

**BY ORDER OF THE COMMANDER  
59TH MEDICAL WING**

**59TH MEDICAL WING INSTRUCTION  
44-157**



**1 NOVEMBER 2016**

**Medical**

**INFECTION PREVENTION AND  
CONTROL PROGRAM**

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This instruction implements Air Force Policy Directive 44-1, *Medical Operations*. This instruction establishes guidelines to identify, control, and prevent healthcare associated infections (HAIs). It provides guidelines for the practice of Infection Control and Prevention (ICP), and assigns responsibility for the Infection Control Function (ICF) Review. This Medical Wing Instruction (MDWI) applies to personnel assigned, attached, or under contract to 59th Medical Wing (MDW), with the exception of healthcare workers (HCWs) assigned to the 959th Medical Group. This instruction does not apply to the Air National Guard or Air Force Reserve. This instruction may require the collection and maintenance of information protected by the Privacy Act of 1974 authorized by Title 10, United States Code, Section 8013, *Secretary of the Air Force*. Privacy Act System of Record F044 AF SG D, *Automated Medical/Dental Record System*, F044 AF SG E, *Medical Record System*, and F044 AF SG R, *Reporting of Medical Conditions of Public Health and Military Significance*, apply. Collected information is "For Official Use Only." Request to release Privacy Act information to persons or agencies outside the DoD must be in accordance with (IAW) AFI 33-332, *Air Force Privacy Act Program*, DoD 5400.7, *Freedom of Information Act*, and DoD 6025.18-R, *DoD Health Information Privacy Regulation*. Refer recommended changes and questions about this publication to the Office of Primary Responsibility (OPR) using the AF Form 847, *Recommendation for Change of Publication*. Requests for waivers must be submitted to the OPR listed above for consideration and approval. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with (IAW) Air Force Manual 33-363, *Management of Records*, and disposed of IAW Air Force Records Information Management System Records

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## ***SUMMARY OF CHANGES***

This document has substantially revised and must be reviewed in its entirety. Major changes include integration of Infection Control Guide procedures.

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## **1. Infection Prevention and Control Program.**

### **1.1. Scope of the Program.**

1.1.1. The 59 MDW Infection Control Prevention and Control Program is a multifaceted function that complies with current applicable external agencies; the Joint Commission National Patient Safety Goals, Occupational Safety and Health Administration (OSHA) regulations and other regulatory agencies.

1.1.2. The program focuses on preventing and controlling infections among patients, personnel, students, and visitors by implementing the appropriate guidelines by the Center for Disease Control and Prevention (CDC), the Association for Professionals in Infection Control and Epidemiology (APIC), Healthcare Infection Control Practices Advisory Committee (HICPAC), Society for Healthcare Epidemiology of America and other professional organizations.

1.1.3. Surveillance, prevention and control activities based on the annual Medical Treatment Facility's (MTF) Infection Prevention and Control Risk Assessment are in alignment with MTF's mission and services offered.

1.1.4. All personnel from units outside the 59 MDW that practice at Wilford Hall Ambulatory Surgical Center will follow this instruction IAW all applicable memorandums of agreement to include the 149th Fighter Wing and the 433rd Airlift Wing.

## 1.2. Reporting Infections.

1.2.1. HCWs notify the Infection Control Office (ICO) of any suspected or confirmed HAIs by fax 292-5917 or telephone 292-7803. At the 359th Medical Group (MDG) call the Infection Preventionist (IP) at 210-652-4191.

1.2.2. When a clinic becomes aware of an infection that a patient acquired from another facility (e.g. post-surgery), the clinic will notify the 59 MDW ICO/359 MDG IP who informs the ICO of the other facility.

1.2.3. The facility reports HAIs to the public through the participation in the appropriate Patient Safety modules in the CDC National Healthcare Safety Network or other databases. The ICO reports HAIs electronically to CDC IAW the Infection Control Annual Plan.

## 1.3. Authority. The 59 MDW and the 359 MDG will utilize their respective ICF to report to their Executive Committee.

1.3.1. The MTF executive management team oversees the ICF through the Executive Committee of the Medical Staff.

1.3.2. The chairperson establishes additional measures to study, prevent, and control infectious diseases when patients, personnel, volunteers or visitors may be at risk.

1.3.3. The chairperson will promptly notify the Chief of the Medical Staff, who then notifies the 59 MDW Commander of situations possessing an imminent hazard to patient care. They will ensure notification of other appropriate personnel (e.g., Risk Manager, Patient Safety Manager). The chairperson will also activate contingency plans based on engineering control failures (e.g., ventilation surveys).

1.3.4. The chairperson, ICO personnel, physician, nurse or technician responsible for the care of the patient have the authority to initiate the appropriate isolation precautions.

1.3.5. The ICF will review this instruction annually to include engineering controls currently used within the MTF, and other commercially available medical devices.

1.3.6. The ICF will establish surveillance methodologies per the Annual Infection Prevention and Control Risk Assessment and the Infection Control Annual Plan to include employee health screening.

1.4. Outbreak Investigation and Sudden Influx of Infectious Patients.

1.4.1. The 59 MDW will adopt the CDC steps for outbreak investigations (<http://www.cdc.gov/excite/classroom/outbreak/steps.htm>). The ICO and Public Health will collaborate to prepare the field work and validate the existence of the outbreak within 59 MDW. Employees report suspected outbreaks to ICO by telephone (292-7803) or pager 594-1992 and to Public Health at 671-9626/9620. At the 359 MDG call the IP at 210-652-4191 and Public Health at 652-2456.

1.4.2. The 59 MDW and 359 MDG will adopt the plan outlined in the Disease Containment Plan, located in the Readiness Emergency Management Plan Section, to respond to a sudden influx of infectious patients.

1.4.3. Environmental Cultures. Unless directed by the ICO or the ICF, no random or routine environmental cultures are performed.

1.5. Responsibilities of all MTF civilians, students, volunteers, contract and military personnel.

1.5.1. All personnel are responsible for knowledge of and compliance with the ICP.

1.5.1.1. Receive initial ICP training during facility orientation or similar forum within 30 days of arrival at the MTF. The ICO will provide the Infection Control (IC) newcomers briefing to new personnel and to those who were unable to attend the scheduled orientation. New personnel who perform any kind of direct patient care or who will encounter blood and body fluid as part of their job responsibilities and/or disinfect instruments must receive unit/area-specific training before they perform any of their duties. IC coordinators or designee will provide the roster of new personnel and their IC orientation dates to the ICO.

1.5.1.2. Receive annual training of IC and Occupational Blood and Body Fluid Exposure Control Plan if assigned to areas of occupational risk for exposure to bloodborne diseases. Training occurs through a facility, computer-based program and section-specific training. IC coordinators or designee will provide copies of the annual section-specific lesson plans and attendance rosters to the ICO.

1.5.1.2.1. Education and Training Division schedules and monitors facility orientation and annual wing training. Annual wing training is accomplished through a central training database (i.e. SWANK) that generates the training rosters.

1.5.1.3. Receive annual training and fit testing for personal respiratory protection if on the Respiratory Protection Program.

1.5.1.3.1. Section-specific IC training (initial and annual) will be documented on the AF Form 55, *Employee Safety and Health Record*.

1.5.2. Report to the Medical Employee Health Office for in-processing into the Medical Employee Health Program (MEHP) within ten days of starting work at the Medical

Treatment Facility (MTF). All personnel will out-process through this office on or before their final work day. Contact Public Health at 292-0353/3140 for questions. At the 359 MDG contact Public Health at 652-2456.

1.5.3. Obtain prompt medical evaluation and treatment IAW MEHP. Notify immediate supervisor of any duty restrictions or limitations as a result of an infectious or communicable disease.

1.5.4. Report suspected HAIs/clusters/outbreaks or communicable diseases according to section 1.2 above.

#### 1.6. Responsibilities of Flight Commanders of Outpatient Services, Managers of Clinics/Patient Care Support Areas.

1.6.1. Ensure personnel know and comply with IC policies and practices listed within this instruction.

1.6.2. Ensure that patients and their families are educated as appropriate about:

1.6.2.1. Multidrug-resistant organisms (MDROs) to include, at a minimum: isolation precautions, hand hygiene (HH), and other HAIs prevention strategies.

1.6.2.2. Central line associated blood stream infection (CLABSI) prevention strategies, prior to accessing the lines, to include sign and symptoms of infections.

1.6.2.3. Catheter associated urinary tract infection prevention strategies prior to insertion of urinary catheter to include signs/symptoms of infections.

1.6.2.4. Surgical site infection (SSI) prevention strategies prior to surgical procedures and signs/symptoms of infections.

#### 1.7. Responsibilities of Infection Control Coordinators.

1.7.1. Assure personnel assigned to work in areas of occupational risk for exposure to bloodborne diseases receive the initial section specific IC orientation before they perform any patient care duties, and the annual section specific IC training. Submit required documentation to the ICO (training rosters, lessons plans and compliance status).

1.7.2. Attend the IC coordinators meetings. If not able to attend, IC coordinators must send a representative. Provide information received to flight commander/clinic managers and disseminate information received accordingly.

1.7.3. Act as a point of contact to area personnel on issues of infection control and assist the ICO with surveillance activities.

1.7.4. Assist in testing new IC products and in the coordination of training.

1.7.5. Appointed officially by flight commander or clinic manager, and attend IC Coordinator course prior to starting official duty.

## 2. Patient Care Practices. (See [Attachment 5](#) for detailed procedures.)

2.1. Infection Control Function Approved Agents. Refer to Attachment 2, Approved Antiseptics and Disinfectants for Healthcare Workers Use and Attachment 3, Approved Disinfectants for Housekeeping Use Only. At the 359 refer to Attachment 9 approved

Antiseptics and Disinfectants for Health Care Workers and Attachment 10 approved Disinfectants for Housekeeping only.

2.2. Fingernails. All HCWs assigned, attached or under contract to the 59 MDW, who perform any patient care duties must keep their nails clean, short (nail tips should be kept to ¼ inch in length) and natural. Artificial nails and nail extenders may not be worn. Fingernail polish is discouraged, but may be worn if it is in good repair and within the 59 MDW dress and appearance requirements.

2.3. Hand Hygiene. Perform HH IAW the CDC/HICPAC guidelines.

2.3.1. Wash hands with either an antimicrobial or non-antimicrobial soap and water if hands are visibly soiled or after contact with a patient who is colonized or infected with a spore forming bacteria (i.e., *Clostridium difficile*).

2.3.1.1. At the 59 MDW, antimicrobial agents are used according to the risk associated with the tasks (i.e., in areas where invasive procedures are performed, when performing high-level disinfection/sterilization and isolation room)

2.3.2. In the absence of visibly soiled hands, alcohol-based products for hand disinfection are preferred.

2.3.3. Use HH product and hand lotion according to product manufacturer's instructions.

2.3.4. Only IC approved lotion is allowed in patient care areas and made available for staff use to prevent dryness of the skin.

2.4. Personal Protective Equipment (PPE). The selection of PPE is based on the nature of the patient interaction and/or the likely mode(s) of transmission.

2.5. Standard Precautions. These precautions must be used for all patient encounters. These precautions include: HH, usage of PPE, handling of soiled patient care equipment, environmental control, handling of textile and laundry, usage of safety needles and other sharps, patient resuscitation, patient placement and respiratory hygiene/cough etiquette.

2.5.1. Patient care equipment must be cleaned between patient encounters.

2.6. Respiratory Hygiene/Cough Etiquette. Applies to any person entering the MTF with signs of illness including cough, congestion, rhinorrhea, or with an increase of respiratory secretions.

2.7. Safe Injection Practices. Use aseptic technique to avoid contamination of sterile injection devices.

2.8. Infection Control Practices for Special Lumbar Puncture Procedures. Wear appropriate PPE including surgical mask when placing a catheter or injecting material into the spinal canal or subdural space.

2.9. Care of Respiratory Therapy Equipment. Attachment 5, table A5.1. Respiratory Therapy Interventions and Guidelines.

2.9.1. Use sterile fluids in nebulization equipment.

2.10. Infection Control Measures for Operative Patients.

2.10.1. Each operative service must instruct the patient and family as appropriate on pre-operative instructions in the following areas: 1) washing or sanitizing hands when changing dressing or when in contact with the intravascular site, 2) bathing/showering the night and/or morning of surgery, 3) requesting pain medications, 4) taking any prescribed antibiotics, 5) not shaving the surgical site the night before or morning of surgery, and 6) any other precautions that are specific for the type of surgical procedure. For current recommendations on wound care, contact the Wound/Ostomy nurse (292-5991).

2.10.2. If necessary, HCW will clip excessive hair around the incisional site, using electrical clippers or a depilatory just before surgery in a pre-op holding area, not in the room where surgery will be performed. Do not use dry or wet razor shaves.

2.10.3. Urinary Bladder Catheterization and Patient Care. Urinary catheters are inserted when necessary and left in place only for as long as clinically necessary.

2.10.4. Procedures performed in the Post Anesthesia Care Unit (PACU).

2.10.4.1. Cast cutting may be performed in the PACU provided that a filtered vacuum is used and it is done at least 10 feet away from other post-operative patients.

2.10.4.2. Procedures involving debridement and/or dressing changes of open wound will not be performed in the PACU.

2.10.4.3. Incision and drainage of wounds will not be performed in the PACU.

2.11. Intravascular Access Device Guidelines. Refer to 59 MDWI 44-151, *Care and Maintenance of Venous and Central Catheters*. Central lines are not inserted routinely at the MTF but can be inserted in case of emergency. In addition, patients with lines may have clinic appointments and lines may be accessed. HCWs will instruct the patient and family as appropriate on how to prevent a CLABSI in the following areas: 1) not allowing anyone to touch them without first washing or sanitizing their hands, 2) maintaining an occlusive dressing over the catheter site, 3) not allowing friends or family to touch the tubing or catheter, 4) inquiring how soon the catheter can be removed, 5) assuring HCWs disinfect the catheter before assessing the hubs or ports, and 6) on signs and symptoms of CLABSI.

2.12. Multiple dose vial/oral medication/single dose vial, handling, labeling and storage of all medications will be according to Pharmacy policies listed in 59 MDWI 44-115, *Pharmacy and Medication Management*.

2.13. Sharps and Employee Safety.

2.13.1. ICF approved safety devices should be used whenever possible. Evaluation of safety devices will be coordinated by the ICO through the Defense Medical Material Program Office/Medical Material Enterprise Standardization Offices with the point of contact being the Designated Senior Logistician for that region, with clinical trials conducted by clinical practice teams or through the ICO. Anytime an employee identifies a problem with a safety device they will notify ICO at extension 292-7803. At 359 MDG call the IP at 652-4191.

2.13.2. Dispose of sharps immediately or as soon as possible after use in a sharps container. Sharps containers must be secured from tampering.

2.13.3. Contaminated needles and other contaminated sharps shall not be bent. They are not recapped or removed unless no alternative is feasible or that such action is required by a specific medical procedure. Recapping or needle removal is accomplished through the use of a mechanical device or one-handed technique.

2.13.4. Reprocessing of contaminated reusable sharps. Sharps shall be placed in appropriate containers until properly reprocessed to prevent against risk of occupational exposure. These containers are puncture resistant, labeled or color-coded, and leak proof on the sides and bottom.

2.13.5. Eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses are prohibited in work areas where there is reasonable likelihood of occupational exposure.

2.13.5.1. Food and drink shall not be kept in refrigerators, freezers, shelves, cabinets, or on countertops or benchtops where blood or other potentially infectious materials are present. Food and drink are prohibited in any work area where medication is prepared or administered except as required to administer the medication to the patient.

2.14. Point of Care Testing (POCT). HCWs will follow standard precautions as outlined in the instruction's attachments. POCT must be in compliance with regulatory accreditation standards and current 59 MDW instructions, 59MDWI 44-103, *Quality Assessment for Point of Care Testing*.

2.14.1. Use only disposable single use fingerstick devices.

2.14.2. After each use, clean and disinfect equipment per manufacturer's instruction.

2.14.3. Use PPE according to task.

2.14.4. Perform HH before and after task.

### **3. Supplies and Equipment (See [Attachment 6](#) for detailed procedures).**

3.1. Disposables and Non Disposables.

3.1.1. Sterile and non-sterile, single patient use disposables items are discarded after use IAW waste management directives. Reprocessing of disposable supplies and equipment items labeled as "single patient use only" will not occur in-house. Policy on Single Use Devices is IAW AFI 44-108, *Infection Control Program*.

