



**Southern Health
Partners**
Your Partner In Affordable Inmate Healthcare

Infection Control Treatment & Prevention Guidelines Health & Safety Guidelines

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Effective: 4/97; Revised 5/02; Updated 5/05; Updated 6/08; Updated 4/2010; Updated 8/2012; Updated 8/2014

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Infection Control Treatment and Prevention Guidelines – Southern Health Partners, Inc.

SHP 000125



ACKNOWLEDGEMENT

I acknowledge I have received, read, and reviewed Southern Health Partners, Inc. Infection Control Program Policies and Procedures. I understand it is my responsibility to discuss any questions I may have about these policies and procedures with my supervisor.

I understand the contents are not to be reproduced and/or given to anyone not employed by Southern Health Partners unless prior approval is obtained from the SHP Vice President of Operations, or SHP Chief of Operations.

Medical Team Administrator

Physician or Physician Provider

Date: _____

Date: _____

Employee Name/Signature/Date: _____

Employee Name/Signature/Date: _____

Employee Name/Signature/Date: _____

Employee Name/Signature/Date: _____

Employee Name/Signature/Date: _____

Employee Name/Signature/Date: _____

Employee Name/Signature/Date: _____

Note to SHP MTA: This signature page must be kept with the Infection Control Manual. Further, this manual is to be reviewed annually and therefore new signatures obtained indicating all staff have reviewed the manual.

Infection Control Treatment & Prevention Guidelines Health & Safety Guidelines

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Southern Health Partners, Inc. is committed to providing a safe and healthful work environment for our entire staff. In pursuit of this endeavor, the following guidelines are provided to eliminate or minimize occupational exposure to infection and bloodborne pathogens in accordance with OSHA standard “Occupational Exposure to Bloodborne Pathogens” (29 CFR 1910.1030). Additionally, these guidelines develop effective measures to identify high risk patients, prevent and control infectious processes, and identify employee safety precautions. Under these guidelines the safety of patients, employees, and county employees can be assured.

Classification of high risk patients includes the following criteria:

1. Any patient with a history of infectious disease such as hepatitis;
2. Renal failure patients on hemodialysis;
3. Sexually active people with multiple partners, including bi-sexuals and homosexuals;
4. Patients with known existing infections (wounds, bone, etc.);
5. I.V. drug abusers.

TERMINOLOGY:

AIDS – Acquired Immune Deficiency Syndrome. Disease caused when HIV damages the immune system, leaving the person open to kinds of infections other people rarely get or fight off easily.

Airborne transmission – occurs by dissemination of either small-particle residue which remains suspended in the air for long periods of time, or dust particles containing an infectious agent.

Bloodborne – Viruses or diseases spread by contact with blood.

Carrier – A person who can spread HIV or HBV.

Centers for Disease Control and Prevention (CDC) – US agency tracking the spread of diseases. Part of the US Department of Health and Human Services.

Chronic – Refers to a disease/condition showing little change or of slow progression.

Contaminate – to make impure or dirty.

Exposure – Contact with blood, body fluids or tissues in a way that could allow the Hepatitis B virus, Hepatitis C, or the virus that causes AIDS to get into the body.

Germicide – A material that is used to kill germs.

Infectious – Capable of transmitting infection.

Mucous Membranes – The tissue that lines the eyes, nose, and mouth.

Sharp Instruments – Needles, instruments, and other objects sharp enough to puncture or cut human skin.



Universal Precautions – The CDC defines Universal Precautions as "a set of precautions designed to prevent transmission of HIV, hepatitis B virus (HBV), and other bloodborne pathogens when providing first aid or health care. Under universal precautions, blood and certain body fluids of all patients are considered potentially infectious for HIV, HBV and other bloodborne pathogens.

COMMUNICABLE DISEASES

Taber's defines communicable disease as "a disease which can be transmitted directly or indirectly from one individual to another."

Exposure may be:

1. Airborne;
2. Direct contact with body secretions (blood, saliva, perspiration, urine, etc.);
3. Contaminated needle sticks.

Treatment:

1. (See specific condition/disease in Provider's Protocols);
2. Report to your Medical Team Administrator and the corporate office HR and/or Risk Mgmt department; if an airborne infectious disease, report to the local health department as well.
3. Document the incident and any & all treatment methods used at the time of the incident.
4. Review and follow the Needlestick Protocol (attached) for all exposure puncture wounds, broken skin, mucous membrane contact with blood or other possibly infectious fluids.

Prevention:

1. Prevention is the most important measure; be aware of your task at hand.
2. Use good hand-washing techniques;
3. Use gloves when handling blood, body secretions, and or other potentially infectious materials. For example, gloves must be worn when changing a dressing and when cleaning up and decontaminating a blood spill. Gloves must also be worn when drawing blood or performing any other invasive procedure. You should wear gloves during patient contact if you or the patient has sores, skin rashes, broken skin, bleeding, or open wounds.
4. Clean equipment properly and as directed by equipment instructions;
5. Dispose of contaminated supplies and equipment properly in established containers;
6. Cover existing wounds on self and patient prior to treatment methods.

EXPOSURES / INCIDENTS INVOLVING INMATES

At times, inmate patients may be faced with exposures and/or incidents involving exposure.

As a reminder, for bloodborne infections, the mode of transmission are needlesticks/sharing of drug user needles; contact with blood or body fluids at the site of an open wound; cut or broken skin and exposure to mucous membranes, and sexual contact. You do NOT contract HIV, HBV, or HCV from casual or environmental contact such as shaking hands, using telephones, toilet seats, drinking fountains, or donating blood.

For inmate patients whom you suspect have an infectious disease, either due to history, receiving screening information, or sick call information presented by the patient, refer to your Medical Director for testing. For any suspected airborne infectious disease, use proper precautions such as isolation, wearing of masks, etc. Make sure you alert the Jail Administrator as well, so any contact with this patient is properly

contained.

For post exposure response and medical evaluation, wash the exposed area immediately. Consult with your Medical Director as to any medical treatment necessary. Testing may be ordered and therefore blood can be drawn to be used as a baseline. Follow up testing will then determine if transmission of any agents has occurred. Whenever feasible and permitted by law, the source individual's blood will be tested to determine if there is infection. If medically indicated, the exposed individual is entitled to post exposure prophylaxis (2 hour window in most cases). Medical counseling about the risk of infection and risk of infection others may be needed, depending upon the exposure. This can be set up through the local health department.

