

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

OSHA (Occupational Safety and Health Administration):

Bloodborne Pathogens and Needle stick Prevention, Standard 1910-1030: <https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1030>

Respiratory Protection Standard 1910.134

<https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.134>

Hazard Communication: Standard 1901.120

<https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1200>

# Management of Potentially Infectious Exposures and Illnesses

<https://www.cdc.gov/infectioncontrol/guidelines/healthcare-personnel/exposures.html>

# Infection Control in Healthcare Personnel

<https://www.cdc.gov/infectioncontrol/guidelines/healthcare-personnel/index.html>

## Clinical Operations Revision Dates:

Originated 2016

Revised June 2019

Revised December 2021

Revised June 2022

# **Purpose**

To protect patients, healthcare staff, correctional staff, waste handlers, and the community from exposure to pathogens generated during medical care. To comply with local, state, and federal regulations regarding regulated, biohazardous, infectious waste and other items contaminated by blood, body fluids or other potentially infectious materials.

# **Policy**

The regulated biohazardous waste disposal company that provides pick-up and disposal will meet all local, state, and federal regulatory requirements for biohazardous waste disposal. As a generator of biohazardous waste, the healthcare unit complies with local, state, and federal regulations and meets infection control guidelines for biohazardous materials generated within the healthcare unit or by the healthcare staff. Regulated biohazardous waste is identified and handled consistently to reduce the risk of exposure to pathogenic microorganisms for patients, facility staff, and the healthcare team. Self-sheathing needles, safer medical devices, and needleless systems are used when available and appropriate. Staff are trained annually on biohazard waste and hazard communication annually.

# **Procedures**

1. The regulated biohazardous waste generated and handled by the healthcare unit includes sharps, other contaminated disposable items, and liquid waste. A biohazardous waste removal contractor completes the disposal of these items.
   * 1. The biohazardous waste removal contractor provides a copy of their permit to do business, the name of the disposal site, and a certificate of insurance as part of the contract agreement. The contractor informs the program director/health services administrator of specific and updated regulations that may affect the handling of biohazardous waste at the facility
     2. Sharps
   1. Used sharps and other items which have the potential to puncture plastic bags and cardboard boxes are placed in puncture-resistant rigid containers at the point of use. This includes razors used in the healthcare unit. The program director/health services administrator collaborates with facility administration in the handling of used razors in housing units if requested
   2. Sharps containers are secured in some manner, such as attachment to the wall, to prevent tampering and possible injury of patients and maintain an upright position. Sharps containers are maintained or transported to the point of care for sharps disposal immediately after use. Small portable sharps containers that may be required for point of care injections outside of usual healthcare delivery areas remain under the physical control of the healthcare staff member and are disposed of in an appropriate larger biohazardous container upon return to the healthcare unit
   3. Sharps containers are not over-filled (not more than 2/3 full) to minimize the risk of injury. Items saturated with blood or body fluids are not placed in the sharps container
   4. Used sharps containers will be closed and sealed prior to handling to prevent spillage and protrusion of contents. The used sharps containers will be immediately placed in the container supplied by the biohazardous waste removal contractor (a rigid box with leak-proof liner and biohazardous labeling)
   5. Used sharps containers will be placed in a secondary closed, leak-proof, labeled container if leaking is possible during handling
   6. Contaminated sharps are any contaminated objects that can penetrate the skin, including, but not limited to, needles, scalpels, broken glass, broken capillary tubes, and exposed ends of dental wires
2. Other contaminated disposable items
3. Patient healthcare areas have red plastic-lined receptacles available for the disposal of contaminated dressings and other items
4. Receptacles for contaminated items preferably have a foot-operated lid. The receptacles are emptied as needed but no less than daily
5. If necessary, used red plastic liners are closed before removal and placed in a second red plastic liner to prevent spilling or protrusion of contents during handling, storage, and transport. If outside contamination of the primary container occurs, the primary container will be placed within a second container which prevents leakage during handling, processing, storage, transport, or shipping and is labeled or color-coded (red)
6. Regulated waste items are placed in the container supplied by the biohazardous waste removal contractor. The container is closed, leak-proof, and labeled
7. Liquid waste
   1. Small amounts of blood and other liquids that may be contaminated with other potentially infectious body fluids can generally be poured into a sanitary sewer
   2. If unable to use facility sanitary sewer system for liquid waste, the handling and storage of the waste must be by the use of closable, leak-proof, and labeled containers for handling, storage, and transport. These containers are supplied by the biohazardous waste removal contractor
8. Storage, containment and removal of regulated biohazardous waste generated by healthcare:
   * 1. Regulated biohazardous waste awaiting removal from the healthcare unit is stored in red plastic bags inside a rigid, sealed, labeled container supplied by the biohazardous waste removal contractor. Boxes are not stored directly on the floor
     2. The storage area for regulated biohazardous waste awaiting pick-up is a secured area with limited access. The area is considered a "dirty" area and clean supplies are not stored in this area. The room must be designated as containing biohazardous material and marked with the biohazard label
     3. Regulated biohazardous waste is removed by the biohazardous waste removal contractor on a regular basis or as needed.
     4. Manifests from the biohazardous waste removal contractor must be supplied by the contractor and maintained in a file by the program director/health services administrator: the manifest states when and what waste was removed and the location and date of disposal. The manifest may be a multi-copy form with the bottom copy left at the facility when waste is taken, and a completed copy returned to the facility after the waste is disposed of. The forms are matched and maintained by the program manager/health services administrator. The required forms related to the destruction notification may be provided electronically from the waste company. These must be retrieved, printed and saved by the program director/health services administrator
9. Labeling identification of biohazardous areas and items will follow requirements of the OSHA Rule 1910.1030 to reduce the risk of exposure to bloodborne pathogens. Additional State rules and regulations will be applied
10. Labels:
11. Warning labels are affixed to containers of infectious/biohazardous waste, refrigerators, and freezers containing blood or other potentially infectious material, including laboratory specimens, and other containers containing blood or other potentially infectious material
12. Required labels include the standard biohazard symbol mandated by OSHA
13. Required labels are fluorescent orange or orange-red or predominantly so, with lettering or symbols in a contrasting color
14. Required labels are affixed as close as feasible to the container by string, adhesive, or another method that prevents their loss or unintentional removal
15. Red bags or red containers may be substituted for labels
16. Individual containers of blood or other potentially infectious materials (OPIMs) that are placed in a labeled container during storage, transport, shipment, or disposal are exempt from the labeling requirements
17. Labels are prominently displayed on refrigerators used to maintain laboratory specimens
18. Refrigerator temperature logs are maintained on all refrigerators
19. Signs
20. Signs that include the standard biohazard symbol as mandated by OSHA are posted at the entrance of areas where red-bagged waste is accumulated or stored before transportation to its final disposal destination
21. Sign color and requirements for affixing them are the same as for labels

## 

## Forms:

## Staff Training:

Hazardous Communication PowerPoint

## Resources:

OSHA Guide to Global Harmonizing System for Hazard Communication

<https://www.osha.gov/dsg/hazcom/ghsguideoct05.pdf>

## Clinical Operations Revision Dates:

Originated 2016

Revised June 2019

Revised December 2021

# **Purpose**

To reduce the risk of microbial transmission to patients and the likelihood of staff exposure through the use of needles and sharps by following the recommended sharp safety and safe injection practices.

# **Policy**

Healthcare staff are expected to follow safe procedures when using needles, cannulas that replace needles in intravenous delivery systems, needles used in laboratory procedures, and all sharps used in medical and dental procedures. Appropriate safer medical devices, such as sharps with engineered sharps injury protections and needleless systems, designed to eliminate or minimize occupational exposures to bloodborne pathogens, are utilized when practical and available. Safety devices are chosen and implemented with appropriate healthcare staff input and training.

# **Procedures**

1. Needle and sharp safety
2. Plan for safe handling and disposal of needles or sharps before use
3. Use Standard Precautions at all times
4. Gather all supplies needed before any procedure involving sharps or needles (injection, phlebotomy, IV insertion, suturing, suture or staple removal, dental procedures, etc.)
5. Know how to use any engineered safety needle or sharp before using it in a procedure
6. When removing the needle from the patient, DO NOT put hands near the removal site until the needle has been removed and discarded
7. Give gauze or cotton ball to the patient and have them place it on the injection/draw site at the time of withdrawal of the needle
8. When using sharps in procedures, be aware of their location, and dispose of sharps immediately or as soon as feasible after the procedure
9. Do not shear or break contaminated sharps. Recapping, bending, or removing needles is permissible only if there is no feasible alternative or if such actions is required for a specific procedure. If recapping, bending, or removal is necessary, ensure that workers utilize a mechanical device or a one-handed technique
10. Do not transport used needle and sharps in your hand to another location
11. Do not pick up broken glass with bare or gloved hands; use an instrument such as a brush and dustpan, tongs, or forceps to prevent exposure to glass. Place in a sharps container immediately
12. Dispose of used needles in an appropriate puncture-resistant sharps container immediately after use. Do not put sharps/needles in a plastic bag
13. Sharps disposal containers must be readily accessible and located as close as feasible to the area where sharps are used
14. If the sharps container is damaged/cracked, place it in another biohazard container to prevent leakage
15. Do not empty a sharps container into another sharps container. Close the container and dispose of it immediately
16. Needle and injection safety
17. Use aseptic technique to avoid contamination of sterile injection equipment
18. Needles, IV cannulas, and syringes are sterile single-use items. Do not administer medications from a syringe to multiple patients, even if the needle or cannula on the syringe is changed. Do not reuse the syringes for another patient or access a medication or solution that might be used for a subsequent patient
19. Use fluid infusion and administration set (intravenous bag, tubing, and connectors) for one patient only. Dispose of appropriately after use. A syringe, needle, or IV cannula is contaminated once it has been used to enter or connect to an intravenous infusion bag or an administration set
20. Use single-dose vials for parenteral medications whenever possible
21. Do not administer medications from single-dose vials or ampules to multiple patients
22. Do not combine leftover contents from single-dose vials or ampules for later use. Discard after every use
23. If multi-dose vials must be used, both the needle or cannula and syringe used to access the multi-dose vial must be sterile and aseptic technique followed
24. Do not keep multi-dose vials in the immediate treatment areas but maintain them in the medication room. Multi-dose vials will be stored in accordance with the manufacturer's recommendations (temperature, light, etc.). Multi-dose vials must be discarded if sterility is compromised or questionable, when the beyond-use date has been reached, and when doses are drawn in the patient's treatment area
25. Multi-dose vials must be dated and initialed when opened. Discard the vial within 30 days from date opened or per manufacturer's recommendations
26. Do not use bags or bottles of intravenous solution as a common source of supply for multiple patients
27. Safer Medical Devices

Appropriate safer medical devices are designed to eliminate or minimize occupational exposures to bloodborne pathogens are utilized. Safer medical devices include sharps with engineered sharps injury protections and needleless systems.

1. Safety devices are chosen and implemented with healthcare staff input. Healthcare staff using safety devices receive orientation and continuing education on safety devices used at the site. Complete selection and evaluation program for safer medical devices is outlined in the Bloodborne Pathogen Exposure Control Plan and is implemented by the Infection Prevention and Control Committee, director of nursing, or designated staff member
2. Approved devices for recapping may be used in the dental area. Small portable sharps containers are provided when security considerations do not allow fixed disposal containers at the point an injection is given
3. Contaminated sharps are any contaminated object that can penetrate the skin including, but not limited to, needles, scalpels, broken glass, broken capillary tubes, and exposed ends of dental wires
4. Discard all contaminated needles, sharps, and razors immediately at the point of use in puncture-resistant containers (sharps containers)

## Clinical Operations Revision Dates:

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Revised December 2021

# **Purpose**

To decrease, prevent or stop the spread of disease. The Centers for Disease Control and Prevention has identified specific precautions and hygienic actions that are effective in decreasing the transmission of microorganisms to protect people from the spread of multiple types of infectious microorganisms.

# **Policy**

All healthcare staff use Standard Precautions to protect themselves from the transmission of pathogens and other infectious agents and to prevent the spread of infectious organisms. Healthcare staff are expected to comply with all practices and safeguards published in this manual and to exercise reasonable caution to protect inmates and facility staff from the spread of infectious agents.

# **Procedures**

1. **Standard Precautions**
2. Combine the major features of Universal Precautions (UP) and Body Substance Isolation (BSI). Standard Precautions are based on the principle that all blood, body fluids, secretions, excretions except sweat, non-intact skin, and mucous membranes may contain transmissible infectious agents.
3. Standard Precautions include a group of infection prevention practices that apply to all inmates, regardless of suspected or confirmed infection status, in any setting in which healthcare is delivered.
4. The application of Standard Precautions during treatment is determined by the nature of the interaction and the extent of anticipated blood, body fluid, or pathogen exposure.
5. Standard Precautions are also intended to protect inmates from healthcare staff carrying infectious agents on their hands or equipment used during healthcare activities.
6. Standard Precautions apply to the following:
   1. Blood
   2. All body fluids, secretions, and excretions except sweat, regardless of whether or not they contain visible blood
   3. Non-intact skin
   4. Mucous membranes
7. In 2007 Centers for Disease Control added three new elements of practice to Standard Precautions that focus on the protection of patients receiving healthcare:
   1. Respiratory hygiene/cough etiquette
   2. Sharp safety
   3. Safe injection practices
8. Use of masks for insertion of catheters or injection of material into spinal or epidural spaces during lumbar puncture procedures (myelogram, spinal or epidural anesthesia)
9. Work area restrictions for healthcare staff include: eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses. These activities are prohibited in work areas where there is a reasonable likelihood of exposure to blood or other potentially infectious materials. Food and drink will not be kept in refrigerators, freezers, shelves, cabinets, or on countertops or bench-tops where blood or other potentially infectious materials are present.
10. All procedures involving blood or other potentially infectious materials are performed in such a manner as to minimize splashing, spraying, spattering, and generating droplets of blood or other potentially infectious materials.
11. The following personal protective equipment is provided for staff:
    * 1. Gloves
      2. Gowns and aprons
      3. Resuscitation equipment-pocket masks
      4. Masks/eye protection and face shields
      5. Surgical caps and shoe covers
12. A handout providing an overview of personal protective equipment and other standard precaution measures is provided for review and distribution to new staff.
13. Hand hygiene is the single most effective infection prevention intervention. The procedure is found in Section #10.
14. **Universal Precautions:**

Is part of Standard Precautions and is an approach to infection control to treat all human blood and certain human body fluids as if they were known to be infectious for HIV, HBV, HCV, and other bloodborne pathogens.

Universal Precautions is part of the Occupational Safety and Health Administration (OSHA) established Bloodborne Pathogens Standard 29 CFR 1910.1030(b) that was developed to eliminate or minimize occupational exposure bloodborne pathogens from blood or other potentially infectious materials (OPIM).

* 1. Under circumstances in which differentiation between body fluid types is difficult or impossible, all body fluids shall be considered potentially infectious materials.
  2. Treat all blood and other potentially infectious materials with appropriate precautions such as:
     1. Use personal protective equipment, gloves, masks, eye protection, and gowns if blood or OPIM exposure is anticipated.
     2. Use engineering and work practice controls to limit exposure.
  3. Other potentially infectious materials (OPIM) include the following human body fluids:

1. Amniotic fluid
2. Cerebrospinal fluid
3. Pericardial fluid
4. Peritoneal fluid
5. Pleural fluid
6. Semen
7. Synovial fluid
8. Vaginal secretions
9. Saliva in dental procedures, or containing blood
10. Any body fluid that is visibly contaminated with blood
11. All body fluids in situations where it is difficult or impossible to differentiate between body fluids
12. Any unfixed tissue or organ (other than intact skin) from a human (living or dead)
13. HIV containing cells or tissue cultures, organ cultures, and HIV, HBV, HCV containing culture medium or other solutions, other solutions, and blood, organs, or other tissues from experimental animals infected with HIV, HBV, or HCV.
14. **Transmission-Based Precautions**

These precautions are guidelines used when the route(s) of transmission are suspected or known. They are part of Standard Precautions, and provide specific precautions for each type of transmission

* 1. There are three categories of transmission-based precautions: Droplet Precautions, Contact Precautions, and Airborne Precautions.
  2. Special handling of laundry, dishes, and other environmental items are not usually indicated with transmission-based precautions unless specified in the precaution guideline. Laundry and equipment are addressed in Infection Prevention and Control policies and procedures: *IPC-18M Cleaning, Disinfecting, and Sterilization.*
  3. Specially designated cells located within the healthcare unit, near the healthcare unit, in the infirmary or designated by the facility are used for contact and droplet Precautions. Airborne precautions require isolation cells, Airborne Infection Isolation Rooms (negative pressure rooms) designed to prevent airborne transmission.
  4. Appropriate signs are placed outside of the cell door to indicate what precautions are in place and what precautions are to be taken. A diagnosis or name of the patient are not noted on the signs. Sample signs for Droplet Precautions, Contact Precautions and Airborne Precautions are provided.

1. **Droplet Precautions**

Intended to prevent transmission of pathogens spread through close contact with respiratory or mucous membrane secretions (including any contaminated surfaces). Droplet precautions are used for patients known or suspected to be infected with pathogens transmitted by respiratory droplets (large-particle droplets greater than 5 microns in size) generated by a patient who is coughing or sneezing.

* 1. Most common illnesses that require droplet precautions include but are not limited to: seasonal/pandemic influenza, mumps, and rubella (German measles).
  2. When droplet precautions are ordered, a single cell with individual bathroom facilities is ideal. Common areas should be avoided. If single cells are not available, ill patients may be confined to an isolation unit or cohorted (housed with patients with the same illness) together in a separate living area away from patients who are not ill.
  3. Staff will wear a surgical mask and gloves when working with the patient or in the patient’s room. Change gloves after contact with infected material (fecal material and wound drainage) or contaminated surfaces. Removed and discard gloves and masks before leaving the cell and wash your hands immediately after removal of gloves. Staff may use protective gowns if there is anticipated contact of clothing with secretions.
  4. Droplet precautions are discontinued after signs and symptoms have resolved. The patient should be afebrile for 24 hours. For influenza and mumps, precautions can generally be discontinued at least five days after symptoms began. In immune-competent patients and for rubella, precautions can usually be discontinued seven days after onset of rash. Isolation can only be discontinued by a provider.
  5. Susceptible/immunocompromised healthcare staff do not provide care for patients requiring droplet precautions if immune healthcare staff are available.
  6. Facility administration is immediately notified if a patient requires droplet precautions to facilitate coordination of correctional staff.
  7. Transport of patient from the isolation room is limited, and the patient must wear a surgical mask during transport. Other personal protective equipment is not required. No mask is required for persons transporting patients on droplet precautions as long as the patient maintains the surgical mask in place.