3.2. Cleaning, Decontamination, and Disinfection. Patient care items (i.e., blood pressure cuff) or medical devices for use with multiple patients should be cleaned or disinfected in-between uses, and immediately after removal from any isolation room. Patient care equipment attached to a patient will be cleaned by HCW using the appropriate method. Disinfectant wipes are available for use. Surfaces must be dry before any patient contact. Manufacturers' recommendations or nationally recognized guidelines are followed. Cloth or surgical stocking coverings over stethoscopes are not approved for use in this facility.

3.2.1. Procedure for preparing contaminated, reusable instruments for reprocessing. All objects must be thoroughly cleaned prior to any type of disinfection or sterilization.

3.3. High-Level Disinfection. Instruments coming in contact with mucous membranes receive high-level disinfection or terminal sterilization regardless of diagnosis. Instruments must be thoroughly cleaned prior to high-level disinfection with an ICF approved agent (detergent, enzymatic agents or other....) per manufacturers' instructions.

3.4. Processing Scopes. Scopes that come in contact with intact mucous membranes receive at least high-level disinfection prior to re-use. Scopes that enter sterile cavities are sterilized after use or reuse.

3.5. Endoscope Reprocessor. (See [Attachment 6](#))

3.5.1. After using a duodenoscope or any endoscope with an elevator mechanism, sampling and culturing of the scope will be performed according to the latest CDC guidelines and AF instructions for sampling and culturing.

3.6. Processing Transesophageal Echocardiogram Ultrasound Probe. See attachment 6.

3.7. Tonometry Prisms. See Attachment 6.

3.8. Processing Flexible Endoscope. See Attachment 6.

3.9. Processing Ultrasound/Vaginal Probes. See Attachment 6.

3.10. Sterilization.

3.10.1. Results of biological indicators are reported every other month to the ICF. The ICO/IP at 359 MDG is notified of positive biological testing.

3.10.2. Recall. When any of the sterilization indicator results (biological, chemical, or mechanical) are not met, a recall procedure is initiated by Sterile Processing & Distribution (SPD), Dental clinics, Photorefractive Keratectomy Clinic, and/or the respective clinic. At 359 MDG recall would be initiated by the Dental Instrument Processing Center (DIPC). All loads will be recalled and reprocessed. In the event that recalled instruments were used on patients, the patients' information is forwarded to the IC office/IC Chair at 359 MDG and providers are notified by the respective area. Logistics Quality Assurance will initiate recall for commercially processed items.

3.10.3. Event Related Shelf Life. Shelf life is event related, not time related, for in-house processed items in disposable wrap, peel packs, or dust covers, and for commercially prepared packs that indicate they are sterile unless opened or compromised. Rigid instrument containers that are processed in-house are event related. Containers are labeled with a date of sterilization for rotation purposes.

3.11. Dental Instruments. Refer to latest United States Air Force Guidelines for Infection Control in Dentistry Guidance on the Processing of Dental Instruments.

3.12. Handling of patients with known or suspected Creutzfeldt-Jakob disease. Surgeries or lumbar puncture will not be scheduled on patients with known or suspected Creutzfeldt-Jakob disease, and they will be scheduled at a local facility. If a patient presents to 359 MDG, the patient will be transferred to higher level of care.

3.13. Supply Storage IAW AFI 44-108.

3.13.1. Soiled and contaminated supplies are separated from those that are clean and sterile. Do not use any sterile product if the sterility is in question. If it appears to be a manufacturing or shipping problem, notify ICO/IP at 359 MDG for follow-up.

3.13.2. Shelves. Place a Plexiglass-type liner at the bottom of all nonsolid shelves and racks or place supplies in bins if there is no liner at the bottom of the rack.

3.14. Clinical Engineering Flight and Equipment Final Turn In. All patient care equipment needing repair will be thoroughly cleaned and disinfected with an ICF approved disinfectant before being sent for repair. All equipment or supplies to be turned-in for credit will be thoroughly cleaned and disinfected by the respective area before being turned-in. Contact Clinical Engineering for specifics.

3.14.1. Any item that cannot be thoroughly cleaned and disinfected will be clearly labeled with a biohazard label and a written explanation so the receiving area will know to take the necessary precautions.

#### 4. Control of the Environment (See [Attachment 7](#) for detailed procedures).

##### 4.1. Housekeeping.

4.1.1. The ICF reviews housekeeping policies, procedures, and cleaning agents annually.

4.1.2. HCWs must ensure housekeeping personnel are appropriately informed of any patient with infectious or communicable disease so proper precautions are taken when cleaning the room.

4.1.3. Customers conduct routine monitoring of their areas to monitor for cleanliness. Observed deficiencies are reported to the Zone Master of the area or the housekeeping Quality Assurance Evaluator (QAE). Do NOT send complaint forms through distribution or directly to housekeeping but hand carry to the QAE. Do not contact the contractor or housekeeping personnel directly to report lapses in contract performance, except for emergency services. At the 359 MDG contact Facility Management at 652-2521.

4.1.4. Emergency Service Response Procedures. A blood or body fluid spill is considered an emergency. The HCW should cordon off the area to prevent slipping or spreading of the spill, then call housekeeping to provide an emergency response. Housekeeping will respond within 10 minutes. For housekeeping emergency service, call 292-5985, or 59 MDW pager 594-6217. If housekeeping does not respond, notify the Medical Control Center at 292-5990 and follow the same reporting procedure. At 359 MDG call housekeeping at 652-3438

4.1.5. Housekeeper will clean all government owned property and equipment unless attached to a patient or specified in the Individual Medical Facility Exhibit as not to be cleaned.

4.2. Linen. Procedures are IAW 59 MDWI 23-101, *Linen Supply Procedure* and AFI 44-108. At 359 MDG follow only AFI-44-108. Clean linen is stored away from direct patient care areas to minimize microbial contamination. Place clean linen in, 1) a cart with a secure cover (disposable plastic or clean reusable material), 2) a covered linen rack, or 3) a closet or cabinet dedicated for clean linen only. Clean linen remains wrapped until point of use. A 24-hour supply of linen may be unwrapped in user areas.

4.3. Environmental Cleanliness. Managers are responsible to ensure cleanliness of those areas not under contractual Housekeeping Service.

4.3.1. Use ICF Approved List of Environmental Disinfectants for all cleaning and disinfecting. Refer to Attachment 2, Approved Antiseptics and Disinfectants for Healthcare Workers Use and Attachment 3, Approved Disinfectants for Housekeeping Use Only. The 359 MDG refer to Attachments 9 and 10.

4.3.2. Refrigerators.

4.3.2.1. Drugs, specimens, breast milk and food will each have their own refrigerators. Batteries can be stored in any refrigerator as long as they are geographically separated. Reagents will be stored IAW with manufacturers' guidelines and the nature of the reagent. Reusable icepacks may be stored in freezers with sealed medication but should remain geographically separated and should be covered with a pillow case and cleaned after patient use prior to return the freezer.

4.3.2.2. The following government owned refrigerators are cleaned weekly: medication, immunization, patient food , breast milk and clinic specimen refrigerators. Laboratory specimen refrigerators are cleaned monthly or sooner if needed. Freezers are defrosted monthly if not frost free. Specimen refrigerators must have a biohazard label placed on the front of the refrigerator.

4.3.2.3. The temperature for medication and patient food refrigerators must be documented on a daily basis using an electronic device or manual thermometer. Patient food refrigerators are not used at the 359 MDG.

4.3.3. Toys. Parents should be encouraged to bring the child's own toys when visiting the facility. If clinic have made toys available in the lobby/treatment room, they should be cleaned weekly and as needed or after being "mouthed." Remove any soiled or mouthed toy until it can be properly cleaned. Stuffed animals will be used only as distracters and not handled by a child. Clean toy using approved disinfectant wipes followed by a thorough rinsing with water.

4.3.4. Fans. Fans should not be used in the following areas: procedure rooms, any areas with immunocompromised patients, and labs. In all other areas, when using fans, they must be off the floor and have a process to clean blades.

4.3.5. Cleaning of Patient Treatment and Care Area.

4.3.5.1. Environmental surfaces, with an emphasis on surfaces in proximity to the patient and those that are frequently touched, are cleaned using a facility approved disinfectant.

4.3.5.1.1. Cleaning includes but not limited to exam tables, chairs, and equipment.

4.3.5.1.2. Examination Table. A clean sheet, towel, blanket, or exam paper is used for each patient.

4.3.5.2. Cleaning is done before use of patient treatment area.

4.3.5.3. Cleaning is done between patients.

- 4.3.5.4. Terminal cleaning is done daily by housekeeping at the end of the day.
- 4.3.5.4.1. When used for isolation, the exam room must be terminally cleaned after patient discharge.
- 4.4. Insect and Rodent Information. Report insect and rodent infestations within the 59 MDW to Civil Engineering (CE) Services, 292-7377. At 359 MDG call Facility Management at 652-2521.
- 4.5. Solid and Contaminated Waste Management. The ICF has an evaluative and consultative role, rather than operational responsibility. Individuals using area must designate location for the placement of contaminated waste containers and ensure the trash and biohazardous waste are routinely picked up by housekeeping personnel. Reusable waste receptacles are routinely cleaned by housekeeping personnel and relined with fresh plastic liners. Report to Facility Management (292-7171). At 359 MDG contact Facility Management at 652-2521 any specific discrepancies or noncompliance issues.
- 4.6. Antineoplastic Waste Spills. Guidance for antineoplastic waste and spill cleanup refer to 59MDWI 32-7001, *Hazardous Materials, Waste Management and Spill Response Procedures*.
- 4.7. Mercury Spills. Refer to 59 MDWI 32-7001 and to 59 MDW Visual Aid (VA) 32-101, *WHASC Spill Response* for spill response procedures.
- 4.8. Air Handler or Exhaust Fan Shutdown Affecting Negative Flow Rooms. See Attachment 7.
- 4.9. Computerized Tube System Spill Prevention. See Attachment 7.
- 4.10. Construction, Demolition and Remodeling. See Attachment 7.
- 4.10.1. Implementation of specific Interim Infection Control Measures (IICM) mitigating actions and surveillance is an integrated effort from Facility Management, 59 MDW Safety and CE. Executive oversight is maintained through the Facilities and Environment Committee (FEC) and the Board of Directors. The ICO is the primary responsible office for conducting the Infection Control Risk Assessment and Permit with the assistance of Facility Management and CE.
- 4.10.2. The multidisciplinary team will evaluate and analyze construction, demolition or remodeling projects that may impact 59 MDW environmental reservoirs to determine appropriate IICMs. Once the IICMs are established, Facility Management conducts ongoing surveillance until the project is complete. Status of IICMs will be briefed at the FEC and ICF meetings.
- 4.10.3. At 359 MDG the IP conduct the IICM and share with Facility Management for execution. All IICM are reported to the ICF.

## **5. Isolation and Precautions. (See [Attachment 8](#) for detailed procedures.)**

- 5.1. Surgeries are not performed on patients on droplet or airborne precautions. Only patients on contact precautions will be prepped and recovered in a designated area within Same Day Surgery/PACU.

5.2. Transmission Based Isolation. Patients screened with communicable disease will be placed on isolation as soon as possible and not be left in the clinic waiting room. In the clinic setting, Contact Precautions are not required to be used on patients known to have a MDRO unless patient has a draining wound that is not covered/cannot be contained or the patient has diarrhea. The designated transmission based isolation visual aid (VA) sign will be posted on the door of the clinic's exam/treatment room (59MDWVA 44-101, *Contact Isolation*, 59MDWVA 44-102, *Droplets Precaution*, 59MDWVA 44-103, *Airborne Precautions*). Personnel, patients' family and patients are required to read and comply with the stated directions. When the patient leaves the area, the sign is left in place until housekeeping or HCW completes cleaning of the room.

5.2.1. The patient is restricted to the room (e.g. clinic treatment room/PACU) during isolation. If the patient must leave the room for a necessary ordered medical procedure, the sending clinic or unit [i.e. Same Day Surgery (SDS)] must instruct the receiving unit of the type of precautions currently being used prior to transport and patient must be instructed on ways by which they can assist in preventing the transmission of their infectious microorganism to others.

5.2.2. Transporting Patients. The patient is changed into a clean patient gown/covered with a clean sheet (if applicable). Volunteers or students without their preceptor will not transport these patients. The use of PPE by the patient and staff is according to Table 5.1. Maximum Barrier Precautions for Patient Transport.

5.2.3. The sending unit (e.g. SDS, Urgent Care Center or clinic) and receiving area will coordinate when the patient will be sent for the procedure or test. The isolation patient will be taken directly to the procedure room and not left unaccompanied and never in a community waiting area. Personnel transporting patient will wait for the patient unless arrangements have been made by the receiving area to call when the procedure is over.

**Table 5.1. Maximum Barrier Precautions for Patient Transport.**

	GLOVES	SURGICAL MASKS	TUBERCULOSIS (TB) RESPIRATOR	ISOLATION GOWNS
<b>CONTACT</b>				
PATIENTS	NO	NO*	NO	NO
PERSONNEL	YES	NO	NO	YES
<b>DROPLET</b>				
PATIENTS	NO	YES	NO	NO
PERSONNEL	NO	NO	NO	NO
<b>AIRBORNE</b>				
PATIENTS	NO	YES	NO	NO
PERSONNEL	NO	NO	NO**	NO
<b>Note:</b>				
Mask worn by patients if sputum is cultured positive with Vancomycin Resistant <i>Enterococcus</i> , Vancomycin Resistant <i>Staphylococcus aureus</i> , Vancomycin Intermediate Resistant <i>Staphylococcus aureus</i> or Glycopeptide Intermediate <i>Staphylococcus aureus</i> , and Multiple Drug Resistant organism				
The HCWs wear an N-95 respirator only when transporting a patient in close proximity				

(i.e. elevators).

Personnel change into new, clean appropriate PPE prior to leaving the isolation room.

5.2.3.1. Transporting personnel cleans the wheelchair or stretcher before returning it to the unit/clinic. Housekeeping is not responsible to clean these equipment between patients (refer to A7.1.5). Receiving area will thoroughly clean all surfaces coming in contact with the patient after the patient has left.

5.2.4. Terminal Cleaning. Upon termination of isolation, notify housekeeping personnel to perform terminal cleaning. Isolation signs are left in place until housekeeping or the HCW completes terminal cleaning.

5.3. Patient Care Equipment and Supplies. See Attachment 8

5.4. Airborne, Droplets or Contact Precautions. See Attachment 8

5.5. Synopsis of Types of Precautions and Patients Requiring the Precautions. See Attachment 8

5.6. Special Considerations for Biological Warfare Agents. Refer to AFMAN 44-156\_IP, *Field Manual Treatment of Biological Warfare Agent Casualties*.