An inmate may refuse treatment of a blood-borne injury and any post blood-borne exposure treatment, but all such refusals must be made in writing and witnessed by the medical staff. The refusal should then be communicated to the Medical Director so the inmate can be once again properly alerted as to possible effect of such refusal. If the patient from whom the exposure occurred refuses to submit to blood tests identifying the presence of blood-borne diseases, such refusal should be documented and communicated to the Medical Director as well. Testing will still be performed on the inmate in accordance with a private physician's order. **NOTE: For an airborne infectious disease (i.e. TB), a patient cannot refuse treatment. If they do, they must be placed in isolation and the Health Department alerted.**

CADAVER AND MORGUE TRANSFERS

All expired patients should be handled wearing gloves. Disaster bags should be used for long-term expired patients. Gloves, mask and other appropriate gear should be used as indicated by existing conditions.

Upon completion of transfer to the morgue, the unit and/or cell area should be thoroughly cleaned using universal precautions during the cleaning process.

PATIENT PLACEMENT – AIRBORNE INFECTIOUS DISEASE

Standard precautions eliminate the need to routinely place patients in private rooms for infection control purposes. However, under certain circumstances a private room may be required for infection control purposes. A private room is necessary if a patient:

1. Has an infection that is transmitted in whole or in part by the airborne or droplet routes. These patients should be placed on Airborne Precautions and given a private negative pressure room or a private room, respectively. **NOTE:** Notify the local County Health Department as to the identification of the airborne infectious disease (TB, etc.). Should a patient test positive through a PPD Test, a confirmation chest x-ray must be performed within 24-48 hours. During the time period prior to confirmation, patient should be placed in private area with use of a paper medical facemask.
2. Produces body fluids or bloody drainage that is large in quantity and/or cannot be properly contained by the patient or by personnel. Such patients may include, but are not necessarily limited to, persons with profuse bleeding or persons who are grossly incontinent. When environmental contamination by blood or body substances is considered likely to occur, a private room is indicated.
3. Has very poor personal hygiene. This includes patients who are unwilling to wash thoroughly after touching infective materials; contaminate the environment with potentially infectious materials; and/or share contaminated articles with other patients.



REPORTING OF COMMUNICABLE/INFECTIOUS DISEASES TO COUNTY HEALTH DEPARTMENT

The following reportable diseases must be reported to the local Health Department as required by law as soon as diagnosis is confirmed. Be prepared to provide information on diagnosis confirmation, patient data, treatment and known contacts if requested. The Health Department may be able to provide treatment plans, and or medication for the disease on an on-going basis, and therefore will need to be notified of any discharge plans for the patient as well. Patients may be placed under court order to comply with treatment as established by the Health Department.

Note: This list is not all inclusive. Please check with your local Health Department for additional reporting criterias, conditions, diseases, etc.

Acquired Immune Deficiency Syndrome (AIDS)	
Anthrax*	Leprosy, Hanson's Disease
Botulism*	Listeriosis
Brucellosis	Lyme disease
Campylobacteriosis	Malaria
Chlamydial Infection, including chlamydial pelvic inflammatory disease, pneumonia, conjunctivitis, cervicitis, and urethritis	Measles* Neisseria meningitidis, invasive disease* Mucopurulent cervicitis (MPC)
Cholera*	Mumps*
Coccidioidomycosis	Non-gonococcal urethritis (NGU)
Cyclospora Infection	Pelvic inflammatory disease (PID), unspecified
Cryptosporidiosis	Pertussis*
Diphtheria*	Plague*
Ehrlichiosis	Pneumocystis pneumonia
Encephalitis, arboviral only*	Poliomyelitis*
Escherichia coli 0157 Infection and other shiga toxin producing E-coli	Psittacosis Rabies in humans or animals*
Food Poisoning*	Rocky mountain spotted fever
Giardiasis	Rubella*, including congenital rubella syndrome
Gonorrhea, including gonococcal ophthalmia neonatorum, pelvic inflammatory disease (PID), and disseminated gonococcal disease	Salmonellosis Shigellosis Syphilis, including congenital syphilis syndrome
Haemophilus influenzae, invasive disease*	Tetanus
Hantavirus pulmonary syndrome*	Toxic shock syndrome(TSS) (streptococcal or staphylococcal)
Hemolytic uremic syndrome	Trichinosis
Hepatitis, Viral: A*, B., E, G	Tuberculosis disease*
Hepatitis, viral,; positive B surface antigen in a pregnant woman	Tuberculosis infection *
Human Immunodeficiency Virus (not name identified)	Typhoid fever*
Invasive group A/B Streptococcus Disease	Typhus fever
Legionellosis	Yersiniosis
	Unusual occurrence or cluster of illness which may post a threat to the public's health*

DISINFECTING THE INFIRMARY

Isolation cells should be cleaned after each use. Use only freshly prepared concentration of 1:10 dilution of bleach when necessary, i.e., hepatitis, AIDS, etc. (Do not use a stronger concentration). Avoid fumes, and use only in well ventilated area. Personnel should use universal precautions when cleaning the cells.

Change contaminated needle bottles as needed. Removal of all medical waste materials will be handled by an authorized disposal services such as Stericycle, Inc. on a regular basis.

Post unit cleaning (use universal precautions – i.e. wear gloves, etc.):

1. Clean work area after each shift;
2. Clean contaminated areas with soap and water, then use appropriate disinfectant;
3. Do not leave soiled or bloody materials in the Unit at any time;
4. All equipment and exam tables will be cleaned with bleach and water on a weekly basis and as needed.

Items designated for single use (disposable) should not be re-used (oxygen mask, suction catheters, etc.). Needles and syringes should be disposed of in rigid, puncture resistant containers.

Needles used should not be recapped, since accidental needle punctures may occur. The entire syringe and needle should be disposed of in the designated medical waste container.

Under no circumstances are needles to be stuck in upholstery or stretcher padding.

All disposable items should be discarded in the proper areas in the infirmary. Contaminated (as opposed to soiled) disposable items, should be placed in a plastic bag and labeled “contaminated.” These bags must be designated as Medical Waste Removal areas. Removal will be in accordance with Disposing of Medical Waste later in this manual.

DECONTAMINATION PROCEDURES/HOUSEKEEPING ISSUES:

Special precautions and techniques must be used to decontaminate areas, instruments, and equipment. Proper clean up of spills can help to protect yourself and others from exposure. Hand washing should be performed just prior to the start of cleaning procedures; following the contamination of the hands by blood or body substances; after wearing gloves; and, after completing cleaning activities. Always wear gloves, gown, and protective eyewear for this type of clean up.

1. Wipe up the spill/area with a disposable towel;
2. Carefully dispose of the contaminated towel;
3. Apply a germicide or bleach mixed with water until the surface is glistening wet. Keep it moist for at least 5 to 10 minutes, allowing for several “cleanings”.
4. Allow the surface to air dry completely.
5. Dispose of all gloves, gowns, and protective eyewear in designated medical waste containers.

