

**BY ORDER OF THE COMMANDER  
459TH AIR REFUELING WING**

**AIR FORCE INSTRUCTION 44-108  
459TH AIR REFUELING WING  
Supplement**



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**Medical**

**INFECTION CONTROL PROGRAM**

**COMPLIANCE WITH THIS PUBLICATION IS MANDATORY**

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This supplements AFI 44-108, *Infection Control Program*, and AFI 44-108\_AFRCSUP1\_I, and outlines the authority, functions, and responsibilities of the Infection Control Review Function (ICRF), and identifies the purpose and goals of the Infection Control Program (ICP). Compliance with this regulation is applicable to all personnel assigned to the 459 ARW Medical Reserve Units (AES, AMDS, and ASTS). This also applies to all personnel assigned, attached, or on contract to a 459 ARW Medical Reserve Unit.

1. Purpose. The purpose of the ICP is to reduce and prevent clinic acquired infections, to identify infections when they occur, implement control measures, and assess situations for infection risk. The ICRF oversees the program and ensures unit Infection Control policies meet The Joint Commission (TJC), Center for Disease Control (CDC), Occupational Safety and Health Administration (OSHA), Air Force and Air Force Reserve Operational Instructions and other regulatory requirements.

2. Authority Statement.

2.1. The ICRF shall have the authority, through its Chairperson and Infection Control Manager (ICM), to institute any appropriate control measures when a situation is identified or reasonably thought to be a danger to patients or personnel. The Executive Management Committee (EMC) must approve all other changes to policy before implementation.

2.2. The Executive Committee of the Medical Staff (ECOMS) gives authority to the ICM or other registered nurse responsible for patient care to report any actual or suspected infections and collect a specimen for culture and sensitivity testing or isolation precautions.

2.3. The ICM will have access to all records and areas for surveillance activities in order to fulfill the responsibilities of the job.

### 3. Environmental Sampling:

3.1. Definition. Environmental sampling is defined as a microbiological culture of an inanimate object. This does not include any inanimate object removed from patients or sterilization biological spore monitoring.

3.2. Environmental cultures will not be done without approval of the ICRF.

3.3. The 459 ARW Bioenvironmental Engineering does not perform environmental testing. Active Duty from Malcolm Grow Medical Center performs ventilation surveys and will notify the 459 AMDS of any adverse findings.

### 4. Responsibilities:

4.1. The 459 AMDS Commander will:

4.1.1. Be the lead unit for the ICP.

4.1.2. Appoints, in writing, a senior physician with expertise/interest in ICP as the Chairperson of the ICRF.

4.1.3. Appoint an ICM, in writing, who is qualified by training, experience, or interest to perform surveillance and coordinate the activities of the ICP for the 459 AMDS and be a resource for the other medical squadrons.

4.1.4. Other medical unit commanders will appoint, in writing, an ICM who is qualified by training, experience, or interest to perform surveillance and coordinate the activities of the ICP for their squadron.

### 4.2. ICRF:

4.2.1. The ICRF is a wing-wide multidisciplinary committee. Membership consists of ICRF Chairperson, medical squadrons ICM, Public Health (PH), Bioenvironmental Engineering (BE), Immunization Clinic representative, Senior Air Reserve Technician (ART), dental representative, and others as required.

4.2.2. The ICRF meets quarterly, either in person or electronically, to review surveillance data and discuss/assess identified problems or issues of concern. In turn, ICRF members inform squadron personnel and squadron EMC members of recommendations and actions.

4.2.3. Review surveillance data and makes recommendations based on surveillance findings regarding management of infections, continuing education programs, and quality improvement (QI) activities.

4.2.4. Reviews and approves all section infection control policies or instructions at least every 2 years.

### 4.3. ICRF Chairperson:

4.3.1. Provides direction and support to the ICM.

4.3.2. Notifies the 459 AMDS Commander of situation posing an imminent hazard to patient care.

4.3.3. Designates ad hoc groups and appoints members to Quality Improvement (QI) activities, when necessary.

4.3.4. Conducts ICRF meetings and ensures documentation of ICRF actions and QI issues in the minutes.

4.4. 459 AMDS ICM:

4.4.1. Reviews Infection Control Program annually and updates as needed. Compiles, analyzes, and reports trends and deviations from baseline rates to the ICRF. Ensures surveillance occurs throughout the facility as outlined in the annual plan.