JOSEPH R. RICHARDS, Lt Col, USAF, MC  
Chief of the Medical Staff

**Attachment 1****GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION*****References***

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### ***Adopted Forms***

*AF Form 55, Employee Safety and Health Record*

*AF Form 847, Recommendation for Change of Publication*

*59 MDW Form 2942, Refrigerator/Freezer Temperature Chart*

### ***Abbreviations and Acronyms***

**APIC**—Association for Professionals in Infection Control and Epidemiology  
**CDC**—Centers for Disease Control

**CE**—Civil Engineering

**CLABSI**—Central Line Associated Bloodstream Infection

**CHG**—Chlorhexidine Gluconate

**CTS**—Computerized Tube System

**CWF**—Central Waste Facility

**DIPC**—Dental Instrument Processing Center

**DSD**—Dual Scope Disinfectant

**ERCP**—Endoscopic Retrograde Cholangiopancreatography

**ERPSS**—En Route Patient Staging System

**FEC**—Facilities and Environment Committee

**HAI**—Healthcare Associated Infection

**HCW**—Health Care Worker

**HICPAC**—Healthcare Infection Control Practices Advisory Committee

**HH**—Hand Hygiene  
**IAW**—In Accordance With  
**IC**—Infection Control  
**ICO**—Infection Control Office  
**ICF**—Infection Control Function  
**ICP**—Infection Control and Prevention Program  
**IP**—Infection Preventionist  
**IICM**—Interim Infection Control Measures  
**IV**—Intravenous  
**LRTI**—Lower Respiratory Tract Infection  
**MDG**—Medical Group  
**MDRO**—Multi-Drug Resistant Organisms  
**MDW**—Medical Wing  
**MDWI**—Medical Wing Instruction  
**MEC**—Minimum Effective Concentration  
**MEHP**—Medical Employee Health Program  
**MERC**—Medical Equipment Repair Center  
**MRSA**—Methicillin Resistant *Staphylococcus Aureus*  
**MTB**—Mycobacterium Tuberculosis  
**MTF**—Medical Treatment Facility  
**NCOIC**—Noncommissioned Officer in Charge  
**OPA**—Ortho-Phthalaldehyde  
**OPIM**—Other Potentially Infectious Materials  
**OPR**—Office of Primary Responsibility  
**OR**—Operating Room  
**OSHA**—Occupational Safety and Health Administration  
**PACU**—Post Anesthesia Care Unit  
**PCR**—Polymerase Chain Reaction  
**PICC**—Peripherally Inserted Central Catheter  
**POCT**—Point of Care Testing  
**PPE**—Personal Protective Equipment  
**QA**—Quality Assurance

**QAE**—Quality Assurance Evaluator

**QC**—Quality Control

**RMW**—Regulated Medical Waste

**SDS**—Same Day Surgery

**SPD**—Sterile Processing & Distribution

**SSI**—Surgical Site Infection

**TB**—Tuberculosis

**TEE**—Transesophageal Echocardiogram

**VA**—Visual Aid

### *Terms*

**Active Tuberculosis (TB)**—Person who has clinical disease demonstrated by X-ray or culture or tissue specimen (e.g., lymph node).

**Airborne Particles**—Can be generated when persons, who have pulmonary or laryngeal TB sneeze, cough, speak or sing. The particles are estimated to be 1-5  $\mu$ m in size, and normal air currents can carry them airborne for prolonged time periods and spread them throughout a room or building.

**Biological Indicators (BIs)**—Specifically identified resistant spores that are used to challenge the sterilizer for effectiveness in killing all forms of microbial growth.

**Blood**—Human blood, human blood components and products made from human blood.

**Community Acquired Infection**—Infection that is not directly attributed to a previous hospitalization, treatment, or clinic visit.

**Droplet Nuclei**—See airborne particles.

**Engineering Controls**—Measures designed to minimize or eliminate the exposure of bloodborne pathogens in the workplace (e.g., sharps containers, needle-free intravenous systems, safety design devices, and PPE).

**Healthcare Associated Infection (HAI)**—Infections associated with healthcare delivery in any setting where healthcare is delivered (e.g., hospital, ambulatory settings.). HAI refers to an infection that was neither present nor incubating on admission or prior to a procedure. This infection can develop during the hospitalization, after a surgical procedure, after discharge from the hospital, after a clinic procedure and refers to a communicable (infectious) disease acquired by a patient as a direct result of a clinic exposure.

**High Risk Patient**—Patient with a disease or condition that reduces resistance to infection (e.g., the immune system is compromised).

**Microbiological Waste**—All cultures and associated materials from medical research, pathological or clinical laboratories, to include culture dishes and disposable devices used to transfer, inoculate, and mix cultures.

**Other Potentially Infectious Material (OPIM)**—Refers to (1) the following human body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids. (2) Any unfixed tissue or organ (other than intact skin) from a human (living or dead); and (3) HIV-containing cell or tissue cultures, organ cultures, and HIV or HBV containing culture medium or other solutions; and blood, organs, or other tissues from experimental animals infected with HIV or HBV.

**Parenteral**—Piercing or mucous membranes or the skin barrier through such events as needle sticks, human bites, cuts and abrasions.

**Patient Reservoir**—Patient infected or colonized with a potentially infectious organism.

**PPE**—Refers to a variety of barriers (e.g., gloves, gown, mask, eye protection, splash shields in lab, covering dental surfaces from aerosolized secretions, or face shield) that are used alone or in combination to protect mucous membranes, airways, skin and clothing from contact with infectious agents.

**Red Bag or Regulated Medical Waste**—Liquid or semi-liquid blood or other potentially infectious materials; contaminated items that would release blood or OPIM in a liquid or semi-liquid state if compressed, items that are caked with dried blood or other potentially infectious materials and are capable of releasing these materials during handling, contaminated sharps (see below for disposal of sharps), and pathological and microbiological wastes containing blood or other potentially infectious materials. Examples of waste not considered regulated medical waste:

Exam gloves with a few spots of blood on them, when removed properly by grabbing at the wrist and folding inside out, one into the other, so the blood is self-contained.

Dressings not saturated with blood or body fluids.

Indwelling urinary catheters.

IV bags and tubing unless there is visible blood in the tubing.

The outside wrapping of the catheter kit, or central line kit, etc.

Nasogastric tubes.

**Reprocessing**—Repackaging and re-sterilization of a single use device that has been opened, but not used on a patient.

**Re-sterilization**—Packaging and sterilization of an unopened single use sterile device that has expired.

**Reuse**—Cleaning, repackaging, and re-sterilization of a single use medical device after use on one patient for the intended purpose of using it on another patient.

**Saturated**—Thoroughly wet such that liquid or fluids flow freely from the item or surface without compression (as defined by OSHA).

**Standard Precautions**—Include a group of infection prevention practices that apply to all patients and equipment used on patients regardless of suspected or confirmed infection status. These practices include: hand hygiene, and use of personal protective equipment (PPE) depending on the anticipated exposure. Respiratory Hygiene Cough Etiquette, safe injection practices and use of masks for insertion of catheters or injection of material unto spinal or epidural spaces via lumbar puncture procedures are new components of SPs.

## Attachment 2

## APPROVED ANTISEPTICS AND DISINFECTANTS FOR HEALTHCARE WORKERS USE

**A2.1.** The Food and Drug Administration approved products are intended for use on human skin or superficial tissue. The National Drug Code usually identifies these products. An example is an antiseptic such as chlorhexidine gluconate.

**A2.2.** Environmental Protection Agency approved products are intended for use on “things” (inanimate objects). An example is a disinfectant such as phenolic product.

**A2.3.** Antiseptic is a chemical germicide formulated for use on skin or tissue. With the exception of alcohol and hydrogen peroxide, antiseptics are not used to decontaminate animate objects.

**A2.4.** Disinfectant is a germicide that inactivates virtually all recognized pathogenic microorganisms, but not necessarily all microbial forms (i.e. bacterial endospores) on inanimate objects.

**A2.5.** New products or substitutions. Submit a request to the ICF for approval before purchase. Once approved, a request must be submitted to Logistics for approval of the new product or the substitution.

**A2.6.** Safety. PPE will be worn in handling any product per the manufacturers’ recommendations. Refer to Safety Data Sheet for product information. The following tables were updated with products listed in section specific operating instructions.

**Table A2.1. Approved Antiseptics (for 59 MDW excluding 359 MDG).**

CHEMICAL AGENT	BRAND NAMES	USES
Alcohol 70% Isopropyl Alcohol	Any brand, sterile single use swab sticks or alcohol pledgets	Patient skin preparation agent
Alcohol based Waterless Hand Cleaner Ethyl Alcohol (62%/70%) Isopropyl alcohol (63%)	Purell Instant Hand Sanitizer Purell Surgical Scrub  Cal Stat Plus with Enhanced Emollients	Used as stated in 59MDWI 44-157 Used as surgical scrubs between cases  Used as stated in 59MDWI 44-157
Propylene Glycol	Provon Foam Wash	General hand hygiene agent and body wash
Chlorhexidine Gluconate *(CHG) CHG (2%)	Bactoshield	Antimicrobial agent for hand washing when a general agent is not sufficient

<b>CHG (4%) Scrub or impregnated sponges</b>	Steris Antiseptic/any brand	Surgical scrubs
<b>CHG (1%)/Ethyl alcohol compound</b>	Avagard Surgical Hand Antisepsis *Substitute : Must be approved by the IC office	Surgical scrubs
<b>Povidone-Iodine</b> *Note: Identify iodine sensitivity before use.	PVP-1 (4 oz. soap/scrub or impregnated sponges) Substitute: Betadine	Antimicrobial/antiseptic [i.e., Urgent Care Clinic, Operating Room (OR)] Surgical hand scrub Not recommended for inanimate objects.
<b>Surgical Skin Preparations</b> Iodophore (10%-5%) Alcohol/Iodine Alcohol/CHG Isopropyl 70%  Chlorohexidine gluconate (4%CHG)/alcohol compound	Any brand  Dura-prep Chloroprep Any brand  Hibiclens	Antiseptics used as surgical scrubs for patients Chloroprep used as well for collection of blood culture  Surgical scrub and pre-op showers when patient allergic to iodine and as ordered

**Table A2.2. Approved Disinfectants for HCWs for 59 MDW excluding 359 MDG.**

<b>CHEMICAL AGENT</b>	<b>BRAND NAMES</b>	<b>USES</b>
<b>Ajax</b>	Comet, or any chlorine based scouring powder	Used for cleaning Custom Ultrasonic Processor processing tanks, filters and outside surfaces
<b>Alcohol</b>	70% Isopropyl Alcohol substitute: any brand, sterile single use swab sticks or alcohol pledgets	Occasionally used to disinfect external surfaces of equipment or surfaces of biological safety cabinets/hood (e.g., stethoscopes)
<b>Chlorine * Sodium Hypochlorite (5.25%)</b>	Any Brand	Used to clean the Computerized Tube System carriers if a spill should occur. Must be diluted at a 1:10 ratio (1 part bleach to 9 parts water) As alternate environmental disinfectant dilute 1:100

<b>Sodium Hypochlorite (0.60%)</b>	Dispatch	Used to clean Hospira pumps, scope washers basins, biohazard safety cabinets/counters in the Clinical Laboratory and other clinics as applicable IAW manufacturer's instructions.
<b>Sodium Hypochloride (0.63%)</b>	Sanicloth Bleach	OR equipment
<b>Sodium Hypochloride (8.25%)</b>	Any brand	Dental, Lab
<b>Enzymatic detergent solution</b>	Enzol Penta prep Microblast with Odorbant (OR) Dornoch Enzyme (OR) OptiPro (SPD) Super Nova (SPD) Metrizyme sponge Steris Valsure (Dental) Renuzyme (Dental) MediClean EZ (area to request approval by ICF)	Instrument cleaner for initial decontamination of instruments (manual/washer/ultrasonic)
<b>Ortho-phthalaldehyde</b>	Cidex OPA substitute: none	Instrument high-level disinfectant
<b>Hydrogen Peroxide (Aqueous Solution)</b>	Sonex HL	Use in Trophon
<b>Hydrogen Peroxide (58%-59.5%)</b>	Advanced Sterilization Product (Johnson & Johnson)	Use in Sterrad
<b>Advanced Hydrogen Peroxide</b>	Oxyvir tb	Used to clean ultrasound machine or as approved by the ICF
<b>Glutaraldehyde</b>	TD 5	Instrument high-level disinfectant used in TD 100 System

<b>Quaternary Ammonia Compound</b>	Super Sani-Cloth  Lysol I.C. Coverage Spray TB Plus Substitute must be approved by ICF	Environmental disinfectants, to be used on inanimate objects.  Equipment cleaner (Clinical Laboratory)
<b>Hydrogen Peroxide Acetic Acid Peroxyacetic Acid</b>	Rapicide PA	Used in Advantage Plus ( Endoscope Reprocessing System)
<b>Phenolic</b>	Envirocide (SPD) Wexcide substitute must be approved by ICF	Environmental disinfectants to be used on inanimate objects.

**Table A2.3. Miscellaneous Agents for 59 MDW excluding 359 MDG.**

<b>CHEMICAL AGENT</b>	<b>BRAND NAMES</b>	<b>USES</b>
<b>Detergents</b>	Any liquid dish washing agent dispensed by non-medical supply  Intercept Detergent	Used to remove gross contaminants from inanimate surfaces GI Clinic for scope cleaning Other areas as approved by ICF
<b>Dish Detergent</b>	Any brand	Cleaning of personal dishes/cups
<b>Non-ionic lotion Mucopolysaccharide lotion Paraben-free lotion</b>	Steris Lotion Soft Skin Conditioner * Eucerin  Biotone *Substitute: None (do not use any other hand lotion unless approved by the ICF)	Employee hand lotion Patient lotion only  PT/OT patient massage
<b>Specific Agents (Listed By Area Of Use)</b>		
<b>Ultrasound/Dermatology/GYN Octyl/Dioctyl dimethyl ammonium chloride Dimethyl benzyl ammonium chloride</b>	Protex wipes	Transducer/cords of Philips CX 50 and Epic Ultrasound machines

<p><b>Sterile Processing and Distribution/Operating room</b></p> <p><b>Hydrochloric Acid</b></p> <p><b>Citric and Phosphoric Acids</b></p> <p><b>Phosphoric Acid</b></p> <p><b>Potassium Hydroxide</b></p> <p><b>Sulfamic acid</b></p> <p><b>Alkaline agent</b></p>	<p>Schedule 90 (SPD)</p> <p>Schedule 7 (OR/SPD)</p> <p>Neodisher (Dental)</p> <p>Tech Wash III detergent (Dental)</p> <p>Lime-A-Way cleaner (Dental)</p> <p>Omni (Dental)</p> <p>Substitutes must be approved through ICF</p>	<p>Sterilizer Chamber Cleaner</p> <p>Sterilizer Chamber Cleaner</p> <p>Washer Cleaner</p> <p>Washer Cleaner</p> <p>Sterilizer Cleaner</p>
<p><b>WHASC Gym</b></p> <p><b>Alkyl dimethyl benzyl ammonium chloride/ Alkyl dimethyl ethyl benzyl ammonium chloride</b></p>	<p>Gym Wipes Professional Formula</p>	<p>Workout equipment cleaner</p>
<p><b>Dental</b></p> <p><b>Sodium Percarbonate compound</b></p> <p><b>Alkaline compound</b></p>	<p>ICX</p> <p>Sterilex Ultra Powder</p> <p>Omni Cleaner XL</p>	<p>Treat water in units</p> <p>Treat dental unit water lines</p> <p>Sterilizer chamber cleaner</p>

## Attachment 3

**APPROVED DISINFECTANTS (HOUSEKEEPING USE) FOR 59 MDW EXCLUDING  
359 MDG**

**Table A3.1. Approved Disinfectants (Housekeeping Use) for 59 MDW excluding 359 MDG.**

CHEMICAL AGENT	BRAND NAMES	USES
Phenolic	Wexcide Substitute must be approved through ICF	Environmental disinfectants to be used on inanimate objects and floors
Germicidal Bleach Sodium Hypochlorite 6.15%	Clorox	Bleach
Ethyl alcohol, n-alkyl dimethyl benzyl ammonium chloride, Di-n-alkyl dimethyl ammonium chloride	Crew Na Bowl Cleaner	Bowl cleaner
Quartz, Dodecylbenzene sulfonic acid	Emerel Creme Cleaner	Bathroom cleaner
Alcohol ethoxylates, Dye	G.P. Forward	General purpose cleaner
Diethylene glycol monoethyl ether	Vectra Floor Finish	Floor wax
Sodium hydroxide, Monoethanolamide, Ethyl alcohol	Bravo Heavy Duty Low Odor Stripper	Floor stripper
Diethylene glycol monoethyl ether	Plaza Sealer Finish	Floor wax
Alcohol ethoxylates, Dye	Stride Neutral Cleaner	Neutral cleaner
Diethanolamine, Diethylene glycol monoethyl ether, Cocamide diethanolamine	Revive	Floor restorer
butoxyethanol, Sodium Hydroxide, Monoethanolamine, Sodium metasilicate, Isobutane	Bravo Foaming Base Board Stripper	Detail stripper
Sodium xylene sulfonate, Alcohol ethoxylates	Extraction cleaner	Carpet solution
Sodium lauryl sulfate	Carpet Shampoo	Carpet solution

Silicones	Defoamer	Carpet defoamer
Sodium lauryl sulfate, Ethyl alcohol	Glance NA Glass Cleaner	Window Cleaner

#### Attachment 4

### PATIENTS COLONIZED OR INFECTED WITH MULTI-DRUG RESISTANT ORGANISMS (MDROS)

**A4.1.** Bacterial resistance has evolved in both the hospital and community, resulting in some bacteria that are resistant to the majority of currently available antibiotics. Patients colonized with an MDRO may develop invasive infections with those organisms. Strategies to control the spread of antibiotic resistant pathogens include: 1) improving antibiotic prescribing practices in order to reduce the selection of antibiotic resistant genes, and 2) scrupulous infection control practices that include adherence to hand hygiene and isolation procedures. MDROs targeted for control in healthcare facilities include:

A4.1.1. Methicillin-resistant *Staphylococcus aureus* (MRSA).