Instruments soiled with infectious materials should be handled carefully and cleaned and sterilized in the established manner. Usually an ultrasonic cleaner is used to remove solid particles, and an autoclave is

used for sterilization. Be sure to maintain the effectiveness of the equipment and to follow the manufacturer's recommendations for sterilization.

STERILIZATION – INSTRUCTION AND GUIDELINES

Autoclaves

Instruments which are not heat sensitive can be sterilized reliably by steam under pressure using autoclaves. Please observe the followings when using autoclaves:

Autoclaves must be located in treatment rooms away from traffic and they must not discharge steam/vapor into waiting area. Autoclaves must be operated only by staff who has been adequately instructed in their use. Traditional table top autoclaves (gravity displacement) without vacuum extraction cycle are intended for used to sterilize solid unwrapped instruments and devices. They should be properly loaded so that surfaces of all instruments are accessible and exposed to the steam. Unwrapped instruments must be sterilized and used at point of care. Hollow and lumen devices, porous loads such as dressings and towels and wrapped instruments, should be placed in sterilization drums and sent to the designated central sterilization centers.

Instruments can be sterilized in autoclave under the following minimal conditions:

- at a temperature of 121C for 15 min. holding time,
- at 132C for 4 min. holding time or at
- 134C for 3 min. holding time.
- Instruments should be removed from the autoclave when a cycle is completed. They should be placed on a trolley laid with sterile paper/cloth and covered with a sterile paper/cloth and used within a session.
- Persons operating the autoclave should record for each cycle the readings on the autoclave gauges in a log book specifically kept for this purpose. The temperature and pressure should be within the ranges specified.
- Water in the filter of the autoclaves should be changed weekly or as recommended by the MTA
- Autoclaves must be checked monthly with spore vials placed on the bottom shelf in the area above the chamber drain. The results of spore test should be entered into the record log.
- In case of unsatisfactory spore test result, the Regional should be notified.
- Autoclave should only be reused when spore test indicates satisfactory performance.
- Autoclaves should be serviced regularly at yearly intervals and as necessary.

Sending drums

- - Items in drums should be loosely packed.
 - The drum should be closed properly and with the autoclaving tape placed on it.
 - Close the valves of the drum during transport to sterilization center.
 - All valves of the drum should be open before autoclaving.
 - Valves of drum should be closed after autoclaving process.
 - Check for the color change of the autoclaving tape.
 - Place the drum in a clean and dry place.
- Shelf-life of sterilized items



- The “shelf-life” of sterilized wrapped items from central sterilization center is suggested as follows:
 - Single wrapped sterilized items to be used within 2 weeks.
 - Double wrapped sterilized items to be used within 4 weeks.
 - Single wrapped sterilized items kept in unopened drum to be used within 4 weeks.
 - Double wrapped sterilized items kept in sealed plastic bag to be used within 3 months.
 - Expiry date should be written on top of every item.
 - Sterilized items should be stored preferably in an enclosed and well-ventilated area to provide protection against dust, moisture, and temperature and humidity extremes.
- Maintain an effective stock management system so that sterile items are used before expired
- Instrument must be re-sterilized before use if it is expired or if there is sign of damage of the package.

Hot air ovens

Instruments and materials which are heat stable and which cannot be sterilized by steam because of deleterious effects or failure to penetrate could be sterilized by the use of hot air ovens. The transfer of heat by air is less efficient than by steam. Hot air ovens use higher temperature and longer times to sterilize than do autoclaves.

When using hot air ovens, please observe the following:

- Hot air ovens must be located in a suitable area away from traffic.
- Hot air ovens must be operated only by staff who has been adequately instructed in their use.
- Non-perforated closed containers such as solid metal trays could be used in hot air ovens.
- Load should be packed in such a way that sufficient space remains between articles to allow hot air circulation.
- Instruments and materials can be sterilized in a hot air oven at a temperature of 160 C for 120 min. holding time or 180 C for 30 min. holding time.
- Persons operating the hot air oven should record for each cycle the reading on the indicating thermometer.
- Hot air ovens must be checked monthly with spore tests.
- In case of unsatisfactory spore test result, EMSD should be notified. Hot air oven should be reused only when spore test indicates satisfactory performance.
- Hot air ovens should be serviced regularly at yearly intervals and as necessary. 15

(N.B. When purchasing hot air oven, please note the requirements of BS 3421: hot air oven should be fan-assisted; it should have a thermocouple entry port and safety device which will keep the door locked until chamber temperature is below 60 oC.)

DISINFECTION

Hot water disinfectors

Boiling water, although being able to effectively disinfect instruments, cannot achieve sterilization since some bacterial spores can withstand boiling.

The followings must be observed when using a hot water disinfectant:

- The hot water disinfectant must be located in treatment rooms.
- The hot water disinfectant must be operated only by staff who have been adequately instructed in their use.
- Cleansed instruments must be fully immersed in water.
- Disinfectants should not be overloaded.
- Leave instruments for a minimum of 10 minutes without interruptions after water returns to the boil e.g. do not add instruments into the hot water disinfectant while boiling. Use a timer with each process.
- Disinfected instruments should be removed with disinfected forceps and placed on a trolley laid with sterile paper/cloth and covered with a sterile paper/cloth and used within a session.
- Water in the disinfectant should be changed at least daily or when it is contaminated. Fill up the hot water disinfectant at the beginning of the day.

Chemical disinfectants

Chemical disinfectants could be alternatives for heat labile instruments. However, they have many drawbacks such as corrosive properties, variability in their effect on different microorganisms, easy inactivation and different rates of microbiocidal action. When using chemical disinfectants, please observe the followings:

- The disinfectant containers must be thoroughly sterilized before refill. Do not top up.
- The containers should be clearly labelled with contents, in-use dilution and expiry date.
- Ensure that optimum dilution is used.
- The disinfectant containers should not be left open as they could easily be contaminated and microbes can grow in the disinfectant solution. Moreover, it may pose occupational hazard as glutaraldehyde vaporizes.
- Use appropriate disinfectants according to instruction (refer to Appendix VI).

LAB SPECIMENS

Specimens from all patients are considered to be potentially infectious. The procedure for handling laboratory specimens is as follows:

1. Always wear gloves when collecting and handling laboratory specimens;
2. Place each laboratory specimen in appropriate leak-proof primary containers (vacutainer tube, specimen cup, etc.). Care should be taken when collecting and handling specimens to avoid contamination of the outside of the container.
3. Secure lids tightly to prevent leakage.
4. Hand washing must be performed following any direct contact with blood or body substances in the handling or transporting of laboratory specimens.

