Infection Prevention and Control for the Medical Staff

Carondelet Health Network (CHN) depends upon you, as a member of the medical staff, to understand and practice our evidence-based policies to prevent healthcare-associated infections (HAI’s).

1. CHN complies with The Joint Commission National Patient Safety Goals
   - Hand Hygiene: We follow guidelines from the Centers for Disease Control and Prevention (CDC) to monitor and improve hand cleaning. We monitor compliance with hand hygiene before and after contact with a patient or patient environment and initiate campaigns to improve compliance. Hands must always be disinfected prior to and after any patient encounter whether patient contact has occurred or not.
   - Infections: We use proven guidelines to prevent infections including Central Line Associated Blood Stream Infections (CLABSI), Catheter Associated Urinary Tract Infections (CAUTI), Surgical Site Infections (SSI) and difficult to treat infections. Carondelet Health Network uses insertion kits and evidence-based bundles to reduce device related infections. We support daily evaluation of device necessity and prompt removal. Strategies to reduce surgical site infections include pre-operative bathing and surgical skin prep with chlorhexidine gluconate, weight-based antibiotics and only allowing essential staff to minimize traffic in the surgery suites.

2. Standard Precautions for All Patients
   Any patient could have an undiagnosed communicable disease. Standard Precautions are used for all patients all of the time and include:
   - Hand Hygiene before and after contact with the patient or the patient’s environment, even if you have worn gloves. You may use alcohol-based hand sanitizer or soap and water. If your hands are visibly soiled, or if the patient has known or suspected Clostridium difficile, use soap and water instead of alcohol-based hand sanitizer.
   - Use appropriate Personal Protective Equipment (PPE) anytime you anticipate contact with blood or body fluids. PPE includes gowns, gloves, goggles, face shields, masks, and N95 respirators.
   - Cleaning/Disinfection of the environment and equipment including personal devices such as stethoscopes, cell phones and tablets.
   - Respiratory Etiquette (covering your/your patient’s cough)
   - Sharps Safety
   - Safe Injection Practices (one syringe, one needle, used one time only)
   - Use of masks when accessing spinal or epidural spaces via lumbar puncture (e.g., myelogram, spinal or epidural anesthesia).

3. Transmission-Based Precautions (Isolation)
   In accordance with CDC recommendations, wear PPE, as indicated on the isolation sign, anytime you enter an isolation room, even if you do not plan to examine the patient or touch anything. There are three types of transmission-based precautions:

   A. Contact Precautions is used for infection/colonization that is transmitted by direct or indirect contact such as multi-drug resistant organisms (MDRO), infectious diarrhea such as Norovirus, Respiratory Syncytial Virus, uncontained draining wounds, scabies or lice. Wear a disposable gown and gloves when entering a Contact/Special Contact Isolation room. A patient with a history of a multi-drug resistant infection or colonization is isolated until cleared with negative cultures - see below. Clostridium difficile and Norovirus requires “Special Contact” Precautions and soap and water for hand hygiene to remove the spores. Suspected cases should also be placed on Special Contact Precautions pending laboratory testing.
B. Airborne Infection Isolation is used if you know or suspect the patient has a communicable disease that is transmitted through small droplets that travel on normal air currents including *Mycobacterium tuberculosis*, active disseminated *Varicella zoster* (shingles), *Rubeola* (measles), Severe Acute Respiratory Syndrome (SARS), Middle East Respiratory Syndrome Coronavirus (MERS-CoV) and Avian Influenza. Wear a disposable N95 respirator in an airborne isolation room. Contact Associate Health and Wellness if you have not been fit-tested for the most appropriate size respirator. Dispose of the respirator after use. In an emergency situation, if you have not been fitted for a respirator, please contact the facility’s Safety Officer to obtain a battery-operated Positive Air Pressure Respirator (PAPR).