A4.1.2. Vancomycin-intermediate *Staphylococcus aureus*.

A4.1.3. Vancomycin-resistant *Staphylococcus aureus*.

A4.1.4. Vancomycin-resistant *Enterococcus*.

A4.1.5. Multi-drug Resistant *Streptococcus pneumoniae*.

A4.1.6. Multi-drug Resistant gram negative bacteria. Organisms that may require isolation at 59 MDW, depending upon their antibiotic resistance/susceptibility pattern include:

A4.1.6.1. *Pseudomonas aeruginosa*.

A4.1.6.2. *Escherichia coli*.

A4.1.6.3. *Klebsiella pneumoniae*.

A4.1.6.4. *Acinetobacter baumannii-calcoaceticus* complex.

A4.1.6.5. *Stenotrophomonas maltophilia*.

A4.1.6.6. *Burkholderia cepacia*.

A4.1.6.7. Extended spectrum beta lactamase producing organisms.

A4.1.6.8. Carbapenem Resistant *Enterobacteriaceae*.

#### **A4.2. Procedures for Isolation.**

A4.2.1. Ambulatory Care Setting.

A4.2.1.1. Standard Precautions will be applied at all time for all patients. Duration of Isolation Precautions is according to the guidelines from the CDC and Healthcare Infection Control Practices Advisory Committee (HICPAC): *Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*.

A4.2.1.2. Contact Precautions WILL NOT be used on patients known to have a MDRO unless patient has a draining wound that is not covered/cannot be contained/the patient has diarrhea/ patient is having a procedure done.

A4.2.2. Untagging of MRSA patient undergoing surgery.

A4.2.2.1. Patient must not have an open wound that was previously infected with MRSA.

A4.2.2.2. Order a MRSA Polymerase Chain Reaction (PCR) test from the nares. No other cultures required.

A4.2.2.3. Infection Control office will un-tag the patient if the PCR result is negative and patient will no longer need to be on isolation.

A4.2.3. Special Population.

A4.2.3.1. En Route Patient Staging System (ERPSS) Unit Isolation Policy.

A4.2.3.2. Standard Precautions will be used with every patient regardless of their diagnosis or presumed infection status.

A4.2.3.3. Patients with lower respiratory tract infections (LRTI) should be placed on Droplet Precautions in addition to Standard and Contact Precautions.

A4.2.3.4. Any patient with a history of trauma, without documented negative cultures should be considered as colonized with Acinetobacter species. For these patients use Standard and Contact Precautions. For patients with wounds and LRTI, Droplet Precautions shall be used in addition to Standard and Contact Precautions.

A4.2.3.5. For all other ERPSS patients and those who need to “Remain Overnight” and do not meet the above criteria, only Standard Precautions are necessary.

## Attachment 5

### PATIENT CARE PRACTICES

#### **A5.1. Indications for Hand Hygiene.**

A5.1.1. Before any direct contact with patients (even if gloves are worn), contact with blood, bloody fluids, excretions, mucous membranes, non-intact skin, wound dressings, after contact with inanimate objects, including medical equipment in the immediate vicinity of the patient.

A5.1.2. After removing gloves.

A5.1.3. Before donning sterile gloves when performing any invasive procedure or an aseptic task (e.g., inserting an indwelling urinary catheters, placing an intravenous (IV)/other invasive devices, and preparing an injection).

A5.1.4. When hands are visibly dirty, soiled with blood or body fluids, contaminated with proteinaceous material, and after using the restroom facilities, wash hands with either an antimicrobial or non-antimicrobial soap and water.

A5.1.5. If hands will be moving from a contaminated-body site to a clean-body site during patient care.

A5.1.6. Before exiting the patient's care area after touching the patient or the patient immediate environment.

#### **A5.2. Basic Technique for General Handwashing.**

A5.2.1. Wet hands first with warm water before applying 3 to 5 ml handwashing agent to hands, as recommended by the manufacturer.

A5.2.2. Rub hands together vigorously, generating friction on all surfaces of the hands, fingers, and wrists for at least 20 seconds before rinsing hands with warm water.

A5.2.3. Dry thoroughly with a disposable towel then use a clean towel to turn off the faucet.

A5.2.4. Discard towel in waste receptacle.

#### **A5.3. Hand Hygiene Procedures with Alcohol-based Hand Rubs (Hand Gel/Foam).**

A5.3.1. Apply product to palm (following the manufacturer's recommendations, regarding the volume of product to use into one hand) then rub hands together covering all surfaces of hands and fingers until hands are dry.

#### **A5.4. Basic Technique for Surgical Hand Scrub for Procedures Performed in an Operative Setting.**

A5.4.1. Rinse hands and arms with warm running water to remove gross contamination. Clean fingernails under running water with nail cleaner and rinse thoroughly.

A5.4.2. Take scrub brush out of package and start surgical hand scrub by washing fingernails, fingers, hands, and arms to two inches above the elbow, using friction to activate approved antiseptic cleaning agent adding antiseptic agent and water as necessary.

A5.4.3. Rinse fingertips to two inches above elbow thoroughly and discard brush in appropriate container.

A5.4.4. Hands and arms are held up and out from the scrub clothes as individuals proceed into the room.

A5.4.5. An alcohol based surgical hand scrub product with persistent antimicrobial activity following the manufacturer's instruction for usage maybe used after the initial hand scrub for subsequent scrubs.

### **A5.5. Personal Protective Equipment (PPE) Usage.**

A5.5.1. Masks. A fluid resistant disposable mask is worn by HCW : 1) during procedures anticipated to generate splashes or droplets of blood or body fluids, 2) when engaged in procedures requiring sterile technique to protect patients from exposure to infectious agents carried in HCW's mouth and nose, and 3) when placing catheter or injecting material unto epidural space. Use mask when reprocessing soiled instruments/devices or equipment per manufactures instructions. Disposable surgical masks should not be confused with disposable particulate respirators (e.g., N-95).

A5.5.1.1. Single use disposable masks are changed between each patient or when contaminated.

A5.5.1.2. Remove mask by elastic or cloth tie strings without touching the face of the mask and discard in general waste container.

A5.5.2. Protective goggles, face shields, or eye wear with side shields. Eye protection is to be worn when it is likely that there will be a splash or spray of any respiratory secretions or other body fluids. Use of safety glasses with side shields are required when performing suctioning procedures. Use eye protection when reprocessing soiled instruments/devices or equipment per manufactures instructions.

A5.5.2.1. Standard prescription glasses and contact lenses are not considered PPE.

A5.5.2.2. Protective Reusable Eyewear/Face Shields are removed by headband or side arms without touching shield or lens area.

A5.5.2.3. Disinfect per manufacturer's instructions and dry thoroughly before reuse.

A5.5.3. Gown. A disposable moisture proof repellent or impervious gown with arm length sleeves is worn during procedures anticipated to generate splashes of blood or body fluids and other potentially infectious material (OPIM). Use gown when reprocessing soiled instruments/devices or equipment per manufactures instructions.

A5.5.3.1. Change between each patient or when contaminated. Do not hang on the door or any other area of the patient's room for re-use.

A5.5.3.2. Remove gown without touching the front. If tied on garment, use the tie strings to remove and peel off garment inside out. Dispose of the gown in a general waste container or regulated medical waste (RMW) container when grossly contaminated with blood or OPIM.

A5.5.4. Gloves. Gloves are required when there is any anticipation of direct contact with blood or body fluids, OPIM, mucous membranes, non-intact skin, touching or handling

potentially contaminated patient care equipment or environmental surfaces, and any direct contact with patients who are colonized or infected with pathogens transmitted by the contact route. Use gloves when reprocessing soiled instruments/devices or equipment per manufactures instructions.

A5.5.4.1. Remove gloves by grasping at the wrist and stripping off the glove "inside-out" then place gloves in general waste containers when not grossly contaminated with blood or OPIM.

A5.5.4.2. Gloves are changed after each patient contact, between procedures on the same patient or when moving from one site to another on the same patient. Immediately perform appropriate hand hygiene each time gloves are removed per paragraph A5.2.

A5.5.4.3. Do not wash gloves with the purpose of reuse.

A5.5.5. Fluid resistant, disposable shoe covers are indicated during procedures anticipated to generate spills.

A5.5.6. Fluid resistant, disposable hair covering is indicated during procedures anticipated to generate aerosols or splashes.

A5.5.7. Remove PPEs before leaving the patient treatment/procedure room and the dirty utility room.

#### **A5.6. Respiratory Hygiene/Cough Etiquette.**

A5.6.1. Respiratory Hygiene/Cough Etiquette procedures include covering the nose and mouth when coughing or sneezing, using tissues to contain respiratory secretions disposing promptly in the nearest waste receptacle after use, donning a surgical mask to any person who is coughing if tolerated and appropriate, and performing hand hygiene IAW paragraph A5.2.

A5.6.2. Recommend greater than or equal to 3 feet separation between a person with respiratory infections and other individuals in common waiting areas.

A5.6.3. The following materials will be made available in common patient/visitor gathering areas throughout the institution:

A5.6.3.1. Tissues.

A5.6.3.2. Alcohol-based hand rub dispensers.

A5.6.3.3. Surgical masks.

A5.6.4. Visual alerts (e.g., signs and posters) will be posted at the entrances to the 59 MDW, all outpatient facilities and other common patient and visitor gathering areas.

A5.6.5. Patients and individuals accompanying patients will be requested to inform HCWs of symptoms of a respiratory infection when they first register for care and/or at first point of entry.

A5.6.6. Patients and visitors will be asked to practice Respiratory Hygiene/Cough Etiquette to include the staff offering masks to persons who are coughing and to sit at least three (3) feet away from other non-respiratory infected individuals in common waiting and gathering areas.

**A5.7. Safe Injection Practices (according to Centers for Disease Control (CDC) Safe Injection Practices). Refer to [paragraph A5.11. Multiple Dose Vial/Oral Medication and Single Dose Vial.](#)**

A5.7.1. Do not administer medications from a syringe to multiple patients, even if the needle/ cannula on the syringe is changed or injection is administered through an intervening length of intravenous tubing. Needles, cannula and syringes are sterile, single-use items; they should not be reused for another patient nor to access a medication or solution that might be used for a subsequent patient.

A5.7.2. Use fluid infusion and administration sets (i.e., IV bags, tubing and connectors) for one patient only and dispose appropriately after use. Consider a syringe or needle/cannula contaminated once it has been used to enter or connect to a patient's intravenous infusion bag or administration set.

A5.7.3. Do not administer medications from single-dose vials or ampoules, or bag or bottles of intravenous solution to multiple patients or combine leftover contents for later use. If multi-dose vials must be used, both the needle or cannula and syringe used to access the multi-dose vial must be sterile.

A5.7.4. Use aseptic technique when preparing medications.

A5.7.5. Clean the access diaphragms of medication vials with 70% alcohol and allow to dry before inserting a device into the vial.

A5.7.6. Do not reuse a syringe to enter a medication vial or solution.

A5.7.7. Dispose of used syringes and needles at the point of use in a sharps container that is closable, puncture resistant, and leak proof.

**A5.8. Care of Respiratory Therapy Equipment.**

A5.8.1. Equipment used to nebulize liquids increase the risk for respiratory infections. Equipment parts where fluid can collect are potential sources of infectious organisms that can deliver contaminated effluent.

**Table A5.1. Respiratory Therapy Interventions and Guidelines.**

<b>Equipment</b>	<b>Circuit Changes</b>	<b>Terminal Cleaning</b>	<b>Device Specific Information</b>	<b>General Information, Applies To All RT Equipment</b>
All Nasal Cannulas, Venturi Masks, and Simple O2 Masks	Use until treatment (TX) is changed, discontinued (D/C'd) or device becomes soiled	Discard if TX is D/C'd or device becomes soiled		Clean frequently touched surfaces of equipment while in use (e.g., pulse oximeter)  Aseptic technique is required for any procedure or manipulation of the

Hand held Nebulizer	Replace entire system, nebulizer and tubing between patients	Discard after use	Follow manufacturer instruction	respiratory tract  The wear of appropriate PPE is dependent on the procedures being performed/patient status
Prefilled Humidifier Bottles and Nasal Cannulas	Single patient use, replace when empty	Discard after use or within 24 hours		All devices entering sterile tissue are to be sterile
Large Volume Nebulizer Bottles Face Tent, Trach. Collar, Aerosol Mask and Accompanying Large Bore Tubing and in-line water traps.	Single patient use, replace nebulizer bottle when empty. Date and time when opened	Discard if modality is changed, discontinued or device becomes soiled	Single patient use	All devices touching mucous membranes are sterilized or high-level disinfected. Use STERILE WATER to rinse off liquid chemical disinfectant (e.g. glutaraldehyde) from devices that will touch mucous membranes  Disposable items are single patient use only and are utilized whenever possible
Ambu Bags	Replace between patient	Discard when device becomes soiled or when patient is discharged	Discard any Ambu Bags not protected by an impervious wipeable cover	Disposable items are NOT reprocessed unless approved, refer to Section 3.1.1.
Single Use Suction Catheters	Change after every use	Discard after use	If suction catheter needs to be cleared while suctioning a patient; use sterile water	Only sterile fluids (water, normal saline, medications etc.) are aseptically placed in any reservoir
Yankauer	Single pt. use	Discard after use		

Pulse Oximeter Sensor Probe (ear or finger)		<u>Reusable device</u> , clean unit with an approved IC disinfectant frequently. <u>Disposable device</u> , for single patient use, discard after use		Water condensed in the tubing is periodically drained and discarded taking precautions not to allow condensate to drain toward the patient or back into the reservoir.  If multi-dose med. vials are used, handle, dispense, and store according to directions on the vial label or package insert.
Suction cannister and Tubing	Single patient use only: discard canister when full.  Multi-patient use: change tubing between patients and change canister when full.	Discard (seal suction cannister and dispose of as red bag trash, do not attempt to empty)	If suction catheter needs to be cleared while suctioning a patient, use sterile water.	The event related shelf life will be followed for all respiratory sterile supplies. Refer to section 3, Supplies and Equipment.
Endotracheal Tube (ETT) and Tracheostomy Tube	Single patient use	Cleaning per manufacturer instructions	Tracheostomy should be performed under sterile conditions.	“Topping Off” of any reservoirs is not permitted
Respironics BiPAP	Change between patients and as needed on the same patient	Throw away all disposables Wipe unit and cord with an approved IC disinfectant	Change filter as needed	
Universal Fiber optic Bronchoscope		Terminal cleaning in accordance with manufacturer’s instructions		
Universal Optical Light Source		Clean unit with an approved IC disinfectant		

Wrights Spirometer		Clean unit with an approved IC disinfectant		
NIF		Clean unit with an approved IC disinfectant		
Cuff Manometer		Clean unit with an approved IC disinfectant		
<b>Note:</b> All Nasal Cannulas, Venturi Masks, and Simple O2 Masks, Hand held Nebulizer, Ambu Bags, Pulse Oximeter Sensor Probe (ear or finger), Suction cannister and Tubing, Endotracheal Tube (ETT) and Tracheostomy Tube.				

### **A5.9. Infection Control Measures for Operative Patients.**

A5.9.1. Use sterile technique for dressing changes.

A5.9.1.1. Sterile occlusive dressings are secured over the incision until the wound edges have approximated and sealed.

A5.9.2. Main prevention strategies of reduction of SSI are appropriate use of prophylactic antibiotics, appropriate hair removal, control of post-operative serum glucose and immediate post-operative normothermia.

### **A5.10. Urinary Bladder Catheterization and Patient Care.**

A5.10.1. HCWs will instruct the patient and family as appropriate (use return patient demonstrations as applicable) on how to prevent a urinary catheter associated infection in the following areas: 1) any person who touches the patient for insertion, irrigation, or catheter hygiene care must first wash or sanitize their hands, 2) making sure the catheter is secured to their leg, 3) ensure the urine collection bag is maintained below the bladder but not on the floor, 4) continue to inquire how soon it can be removed as soon as possible, and 5) the signs and symptom of urinary tract infection.