1. **Contact Precautions** are intended to prevent the direct (person to person) and indirect (person to object to person) transfer of an infectious agent. Hands are the greatest offender in indirect contact transmission. Standard precautions, including strict hand hygiene, are sufficient in most instances to provide adequate prevention of contact transfer of organisms.
2. Common illnesses that require contact precautions are diarrhea in an incontinent patient, an uncooperative patient who cannot complete self-care, and patients with draining lesions where the drainage cannot be contained with a dressing. These patients may be cared for in the regular housing unit depending on the diagnosis and ordered by the provider.
3. When contact precautions are ordered, a single cell with individual bathroom facilities is ideal. Common areas should be avoided. If single cells are not available, ill patients may be confined to an isolation unit or patients cohorted (housed with patients with the same illness) together in a separate living area away from patients who are not ill.
4. Staff members entering the cell should wear gloves. Gloves are changed after contact with infected material (fecal material, wound drainage) or contaminated surfaces. Gloves are removed and discarded before leaving the cell, and hands are washed immediately after removal of gloves.
5. The anticipation of significant contact with feces or wound drainage requires additional personal protective equipment, including wearing a gown, a mask, and eye protection when indicated. Remove and discard gowns, gloves, and other personal protective equipment before leaving the cell or immediately outside the cell. Wash your hands. Ensure that hands and clothing do not come in contact with contaminated environmental surfaces.
6. Limit the amount of non-disposable healthcare items used with the patient on Contact Precautions and ensure the items are disinfected before use on another patient.
7. When transport or movement is necessary, ensure that infected or colonized areas of the patient’s body are contained and covered. Remove and dispose of contaminated personal protective equipment and perform hand hygiene prior to transporting patients on contact precautions.
8. Discontinue contact precautions after signs and symptoms of the infection/ condition have resolved or drainage is controlled, and when ordered by a provider.
9. **Airborne Precautions**

Used for patients known or suspected to be infected with microorganisms transmitted by airborne droplet nuclei (small-particle residue - 5 microns or smaller - of evaporated droplets containing microorganisms) that remain suspended in the air and can be dispersed widely by air currents within a room or over a long distance. Most droplets fall within 3 feet of the patient, but some microorganisms may remain suspended and can be carried by air currents and inhaled by susceptible individuals who have not had face-to-face contact with or been in the same room with the infectious patient.

* 1. Airborne precautions are most commonly used in a correctional environment for isolation of *M. tuberculosis* (confirmed or suspected active cases)*,* acutevaricella-zoster virus (chickenpox), and Rubella (measles).
  2. Staff will wear an N-95 mask and gloves when working with the patient or in the patient’s room. Change the gloves after contact with infected material or contaminated surfaces. Remove and discard gloves and masks before leaving the cell and wash hands immediately after removal of gloves
  3. Airborne precautions require Airborne Infection Isolation Rooms (AIIRs) that are monitored for negative pressure relative to the surrounding area. AIIRs provide at least 12 air exchanges per hour for new construction and renovation and at least 6 air exchanges per hour for existing facilities. Air is exhausted directly to the outside or recirculated through HEPA filtration before return or exhaust. The unoccupied Airborne Infection Isolation Rooms are monitored as indicated in *IPC-20M, Respiratory Protection: Airborne Infection Isolation Rooms.*
  4. When airborne precautions are ordered, notify facility administration or shift command, and immediately place the patient in a single cell or examination room that has a solid door that can be closed and is away from staff and others. If possible, the air in the room is vented to the outside or appropriate filter system in place. An exhaust fan may facilitate the air movement to the outside. Healthcare and security staff use standard precautions, including airborne precautions. The patient is instructed to wear a surgical mask if outside of the cell, and observe respiratory hygiene/cough etiquette at all times. Healthcare and transportation staff provide the patient with tissues, a red plastic bag for used tissues, and masks to change if wet or soiled.

1. ***Procedures below refer to facilities that DO NOT have Airborne Infection Isolation Rooms***
2. If AIIR is NOT available, healthcare staff will notify the medical director or designee. Security staff are alerted to facilitate immediate transfer of the patient for airborne precautions to a designated hospital or correctional facility that has a letter of memorandum/agreement with the facility. Healthcare staff will alert and give a report to the designated hospital or facility to arrange for safe transport to the required AIIR.
3. Transportation of a patient with suspected/diagnosed airborne infection (including but not limited to tuberculosis, chicken pox, measles) should be done safely following the CDC recommendations. The type of transportation of the patient is discussed with security, (security vehicle or ambulance) using best practices. Refer to the client and facility policies for security transportation
4. **Transportation of Airborne Infection patient best practices:**
5. Staff are to follow infectious airborne precautions
6. The patient is to wear a surgical mask at all times and observes respiratory hygiene/cough etiquette at all times
7. Staff is to wear N-95 respirator masks
8. If transporting by security vehicle:
9. Do not use recycled air setting.
10. Have air on blowing toward the back of the vehicle
11. Lower the front windows as much as possible
12. DO NOT open the back windows

* Once the patient is transferred, the room/cell remains vacant for the appropriate time, a minimum of two hours, to allow for a full exchange of air.

1. ***The remaining procedures apply to facilities with Airborne Infection Isolation Rooms***
2. Keep food trap doors closed at all times, only open to pass medications or foods to patient.
3. Anytime staff enter room, they must wear an N-95 respirator.
4. Discontinuation of airborne precautions must be done by a provider.
5. Criteria for release from airborne isolation: After signs and symptoms have resolved according to the microorganism/disease involved including but not limited to TB
6. Active TB disease must be ruled out.
7. If there is a diagnosis of active TB (on four medications for a minimum of 2 weeks (daily doses x 14 days), the patient must demonstrate improvement in symptoms and three negative sputum smears. (follow *Tuberculosis Disease Management Guidelines*)
8. Chicken pox - after lesions have scabbed over
9. Measles - afebrile, and seven days after the rash appeared
10. Once the patient is transferred, the room/cell remains vacant for the appropriate time, a minimum of two hours, to allow for a full exchange of air
11. The respiratory protection program follows the OSHA standard and includes: education about the use of respirators, fit-testing, and user seal checks as required in any facility with AIIRs and follows contractual agreements. Details of the respiratory protection are outlined in policy and procedures on particulate respirators
12. **Respiratory Hygiene- Cover your cough.**
13. Do not cough into your hands
14. Use a tissue to cover your mouth and nose when you cough or sneeze, throw the tissue in wastebasket, or
15. Cover your cough or sleeve with your upper sleeve, not your hands
16. After coughing or sneezing, wash hands for 20 seconds with soap and warm water or clean with hand sanitizer
17. **Hand Hygiene**
18. Hand washing is defined as a vigorous, brief rubbing together of all surfaces of lathered hands, including under and around nails for 15 to 20 seconds, followed by rinsing under a stream of water.
19. Hand washing is required when hands are visibly dirty, contaminated with body fluids of any type, touching patients, or touching contaminated surfaces.
20. For general patient care and routine hand washing, a plain, non-antimicrobial soap is acceptable. Liquid soap in a disposable dispenser or refillable dispenser that has been emptied and thoroughly cleaned and dried before refilling is preferred. Bar soap is not appropriate for use in the healthcare unit.
21. Hands may be washed with soap and water or by using alcohol-based cleaners on hands. (Note: do not use only alcohol cleaners on visibly soiled hands)
22. Perform hand hygiene:
23. Before and after direct contact with a patient
24. After situations involving contact with mucous membranes, blood or body fluids
25. Before eating
26. After using the restroom
27. After removing gloves
28. At the end of the work assignment
29. Lotion may be used, but note that petroleum and oil emollient lotions may adversely alter glove integrity.
30. Hand washing or surgical scrub using antimicrobial-containing soap is used before the performance of invasive procedures including suturing, biopsies, indwelling urinary catheters, intravascular catheters, and when caring for persons on isolation precautions.
31. Hand washing technique includes:
32. Wet hands under running water
33. Keep hands lower than elbows and apply the amount of soap recommended by the manufacturer (usually a quarter size amount is adequate)
34. Wash vigorously for at least 15 to 20 seconds
35. Use friction to cover all surfaces of the hand with particular attention to fingertips and nails
36. Rinse under running water (water should run off ends of fingers)
37. Use a paper towel or hot air dryer to dry
38. Avoid recontamination of hands-on sink or sink components
39. Turn off faucet with a clean paper towel
40. Surgical hand scrub technique is:
41. Apply antimicrobial agent to wet hands and forearms with friction for at least 120 seconds
42. Wash hands and forearms thoroughly
43. Clean under nails with a nail cleaner
44. Rinse thoroughly
45. Waterless hand washing technique:
46. Note: Only use this type of cleaner on hands without any type of soilage. These can be used to decontaminate, but you must wash hands in soap and water as soon as possible
47. Apply the alcohol-based hand product using the amount recommended by the manufacturer (usually a quarter-size amount is adequate)
48. Apply to all surfaces of both hands (palm, back and between fingers)
49. Allow to air-dry
50. Wash hands as soon as handwashing facilities are available
51. Hand sanitizers are not effective against some microorganisms
52. Nails should be a quarter (¼) inch or shorter, and artificial nails may not be worn by direct care staff.
53. Paper towels or hand blowers needed are within easy reach of the sink.
54. Healthcare staff are expected to comply with hand washing procedures and are to immediately report to supervisory staff any obstacles or lack of supplies.
55. Peer review of appropriate hand washing technique is recommended as an annual quality assurance activity. The *Hand Hygiene Audit Tool* is used to record findings

## Referenced Forms:

IPC-037 Refrigerator Temperature Log

IPC-002 Verification of Negative Airflow-Airborne Isolation Room Check

IPC-014 Hand Hygiene Audit Tool

Signs: Cover Your Cough (English and Spanish)

Hand Washing

## References:

Click or tap here to enter text.

## Clinical Operations Revision Dates:

Originated 2016

Revised June 2019

Revised December 2021

# **Purpose**

To provide surveillance of infectious diseases to prevent or limit transmission and provide treatment and education. To track diseases and monitor trends of diseases.

# **Policy**

The infection prevention and control coordinator or designee will track patients with known, newly diagnosed, or acquired infectious diseases, report healthcare associated infections and epidemiologically significant infections to the Infection Prevention and Control Committee, and complete all reporting required by the department, state or national authorities.

# **Definitions**

1. *Infection*: The presence and growth of a microorganism that produces tissue damage or causes disease
2. *Colonization*: Presence of microorganisms in or on the host but without tissue invasion, damage, or disease
3. *Community Infection*: An infection present upon intake to the facility or that develops within the incubation period of the condition after intake
4. *Healthcare Associated Infection (HAI)*, previously known as *Nosocomial infection*: An infection which develops after intake or after performance of an invasive procedure and for which the patient did not have disease exposure, colonization, or incubation of the disease prior to admission to the system/facility

# **Procedures**

1. The surveillance reporting system monitored by the infection prevention and control coordinator and designed for identification of patients with infections or infectious diseases includes, but is not limited to:
2. Review of intake screening for history and any signs and symptoms of infections, including screening testing for communicable diseases as per contract
3. Reports of infections from healthcare staff
4. Review of sick call, clinic, TST, and chronic care logs
5. Review of all positive cultures and review of clinical data for evaluation of infection
6. Review of antibiotic records of patients diagnosed with infectious disease
7. Review of reports of IV or surgical wound infections
8. Review of wound care/treatment logs
9. Communication with providers and healthcare staff to report infections or suspects identified at the time of a healthcare encounter.
10. **Surveillance and Infection Identification**
11. A physician’s diagnosis of infection derived from direct observation during a procedure, endoscopic examination, other diagnostic study, or based on clinical judgment is an acceptable criterion for an infection, unless there is compelling evidence to the contrary, e.g., information written on the wrong medical record or a presumptive diagnosis that was not substantiated by subsequent studies. Refer to *Centurion Clinical Treatment Guidelines, Centurion Disease Management Guidelines* and *Centurion Nursing Protocols.*
12. Identification of acute and chronic infection or infectious diseases which include, but are not limited to:
13. HIV, hepatitis A, hepatitis B, hepatitis C
14. Sexually transmitted infection: syphilis, chlamydia, gonorrhea, Zika virus
15. Tuberculosis: Latent tuberculosis infection , active tuberculosis disease
16. Ectoparasites: lice (head, pubic), scabies
17. Gastroenteritis: foodborne, C diff, norovirus, other pathogens
18. Communicable diseases: varicella, measles, mumps
19. Healthcare Associated Infections (HAI): IV site infections, surgical site infections, invasive medical devices (i.e. foley catheters, pacemakers, pic lines, etc.)
20. Respiratory infection: pneumonia, influenza, bronchitis, respiratory syncytial virus (RSV), pertussis, SARs-CoV (1 & 2, MERS)
21. Wound: skin infection, MRSA, surgical site
22. Urinary tract infection
23. Vectorborne diseases: West Nile, Zika,
24. Emerging and reemerging infectious diseases: EBOLA, new influenzas, MERS-Cov, SARS, communicable diseases
25. Epidemics and Pandemics
26. **Common signs and symptoms of infections include, but are not limited to:**
27. Cutaneous Infection: Presence of any purulent drainage, pain, heat, redness, or edema
28. Gastroenteritis: Greater than three stools per day, fever, abdominal cramping, and dehydration
29. Intravenous (IV) Site Infection: Purulent drainage or cellulitis at site, inflammation
30. Respiratory: Cough, fever, chest pain, shortness of breath, abnormal lung sounds (rales, rhonchi, wheezing), increased sputum, color of sputum
31. Sepsis/Bacteremia: (NOTE: urgent action required) Shivering (either fever or hypothermic), extreme pain or discomfort, clammy or sweating, confusion or disorientation, shortness of breath, elevated heart rate
32. Tuberculosis: Cough, significant weight loss, fever, chest pain, positive TB screening
33. Urinary Tract Infection (UTI): Fever, urinary frequency, dysuria, or suprapubic tenderness, positive urine dipstick or test, cloudy urine
34. Varicella: Blister-like rash (commonly starts on head or trunk), fever, cold symptoms
35. Sexually transmitted infection: Symptoms vary. Refer to *Centurion Treatment Guidelines for diagnosis and treatment, as ordered by provider.*
36. **Documentation to include:** (refer to logs, database, tracking system per site)
37. Patient name
38. Identification number
39. Location of infection
40. Housing unit
41. Work detail (if applicable)
42. Movements (relocation, court, clinic visits)
43. Diagnosis
44. Co-morbidities
45. If isolation/quarantine ordered
46. Date and time isolated/quarantined
47. Date and time isolation/quarantine discontinued
48. **Action Plan**
49. Refer patient to an appropriate provider for diagnosis and treatment. If urgent, notify medical director, health services administrator, director of nursing, and infection prevention and control coordinator or their designee
50. Isolate as indicated with specific precautions as warranted with order
51. Notify administration per site notification requirements
52. Notify on site and regional infection prevention and control coordinator or designee
53. Draw labs as ordered
54. If reportable disease, complete forms and notify Health Department
55. Complete appropriate forms and logs: *IPC-003 Infectious Disease Monthly Report; IPC-016 Infection Control Monitoring Log, IPC-017 Infectious Disease Outbreak Suspect Worksheet, IPC-018 Infectious Disease Outbreak Worksheet*
56. **Surveillance/Monitoring**
57. Identify any potential transmittable infection or disease
58. Monitor of exposed patients for history, signs, and symptoms as required
59. Document all relevant monitoring information in Infection Prevention and Control files.
60. Complete appropriate log(s)
61. Report pertinent information at Infection Prevention and Control Committee meeting
62. Enter data on IPC-003 Infectious Disease Monthly Statistics Log

## Referenced Forms:

IPC-003 Infectious Disease Monthly Report

IPC-012 HIV Log

IPC-013 Hepatitis C Monthly Log (*Note: Portal printable form)*

IPC-016 Infection Control Monitoring Log

IPC-022 Skin and Soft Tissue Infection (SSTI) / MRSA Tracking Log

IPC-024 STD/STI Tracking Log

## References:

ABCs of Hepatitis

Ebola Fact Sheet

Sepsis Fact Sheet

Zika Fact Sheet

Vector-Borne Transmitted diseases chart

Novel Coronavirus

Communicable disease chart

STI Facts brochures: Link: <https://www.cdc.gov/std/healthcomm/the-facts.htm>

Summary of CDC STI Treatment Guidelines, 2021: Link: <https://www.cdc.gov/std/treatment-guidelines/wall-chart.pdf>

Hepatitis Tutorial (understanding the hepatitis viruses and laboratory testing): <https://www.cdc.gov/hepatitis/resources/professionals/training/serology/training.htm>

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# **Purpose**

To report communicable diseases to the local or state department of health as required by local, state, and national statutes.

# **Policy**

The program director, health services administrator, or designee is responsible for ensuring that the healthcare unit has the most current listing of reportable diseases and the forms for reporting to the local or state health department. The infection prevention and control coordinator or designee submits the required forms and communicates with the local and state department of health.