4.4.2. Serves as consultant regarding appropriate isolation precautions, observes patient care practices, and provides the ICRF with observations and recommendations for improvement.

4.4.3. Coordinates infection control and bloodborne pathogen education with 459 ARW units (ASTS, AES, SFS, CES, and LRF). Public Health may handle the BBP training for outside units.

4.4.4. Disseminates changes in infection control guidelines and policies to 459 ARW unit (ASTS, AES, SFS, CES, and LRF) personnel when necessary.

4.4.5. Assists in the development and implementation of on-going issues concerning immunizations, monitoring of possible outbreaks within the facility and development of Exposure Control Plans.

4.4.6. Functions as a consultant for units of the 459 ARW in areas related to infection control.

4.4.7. Maintains current infection control statistics and records. Infection control work sheets and summaries will be on file in the ICM office for 2 years.

4.4.8. Consults on the purchase of supplies and equipment related to infection control.

4.5. Medical Unit ICM:

4.5.1. Reviews IC Program annually at ICRF and updates as needed. Compiles, analyzes and report trends and deviations from baseline rates to the ICRF. Ensures surveillance occurs throughout the facility as outlined in the annual plan.

4.5.2. Serves as consultant regarding appropriate isolation precautions, observes patient care practices, and provides the ICRF with observations and recommendations for improvement.

4.5.3. Assists in the development and implementation of on-going issues concerning immunizations, monitoring of possible outbreaks within the facility and development of Exposure Control Plans.

4.5.4. Maintains current infection control statistics and records within their units. Infection control work sheets and summaries will be on file in the ICM office for 2 years.

4.5.5. Consults on the purchase of supplies and equipment related to infection control.

4.5.6. Ensures all BBP exposures are reported the 459 AMDS Infection Control or Public Health Officer for tracking.

4.6. Medical and Dental staff will:

4.6.1. Report suspected clinic related infections to ICM.

- 4.6.2. Ensures clinic related infections are documented in the member's clinical record.
- 4.6.3. Evaluate wing members with infection; make recommendation on duty limitation, and clear members before returning to work.

4.7. Laboratory. Reports significant results on any cultures or lab work to ICRF.

4.8.

Section S upervisors:

- 4.8.1. Develops section policies for areas not covered in this program.
- 4.8.2. Submits to ICRF annually and whenever changes occur.
- 4.8.3. Ensure personnel have the knowledge and comply with infection control policies and procedures.
- 4.8.4. Reports members with suspected infection or communicable disease.
- 4.8.5. Assists ICM with surveillance in their respective areas.
- 4.8.6. Accompanies ICM during visual surveillance inspection of section as requested.
- 4.8.7. Ensure staff members attend Newcomer's Orientation within the first three UTA's and annual exposure control plan (BBP and TB) training as required.

4.9. The 459 ARW personnel will:

- 4.9.1. Report to a healthcare provider in accordance with the Employee Health Program for evaluation of possible infections and communicable diseases.
- 4.9.2. Attend Newcomer's Orientation and annual infection control training as required.
- 4.9.3. Comply with duty section infection control policies and procedures.
- 4.9.4. Identify and report any deviations from infection control work practices to supervisory personnel.
- 4.9.5. Education and training will maintain a database of hospital newcomer's initial orientation to BBP and TB training.

5. Orientation and Training:

- 5.1. All incoming medical personnel assigned to the 459 ARW receive an orientation to the Infection Control Program through unit Newcomer's Orientation.
- 5.2. All 459 ARW personnel at risk for bloodborne exposure, as identified in the BBP Exposure Control Plan are required to receive annual BBP training approved by infection control or public health personnel.
- 5.3. A copy of the training plan, attendance rosters, and dates attended will be maintained in the IC office and reported quarterly at the ICRF.

6. Reporting Hospital Infections and Communicable Disease:

- 6.1. Medical professionals order or collect body site cultures of suspected infections and report known or suspected infections and communicable diseases to appropriate offices (PH and IC).

6.2. Nursing staff have the authority to institute transmission-based precautions and obtain cultures (non-invasive) when an infection is suspected.

6.3. Reporting Healthcare-Associated Infections:

6.3.1. Inpatients do not apply to the 459 AMDS, 459 ASTS, or 459 AES. 459 AES may document infections that were associated with missions flown.