A5.10.2. Patient Care. Limit the use and duration to situation necessary for patient care. Use aseptic techniques for site preparation, equipment, and supplies.

A5.10.2.1. Female patients. If the catheter is inadvertently inserted into the vagina, leave it there temporarily as a mapping aid. Obtain another sterile catheter and insert it properly. Secure the catheter to the thigh. Do not allow dependent loops to form in the collection tubing, allowing unobstructed flow to collection bag and preventing back flow.

A5.10.2.2. Male patients. Anchor male patient's catheter to the leg to prevent accidental dislodgement, excessive movement and ureteral trauma.

A5.10.2.3. For free flow of urine into the bag, arrange tubing either by coiling it on the bed or by laying straight out. Maintain the drainage unit below the level of the patient's bladder at all times. Do not allow collection bag to touch the floor. Instruct ambulatory patients to carry the bags below bladder level.

A5.10.2.4. Maintain a closed system at all times.

A5.10.2.5. Change the catheter and entire system when it no longer functions properly, if encrustations accumulate, or if disconnection occurs.

A5.10.3. Bladder irrigation.

A5.10.3.1. Intermittent irrigation requires aseptic techniques and sterile solutions.

A5.10.3.2. Continuous irrigation requires a 3 way catheter in which the third lumen is for the irrigation solution connection.

A5.10.3.3. Intermittent Self-Catheterization Care. While the patient is in the Facility for an extended period of time or overnight stay, self-catheterization is done using sterile technique and equipment. At home the patient may use a clean non-sterile technique.

A5.10.4. Routine urine cultures are not required and Foley catheter tips are not cultured. Collect urine samples according to evidence based nursing guidelines (i.e., Lippincott).

A5.10.5. Disposal of Urinary Equipment.

A5.10.5.1. Urinary catheters, collection tubing/bags, irrigation tubing/solution, specimen containers, irrigation syringes, emptying containers (i.e., urinals, toilet hats, etc.) are emptied into the bathroom toilet or dirty utility room hopper.

A5.10.5.2. Don non-sterile gloves and appropriate PPE when anticipating splashing, empty all residual urine equipment into an emptying container or toilet, and discard equipment in general waste receptacles. Only empty urinary equipment with visible blood is discarded in a RMW container.

A5.10.6. Urinals and bedpans are single patient use only. Discard when the patient leaves the Facility. These items will not be reused or reprocessed.

**A5.11. Multiple Dose Vial/Oral Medication and Single Dose Vial.**

A5.11.1. Handling, labeling and storage of medications will be according to Pharmacy policies. Refer to 59 MDWI 44-115.

A5.11.2. Medication will be drawn up in a designated clean medication preparation area away from immediate treatment areas and specimen collection. If reconstitution of the drug is required, follow the manufacturer's instruction.

A5.11.3. Dedicate multi-dose vials to a single patient whenever possible. If multi-dose vials will be used for more than one patient, they should be restricted to a centralized medication area and should not enter the immediate patient treatment area (e.g. operating room, patient room/cubicle). If multi-dose vials enter the treatment room they are to be handled as single dose vials and are discarded after use.

**A5.12. Intravascular Access Device Guidelines.** For additional information, refer to [www.cdc.gov/hicpac/pdf/guidelines/bsi-guidelines-2011.pdf](http://www.cdc.gov/hicpac/pdf/guidelines/bsi-guidelines-2011.pdf). At the 359 MDG and 559 MDG only peripheral venous catheters are placed.

A5.12.1. Training.

A5.12.1.1. Personnel involved in placement/access of central line will receive training on the indications for IV catheter use, proper procedures for the insertion/ maintenance of IV catheters (as applicable) and appropriate infection control measures to prevent central-

line associated bloodstream infections initially and annually thereafter. Area supervisors are responsible to assure competency of HCWs by using a checklist that includes the Institute for Healthcare Improvement bundle components.

A5.12.1.2. Except in the event of an emergency, patients and family members will also be advised of infection and prevention strategies prior to insertion of any central venous devices.

A5.12.1.3. All items necessary for central line catheter insertion must be gathered prior to the procedure.

A5.12.1.4. Maximum sterile barrier precautions will be used.

#### A5.12.2. Skin Prep and Hand Hygiene Prior to Insertion of Access Devices.

A5.12.2.1. Optimum site selection. Select catheters on the basis of the intended purpose and duration of use, known infectious and non-infectious complications (e.g. phlebitis and infiltration), and experience of the staff inserting the catheter. For tunneled central catheter, use the subclavian vein as the preferred site.

A5.12.2.2. Hand Hygiene. Hand hygiene should be performed with an antimicrobial soap before and after palpating catheter insertion sites as well as before and after inserting, replacing, accessing, repairing, or dressing an IV catheter. Palpation of the insertion site should not be performed after the application of antiseptic, unless aseptic technique is maintained.

A5.12.2.3. Maximum Barrier Precautions. Use sterile technique, including sterile gown, gloves, cap, mask and large sterile drape for the insertion of all central venous, peripherally inserted central catheter (PICC), midlines catheters, arterial catheters or guide wire exchanges. Use these precautions even if the catheter is inserted in the operating room.

A5.12.2.3.1. Wearing clean gloves is acceptable for the insertion of peripheral venous catheters if aseptic technique can be maintained.

A5.12.2.4. For peripheral venous catheters, clean site using an antiseptic (70% alcohol, tincture of iodine or alcoholic chlorhexidine gluconate solution). For central catheters, use 2% chlorhexidine gluconate (CHG) or >0.5% chlorhexidine preparation with alcohol. Antiseptics should be allowed to completely dry (at least 30 seconds) before catheter insertion.

A5.12.2.4.1. Use tincture of iodine, iodophor or 70% alcohol if the patient has an allergy to CHG.

A5.12.2.4.2. Maintain aseptic technique for the insertion and care of IV catheters.

#### A5.12.3. Maintenance and Site Care of Peripheral and Central Venous Catheters.

A5.12.3.1. Use either sterile gauze or sterile, transparent, semipermeable dressing to cover the catheter site.

A5.12.3.2. Replace catheter site dressing if the dressing becomes damp, loosened, or visibly soiled.

A5.12.3.3. Do not use topical antibiotic ointment or creams on insertion site because of their potential to promote fungal infections and antimicrobial resistance.

A5.12.3.4. Primary and piggyback IV administration sets are single patient use and will be changed at any time contamination occurs. If disconnected from patient, place sterile cap on end of administration set.

A5.12.3.5. Any IV fluid bag will not be hung longer than 24 hours.

A5.12.3.6. Disinfection of catheter hubs, ports and connectors, with a friction scrub for 15 seconds, with a 70% alcohol base or chlorhexidine-alcohol preparation will be performed prior to accessing the catheter. Usage of approved catheter cap is highly encouraged.

A5.12.3.7. Evaluate the catheter insertion site. All vascular access sites should be assessed for signs and symptoms of infection. Document findings.

A5.12.3.8. All intravascular devices should be removed as soon as no longer clinically indicated.

A5.12.3.8.1. Replace peripheral venous catheters when the patient has developed signs and symptoms of infection.

A5.12.4. Catheter Site Care. Catheter site care will be performed using aseptic or sterile technique and observation of standard precautions to coincide with dressing changes.

A5.12.4.1. Peripheral IVs. Secure with an approved securing device; use aseptic technique, clean with chloroprep, and use a transparent dressing.

A5.12.4.2. Non-Tunneled or Tunneled Catheter. Use aseptic technique, clean with chloroprep, use transparent dressing and replace every 7 days (unless the dressing is soiled or loose) until the insertion site has healed. Replace gauze dressing every 2 days.

A5.12.4.3. PICC. Use sterile technique, transparent dressing and change every 5-7 days. Replace gauze dressing every 2 days. Measure the arm circumference 10 cms above antecubital with each dressing change.

A5.12.4.4. Implanted Ports. Use sterile technique, gauze dressing until the incision stops draining; use transparent dressing when port is accessed, chloroprep before accessing port; use non-coring Huber needle.

A5.12.5. Procedure for Central Venous Catheter Dressing Changes IAW Mosby Nursing Skill Procedures.

## Attachment 6

### SUPPLIES AND EQUIPMENT

#### A6.1. Disposables and Non Disposables.

A6.1.1. Reusable medical equipment must be cleaned, reprocessed and maintained according to the manufacturer instructions.

A6.1.2. Reusable equipment that has been cleaned properly is stored in a dedicated equipment storage room/area.

A6.1.2.1. Reusable medical equipment (e.g., blood glucose meters and other point of care devices, surgical instruments, endoscopes) is cleaned and reprocessed appropriately prior to use on another patient.

A6.1.2.2. Maintain copies of the manufacturer's instructions for reprocessing of equipment in use in the area.

A6.1.2.3. HCWs wear appropriate PPE when handling and reprocessing contaminated patient equipment.

A6.1.3. Torn Vinyl. Call Medical Equipment Repair for items with 59 MDW sticker. Consult with supply/equipment custodian for items that do not have a sticker. Notify Facility Interior Designer at 292-7172, to evaluate furniture if torn vinyl is found. At 359 MDG contact Medical Maintenance for repair at 210-292-5103 after hours call 210-292-7654.

**A6.2. Cleaning, Decontamination, and Disinfection.** Items are not considered decontaminated until they meet requirements stated in the manufacturer instructions and in accordance with the CDC recommendations (Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008(<http://www.cdc.gov/hicpac/pubs.html>))

A6.2.1. Procedure for preparing contaminated, reusable instruments for reprocessing. After procedure, remove gross contaminants (e.g., blood, tissue) from instrument per manufacturer's instructions.

A6.2.1.1. The contaminated instruments/devices must be carried as soon as possible in a covered instrument tray or other container with leak proof sides and bottom from point of use to dirty utility room. Instruments/devices cannot be reprocessed in the treatment room. The container must be identified as biohazardous by using a biohazard sticker. If the container does not have a biohazard label on it, place the container into a red bag to be transported to SPD/ (DIPC at 359 MDG) by unit or clinic personnel. Wearing gloves is required when handling contaminated items during transportation.

A6.2.1.1.1. Use a dedicated cart to carry instruments to be reprocessed to SPD. Cart must be wiped down with an approved disinfectant wipe after instruments have been transported to the reprocessing area and prior to leaving SPD. Use gloves when handling dirty cart. At 359 MDG instruments are carried by hand to DIPC.

A6.2.1.2. Handling of Instruments with Little or Heavy Soiling.

A6.2.1.2.1. Instruments with Little Soiling.

A6.2.1.2.1.1. First Option. Instruments are gently rinsed by submerging under

water (avoid splashing) to remove body fluids and secretions before taking to SPD according to paragraph A6.2.2.1.1.

A6.2.1.2.1.2. Second Option. Instruments are coated with an enzymatic detergent/detergent spray or a and immediately taken to SPD or are coated with an enzymatic detergent/detergent spray (no longer than time allowed by manufacturer) and handled per product's manufacturer before taking to SPD. This is the only option used at the 359 MDG.

A6.2.1.2.2. Instruments with Heavy Soiling.

A6.2.1.2.2.1. Instruments are placed in an enzymatic detergent that has been mixed per the manufacturer's directions and allowed to soak (no longer than time allowed by manufacturer). Used detergent is poured down the drain avoiding splashing. Instruments are rinsed by submerging under water before taking to SPD. Another option is to coat instruments with an enzymatic detergent spray and follow instruction listed on paragraph A6.2.1.2.1.2 option#2.

A6.2.1.3. Areas that do not routinely reprocess instruments, but had the instruments in the code cart opened, will place the instruments in the rigid wall container where originally stored, and spray the instruments with an enzymatic detergent spray. Promptly transport to SPD for reprocessing.

A6.2.1.3.1. All areas with no dirty utility room, will spray the instruments with an enzymatic spray after completion of the procedure and transport immediately to SPD/DIPC at 359 MDG in a covered bin. Prior arrangement must be made with SPD/DIPC at 359 MDG.

A6.2.1.4. Clinics must maintain separate designated areas for pick-up of soiled items and delivery of sterile items.

A6.2.1.5. Hydrocollators.

A6.2.1.5.1. Hydrocollators, hydrocollator pads, paraffin bath will be cleaned per manufacturer's instruction. Remove wax per manufactures instructions, or as needed when it becomes significantly discolored or when there is excessive sediments in the tank.

A6.2.1.6. Mass Flow Sensor.

A6.2.1.6.1. Pulmonary Function Testing with the exception of Cardiopulmonary Exercise Testing will be done with a bacterial filter placed in-line with the mass flow sensor.

A6.2.1.6.1.1. Use a new filter for each patient.

A6.2.1.6.2. Cleaning and disinfecting of mass flow sensors is done at a minimum weekly or after usage on a patient infected with Mycobacterium Tuberculosis (MTB) or suspected to have MTB. Disinfection will be performed using Cidex Ortho-Phthaldehyde (OPA).

A6.2.1.7. Washer and Dryer En Route Patient Staging System (ERPSS).

A6.2.1.7.1. ERPSS formally known as Aerospace Staging Flight or ASF.

A6.2.1.7.1.1. The washer and dryer will be cleaned after each use using a facility approved disinfectant. The inside drum as well as the outside of the machine must be cleaned.

A6.2.1.7.1.2. The dryer lint filter will be cleaned after each use.

A6.2.1.7.1.3. Each user of the washer and dryer may not combine their laundry with another person's laundry.

A6.2.1.7.1.4. Patients will use unit-supplied detergent.

#### A6.2.1.8. Tonometer Tips.

A6.2.1.8.1. Contact tonometry tips that come into direct contact with the eye during examination will be disinfected between usage. Three options are approved for the cleaning of instruments within the facility. Disinfecting with the Tonowash is the preferred method.

A6.2.1.8.2. Tonowash Cleaning. Follow manufactures instructions for proper usage.

A6.2.1.8.2.1. Each tip is rinsed with tap water and disinfected by placing in Tonowash (10% bleach solution) for 5 minutes.

A6.2.1.8.2.2. Rinse tips twice with sterile water.

A6.2.1.8.2.3. Allow tips to air dry or dry tip with lint free clean cloth or tissue paper.

A6.2.1.8.2.4. Containers will be cleaned and replenished with fresh bleach solution and sterile water on a daily bases.

A6.2.1.8.3. Manual Cleaning. Wipe tonometer tip clean to remove debris.

A6.2.1.8.3.1. Rinse the tip under cold tap water for 30-60 seconds.

A6.2.1.8.3.2. Submerge tip in a container of 10% Sodium Hypochlorite (bleach) solution for 5 minutes.

A6.2.1.8.3.3. Rinse tip thoroughly with sterile water to remove bleach solution for 30-60 seconds. Allow tips to air dry or dry tip with lint free clean cloth or tissue paper.

A6.2.1.8.3.4. Containers will be cleaned and replenished with fresh bleach-sterile water solution on a daily basis.

A6.2.1.8.4. Alcohol Cleaning. Each tip will be thoroughly wiped with an alcohol wipe and allowed to air dry.

A6.2.1.8.4.1. End of day processing will include a cycle through the Tonowash or manual submersion of the tonometer tip in 10% sodium hypochlorite solution for 5 minutes followed by rinsing twice in sterile water. Refer to paragraph A6.2.2.1.9.2. and A6.2.2.1.9.3.

A6.2.1.8.4.2. Containers will be cleaned and replenished with fresh bleach solution and sterile water on daily basis.

### **A6.3. High-Level Disinfection.**

A6.3.1. Instruments must be thoroughly cleaned prior to high-level disinfection with an enzymatic detergent or mild soap or other agent per the manufacturer's instructions. Rinse off enzymatic solution/soap. Dry instruments/probes/scopes before proceeding to disinfection.

A6.3.1.1. In the event of failure of high level disinfection parameter (i.e., test strip quality control (QC) of Cidex OPA)/Hydrogen Peroxide/ Rapicide PA, follow manufacturer's troubleshooting instructions. If applicable, a) reprocess instruments/devices before use on a patient; b) activate a recall process; and/or c) notify provider and IC officer if item was used on a patient.

A6.3.1.2. Enzol Solution Requirements:

A6.3.1.2.1. Enzol Solution is to be mixed by adding 1 ounce of Enzol per 1 gallon of water. The water does not have to be sterile or filtered to prepare the solution.