# **Procedures**

1. Healthcare staff are knowledgeable of infectious diseases symptoms. Physicians, nurse practitioners, and physician assistants are knowledgeable about communicable diseases and diagnosis and follow *Centurion Clinical Treatment Guidelines*. The practitioner are aware of the diseases that must be reported to the infection prevention and control coordinator or designee when suspected or diagnosed infectious diseases that are reportable.
2. The infection prevention and control coordinator or designee prepares and submits all required reports to the department of health. The coordinator will track and trend data for the Infection Prevention and Control Committee, any designated committee, and for internal data reporting.
3. The laboratory provider reports all positive serology tests, specific reportable diseases, and culture results as required by law. The infection prevention and control coordinator or designee will monitor the lab reports provided by the contracting lab for reportable infectious diseases.
4. The infection prevention and control coordinator or designee will communicate, cooperate and collaborate with the local or state health department. They will report all communicable diseases and treatments in compliance with the appropriate local or state department of health in the period as required by law or statute.
5. Report all communicable diseases to corporate infection prevention and control program, Notify immediately for urgent notifications of communicable disease outbreaks

## Referenced Forms:

Click or tap here to enter text.

## References:

US Reportable Diseases

State Reportable Disease Report

(For link, go to the Department of Health website and print out your department of health/state’s list). Place the state’s instructions and a copy of the form behind this policy.

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# **Purpose**

The purpose of this policy is to provide information on the identification of common infections and communicable diseases, to increase awareness for early identification, to decrease and prevent the introduction of disease into the facility, or to stop the transmission of disease.

# **Policy**

It is the responsibility of all healthcare workers to report suspected or diagnosed infectious diseases. Staff is educated in the types of microorganisms, the chain of infection, the signs and symptoms, transmission, and communicability of the most common infections that are seen in the correctional setting. The importance of early recognition and identification of risk factors, signs, and symptoms is emphasized. All inmates are screened at intake, and surveillance is essential in the reduction of the spread of diseases. All suspected and diagnosed inmates with infections are reported to the infection prevention and control coordinator or their designee. Confidentiality under HIPAA laws is maintained.

# **Definitions**

1. *Infection*: The presence and growth of a microorganism that produces tissue damage or causes disease.
2. *Colonization*: Presence of microorganisms in or on the host but without tissue invasion, damage, or disease.
3. *Carrier*: Person with an infection who is capable of transmitting the pathogen to others.
4. *Risk factors*: something (condition or disease) that increases risk or susceptibility to infections, diseases or conditions.
5. *Transmission:* the passing of a pathogen (viruses, bacteria, parasites, and fungi) causing communicable disease from an infected host individual or group to a particular individual or group, regardless of whether the other individual was previously infected (contact, droplet, airborne, vector-borne)
6. *Chain of infection*: the cycle of infection: from the host, transmission to susceptible person, transmission to another person or surface, transmission to another susceptible person. Break any part of the chain to stop the transmission.
7. *Infectious period*: the period during which an infected person can transmit a pathogen to a susceptible host.
8. *Exposure period*: the period of time that the person came in contact with an infected person and the incubation period for the disease
9. *Incubation period*: the time from the moment of exposure to an infectious agent until signs and symptoms of the disease appear Length of time dependent on causative organism and type of disease; some patients may not become symptomatic.
10. *Spectrum of disease: Progression of disease that becomes clinically apparent, ranging from mild to severe, or fatal. Not all infected individuals will progress from subclinical (asymptomatic) to clinical disease (symptomatic).Social Distancing:* also called “physical distancing”- keeping space between yourself and other people. To practice social distancing stay at least 6 feet from other people, do not gather in groups, stay out of crowded places and avoid mass gatherings.
11. *Quarantine:* the procedure of separating and restricting the movement of persons who are not sick yet, but who were exposed or is being investigated for possible exposure. This allows rapid identification of those who will become sick.

*Isolation:* the procedure of separating a person who is already sick from others who are not ill in order to prevent the spread of disease. The term isolation is distinct from the term quarantine.

# **Procedures**

1. Inmates are screened at intake and as indicated for infections.
2. Symptom screening for sexually transmitted infections is conducted at intake. Testing is offered during the health assessment or per contract and upon request with suspicion of disease. Persons identified with exposure through contact tracing may be treated without testing.
3. Symptom screening for tuberculosis is conducted at intake, annually, and as indicated. Tuberculin skin testing or interferon-gamma release assays are conducted according to the contract (i.e. health assessment, and periodically, as indicated for all inmates and staff as per contract and facility risk assessment.
4. Staff is trained to always practice standard precautions *(IPC-06 Infection Control Precautions),* including strict hand and respiratory hygiene*.*
5. Training and education for infection prevention and control is given at orientation and annually, including training on the use of protections and precautions when risks are present.
6. The infection prevention and control coordinator or designee and healthcare staff maintain active surveillance for the identification of patients with infections or infectious diseases.
7. Identification, treatment, education, and follow-up is guided by *Centurion Nursing Protocols* and *Centurion Disease Management Guidelines* as per contract.
8. A provider confirms the diagnosis of infectious disease.
9. Stop movement, segregate, social distancing, quarantine, or isolation is implemented per provider order or by policy

**Common Infections/Diseases**

1. Common signs and symptoms of infections include, but are not limited to:
   1. Cutaneous infection: the presence of any purulent drainage, pain, heat, redness, or edema
   2. Gastroenteritis: greater than three stools per day, fever, abdominal cramping, and dehydration
   3. Acute hepatitis: fever, abdominal or flank pain, jaundice
   4. Intravenous (IV) site infection: purulent drainage or cellulitis at the site, or internal infection of the heart (endocarditis), spinal cord (abscess); other indications of IV site related infection
   5. Measles: sudden onset of fever, cough, conjunctivitis, coryza (runny nose), the patient may have white patches in the mouth, rash 2-3 days after onset of symptoms
   6. Respiratory: cough, fever, chest pain, abnormal lung sounds (rales, rhonchi, wheezing shortness of breath, decrease in pulse ox, increased sputum, the color of sputum, new loss of taste or smell (example: influenza, pneumonia, COVID-19, SARS, MERS, et. al.)
   7. Sepsis/Bacteremia: shivering (either fever or very cold), extreme pain or discomfort, clammy or sweating, confusion or disorientation, shortness of breath, elevated heart rate, hypotension, loss of appetite (elderly or mentally ill)
   8. Tuberculosis: cough, significant weight loss, fever, chest pain, positive TB screening
   9. Urinary Tract Infection (UTI): fever, urinary frequency, dysuria, or suprapubic tenderness, positive urine dipstick or test, cloudy urine, altered mental status
   10. Varicella: blister-like rash (commonly starts on head or trunk), fever, cold symptoms
   11. Sexually Transmitted Infections: Symptoms vary. Refer to *Centurion Treatment Guidelines for diagnosis and treatment, as ordered by the provider*
2. Common risk factors for infections
3. Advanced age (> 50 years of age)
4. Chronic diseases
5. Hepatitis B or C
6. Immunocompromised conditions due to disease or medications
7. Malnourishment
8. Homelessness
9. Asplenia
10. Recent international travel or exposure to infected persons
11. Foreign-born (at-risk for tuberculosis and other endemic infections)
12. Common infectious diseases in corrections
    1. Tuberculosis
    2. Bloodborne infectious diseases
       1. HIV
       2. Hepatitis B & C
13. Hepatitis A
14. Endocarditis or other infectious complications of injection drug use
15. MRSA (methicillin-resistant staph aureus)
16. Influenza (flu)
17. Strep throat
18. Varicella (chickenpox, shingles)
19. Measles (rubella, Rubeola)
20. Gastrointestinal infections (e.g., norovirus, C.diff., parasites)
21. Sexually-transmitted infections (STI)
    * 1. HIV
      2. Hepatitis A, B and C
      3. Syphilis
      4. Chlamydia
      5. Gonorrhea
      6. HPV
      7. Other sexually transmitted infections are listed in the CDC’s *STD 2020 Guidelines*
22. Ectoparasites (body lice, pubic lice, head lice, scabies)
23. Conjunctivitis (pink eye)
24. Identification of acute and chronic infections or infectious disease which include, but are not limited to:
25. HIV, hepatitis A, hepatitis B, hepatitis C
26. Sexually transmitted disease: syphilis, chlamydia, gonorrhea, Zika virus
27. Latent tuberculosis, active tuberculosis
28. Ectoparasites: lice (head, pubic), scabies
29. Gastroenteritis: foodborne, C diff, pathogenic, other
30. Communicable diseases: varicella, measles, mumps
31. Injection drug site or IV site infections
32. Respiratory infection: pneumonia, influenza, bronchitis
33. Wound: skin infection, MRSA, surgical site
34. Urinary tract infection
35. Seasonal or geographical outbreaks as per local disease control guidance, such as H1N1 influenza, hepatitis a, Zika, Ebola, dengue, cholera, etc.

## Referenced Forms:

IPC-003 Infectious Disease Monthly Report

IPC-012 HIV Log

IPC-013 Hepatitis C Monthly Log (*Note: Portal printable form)*

IPC-016 Infection Control Monitoring Log

IPC-022 SSTI/MRSA Tracking Log

IPC-024 STD/STI Tracking Log

## Trainings on Centurion Central:

New Employee Orientation

Vector-Borne Transmitted Diseases

Sepsis

Bloodborne pathogen

Tuberculosis

## Resources:

Infectious/Communicable Disease Chart

Chain of Infection

ABCs of Hepatitis

Sepsis Fact Sheet

Zika Fact Sheet

STD/STI Facts brochures: Link: <https://www.cdc.gov/std/healthcomm/the-facts.htm>

Hepatitis Tutorial (Viral Hepatitis Serology Training): <https://www.cdc.gov/hepatitis/resources/professionals/training/serology/training.htm>

## Clinical Operations Revision Dates:

Originated 2016

Revised June 2019

Revised December 2021

# **Purpose**

The purpose of this policy is to provide continuity of care for patients incarcerated that are infected, screened, or diagnosed with Human Immunodeficiency Virus (HIV) or acquired immunodeficiency syndrome (AIDS).

# **Policy**

Patients are screened for HIV according to facility requirements (opt in, opt out, or by request). Patients with a diagnosis of HIV are treated in compliance with *Centurion* *Disease Management Guidelines* and national standards of care. When required, written consent will be obtained from patients prior to testing for HIV. Education will be provided to patients about HIV. Disclosure of HIV status will follow HIPAA guidelines for confidentiality. The patients will be followed in the chronic care clinic and provided medication according to treatment plans.

# **Procedures**

1. Patients will be questioned upon their arrival at the institution regarding their HIV status as part of the Receiving Screening process.
2. HIV status will be confirmed and documented in the health record on the problem list. Current HIV treatment, if any, will be documented, confirmed and per provider order, continued
3. HIV positive patients will be referred to the Chronic Care Clinic and treated according to Centurion Treatment Guidelines, or by a specialist as per contract
4. HIV testing will be ordered by the clinician, by contract, or upon voluntary request of the patient. Counseling will be completed by the provider, or trained counselor
5. Any patient who requests HIV testing will be given the test per facility, state, and national guidelines. Education will be done by the provider or a qualified professional. HIV antibody testing results notification is done by a health care staff member qualified to do so. An interpreter or language line will be provided if needed, and the patient will be given ample time to ask questions.
6. The patient will sign the “Consent for HIV Antibody Testing” form if required, before being tested
7. Patients who have positive test results will be referred to the Chronic Care Clinic for evaluation, education, treatment plan, and follow-up
8. Test results will be documented in the health record and kept confidential to the extent permitted by law, and will be released only to the health care providers giving care, and the Department of Public Health as required. No person to whom test results have been disclosed may disclose the test results to another person not authorized for access to this information
9. HIV test results may be divulged to the Sheriff or Chief Correctional Officer on a “need to know” basis, but such information shall be exempt from the public records provision of HIPAA guidelines
10. Treatment of HIV will be provided in a manner that is consistent with national standards of care, as recommended by nationally recognized organizations and specialists
11. The HSA, infection control nurse or designee will maintain a current log or database of all HIV positive patients

## Referenced Forms:

IPC-003 Infectious Disease Monthly Report

IPC-012 HIV Log

## References:

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## Clinical Operations Revision Dates:

Originated 2016

Revised June 2019

Revised December 2021

# **Purpose**

The purpose of this policy is to identify inmates incarcerated who are infected, screened, or diagnosed with hepatitis A, B, or C and to provide continuity of care for patients with acute or chronic hepatitis.

# **Policy**

Inmates are screened for hepatitis C according to the contract (op-tin, opt-out, or by request). Patients are screened for hepatitis history, risk factors, and current symptoms. Patients diagnosed with hepatitis will be monitored according to *Centurion Disease Management Guidelines* and according to contract.

# **Procedures**

1. All patients are evaluated for history and risk factors of hepatitis during the receiving screening process
2. The patients with acute onset of jaundice will be isolated until the possibility of transmission of infection is ruled out
3. All patients will be monitored according to Centurion Disease Management guidelines
4. Patients will be evaluated and treated by the health care provider or specialist per recommendations of the on-site provider
5. Hepatitis A and hepatitis B vaccinations may be offered to inmates as ordered by the provider
6. There is no vaccine for hepatitis C
7. Patients are provided education on hepatitis and treatment plans according to the contract’s parameters
8. Test results will be documented in the health record, kept confidential to the extent permitted by law, and released only to the health care providers giving care and the Department of Public Health as required. Results are protected under HIPAA law
9. Acute hepatitis will be reported to the local health department as required
10. An outbreak and contact investigation will be completed as indicated per policy IPC-19M Outbreaks and Contact Investigation
11. Hepatitis C will be confirmed, and the patient evaluated for treatment according to Centurion Disease Management guidelines and contract requirements
12. The health services administrator and infection prevention and control nurse or designee will maintain a current log or database of all hepatitis B and C patients, including staging and treatment information

## Referenced Forms:

IPC-003 Infectious Disease Monthly Report

IPC-013 Hepatitis C Monthly Log

## Resources:

ABCs of Hepatitis: <https://www.cdc.gov/hepatitis/resources/professionals/pdfs/ABCTable.pdf>

Hepatitis Tutorial (Serology Training for Hepatitis): <https://www.cdc.gov/hepatitis/resources/professionals/training/serology/training.htm>

Portal database

Recommended Testing Sequence for Identifying Current Hepatitis C Virus Infection: <https://www.cdc.gov/hepatitis/HCV/PDFs/hcv_flow.pdf>

## Clinical Operations Revision Dates:

Originated 2016

Revised June 2019

Revised December 2021

# **Purpose**

To control and prevent the transmission of Ectoparasite, including but not limited to pediculosis (capitis, corporis, pubis) and scabies in the correctional setting.

# **Policy**

Inmates are screened at intake and as needed. Patients are evaluated, treated, and tracked for pediculosis and scabies following current Centurion Clinical Guidelines. Housing is assigned during treatment according to facility guidelines.

# **Procedures**

1. Screening:
   1. All patients are screened at intake and as needed for signs and symptoms of skin rash, pediculosis, and scabies
   2. Patients will be evaluated by a provider or trained healthcare staff member for complaints of skin rashes and the potential for scabies and pediculosis
   3. Healthcare staff remains vigilant for evidence or symptoms of any Ectoparasite
   4. Patients presenting with complaints of skin rash, head, pubic, or body lice are referred to a provider for treatment. The evaluation will be documented on the *Skin Integrity Documentation* form (NUR-006) of the *Centurion Nursing Protocols*. Vital signs, location of the rash, when symptoms began, and history of previous treatment will be documented
2. Treatment: Per Centurion Clinical Guidelines*:* Scabies, and Centurion Policy: Ectoparasite Control:
   1. Patients are treated on an individual basis. Routine delousing of individuals upon admission is not done without indications
   2. Treat close contacts (close housing, sharing of personal items, etc.)
   3. Female patients should have pregnancy ruled out with a urine pregnancy test before treatment. Appropriate facility/security notification must be completed
   4. Bedding and clothing are to be bagged, marked, and cleaned per facility policy Linens are changed after each treatment. Employ standard precautions, wear gloves and gown when handling linen to prevent transmission
   5. Items unable to be cleaned (such as court papers) should be bagged, sealed, labeled with patient name, and dated. Items will remain sealed for a minimum of 10 days
   6. Mattresses should be disinfected as per facility guidelines. If mattresses are cloth or there are cracks in a mattress, mattresses should be bagged for a minimum of 10 days
   7. Cell-mates and close contacts should be examined for infestation
   8. House alone or cohort with other patients that have scabies. Follow facility guidelines for contact isolation (if initiated) for 24 hours after initial treatment
   9. No kitchen duty for 7 to 10 days until recheck and medical clearance
   10. Lice treatment includes:
3. Topical treatment (lotion or Shampoo) as prescribed, one application at the time of diagnosis, and another application in 7 to 10 days
4. If topical treatment is given, confirm that the patient applies to all body parts from the neck down and the lotion remains on the body for 8 to 12 hours before showering
5. Document intervention on MAR
   1. Scabies Treatment includes:
6. If treatment prescribed by the provider is an oral medication, it is given one time and repeated in 1-2 weeks
7. If topical treatment is prescribed, one application is applied at the time of diagnosis, and one in 7 to 10 days
8. If topical treatment is ordered, confirm that the patient applies to all body parts from the neck down, and lotion remains on the body for 8 to 12 hours before showering
9. Document the intervention on the MAR
   1. Patients with head lice will be provided with nit combs for removal of nits
10. Contact Investigation:
    1. All patients who are identified as close contacts should be screened for Ectoparasite (scabies, lice) symptoms and previous treatment
    2. Those who are symptomatic should be isolated and treated. Asymptomatic contacts do not need to be isolated
    3. Asymptomatic close contacts should be presumptively treated for scabies. This is because symptoms can take 2 to 6 weeks after a person is infested to appear, but scabies can be transmitted
    4. During this asymptomatic period, contacts should be retreated in 7-10 days
    5. To avoid re-infection, the treatment of cases and contacts must be carefully coordinated to ensure all are treated within the same time period
    6. Linens, towels, and clothing of contacts should be laundered simultaneously with both treatments
    7. Crusted scabies is highly contagious. Isolation is required, and the investigation may need to be extended
    8. Document the process on *IPC-016, Infection Control Monitoring Log*
11. Notifications:
    1. Notify the health services administrator, director of nursing, provider for treatment orders, and infection prevention and control nurse or designee
    2. Notify security per facility protocol and for special handling of laundry
    3. Laundry will be appropriately bagged and marked
    4. Laundry should not be sorted
    5. Laundry should be put directly in the washing machine and washed according to facility guidelines
    6. Recommendation: wash laundry in hot water [55 ͦ C /131 ͦ F] for 20 minutes and dry in a dryer at a high setting until completely dry, or dry clean to destroy both scabies and their eggs
    7. Document the process on *IPC-016, Infection Control Monitoring Log*
12. Education:
    1. Patient education is conducted at the time of diagnosis
    2. Provide the patient with the facility-approved handouts: *Scabies Education and Self-Care* and *Lice Education and Self-Care*

## Referenced Forms:

IPC-016 Infection Control Monitoring Log

IPC-017 Infectious Disease Suspect Index Case Worksheet

IPC-018 Infectious Disease Outbreak Worksheet (if applicable)

## References:

Skin Lesion Documentation – Nursing Protocol

Ectoparasite Information

Lice Education and Self Care

Scabies Education and Self Care

Head Lice - Frequently Asked Questions

Body Lice - Frequently Asked Questions

Pubic Lice - Frequently Asked Questions

Bed Bugs - Frequently Asked Questions

## Clinical Operations Revision Dates:

Originated 2016

Revised June 2019

Revised December 2021

# **Purpose**

To ensure the health and safety of all patients and staff with screening, testing and treatment for tuberculosis (TB) in accordance with Centers of Disease Control and Prevention (CDC) guidelines, federal, state/local health department recommendations and correctional healthcare standards.