C. Droplet Precautions are used when you know or suspect an infection that is transmitted through heavy droplets that are released through coughing, sneezing, talking, suctioning including pertussis, influenza, and bacterial meningitis caused by *Neisseria meningitidis* or *Haemophilus influenza*. Wear a disposable paper surgical mask in a droplet isolation room.

Some conditions require combining the isolation precautions listed above. Follow the instructions listed on the signs regarding required PPE and hand hygiene.

4. Active Surveillance Cultures
Surveillance cultures help us determine which patients need to be placed in isolation to reduce the risk of MDRO transmission. All intensive care admissions have a surveillance culture for Methicillin Resistant *Staphylococcus aureus* (MRSA) as part of the admission protocol. Additional physician orders for cultures should be obtained for patients that meet high risk criteria:

<table>
<thead>
<tr>
<th>Multidrug-Resistant Organism</th>
<th>High Risk Patients: Order specimen/culture</th>
<th>Source</th>
</tr>
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</table>
| Methicillin Resistant *Staphylococcus aureus* (MRSA) | Any of the following:  
- History of MRSA (infection or colonization) per report or as noted on Cerner banner/ problem list  
- Transfer from Long Term Care (LTC) or Long Term Acute Care (LTAC)  
- Skin or soft tissue infection on admission  
- HIV infection  
- Injection Drug Use  
- Homeless  
- Crowded living conditions including shelter or corrections facility  
- Hemodialysis recipient | Nares  
Original infection site (urine, sputum or unhealed wounds) if patient has known history |
| Vancomycin Resistant Enterococcus (VRE)  
Extended Spectrum Beta Lactamase producing Organism (ESBL)  
Carbapenem Resistant Enterobacteriaceae CRE | Either of the following:  
- Previous history of the organism per patient report or as indicated on the Cerner banner or problem list  
- Transfer from a Long-Term Acute Care (LTAC) facility | Rectal swab  
Original infection site (urine, sputum or unhealed wounds) if patient has known history |
| *Clostridium difficile* | Acute diarrhea with 2 or more stools within 12 hours AND any of the following:  
- History of *C. difficile*  
- Antibiotic use within past 6 months  
- Hospitalization, acute or LTC, within past year | Stool, unformed |
Surveillance cultures are also used to clear patients from isolation. A patient with a history of an MDRO can be re-cultured to remove from isolation if the last positive culture was ≥ six months ago and the patient has been off antibiotics for at least one week. (The exception is CRE. The patient can be re-cultured if the last positive culture was ≥ one year and the patient has been off antibiotics for at least one week) The patient is considered “cleared” from isolation if the surveillance culture is negative AND the original site (urine, sputum or unhealed wound) is negative. For MRSA, the surveillance site is the nares. For other MDROs such VRE, ESBL and CRE, the surveillance site is the rectum.

Patients with confirmed *Clostridium difficile* should remain in Special Contact isolation for the duration of their hospitalization including inpatient Rehabilitation. Repeat stool testing for cure is not recommended. Contact Infection Prevention if the patient is expected to have an extended admission and is asymptomatic following treatment.

Reference the Infection Prevention and Control Transmission-Based Precaution Policy found on the Carondelet Intranet (Iconnect) for more information about MDROs and isolation/removal of isolation for other conditions such as tuberculosis, varicella zoster, meningitis.

**5. Exposures**

Notify Infection Prevention and Control immediately if you or others were exposed to a patient with a communicable disease. Infection Prevention and Control works closely with Associate Health and Wellness, our Laboratories and our Health Departments to confirm or rule out exposures, and to conduct follow-up with all associates, physicians or patients who may have been exposed. Report any sharps injury or body fluid splash to Associate Health and Wellness.

**6. Reportable Diseases**

Reference the enclosed chart for diseases that must be reported to the Health Department. Please alert Infection Prevention and Control if any of your patients have a communicable disease that requires reporting within 24 hours.