LINENS

If linens are used at your facility, and they have been contaminated with blood or other risky materials:

1. Contaminated linens should be handled as little as possible;

Effective: 4/97; Revised 5/02; Updated 5/05; Updated 6/08; Updated 4/2010; Updated 8/2012; Updated 8/2014

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2. Protective gloves must be worn;
3. Never rinse or sort linens in care areas. Instead, carefully bag soiled linens right where they are, avoid skin contact and roll them away from your body.
4. Bag of contaminated laundry must be placed in an appropriately designated container that prevents leakage or soak-through.

DISPOSING OF MEDICAL WASTE

Disposable items that could be contaminated may require special handling in accordance with laws in your area. Items like used gauze pads or used gloves should be disposed of within designated medical waste containers and areas. Waste that is wet, dripping or oozes fluids when pressure is applied is considered regulated waste. It must be placed in containers that are closeable, prevent leakage, and are color-coded red or clearly labeled "BIOHAZARD". The biohazard receptacle should be located in areas for use by medical personnel. A contracted local medical waste removal provider will be responsible for removal of all medical waste containers.

The potential for transmission of bloodborne pathogens is greatest when needles, scalpels, and other sharp instruments are used. Precautions should be taken to prevent injuries during procedures where needles and sharp instruments are required, especially during the disposal of contaminated items. Gloves and other personal protective clothing will not prevent penetrating injuries due to accidental needlesticks or cuts from scalpel blades and other sharp instruments. To prevent injury:

- Avoid rushing when handling needles and sharps
- Use extreme care when handling contaminated needles and sharp instruments.
- Dispose of all needles and other sharps promptly. It is imperative these items not be left in patient care areas, or inadvertently deposited in regular trash containers.
- **Contaminated needles should not be recapped by hand, removed from disposable syringes by hand, or purposefully bent, broken, or otherwise manipulated by hand. In the event recapping is unavoidable, the one-handed scoop technique or a needle-recapping device should be used.**



SHP EMPLOYEE HEALTH

Immunization:

1. Tetanus (every 5 to 10 years);
2. Influenza (annually);
3. Hepatitis B Vaccine;
4. MMR (measles, mumps, rubella).

Employees should be well informed of side effects and risks from immunizations.

SHP EMPLOYEE HYGIENE:

Good hygiene can greatly reduce the spread of contamination:

1. Wash hands prior to and after eating or handling food;
2. Cover mouth when coughing or sneezing;
3. Use disposable Kleenex rather than cloth handkerchiefs;
4. Wash hands vigorously for 3+ minutes after using restroom.
5. Keep fingernails short, no longer than tips of fingers, and clean.

HAND-WASHING

Frequent hand-washing is necessary to prevent the direct or indirect transmission of organisms.

Thorough hand-washing is the single most important factor in preventing the spread of disease.

Accomplish the following when at the scene:

1. When applicable, clean hands with soap from the dispenser in the rescue unit prior to contaminating other areas;
2. Wash hands as soon as possible after transferring patient to the infirmary;
3. Moisten hands and work up a good lather with soap, extending beyond area of contamination. Use friction while washing both hands and wash for fifteen (15) seconds;
4. Rinse hands thoroughly under running water;
5. Dry hands with paper towels and turn off faucet with same towels; and
6. Avoid touching face with hands.

NEEDLE STICK PROTOCOL

Any SHP employee who sustains a needlestick or other wound resulting in exposure to blood or body fluids should follow the following protocol. Please keep in mind drug prophylaxis following a high-risk exposure is time sensitive, therefore you **must** immediately notify your site administrator, the corporate office, and seek treatment from a designated physician/treating facility as listed on your approved medical panel. In case of afterhours exposure, do not delay, please seek initial treatment at the Emergency facility listed on your medical panel.

Only reasonable medical expenses related to job-related injury or illness will be covered by our worker's compensation policies. Injuries or illnesses that occur on the job, but are not caused by a work-related activity, will not be covered. The employee is responsible for all non-covered medical expenses.



Upon receiving a needlestick:

1. Wash the affected area with soap and water;
2. Cover the area with a dressing, if possible.
3. For an ocular exposure, flush thoroughly with water;
4. Notify your site administrator immediately of the needlestick;
5. Notify the H.R. department at the corporate office by calling 888-231-2888;
6. The patient from whom the needlestick occurred should be notified of the employee's injury and therefore be requested to submit to blood tests to identify the presence of bloodborne diseases;
7. Base-line blood tests should also be drawn from the employee (this function should be done at an approved facility as listed on the posted medical panel for your facility);
8. Follow up testing may be required.
9. Employee must complete the First Report of Occupational Injury form and fax it to the corporate office within 24 hours of the injury. In the event the employee is unable to complete the form, the site administrator must complete the form with the available information received from the employee.
10. All injuries will be reported to the state worker's compensation carrier in accordance with our policy carrier information. The corporate office will do this reporting.
11. All physician and testing expenses an employee incurs as a result of the needlestick will be paid in accordance with SHP state worker's compensation policy. However, should the employee receive a billing statement for such services please forward it to the Human Resources department.

Refusal(s) of Treatment:

1. An employee may refuse treatment of a needlestick injury, but all such refusals must be made in writing and witnessed by the site medical administrator. The refusal should then be faxed to the corporate office for inclusion in the employee's file.
2. If the patient from whom the needlestick occurred refuses to submit to blood tests identifying the presence of bloodborne diseases, such refusal should be documented and faxed to the corporate file. Testing will still be performed on the employee in accordance with the approved physician's order. Further testing may be required due to the types of bloodborne exposures.

Questions:

Any questions and/or comments can be directed to the human resources department at the corporate office by calling 888-231-2888.

SHP EMPLOYEE SAFETY -- WORKING ALONE

Working alone in certain circumstances, situations, or environments is unsafe and requires special arrangements to minimize potential hazards. "Alone" means beyond the visual or audible range of any other individual for more than a few minutes at a time.

If work performed makes an operation without a correctional officer relatively safe (e.g., working within the medical unit), a telephone call or visual check during a guard's inspection tours may be adequate. Work of a clearly hazardous nature (e.g., tasks performed without a correctional officer present) must not be conducted alone. Such activities must be communicated to the Medical Team Administrator.

Administrative or clerical employees and others working in low-hazard locations shall not be alone longer than two hours without an established safety check procedure. The procedure may be part of a guard's

Effective: 4/97; Revised 5/02; Updated 5/05; Updated 6/08; Updated 4/2010; Updated 8/2012; Updated 8/2014

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standard inspection tour, or it may consist of a phone call or work (e.g., coffee) break with a contact person. The procedure must be prearranged to assure assistance to an ill or injured worker in need of help.