# **Policy**

All patients are screened for tuberculosis at intake and at least annually thereafter.

Appropriate testing by tuberculin skin testing (TST) or blood test Interferon-Gamma Release Assay (IGRA) is performed based upon annual facility tuberculosis risk assessment, type of facility where patient is housed and contractual requirements.

Patients exhibiting symptoms of active disease are isolated in Airborne Infection Isolation Rooms (AIIR) or are transferred to another facility or hospital for appropriate housing

Screening, isolation and treatment is provided adhering to current guidelines and recommendations. CDC

Treatment for tuberculosis is based upon most current treatment guidelines and recommendations of nationally recognized entities. Treatment guidelines are providers. approved by the physician leadership who are responsible for the development, review and revision of clinical guidelines

# **Definitions**

1. TB symptom screen: interview of patients with specific questions, common symptoms and other criteria that evaluates risk of tuberculosis
2. TST: Tuberculin Skin Test (previously referred to as PPD- solution used for TST), one of diagnostic tool to determine previous exposure or current tuberculosis
3. PPD; purified protein derivative, solution that provides a protein to tuberculosis to challenge immune system for presence
4. Interferon-Gamma Release Assay *(IGRA), QuantiFERON®-TB Gold Test (QFT-G) or T-Spot)*: blood tests used as a diagnostic tool for identifying the presence of the *M. tuberculosis bacteria. It does not identify the patient has TB* infection or active TB disease. BCG history does not affect results.
5. *BCG (Bacillus Calmette-Guérin (BCG)*: a vaccine currently in some countries to:
   1. Against tuberculosis. The efficacy and strength is varies and effects wane within 10 years).
   2. BCG vaccine history does not contraindicated TB testing.
6. *Medical Isolation:* Housing in a separate room with a separate toilet, handwashing facility, soap, and single-service towels, and with appropriate accommodations for showering.
7. An *Airborne Infection Isolation Room (AIIR)*, also referred to as a negative pressure room, is a single-occupancy patient care room used to medically isolate patients with a suspected or confirmed airborne infectious disease. Environmental factors are controlled in AIIRs to minimize the transmission of airborne infectious agents that are usually transmitted from person to person by droplet nuclei associated with coughing or aerosolization of contaminated fluids. AIIRs provide negative pressure so that air flows under the door gap into the room and is exhausted safely.

# **Procedures**

### Screening and Testing

1. When an patient is admitted to the correctional system, the receiving healthcare screening includes review for symptoms: persistent cough lasting greater than 3 weeks, blood-tinged sputum and complaints of chest pains associated with:
   1. Fever/chills
   2. Night sweats
   3. Lethargy/easy fatigability
   4. Weakness
   5. Weight loss (significant >10lbs in less than a month)
   6. Loss of appetite
2. Patients are asked if they have a history of tuberculosis (TB) disease, if they have been treated for latent tuberculosis infection (LTBI), or for tuberculosis disease in the past. Documentation of any history should be obtained from the treatment source or medical records, if possible.
3. Patients with symptoms suggestive of tuberculosis disease are placed in an Airborne Infection Isolation Room (AIIR) until they have undergone a thorough medical evaluation and are medically cleared as no longer infectious. Facilities without an on-site AIIR have a written plan for transferring patients with suspected or confirmed tuberculosis. Refer *to IPC-18M, Transmission-Based Precautions; IPC-03M, Exposure Control Plan* and *IPC-20M, Respiratory Protection: Airborne Infection Isolation Room.*
4. Only facilities with a facility annual tuberculosis risk assessment of “minimal” may elect, after consulting with the local health department and facility administration, to perform tuberculosis symptom screening at intake, and tuberculin skin test or IGRA blood test for tuberculosis within according to facility’s policy, for the following clinical conditions and immunocompromising factors including but not limited to:
   1. HIV infection
   2. Recent immigration
   3. History of tuberculosis
   4. Recent close contact with a person with tuberculosis disease
   5. Injection-drug use
   6. Diabetes mellitus
   7. Immunosuppressive therapy or condition
   8. Hematologic malignancy or lymphoma
   9. Chronic renal failure
   10. Medical conditions associated with substantial weight loss or malnutrition or history of gastrectomy or jejunoileal bypass
5. Tuberculosis screening tests are done by either the tuberculin skin testing (TST) using 0.1 mL of 5 tuberculin units (TU) of purified protein derivative (PPD) or IGRA blood test for TB per contract. The chosen method, per CDC guidelines, should be used consistently for screening and annual testing and used in all other facilities as an addition to symptom review in screening for tuberculosis infection.
6. Patients who have a documented history of positive TST based on a millimeter reading, a documented history of tuberculosis disease, or a reported history of a severe necrotic reaction are exempt from TST. These patients are screened for symptoms of tuberculosis and may receive a chest radiograph.
7. Bacillus Calmette-Guérin (BCG) is a vaccine currently used worldwide against   
   tuberculosis. BCG is prepared from a live attenuated strain that stimulates the immune system to protect against tuberculosis. TST is not contraindicated for persons who have been vaccinated with BCG and the same criteria for interpretation of TST results are used for both BCG-vaccinated and non-vaccinated patients.
8. Trained healthcare staff place the TST on all patients new to the correctional system unless the patient has a documented history of positive TST result, a documented history of tuberculosis disease, or a reported history of a severe necrotic reaction In those situations, the patient is to be scheduled for a chest x-ray within seven days, unless documentation of a previous negative chest x-ray report is available, or documented in past medical record.
9. Patients who refuse the TST process will be managed in accordance with the facility’s policies, which may include isolation for public health reasons.
10. Training for healthcare staff placing and interpreting TST includes **observation and verification of TST placements and readings by an approved trainer and** may includewatching the CDC **Mantoux Tuberculin Skin Testing video. Training verification is maintained in the staff member’s training file.**
11. **TST placement is documented on the appropriate forms for timely interpretation and on-going documentation of individual patient results in the health record**
12. Trained healthcare staff interpret the reaction to the TST within 48 to 72 hours of the planting of the PPD by measuring the area of induration (the palpable swelling) at the injection site. The diameter of the indurated area is measured across the width of the forearm. Erythema (the redness of the skin) is not measured.
    1. 10 or more (≥ 10) mm induration is considered a positive result in the majority of cases
    2. 5 or more (≥ 5) mm induration is considered positive for select persons such as individuals with HIV, persons having recent contact with tuberculosis, organ transplant recipients, and individuals with immunocompromised conditions (persons receiving greater than 15 mg of prednisone/day for longer than one month), and persons suspected of having tuberculosis
    3. All reactions, even those classified as negative, are recorded in millimeters of induration (00 mm, 1 mm, etc.)
13. Two-step testing may be required by the correctional system. Two-step testing can reduce the number of positive TSTs that would otherwise be misclassified as recent skin test conversions during future periodic screenings. For two-step testing, patients and staff, with a baseline TST negative result are retested 1 to 3 weeks after the initial test. If the second test result is negative, they are considered not infected. If the second test result is positive, the patient is considered to have a previous infection and receives follow-up for a positive TST. This is known as “boosting.” Two-step testing of patients is performed when contractually required or required by the Public Health Department.
14. IGRA, QuantiFERON®-TB Gold Test (QFT-G) or T-Spot are blood tests used as a diagnostic tool for *M. tuberculosis* infection, including both tuberculosis disease and latent tuberculosis infection. It is not used under normal circumstances when TST solution is available. This blood test must be performed at a certified laboratory on the patient’s whole blood sample and requires special handling. This requirement is not possible in the vast majority of correctional facilities and can make the use of the blood test impractical and more costly than the TST. This test is only done by specific contracts when available.

**Periodic Screening for Patients**

1. Periodic screening for all patients who have a negative TST includes follow-up testing on an annual basis and symptom screening as determined by facility policy and the annual risk assessment .
2. Periodic symptom screening for tuberculosis disease is conducted for patients with a positive TST or IGRA result .
3. Annual chest X-rays are not necessary unless the patient has developed new symptoms of active TB disease.
4. Periodic screening may be performed in the birth month of the patient, the month of incarceration or per correctional system policy.

**Screening Follow-up and Case Reporting**

* 1. Follow-up for a positive TST or positive IGRA:
  2. Chest X-ray is performed within 72 hours to rule out active tuberculosis. Isolation is not necessary while waiting for the x-ray if the patient is asymptomatic and has a low likelihood of active disease.
  3. Referral to a nurse or provider for evaluation and education. Treatment is discussed and considered.
  4. HIV counseling, testing, and follow-up is routinely offered to all patients with latent tuberculosis infection or tuberculosis disease when HIV infection status is unknown.
  5. Airborne Infection Isolation Room (AIIR) is used if symptoms of active disease are present or active disease is suspected, until tuberculosis disease is ruled out.
  6. The Medical Director or designee, the Health Services Administrator, the Director of Nursing and the Infection Prevention and Control Coordinator are notified.

1. Patients with an abnormal chest radiograph or symptoms of tuberculosis, positive TST or IGRA (suspected tuberculosis) are further evaluated to rule out tuberculosis disease and reported to the state or local health department.
2. Placement in an Airborne Infection Isolation Room (AIIR) is indicated until active tuberculosis disease is ruled out. Transfer of the patient is required if no AIIR is available on-site.
3. Notification of the local or state health department for suspected and confirmed cases of tuberculosis is a requirement in all states. Notification of the health department benefits the correctional facility by allowing the facility to obtain health department resources for case management and contact investigation in both the facility and the community
4. Centurion staff work closely with local health departments and notify them according to the respective state’s requirements (suspected active tuberculosis is usually required reporting within 24 hours). The health department may perform cross-matches with the local tuberculosis registry and search for matches of known aliases, birth dates, maiden names, and other personal information for patients suspected of having tuberculosis infection. A readily accessible record of previous tuberculosis history, drug-susceptibility patterns, treatment, and compliance can be useful in determining the disposition of a given patient with suspected tuberculosis.
5. Immigration and Customs Enforcement (ICE) patients with confirmed or suspected tuberculosis disease are reported to the ICE health services program responsible for the patients’ care.
6. Patients who do not have an abnormal chest radiograph or symptoms of tuberculosis but have a positive TST or IGRA are considered for latent tuberculosis infection therapy.
7. Decisions regarding initiation of latent tuberculosis infection treatment will include consideration of the likelihood of the patient continuing and completing latent tuberculosis infection treatment under supervision, if released from the facility before the treatment program is completed.
8. For each suspected case of tuberculosis, the diagnosis or the exclusion of a diagnosis of tuberculosis is entered immediately into the patient’s health record, the retrievable aggregate tuberculosis-control database at the facility, and the database at a centralized office if the system has multiple facilities. The database is also maintained to show results of initial and repeat TST or IGRA, and symptom screening.

**Isolation and Contact Investigation**

1. Airborne Infection Isolation Room (AIIR) precautions are initiated for any patient who has signs or symptoms of tuberculosis disease or who has documented tuberculosis disease and has not been determined to be noninfectious.
2. Patients are transferred to a designated facility when AIIR precautions are indicated but cannot be provided on-site.
3. For patients placed in an AIIR because of suspected infectious tuberculosis disease, precautions can be discontinued by a physician, when infectious tuberculosis disease is considered unlikely, another diagnosis is made that explains the clinical syndrome, or the patient has three negative acid-fast bacilli (AFB) sputum-smear results. The three sputum specimens should be collected 8 to 24 hours apart with at least one being an early morning specimen.
4. Patients, whose tuberculosis disease cannot be ruled out or has been confirmed, are placed on standard multi-drug anti-tuberculosis treatment per *Centurion Disease Management Guidelines for Tuberculosis* by the on-site provider.AIIR precautions remain until the patient has had three consecutive negative AFB sputum-smear results collected 8 to 24 hours apart, with at least one being an early morning specimen, and the patient has demonstrated clinical improvement. Only a provider can discharge patients from isolation.
5. Healthcare leadership will investigate the need for implementation of environmental controls with the facility administration if the risk for tuberculosis transmission persists despite efforts to screen and treat patients.
6. The focus of tuberculosis contact investigation is identifying contacts of a patient diagnosed with active tuberculosis disease and providing testing and treatment to those contacts.
7. Security staff will be part of the contact investigation, but testing and treatment may be done by the facility/DOC worker’s compensation per the facility/DOC exposure control plan and by contractual agreement. All results of testing and treatment by worker’s compensation will be available to the Infection Prevention and Control Coordinator as per CDC and Health Department guidelines for completion of the contact investigation.
8. A multidisciplinary team is involved in planning and prioritizing contact investigations in the correctional facility. The local or state health department advises the healthcare staff in planning, implementing, and evaluating a tuberculosis contact investigation.

**Treatment, Case Management, Discharge Planning**

1. Patients are treated for tuberculosis disease and latent tuberculosis infection according to *Centurion Disease Management Guidelines* and current CDC local and state health department guidelines.
2. Effective liaisons with local and state health department staff are established and fostered by Health Services Administrator, Medical Director, Director of Nursing or designated staff, and the facility Infection Prevention and Control Coordinator or designee.
3. Case management for patients being treated for tuberculosis and latent tuberculosis infection includes indicated testing, direct observation medication therapy, and no less than monthly monitoring during the prescribed course of therapy.
4. Patients receiving treatment for tuberculosis disease or latent tuberculosis infection who are released receive a supply of medication, and the public health department is notified of the patient’s release according to the health department requirements. Contact with the patient from the public health department is encouraged before release.
5. Education that addresses tuberculosis including but not limited to transmission, misconceptions about tuberculosis, signs and symptoms, successful treatment, risks/benefits of treatment, and contact investigations are provided to the patient population and to the facility staff.

**Facility Tuberculosis Risk Assessment**

A facility Tuberculosis Risk Assessment should be performed each year. The findings are used to trend data and identify unsuspected transmission within a facility. The Infection Prevention and Control Committee reviews and acts upon the risk assessment as part of the annual review of the Infection Prevention and Control Program.

1. The Infection Prevention and Control Nurse or the Infection Prevention and Control Committee designates a member to perform and report on the annual Tuberculosis Risk Assessment.
2. The Infection Prevention and Control Committee reviews the assessment and classifies the facility. The facility is classified as having minimal tuberculosis risk based on four criteria:
3. No cases of infectious tuberculosis have occurred in the facility in the last year
4. The facility does not house a substantial number of patients with risk factors for tuberculosis (HIV infection and injection-drug use)
5. The facility does not house a substantial number of new immigrants (persons arriving in the United States within the previous five years) from areas of the world with high rates of tuberculosis
6. Staff of the facility are not otherwise at risk for tuberculosis
7. No evidence of undiagnosed tuberculosis transmission
8. Any facility that does not meet all of these criteria should be categorized as being a nominal tuberculosis risk facility
9. The Tuberculosis Risk Assessment is used to determine types and levels of administrative and environmental controls that may need to be added or changed.

Tuberculosis Risk Assessments and review of findings and recommendations are maintained by the Infection Prevention and Control Committee as part of the committee minutes.

As part of the complete control plan, the employee tuberculosis screening is addressed in *IPC-22M Staff Health Guidelines*

## Referenced Forms:

IPC-027 Tuberculosis Facility Risk Assessment

IPC-028 Tuberculosis Screening/Testing - Patient

IPC-029 Tuberculosis Annual Symptom Review, Tuberculin Skin Test

Reactors or Positive QFT-G Test

IPC-030 Active TB Suspect Log

## References:

Tuberculosis General Information - English

Tuberculosis General Information - Spanish

IGRA - Blood Tests for TB Infection Fact Sheet

Patient TB Education Materials:

CDC Mantoux Skin Testing Video on-line

<https://tools.cdc.gov/medialibrary/index.aspx#/media/id/302210>

## Clinical Operations Revision Dates:

Originated 2016

Revised June 2019

Revised December 2021

# **Purpose**

To identify and reduce the risk of transmission of skin and soft tissue infections (SSTIs), including Methicillin-Resistant Staphylococcus Aureus (MRSA).

# **Policy**

Patients are screened at intake for skin integrity. Patients presenting with skin lesions, rashes, or wounds are evaluated, treated, and referred for follow up and wound care according to nurse protocol. Serious wounds and suspected or confirmed cases of MRSA and resistance patterns are tracked by the infection prevention and control coordinator/nurse. Treatment of SSTIs, including MRSA, follow the most current Centurion Clinical Disease Management Guidelines.

