

Infection Control Program

2019-2020



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Section One: Infection Control Program Composition and Communication

Policy 1: Infection Control Program Structure

Purpose: To provide a structure for the components of the infection control program.

Policy: The Infection Prevention and Control program will be executed by standard participants and committees.

Procedure:

1.0. Infection and Prevention Control Structure

- 1.1. Coastal Family Health Center (CFHC) will designate at least three nurses to serve as infection control liaisons for the organization.
 - a. Those designated will be trained in infection control and prevention procedures.
 - b. Responsibilities of the infection control liaisons include:
 - Implement infection control strategies in the clinic under the direction of the Safety and Risk Management Committee (SRMC) and the Clinical Performance Improvement Team (CPIT).
 - Facilitate the monitoring of the effectiveness of prevention/control activities and interventions through the infection control report submitted to the SRMC.
 - Educate staff and providers on infection prevention and control principles and techniques for patient and caregiver education.
 - Take action on recommendations of the SRMC.
 - Round in clinical areas.
 - c. The infection control liaisons will be responsible to submit a quarterly infection control report, as well as any issues or concerns that need addressing, to the SRMC.
- 1.2. The Director of Nursing (DON) and the Director of Quality Management will be responsible to:
 - a. Collect surveillance data pertinent to the geographical locations of the CFHC clinics/administration office as specified within Policy 2: Surveillance and Outbreak Analysis. This information will be brought to the SRMC for discussion of action items necessary to respond to possible community outbreaks and issues including, but not limited to, additional laboratory tests, vaccines, medications, etc. needed to respond to the critical infection control data/possible influx of patients.
 - b. Ensure that a backup infection control designee is provided appropriate instructions.
 - c. Ensure the Executive Team (ET) and other leadership are aware of his/her absence and have the appropriate contact information for the designee

- 1.3. The responsibilities of SRMC include:
 - a. Review the infection control report and any epidemiological data obtained from surveillance and outbreak analysis activities, and discuss any issues or concerns related to infection control and prevention found within or that could impact the clinics.
 - b. Conduct an annual risk assessment in order to define organizational infection control and prevention priorities.
 - c. Set and monitor goals related to the following:
 - Address Prioritized Risks identified through the risk assessment process
 - Limit unprotected exposure to pathogens
 - Limit the transmission of infection associated with procedures.
 - Limit the transmission of infection associated with the use of medical equipment, devices, and supplies
 - Improve compliance with hand-hygiene guidelines.

1.4. The Chair of SRMC will report all findings and recommended actions to CPIT and ET for approval.

1.5. Once approved, the infection control liaisons will communicate the actions to the appropriate clinics/staff and will monitor the actions for compliance within the clinics with the assistance of staff and providers.

- 2.0. All employees will be trained in infection control processes during New Hire Orientation and annual staff training requirements.

Guidelines: N/A

Definitions: N/A

Related Links/Forms: N/A

References: N/A

Appendix: N/A

Policy 2: Surveillance and Outbreak Analysis

Purpose: To outline the systematic method to collect and analyze data to be used in the infection control program.

Policy: SRMC is responsible to utilize surveillance data and outbreak analysis to ensure that proper steps are taken to protect patients and employees.

Procedure:

Surveillance (National, Regional, Community)

- 1.0. DON and/or the Director of Quality Management will be responsible for bringing benchmark and reportable data impacting the state and local community from the following organizations to SRMC when available:
 - 1.1. National Nosocomial Infection Surveillance (NNIS)
 - 1.2. National Healthcare Safety Network (NHSN)
 - 1.3. The Mississippi State Department of Health (MSDH)
 - 1.4. Other local reporting entities as necessary
- 2.0. SRMC will utilize the data to conduct a risk analysis in order to evaluate the potential threat of infection to the patients and/or staff within the organization.
- 3.0. If there is a significant threat to the organization, SRMC will propose necessary actions to be taken to prevent or mitigate the threat of infection. These proposed actions will be submitted directly to ET for immediate execution. If the threat is low or there is no threat, the results will follow general quality reporting guidelines.

Surveillance and Outbreak Analysis (Internal)

- 4.0. Problem or outbreak response surveillance will be used in the investigation of potential increases in infectious diagnoses within CFHC.
- 5.0. Internal surveillance data can be obtained from the following sources within the clinics:
 - 5.1. Lab results
 - 5.2. Incident Reports
 - 5.3. Radiology results
 - 5.4. Increases in infectious disease diagnoses

5.5. Medical Records review

- 6.0. Once data is received that there may be a potential increase in infections or an outbreak situation, SRMC will meet to analyze the data.
 - 6.1. The data will be assessed to determine the following components:
 - a. The nature of the potential infection increase or outbreak
 - b. The magnitude and gravity of the situation
 - c. The control measures that must be instituted before further investigation takes place
 - d. The actions required to ensure the availability of adequate data
 - e. The need to notify or consult others
 - 6.2. After the initial assessment, the data will be characterized according to epidemiological features (time, place, person/people affected)
 - 6.3. Based on the analysis, a hypothesis must be formulated and refined through additional analysis and studies so that causality can be identified.
 - 6.4. Once causality is determined, measures must be established to eliminate further outbreak.
 - 6.5. A summary report will be distributed to the executive team for approval of necessary actions and to ensure proper reporting mechanisms within the organization and to outside agencies as necessary.

Guidelines:

Definitions: N/A

Related Links/Forms:

References: N/A

Appendix: N/A

Policy 3: Methods of Communication

Purpose: To establish a formal means of communication between SRMC, CFHC staff and patients, and the external reportable agencies as applicable for surveillance reporting requirements.

Policy: Surveillance data, infection control activities, infection control reports and actions, and information will be communicated to the appropriate persons, groups and/or departments. Appropriate persons include clinic staff and providers, department heads, ET, the CFHC Board of Directors, patients, and when applicable, the MSDH and the CDC.