6.3.2. Outpatients suspected of a clinic-acquired infection will be reported to infection control.

6.3.3. The following situations require immediate notification of the ICM with subsequent follow-up:

6.3.3.1. Highly contagious diseases such as chicken pox, active tuberculosis, or measles.

6.3.3.2. Any communicable disease in healthcare personnel.

6.3.3.3. Any bloodborne pathogen exposure after being seen at the emergency room at Malcolm Grow Medical Center.

7. Types of Isolation Precautions . The wing follows the 2007 CDC Guidelines for Isolation Practices in the Healthcare Setting. There are two tiers of precautions. The first tier is “Standard Precautions” and the second tier is “Transmission-Based Precautions.”

7.1. Standard Precautions:

7.1.1. Standard Precautions treat all blood, body fluids, secretions, and excretions except sweat regardless of whether or not they contain visible blood; non-intact skin; and mucous membranes as if contaminated with a bloodborne pathogen. This includes Universal Precautions related to Bloodborne Pathogens.

7.1.2. Standard Precautions will be used in the care of all patients and employ the following work practices and personal protective equipment:

7.1.3. Hand Hygiene in accordance with CDC guidelines. Correct and appropriate hand hygiene can decrease the incidence of infections by half.

7.1.3.1. Upon arriving to work.

7.1.3.2. Before patient contact

7.1.3.3. After patient contact

7.1.3.4. Before and after handling patient care devices such as IV catheters, urinary drainage systems, and respiratory therapy equipment or patient specimens.

7.1.3.5. After removing gloves.

7.1.3.6. After blowing or wiping the nose, coughing into the hands, or touching nose or eyes.

7.1.3.7. Before and after eating, smoking, or drinking.

7.1.3.8. After personal use of toilet.

7.1.3.9. Before leaving the work area.

7.1.4. Personal Protective Equipment:

7.1.4.1. Gloves will be worn whenever contact with blood, body fluids, secretions, excretions and contaminated items are anticipated, and whenever accessing the circulatory system.

7.1.4.2. Mask and eye protection must be worn when the task could result in a splash exposure of blood or other potentially infectious materials (OPIM) are possible. Both eye, nose and mouth protection is required.

7.1.4.3. Gowns will be worn whenever soiling of clothes with blood, body fluids, secretions, excretions, and contaminated items is possible.

7.1.5. Handling of Needles and Sharps. Place all used sharps directly into a puncture-resistant container immediately after use. Safety devices must be activated before discarding. Do not bend, break or recap needles before disposal. In rare instances, needles may be recapped using a one-handed scoop or hook technique.

7.1.6. Cough Etiquette Practices. Staff will request coughing or sneezing members to wear a mask. Instruct members to cover mouth and nose with tissue or use elbow when coughing or sneezing and perform hand hygiene using alcohol based hand rub afterwards.

7.1.7. Safe Injection Practices. Use single use devices for single patient. Do not enter a multi-dose vial with a used or contaminated needle or device.

7.2. Transmission-Based Precautions. Since we do not provide hospital care as part of our mission, type of precautions required is available on-line at [www.cdc.gov/ncidod/dhqp/pdf/guidelines/isolation2007.pdf](http://www.cdc.gov/ncidod/dhqp/pdf/guidelines/isolation2007.pdf). In addition to Standard Precautions, Transmission-Based Precautions are used for patients known or suspected to be infected by epidemiologically important pathogens spread by airborne or droplet transmission, or by contact with skin or contaminated surfaces.

7.2.1. Airborne Precautions are used for diseases that can be transmitted via small droplet nuclei (Tuberculosis, measles, and chickenpox) and requires special negative pressure ventilation in the room and staff must wear National Institute for Occupational Safety and Health (NIOSH) approved respiratory protection (N-95 or HEPA filter).

7.2.2. Contact Precautions are used for diseases that can be transmitted via direct or indirect contact and requires gown and gloves are worn when contacting patient or patient environment.

7.2.3. Droplet Precautions are used for disease that can be transmitted via droplets that travel short distances (3-6 feet) and requires staff to wear a surgical or isolation mask when within 6 feet of the patient.

7.3. The duration of isolation and precautions for specific diseases is outlined in CDC guidelines.

7.4. Place patients with signs or symptoms of an infectious on appropriate precautions until a definitive diagnosis can be made.

7.5. Contact the ICM for any questions or concerns regarding appropriate isolation practices.

7.6. The final decision regarding any conflict of opinions pertinent to starting or terminating precautions rest with the ICFR Chairperson.