# **Definitions**

1. SSTI: Skin and Soft Tissue Infection. Any lesion identified as infected skin in any layer of the skin. Usually identified by edema, erythema, with or without drainage or pain,
2. Cellulitis: Inflammation of subcutaneous connective tissue
3. MRSA: Methicilin-resistant Staphylococcus aureus (MRSA). A bacteria that that causes and infection of the skin that is resistance to some antibiotics
4. MSSA: Methicilin-susceptible Staphylococcus aureus (MRSA). A bacteria commonly found on the skin that may cause an infection
5. MDRO: Multidrug-resistant organism. Bacteria that are resistant to treatment with more than one antibiotic.
6. Sepsis: A body’s extreme response to any infection. It can be triggered by a skin infection as well as other infections in the body. It is a life threatening medical emergency and recognition is imperative.

# **Procedures**

1. **Screening**
2. All patients are screened at intake for wounds, skin lesions, or rashes.
3. Patients are evaluated by a provider or trained healthcare staff member for complaints of sores, boils, carbuncles, wounds, insect bites, spider bites, cellulitis, and open areas, and encouraged to report if such symptoms develop.
4. All inmate workers are routinely checked by security staff.
5. Healthcare staff remain vigilant for evidence or symptoms of skin infections at each healthcare encounter.
6. The evaluation, treatment plan, referral, or follow up is documented in the patient’s health record.
7. Centurion Nursing Protocol (*Skin Integrity Documentation and Guidelines)* provides documentation and approved nursing actions or referrals.
8. **Diagnosis**
9. The clinical appearance: SSTI’s have several presentations, and can be caused by different microorganisms, including Methicillin-Resistant Staphylococcus aureus (MRSA). MRSA has a characteristic purulent appearance that can be accurately recognized in the majority of cases. MRSA can appear as scalded skin lesions.
10. Since MRSA has unique characteristic features, cultures may not have to be completed on every typical MRSA lesion. However, cultures should be considered for confirmatory diagnosis and evaluation for sensitivity to antibiotics in the following cases:
    1. Uncertainty of diagnosis.
    2. Systemic illness such as fever, rigors, malaise, etc.
    3. Significant cellulitis.
    4. High-risk patients such as diabetics, other immunocompromised patients, patients with chronic illness, the elderly, etc.
    5. High-risk locations such as the face, hands, or genitalia.
    6. Whenever a simple incision and drainage fails to resolve the infection.
    7. MRSA carrier state should be suspected in the following cases:
       * Multiple MRSA lesions appearing at same time.
       * Recurrent MRSA lesions in the same patient.
11. Cultures: Not all SSTIs are MRSA. To confirm the diagnosis of MRSA, the culture must be positive or meet the unique MRSA characteristics.
    1. Do not delay treatment awaiting culture reports.
    2. Sensitivity reports are correlated with antibiotic therapy as soon as possible and changes made if indicated
12. **Treatment and Management**
13. Treatment: Treatment guidelines are found in Nursing Protocols, *“Skin Integrity Guidelines”;* Centurion Clinical Guidelines, *Methicillin Resistant Staph Aureus (MRSA) Infections and Skin and Soft Tissue Infections (SSTIs);* and wound care is completed as prescribed.
    1. Daily wound care.
    2. Self-care or daily wound care consistent with facility protocol.
14. Perform safe dressing changes.
15. Use standard precautions.
16. Use personal protective equipment appropriately(i.e., gloves, gown).
17. Complete hand hygiene before and after removal of gloves.
18. Clean draining wounds with saline or chlorhexidine solution as prescribed by the medical provider. Hydrogen peroxide (H2O2) is not recommended for use on these wounds unless ordered by the provider.
19. Change dressings daily and documented wounds appropriately.
20. Dispose of bandages in accordance with OSHA and facility policy.
21. Place bandages with drainage in leak-proof bags and treat as regulated medical waste.
22. Follow-up with the clinic within 5 to 7 days as ordered or PRN if indicated earlier.
23. Notify Infection Prevention and Control Nurse of all SSTIs including MRSA.

***NOTE: Providers should avoid unnecessary or indiscriminate antibiotic prescribing.***

1. **Housing** (s*ee Correctional Housing Containment Guidelines* attachment*)*
2. In general, patients with draining wounds, that can be completely contained, can be housed in general population.
3. Factors influencing decisions about where to house patients with MRSA and SSTI’s include:
   1. The degree to which wound drainage can be contained.
   2. The ability or willingness of a patient to follow infection control instructions.
   3. Available housing options.
4. If drainage cannot be contained or the patient is noncompliant with covering the wound, the patient should be housed separately.
5. Patients with MRSA pneumonia can generally be housed with other patients. The exception about housing should be made on a case-by-case basis. Patients with MRSA pneumonia who have copious respiratory secretions or who have poor hygiene habits and are likely to contaminate the environment should be housed in separate rooms on contact precautions,
6. Contact precautions are instituted when drainage cannot be contained with a dressing, the patient is uncooperative, or the patient cannot follow self-care instructions and the wound is draining. Correctional staff are notified to assist with cell assignment and linen exchange increases when contact precautions are required.
7. **Environmental Cleaning and Laundry for Culture Positive MRSA or other Microorganism**
8. Cells and areas where the patient was housed should be cleaned with EPA approved disinfectant approved for MRSA or a 10% bleach solution.
9. If the patient is in suspect status but remains in his/her housing unit, or has been relocated to the infirmary, the cells and bunks in close proximity and the common areas should be cleaned.
10. The patient should have daily linen and uniform exchanges for at least 3 days, or when clothes or linens have wound drainage.
11. **Carrier Status**
12. Asymptomatic carriers: Testing for carrier status (such as nasal cultures) in asymptomatic patients should not be routinely done.
13. Symptomatic carriers: Carrier status in patients with MRSA infections may be suspected if patients have one of the following clinical indications as determined by a medical provider:
    1. Multiple recurrent MRSA infections in the same patient.
    2. Multiple simultaneous MRSA abscesses at the same time in the same patient.
14. The suspected carrier should be identified and monitored. Treatment is given per provider orders.
15. Treatment to eliminate colonization with MRSA (decolonization) is not routinely recommended. The effectiveness of decolonization methods to interrupt MRSA recurrence and transmission are not well-established. However, it may be reasonable to consider decolonization on a case-by-case basis in two circumstances:
    1. For patients with recurrent MRSA infections (three or more infections in less than six months).
    2. In outbreak situations in which ongoing MRSA transmission is occurring among a well-defined cohort with close contact.
16. **Complications**
17. Extensive cellulitis: Specialty Infectious Disease consultation should be obtained in such cases.
18. Necrotizing fasciitis: This is a serious complication and always requires hospital admission and extensive surgical intervention. Suspected necrotizing fasciitis should always be immediately reported to the healthcare provider in consultation with the Statewide Medical Director.
19. Sepsis: Sepsis or impending sepsis should be considered if the patient shows signs of systemic toxicity, especially if the patient is immunocompromised or has serious underlying medical problems.
20. Sepsis or impending sepsis should be treated as a medical emergency, considered in patients with active MRSA lesions plus the following:
21. High fever, especially with rigors
22. Vomiting
23. Anorexia
24. Severe malaise
25. The Statewide Medical Director should be notified in all cases of suspected MRSA sepsis.
26. Patients with suspected sepsis should usually be referred to the emergency room for evaluation.
27. **Surveillance**
28. Skin lesions are tracked using the *IPC-022,* *Skin Lesion and MRSA Tracking Log*.
29. The Health Services Administrator and Infection Prevention and Control Coordinator or designee review and report status in the Infection Prevention and Control report.
30. Statistical data is submitted monthly to the Corporate Infection Prevention and Control Nurse.
31. Outbreaks are monitored. An outbreak is two or more patients with contact or common housing or work area diagnosed with MRSA within seven days of initial diagnosis.
32. **Outbreak Management**
33. MRSA outbreaks within the inpatient setting can be extremely difficult to control and are affected by multiple factors that vary among inpatient units.
34. The most effective methods to eradicate MRSA infections from the inpatient setting have involved the active surveillance and isolation of the patients with MRSA infection, along with using strict Contact Precautions when managing these patients.
35. The Medical Director and the Infection Prevention and Control Coordinator should be consulted when developing a specific infection control strategy due to the difficulties in managing MRSA outbreaks in the inpatient setting and the inherent risks to the patient population.
36. Public health authorities may also be consulted.
37. Follow outbreak and contact investigation as indicated in *IPC-28M, Outbreaks and Contact Investigations.*
38. **Prevention**
39. All staff follow Standard Precautions when working with patients.
40. Good personal hygiene is enforced for all patients and staff.
41. Hand hygiene between contacts with each patient is necessary. If handwashing facilities are unavailable, use of alcohol-based hand sanitizers/bacterial wipes/after removing gloves following Standard Precautions is possible.
42. Post facility approved hand hygiene reminder signs.
43. Scheduled cleaning and sanitation of housing areas, recreation facilities, health care area, work area, is increased in the event of an outbreak of SSTIs or MRSA.
44. All shared laundry items are to be washed regularly with detergent and hot water and thoroughly dried. The water should be 160 degrees and contain a 10% bleach solution, and thoroughly dried at 160 degrees for a minimum of 20 minutes or until completely dry. If cold water washing detergent is used, follow the manufacturer’s recommendations for decontaminating for MRSA, and follow drying directions.
45. **Education**
46. All patients with MRSA receive education about this infection from the treating provider or qualified health staff
47. Patients with manageable infections receive self-care education (Inmate Skin Infection Self Care Education) and are rechecked by healthcare staff in 5 to 7 days or sooner if indicated.
48. Education should include the following:
49. Importance of keeping wound covered.
50. Importance of personal cleanliness.
51. Importance of using facility laundry rather than self-hand-washing clothes.
52. Importance of alerting medical staff if he/she is getting worse instead of better after treatment is initiated.
53. Centurion staff infection prevention and control training about MRSA/SSTIs is completed at orientation and during annual training, to include but not limited to:
    1. Standard Precautions
    2. Hand Hygiene
    3. Transmission precautions including Contact Precautions
    4. MRSA and SSTIs
54. **Administration Responsibilities**
55. The Health Services Administrator facilitates MRSA education for correctional staff and patients by the distribution of approved *MRSA Fact Sheet.*
56. Health Services Administrator completes *IPC 023,* *Facility Checklist for MRSA Readiness* if requested by facility administration.

## Referenced Forms:

IPC-022 SSTI/MRSA Tracking Log

IPC-023 Facility Checklist for MRSA Readiness

## References/Infection Control Manual Resources:

Skin Integrity Documentation - Nursing Protocol

Centurion Clinical Guideline: *Methicillin Staph Aureus (MRSA) Infections*

MRSA Fact Sheet

Correctional Housing Containment Guidelines

Patient Education and Self Care in Skin Infections

Multi-Drug Resistant Organisms:

<https://www.cdc.gov/hicpac/mdro/mdro_4.html>

Antibiotic Stewardship:

<https://www.cdc.gov/drugresistance/solutions-initiative/antibiotic-stewardship.html>

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# **Purpose**

To provide administrative and operational guidelines to manage foodborne and gastrointestinal infections and outbreaks.

# **Policy**

Healthcare staff provide patient care for gastroenteritis and will interview and work with the provider, kitchen staff, and department of health as necessary to identify a foodborne illness. Treatment will follow current guidelines as ordered by the provider. The infection prevention coordinator/nurse will coordinate any investigation required and report infections to administration, department of health as required, and the infection control committee.

# **Definitions**

1. *Foodborne Illness*: Disease acquired by consumption of contaminated food. Bacteria, viruses, parasites, toxins produced by microorganisms, other toxins, or chemicals, can contaminate food.
2. *Foodborne Outbreak***:** An incident in which 2 or more persons experience similar illnesses after ingestion of common food, and epidemiologic analysis implicates food as a source of illness.
3. *Gastroenteritis:* An inflammation of the stomach and intestines which can be caused by viruses, bacteremia or parasitic (Norovirus, salmonella, Clostridium difficile, cryptosporidium, giardia, etc.), acute and chronic medical conditions (Crohn’s disease, irritable bowel disease, ulcerative colitis, etc.), or as a side effect from medications.

# **Procedures**

1. Screening:
   1. All inmates are screened at intake for medical complaints and history per intake/ receiving screening guidelines
   2. Patients complaining of vomiting, frequent diarrhea, and nausea are evaluated by the healthcare provider. History of previous GI illness is obtained
   3. If two or more patients that share a common housing or work environment complain of the same symptoms, foodborne illness or outbreak will be investigated
   4. Foodborne outbreak evaluation is conducted to determine if the cause might be foodborne, infection, or parasite, and not a medical condition. Patient interviews are completed and documented to find a common or the root cause of the symptoms
   5. Questions include but are not limited to:
2. When was the last time the patient ate?
3. What did the patient eat?
4. Was food consumed saved from a previous meal?
5. When did symptoms start after eating?
6. Has the patient had more than three watery stools a day?
7. Any nausea or vomiting?
8. Notification
   1. The healthcare staff notifies the provider for medical evaluation/treatment orders
   2. The healthcare staff is to notify the health services administrator, director of nursing and infection prevention and control coordinator, or designee if an outbreak is suspected
   3. Notify the kitchen director immediately to hold the previous 72-hour sample trays held in the kitchen until the determination of foodborne or other etiology can be made
   4. Notify security/correctional administration according to facility standard operating procedures
   5. The health department is notified if it is determined that the incident is reportable
   6. Stool cultures will be collected for laboratory evaluation as ordered by the provider or department of health
9. Housing
   1. If not infectious and not critical, the patient can remain in current housing; however, it is preferable to house in a single cell with a toilet facility in medical housing
   2. If the patient is infectious, house alone or cohort in the infirmary with their own toilet
10. Treatment is provided as prescribed by the healthcare provider.
11. If an outbreak is determined, refer to *IPC-19M, Outbreaks and Contract Investigation*, and complete all appropriate notifications and forms.
12. Common gastrointestinal infections
    1. Clostridium difficile/ Clostridioides: A highly contagious, spore-forming bacillus, not destroyed by alcohol hand rubs. Use an Environmental Protection Agency (EPA)-registered disinfectant with a sporicidal claim for environmental surface disinfection after cleaning in accordance with label instructions. (Note: Only hospital surface disinfectants listed on <https://www.epa.gov/pesticide-registration/list-k-epas-registered-antimicrobial-products-effective-against-clostridium> are registered as effective against C. diff spores)., or use a 1:10 bleach solution
       * 1. Symptoms
            + Watery diarrhea
            + Fever
            + Stomach tenderness
            + Nausea
            + Loss of appetite
         2. Risk factors

* Age (more common over 50 years of age)
* Immunodeficiency
* Underlying diseases
* Antibiotic use
* Patients taking a protein-pump inhibitor
* Burden of C. difficile spores
* Gastrointestinal surgery/manipulation
* Long length of stay in healthcare settings
  1. Norovirus: A highly contagious virus, spreads quickly from, food, person and surfaces, not destroyed by alcohol hand rubs, disinfectants must be specific for norovirus and can be found on the US Environmental Protection Agency’s list of approved products for healthcare settings or a 1:6 or 1:10 bleach solution.
     + 1. Symptoms
          - Watery, non-bloody diarrhea with abdominal cramps
          - Stomach tenderness
          - Nausea
          - Vomiting
          - Low grade fever
          - Body aches
  2. Hepatitis A, (oral-fecal transmission) spreads quickly from, contaminated food or water, person-to-person contact with an infected person, and sexual contact with an infected person. Good hand hygiene after using the bathroom, changing diapers, and before preparing or eating food is integral to hepatitis A prevention..
     + 1. Symptoms-sudden onset of:
          - Dark urine
          - Clay-colored stools
          - Stomach or flank pain
          - Fatigue
          - Loss of appetite
          - Nausea
          - Vomiting
          - Diarrhea
          - Fever
          - Joint pain
          - Jaundice
       2. Risk factors
          - Homelessness
          - International travelers
          - Men who have sex with men
          - People with occupational risk for exposure
          - Drug use
          - Exposure to Hepatitis Immunodeficiency
          - Immunodeficiency
          - Underlying diseases
          - Liver disease
          - Hepatitis B or C
  3. Salmonella or other foodborne infection caused by ingestion of contaminated food products. Symptoms include sudden onset of
     + - * Nausea
         * Vomiting
         * Diarrhea
         * Stomach pain

1. Parasitic infection, ingestion of contaminated food products or contaminated water, travel outside the United States. Symptoms: sudden onset and intermittent
   * + - * Nausea
         * Vomiting
         * Diarrhea
         * Stomach pain

## Referenced Forms:

IPC-017 Infectious Disease Suspect Index Case Worksheet

IPC-018 Infectious Disease Outbreak Worksheet Excel

## Resources:

Clostridium difficile Fact Sheet

Norovirus Illness - Key Facts

[FAQs for Clinicians about C. diff | CDC](https://www.cdc.gov/cdiff/clinicians/faq.html)

[Norovirus in Healthcare Facilities Fact Sheet (cdc.gov)](https://www.cdc.gov/hai/pdfs/norovirus/229110-ANoroCaseFactSheet508.pdf)

[Hepatitis A Q&As for Health Professionals | CDC](https://www.cdc.gov/hepatitis/hav/havfaq.htm)

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# **Purpose**

To prevent the transmission of bloodborne pathogens and other microorganisms when performing phlebotomy, collection, processing, and handling of laboratory specimens.

# **Policy**

Healthcare staff collect and handle laboratory specimens in a manner that protects the phlebotomist from exposure to bloodborne pathogens and other microorganisms, and prevents specimens from the cross-contamination of other microorganisms.