Procedure:

- 1.0. SRMC:
 - 1.1. Reviews healthcare associated infection reports of target surveillance.
 - 1.2. Reviews environmental studies and data collected from the MSDH and CDC as necessary.
 - 1.3. Reviews employee illness pertaining to infections.
 - 1.4. Reviews policies and procedures that affect patient care, pertaining to infection risk.
 - 1.5. Communicates the actions and recommendations of the committee through the minutes of the meeting to CPIT, ET, and the CFHC Board of Directors.
 - 1.6. Performs individual communication with a provider concerning clinical activities via the Chair of the SRMC.
- 2.0. Infection Control Program methods of communication includes:
 - 2.1. The use of letters and memos to departments for review of policy and/or change in policy.
 - 2.2. The use of communication method (memo, email, flyer, poster, phone, fax, alerts, verbal communications, etc.) appropriate to the situation for addressing potential outbreak and infection issues, events, etc.
 - 2.3. The use of Incident Reporting forms and reports for communication from all nursing areas, departments and providers about an infection incident.
 - 2.4. The use of phone and fax/electronic reports for acute situations of communicable disease exposure, as well as for recommendations for handling and containment of these situations.

- 2.5. The use of the surveillance systems as referenced in the Policy 2: Surveillance and Outbreak Analysis.
- 2.6. The use of in-service education to orient new personnel and remind current personnel of the important of infection control processes.
- 2.7. The use of in-service education to introduce changes in procedures.
- 2.8. The dissemination of information from referring or receiving organizations when a patient was transferred or referred, and the presence of a healthcare associated infection or communicable disease was not known at the time of the referral.

Guidelines:

Definitions: N/A

Related Links/Forms:

References: N/A

Appendix: N/A

Policy 4: Patient Education

Purpose: To provide a process for patient education in relation to infection control information and activities.

Policy: The Clinical Care Team will provide education to patients regarding various infectious processes and assist the patient and/or family to prepare a home care plan as necessary.

Procedure

- 1.0. The Clinical Care Team will assess the patient's learning needs of the particular disease, preferences, readiness, and ability to learn. Documentation of the patient's learning needs must take place in the Electronic Health Records (EHR).
- 2.0. The Clinical Care Team must expand or explain pertinent information in a manner that patient understands the information about the disease process.
- 3.0. The provider must make recommendations pertinent to the care and prevention of the spread of the disease and must discuss and outline precautionary measures to be used at home.
- 4.0. Documentation of patient education, including instructions given and patient/family understanding of these instructions, materials taught, barriers to learning, learning method used, and patient/family comprehension must be completed in the patient's EHR.

Guidelines:

Definitions: N/A

Related Links/Forms:

References: N/A

Appendix: N/A

Section Two: Infection Control and Prevention Processes

Policy 5: General Infection Control and Prevention

Purpose: To control the spread of infection in all patient care locations.

Policy: **Universal Precautions** will be used during interaction with all patients regardless of diagnosis or presumed infection status.

Procedure:

1.0. Universal Infection Control

- 1.1. Wash hands using soap and water or waterless antiseptic before and after each patient contact, after using the bathroom, after handling soiled material, and after eating is mandatory for all staff. All staff must follow procedures set forth in the CFHC Hand Hygiene policy.
- 1.2. Gloves should be worn whenever contact with any of the following is expected to occur as mandated by the Occupational Safety and Health Administration (OSHA) blood borne pathogens final rule: blood; any body fluids, secretions and excretions *except sweat*, regardless of whether or not they contain visible blood; non-intact skin and/or mucous membranes.
- 1.3. In addition, medical gloves should be worn even if not explicitly delineated above whenever there is:
 - a. a risk of gross contamination of the hands;
 - b. special care to avoid contamination of patients during patient care procedures, including, but not limited to suctioning, phlebotomy, dressing changes, nail clipping, injections, and wound irrigation;
 - c. the possibility of transmission from one patient to another exists; or
 - d. the handling of contaminated items is required.
- 1.4. Protective eyewear and masks should be worn to protect mucous membranes of the mouth, nose and eyes whenever there is a risk of a splash or spray of blood or body fluids. This includes, but is not limited to, the performance of the following procedures: suctioning, nail clipping, wound irrigation and dental work.
- 1.5. Non-sterile gowns should be worn when splashes, sprays, or spills of blood or bodily fluids are likely to come into contact with the caregiver's body or clothes. Remove soiled gown as promptly as possible and wash hands.
- 1.6. Soiled patient care equipment will be handled in a manner to prevent skin and mucous membrane exposure, contamination of clothing, and transfer of

microorganisms to other patients and environments. Patient care equipment should not be used until it has been cleaned and reprocessed appropriately according to the Section 4: Cleaning, Disinfecting, and Sterilizing Patient Care Equipment. Discard single use items properly.

- 1.7. For reusable instruments, handle contaminated instruments using caution to prevent skin and mucous membrane exposures. Equipment should carefully be taken to the autoclave area and sanitized per the Autoclave policy.
- 1.8. Reusable equipment that is used on multiple patients (e.g. blood pressure cuffs, pulse ox probe, etc.) must be disinfected between patients. See Cleaning, Disinfecting, and Sterilizing Patient Care Equipment Policy.
- 1.9. All sharps will be discarded in puncture resistant/ leak proof containers located in the clinics per policy. Sharps containers will be inspected daily by designated staff. Needles will never be recapped. See the Safe Handling of Sharps/Needles and the Biohazard Communication policies for specifics on sharps handling and disposal.
- 1.10. A one way mask should be used whenever possible if the need for resuscitation arises. These items are located in designated areas within the clinic.
- 1.11. If a possible exposure occurs due to needle stick, splash, or other accident, refer to the Occupational Exposure policy for **immediate action**.

2.0 Transmission based precautions

- 2.1. Transmission based precautions will be utilized for patients documented or suspected to be infected with highly transmissible or epidemiologically important pathogens for which additional precautions beyond universal precautions are needed to interrupt transmission.
- 2.2. Precautions are determined based on the mode of transmission of the disease/pathogen involved. There are three types of transmission-based precautions: Airborne, Droplet, and Contact.
 - a. Airborne precautions require special air handling and ventilation specifications that are not available at CFHC.
 - b. A patient or employee with a high suspicion of being an infectious carrier of an airborne pathogen must be referred to a local hospital or health care clinic with available resources.
- 2.3. In addition to standard precautions, patients known or suspected to be infected with microorganisms transmitted by droplets should be treated with the following precautions:

- a. Place patient in an isolated waiting area until he/she can be moved to an exam room.
 - b. A mask should be worn by the staff when within three feet of the patient.
 - c. If a patient leaves the isolated waiting area or exam room, he/she must wear a mask. Minimize travel of patient from the isolated waiting area or the exam room.
 - d. See Policy 7: Respiratory Hygiene/Cough Etiquette for specifics on assisting patients with respiratory a suspicion of respiratory tract infections.
- 2.4. In addition to standard precautions, patients known to be infected or colonized with an epidemiologically important pathogen that can be transmitted by direct or indirect contact should be treated with the following precautions.
- a. Place patient in an isolated waiting area until he/she can be move to an exam room.
 - b. All staff must wear gloves when coming in direct contact with the patient. Dispose of gloves **before** leaving the exam room after contact with the patient.
 - c. Change gloves after contact with material that may have a high microorganism count (fecal material, wound drainage etc.). Wash hands immediately after removing **or use waterless antiseptic**.
 - d. Wear a gown when entering the exam room if you anticipate direct contact with the patient, environmental surfaces or items in the patient's room or if the patient has diarrhea, an ileostomy, a colostomy, or wound drainage not contained by a dressing. Remove gown **before** leaving the patient's exam room. After gown removal, ensure that clothing does not contact potentially contaminated surfaces.
 - e. Parameters of patient movement will be decided based on the organism in question and the likelihood of environmental contamination by the patient.
 - f. When indicated, dedicate the use of patient care equipment (e.g. stethoscope, BP cuff, and thermometer) to the cohort of patients with a single pathogen. Adequately clean and disinfect it between uses with 60% isopropyl alcohol or with disinfectant spray.
 - g. A red biohazard trash bag should be placed in the patient's exam room for disposal of contaminated material (gloves, masks, etc.).
 - h. The room should be completely sanitized with disinfectant detergent surface cleaner followed by germicidal detergent when patient is discharged. Used red biohazard bags are moved to the biohazard waste room.
- 3.0. Infection Control Liaisons will conduct personal protective equipment (PPE) Competency assessment of all staff at least annually. This assessment will be reviewed with staff and will be placed in their file.

List of Infections that require precautions in addition to Standard Precautions:

Organism/illness:	Patients should remain on precautions until/for:
<i>Infections that require droplet precautions:</i>	
Pharyngeal Diphtheria	Off antibiotics 2 cultures taken 24 hours apart are negative
Influenza	Duration of symptoms or seven days, whichever is longer, avoid room sharing with high risk patients, cohort when possible
Haemophilus influenzae, known or suspected	24 hrs after initiation of effective therapy
Neisseria meningitidis (meningococcal), known or suspected	24 hrs after initiation of effective therapy
Meningococcal pneumonia	24 hrs after initiation of effective therapy
Meningococemia	24 hrs after initiation of effective therapy
Mumps (infectious parotitis)	For 9 days after onset of swelling
Mycoplasma pneumonia	Duration of illness
Pertussis (whooping cough)	5 days after initiation of effective therapy
Pneumonic plague	72 hrs after initiation of effective therapy
Adenovirus pneumonia	Duration of illness
Rubella	7 days after onset of rash
MRSA – respiratory infections	Resolution of cough
<i>Infections that require comprehensive contact precautions:</i>	
Methicillin/oxacillin resistant <i>Staph aureus</i> (MRSA) – skin infections	Call State Health Dept. and CDC for specific advice
Vancomycin resistant enterococcus (VRE)	Call State Health Dept. and CDC for specific advice
Cutaneous Diphtheria	Off antibiotic 2 cultures 24 hrs apart are negative
Ebola viral hemorrhagic fever	Call State Health Dept. and CDC for specific advice

Lassa fever	Call State Health Dept. and CDC for specific advice
Marburg Virus disease	Call State Health Dept. and CDC for specific advice
E coli 0157:h7 in a diapered or incontinent patient	Duration of illness
Rotavirus in a diapered or incontinent patient	Duration of illness
Shigella in a diapered or incontinent patient	Duration of illness
Hepatitis A in a diapered or incontinent patient	Duration of illness
Disseminated or severe primary mucocutaneous <i>Herpes simplex</i>	Duration of illness
Impetigo	24 hrs after initiation of effective therapy
Adenovirus pneumonia	Duration of illness
<i>Clostridium difficile</i> in a diapered of incontinent patient	Stool culture negative 1 week after last dose of treatment medication (flagyl or vancomycin)
<i>Conditions that require Modified Contact Precautions (Precaution parameter orders to be written on a case by case basis and approved by medical director or designee):</i>	
Lice (pediculosis)	Call State Health Dept. and CDC for specific advice
Scabies	Call State Health Dept. and CDC for specific advice
<i>Clostridium difficile</i>	Call State Health Dept. and CDC for specific advice
Acute viral (acute hemorrhagic) conjunctivitis	Call State Health Dept. and CDC for specific advice
Body Surface Infections that are not contained by a dressing including: major draining abscess, significant weeping cellulitis, decubitus ulcer with major infection and major wound infections	Call State Health Dept. and CDC for specific advice

NOTE: Precautions that apply to infants and children only ARE NOT included in this list.

Guidelines:

1. All blood and body fluids will be considered infectious regardless of the perceived status of the source individual.
2. Gloves are single-use items, to be used only one time and discarded. Remove gloves promptly after use, before touching non-contaminated items and surfaces, and before going to another patient, and wash hands immediately after removing gloves to avoid transfer of microorganisms to other patients or environments.
3. Gloves are located in all exam rooms, dental operatories, and labs. It is the responsibility of the clinic staff to ensure that clinics are adequately stocked and new gloves are ordered from purchasing in a timely manner.
4. Wearing gloves and changing them between patient contacts DOES NOT replace the need for handwashing. Failure to change gloves between patient contacts is an infection control hazard.

Definitions:

1. Airborne pathogens include pathogens that can be transmitted by “droplet nuclei” (residue from evaporated droplets 5um or smaller in size) or dust particles. Diseases that require airborne precautions include: measles, disseminated Varicella zoster (including primary infection), Varicella pneumonia, and pulmonary tuberculosis.
2. Droplet transmission of diseases involves the contact of eyes or the mucous membranes of the nose or mouth of a susceptible person with “large particle droplets” (larger than 5 um in size) containing microorganisms generated from whom is infected by or a carrier of that pathogen. Droplets are generally formed during coughing, sneezing, talking, suctioning and other similar activities. Droplet transmission requires close contact between source and recipient because droplets generally remain suspended in air for three feet or less. Special air handling and ventilation is not required. Diseases that require droplet precautions include, but are not limited to, MRSA pneumonia.
3. Transmission of disease can occur through direct and indirect contact. Direct contact transmission involves direct skin-to-skin contact and physical transfer of microorganisms from a source person to a susceptible host. Indirect-contact transmission involves contact of a susceptible host with a contaminated intermediate object.