HEALTH CARE WORKERS -- OCCUPATIONAL RISK

What is the occupational risk of bloodborne infection amount healthcare workers? For AIDS, the risk is very small. The latest statistics from the CDC indicate the out of approximately 4 million healthcare workers, there are 222 documented or probable cases of occupationally acquired HIV. But keep in mind that AIDS is growing in the general population. One of the reasons is that once a person is infected with HIV, they are a carrier for life. The CDC estimates that there are 850,000 carriers in the United States infected with HIV and capable of transmitting it to others. For Hepatitis B, the risk is more significant. About 9,000 healthcare workers get hepatitis B from occupational exposure each year, between 400 and 500 are hospitalized, and about 200 die as a result. Because health care workers are being immunized against Hepatitis B, these numbers are coming down. But keep in mind there may be as many as 1 million carriers of HBV in the U.S. The risks for Hepatitis C are also significant, though only about 10% are at risk for catching Hepatitis B. On average, 1.8% of those exposed to HCV by needlestick accident will develop Hepatitis C. Like Hepatitis B, it can be detected through serum blood testing.



PRECAUTIONS TO BE USED BY SHP EMPLOYEES FOR ALL PATIENT CARE ISSUES:

PROCEDURE	HAND-WASHING	WEAR GLOVES	WEAR GOWNS	WEAR PROTECTIVE MASK/EYEWEAR
Adjusting IV Fluid or non-invasive equipment	X			
Examining Patient <i>without</i> touching body substances, mucous membranes, non-intact skin and contaminated items.	X			
Examining Patient <i>including</i> contact with body substances, mucous membranes, nonintact skin and contaminated items.	X	X		
Drawing Blood	X	X		
Inserting venous access	X	X		
Inserting NC, GT or Foley Catheters	X	X		
Handling soiled waste, linen, other materials	X	X		
Intubations	X	X	X	X
Inserting arterial access	X	X	X	X
Operative and other procedures which produce extensive body fluid splattering	X	X	X	X

Use gown, mask, eyewear if body fluid splattering is likely

Use gown, mask, eyewear if body fluid splattering is likely

Use gown, mask, eyewear if body fluid splattering is likely

Use gown, mask, eyewear only if waste or linen are extensively contaminated and splattering is likely



MEDICAL EMERGENCY SITUATIONS

Medical emergencies may arise when the patient requires immediate attention and quick responses. In these situations, staff members may feel that they have only a limited amount of time in which to take all necessary precautions. Even in emergency situations, medical personnel have both the right and the responsibility to protect themselves from exposure to potentially infectious blood and body substances. As an absolute minimum, medical personnel responding to a medical emergency are required to wear gloves when in contact with blood and body substances. Other barrier protection should be put on as time permits or when other personnel become available to assist. In addition, the staff must continue to use the utmost care and caution in handling contaminated materials, needles and sharp instruments. Manual respiratory resuscitation equipment is to be available and all medical personnel should be trained in the proper use of these devices. Medical personnel should avoid direct mouth-to-mouth resuscitation whenever possible.

REPORTING OF EXPOSURES / INCIDENTS

SHP Staff should report employee exposures and/or employee incidents within 12 hours to the corporate office using the Report of Injury Form. The form is to be completed and faxed to 423-553-5645. Any emergent situations should be called into the corporate office to Katie Utz, Vice President, Human Resources at 423-553-5635 ext. 17.



STANDARD OPERATING PROCEDURES - Management of Inmates with AIDS and ARC.

Housing. Based on guidelines from the Center for Disease Control, no special housing arrangements are required except under certain medical circumstances:

1. A private room or cell is indicated only when a patient is too ill to use good hygiene or displays altered behavior as a result of central nervous system disorder.
2. Housing decisions regarding AIDS and ARC inmates will be made on a case-by-case basis, strictly on the basis of medical advice.

Evaluation of Symptomatic Patient with a Positive Antibody Test to HTLV-III.

Patients with AIDS-related complex or AIDS should receive the same evaluation as those who are asymptomatic with the addition of a more extensive medical evaluation of symptoms. This evaluation may be provided in an off-site health care setting.

These patients all should receive extensive counseling regarding sexual activity, drug abuse, and emotional support. Counseling services are usually provided by the County Health Department.

Hepatitis A:

1. If inmate relates history of hepatitis A with recovery over two (2) weeks ago, this person can now be considered immune and immunologically safe to house in general population without special precautions.
2. There is no "carrier" state for recovered hepatitis A patients.
3. There is virtually no recurrence for hepatitis A.

Hepatitis B:

1. Isolation is required for the patient with B type hepatitis or inmate relating history of illness within the last thirty (30) days.
2. No sexual contact and no food handling allowed.
3. "Carrier" status is apparently possible.
4. Re-infection is possible.
5. All hepatitis histories require careful instructions:
 - a. Toilet habits;
 - b. Hand-washing technique;
 - c. Needle tattoo implications.

Hepatitis C:

1. No sexual contact and no food handling allowed.
2. All hepatitis histories require careful instructions:
 - a. Toilet habits;
 - b. Hand-washing technique;
 - c. Needle tattoo implications.

Gowns, Masks, and Gloves:

1. Gowns and masks may be worn any time protection is desired.
2. Follow general guidelines for specific diseases.
3. Dispose of garments in the infirmary.



4. Masks should only be used once (masks become ineffective when moist).
5. Once used, masks should be discarded. A mask should not be lowered around the neck and reused.
6. If patient may have a communicable disease, place disposable mask on patient if possible.
7. Gloves should be worn under the following conditions:
 - a. Contact with patient's blood or other body secretions is expected;
 - b. Any time strict isolation is desired; and
 - c. Whenever it is necessary to handle an expired patient.

ISOLATION

Isolation is used to prevent cross contamination and spread of communicable diseases, and to protect the debilitated or high risk patient.

The items needed when encountering patient contact will depend upon the type of isolation required:

Blood Precautions - Gloves

Respiratory Isolation - Masks

Complete Isolation - Gloves, masks, and gowns

All bodily secretions and excretions should be handled with gloves.

PATIENT CARE PRECAUTIONS

Masks are not routinely necessary for care of AIDS patients. The masks are recommended for any personnel who have direct, sustained contact with a patient who is coughing extensively, or a patient who is intubated or being suctioned if patient is infectious.

Nonsterile Gloves are recommended if contact with blood or body fluids, secretions or excretions are anticipated. Gloves should be changed in between patients. Gloves should also be worn when handling post mortem bodies.

Hands should be thoroughly washed after care of each patient. This precaution should be observed regardless of the use of gloves.