# **Procedures**

1. Healthcare staff use proper hand washing and Standard Precautions when performing phlebotomy, collecting, handling, or processing laboratory specimens.
2. Gloves will be worn when:
   1. Obtaining and handling specimens
   2. When in direct contact with soilage or equipment that is soiled
   3. When cleaning equipment, spills, or counter space
   4. Wash hands after removal of gloves
3. Equipment will be cleaned and disinfected according to manufacturer directions. Countertops and blood spills are cleaned immediately and disinfected following policy and procedure *IPC-18M, Cleaning, Disinfecting, Sterilization.*
4. Laboratory specimens are transported in an impervious (plastic) bag so that the contents will be contained if spillage occurs.
5. All sharp items, including needles, tubes, or slides, are disposed of in puncture-resistant containers. These containers are sealed when 2/3 full and placed in a proper regulated waste disposal container. Never combine sharps containers.
6. Blood tube holders are not to be reused. Safety devices are used when obtaining blood and samples, including blood for fingerstick blood glucose or any laboratory test requiring a finger stick (e.g., INRs).
7. Laboratory tests that may be conducted on-site include but are not limited to:
   1. Multiple-test dipstick urinalysis
   2. Finger-stick blood glucose testing
   3. Hand-held peak flow meter
   4. Occult stool testing
   5. Urine pregnancy testing at facilities with female patients
   6. Fluorescent Immunoassay
   7. Rapid Antigen testing
   8. Other tests as per facility license, policy, and procedure.
8. Mouth pipetting or suctioning of blood or other potentially infectious material is prohibited.
9. Licensed and accredited laboratories process and perform laboratory tests.
10. Laboratory specimens are stored in a refrigerator before transport to the laboratory. Frozen specimens will be handled according to laboratory recommendations.
11. The temperature of the refrigerator will be documented to ensure proper functioning. A temperature log will be maintained if a computerized monitor is not used. The appropriate temperature range is 35° to 45° F. The refrigerator will be labeled with an approved “Biohazard” symbol and not used for any other purpose.
12. Healthcare staff will wear appropriate personal protective equipment and use other indicated Standard Precautions when obtaining, collecting, handling, and processing laboratory tests. The applicable Clinical Laboratory Improvement Amendments (CLIA) waiver or certification to conduct laboratory testing on-site is obtained, and the certificate is displayed in the laboratory area.
13. Centrifuges are equipped with a cover that is in place when in operation. Equipment is maintained and serviced at least annually. Documentation of service is maintained in the laboratory.
14. Specimens that are prepared for contracted laboratory services are packaged according to instructions from the laboratory service in packages/containers with biohazard labeling, which are supplied by the laboratory services to prevent leaking and spilling. Requisitions are placed on the outside of the actual packet that contains specimens.
15. Specimens that must be transported by healthcare or security staff out of the facility for STAT services are transported in a closed container that prevents leaking and spilling. The container will be labeled with the approved biohazard label.



## Referenced Forms:

LOG-021 Refrigerator Log

## References:

IPC-18M Cleaning, Disinfecting, Sterilization

## Clinical Operations Revision Dates:

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# **Purpose**

To reduce the risk of infection from the use of intravenous (IV) therapy.

# **Policy**

Qualified healthcare staff administers IV therapy using aseptic techniques. The therapy is monitored according to the most recent Centers for Disease Control and Prevention (CDC) guidelines.

# **Procedures**

**Peripheral IV Lines**

1. Proper handwashing and Standard Precautions are used when performing IV insertion or during any manipulation of the catheter site or line. Examination gloves with a proper fit are adequate for peripheral line insertion.
2. Prepare the skin by cleaning the insertion site either with alcohol 70% or tincture of iodine, iodophor, or chlorhexidine gluconate, for 30 seconds, starting at the center and moving outward in a circular motion. Do not palpate the insertion site after the skin has been cleansed with the antiseptic.
3. Rotate peripheral sites every 96 hours unless rotation is needed sooner due to infiltration or phlebitis. Label the insertion site with the date and time. If for medical reasons, such as poor venous access, the site may not be changed at 96 hours, perform a visual inspection of the site and include documentation indicating the status of the site in the patient’s health record.
4. Change dressings when damp, loose, or soiled. Mark dressings with the date and time changed. Change gauze dressings in no less than 72 hours, or a chlorhexidine-impregnated transparent dressing or antimicrobial disc no less than every seven days.

**Central Lines**

1. Central lines are inserted using sterile technique and maximum barrier precautions, including a full-body drape. Wash hands with an antimicrobial product before putting on sterile gloves.
2. Put on a procedure/surgical mask; the patient wears a mask or turns their head to the opposite side used.
3. Prepare the skin using >0.5% chlorhexidine gluconate with alcohol. If the patient is allergic to chlorhexidine, use 70% alcohol. Permit the site to air-dry.
4. Use sterile drapes to protect the insertion site from contamination.
5. For patients 18 and older, chlorhexidine-impregnated transparent dressings or use of antimicrobial discs can be used to reduce the risk of infection.
6. Sterile technique is utilized for all dressing changes and manipulation of the insertion site.
7. Central line dressings will be changed weekly if there is an impervious dressing, every 72 hours if there is a gauze dressing, when the catheter is changed, or when the dressing becomes loose, soiled, or damp.

**Fluid and Line Management**

1. Fluids may hang for 48 hours. Total parenteral nutrition, fat emulsions, and other medications which are not stable do not hang for more than 24 hours or as directed by the pharmacy. Bags are marked with date and time hung.
2. Change tubing for fluids every 96 hours. Total parenteral nutrition, fat emulsions, blood, and blood product tubing are changed within 24 hours of initiating infusion. Mark the tubing with the date and time hung.

**Care for all IV Sites and Lines**

1. Clean injection ports with 70% alcohol, povidone-iodine (Betadine), or approved antiseptic before accessing the system for at least 5 seconds, allowing it to dry completely.
2. Each shift visually inspects the catheter insertion site through the dressing for tenderness or signs of infection. Document findings of the inspection in the patient’s health record.
3. Needle disposal is the same as for other sharps and includes disposal in a puncture-resistant container.
4. Dispose of the bag and tubing in a container away from the patient room. This will prevent the patient from possibly having access to contraband. Generally, tubing and bag are not considered infectious waste unless a large amount of blood is noted in the tubing, in this instance they would be placed in a biohazard bag and then removed from the patient’s room.
5. Report any sites with signs of infection to the physician or designee and the director of nursing or designee.

Report immediately to a provider if the site develops signs of phlebitis at the insertion site of an IV or central line. Document consultation and orders and carry out orders. When the catheter is removed, documentation includes the status of the catheter (e.g., intact), condition and location of the site, amount and type of fluid remaining in the bag, date, time, signature, and title. Report on the form: *IPC-003 Infectious Disease Monthly Log*

## Referenced Forms:

IPC-003 Infectious Disease Monthly Log

## References:

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# **Purpose**

To reduce the risk of microbial transmission to the environment, patients, and staff by adequately cleaning and disinfecting environmental surfaces in the healthcare unit and sterilizing non-disposable instruments.

# **Policy**

The healthcare unit, healthcare areas, and non-disposable instruments are maintained to prevent the spread of infection from one patient to other patients or staff through proper cleaning, disinfecting, and sterilization.

# **Procedures**

**Peripheral IV Lines**

1. Routine cleaning of healthcare areas is provided at least daily or when visibly soiled. This includes floors in patient care areas and bathrooms. Cleaning and disinfection of all care areas are essential, especially for frequently touched surfaces. Surfaces likely to be contaminated are bed rails, bedside tables, sinks, commodes, doorknobs, surfaces, and equipment in close proximity to the patient.
2. Consultation/examination areas are cleaned at least twice daily with a neutral detergent and water. The last clean of the day should include the floor. In addition, clean low touch surfaces on a scheduled basis (e.g., weekly).
3. Follow the manufacturer's instructions for cleaning and maintaining non-critical medical devices/equipment.
4. Trash will be removed on a routine basis and properly disposed of in accordance with local and state regulations. Red bags will be used to dispose of biohazardous materials in the workplace.
5. Paper is changed on examination tables between patients.
6. When inpatient infirmary beds are maintained, terminal cleaning is performed when discharges occur.
7. Kitchen area and specimen handling areas are cleaned and disinfected daily, and when visibly soiled per facility standing operating procedures.
8. A detergent disinfectant that is bactericidal, virucidal, and tuberculocidal (i.e., kills HIV and TB or HBV) is used for cleaning surfaces contaminated with blood or body fluids. The CDC recommendation for disinfecting environmental surfaces includes use of a 1:100 dilution of household bleach (or 1/4 cup bleach to 1-gallon tap water) or another appropriate disinfectant such as commercial disinfectant-detergent registered by the EPA, using the manufacturer's instructions for mixing and storage.
9. Certain organisms require special disinfectants. Disinfectants for Norovirus, hepatitis A, and C.diff must have specific ingredients that are labeled as sporicidal, or lists norovirus as killed by the disinfectant. The alternative is a 1:10 or 1:6 bleach solution as recommended by CDC. EPA registered disinfectants for non-enveloped viruses can be found online at <https://www.epa.gov/pesticide-registration/list-g-epas-registered-antimicrobial-products-effective-against-norovirus>.
10. When mixing bleach, add the bleach to the water. A solution of bleach and water loses its strength very quickly and easily. It is weakened by organic material, evaporation, heat, and sunlight. Bleach solution should be mixed fresh each day to make sure it is effective. Any leftover solution should be discarded at the end of the day. Never mix bleach with anything but fresh tap water. Other chemicals may react with bleach to create and release toxic chlorine gas. Mark the container with appropriate labeling and discard after use or at the end of the workday.
11. Use personal protective equipment (PPE) when working with cleaning solutions.
12. Inmate workers will not be responsible for handling biohazardous waste in the healthcare unit. Inmate workers will not be assigned to clean inpatient rooms if the cleaning procedure requires the worker to wear PPE other than gloves.
13. Training in proper cleaning will be provided to all inmate workers prior to working in the healthcare unit. Training will include recognition of biohazard signs. If the facility administration requests inmate training for cleaning blood spills and handling biohazardous items, training must include cleaning a blood spill and information on bloodborne pathogens and offering of Hepatitis B vaccine to the inmate.
14. Bloodborne pathogen training is required for all healthcare staff at orientation and annually. Training includes the appropriate use and sequence of donning (putting on) and doffing (taking off) personal protective equipment.
15. Sample inmate worker training program and inmate worker checklist are available. Refer to *IPC-02 Infection Prevention Education.* Inmate worker infection prevention training is available on the portal.
16. Terminal Cleaning of an area includes but is not limited to:
17. Remove soiled/used personal care items for reprocessing or disposal
18. Remove facility-provided linens for reprocessing or disposal
19. Reprocess all reusable patient care equipment
20. Clean and disinfect all low and high-touch surfaces, including those that may not be accessible when the room was occupied (e.g., patient mattress, bedframe, tops of shelves, vents, and floors)
21. Disinfect toilet and sink

**Blood and Body Fluid Spill Clean Up**

1. Use Standard Precautions when cleaning blood spills. Use gloves and PPE if indicated. Use the *Donning and Doffing Personal Protective Equipment* attachment to educate and reinforce the proper sequence for putting on and removal of PPE.
2. Use googles or face shield if splashing is anticipated.
3. Contain the spill with disposable paper towels, cloths, or absorbent granules if blood spill kits are available. All should then be disposed of as infectious waste.
4. If there is glass or other sharps**, do not use hands to pick up;** use forceps, dustpan, etc. to remove glass.
5. Glass or other sharps are disposed of in a puncture-resistant, labeled sharps container.
6. Mop the spill with the paper towels. Discard the disposable paper towels in a biohazard container. When using any commercially available spill kit, follow the directions on the package.
7. Clean thoroughly, using neutral detergent and warm water solution.
8. Disinfect the area with an appropriate diluted bleach solution (1:10 or 1:6 concentration) or approved disinfectant. Do not pour any disinfectant solution directly on spill: always absorb with paper towels first and wipe or spray the area. Leave the disinfectant on the spill area per manufacturer's recommended kill time, (usually 10 minutes) or let air dry.

Remove all personal protective equipment (i.e., gloves, face shield, gown, shoe covers) and dispose in a biohazard container, and wash hands.

**Sterilization**

Centurion utilizes disposable medical items and devices. In most facilities, the dental department is responsible for the proper sterilization of medical or dental items/devices that cannot be obtained in a disposable format. The sterilization and high-level disinfection of all reusable medical and dental items and devices are the responsibility of the dentist and dental department at the facility unless stated in an addendum to this policy.

1. Any used or contaminated sterile disposable item designed for single-use will not be reused or re-sterilized.
2. Any sterile item is considered contaminated and not used if the sterility is questioned due to its package being punctured, torn, wet, or with any breach of the integrity of package. If unsure of the breach, re-sterilize.
3. Reusable medical and dental items/devices are cleaned and either disinfected or sterilized according to guidelines and manufacturers' standards.
4. All objects are to be thoroughly cleaned to remove all organic matter and other residue prior to high-level disinfection or sterilization.
5. Healthcare staff cleans all items/devices before securely transporting in a plastic bag to the area for sterilization.
6. The program director/health services administrator or designee collaborates with the medical, and dental department to ensure that appropriate monitoring includes but limited to:
   1. Proper labeling of sterilized packages that includes:
   2. Date of sterilization (for purpose of identification and rotating instruments)
   3. Sterilizer load number (if more than one sterilizer, a separate log should be maintained on each sterilizer)
   4. Initials of the person operating the sterilizer
7. Maintaining a log to identify items in a particular load by date and time as well as the recording of temperature reading. For each sterilization cycle, record the type of sterilizer and cycle used; the load identification number; the load contents; the exposure parameters (e.g., time and temperature); the operator's name or initials; and the results of mechanical, chemical, and biological monitoring
8. Sterilization indicators such as steam tape or pouch sterilization indicators are used on the outside and inside of each package
9. Biological indicators to ensure sterilizers are performing correctly are determined using spore tests. Sterilizers are monitored no less than weekly with commercial preparations of *Bacillus stearothermophilus.* The dentist or designee monitors and records the results of the spore tests. The dentist or designee has a procedure for responding to a positive spore test result. Positive test results are reported to the infection prevention and control nurse, and the infection control committee. Records and results of commercial off-site laboratory spore test processing are maintained for review
10. Sterilizer(s) receive preventive maintenance as recommended by the manufacturer
11. All contaminated objects are received and decontaminated in one area, disinfected or sterilized in another area, and stored once cleaned or sterilized in a third area. The three areas are separate: (example: wash/decontaminate in one sink, disinfect or sterilize in another sink, store in a locked cabinet. Do not comingle contaminated, clean, and sterilized instruments
12. Records related to sterilization practices are available at all times for inspections and quality improvement activities
13. Sterile items remain sterile and have a shelf life for as long as the integrity of the package remains intact and it has not become wet.
14. Sterility is not determined by a timeframe. Sterility is compromised by the following indicators:
    1. Holes in packaging or torn wrappers
    2. Securing tapes that have been tampered with or removed
    3. Broken seals in peel pouches or sterility maintenance covers
    4. Items dropped that are wrapped or in peel pouches
    5. Exposure to a contaminated or potentially unsafe environment
    6. Exposure to any wetness or excessive moisture

## Referenced Forms:

IPC-004 Autoclave/Sterilization Log

## Resources:

Donning and Doffing Personal Protective Equipment

Sterilization - Frequently Asked Questions – Packaging and Storage

[Sterilization: Monitoring | FAQs | Infection Control | Division of Oral Health | CDC](https://www.cdc.gov/oralhealth/infectioncontrol/faqs/monitoring.html)

CDC Personal Protective Equipment Donning and Doffing

[Environmental Cleaning Procedures | Environmental Cleaning in RLS | HAI | CDC](https://www.cdc.gov/hai/prevent/resource-limited/cleaning-procedures.html#S45)

## Clinical Operations Revision Dates:

Originated 2016

Revised June 2019

Revised December 2021

# **Purpose**

To provide administrative and operational guidelines for identifying and managing disease outbreaks to prevent transmission. To provide guidance in conducting a contact investigation to identify possible exposed patients for the purpose of monitoring and prophylactic treatment as prescribed by a healthcare provider.

# **Policy**

Healthcare staff identify and report any possible cluster or outbreak of infectious disease to prevent transmission and contain an outbreak as quickly as possible. Healthcare staff follow department/facility and corporate reporting guidelines.

# **Definitions**

Cluster: An unusual aggregation, real or perceived, of health events that are grouped together in time and space. Example: over two week period, patients with a common housing or work environment complain of the same symptoms such as fever, cough

Outbreak: An incident in which two or more persons experience similar symptoms/illness in a short period with a common environment. Exception: One case of meningitis is considered an outbreak

Index Case: First case identified with the infection

Source : during interview of the determine a possible source (exposure to environment or person) that the index case could have contracted the infection

Case Investigation: process of interviewing the patient with a suspected or confirmed infection that includes education, and history of contact with anyone they came in contact with during the timeframe which the may have been infections. (See communicable disease chart)

Contract tracing: involves identifying person that may have been exposed to an infectious agent and education on the symptoms, and what possible testing required. This type of tracing are people that were exposed and may develop the disease

Source investigation: during index case interview, identifying and investigating persons that may have been have been the source of the infection

Incubation period: Time interval between exposure to a disease-causing infectious agent and the onset of symptomatic disease or transmissibility of infection as determined by scientific knowledge and history of the disease. This time frame varies with diseases

Infectious period: the recognized time interval during which the patient is infectious (whether symptomatic or asymptomatic). The transmissibility and infectious period is based on scientific history of the specific disease. the time frame varies with diseases

# **Procedures**

1. Surveillance *(IPC-07M, Infectious Disease Surveillance)*
   1. Patients are screened at intake for infectious/communicable disease
   2. Laboratory reports are monitored for positive results for infectious disease
   3. On-going surveillance of sick call and patient complaints is conducted for possible infectious disease
   4. Surveillance includes, but is not limited to, the state and CDC reportable disease list. *Refer to IPC-08M Reportable Diseases.*
2. Identification
   1. Medical staff recognize a possible infectious disease or outbreak at intake or any time during a patient’s incarceration
   2. Notify the medical provider and the infection prevention and control nurse/coordinator for orders
   3. Identify the outbreak disease, organism, type of transmission (respiratory, gastrointestinal, or contact) and if it is a reportable disease, review communicable/infectious disease chart (in appendix)
   4. Identify the index patient’s contacts (including housing, work detail, common area, transports)
   5. Complete *Suspect Index Case Interview of Infectious Disease Outbreak* worksheet (IPC-017)
   6. Common Infectious Diseases include but are not limited to:
3. Tuberculosis Suspect: Follow *IPC-13M,* T*uberculosis Control Plan*
4. *COVID-19*
5. Chicken Pox (Varicella): Follow Chicken Pox Check List
6. Ectoparasites: Follow *IPC-12M,* *Ectoparasites Control Plan*
7. Gastrointestinal: Follow *IPC-15M,* *Gastrointestinal Control Plan*
8. Measles, mumps, and other vaccine preventable diseases
9. Respiratory (including COVID-19, respiratory syncytial virus infection –RSV, influenza, pneumonia, legionaries, pertussis, et.al.). Follow current clinical guidelines for specific diseases. Follow current clinical guidelines for diseases
10. Hepatitis, A, B, C, chronic vs. acute: Follow healthcare provider orders
11. Ebola: Follow current Ebola resource
12. Any emerging or re-emerging diseases identified outbreak, epidemic or pandemic of an infectious disease when identified locally or by infectious disease monitoring organization such as the Department of Health, Centers for Disease Control, or World Health Organization
13. Outbreak Determination
14. Single case outbreak: one case is considered an outbreak until contact investigation reveals no other cases. Isolate the patient immediately, and contact the provider to confirm the diagnosis.
15. Most Common:
    * + Suspect / active tuberculosis
      + Chicken Pox
      + Norwegian/crusted scabies/severe scabies
      + COVID-19
16. Less Common:
    * + Hepatitis A
      + Measles
      + Mumps
      + Pertussis
      + Meningitis (until meningococcal ruled out)
17. Multiple Case Determination: Number of cases/time frame outbreak determination:
18. 2 to 3 cases in 24 to 72 hours with common food history and symptoms (abdominal pain, nausea, vomiting diarrhea.