Related Links/Forms: PPE Competency Assessment (CDC)

References: N/A

Appendix: N/A

Policy 6: Hand Hygiene

Purpose: To minimize the risk of spreading infection through the use of proper handwashing.

Policy: Employees must use precautionary measures to prevent the spread of or minimize exposure to potentially infectious material.

Procedure:

- 1.0. Wash hands with soap and water:
 - 1.1. Indications for hand hygiene:
 - a. When hands are visibly soiled or contaminated with blood or bodily fluids
 - b. Before and after eating
 - c. After using the bathroom
 - d. After contact with patient who has diarrhea of unknown etiology
 - e. In all situations described in section 2.1 if hand sanitizer is not available
 - 1.2. How to wash hands:
 - a. Turn on water, adjust temperature, and allow water to run continuously.
 - b. Wet hands and keep fingers pointed down at all times.
 - c. Apply a generous amount of soap. Lather surfaces of hands (including palms) and wrists including the backs of the hands and between fingers, and the areas around the nail edges.
 - d. Wash for 15 seconds using friction.
 - e. Rinse thoroughly, holding hands downward. Avoid splashing or allowing hands to touch the sink.
 - f. Dry hands thoroughly with paper towel.
 - g. Turn off faucets using a dry paper towel.
 - h. If there is a door that needs to be opened, utilize the paper towel to open it.
 - i. Discard paper towel into trash can.
- 2.0. Hand cleaning with hand sanitizers:
 - 2.1. Indications for hand hygiene:
 - a. Before having direct contact with patients
 - b. Before performing a procedure or inserting invasive devices that do not require a sterile procedure (e.g. lab draws, injections)
 - c. After contact with a patient's intact skin (e.g. when taking a pulse or blood pressure)
 - d. After contact with non-intact skin if hands are not visibly soiled
 - e. After removing gloves
 - f. After handling garbage or something that could be contaminated, such as sharps containers or red biohazard bags if hands are not visibly soiled
 - 2.2. How to use hand sanitizer:
 - a. Apply product to palm of one hand.
 - b. Rub hands together, covering all surfaces of hands and fingers, including the palms, between the fingers, the back of the hands and the wrists.
 - c. Let hands air dry.
- 3.0. All clinic staff will undergo an annual competency assessment on handwashing that will be reviewed with them and placed in their file.

Guidelines:

United States Centers for Disease Control and Prevention (CDC) recommended guidelines:

1. Washing hands with soap and water is the best way to reduce the number of germs on hands in most situations.
2. When hands are not visibly dirty, alcohol hand sanitizers are an acceptable alternative to soap and water for hand hygiene. Alcohol hand sanitizers kill many different kinds of bacteria, including antibiotic resistant and Tuberculosis bacteria. Alcohol hand sanitizers also have effective germicidal activity against fungi, MRSA, herpes simplex virus, HIV, Hepatitis B virus and influenza virus.
3. All sinks will be supplied with soap and paper towels.
4. If soap and water are not available, use an alcohol-based hand sanitizer that contains between 60% and 95% alcohol.
5. In the event of an allergic reaction to soap or hand sanitizer, discontinue use and revert to brands which have not caused an allergic reaction. Seek medical attention if symptoms worsen, or if skin becomes raw or infected.

Definitions:

1. Infection - the state or condition in which the body (or part of it) is invaded by living, disease-causing microorganisms that multiply and produce effects resulting in illness.
2. PPE (Personal Protective Equipment) - wearable equipment that is intended to protect clinical staff from exposure to or contact with infectious agents. Examples include: gloves, gowns face mask, goggles and face shield.
3. Aseptic- A condition free from germs that will minimize infection.
4. Sterile- Free from *any* living microorganisms including bacteria, fungi, mold spores and certain viruses.
5. Invasive procedure- Any procedure in which the body is entered (by use of a needle, tube, or device) that increases the risk of infection.

Related Links/Forms: N/A

References: (accessed as of 12/19/2013)

<http://www.cdc.gov/handwashing/when-how-handwashing.html>

<http://www.cdc.gov/mmwr/PDF/rr/rr5116.pdf>

<http://www.cdc.gov/handwashing/show-me-the-science.html>

Appendix: N/A

Policy 7: Respiratory Hygiene/Cough Etiquette

Purpose: To provide a process for handling patients with a suspected respiratory tract infection by utilizing standard respiratory hygiene/cough etiquette procedures.

Policy: The staff will assist patients suspected of a respiratory tract infection by executing the following procedures.

Procedure

- 1.0. Staff education on respiratory hygiene/cough etiquette will be provided by DON during new hire orientation and during seasonal outbreaks of viral respiratory tract infections.
- 2.0. Implementation of the following measures to contain the source of respiratory secretions in patients and accompanying individuals who have signs and symptoms of respiratory tract infection, beginning at the point of the initial encounter, will take place in the clinics.
 - 2.1. Signs should be posted in the waiting room with educational information on respiratory hygiene/cough etiquette.
 - 2.2. The person should be instructed to cover their mouth/nose with tissue when coughing and to promptly dispose of used tissues in an appropriate receptacle.
 - 2.3. A surgical mask should be placed on the coughing person when tolerated.
 - 2.4. The person should be instructed to perform hand hygiene after contact with respiratory secretions (e.g. sneezing or coughing).
 - 2.5. Persons with signs and symptoms of respiratory infections should be separated from others in waiting area by three feet or greater, when possible.
 - 2.6. A mask should be worn by staff when examining patients with signs and symptoms of respiratory infection.

Guidelines:

Definitions: N/A

Related Links/Forms:

References: N/A

Appendix: N/A

Policy 8: Injection and Laboratory Draw Safety

Purpose: To provide safety procedures for the use of needles to vaccines, medication, and lab procedures.

Policy: All injections/needle use must be performed via standardized procedures to prevent the spread of infection.

Procedure:

1.0. Injectable medications

- 1.1. Perform hand hygiene prior to the preparation and administration of medications.
- 1.2. Prepare injections using aseptic technique in a clean area free from contamination or contact with blood, body fluids, or contaminated equipment.
- 1.3. Administer medications within one hour of preparation.
- 1.4. Use needles and syringes for only one patient.
- 1.5. Disinfect rubber septum on medication vials with alcohol prior to piercing.
- 1.6. Enter medication vials with a new needle and new syringe, even when obtaining additional doses for the same patient.
- 1.7. Use single-dose or single-use medication vials, pens (i.e. insulin pens) ampules, and bags/bottles of intravenous solutions for only one patient.
- 1.8. Use medication administration tubing and connectors for only one patient.
- 1.9. Ensure that multi-dose vials are dated when first opened and discarded within 28 days unless manufacturer specifies a different (shorter or longer) date for opened vial.
- 1.10. Dedicate multi-dose vials to individual patients whenever possible (e.g. insulin vials, lidocaine, etc.)
- 1.11. Keep multi-dose vials dedicated for more than one patient in a centralized medication area.