It is imperative to notify the medical staff/correctional officer supervisor if the patient is suspected of having a contagious disease.



MEDICAL EQUIPMENT MAINTENANCE

Infrequently or seldom used equipment in proper working order will be stored in a designated area within the medical unit. Unused equipment will be surplus. All equipment must be inspected before use. Defective items will be repaired before use or disposal. Equipment will be maintained in safe operating conditions. Frayed electrical cords and plugs will be repaired. Acid or solvent resistant electrical cords will be used as determined by the nature of the work and Medical Team Administrator. Electrical plugs will be 3 pronged and all outlets will be grounded. **NOTE:** Equipment, which is double insulated, may not require 3 pronged plugs. Leaks in equipment using fluids will be fixed immediately. Use of the equipment is not allowed until the leak is fixed. Malfunctioning or broken switches, knobs, valves, gauges, indicators, alarm or warning devices, etc. will be replaced or fixed immediately. Other forms of good technique in the use, care and maintenance of instruments and equipment must be carried out by the users in accordance with manufacturer's recommendations.

COMPRESSED GAS CYLINDERS

Compressed gas cylinders must be secured at all times so they cannot fall. (Securing equipment should be available from the facility maintenance department – check with the Correctional Supervisor/Administrator).

Valve safety covers should be in place until pressure regulators or needle valves are ready to be attached. The names of the cylinder contents must be permanently attached to the cylinders. Color coding alone is not acceptable. This identification shall not be removed, covered or defaced.

Cylinders may be moved on chain equipped hand trucks or carts; they must never be rolled or dragged. Employees must not attempt to repair cylinders or cylinder valves, or to force stuck or frozen cylinder valves. The cylinder valve is never to be opened or cracked without first attaching the proper pressure regulator. Compressed gas cylinders will not be used in environmental rooms unless an oxygen monitor with an audible alarm is present and permission has been granted by the Medical Team Administrator.

Compressed gas must not be used to dust off clothing. Cylinders shall not be stored near corrosive chemical or fumes.

The purchase and use of highly toxic gases are controlled. The Medical Team Administrator must be notified of intent to work with highly toxic gases prior to their proposed use to allow time for making necessary safety preparations. Large cylinders of toxic gases should not be purchased if it is possible to use small cylinders.

Acceptance of Cylinders from Vendors:

- a. The contents of cylinders must be identified with decals, stencils, or other markings on the cylinders. Color codes alone or tags hung around the necks of the cylinders are not acceptable. Cylinders lacking proper identification must not be accepted from the vendors.
- b. Cylinders must not be accepted from the vendors unless the valve safety covers are in place and properly tightened.
- c. Vendors moving cylinders must use chain equipped hand trucks or carts. Cylinders must not be dragged or rolled.

Handling and Storage of Cylinders:

- a. Cylinders should never be dropped or permitted to strike each other violently.
- b. The valve safety covers must be left on the cylinders until cylinders are secured to walls, benches, or stable pieces of equipment.
- c. Cylinders must be transferred only by suitable carts or hand trucks. They must not be rolled or dragged. The valve safety covers must be in place and the cylinders secured to the carts during transport.
- d. Tags marked full, in use, and empty will be placed on cylinders of compressed gases. The user shall remove the portion of the tag to indicate the status of the tank in question. If the tags are absent, cylinders must be marked empty or "MT".

Pressure Regulators and Needle Valves:

- a. The valve fittings of cylinders used to store different families of gases are different and will allow regulators or needle valves to be attached that are safe for use with those gases. Use of adapters to connect regulators to cylinder valves defeats this safeguard and is not authorized. Only pressure regulators and needle valves approved for the gases may be used.
- b. Threads and points of unions must be clean. These surfaces must be inspected before they are connected.
- c. When attaching regulators or needle valves, the connections must be tightened firmly. Wrenches of the proper size should be used. Pliers should not be used, as they damage the soft brass nuts. Need for excessive force often indicates that the regulators or needle valves do not fit the cylinders. Leaks at the unions between the regulators and the cylinder valves are usually due to damage to the faces of the connections. Attempts to force a tight fit may damage the previously undamaged half of the connection. If the cylinder valve faces are damaged, the cylinders shall be returned to the vendors. Employees shall not attempt to repair them. Damaged regulators shall not be used until repaired.
- d. After attaching the pressure regulator to the cylinder, the delivery pressure adjusting screws of the regulators should be turned out until they turn freely. The cylinder valves should be opened slowly. Laboratory personnel should avoid standing directly in front of the regulators at this time as the pressure of the cylinders may blow the glass from the front of a faulty gauge. After the valves are opened, the regulators and fittings should be checked for leaks. The cylinder valve handles should be left attached to the valves while the cylinders are in use. Cylinder valves that "stick" and do not open when the usual amount of force is applied may be damaged. Personnel must not attempt to force them open, but should return these cylinders to the vendors, stating on the cylinders that the valves are stuck.
- e. Pressure in full cylinders should be indicated on the cylinders or labels. Lack of full pressure may indicate leaks at the connections between the cylinders and regulators, damaged regulators, or incompletely filled cylinders.
- f. Employees should connect delivery lines to the low pressure outlets of the regulator valves or to the needle valves. Where low pressure lines are used, their valves should be closed and line pressures adjusted by turning the regulator

delivery pressure adjusting screws until the desired pressures are shown on the delivery pressure gauges.

- g. If the gases are not to be used over a considerable length of time, the cylinder valves should be closed, the lines bled, and the pressure adjusting screws turned back until they turn freely. Damage to the gauges may result if pressure is left on the gauges during extended periods of nonuse.

Cylinder Leaks:

- a. Soapy water painted over the valves and connections will indicate most gas leaks.
- b. Compressed gas cylinders are tested for leaks when they are filled; however, leaks have been detected when cylinders were connected in laboratories. Personnel should not attempt to repair leaks caused by loose valve stem packing. Leaking cylinders of nontoxic, nonflammable gas shall be returned to the vendor. Leaks from cylinders of toxic or flammable gases require immediate attention. Decisions of how to handle the problem will depend on the kind of gas, the size of the leak, the area where the cylinder is located, and other factors. Personnel must wear appropriate protection when attempting to move leaking cylinders of toxic gases.

Empty Cylinders:

Small amount of gas must be left in the cylinders and the cylinder valves must be closed to prevent contamination of the inside of the cylinders. Empty cylinders should be marked "EMPTY" or "MT". Valve safety covers and the labels showing contents must be in place. Empty cylinders should be stored separately from full cylinders. Empty cylinders must be secured at all times so they cannot fall.