A6.3.1.2.2. Enough solution should be made so the instrument can be completely submerged for a minimum of 1 minute.

A6.3.1.2.3. Wipe any gross contaminant from the outside of the instrument immediately after procedure before submerging in Enzol Solution.

A6.3.1.2.4. Rinse thoroughly with water and dry, making sure to submerge instrument under water. Sterile or filtered water does not need to be used at this stage.

A6.3.2. Instruments coming in contact with mucous membranes receive high-level disinfection or terminal sterilization (e.g. ultrasounds probes, vaginal probes).

A6.3.3. The room used for OPA, TD-5 TM, Hydrogen Peroxide (Tropon Sonex-HL), Rapicide PA must be well ventilated per manufactures instructions. Each section using high-level disinfection will be evaluated by Bioenvironmental Engineering as applicable. The room will be placed on the ventilation study program with air exchange per hour measured every six months by CE/Bioenvironmental Engineering at 359 MDG. Keep a copy of the air flow studies in the work area. An eyewash station affixed to a faucet or a portable unit must be available in the immediate area.

A6.3.3.1. Don PPE to include fluid resistant mask, goggles or face shield, moisture repellent full sleeve gown, and gloves. Powder-free gloves or rubber gloves are appropriate for manual cleaning and placing items into the automated reprocessor if no contact will be made with the solution. If the exposure will be of a prolonged nature or there is any opportunity for skin contact with disinfectant or instruments coated with disinfectant, the HCW will wear specific type gloves per manufacturer's instructions (i.e. nitrile gloves).

A6.3.3.2. Cidex OPA Requirements.

A6.3.3.2.1. Cidex OPA solution is stored in original container for 75 days after opening. This product does not require activation and is ready to use.

A6.3.3.2.2. Cidex OPA may be reused for 14 days after pouring into soak container or Dual Scope Disinfector (DSD) machine. Check OPA solution temperature daily

prior to each use (>20 degree Celsius for manual soaking and > 25 degree Celsius for use in DSD machine).

A6.3.3.2.3. Date the original container of Cidex OPA solution and test strip bottle when opened. Specify the new expiration date.

A6.3.3.2.4. Test concentration level of the Cidex OPA (in the soak container or DSD compartment) with QC strip before each use using manufacturer's recommended method (i.e., test strip). Record test results.

A6.3.3.2.5. Dip the test strip in soak tray or reservoir for 1 second.

A6.3.3.2.5.1. Read results at 90 seconds.

A6.3.3.2.5.2. The indicating pad will exhibit a complete color change to purple to indicate the solution is above minimum effective concentration (MEC).

A6.3.3.2.6. Cidex OPA solution test strip bottle may be used for 90 days after opening.

A6.3.3.2.6.1. New bottles of Cidex OPA test strips will have a QC test performed before using test strips.

A6.3.3.2.6.2. Prepare a positive control by pouring a small amount (1 ounce) of full strength Cidex OPA solution into an appropriate container.

A6.3.3.2.6.3. Prepare a negative control by diluting 1 part full strength Cidex OPA solution with 1 part water in an appropriate container.

A6.3.3.2.6.4. Dip 3 test strips into each of the freshly prepared controls one at a time. A total of 6 strips, 3 per control are required for the test. Ensure that the indicating pad on the strip is completely submerged for a full second.

A6.3.3.2.6.5. Verify the following results at 90 seconds after the test strip is removed from the solution. All 3 strips dipped in the positive control should exhibit complete color change to purple. If any blue appears on the indicating pad apart from the top line, the solution is below the MEC. Refer to the color chart on the bottle of test strips for interpretation of test results.

A6.3.3.2.6.6. All 3 strips dipped in the negative control should appear blue or exhibit an irregular (i.e. marbled) color change to purple.

A6.3.3.2.6.7. Discard the remaining strips if the results obtained from the QC test indicate that the test strips are not functioning properly. Retest using a newly opened bottle of Cidex OPA solution test strips. If result is still out of range contact your supervisor.

A6.3.3.2.6.8. Document the QC of test strips with the lot number and date when bottle is opened.

A6.3.3.3. Manual Soaking of Instruments in Cidex OPA.

A6.3.3.3.1. Submerge the instrument or object completely in the OPA for at least 12 minutes.

A6.3.3.3.2. Remove all bubbles from the surfaces and lumens if applicable. Avoid splashing.

A6.3.3.3.3. Replace the lid securely covering the disinfecting solution.

A6.3.3.3.4. Note the start and stop times.

A6.3.3.3.5. Upon completion of the disinfection phase, don the appropriate PPE, remove the object and dry completely. Rinse by soaking in copious amounts of sterile water (3 times) for a minimum of 1 minute to eliminate any chemical residue. Sink water that is filtered through a 0.2 Micron filter is also acceptable. Use rinse containers or tube and discard water between rinses.

A6.3.3.3.5.1. Ensure that all instruments are completely submerged in the rinse water.

A6.3.3.3.6. Reusable items that stay in the clinic will be reassembled after drying and stored appropriately.

A6.3.3.3.7. If the disinfectant is placed in a soaking bin for multiple uses, that bin may be securely covered and stored appropriately. Clean bin when replacing chemical.

A6.3.3.3.8. Collect the CIDEX OPA solution as "Non Hazardous Waste" when expired, visibly contaminated or when concentration is below proper level based on QC testing. Follow 802 CES/CEAN and 59 MLRS/SGSKF guidance on proper collection and disposal of the waste.

A6.3.3.3.9. After discarding OPA remove any labels from the plastic container and clean it with enzymatic detergent and water, rinse, and air-dry before reuse.

A6.3.3.3.10. Areas using the GUS unit to process instruments/probes ( i.e., ENT Clinic) must perform maintenance (changing of filters) and cleaning of unit/canisters according to manufacturer's instruction. Refer to paragraph A6.2.3.3.3 for manual soaking of instruments in Cidex OPA.

#### A6.3.3.4. Spill Clean-up.

A6.3.3.4.1. Keep a spill kit in the area where Cidex OPA is used. Refer to product's Safety Datasheet.

A6.3.3.4.2. Spills of 1 gallon or less can be cleaned by the user. If the amount of spill exceeds the capability of the user to clean up (i.e. more than 1 gallon), call 911 and initiate response assistance. Refer to 59MDWVA, 32-101 for further response information.

### **A6.4. Processing Endoscopes.**

A6.4.1. Training document or checklist is required for unit-specific procedures. Manufacturers' specific guidance for all scopes must be followed. The training document or checklist is reviewed annually by the unit and the ICO.

A6.4.2. Pre-Cleaning.

A6.4.2.1. Perform pre-cleaning at the bedside immediately after each procedure. Wipe the insertion tube with a detergent solution.

A6.4.2.1.1. Suction detergent solution through the instrument channel for 30 seconds.

A6.4.2.1.2. Suction air & water for 10 seconds through the instrument channel.

A6.4.2.1.3. Discard disposable valves. Place reusable valves and removable parts in a container of detergent solution. Inspect and attach the water resistant cap.

A6.4.2.1.4. Place scope in a covered container and transport to the reprocessing area.

A6.4.2.1.5. Leak test flexible endoscopes with ports prior to submersion. Follow manufacturer's instructions.

A6.4.2.1.6. All channels are to be cleaned even if not used.

#### A6.4.3. Manual Cleaning.

A6.4.3.1. Measure and mix the enzymatic instrument detergent per manufacturers' directions and pour into the soaking container.

A6.4.3.2. Immerse the entire scope in the enzymatic detergent.

A6.4.3.3. Wipe down entire scope with a soft brush or lint free cloth soaked in enzymatic detergent. Use manufacturer's instructions for proper brush size.

A6.4.3.4. Brush biopsy/suction channel in the insertion tube with the channel cleaning brush until all debris is removed.

A6.4.3.5. Brush biopsy/suction channel in the universal cord until all debris is removed.

A6.4.3.6. Brush suction valve housing & instrument channel port until all debris is removed.

A6.4.3.7. Use the suction channel cleaning adapter to suction detergent through the suction/biopsy channel for 30 seconds.

A6.4.3.8. Attach the channel plug and injection tube and inject detergent through the air/water channel.

A6.4.3.9. Use all channel cleaning adapters & brushes (some endoscopes require the use of special cleaning adapters and brushes (e.g. auxiliary water and elevator wire channels).

A6.4.3.10. Disconnect the channel plug, injection tube, and special cleaning adapters.

A6.4.3.11. Soak the endoscope in enzymatic detergent IAW manufacturer's recommendations.

A6.4.3.12. Brush and flush the valves and removable parts until debris is removed.

A6.4.3.13. Perform the final rinses and air purge using the channel plug, tube, and special cleaning adapters.

A6.4.3.14. Thoroughly dry the exterior of the endoscope and all removable parts using a clean lint-free cloth.

A6.4.3.15. Inspect the endoscope for residual debris and repeat the manual cleaning process if debris remains. Prepare valves and removable parts for high level disinfection.

A6.4.3.16. Discard enzymatic detergent solution per the manufacturer's recommendation.

A6.4.3.17. Inspect the endoscope for damage at all stages of handling.

A6.4.3.18. Clean the plastic container with enzymatic detergent and water, rinse and dry thoroughly before reuse.

A6.4.3.19. Reusable accessories that penetrate mucosal barriers (i.e., biopsy forceps, cytology brushes, etc.) and water bottles are cleaned after each patient use then sent to SPD for sterilization.

#### A6.4.4. Manual Disinfection:

A6.4.4.1. Test the OPA potency before soaking each scope.

A6.4.4.2. Flush the endoscope channels with OPA solution.

A6.4.4.3. Disconnect the channel plug, injection tube, and special cleaning adapters.

A6.4.4.4. Cover the container and soak the endoscope as defined in section A6.2.3.3.3.

A6.4.4.5. Flush air through the endoscope channels using adapters.

A6.4.4.6. Immerse the endoscope in fresh sterile water.

A6.4.4.7. Rinse the endoscope and flush all channels with sterile water. This step is to be repeated 3 times.

A6.4.4.8. Flush all channels with forced air and alcohol (use large syringe if forced air is not available) to dry entire scope and lumens.

A6.4.4.9. Wipe the exterior of the scope exterior with lint free cloth moistened with alcohol.

A6.4.4.10. Scope Storage. The storage location will be clean, dry, well ventilated, and maintained at a specific room temperature.

A6.4.4.11. Scopes are stored hanging with the insertion tube as straight as possible. Do not roll or coil the tube as this will damage the fiber-optic cable.

A6.4.4.12. Do not use the carrying case for storage. Routine storage of the fiberscope in a humid, dark, non-ventilated environment, such as the carrying case, may promote the growth of microorganisms.

A6.4.4.13. Clean lens with sterile cotton tip applicator and dry with sterile lens paper.

#### **A6.5. Automated Processors with Water Filtration System.**

A6.5.1. Any automated processor of endoscopic equipment is reviewed by ICF before purchase and use.

A6.5.2. Each area employing an Automated Processor will refer to the manufacturer instructions for specific operations of the processor.

A6.5.3. Meticulous manual cleaning precedes the use of automated machines.

A6.5.4. Proper connectors must be used when placing in processor.

#### **A6.6. Endoscope Re-processor (DSD) and Advantage Plus.**

A6.6.1. Follow detailed step-by-step instructions in the Operator's Manual for use and maintenance of the automated processor. Scopes must be pre-cleaned prior to placing in the system.

A6.6.1.1. Filters, Cidex OPA/Rapicide PA are to be changed according to manufacturer's instructions.

A6.6.1.2. If the "Scope Buddy" is used to flush the channels, follow manufacturer's instruction for usage and maintenance. Prior to use Scope Buddy, use the suction channel cleaning adapter to suction detergent through the instrument/suction for 30 seconds.

A6.6.1.3. Wipe door of DSD basin and change gloves prior to removing scope from processor.

A6.6.1.4. Endoscopic retrograde cholangiopancreatography (ERCP) endoscopes are equipped with special components that require manual cleaning and disinfecting of the elevator channel.

A6.6.2. ERCP Elevator (distal tip) is meticulously brushed in both the closed and open positions.

A6.6.3. Connect the automatic processor to the ERCP scope, using the correct elevator channel adapter to permit detergent, disinfectant, and air to travel through the scope during processing.

#### **A6.7. Processing Trans-esophageal (TEE) Ultrasound Probe.**

A6.7.1. TD-100 TM is an automated disinfectant designed to provide high-level disinfection of TEE probes.

A6.7.2. Follow manufacturer instructions for processing probes in the TD-100 TM.

A6.7.2.1. Wear the appropriate PPE to include goggles, gown, face shield/mask, and gloves.

A6.7.2.2. Probes are manually cleaned using an enzymatic detergent per manufacture instructions. Enzymatic detergent is rinsed off and scope is thoroughly dried prior to placing into TD 100 reprocessor.

A6.7.2.3. The system uses TD-5 TM disinfectant which is designated only for use with the TD-100 TM. There is no requirement for conducting QC measures on the TD-5 disinfectant.

A6.7.2.4. Do not soak or submerge electrical connector or steering mechanism.

A6.7.2.5. One bottle of disinfectant is used for each process cycle. The disinfectant bottles are not designated to be re-used in the system.

A6.7.2.6. TEE probes must be manual cleaned prior to placing in the system. Do not clean with iodine-base soap, hydrogen peroxide-based disinfectants, or bleach.

A6.7.2.7. A final drying step is recommended following the TEE probe manufacturer's recommendations. In the absence of a recommended drying procedure, perform a final wipe down using 70% isopropyl alcohol solution.

A6.7.2.8. TD-5 TM is emptied at the end of the cycle unto a container for disposal. Follow 802 CES/CEAN and 59 MLRS/SGSKF guidance on proper collection and disposal of the waste.

A6.7.2.9. The probes are stored hanging straight in probe storage cabinet and controls are placed in free neutral position. Do not store in carrying case.

#### **A6.8. Reprocessing of Ultrasound Vaginal Probes (Tropon).**

A6.8.1. Wear appropriate PPE.

A6.8.2. Remove cartridge lid and insert the Sonex-HL cartridge bottle.

A6.8.3. Insert the chemical indicator into the disinfection chamber.

A6.8.4. Clean probe with approved ICF agent per manufacturer's instruction and dry according to instructions prior to place in Tropon.

A6.8.5. Load probe into the disinfection chamber and close the system.

A6.8.6. Press the start button to begin the high-level disinfection (7 minute cycle).

A6.8.7. Change gloves and remove chemical indicator and compare to indicator chart.

A6.8.8. Log results and discard indicator.

A6.8.8.1. If indicator fails, troubleshoot per manufacturer instruction and reprocess probe.

A6.8.9. Remove probe and wipe dry prior to use or storage.

#### **A6.9. Sterilization.**

A6.9.1. SPD and PRK Clinic will follow practices outlined in AFI 44-108 and testing of automated cleaning equipment will be done IAW with AAMI and the American Association of Operating Room Nurses Standards. Sterilization at 359 MDG is performed by DIPC.

A6.9.2. In the event of failure of sterilization parameter, follow manufacturer's troubleshooting instructions. If applicable, a) reprocess instruments/devices before use on a patient; b) activate a recall process; and/or c) notify provider and IC officer if item was used on a patient.

#### **A6.10. Recall.**

A6.10.1. Instruments reprocessed by SPD.

A6.10.1.1. SPD personnel will identify the following information from the locator card: sterilization load, Julian date, and sterilization date of in house processed items.

A6.10.1.2. SPD personnel notify all sections to collect the recalled items, bearing the specific locator information cited.

A6.10.1.3. Individual area noncommissioned officer in charge (NCOIC) or their designee will return all recalled items to SPD Decontamination Section for reprocessing.

A6.10.1.4. For any instruments already used on a patient, SPD personnel will notify the patient's provider within the Surgical Suite or have the NCOIC of the clinic notify the provider and ICO (292-7803).

A6.10.1.5. At the 359 MDG, instruments are processed by DIPC. If a positive spore test occurs the following steps will be taken:

A6.10.1.5.1. All instruments sterilized in the defective sterilizer, back to the last negative spore test, will be re-sterilized using a properly functioning sterilizer.

A6.10.1.5.2. The Dental Infection Preventionist will be alerted at 652-8435.