2.0. Point of Care Testing and lab testing

- 2.1. Perform hand hygiene and ensure that gloves are worn.
- 2.2. Use single-use auto-disabling finger stick devices for only one patient and discard in sharps container.

- 2.3. Individual patient dedicated glucometer is preferred and is stored to avoid cross-contamination and inadvertent use on additional patients.
 - 2.4. Clean and disinfect shared glucometers/equipment after every use per the manufacturer instructions.
 - 2.5. Use single-use needles and urine containers for all other labs not specified above.
 - 2.6. Waste and trash that is contaminated with blood or other bodily fluids should be disposed of in a red biohazard bag.
 - 2.7. When preparing specimens for the lab, the specimen container must be placed inside a specimen bag which is labeled “biohazard.” The bag is to be zip locked prior to lab pick up. If scheduled pick up is after hours, place specimens in lock box located outside the clinic. Gloves are to be worn when handling lab specimens.
 - 2.8. Remove gloves when point of care testing/lab draws are complete.
 - 2.9. Perform hand hygiene.
 - 2.10. Place patients who do not (or cannot be expected to) assist in maintaining appropriate hygiene or environmental control in an exam room as soon as possible.
- 3.0 The Infection Control Liaisons will conduct an injections and point of care testing competency assessment of clinical staff involved at least annually. The assessment will be reviewed with staff and will be placed in their files.

Guidelines: N/A

Definitions: N/A

Related Links/Forms: Injection Safety Competency Evaluation (Resource: CDC)

References:

Appendix: N/A

Policy 9: Safe Handling of Sharps/Needles

Purpose: To provide procedures for the safe handling of sharps/needles.

Policy: All handling of sharps/needles use must be performed via standardized procedures to prevent the spread of infection.

Procedure:

- 1.0. Take care to prevent injuries when using needles, scalpels, and other sharp instruments, when handling sharps during and after procedures, when cleaning used instruments, and when disposing of used needles.
- 2.0. Never recap needles or otherwise manipulate them using both hands, or any other technique that involves directing the point of a needle toward any part of the body; if necessary to recap, use a one-handed “scoop” technique.
- 3.0. Place used disposable syringes and needles and other disposable sharp items in appropriate puncture-resistant containers located as close as practical to the area in which the items were used and place reusable syringes and needles in a puncture-resistant container for transport to the reprocessing area.

Guidelines: N/A

Definitions: N/A

Related Links/Forms: N/A

References: N/A

Appendix: N/A

Policy 10: Biohazard Disposal and Communication

Purpose: To properly handle biohazard materials and to dispose of these materials using a standard process.

Policy: Biohazard labels will be utilized to communicate a hazard. Biohazard labels and red bags are used ONLY for biohazard and NOT for regular waste.

Procedure: Biohazard labels are attached to containers of regulated waste, refrigerators that contain regulated waste, and other containers used to store or transport any potentially infectious materials.

Guidelines:

1. Biohazard labels are not required if designated biohazard containers are used or if the items have been decontaminated.
2. A biohazard label is a label of orange or orange-red color with the words Biohazard and Peligro Biologico containing the biohazard symbol. The label should be attached by sticker, string, or wire that prevents loss or unintentional removal.
3. Arrangements will be made by the Facilities Director to ensure that biohazard materials from school health services and from the mobile unit are picked up from the designated site.

Definitions: N/A

Related Links/Forms: N/A

References: N/A

Appendix: N/A

Section Three: Occupational Post-Exposure Processes

Policy 11: Occupational Post-Exposure

Purpose: To provide guidelines for documentation and testing of employee occupational exposures to blood or Other Potentially Infectious Materials (OPIM).

Policy: All employees will report exposure incidents and will follow up in accordance with *The Occupational Safety and Health Administration (OSHA)* guidelines and additional directives set forth by CFHC.

Procedure:

- 1.0. Provide immediate care to the exposure site.
 - 1.1. Wash with soap and water. If appropriate, bandage the site.
 - 1.2. Flush contaminated mucosal and conjunctival sites with large quantities of water using an eyewash station for at least 15 minutes.
- 2.0. Obtain consent for exposed employee and source antibody testing for Hepatitis Panel and HIV by completing the Source Occupational Exposure Consent and the Employee Occupational Exposure Consent.
 - 2.1. If the employee declines consent, complete the Employee Post-Exposure Medical Evaluation Record of Informed Refusal for Examination Form. *If the employee decides against immediate testing, the blood sample should be preserved for 90 days.*
 - 2.2. If the source individual declines consent for testing or is unknown, follow the guidelines in the OSHA manual “*What to Do After An Occupational Exposure When the Source Patient is Unknown or Refuses to be Tested*”
- 3.0. Complete OSHA’s Accident Report/Sharps Injury Log (Form 14) and Post Exposure Checklist (Form 17)
- 4.0. Report the incident as soon as possible, following the guidelines set forth in the *CFHC Incident Reporting* policy.
- 5.0. Employee will be referred to healthcare provider for the following:
 - 5.1. Counseling and, if required, initiation of post exposure prophylaxis (PEP) for employee exposures posing risk of infection transmission of HBV and/or HIV.
 - 5.2. Review of source individual’s test results (if source was tested) and employee test results.
- 6.0. Any subsequent testing/follow up should be repeated in accordance with OSHA guidelines and Policies and Procedures.

- 7.0. Scan Employee and Source Occupational Exposure Consent forms into the corresponding electronic medical record.
- 8.0. All original forms must be forwarded to DON immediately.

Guidelines:

For OSHA purposes, a reportable event is:

1. A cut to the skin or a mucous membrane from an article contaminated with blood or other potentially infectious material (OPIM).
2. A splash or spray of blood or OPIM to non-intact skin or to a mucous membrane.