**7. Immunizations**

Associate Health and Wellness provides Influenza, Hepatitis B, Measles, Mumps, Rubella and Varicella vaccines, as well as annual TB skin testing.

**8. Influenza Prevention**

Annual influenza vaccination is required for all medical staff and Carondelet associates since a person can be communicable 1-2 days before becoming symptomatic with the flu. The flu can cause mild to severe illness, and at times can lead to death. Older people, young children, and people with certain health conditions are at high risk for serious flu complications. The virus is spread by droplets when people with flu cough, sneeze or talk or by touching a surface or object that has flu virus on it and then touching their own mouth or nose. Free flu vaccines are administered through Associate Health and Wellness beginning in fall of each year.

**Infection Prevention and Control Contact Information**

St. Joseph’s Hospital
Office: 873-6574
St. Mary’s Hospital and Holy Cross Hospital: Office: 872-1433

After hours, contact the Clinical Supervisor. Additional information can be found on the intranet and in the Infection Control manual.
<table>
<thead>
<tr>
<th>Clinical Syndrome or Condition</th>
<th>Potential Pathogens</th>
<th>Standard + Empiric Precautions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute diarrhea with a likely infectious cause in an incontinent or diapered patient</td>
<td>Enteric pathogens</td>
<td>Special Contact Precautions</td>
</tr>
<tr>
<td>Diarrhea in an adult with a history of recent antibiotic use</td>
<td><em>Clostridium difficile</em></td>
<td>Special Contact Precautions - private room or if confirmed cohort with same</td>
</tr>
<tr>
<td>Meningitis</td>
<td><em>Neisseria meningitidis</em></td>
<td>• Droplet - mask and face protection&lt;br&gt;• Contact for infants and children</td>
</tr>
<tr>
<td>• Petechial/ecchymotic rash &amp; fever&lt;br&gt;• Vesicular rash&lt;br&gt;• Maculopapular rash with coryza and fever</td>
<td>• Neisseria meningitidis&lt;br&gt;• <em>Varicella/Smallpox</em>&lt;br&gt;• <em>Rubeola</em> (measles)</td>
<td>• Droplet&lt;br&gt;• Airborne &amp; Contact&lt;br&gt;• Airborne Infection Isolation</td>
</tr>
<tr>
<td>Cough/fever/upper lobe pulmonary infiltrate in an HIV-negative patient or a patient at low risk for HIV infection</td>
<td>• <em>Mycobacterium tuberculosis</em>&lt;br&gt;• Possible SARS (Severe Acute Respiratory Syndrome)&lt;br&gt;• MERS-CoV (Middle East Respiratory Syndrome Coronavirus)&lt;br&gt;• Avian Flu</td>
<td>• Airborne Infection Isolation;&lt;br&gt;• Add Contact Precaution plus eye protection if history of SARS, MERS Avian Flu exposure, travel history to CDC identified countries</td>
</tr>
<tr>
<td>Cough/fever/pulmonary infiltrate in any lung location in an HIV-infected patient or a patient at high risk for HIV infection</td>
<td><em>Mycobacterium tuberculosis</em></td>
<td>Airborne Infection Isolation</td>
</tr>
<tr>
<td>Paroxysmal or severe persistent cough in period of pertussis activity</td>
<td><em>Bordetella pertussis</em></td>
<td>Droplet Precautions</td>
</tr>
<tr>
<td>• Bronchiolitis and croup, in infants and young children&lt;br&gt;• Fever &gt;100.5, travel history, atypical pneumonia on chest x-ray&lt;br&gt;• Fever &gt;100.5, headache, myalgia, cough, fatigue</td>
<td>• Respiratory syncytial or parainfluenza virus&lt;br&gt;• SARS/MERS-CoV&lt;br&gt;• Influenza</td>
<td>• Contact plus Droplet&lt;br&gt;• Airborne &amp; Contact with eye shield protection&lt;br&gt;• Droplet</td>
</tr>
<tr>
<td>History of infection or colonization with multi-drug resistant organisms</td>
<td>Resistant bacteria</td>
<td>Contact</td>
</tr>
<tr>
<td>Skin, wound, or urinary tract infection in a patient with a recent hospital or nursing home stay in a facility where multi-drug resistant organisms are prevalent</td>
<td>Resistant bacteria</td>
<td>Contact</td>
</tr>
<tr>
<td>Abscess or draining wound that cannot be covered/contained</td>
<td><em>Staphylococcus aureus</em>, <em>Group A Streptococcus</em></td>
<td>Contact</td>
</tr>
</tbody>
</table>
Arizona Administrative Code requires providers to:

Report Communicable Diseases to the Local Health Department

- Amoebiasis
- Anthrax
- Aseptic meningitis: viral
- Bacterial meningitis
- Botulism
- Brucellosis
- Campylobacteriosis
- Chagas disease (American trypanosomiasis)
- Chancroid
- Chlamydia infection, sexually transmitted
- Cholera
- Coccidioidomycosis (valley fever)
- Colorado tick fever
- Conjunctivitis: acute
- Creutzfeldt-Jakob disease
- Cryptosporidiosis
- Cyclospora infection
- Cysticercosis
- Dengue
- Diarrhea, nausea, or vomiting
- Diphtheria
- Ehrlichiosis and Anaplasmosis
- Emerging or exotic disease
- Encapsulated, viral or parasitic
- Enterohemorrhagic Escherichia coli
- Enterotoxigenic Escherichia coli
- Giardiasis
- Gonorrhea
- Hemophillus influenzae: invasive disease
- Hansen's disease (Leprosy)
- Hepatitis A
- Hepatitis B and D
- Hepatitis C
- Hepatitis E
- Herpes genitalis
- HIV infection and related disease
- Influenza-associated mortality in a child
- Kawasaki syndrome
- Legionellosis (Legionnaires' disease)
- Leprosy
- Lassa fever
- Lyme disease
- Lymphocytic choriomeningitis
- Malaria
- Measles (rubeola)
- Meningococcal invasive disease
- Mumps
- Pertussis (whooping cough)
- Plague
- Poliomyelitis
- Pneumonia (omnibus)
- Q fever
- Rabies in a human
- Relapsing fever (borreliosis)
- Rheumatic fever
- Rocky Mountain spotted fever
- Rubella (German measles)
- Rubella syndrome, congenital
- Salmonellosis
- Scarlet fever
- Severe acute respiratory syndrome
- Shigellosis
- Smallpox
- Streptococcal group A: invasive disease
- Streptococcal group B: invasive disease in infants younger than 90 days of age
- Streptococcus pneumoniae (pneumococcal invasive disease)
- Syphilis
- Tetanus
- Toxic shock syndrome
- Trichinosis
- Tuberculosis, active disease
- Tuberculosis latent infection in a child 5 years of age or younger (positive screening test result)
- Typhoid fever
- Typhus fever
- Unexplained death with a history of fever
- Vaccinia-related adverse event
- Vancomycin-resistant or Vancomycin-intermediate Staphylococcus aureus
- Vancomycin-resistant Staphylococcus epidermidis
- Varicella (chickenpox)
- Vibrio infection
- Viral hemorrhagic fever
- West Nile virus infection
- Yellow fever
- Yersiniosis

Submit a report by telephone or through an electronic reporting system authorized by the Department within 24 hours after a case or suspect case is diagnosed, treated, or detected if an occurrence is detected.

* If a case or suspect case is a food handler or works in a child care establishment or a health care institution, instead of reporting within the general reporting deadline, submit a report within 24 hours after the case or suspect case is diagnosed, treated, or detected.

Submit a report within five working days after a case or suspect case is diagnosed, treated, or detected.

Submit a report within 24 hours after detecting an outbreak.

http://www.azdhs.gov/phs/oids/reporting/providers.htm

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