RESPIRATORY EQUIPMENT

Respiratory equipment that touches mucous membranes or secretions should be sterilized before use on other patients (if not disposable). Items that are to be disinfected should be soaked in O-syl or Cidex solution for 15 to 20 minutes.

All tubing must be changed in between patients. All tubing should be disposable.

For sanitary and health reasons, respiratory equipment (i.e. masks) shall be used by one individual only and shall be returned to the Medical Team Administrator and/or designated medical staff member for cleaning, maintenance, and repairs. Cleaning and disinfecting of reusable components of a respirator unit will be performed by utilizing recognized procedures corresponding to the exposure atmosphere. The individual will discard disposable respirators properly after use. (Note: Cleaning or maintenance of respiratory and other protective devices by anyone other than the Medical Team Administrator and/or designated medical staff member is not recommended except in emergency situations).

Inspection frequency for all unused devices shall be monthly. The employee shall inspect units receiving routine use before and after each use. The inspection shall include the following checks when applicable.

1. Tightness of connections
2. Condition of facepiece, headbands, exhalation and inhalation valves, connecting tube, and canister

3. Pressure in cylinders (do not use if less than 1500 psi)
4. Deterioration of all rubber parts
5. Regulator mechanism
6. Lens of facepieces
7. Warning alarm (self-contained units)
8. Seal on cartridge package

Location and Storage of Respirators - Location and storage of all respiratory devices shall be controlled by the Medical Team Administrator. When the need for respiratory equipment is anticipated, approval by the Medical Team Administrator should be obtained in advance.

Self-Contained Breathing Apparatus - Emergency respirators in carrying cases shall be located in areas designated by the Medical Team Administrator. These respirators are provided for emergency situations only, and for use by authorized personnel. Any conditions requiring the use of these devices shall be reported to the Medical Team Administrator.

Special Requirements for Confined Spaces - In areas immediately hazardous to life or health, self-contained breathing apparatus, air line respirators or hose masks with blowers shall be used. For emergency rescue, a standby person with suitable self-contained breathing apparatus shall be at the nearest fresh air base. Communications (visual, voice or signal line) shall be maintained between all individuals present. Persons using air line respirators and hose masks with blowers shall be equipped with safety harnesses and safety lines for lifting or removing them from hazardous atmospheres, or other equivalent provisions for rescue from hazardous atmospheres shall be used.

WARNINGS SIGNS/LABELS FOR HAZARDOUS MATERIALS

All devices, structures and areas where hazardous materials are used, or where hazards or possible hazards may exist will be identified with appropriate hazard warnings. Appropriate warning signs for materials of a hazardous nature (poisonous, toxic, flammable, carcinogenic, biological hazard, radioactive, etc.) or hazardous conditions (high voltage, slippery when wet, welding arcs, etc.).

Employees will conduct themselves in the manner (safe procedures, protective equipment, clothing, etc.) as called for by the hazard warning signs and training.

Employees will assist the supervisor in recognition of any potentially hazardous condition that may need identification by hazard warning signs. Common sense is required in the use of Hazard Warning Signs so their effectiveness is not lost by over use. Hazard Warning Signs are not to be abused for personal reasons such as to keep people out of an area or to discourage use of laboratory materials, equipment, etc.

Any temporary posting of a hazard should be replaced as soon as possible by an acceptable permanent sign or removed when the hazard no longer exists.

Safety colors and specifications for accident prevention signs and tags shall be in accordance with applicable federal and state regulations. The following key colors will be used in the signs, paint, tape, etc. for warning personnel of hazardous conditions and identifying emergency equipment.

Red - basic color for fire protection equipment and apparatus, danger, and emergency stop devices.

Orange - designates dangerous parts of machines or energized equipment which may cut, crush, shock, or otherwise injure.

Yellow - designates caution and is used for marking physical hazards. Solid yellow, yellow and black stripes, or checkers should be used interchangeably to attract the most attention in the area in question.

Green - used as a safety designation and for marking the location of first aid equipment.

Blue - also designates caution, but limited to warning against the starting, use of, or movement of equipment under repair or being worked on.

Black, Purple or magenta on yellow - designates radiation hazards.

Black on white - designates traffic and housekeeping markings.

Signs and Tags

1. *Danger* - should be used only where an immediate hazard exists. Employees must be instructed that these signs indicate immediate danger and that special precautions are necessary.
2. *Caution* - used only to warn against potential hazards or to caution against unsafe practices. All employees shall be instructed that caution signs indicate a possible hazard against which proper precaution should be taken.
3. *Safety Instruction* - shall be used where there is a need for general instructions and suggestions relative to safety measures.
4. *Biological Hazard Signs* - shall be used to signify the actual or potential presence of a biohazard and to identify equipment, containers, rooms, materials, experimental animals, or combinations thereof, which contain, or are contaminated with, viable hazardous agents.
5. *No smoking, eating or drinking signs* - will be placed in all designated areas where there are flammable, toxic, carcinogenic, mutagenic, teratogenic, or radioactive materials stored or used.

Special signs or tags - will be used as needed (e.g. labels for chemical carcinogens).

Radiation warning signs are strictly regulated, refer to the Radiation Guide for their use.

No Smoking Signs – All medical units are a smoke free environment and smoking is prohibited inside all county buildings. No Smoking Signs will not be required due to this designation.



TRAINING (See Attached Bloodborne Pathogens Information, as well as SHP website online support graphics to be used as a visual training aid supplement. Contact H.R. Department for attachment if needed. This training is done annually, and tracked by the SHP H.R. Department.

Bloodborne Infections

AIDS, Hepatitis B, and Hepatitis C are bloodborne infections caused by bloodborne pathogens. Bloodborne pathogens are disease causing agents found in the blood. There are many other types of bloodborne infections but these three are considered to be the main causes for concern.

What is the risk of bloodborne infection among healthcare workers?

For AIDS the risk is small, out of four million healthcare workers there are only 197 documented or probable cases of occupationally acquired HIV.

Hepatitis B risk is more significant. About 9,000 healthcare workers get Hepatitis B from occupational exposure each year. Between 400 and 500 are hospitalized and about 200 die as a result of this exposure. Immunization against Hepatitis B is bringing these numbers down but keep in mind there are nearly 1 million carriers of HBV in the United States. For a susceptible person, the risk from a single needlestick or cut exposure to HBV infected blood ranges from 6-30%. If you have not yet been immunized contact your supervisor and make arrangements to receive this immunization series as soon as possible. It could save your life.

The risk for Hepatitis C is also significant, though only about 10% of the risk for catching Hepatitis B. On average 1.8 percent of those exposed to HCV through needlestick will develop Hepatitis C. There are no exact estimates on the number of healthcare workers who have been occupationally infected with HCV. About 3% of the United States population has evidence of Hepatitis C infections (1% of all healthcare workers).