Definitions: N/A

Related Links/Forms:

OSHA's Accident Report/Sharps Injury Log (Form 14)

Post Exposure Checklist (Form 17)

References:

CFHC Incident Reporting Policy

Appendix: N/A

Section Four: Cleaning, Disinfection, and Sterilization Processes

Policy 12: Cleaning of Toys

Purpose: To prevent transmission of microorganisms from one patient to another by toys.

Policy: Toys should be selected based on infection control considerations and must be cleaned following standard guidelines.

Procedure:

- 1.0. Place used toys in a plastic, lidded bin which is labeled for toy use.
- 2.0. Clean toys at the end of the day.
- 3.0. Large toys, such as playhouses, kitchens, and other such items are cleaned with a hospital approved germicide.
- 4.0. Acceptable methods of cleaning toys include:
 - 4.1. Washing them in a dishwasher using a dishwasher detergent.
 - 4.2. Cleaning them in a hospital approved germicide.

Guidelines:

1. Toys should be selected with the following considerations.
 - a. Toys used by more than one patient should be solid, non-absorbable, and easily washable.
 - b. Toys should not have drainage holes (bath tub toys) or “squeakers” (holes to suck in air to produce the squeaking).
 - c. If a dishwasher is to be used for cleaning, the toys should be able to withstand the wash cycle.
 - d. Stuffed toys are only acceptable if new and are to be given to the patient to keep and not reissued to another patient.
2. Toys that are brought in by the patient’s family/visitors should not be shared. Parents/care givers should be instructed to wash personal toys and blankets at least once a week and whenever visibly soiled.

Definitions: N/A

Related Links/Forms:

References: N/A

Appendix: N/A

Policy 13: Computers and Other IT Equipment Cleaning

Purpose: To decrease potential cross contamination to patients and staff via the high touch use of computer devices in patient care areas.

Policy: All patient care computer devices and IT equipment (i.g. phones, scanners) will be cleaned and disinfected in order to prevent cross-contamination and the transmission of pathogens throughout the facility. Computer devices include, but are not limited to, computer keyboards, mice, and bar code scanners.

Procedure:

- 1.0. Clinic staff will clean or disinfect computer hardware, phones and other electronic equipment on a routine basis by using an EPA-registered hospital detergent/disinfectant after use in patient-care areas. This includes computer keyboards and mice, phones and other equipment located in the exam rooms, office areas, front desk areas or other areas where computer workstations are located.
- 2.0. Lab and dental computer equipment in patient care areas must use a disposable plastic barrier on key boards.
- 3.0. All staff must remove gloves and clean their hands after patient contact and prior to using the computer and other electronic equipment.

Guidelines: N/A

Definitions: N/A

Related Links/Forms:

References: N/A

Appendix: N/A

Policy 14: Exam Room Maintenance

Purpose: To ensure cleaning and disinfection of patient examination rooms.

Policy: Clinic staff, responsible for placing patients in rooms, are also responsible for ensuring the cleanliness of the exam room.

Procedure

The following procedure will be used for each exam room:

- 1.0. Exam tables will be cleaned with germicidal cleaner or 1:10 parts bleach solution after each use.
- 2.0. Clean table paper will be pulled down for each patient.
- 3.0. If the patient uses a pillow, the pillowcase will be changed.
- 4.0. If any bodily fluids or waste material of an unknown origin is spilled on the exam table, it is to be cleaned with a 1:10 bleach solution to prevent growth of HBV and HIV. (Hypochlorous acid solutions are more effective against these viruses.)
- 5.0. The complete exam room is to be cleaned each evening by housekeeping staff. This shall include:
 - 5.1. Dusting pictures and other items
 - 5.2. Wiping down all hard surfaces by applying friction and using a germicidal solution for cleaning and disinfecting
 - 5.3. Sweeping
 - 5.4. Mopping floors, as needed, by using a wet mop submerged in a disinfectant solution
- 6.0. Rooms are to be restocked weekly or as necessary by nurses/MAs.

Guidelines:

The following guidelines should be observed at all times:

1. Adequate spacing should be maintained between waiting room chairs. Arm rests and seats are to be wiped with a disinfectant daily or more frequently if necessary. Special consideration should be given to this disinfection during the cold and flu season.
2. All potentially infectious residues should be collected, bagged and disposed of immediately, and all surrounding surfaces cleaned and disinfected.

3. Trash receptacles are to be lined with disposable liners and are to be emptied daily. All receptacles that are used for collecting medical waste items are to be covered and lined with a red bag. These receptacles should be emptied daily or more often when they are 80% full.
4. No trash should be stored or collected in proximity to medical supplies, instruments, equipment or similar items.
5. Exam table paper is to be disposed of after each patient contact.
6. Thermometer sheaths are to be used at all times.
7. Countertops, cabinet doors and other secondary surfaces are to be cleaned with disinfectants at least daily and more often if needed
8. Restrooms are to be cleaned daily with a disinfectant. This includes cleaning of the toilet bowl, sink and plumbing fixtures.
9. Floors are to be swept at least daily and mopped with disinfectant at least weekly or more often if needed.
10. The refrigerator is to be cleaned with a mild soap weekly or more often if needed. Food products are not to be allowed in the clinical area refrigerator at any time.
11. Air conditioner filters are to be cleaned at least monthly and replaced at least twice annually.
12. Items should be thoroughly cleaned and dried prior to storage. In no case should these items be stored in areas containing sterile mediums or medical supplies.
13. Consideration should be given to any condition of a clinic's exterior grounds, which may pose a hazard to personnel, patients, or visitors. Trash should be collected and disposed of daily, and any standing water or sewage is to be cleared or reported to administration immediately.

Guidelines: N/A

Definitions: N/A

Related Links/Forms: N/A

References: N/A

Appendix: N/A

Policy 15: Aseptic Procedures Between Dental Patients

Purpose: To prevent clinic acquired sepsis of all dental patients.

Policy: The dental assistant is responsible to ensure that all dental equipment and supplies are aseptic prior to use with each patient.

Procedure:

Daily Procedures

- 1.0. The dental chair is wiped down with appropriate germicide or 1:10 parts bleach solution.
- 2.0. Light handles, chair arms and hand pieces are cleaned with germicide and then covered. Countertops are also disinfected.
- 3.0. Head covers are replaced after each patient.
- 4.0. Disposable trays are replaced after each patient.
- 5.0. Suction or evacuator tips are disposed of and replaced after each patient.
- 6.0. Contaminated burs are removed and cleaned per autoclave policy.
- 7.0. Used surgical and dental hygiene instruments are sterilized per autoclave policies. (This includes mirrors, explorers and restorative instruments.)
- 8.0. Disposable gloves are changed between each patient and hands are washed prior to donning gloves and after removing gloves. An antimicrobial soap is used.
- 9.0. New masks and appropriate clean PPE are used with each patient.
- 10.0. Instruments are disinfected in cold sterilant for a minimum of 10 minutes. Sterilization is then achieved by autoclaving at 270 degrees, 25psi for 15 minutes.
- 11.0. The x-ray unit head is re-bagged after each patient and the control is wiped with disinfectant wipes.
- 12.0. Cold sterilant is replaced as indicated by manufacturer instructions.