A6.10.2. Instruments reprocessed by clinics (Photorefractive Keratectomy and Dental).

A6.10.2.1. Clinic personnel will identify items to be recalled. These items will be reprocessed. See process outlined in A6.2.10.1.4 for instruments already used on patients.

A6.10.3. Commercially manufactured supplies.

A6.10.3.1. Medical Material Quality Assurance (QA) will notify all sections to collect the commercially recalled items and return them to the QA section of the Medical Supply Warehouse.

A6.10.3.2. Medical Material QA will provide the manufacturer's name, nomenclature of supply, lot and catalog number, and any other pertinent information.

A6.10.3.3. When the patient exposure to any recalled item is identified, a representative of the section (preferably the NCOIC or the section's manager/flight commander) in which the patient was located at the time of the exposure will notify the attending physician, Medical Material QA (292-7007), Pharmacy (292-8409), Risk Management (292-6004) and ICO (292-7803). At the 359 MDG notify Medical Material QA (652-3061), Risk Management (652-5348) and the IP (652-4191).

#### **A6.11. Event Related Shelf Life.**

A6.11.1. Shelf life for sterility of instruments is event related (i.e., container dropped on the floor, accumulation of moisture, etc.).

A6.11.2. Items will be processed in appropriate wrap and manner.

A6.11.3. All in-house processed items issued from SPD will include the following information on the label:

A6.11.3.1. The date of sterilization for rotation purposes.

A6.11.3.2. A sterilizer load control stamp for recall purpose.

A6.11.3.3. The statement "sterile unless damaged or open" indicates package integrity is dependent on "events".

A6.11.3.4. An external chemical indicator showing exposure to sterilization cycle.

A6.11.3.5. The processing technicians' initials.

A6.11.3.6. Sterile packs of equipment and instruments are handled and stored in a manner that maintains their sterility. For specifics, refer to AFI 44-108.

A6.11.3.6.1. Sterile supplies are stored separate from non-sterile items.

A6.11.3.6.2. Sterile supplies are stored in enclosed shelving, covered racks or a closed cabinet.

A6.11.3.6.3. Sterile supplies are stored 8-10 inches from the floor and 18-20 inches from the ceiling.

A6.11.3.6.4. Do not use elastic rubber bands to bundle items together.

A6.11.3.6.5. Use washable bins/dividers to organize and store supplies.

## Attachment 7

### CONTROL OF THE ENVIRONMENT

#### A7.1. Housekeeping.

A7.1.1. Quarterly, QAEs instruct all management representatives of contract requirements pertaining to them and the proper method for completing the 59 MDW Complaint Form. The 359 MDG Facility Manager oversee directly housekeeping issues and waste disposal.

A7.1.2. Customers coordinate with the contractor to provide access to various rooms and areas. The 359 MDG Facility Manager oversee directly housekeeping issues and waste disposal.

A7.1.3. Dedicated Cleaning Areas. Reid Clinic has a dedicated housekeeper. There is no dedicated housekeeper at the 359 MDG.

A7.1.4. Facility Management reviews the housekeeping contract annually and supervises the Housekeeping Department. Housekeeping service surveillance is a function of the QAEs of Facilities Management. Contact QAE at ext. 292-7171 for any questions or concerns. Call Facility Management at 210-652-0243 at the 359 MDG.

A7.1.5. Housekeeping is responsible for cleaning of the environment including patient care and non-patient care areas as specified in their policy/procedure manual. Housekeeping procedures and list of disinfectants are reviewed and approved yearly by the ICF. Contaminated surfaces in the treatment/exam rooms will be cleaned by the HCWs after each patient use.

#### A7.2. Linen.

##### A7.2.1. Soiled Linen Collection.

A7.2.1.1. All soiled linen is handled in the same manner with no separation of wet or dry soiled and isolation linen.

A7.2.1.2. Handle soiled linen as minimally as possible by placing in clear plastic bags on a rolling hamper in the patient's treatment room. Un-bagged linen must NOT be hand carried by personnel through the hallway corridor to the hamper.

A7.2.1.3. Do not fill linen bags more than 2/3 full. Filled linen bags are closed and carried to a designated collection area for pick-up by housekeeping personnel.

A7.2.1.4. At a minimum, personnel who have contact with soiled laundry must wear gloves. Other appropriate PPE is based on the exposure of the worker's skin and clothing.

A7.2.1.5. Once closed, soiled linen bags are not opened except by contract laundry personnel at the laundry facility.

A7.2.2. Linen Hamper Covers. The use of linen hamper covers is not required. If used, they must be made of nonporous material and kept clean by housekeeping.

A7.2.3. Linen Hamper Stands. The cleaning of linen hamper stands is the responsibility of housekeeping.

A7.2.4. Cubicle curtains and window drapes are changed every 6 months by housekeeping, sooner if soiled. The area is responsible for initiating and maintaining the cleaning schedule. Coordinate with Linen Control to arrange for curtain change (292-5591). At 359 MDG call Facility Management at 652-2521

A7.2.4.1. If using the disposable privacy curtains, changed immediately when soiling occurs with blood and body fluid, after dismissal of a patient on isolation, and/or every six months. Housekeeping is responsible for cleaning curtains daily by wiping down the entire curtain with an approved disinfectant.

### **A7.3. Refrigerators.**

A7.3.1. Patient food refrigerators are maintained at a temperature range of 32° - 41 ° Fahrenheit, IAW Tri Service Food Code. Medication and specimen refrigerators are maintained at a temperature range of 36 ° - 46 ° Fahrenheit (2° - 8° Celsius). Temperature ranges for freezers used to store medications is per package insert.

A7.3.2. In the event that a HCW is storing personal breast milk, it must be stored in a dedicated refrigerator for breast milk storage or in a personal cooler. It can be stored for a maximum of 48 hours in a refrigerator. Breast milk must be labeled with HCW name and date.

A7.3.3. If refrigerator does not fall within the appropriate temperature, as listed above, attempt to readjust the temperature setting then re-evaluate in 15 minutes. If refrigerator temp remains out of range, notify Medical Equipment Repair Center (MERC) at 292-5103 for repairs during duty hours or notify the Medical Control Center 292-5990 who will in-turn contact MERC 210-594-2485 or 210-396-1923 after normal duty hours. At 359 MDG contact Medical Maintenance at 292-5103 after hours call 292-7654.

A7.3.4. Opened multiple dose vials and multiple dose oral medication are refrigerated only if specified by the manufacturer or pharmacy. Refrigerated temperature range for medication storage is 2°-8° degrees Celsius (36°- 46° degrees Fahrenheit).

A7.3.4.1. For refrigerators used for medication document refrigerator temperature daily on 59 MDW Form 2942, *Refrigerator/Freezer Temperature Chart*. Clinics closed on the weekend must document the temperature using a monitoring device or move the medications to another refrigerator that is being monitored. Refrigerator for medication must be cleaned weekly and will not contain food. Follow Allergy Immunization clinic policies for monitoring of refrigerators used to store vaccines.

A7.3.4.2. If the medication storage refrigerator/freezer is out of range, report problem as above and notify Pharmacy personnel at 292-5414 before closure for instruction on handling the medications. At 359 MDG contact Medical Maintenance at 652-2521.

A7.3.4.3. Document all actions taken as well as follow up temperatures on the daily refrigerator temperature sheet.

### **A7.4. Area Specific General Cleaning.**

A7.4.1. Medication cabinet shelves are cleaned weekly and as needed by unit or clinic personnel.

A7.4.2. Supply and Linen Shelves. Opened shelves are cleaned weekly in clinical areas (e.g. treatment rooms, supply rooms). In areas (such as Laboratory, Pharmacy, etc.) storing supplies not used for patient care, opened shelves are cleaned monthly and as needed. In all areas, closed shelves are cleaned minimum monthly and as needed. Unit or clinic personnel clean the shelves with an ICF approved environmental disinfectant.

A7.4.3. HCWs ensure frequent cleaning and disinfection of surfaces that are likely to be contaminated with pathogens, including those within 3 feet of patient (i.e., bed rail, table stand) and frequently touched surfaces in the patient care environment (e.g. door knobs).

A7.4.4. Exam tables are maintained in good repair to facilitate proper cleaning.

A7.4.5. Rounds. The officer in charge, NCOIC or civilian equivalent for each functional area conducts informal visual inspections on a regular basis (e.g., weekly, daily when the clinic is open) and completes the facility customer complaint form if work is not completed to their satisfaction.

A7.4.6. Crash Cart. Flight commander/clinic managers ensure weekly cleaning of the crash cart with an approved disinfectant.

A7.4.7. Wheelchairs and Gurneys. Wheelchairs and gurneys are wiped down by HCWs after each use with an approved IC disinfectant. Wheelchairs located in common areas (e.g. clinic entrances) are cleaned daily by housekeeping.

A7.4.8. Eyewash stations. Mounted eyewash stations are cleaned weekly with an approved IC disinfectant.

A7.4.9. Document cleaning as applicable.

### **A7.5. Disposal of SHARPS.**

A7.5.1. Sharps used in surgery, and/or other medical procedure.

A7.5.2. Intravenous stylets and rigid introducers.

A7.5.3. Glass pipettes, specimen tubes, microscope slides, and glass capillary tubes, broken glass, and medicine ampules.

A7.5.4. Needles including “dry needling” needles.

A7.5.5. Housekeeping checks daily and exchanges 3/4 full sharps containers for empty ones, then transports all sharps containers for disposal from point of generation. At 359 MDG, HCWs are tasked with monitoring/ changing sharps containers that are disposed of by housekeeping.

A7.5.5.1. Contact housekeeping, ext. 292-5985, for disposal of sharps, if additional pick-up is needed (does not apply to 359 MDG). Never place glove boxes or other items on top of sharps container.

A7.5.5.2. If HCW replaces a sharp container, it is placed in a dedicated secured area (i.e., dirty utility room), and not left on the floor.

A7.5.6. Sharp containers are hung at 52-56 inches from the floor.

A7.5.7. Glass Waste. Large glass and hard, small metal items such as medication vials and bottles, screws and nuts, and disposable scissors are placed in corrugated cardboard “glass”

containers or other containers approved by Facility Management. Place broken glass in sharp containers.

A7.5.8. Any glass container contaminated with bulk blood or OPIM in bulk will need to be placed in the appropriate sharps container. At 359 MDG all glass is placed in sharp container.

#### **A7.6. Handling of Waste.**

A7.6.1. Hazardous Waste. Refer to 59 MDWI-32-7001, *Hazardous Materials, Waste Management and Spill Response Program*.

A7.6.2. Regular waste or office waste. Office trash and all disposable articles not saturated with blood or body fluids are collected in plastic bags, sealed and disposed of in the landfill.

A7.6.3. Microbiological Waste. Disposed of as regulated medical waste.

A7.6.4. Pathological Waste. Is placed in a red bag and closed with a tape labeled "Path Waste."

A7.6.5. Blood and Body Fluids that are collected as fluids in containers (e.g., suction drainage canisters) will not be emptied into the sewage system. These items are securely closed and placed into red bags for disposal.

A7.6.6. Waste of highly contagious pathogens ( i.e., Ebola virus) will be handled according to Department of Transportation standards.

A7.6.7. Red bags and containers that will hold biohazardous waste will have a visible biohazard symbol to signify RMW.

A7.6.8. Double bagging is not required, unless the outside of the waste bag is contaminated with blood or bodily fluids.

A7.6.9. Used Vaccine Vials. IAW AFJI 48-110, *Immunization and Chemoprophylaxis for the Prevention of Infectious Diseases*, immunizing and chemoprophylaxis agents are stored and handled IAW the pharmaceutical manufacturer's instructions as outlined in the product's package insert or other guidance. At 359 MDG chemoprophylaxis agents are not used.

A7.6.10. Animal Waste. Animal waste is considered "Pathological Waste" and disposed as such.

#### **A7.7. Responsibilities for Solid and Contaminated Waste Disposal.**

A7.7.1. Facilities Management monitors housekeeping and Central Waste Facility (CWF) operations; obtains dumpsters for waste collection; and establishes waste collection pick-up schedules. At the 359 MDG Facility Management is the responsible for waste disposal.

A7.7.2. Housekeeping.

A7.7.2.1. Removes all waste from the Medical Center, wearing appropriate PPE.

A7.7.2.2. Collects properly bagged regulated or red bag trash bags at point of generation and transports to CWF for processing.

A7.7.2.3. Prepares waste for pick-up by contractor.

A7.7.2.4. Collects 3/4 filled sharps containers at point of generation from all areas and transports for disposal. Replaces sharps containers with new units.

A7.7.2.5. Maintains, operates and secures CWF.

A7.7.2.6. Cleans vehicle used to transport waste to the CWF with an ICF approved environmental disinfectant daily.

A7.7.2.7. Housekeeping receives pathological waste from the main facility. Clinical Research Division and Veterinary clinics generates pathological waste, prepares the packages which are taken to CWF picked up by contractor. The pathological waste will be identified by tape labeled "Path Waste."

A7.7.2.8. Cleans the exterior surface and surrounding areas of sharp containers.

A7.7.2.9. All trash from airborne, droplet, and contact precautions is placed in clear impervious trash bags unless saturated with blood or body fluids as defined above.

#### **A7.8. Air Handler or Exhaust Fan Shutdown Affecting Negative Flow Rooms.**

A7.8.1. Scheduled:

A7.8.1.1. Prior to scheduled shutdown time, CE will contact the ICO and affected areas within the facility about scheduled power outages and shutdowns.

A7.8.1.1.1. For clinics with a negative flow room.

A7.8.1.1.1.1. The affected areas will coordinate with attending physicians for course of actions to take if a patient needs to be on airborne isolation. The Director of Infection Control, or designee should be utilized as a consultant.

A7.8.1.2. All patient transfers will be accomplished at least one hour before scheduled shutdown time.

A7.8.2. Unscheduled:

A7.8.2.1. During normal duty hours.

A7.8.2.1.1. CE will contact clinic's flight commander or designee of the affected areas within the facility and the Director of Infection Control or designee to brief them on the time of shutdown and imminent unscheduled air handler and exhaust fan shutdown.

A7.8.2.1.2. Clinic's flight commander or designee will assess patient currently in negative flow rooms and coordinate with the attending physician for transfer to another clinic or facility (this includes patients in the Urgent Care).

A7.8.2.1.3. Clinic's flight commander or designee will make transfer arrangements.

A7.8.2.1.4. CE will notify the clinic flight commander or designees when the air handlers or exhaust fans are again operational and negative flow rooms are functional.

A7.8.2.1.5. Problems with the shutdown will be communicated to the flight commanders or designee for analysis. Problems should also be documented on the Utility Outage Checklist as directed.

A7.8.2.2. After normal duty hours or weekends:

A7.8.2.2.1. CE will notify Urgent Care Clinic/ERPSS shift leader or designee (depending of the areas affected) about the proposed time frame or areas affected by the imminent unscheduled air handler and exhaust fan shutdown.

A7.8.2.2.2. The Urgent Care/ERPSS shift leader will notify the Infectious Disease physician on call via pager 513-6060 if there are questions about transfer of patient in negative flow room.

A7.8.2.2.3. CE will notify the Urgent Care/ERPSS shift leader when air handlers or exhaust fans are again operational and negative flow rooms are functional.

A7.8.2.2.4. The shift leader will verify the negative flow is actually working by performing a smoke tube test.

A7.8.2.2.5. Problems with the shutdown will be communicated to the flight commanders or designee for analysis. Problems should also be documented on the Utility Outage Checklist as directed.

### **A7.9. Computerized Tube System (CTS) Spill Prevention.**

A7.9.1. Spills will be greatly reduced if the sender follows these simple precautions:

A7.9.1.1. Use a primary collection container that has been tested and approved to be sent through the CTS (e.g., vacutainers, blood culture bottles, and urine in vacutainers).

A7.9.1.2. The lids are securely closed and tightened.

A7.9.1.3. All lab specimens approved for sending through the CTS must be sent in a secondary containment device and need to be properly immobilized. Use the biohazard labeled "Zip N'Fold" type pouches.

A7.9.1.4. When closing the biohazard labeled "Zip N'Fold" type, leave some air for cushion. Do not use foam, blue chux or any other padding.

A7.9.1.5. If the outside of the primary collection container gets contaminated, place in a Ziploc bag before placing into the biohazard labeled "Zip N'Fold" type pouch.