7.7. Compliance. All personnel are responsible to comply with the requirement of these precautions.

8. Patient Care Equipment. Handle used patient care equipment soiled with blood or body fluids in a manner that prevents exposure, contamination of clothing and transfer of microorganisms to the other patients and environments.

9. Linen. All soiled linen is considered contaminated and is bagged at the point of use into fluid-resistant laundry bags. Since off site laundry practices follow standard precautions when handling any soiled linen, they do not need to be labeled "biohazard."

10. Preventive Measures. Healthcare personnel found to be infectious should be removed from direct patient care and evaluated by a medical doctor for treatment and follow-up.

11. Approved Agents:

11.1. Disinfectants used on instruments (lenses, ventilator parts, non-disposable anesthesia equipment, removable prosthetic dental devices, dental cartridges, and selected dental sharps) must be approved for the device and cleaned IAW manufacturer's instruction. Appropriate personal protective equipment is required.

11.2. Reusable equipment must be cleaned with a detergent to remove blood, body fluids and organic material from contaminated instruments before high-level disinfection or sterilization. Detergents have no disinfectant qualities; appropriate PPE is required.

11.3. Each unit will have an approved list of disinfectants and detergents as part of their unit policy.

11.4. Cleaning agents used by housekeeping will be approved by the ICFR during annual review of the housekeeping contract.

11.5. Hand Hygiene agents:

11.5.1. The host facility products for hand washing are approved for use by the 459 ARW members.

11.5.2. Alcohol-based hand rubs can replace soap and water unless hands are visibly soiled, after using the bathroom (unless soap and water not available), before handling food, and when dealing with a patient who has diarrhea.

12. Storage:

12.1. Effective control of dust a primary concern and should be evaluated by the individual area when designing their storage method.

12.2. Supplies are stored, at a minimum, behind a single barrier (behind a closed supply room door or in a covered or closed cabinet. Maintain the area free from moisture, dust, and vermin.

12.3. Visibly dirty supplies are considered contaminated and must be discarded.

12.4. Supplies are stored 8-10 inches from the floor (to permit adequate cleaning of the floor), and 18 inches from the ceiling (away from vents, sprinklers and lights), and 2 inches from an outside wall (to permit circulation and protect package integrity).

12.5. Sterile items are stored on the upper shelves; and clean on the lower shelves.

12.6. Outdates are checked monthly. Supplies outdated or those that will outdate before the next check are removed and discarded, if disposable.

12.7. Rotate supplies so the oldest stock is used first.

12.8. Warehouse boxes or shipping cartons will not be stored in clean supply areas; units of issue (contents of boxes) may be stored in clean storage areas. Although plastic bins to contain these items is preferred.

13. Expirations:

13.1. All multi-dose vials, stock medication bottles, ointments, and tubes once opened will be discarded at the manufacturer's date of expiration or if contamination is suspected except Purified Protein Derivative (PPD) skin testing solutions.

13.2. PPD skin testing solution bottles must be dated when opened and discarded after 30 days.

13.3. Reconstituted drugs will be discarded after 14 days or as directed by accompanying literature.

RUSSELL A. MUNCY, Colonel, USAF  
Commander, 459 ARW

**Attachment 1****GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION***Abbreviations and Acronyms*

**AES**—Aeromedical Evacuation Squadron

**AMDS**—Aerospace Medicine Squadron

**ART**—Air Reserve Technician

**ARW**—Air Refueling Wing

**ASTS**—Aeromedical Staging Squadron

**BBP**—Bloodborne Pathogens

**BE**—Bioenvironmental Engineering

**CES**—Civil Engineering Squadron

**CDC**—Center for Disease Control

**ECOMS**—Executive Committee of the Medical Staff

**EMC**—Executive Management Committee

**ICM**—Infection Control Manager

**ICP**—Infection Control Program

**ICRF**—Infection Control Review Function

**LRF**—Logistics Readiness Flight

**OPIM**—Other Potential Infectious Materials

**OSHA**—Occupational Safety and Health Administration

**NIOSH**—National Institute for Occupational Safety and Health

**PH**—Public Health

**PPE**—Personal Protective Equipment

**PPD**—Purified Protein Derivative

**QI**—Quality Improvement

**SFS**—Security Forces Squadron

**TJC**—The Joint Commission

**UTA**—Unit Training Assembly