Weekly Procedures

- 13.0. Dental chairs are disinfected from the top down.
- 14.0. The suction system is disinfected with commercial cleaner or a 1:10 parts bleach solution.
- 15.0. Dental counters and drawers are cleared and disinfected.

Guidelines: Guidelines from OSHA and the American Dental Association must be followed.

Definitions: N/A

Related Links/Forms:

References: N/A

Appendix: N/A

Policy 16: Sterilizing Solution

Purpose: To make certain that all disinfectant solutions are utilized correctly in order to eliminate the spread of bacteria and other infection causing germs.

Policy: It is the responsibility of the clinic staff to order, mix, utilize, and dispose of all disinfecting solutions.

Procedure:

- 1.0. The clinic staff will use only approved disinfectant solution for sterilization of instruments.
- 2.0. The disinfectant solution is an effective sporicidal, virucidal, fungicidal, bactericidal, and pseudomonacidal agent recommended for routine disinfecting and cleaning of instruments.
- 3.0. The disinfectant solution must be used according to the manufacturer's instructions.
- 4.0. Containers should be clearly labeled with the date of mixing, the expiration date, and the initials of the person mixing the solution.

Guidelines: N/A

Definitions: N/A

Related Links/Forms:

References: N/A

Appendix: N/A

Policy 17: Preparation and Autoclaving of Reusable Supplies

Purpose: To ensure the proper preparation of packages for autoclaving so that optimum sterilization is achieved.

Policy: All reusable instruments will be prepared in an appropriate and timely manner so that autoclaving may occur and the availability of sterile supplies will not be compromised.

Procedure:

- 1.0. Rinse all instruments with warm water to remove visible gross contamination and place in the Ultrasonic with Ultrasonic solution or appropriate germicidal solution per manufacturer's guidelines. Let the instruments soak for 10 minutes to complete the disinfection process.
- 2.0. Dry instruments and materials should be assembled in packages.
 - 2.1. All packs will be wrapped and secured with autoclave tape or sealed per manufacturer's guidelines.
 - 2.2. All packs are to be autoclaved for at least 30 minutes at a temperature of 250° Fahrenheit or according to manufacturer guidelines (whichever is most stringent).
 - 2.3. All packs are to be allowed to dry for 30 minutes or until completely dry.
- 3.0. All packs are to be labeled with the date, the initials of the employee who wrapped them and the expiration date. (See example below)
- 4.0. Packages that are encased in plastic or in a paper/plastic pouch have a shelf life of six months.
- 5.0. Instruments wrapped in paper have a shelf life of 30 days.
- 6.0. Instruments double wrapped in paper have a shelf life of 12 months.

Guidelines:

1/15/19 AC Exp. 2/15/19
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Example of labeled packs:

Definitions: N/A

Related Links/Forms:

References: N/A

Appendix: N/A

Policy 18: Monitoring Autoclaved Supplies

Purpose: To ensure the integrity and sterility of products used in the delivery of direct patient care and to prevent outdated or damaged sterile supplies from being a potential source of infection.

Policy: It is the responsibility of the designated clinic staff to monitor autoclaved supplies.

Procedure:

Designated staff will follow the procedures below:

- 1.0. Visually audit autoclaved supplies monthly for expiration dates, torn wrappers, broken seals, etc.
- 2.0. Inspect all autoclaved instruments for date they were autoclaved and date sterility expires.
- 3.0. Remove expired or contaminated supplies from stock and prepare for re-sterilization.
- 4.0. Follow procedure for preparation and autoclaving per the autoclaving policies.
- 5.0. Place autoclaved goods on shelves rotating previously autoclaved supplies toward front and newly prepared goods toward rear.
- 6.0. Dispose of all disposable sterile supplies if they have been opened but not used. (These supplies are considered contaminated.)

Guidelines: N/A

Definitions: N/A

Related Links/Forms:

References: N/A

Appendix: N/A

Policy 19: Autoclave Quality Control

Purpose: To ensure that the autoclave is functioning properly.

Policy: Controls are to be documented each day the autoclave is operated and results are to be reported for Performance Improvement program (PIP) activities.

Procedure:

- 1.0. Document the results of the autoclave indicator strips on the quality control calendar. Autoclave packages are equipped with indicator strips that change color when sterilization occurs.
- 2.0. Place packets with the indicator strips in the autoclave.
- 3.0. Autoclave the load according to the autoclaving policies.
- 4.0. When the load is removed, examine one of the indicator strips immediately to verify that external processing conditions were met.
- 5.0. If the strip shows incomplete sterilization, the contents of that load must not be used. Careful examination of the autoclave should occur.
 - 5.1. If the cause of the autoclave malfunctioning is apparent (i.e. rubber gasket broken), report this to the Facilities department who will notify the party responsible for the repair.
 - 5.2. If there is no apparent reason for the incomplete sterilization, the autoclave should be cleaned, flushed and the load run again as directed above. If the repeat indicator strip still shows that sterilization is incomplete, the results should be documented and the cause for failure determined and addressed before another cycle is attempted.
- 6.0. The result of the indicator and the actions taken should be documented on the quality control calendar.
- 7.0. The autoclave must be inspected per manufacturer guidelines.

Guidelines:

1. It is recommended that in such cases all packages sterilized in that cycle and in subsequent cycles be regarded as questionable until a determination is made about their status.
2. All packages sterilized in these runs are not to be used until they are re- autoclaved and found to be safe.

Definitions: N/A

Related Links/Forms:

References: N/A

Appendix: N/A

Policy 20: Autoclave Spore Testing

Purpose: To ensure sterility of autoclaved goods and to meet proficiency standards.

Policy: Biological indicator packs will be processed minimally on a monthly for the purposes of spore testing by designated staff responsible for autoclaving and the results will be documented.