* Potential Gastrointestinal Infection:
* Notify Food Services to hold 72-hour sample trays until the source is identified in all GI investigations
* Stool cultures done for determination of source.

1. 2 to 3 cases in 3 to 5 days from shared/common location

* Potential infectious respiratory illness other than COVID-19

1. 2 to 3 cases in 3 to 5 days with close contact, or in 7 to 10 days from a shared or common location
   * MRSA
   * Lice
   * Scabies
   * Patients with common symptoms (fever, cough, etc.) for a shared or common location
2. Infectious periods can be longer: consult the provider for diagnosis and orders
3. Notify the infection prevention and control coordinator of all outbreaks
4. Report outbreaks as required by state department of health
5. In the event of a community outbreak of any infectious/communicable disease, the infection prevention and control nurse/coordinator will advise providers of the increased incidence in the community so that they are aware of potential cases that could enter the facility.
6. Infection prevention and control nurse/coordinator or designee will complete IPC forms (*IPC-017 Infectious Disease Suspect Index Case Worksheet, IPC-018 Infectious Disease Outbreak Worksheet (contact listing, report the incident to the corporate infection prevention and control director. Upon completion of outbreak, complete IPC-019 Infectious Disease Outbreak Summary reported to the corporate infection prevention and control director )*
7. Notification: *Maintain notification list with current contact numbers*
8. Notify healthcare provider for medical diagnosis, evaluation, and treatment orders.
9. Notify the health services administrator, director of nursing, and infection prevention and control nurse/coordinator or designee
10. Notify security staff and follow facility guidelines for movement restriction, housing, and transportation
11. Notify the site or appropriate medical Director, director of nursing, and infection prevention and control coordinator
12. Notify the corporate infection prevention and control director
13. For sites with oSel program on the portal, report in oSel event type
14. Notify the health department as required by reportable disease list for the state
15. Housing
    1. The type of infection will determine housing. Refer to attachment*: Correctional Housing Containment Guide*
    2. Healthcare staff may consult the provider for housing order
    3. Cohort patients with like illness involved in an outbreak, or house in medical housing per case determination as appropriate
    4. House infectious patients in the infirmary or medical unit as determined by a healthcare provider.
    5. When housing is limited, plan of care for alternative housing must be coordinated with correctional staff or local medical centers
    6. Patients with suspected airborne or droplet infections (tuberculosis, COVID-19, chicken pox, measles) will be housed in an Airborne Infection Isolation Room (AIIR) with negative airflow. *Refer to IPC-20M Respiratory Protection: Airborne Infection Isolation Room,* and *IPC-21M, Tuberculosis Control Plan.*
16. Contact Investigation
    1. Infection prevention and control nurse/coordinator or designee will work with healthcare staff to:
17. Complete the *Infectious Disease Suspect Outbreak Worksheet (IPC-017)*
18. Coordinate care with the medical staff team
19. Consult with the corporate infection prevention and control director as necessary
20. Coordinate testing as applicable
21. Coordinate with the local health department for reporting and testing
22. Coordinate with security for exposures, education and housing restriction plan
    1. Complete a report of the outbreak as required to and notify:
    2. Department of corrections, site administration
    3. Regional medical director, health services administrator, director of nursing, infection prevention and control nurse, and corporate infection prevention and control director
23. Treatments:
24. As prescribed by the healthcare provider
25. Recommendations of
26. Provider
27. Infectious disease consultant
28. Guidelines of the state or local department of health and CDC
29. Prevention
    1. Immunizations for vaccine-preventable diseases are provided to patients per *Centurion Clinical Guidelines* for vaccinations
    2. Follow all infection prevention and control protocols to prevent transmission of diseases
    3. Training and following strict hand washing protocol
    4. Training and following disease specific precautions as indicated
30. Epidemics and Pandemics
    1. The infection prevention and control nurse/coordinator will monitor notifications by the Centers for Disease Control and the World Health Organization for events of epidemics and pandemics
    2. In the event of an epidemic or pandemic that affects the areas of the facilities, directions for screening, surveillance, treatments, and any additional training required will be provided in collaboration with the department of health and facility plans
    3. Preparation for either event will follow the department of health, the department of corrections/site facility, or the county/state recommendations for planning including the facility’s policy and training on the CDC’s use of the Strategic National Stockpile (SNS) program and any additional federal or department of health and human services as indicating

## Referenced Forms:

IPC-017 Infectious Disease Suspect Index Case Worksheet

IPC-018 Infectious Disease Outbreak Worksheet Excel

IPC-019 Infectious Disease Outbreak Summary

## References:

Communicable /Infectious Disease quick reference chart.

Pandemic Tier Preparation

Pandemic Plan

Correctional Housing Containment Guide

Meningitis Information

Shingles Management

Varicella/Chicken Pox Checklist

Zika Fact Sheet

SNS Fact Sheet

## Clinical Operations Revision Dates:

Originated 2016

Revised June 2019

Revised December 2021

# **Purpose**

To provide administrative and operational guidelines for vaccine-preventable diseases, types of vaccines, storage, and handling of vaccines, administration guidelines, and complications of vaccines.

# **Policy**

Inmates are screened at intake/receiving screening for immunization history (verbally or by health record review). Vaccinations are given according to *Centurion Clinical Guidelines* as ordered by a provider.

# **Definitions**

1. *Immunity or Immunization*: Immunization is the process whereby a person is made immune or resistant to an infectious disease by exposure or vaccination.
2. *Vaccination*: A vaccine is a product, usually an injection, of killed or live microbes that stimulate the immune system against the microbe, immunizing it against a particular disease or group of diseases (in combination vaccines such as the MMR [Measles, Mumps, Rubella]).
3. *Herd Immunity*: When a majority of a group has immunity to a disease, it decreases the chances of transmission within the group.

# **Types of Vaccines**

1. Live virus vaccines use the weakened (attenuated) form of the virus. The measles, mumps, and rubella (MMR) vaccine, varicella (chickenpox) vaccine, some influenza (nasal spray) are examples.

***Note:*** *Live vaccines are generally avoided in persons with immune deficiencies or in immunocompromised conditions*.

1. Killed (inactivated) vaccines are made from a protein or other small pieces taken from a virus or bacteria. Whooping cough (pertussis) vaccine is an example.
2. **Toxoid vaccines** contain a toxin or chemical made by the bacteria or virus. They make the person immune to the harmful effects of the infection instead of to the infection itself. Examples are diphtheria and tetanus vaccines.
3. Biosynthetic vaccines contain manmade substances that are very similar to pieces of the virus or bacteria. The Hepatitis B vaccine is an example.
4. A recombinant vaccine is a vaccine produced through recombinant DNA technology. It is done by inserting the DNA encoding into an antigen that stimulates an immune response, expressing the antigen in these cells, and purifying it.

# **Procedures**

1. Immunizations/Vaccinations
   1. Patients are screened at intake for a history of vaccine-preventable diseases and vaccination history, including but not limited to:
2. History of childhood diseases (chickenpox, measles, mumps, if known)
3. History of vaccinations (Include history of allergies and adverse reaction)
4. Year of birth
5. Military service
6. School: completed 7th grade in the United States
7. Transfer records: other correctional facilities
8. Prior incarceration records
9. Electronic databases, available in most states, or Immunization Information Systems (IIS) can provide immunization history
10. Vaccines are documented in the patient's medical record
11. Patients with limited or unknown history are referred to the provider for vaccination evaluation, according to CDC/APIC scheduled vaccine guidelines
12. Vaccine Storage and Handling (General)
    1. Proper vaccine storage and handling practices play a critical role in protecting individuals and communities from vaccine-preventable diseases.
    2. Appropriate storage is important for every link from the manufacturer, to the facility, to refrigeration, to administration – maintain a cold chain and ensure that delivery is not on a Thursday, Friday, Saturday, or Sunday
    3. Vaccine quality is the shared responsibility of everyone, from the time the vaccine is manufactured until it is administered

***Note****: For more detailed information on storage and handling recommendations and guidance for individual vaccines, please refer to the manufacturer's package inserts*

* 1. Handling errors result in:
     1. Decreased potency of the vaccine
     2. Inadequate immune responses
     3. Poor protection against disease
     4. Need to revaccinate patients
     5. Patient loss of confidence
     6. Significant financial loss
  2. If the facility participates in state immunization programs, follow their instructions for handling and storage requirements.
  3. Equipment to ensure the safety of vaccines includes but is not limited to:
     1. Stand-alone refrigerator/freezer, no compact refrigerators
     2. Refrigerator temperatures 36 ͦ F to 46 ͦ F (2 ͦ C to 8 ͦ C)
     3. Freezer temperatures -58 ͦ F to 5 ͦ F (-50 ͦ C to -15 ͦ C)
     4. Avoid crowding
     5. When possible, avoid refrigerator/freezer combinations/bar refrigerator with freezers for large amounts of vaccines
     6. A temperature monitoring system is to be utilized. Digital tracking is preferred and mandatory if the department of health provides the vaccine
     7. Document on the temperature log or print out electronic temperature report if available
     8. A power supply that is not easily tripped or switched off is to be utilized. In the event of a power outage, do not open the unit unless necessary. An uninterruptible power supply will assure continual power to the equipment
  4. Vaccine Handling

1. Transport maintaining cool temperature (refrigerator temperatures). May use cold pack with temperature monitoring, never dry ice
2. Avoid exposure to light (per recommendations)
3. Draw up vaccines only at the time of administration
4. Do not use beyond expiration date:

* The expiration date is month and year-use until the end of the expiration month
* If the date is month day and year, use it until the end of the day of that date
  1. Vaccine Disposal

1. Check with the pharmacy, The CDC recommendations for disposal guidelines, or state environmental agency and manufacturer's insert
2. General disposal guidelines:

* Expired or compromised vaccines: contact infection control nurses
* Most vaccines are not considered hazardous or pharmaceutical waste
* Leave at room temperature for 24 hours
* Empty vaccine vials
* Vaccines usually do not require disposal in a biomedical waste container

1. Vaccine Administration
   1. Before vaccine administration
2. Determine appropriate immunization history
3. Review history
4. Do not repeat if immunizations were completed but were late
5. Check state immunization database (where available)
6. Obtain provider orders per facility policy
7. Review vaccine insert for the correct dosage
8. Provide current Vaccine Information Statement (VIS) in the patient's language (available online at <http://www.cdc.gov/vaccines/hcp/vis/index.html>)
9. Complete consent for vaccination
10. Verify no history of allergic reactions to vaccines
11. Provide additional information verbally as needed
12. Keep a master copy of each VIS and make copies as needed
13. If vaccination is refused, a refusal form must be completed
    1. Vaccine administration
14. Review package insert information accompanying each vaccine and evaluate for:

* Dosage and route (subcutaneous or intramuscular)
* Precautions
* Warnings
* Contraindications
* Adverse effects
* Other relevant concerns of vaccine for each patient

1. Keep vaccines cool, not at room temperature
2. Document all vaccinations according to policy/state requirements
3. Complete all forms, including the manufacturer's lot number and expiration date
4. If a multi-dose vial is used:

* Date and initial when opened
* Do not use after 28 days, or per manufacturer's recommendation

1. Hand hygiene (before and after vaccination)
2. Where the state requires, enter into an electronic database.
3. Vaccine Adverse Reactions
4. Adverse reactions may include mild to severe allergic reactions and may vary with the type of vaccine
5. Common reactions are:
   * + 1. Tenderness, redness, itching lump, or bruise at the injection site
       2. Fever
       3. Muscle aches
       4. Temporary limitation of arm movement
       5. Headaches
       6. Fatigue
       7. Severe allergic reaction
6. Documentation of adverse reactions
7. Notify the provider immediately
8. Treat according to orders or per protocol
9. Document adverse reaction events in the patient's medical record
10. Significant adverse reactions to any vaccines are to be reported to *Vaccine Adverse Effects Reporting System* (VAERS) per CDC requirements
11. Notify the regional infection prevention and control coordinator or designee of adverse reaction
12. Vaccines administered according to facility guidelines and in compliance with CDC's APIC (Advisory Committee on Immunization Practices) list may include but are not limited to:
13. Tetanus, diphtheria (Td)
14. Tetanus, diphtheria, and pertussis (Tdap) (Pertussis is a one-time vaccine)
15. Measles, Mumps, Rubella vaccine live virus (MMR)
16. Pneumococcal vaccine (PCV13 and PPSV23)
17. Hepatitis B vaccine
18. Hepatitis A & B combination vaccine
19. Hepatitis A vaccine
20. Influenza vaccine
21. Shingles vaccine
22. HPV vaccine (may include juveniles to age 26)
23. COVID-19
24. Vaccine Information
    * 1. Review Centurion Vaccination Clinical Guidelines
      2. Immunization for vaccine-preventable diseases are provided to patients per Centurion Clinical Guidelines and contractual requirements

## Referenced Forms:

IPC-031 Vaccination Log

IPC-032 Influenza Vaccine Administration Report

IPC-033 Employee Hepatitis B Vaccine Consent or Decline Form

IPC-034 Inmate Hepatitis B Vaccine Consent or Decline Form

IPC-035 Vaccine Consent or Declination Form

IPC-036 Inactivated Influenza Vaccine Standing Order

IPC-048 Staff COVID Vaccine Documentation

## References:

Vaccine Quick Reference Sheets

Recommended Immunization Schedule for Adults Aged 19 Years or Older, US\*

Recommended Immunization Schedule for Children and Adolescent 18 Years or Younger, US\*

Centurion Clinical Guidelines for Vaccinations

List of State Electronic Immunization Systems (registration required)

Vaccine Information Statements: <http://www.cdc.gov/vaccines/hcp/vis/index.html>

Vaccine Schedules (CDC) <http://www.cdc.gov/vaccines/schedules/hcp/index.html>

*\* Updated by ACIP annually available online:* [*https://www.cdc.gov/vaccines/schedules/*](https://www.cdc.gov/vaccines/schedules/)

## Clinical Operations Revision Dates:

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Revised June 2019

Revised December 2021

1. **Purpose**

To control or prevent the spread of communicable diseases from healthcare staff to others within the workplace and to promote a healthy workplace.

1. **Policy**

Every effort will be made by healthcare staff to refrain from exposing others to contagious diseases and to protect themselves and others from the spread of disease. They will follow the procedures of *IPC-03M, Exposure Control Plan.* Staff is screened for tuberculosis and are educated in the importance of infection prevention and control including proper use of personal protective equipment, and the importance of vaccinations for immunity to vaccine-preventable diseases.