A7.9.1.6. If there is more than one vacutainer being sent, use a rubber band or a tube insert to keep them together so they do not move within the biohazard labeled "Zip N'Fold" type pouch.

A7.9.2. Care of the "Zip N'Fold" type pouch:

A7.9.2.1. Each carrier will contain their own biohazard labeled "Zip N'Fold" type pouch.

A7.9.2.2. Replacement "Zip N'Fold" type pouches are available from Medical Logistics.

A7.9.2.3. If the sender notices a small amount of liquid in the pouch or any sign of contamination, wear gloves and clean it out using the approved disinfectant wipes. Allow the pouch to air dry.

A7.9.2.4. Clean canister before each usage using an approved IC disinfectant.

## Attachment 8

## ISOLATION AND PRECAUTION

**Table A8.1. Clinical Syndromes or Conditions Warranting Empiric Transmission-Based Precautions in Addition to Standard Precautions Pending Confirmation of Diagnosis.**

Clinical Syndrome or Condition†	Potential Pathogens‡	Empiric Precautions (Always includes Standard Precautions)
<b>DIARRHEA</b>		
Acute diarrhea with a likely infectious cause in a incontinent or diapered patient	Enteric Pathogens§	Contact Precautions (Pediatrics and Adult)
<b>MENINGITIS</b>		
	<i>Neisseria meningitides</i>  Enteroviruses  <i>M. tuberculosis</i>	Droplet Precautions for first 24 hours of antimicrobial therapy, mask and face protection for intubation Contact Precautions for infants and children  Airborne Precautions if pulmonary infiltrate Airborne Precautions plus Contact Precautions if potentially infectious draining body fluid present
<b>RASH OR EXANTHEMS, GENERALIZED, ETIOLOGY UNKNOWN</b>		
Petechial/ecchymotic with fever (general)  If positive history of travel to an area with an ongoing outbreak of VHF in the 10 days before onset of fever	<i>Neisseria meningitides</i>  Ebola, Lassa, Marburg viruses	Droplet Precautions for first 24 hours of antimicrobial therapy  Droplet Precautions plus Contact Precaution, with face/eye protection, emphasizing safety sharps and barrier precautions when blood exposure likely. Use N95 or higher respiratory protection when aerosol-generating procedure performed (must be fit-tested for N-95 mask)
Vesicular	Varicella-zoster, <i>herpes simplex</i> , variola (smallpox), vaccinia viruses  Vaccinia virus	Airborne plus Contact Precautions  Contact Precautions only if <i>herpes simplex</i> , localized zoster in an immunocompetent host of vaccinia viruses most likely
Maculopapular with cough,	Rubeola (measles)	Airborne Precautions

coryza and fever	Virus	
<b>RESPIRATORY INFECTIONS</b>		
Cough/fever/upper lobe pulmonary infiltrate in an HIV-negative patient or a patient at low risk for human immunodeficiency virus (HIV) infection	<i>M. tuberculosis</i> , Respiratory viruses, <i>S. pneumoniae</i> , <i>S. aureus</i> (MSSA or MRSA)	Airborne Precautions plus Contact precautions
Cough/fever/pulmonary infiltrate in any lung location in an HIV-infected patient or a patient at high risk for HIV infection	<i>M. tuberculosis</i> , Respiratory viruses, <i>S. pneumoniae</i> , <i>S. aureus</i> (MSSA or MRSA)	Airborne Precautions plus Contact Precautions Use eye/face protection if aerosol-generating procedure performed or contact with respiratory secretions anticipated If tuberculosis is unlikely and there are no AIIRs and/or respirators available, use Droplet Precautions instead of Airborne Precautions Tuberculosis more likely in HIV-infected individual than in HIV negative individual
Cough/fever/pulmonary infiltrate in any lung location in a patient with a history of recent travel (10-21 days) to countries with active outbreaks of SARS, avian influenza, MERS, CoV	<i>M. tuberculosis</i> , severe acute respiratory syndrome virus (SARS, CoV, MERS), avian influenza	Airborne plus Contact Precautions plus eye protection If SARS and tuberculosis unlikely, use Droplet Precautions instead of Airborne Precautions
Respiratory infections, particularly bronchiolitis and pneumonia, in infants and young children	Respiratory syncytial virus, parainfluenza virus, adenovirus, influenza virus, Human metapneumovirus	Contact plus Droplet Precautions; Droplet Precautions may be discontinued when adenovirus and influenza have been ruled out
<b>SKIN OR WOUND INFECTION</b>		
Abscess or draining wound that cannot be covered	<i>Staphylococcus aureus</i> (MSSA or MRSA), group A streptococcus	Contact Precautions Add Droplet Precautions for the first 24 hours of appropriate antimicrobial therapy if invasive Group A streptococcal disease is suspected
<b>Notes:</b> * Infection control professionals should modify or adapt this table according to local conditions. To ensure that appropriate empiric precautions are implemented always, hospitals must have systems in		

place to evaluate patients routinely according to these criteria as part of their preadmission and admission care.

† Patients with the syndromes or conditions listed below may present with atypical signs or symptoms (e.g. neonates and adults with pertussis may not have paroxysmal or severe cough). The clinician's index of suspicion should be guided by the prevalence of specific conditions in the community, as well as clinical judgment.

‡ The organisms listed under the column "Potential Pathogens" are not intended to represent the complete, or even most likely, diagnoses, but rather possible etiologic agents that require additional precautions beyond Standard Precautions until they can be ruled out.

§ These pathogens include enterohemorrhagic *Escherichia coli* O157:H7, *Shigella spp*, hepatitis A virus, noroviruses, rotavirus, *C.difficile*.

### **A8.1. Patient Care Equipment and Supplies.**

A8.1.1. Thermometers. For patient on isolation, consider the use of disposable oral thermometer. If a thermometer is used it must be thoroughly cleaned immediately upon removal from the isolation room.

A8.1.2. Sphygmomanometer and Stethoscope. Disposable single patient use blood pressure cuffs and stethoscopes are available. Non-disposable sphygmomanometers and stethoscopes soiled with infective material are cleaned per manufacturer's instructions or disposed of if unable to be cleaned properly.

A8.1.3. Disposable Equipment. Disposable articles are only brought into the patient/treatment room as needed. Any disposable articles left in the room after the patient is discharged, will be discarded.

A8.1.4. Non-Disposable Equipment. Non-disposable equipment will be cleaned immediately upon exit with an ICF approved disinfectant. When isolation is discontinued or the equipment is removed, articles NOT processed by SPD/DIPC at 359 MDG are disinfected with an approved disinfectant in the isolation room. Articles processed by SPD refer to Attachment 6, Supplies and Equipment.

A8.1.5. Charts. Do not take charts into isolation rooms for patients on Contact Isolation precautions. For patients on other isolations, charts are not allowed to come in contact with infective material or potentially contaminated objects.

A8.1.6. Laboratory Specimens. All laboratory specimens are handled IAW SPs. Gloves are the minimum barrier precautions to be worn when handling any specimen. Specific specimen requirements are outlined in 59 MDWI 44-136, *Laboratory Program*. At the 359 MDG, specimen requirements are outlined in 2015 Clinical Laboratory Guide.

A8.1.6.1. All specimens are placed inside clear "Zip N'Fold" type red labeled biohazard inserts. See paragraph A7.9 for guidance on spill prevention. The laboratory request is placed outside the wrapping material.

A8.1.6.2. Lab specimens hand carried to the laboratory must be contained in a fluid resistant secondary container such as the Ziploc bags.

A8.1.7. Waste. All trash from patients on any type of isolation precautions are thrown away in the regular trash or office trash unless drippy, soaked, soggy or caked with blood or OPIM. Refer to Attachment 7, Control of the Environment.

**A8.2. Airborne, Droplets or Contact Precautions.** Per CDC and HICPAC: *Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*, 2007. <http://www.cdc.gov/ncidod/dhqp/pdf/isolation2007.pdf>

**A8.2.1. Airborne Precautions.**

A8.2.1.1. Room Requirements. For Airborne isolation a negative pressure room is required. The room will have a minimum of six to twelve air exchanges per hour. An "Airborne Isolation" sign is posted on the door. The door is kept CLOSED in order to maintain negative pressure. Loose ceiling tiles will be replaced. For location of Negative Pressure Rooms, see Table A8.3. Policy for airborne precaution at the 359 MDG is according to A8.2.1.1.1.

A8.2.1.1.1. If the clinic does not have a negative air flow room, the patient will be masked and placed in an exam room. Arrangement will be made as soon as possible for the patient to be seen in another clinic with a negative air flow room. At 359 MDG patient is transferred to San Antonio Military Medical Center. HCWs with patient care will wear a mask (N-95) if the patient is not masked. HCWs are required to be fit-tested prior to wearing an N-95 respirator.

A8.2.1.2. An initial smoke tube is required prior to admitting a patient to the isolation room and a daily smoke tube test performed for the duration of the patient's stay to that room (ERPSS).

A8.2.1.3. Smoke tube test training and information may be obtained through Facility Management (292-7171) or designee.

A8.2.1.4. Respirator Requirements. A National Institute of Occupational Safety and Health -approved respirator is worn by HCWs and patient visitors when entering the room of a patient with a probable, suspected or confirmed diagnosis of TB, chickenpox, measles, disseminated shingles or small pox. Visitors are instructed by nursing personnel on how to wear the respirator, but are not required to be "Fit Tested." The respirator is worn once per patient contact and is discarded in the closest trash bag waste receptacle after each use.

A8.2.1.5. Transporting the Patient. The HCW wears a disposable high efficiency, 0.1 micron cup style surgical mask properly fitted to cover the nose and mouth while transporting the patient who requires Airborne Isolation. The HCWs wear an N-95 respirator only when transporting a patient in close proximity (e.g. elevators).

A8.2.1.6. Occupancy of a Negative Flow Room after Patient Departure/Termination of Treatment of a Patient on TB Isolation. The HCW wears an N-95 mask when entering the isolation room based on time specification as determined per CDC guidelines after patient departure (*Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings*). Do not place a patient in the room until it has been terminally cleaned and appropriate time has elapsed.

A8.2.1.7. Power Outage Which Affects the Ventilation System.

A8.2.1.7.1. Refer to paragraph A7.8 in the event there is a power outage which will affect the negative air flow rooms used for Airborne Isolation. During such power outage the door must remain closed at all times. The patient wears a cup style surgical mask every time a staff member enters the room. The staff must continue to wear the respirator each time they enter the room.

**Table A8.2. Location of Negative Pressure Rooms.**

<b>LOCATION OF NEGATIVE FLOW ROOM USED FOR PATIENT CARE</b>			
<b>LOCATION</b>	<b>UNIT ROOM #</b>	<b>FACILITY ROOM.#</b>	<b>FUNCTION</b>
Urgent Care Center	16	BV03	Exam room
Urgent Care Center	6	BV82	Alternate isolation room
Pediatric Clinic	51	1H33	Pt isolation
Pulmonary Clinic		6A35A 6A37	Bronchoscopy room Procedure room
ERPSS	763	7D27	Pt isolation
ERPSS	764	7D31	Pt isolation

### **A8.3. Contact Precautions.**

A8.3.1. Room Requirements. A private room is required.

A8.3.2. During an outbreak or in the event a single room is not available for isolation, consultation with the ICO/IP at 359 MDG is recommended if cohorting is being considered.

A8.3.2.1. In an open bay area, greater or equal 3 feet special separation between beds is advised. A negative pressure room is NOT indicated. 59MDWVA 44-101 is posted on the door.

A8.3.3. PPE. Gloves and gown are required when entering the patient's room.

### **A8.4. Droplet Precautions.**

A8.4.1. Duration of Isolation. Duration of isolation is according to guidelines from the CDC and HICPAC: *Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*.

A8.4.2. Room Requirements. A private room is required. In the event a single room is not available for isolation, consultation with the ICO is recommended. Special separation of greater than 3 feet and drawing the curtain between patient beds is especially important for patients in open bay rooms. Negative pressure room is not indicated. 59 MDWVA 44-102 is posted on the door.

A8.4.3. Patients on Droplets Precautions must be instructed to follow recommendations for Respiratory Hygiene/Cough Etiquette.

A8.4.4. PPE. A cup style surgical mask is indicated for close or direct patient contact. Don mask upon room entry.

A8.4.5. Transporting the Patient. The patient on Droplet Precaution Isolation who must be transported outside the room should wear a cup style surgical mask if tolerated and follow respiratory etiquette. No mask is required for persons transporting the patient.

A8.4.6. Family/companion are required to wear the appropriate PPE such as the blue surgical mask.

## Attachment 9

## 359 MDG APPROVED DISINFECTANTS FOR HCWS

Table A9.1. Approved Disinfectants for HCW's for use at the 359 MDG.

CHEMICAL AGENTS	BRAND NAMES	USES
Phenolic	Wexcide; substitute must be approved by ICF	Environmental disinfectants to be used on inanimate objects
Enzymatic detergent solution	Instru-zyme	Instrument cleaner for initial decontamination of instruments
Phosphoric Acid	Neodisher (Dental)	Washer cleaner
Sodium Hypochlorite (0.60%)	Dispatch	
Quaternary Ammonia Compound	Super Sani-cloth Cavi-wipes (Dental)	Environmental disinfectants, to be used on inanimate objects
Hydrogen Peroxide (Aqueous Solution)	Sonex HL	Use in Trophon

Table A9.2. Approved Antiseptics for HCW's at 359 MDG.

CHEMICAL AGENTS	BRAND NAMES	USES
Alcohol 70% Isopropyl Alcohol	Any brand, sterile single use swab sticks or alcohol pledgets	Patient skin preparation agent
Alcohol based Waterless Hand Cleaner Ethyl Alcohol (62%/70%)	Purell Instant Hand Sanitizer with dermaglycerin	Used as stated in 59MDWI 44-157
1% Chloroxylenol (PCMX)	Acute Kare Soap	Antimicrobial wash
Chlorhexidine Gluconate *(CHG) CHG (2%)	Bactoshield	Antimicrobial agent for hand washing when a general agent is not sufficient
0.3% Chloroxylenol (PCMX)	Provon lotion soap	Antimicrobial hand wash
0.3% Triclosan	Provon Foam soap	Antimicrobial hand wash

Table A9.3. Miscellaneous Agents Approved for the 359 MDG.

CHEMICAL AGENTS	BRAND NAMES	USES
Dish Detergents	Any brand	Cleaning of personal dishes/cups
Chlorine Dioxide	Bioclenz	Treat dental unit water lines

## Attachment 10

## APPROVED HOUSEKEEPING DISINFECTANTS FOR 359 MDG.

Table A10.1. Approved Housekeeping Disinfectants for 359 MDG.

CHEMICAL AGENTS	BRAND NAMES	USES
Phenolic	Wexcide Substitute must be approved through ICF	Environmental disinfectants to be used on inanimate objects and floors
Ethyl alcohol, n-alkyl dimethyl benzyl ammonium chloride, Di-n-alkyl dimethyl ammonium chloride	Crew Na Bowl Cleaner	Bowl cleaner
Quartz, Dodecylbenzene sulfonic acid	Emerel Creme Cleaner	Bathroom cleaner
Alcohol ethoxylates, Dye	G.P. Forward	General purpose cleaner
Diethylene glycol monoethyl ether	Vectra Floor Finish	Floor wax
Sodium hydroxide, Monoethanolamine, Ethyl alcohol low Odor	Bravo Heavy Duty L Stripper	Floor stripper
Diethylene glycol monoethyl ether	Plaza Sealer Finish	Floor wax
Butoxyethanol, Sodium Hydroxide, Monoethanolamine, Sodium metasilicate, Isobutane	Bravo Foaming Base Board Stripper	Detail stripper
Diethanolamine, Diethylene glycol monoethyl ether, Cocamide diethanolamine	Revive	Floor restorer
Sodium xylene sulfonate, Alcohol ethoxylates	Extraction cleaner	Carpet solution
Sodium lauryl sulfate	Carpet Shampoo	Carpet solution
Silicones	Defoamer	Carpet defoamer
Stride Neutral cleaner Alcohol ethoxylates, Dye	Stride Neutral Cleaner	Neutral cleaner
Sodium lauryl sulfate, Ethyl alcohol	Glance NA Glass Cleaner	Window cleaner
Germicidal Bleach Sodium Hypochlorite 6.15%	Clorox	Bleach