Procedure:

- 1.0. Place the indicator packs in the autoclave in the position usually determined as the most challenging area of sterilization.
- 2.0. Turn the autoclave on and run a full cycle.
- 3.0. Remove the indicator packets from the autoclave and send to the referenced lab for culture. The indicator packet should be labeled as follows: clinic name, date run, location of packet in autoclave.
- 4.0. Once the spore test is complete and the results are received, they are to be kept in the clinic autoclave manual under autoclave spore test.
- 5.0. For positive cultures (bacteria not sterilized by autoclaving), suspend the use of the autoclave. Recall all sterilized goods dated past the last negative spore test.
- 6.0. If the cause of the autoclave malfunction is apparent (i.e. rubber gasket broken) report this to Facilities who will notify the party responsible for the repair. If there is no apparent reason for the positive results, the autoclave should be cleaned, flushed and the spore test run again as directed above.
- 7.0. Resume autoclave use when spore test is negative.
- 8.0. Clean and flush once a month according to manufacturer guidelines to increase the life and ensure trouble free operation of the autoclave.

Guidelines: N/A

Definitions: N/A

Related Links/Forms:

References: N/A

Appendix: N/A

Section Five: Employee Health Processes

Policy 21: Basic Employee Health

Purpose: To promote employee health and wellness at CFHC.

Policy: CFHC offers employee screenings, immunizations, and services free or at reduced rates.

Procedure:

1.0. Tuberculosis (TB) Screening

- 1.1. Upon hire and annually thereafter, employees are required to receive a TB skin test, not applicable if history of positive TB.
 - a. If a new hire had a TB skin test within the past three months, he or she will provide documentation to the DON.
 - b. The DON will coordinate annual TB skin tests.
- 1.2. The TB skin test will be administered and read by a Mississippi State Department of Health (MSDH) certified healthcare professional.
 - a. The TB skin test will be read between 48-72 hours after the administration.
 - b. Screening results will be forwarded to the DON.
 - c. Employee with a positive TB skin test will be referred to the MSDH.
- 1.3. An employee with a history of a positive TB skin test:
 - a. Must fill out a questionnaire for any signs and symptoms of active TB upon hire and annually thereafter.
 - b. Symptomatic employees will be fully evaluated for active TB disease with a chest x-ray.
 - b. Employee with a positive chest x-ray will be referred to the MSDH.

2.0. Human Immunodeficiency Virus (HIV) Screening

- 2.1. Rapid HIV tests and blood screenings are available to all CFHC employees after exposure per post exposure protocol.
- 2.2. The DON will follow up with the affected employee and monitor according to the Occupational Post Exposure Policy.

3.0. Hepatitis B Vaccination

- 3.1. Upon hire, employees will be offered Hepatitis B vaccination or titer.
- 3.2. All employees will complete the following for the Hepatitis B Vaccine:
 - a. Sign the CFHC Declination, Consent and Release for Hepatitis B Vaccine form.
 - b. Obtain a physician order for the Hepatitis B vaccination.
 - c. Coordinate the series of three Hepatitis B injections given at 0, 1 and 6 months.
 - d. Employees who do not elect to have vaccination for Hepatitis B must sign and

date the CFHC Declination, Consent and Release for Hepatitis B Vaccine and return this form to the DON.

3.3. Employees will receive the most current Vaccine Information Statement (VIS).

4.0. **Influenza Vaccine**

4.1. CFHC employees, as well as designated students (see definitions), may receive an annual Influenza Vaccine (flu shot) at no charge.

4.2. Employees who choose to receive the flu shot will receive the most current VIS.

4.3. If the employee declines the annual flu shot, he/she may opt to have the flu shot at another time at no charge.

5.0. **Access to Care**

5.1. Employees and their families who choose to use CFHC will comply with patient policies and procedures including, but not limited to, scheduling, no shows, and confidentiality.

Guidelines:

1. Any component of procedure in this policy is subject to adjustment by CFHC according to CDC recommendations and updates.
2. Upon hire, and annually, staff will complete patient registration paperwork and submit to the clerical staff in their clinic location.
3. CFHC reserves the right to bill insurances for services, including those offered at no cost for employee.

Definitions:

1. Designated Students: Flu shots are available to any student working at CFHC for a period of two weeks or longer free of charge. The student must complete all necessary paperwork to be registered in the system and documentation must be recorded for the services provided in EHR and Practice Management (PM) systems. CFHC will adjust the charges as an employee/admin discount.

Related Forms:

1. Occupational Post Exposure Policy
2. History of Past Positive TB Skin Test Questionnaire
3. CFHC Declination, Consent and Release for Hepatitis B Vaccine
4. Patient registration forms
5. Vaccine Information Statement (VIS)
6. Checklists/questionnaires may be utilized for screenings and vaccinations until such time

that the information may be completed within the EHR (do not scan into EHR):

- a. For adult immunization (Hepatitis B): www.immunize.org/catg.d/p4065.pdf
 - b. For flu vaccine: www.immunize.org/catg.d/p4066.pdf
 - c. Influenza Vaccination of People With a History of Egg Allergy:
<http://www.immunize.org/catg.d/p3094.pdf>
7. Medical Management of Vaccine Reaction in Adult Patients:
www.immunize.org/catg.d/p3082.pdf
 8. Vaccine Adverse Event Reporting System (VAERS): <http://vaers.hhs.gov/index>

References:

1. http://msdh.ms.gov/msdhsite/_static/resources/877.pdf
2. <http://www.cdc.gov/vaccines/pubs/pinkbook/index.html>
3. <http://www.immunize.org/>
4. MSDH Reportable Diseases and Conditions Hotline: 1-800-556-0003 or 601-576-7700.

Appendix: N/A

Policy 22: Employee Health for Pregnant Staff

Purpose: To communicate protective measures for pregnant employees.

Policy: The pregnant employee may continue to work under the guidelines of her provider as long as the employee can perform the major requirements of the job.

Procedure:

- 1.0. Prenatal care should be obtained by the employee at the first indications of pregnancy in order to protect the fetus and mother.
- 2.0. The pregnant employee must use all precautions for her particular work area.
- 3.0. The pregnant employee should be aware of the mode of transmission of communicable diseases and precautions to prevent transmission.
- 4.0. The pregnant employee may contact the DON for further information regarding the risk of transmission of infectious disease.
- 5.0. The pregnant employee should seek written approval from her provider before using any medications including preventative measures.

Guidelines: N/A

Definitions: N/A

Related Links/Forms: Attachment 1

References: N/A

Appendix: N/A