Modes of transmission on the job include: needlesticks, contact with blood or body fluids at the site of an open wound, cut or broken skin and exposure to mucous membranes.

Universal Precautions

In 1983, CDC published a document entitled "Guideline for Isolation Precautions in Hospitals" that contained a section entitled "Blood and Body Fluid Precautions." The recommendations in this section called for blood and body fluid precautions when a patient was known or suspected to be infected with bloodborne pathogens. In August 1987, CDC published a document entitled "Recommendations for Prevention of HIV Transmission in Health-Care Settings". In contrast to the 1983 document, the 1987 document recommended that blood and body fluid precautions be consistently used for all patients regardless of their bloodborne infection status. This extension of blood and body fluid precautions to all patients is referred to as "Universal Blood and Body Fluid Precautions" or "Universal Precautions." Under universal precautions, blood and certain body fluids of all patients are considered potentially infectious for human immunodeficiency virus (HIV), hepatitis B virus (HBV), and other bloodborne pathogens. Universal precautions are intended to prevent parenteral, mucous membrane, and nonintact skin exposures of health-care workers to bloodborne pathogens. In addition, immunization with HBV vaccine is recommended as an important adjunct to universal precautions for health-care workers who have exposures to blood.

Universal Precautions apply to blood and other body fluids containing visible blood. Blood is the single most important source of HIV, HBV, and other bloodborne pathogens in the occupational setting. Universal precautions also apply to semen and vaginal secretions. Although both of these fluids have been implicated in the sexual transmission of HIV and HBV, they have not been implicated in occupational transmission from patient to health-care worker. Universal precautions also apply to tissues and to the following fluids: cerebrospinal fluid (CSF), synovial fluid, pleural fluid, peritoneal fluid, pericardial fluid, and amniotic fluid. Universal precautions do not apply to feces, nasal secretions,

Effective: 4/97; Revised 5/02; Updated 5/05; Updated 6/08; Updated 4/2010; Updated 8/2012; Updated 8/2014

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sputum, sweat, tears, urine, and vomitus unless they contain visible blood. The risk of transmission of HIV and HBV from these fluids and materials is extremely low or nonexistent. Protective barriers reduce the risk of exposure of the health-care worker's skin or mucous membranes to potentially infective materials. For universal precautions, protective barriers reduce the risk of exposure to blood, body fluids containing visible blood, and other fluids to which universal precautions apply. Examples of protective barriers include gloves, gowns, masks, and protective eyewear. Gloves should reduce the incidence of contamination of hands, but they cannot prevent penetrating injuries due to needles or other sharp instruments. Masks and protective eyewear or face shields should reduce the incidence of contamination of mucous membranes of the mouth, nose, and eyes.

Universal precautions are not intended to change waste management programs previously recommended by CDC for health-care settings. Policies for defining, collecting, storing, decontaminating, and disposing of infective waste are generally determined by institutions in accordance with state and local regulations. Information regarding waste management regulations in health-care settings may be obtained from state or local health departments or agencies responsible for waste management.



Standard Precautions VS Universal Precautions

Standard Precautions are guidelines recommended by the Centers for Disease Control and Prevention for reducing the risk of transmission of blood-borne and other pathogens in hospitals. The standard precautions synthesize the major features of universal precautions (designed to reduce the risk of transmission of bloodborne pathogens) and body substance isolation (designed to reduce the risk of pathogens from moist body substances) and apply them to all patients receiving care in hospitals regardless of their diagnosis or presumed infection status. Standard precautions apply to blood; all body fluids, secretions, and excretions *except sweat*, regardless of whether or not they contain blood; non-intact skin; and mucous membranes. The precautions are designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection in hospitals.

It is important to know and recognize the differences and be certain you are always in compliance and utilizing proper precautions to avoid any potential exposure. CDC also recommends Transmission Based Precautions which include specific airborne, droplet, and contact precautions, for use with patients documented or suspected to be infected with pathogens (i.e. Tuberculosis) for which additional precautions are needed.

Sharp Safety Rules

- Never bend, break or manipulate used needles.
- Immediately discard used disposable sharps in containers that are clearly marked, closeable, puncture-resistant, and leak proof on the sides and bottom.



- Sharps containers must be readily available and must be replaced before they become overfilled.
- Do NOT recap used conventional needles unless absolutely necessary.
- If recapping is unavoidable, use the one-handed scoop method or a recapping device to prevent accidents.

Handling Sharps

In 2000, the CDC estimated that 600,000 to 800,000 needlestick or percutaneous injuries occur annually among healthcare workers in all fields. CDC says this number could be reduced by 62 to 88 percent through the use of safer medical devices. OSHA regulations now REQUIRE the use of engineering controls to help prevent sharps and needlestick injuries, and a number of safer medical devices have been developed.

Personal Hygiene and Health

Wash your hands thoroughly with soap and water for 10 to 15 seconds before and after contact with each patient. Do this even if gloves were worn.

Immediately wash any body parts that have been exposed to blood or other potentially infectious materials. Remember to report incidents of exposure as soon as possible.

If you have an oozing wound or sore, or if medications have weakened your immune system, consult your physician or employer. Special precautions may be necessary.

Decontaminating Care Areas & Equipment

Standard cleaning and disinfection procedures apply to care areas. Wear gloves and use EPA approved products.

Disposable protective barriers may be placed on surfaces and objects in a treatment area. Dispose of these coverings after use with each patient.

Soiled instruments should be cleaned and sterilized in the appropriate manner.

If equipment is to be picked up for repair, make sure it is decontaminated to prevent infection of others who may handle it.

Linens contaminated with blood or other risky materials should be handled as little as possible. Protective gloves should be worn.

Cleaning & Disinfecting the Blood Glucose Meter

Standard cleaning and disinfecting blood glucose meters between each patient's use is to be done to avoid cross-contamination issues. Alcohol based solution or a bleach based solution should be used for cleaning/disinfectant.

Cleaning guidelines – use a lint free cloth dampened with soapy water or isopropyl (70%-80%) to clean the outside of the blood glucose meter.

Disinfecting Guidelines – to disinfect the meter, dilute 1ml of bleach (5%-6% sodium hypochlorite solution) in 9 ml of water to achieve a 1:10 dilution. The solution can then be used to dampen a paper towel. Use the dampened towel to thoroughly wipe down the meter.

Germicidal wipes are also compliant with CDC guidelines for disinfection and sterilization.

When using any disinfection wipe, take extreme care not to get liquid in the test strip dock or key code parts of the meter. With all glucose meter cleaning methods, it is crucial the glucose meter be completely dry before testing a patient's glucose level.