1. **Procedures**
2. Healthcare staff will following site protocol reporting when diagnosed with a contagious disease and will return to work only when released by their primary care provider. Such diseases include, but are not limited to conjunctivitis (pink eye), acute diarrhea, Group A strep throat, chicken pox, influenza or influenza type illness, and tuberculosis.
3. Healthcare staff who have exudative lesions or weeping dermatitis should refrain from all direct patient care and from handling patient-care equipment until the condition resolves. Non-latex and powder-free gloves will be readily available to healthcare staff to reduce the incidence of dermatitis.
4. Current CDC healthcare worker immunization guidelines suggest vaccinations for the following communicable diseases: Tdap (tetanus, diphtheria, pertussis), MMR (measles, mumps, and rubella), varicella (chickenpox), hepatitis A, and hepatitis B series. Centurion encourages our employees to discuss the need for these vaccinations with their primary care providers. If an occupational exposure occurs, staff will be required to provide proof of either vaccination or immunity (lab confirmation) or may be subject to vaccination or furlough based upon Public Health Department guidance at the time.
5. The CDC, the Advisory Committee on Immunization Practices (ACIP), and the Healthcare Infection Control Practices Advisory Committee (HICPAC) recommend that all U.S. healthcare workers get vaccinated annually against influenza. The Centurion Human Resources Department advises employees of the methods to access flu vaccine.
6. Staff is provided with the current Employee Handbook & Code of Business Conduct, Section VIII, *Safety, and Health*.
7. Hepatitis B vaccine series is offered to all new employees at the time or hire.
8. The employee has the right to refuse the series and must sign a declination for the vaccine. If the employee changes their mind, they can request the vaccine at any time.
9. If previously vaccinated, they should provide the year they completed the series.
10. If the series was never completed, they are offered the opportunity to complete the series
11. If the employee accepts and receives the vaccine series, they are to request a hepatitis B titer lab test (outlined in IPC-003 *Exposure Control Plan*).
12. Screening for tuberculosis
    1. Facility staff are screened as per contract.
    2. Tuberculosis (TB) screening is required for all Centurion healthcare staff at the time of employment and annually thereafter.
    3. A staff member with a positive TST initial or conversion, a positive IGRA, or exhibiting symptoms of active tuberculosis disease will not be permitted to work until appropriate clearance for work is obtained.
    4. Occupational exposure is investigated under the guidance of the local or state health department.
    5. Healthcare staff participation in tuberculosis screening and compliance with the tuberculosis control program is a condition of employment.
13. New Healthcare Staff Tuberculosis Screening:
14. All new staff are screened for symptoms of tuberculosis before assignment of duties. Any staff member exhibiting symptoms of tuberculosis at any time is promptly referred to the local health department or a private physician for evaluation and examination. Written documentation of medical clearance for work is required prior to resuming job responsibilities. The top section of the *IPC-026, Healthcare Staff Tuberculosis Screening Record*, is used to document symptom screening on the first day of employment.
15. Active tuberculosis disease in staff, either confirmed or suspected, is reported to the local or state health department. The health department recommends and facilitates any indicated follow-up and contact investigation.
16. All new staff are screened for the presence of tuberculosis infection using a two-step Tuberculin Skin Test (TST) unless new staff reports previous positive TST, previous positive tuberculosis blood test, documented history of previous treatment for latent tuberculosis infection, or active tuberculosis disease.
17. IGRA blood test for may not be used for TB screening of healthcare staff or correctional staff unless required by the contract due to handling and testing requirements and cost-benefit considerations.
18. Bacillus Calmette-Guérin (BCG) is a vaccine currently used worldwide against tuberculosis. BCG is prepared from a live attenuated strain that stimulates the immune system to protect against tuberculosis. Originally given in endemic countries to prevent the bacteria from crossing the blood/brain barrier. History of BCG vaccination is not considered when implanting and interpreting TST results
19. *IPC-026, Healthcare Staff Tuberculosis Screening Record*, (bottom section), is used to document TB testing (IGRA or TST implant and interpretation.
20. TST implant of 0.1 mL of 5 tuberculin units (TU) of purified protein derivative (PPD) and interpretation is performed by trained healthcare staff.
21. Results of the TST are interpreted within 48 to 72 hours and documented in millimeters (mm) of induration.
22. Patients are instructed not to rub, scratch or put a bandage on the injection site.
23. Evaluation of the TST includes observing and palpation of the test site. Only the induration is measured and documented. Redness without induration is not measured and is not considered a positive result.
24. A 10mm or more induration is considered a positive result for most healthcare workers in correctional settings. If immune-compromising conditions are present or the staff member has been exposed to active tuberculosis, >5mm is considered a positive result.
25. A new staff member with a 10 mm or more induration TST result from the initial tuberculosis screening is required to be assessed by the public health department or by a private physician experienced in managing active tuberculosis disease, and to receive a chest X-ray, read by a qualified radiologist or health department tuberculosis specialist, to exclude active infectious tuberculosis disease. The person is to be assessed for treatment of latent tuberculosis infection. Documentation is required from the health department or physician that the staff member is determined to be non-infectious before they may report for work.
26. If an IGRA is done and is positive, employees must follow the same procedure as for a positive TST, if not previously evaluated for tuberculosis.
27. A new staff member with TST reading of 5 to 9 mm, is informed that it is strongly encouraged that they are seen by their personal healthcare provider to evaluate for immunocompromised condition and history of exposure and to discuss test results. It is not required that the company is advised of the nature of a staff member’s condition nor the results of protected health conversations with a personal healthcare provider. Staff member must provide documentation of no active disease.
28. When the first TST is negative, a second TST is implanted in 1 to 2 weeks after the first negative TST. This two-step TST is performed at baseline to identify individuals who may have a negative reaction to the first TST but may have a “boosted” reaction to the second TST. New staff who present documentation of negative TST within the past 12 months do not require the second TST.
29. Positive TST reactions are required reporting in some states. The local health department is notified when required.
30. New staff with written documentation of previous positive TST, previous positive tuberculosis blood test, documented history of previous treatment for latent tuberculosis infection, or active tuberculosis disease do not need a repeat TST or tuberculosis blood test. The staff member is assessed for current tuberculosis symptoms using *IPC-029, Tuberculosis Annual Symptom Review, Tuberculin Skin Test Reactors, or Positive QFT-G Test.*
31. *IPC-029, Tuberculosis Annual Symptom Review: Tuberculin Skin Test Reactors or Positive QFT-G Test*, is used to document the process. Proof of a negative chest X-ray dated after a positive TST, a positive tuberculosis blood test, an initial diagnosis of latent tuberculosis infection, or a diagnosis of active tuberculosis disease is also required.
32. If the staff member has a written chest X-ray report read by a radiologist indicating no active tuberculosis disease dated after the treatment date of the positive TST or tuberculosis blood test, after the initial diagnosis and treatment of latent tuberculosis infection, or diagnosis and treatment of active tuberculosis disease, another chest X-ray is not needed at the time of hire. The chest X-ray report is attached to completed *IPC-029, Tuberculosis Annual Symptom Review, Tuberculin Skin Test Reactors, or Positive QFT-G Test,* and treatment records if indicated. This documentation is filed in the employee’s confidential Health & Safety File.
33. Achest X-ray to exclude a diagnosis of infectious tuberculosis disease must be obtained before the staff member has direct patient contact if:

* The staff member does not have written documentation of a negative chest X-ray after the date of the positive TST
* After the initial diagnosis of latent tuberculosis infection, or
* After diagnosis and treatment of active tuberculosis disease with documentation.

1. The staff member will be referred to the health department or private healthcare provider or on-site, if available from subcontracted radiology services. Negative chest X-ray report is attached to *IPC-029, Tuberculosis Annual Symptom Review, Tuberculin Skin Test Reactors, or Positive QFT-G Test* form. This documentation is filed in the employee’s confidential Health & Safety File.
2. After the baseline chest X-ray is documented, repeat X-rays are not needed unless symptoms or signs of tuberculosis disease develop, or a provider recommends a repeat chest X-ray.
3. New staff with an undocumented history of a previous positive TST or tuberculosis blood test must undergo the same screening process as new staff with a determination of the need for TST. If TST is not indicated, these staff will follow the process of new staff with a previous positive result.
4. Serial Tuberculosis Screening and Testing for Healthcare Staff
5. Annual tuberculosis screening for past positive TB test (i.e. TST reactors, or positive IGRA) is accomplished by completion of *IPC-029, Tuberculosis Annual Symptom Review, Tuberculin Skin Test Reactors or Positive QFT-G Test*.
6. TB testing for previously negative TST employees is conducted annually using one-step TST. Annual serial tuberculosis screening consists of:

* Review for current symptoms of active tuberculosis disease.
* Testing for infection by administering a tuberculin skin test (TST). Administration and interpretation are pertinent for serial screening and testing.

1. Any staff member converting from a documented negative TB test (either TST or IGRA) or have current positive symptms during annual screening. will be instructed to report to the local health department to have active tuberculosis disease ruled out by chest x-ray and to have an evaluation for chemoprophylaxis for Latent Tuberculosis Infection treatment. When no symptoms of tuberculosis are present, this evaluation should take place as soon as possible. There is no need for isolation, and the employee may continue to work when no symptoms are present. The employee must provide a statement from the community provider that an evaluation has been completed and a negative chest x-ray report must be provided.
2. If symptoms of tuberculosis are present, the evaluation must be as soon as possible; the employee is sent home and may not work until cleared by the medical provider. The local health department will notify the facility if the employee has active tuberculosis and guide needed staff follow-up. Positive TST reactions are required reporting in some states. Local or state health department is notified when required. If any employee has been exposed while at work (occupational exposure) to anyone with a known case of active tuberculosis and subsequently develops a tuberculosis infection as evidenced by a positive skin test or diagnosis by a provider, this incident must be recorded on the OSHA 300 log as detailed in *Active Tuberculosis Disease* below. Employee tuberculin screening conversions from negative to positive are documented in Infection Prevention and Control statistics and tracked for significance.
3. Annual serial tuberculosis testing may not be required based upon the facility’s risk assessment, written recommendation from the local or state health department, and written approval from the client.
4. Pregnancy

Centers for Disease Control and Prevention and the American College of Obstetricians and Gynecologist have determined that TST for pregnant and nursing staff is safe, and these staff should be included in initial and annual skin testing or a contact investigation because no contraindication for skin testing exists. If, despite these reassurances, the pregnant or nursing staff member insists on postponing the TST, she must present written documentation of results of a recent TST or the treating obstetrician’s written opinion to postpone the TST testing and documentation that the staff member does not have symptoms of tuberculosis.

1. Tuberculosis Conversion
2. A conversion occurs when an individual’s TST or tuberculosis blood test result changes from negative to positive with subsequent testing. A conversion is a TST increase of ≥10 mm in a two-year period.
3. A positive TST or tuberculosis blood test is classified as a tuberculosis conversion only after at least one negative TST or TB blood test is documented on the same individual.
4. OSHA does not require documentation of a positive TB skin test result obtained at initial employment physical on the OSHA 300 log as this exposure did not occur at this worksite.
5. Tuberculosis conversions are investigated by the facility Infection Prevention and Control Coordinator or designee and the Infection Prevention and Control Committee to determine root causes within the tuberculosis program.
6. Tuberculosis Active Disease Contact Investigation:
7. The focus of tuberculosis contact investigation is to identify contacts in the facility of an inmate, correctional/security or healthcare staff member diagnosed with active tuberculosis disease, and to provide testing and treatment for those contacts. Decisions involved in planning and prioritizing contact investigations in correctional facilities is complicated, and a multidisciplinary team is needed.
8. The local or state health department advises the healthcare staff in planning, implementing, and evaluating a tuberculosis contact investigation.
9. Staff who have occupational exposure should be notified, complete the *First Report of Injury or Illness* form, and adhere to the recommendations of the local or state health department. Correctional staff will follow the client’s policy and procedures.
10. Outbreaks, epidemics and pandemics
    1. In event of an infectious disease health crisis, including outbreaks, epidemics and pandemics staff are required to follow current corporate and facility infection prevention and control policies and guidelines
11. Education and Training
    1. Healthcare staff receive education on the infection control exposure control plan, bloodborne pathogens, and infectious diseases including tuberculosis disease, screening, isolation, and treatment during orientation and annually thereafter. Refer *to IPC-002 Infection Control Education, and IPC-003 Exposure Control Plan.*
    2. Tuberculosis(TB) screening and testing training is required for medical staff including:
       1. TB infection and disease
       2. TB symptom screening
       3. For staff performing TB testing Training includes, but limited to:
          1. Training Centurion TB power point, attend TB training onsite or by qualified outside provider (TB centers, department of health or CDC: TST <https://www.cdc.gov/tb/publications/factsheets/testing/igra.htm> IGRA <https://www.cdc.gov/tb/publications/factsheets/testing/igra.htm>)
          2. Tuberculin skin test (TST)
             1. Placing PPD solution, interpretation, and follow up
             2. Tuberculin Skin Testing training at CDC web site:
             3. Observation and verification of TST placement and interpretation by an approved trainer
          3. IGRA blood tests procedure and interpretation (CDC: <https://www.cdc.gov/tb/publications/factsheets/testing/igra.htm>
       4. Training verification is maintained in the staff member’s training file.
    3. Medical and mental health staff who provide face to face patient care or provide care in Airborne Infection Isolation Rooms (AIIRs) must complete initial, annual, and prn training on respiratory protection in accordance with OSHA recommendations. This will include training and fit testing for use of disposable NIOSH N95 face fitting particulat filtering mask (referred to as N95 mask). In event of supply limitation due to health crisis or shortage of N95 masks, additional instructions and use will follow recommended CDC guidelines.

Referenced Forms:

IPC-026 Healthcare Staff Tuberculosis Screening Record

IPC-029 Tuberculosis Annual Symptom Review: Tuberculin Skin Test Reactors

or Positive QFT-G Test

IPC-033 Employee Hepatitis B Vaccine Consent or Decline Form

Resources

CDC: Tuberculosis; <https://www.cdc.gov/tb/default.htm>

CDC: TB testing & diagnosis https://www.cdc.gov/tb/topic/testing/default.htm

CDC Occupational Exposure to Blood <https://www.cdc.gov/oralhealth/infectioncontrol/faqs/occupational-exposure.html>

OSHA: Bloodboren pathogens and Needlestick kPrevention

<https://www.osha.gov/bloodborne-pathogens>

CDC Recommended Vaccines for Healthcare workers

<https://www.cdc.gov/vaccines/adults/rec-vac/hcw.html>

Clinical Operations Revision Dates:

Originated 2016

Revised June 2019

Revised December 2021

# **Purpose**

The purpose of this policy is to provide guidance for the timely reporting of infectious/communicable diseases following facility, regional office, state, and corporate timelines.

# **Policy**

The infection prevention and control nurse/coordinator or designee, is responsible for surveillance and reporting of all infectious/communicable diseases, outbreaks, suspects and provide statistical information to evaluate trends, educations, and improvements in the infection prevention and control program.

# **Procedures**

1. Reportable diseases: Reports should be completed in the time frame set by the state of the facility for reportable diseases. Reporting should be to the local health department, or as indicated by the health department.
   1. The site is responsible for printing the reportable disease information for their county/state, posting it in the clinical areas, and placing a copy behind policy *IPC-08M Reportable Diseases.*
2. Regional reporting as directed by the regional program director or HSA.
   1. The program director/HSA is responsible for informing the infection prevention and control nurse of required reporting for their contract
3. Surveillance of infectious and communicable diseases and preventative measures should be documented on logs at least weekly to evaluate and identify trends. If there is an electronic medical record, an infectious disease report should be run at least weekly.
4. Preventative protocols and guideline information should include but not limited to:
   1. Vaccines given for the month.
   2. Tuberculosis screening information (number of tests done, number of positives, number or chest x-rays, new diagnoses of LTBI (latent TB infection), number of patients on medication, number of active cases during the month, etc.
5. Education of current or trending disease or concerns to the facility.
6. Number of hepatitis B patients, and number of patients on treatment.
7. Number of hepatitis C patients, the number of patients receiving treatment, and the number of patients who have completed treatment.
8. Statistical information will be included in the health services report.
9. Other information as required.
10. Corporate reporting:
11. Corporate monthly infection control statistical data can be reported on the corporate monthly infection control log. (IPC-003. Reporting is mandatory is is due by the 5th of each month
12. Statistical and specific disease reporting
13. Any patient that is a suspect or diagnosed active TB disease.
14. Any patient placed in infectious disease isolation
15. Any Outbreak with updates and information regarding contact investigation
16. IPC-017 Infectious Disease Suspected
17. IPC-018 Infectious Disease Outbreak Worksheet
18. Report outbreaks on portal oSel program (event type: PCDO –potential communicable disease outbreak; or AT-Active TB)
19. Special Reporting (contact corporate infection control coordinator within 24 hours.)
20. Correspondence and notification by email, and report on oSel (on portal)
21. Urgent or emergent infection control concerns by phone followed up with information by email
22. Additional reporting as needed or requested for specific concerns
23. Infection Control Committee meeting: report pertinent activities, statistics outbreaks, contact investigations, and education
24. CQI report: as required per CQI schedule
25. Annual evaluation:
26. The annual report should include but not limited to a summary of statistics, outbreaks, concerns, trends, accomplishments, challenges, and goals for the next year.

## Referenced Forms:

IPC-003 Infectious Disease Monthly Report

IPC-017 – 019 Infectious Disease Suspected, Outbreak, and Summary

## References:

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## Clinical Operations Revision Dates:

Originated 2016

Revised June 2019

Revised December 2021

# **Purpose**

To identify and reduce the risk of transmission of skin and soft tissue infections (SSTIs), including Methicillin-Resistant Staphylococcus Aureus (MRSA).

# **Policy**

Specialty services provided on site will vary at sites. All specialty services are responsible for following standard precautions and specific infection control practices as governed by the specialty and outlined in their specific manual or contractor provided information addressing infection prevention and control.

# **Definitions**

Specialty services provided on site will vary at sites. All specialty services are responsible for following standard precautions and specific infection control practices as governed by the specialty and outlined in their specific manual or contractor provided information addressing infection prevention and control.

# **Procedures**

1. Specialty services that may be provided on site may include but not limited to:
   1. Dental Services
      1. Infection prevention and control is addressed in the Dental Provider Reference Manual Chapter 12: *Infection Prevention and Control*
   2. *Telehealth*
      1. Infection prevention and control is addressed in the Telehealth Manual Section 4.4 Infection Control
   3. Dialysis
      1. Dialysis follows current infection prevention and control standards of practice for dialysis provided by the contracted company or dialysis manual
   4. Opioid Treatment Programs (OTP)
      1. All aspects of the standard are addressed by written policy and defined procedures in the Centurion Infection Prevention and Control Manual and the OPT manual.
      2. The program follows Centurion written exposure control plan that is approved by the responsible physician. IPC-03M, and the plan is reviewed and updated annually.
      3. The program sponsor ensures that:
   * Appropriate equipment and instruments are decontaminated
   * Sharps and biohazardous wastes are disposed of properly
   * Surveillance to detect inmates with serious infectious and communicable disease (e.g., skin infections) is effective
   * Immunizations to prevent disease are provided when appropriate
   * Infected patients receive medically indicated care
   * If appropriate, patients with contagious diseases are medically isolated
   * Standard precautions are always used by health care practitioners to minimize the risk of exposure to blood and body fluids of infected patients.
   * All sanitation workers are trained in appropriate methods for handling and disposing of biohazardous materials and spills.
   * The program assures that inmates who are released with communicable or infectious diseases are given community referrals.
   * The program completes and files all reports as required by local, state, and federal laws and regulations.
   * A monthly environmental inspection is conducted of areas where OTP services are provided to verify that:

* Equipment is inspected and maintained
* The unit is clean and sanitary
* Measures are taken to ensure the unit is occupationally and environmentally safe.

## References:

Centurion Infection Prevention and Control Manual

Centurion Dental Provider Reference Manual

Centurion Opioid Treatment Program

## Clinical Operations Revision Dates:

Originated January 2022