Resources

Table of Contents

10A NCAC 41A .0206 INFECTION PREVENTION – HEALTH CARE SETTINGS

(a) The following definitions apply throughout this Rule:

(1) "Health care organization" means a hospital; clinic; physician, dentist, podiatrist, optometrist, or chiropractic office; home care agency; nursing home; local health department; community health center; mental health facility; hospice; ambulatory surgical facility; urgent care center; emergency room; Emergency Medical Service (EMS) agency; pharmacies where a health practitioner offers clinical services; or any other organization that provides clinical care.

(2) "Invasive procedure" means entry into tissues, cavities, or organs or repair of traumatic injuries. The term includes the use of needles to puncture skin, vaginal and cesarean deliveries, surgery, and dental procedures during which bleeding occurs or the potential for bleeding exists.

(3) "Non-contiguous" means not physically connected.

(b) In order to prevent transmission of HIV, hepatitis B, hepatitis C and other bloodborne pathogens each health care organization that performs invasive procedures shall implement a written infection control policy. The health care organization shall ensure that health care workers in its employ or who have staff privileges are trained in the principles of infection control and the practices required by the policy; require and monitor compliance with the policy; and update the policy as needed to prevent transmission of HIV, hepatitis B, hepatitis C and other bloodborne pathogens. The health care organization shall designate one on-site staff member for each noncontiguous facility to direct these activities. The designated staff member in each health care facility shall complete a course in infection control approved by the Department. The Department shall approve a course that addresses:

(1) Epidemiologic principles of infectious disease;

(2) Principles and practice of asepsis;

(3) Sterilization, disinfection, and sanitation;

(4) Universal blood and body fluid precautions;

(5) Safe injection practices;

(6) Engineering controls to reduce the risk of sharp injuries;

(7) Disposal of sharps; and

(8) Techniques that reduce the risk of sharp injuries to health care workers.

(c) The infection control policy required by this Rule shall address the following components that are necessary to prevent transmission of HIV, hepatitis B, hepatitis C and other bloodborne pathogens:

(1) Sterilization and disinfection, including a schedule for maintenance and microbiologic monitoring of equipment; the policy shall require documentation of maintenance and monitoring;

(2) Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules;

(3) Accessibility of infection control devices and supplies; and

(4) Procedures to be followed in implementing 10A NCAC 41A .0202(4) and .0203(b)(4) when a health care provider or a patient has an exposure to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV or hepatitis B.

(d) Health care workers and emergency responders shall, with all patients, follow Centers for Disease Control and Prevention Guidelines on blood and body fluid precautions incorporated by reference in 10A NCAC 41A .0201.

(e) Health care workers who have exudative lesions or weeping dermatitis shall refrain from handling patient care equipment and devices used in performing invasive procedures and from all direct patient care that involves the potential for contact of the patient, equipment, or devices with the lesion or dermatitis until the condition resolves.

(f) All equipment used to puncture skin, mucous membranes, or other tissues in medical, dental, or other settings must be disposed of in accordance with 15A NCAC 13B .1200 after use or sterilized prior to reuse.

History Note: *Authority G.S. 130A-144; 130A-145; 130A-147;*
Eff. October 1, 1992;
Amended Eff. January 1, 2010; December 1, 2003; July 1, 1994; January 4, 1994.

This policy has been adopted by UNC Health Care for its use in infection control. It is provided to you as information only.

Infection Control Manual		
UNC HEALTH CARE	Policy Name	**Ambulatory Care Clinical Services**
	Policy Number	**IC 0002**
	Date this Version Effective	**June 2017**
	Responsible for Content	**Hospital Epidemiology**

I. Description

Describes infection prevention practices followed in UNCH Outpatient Care Services sites to reduce the risk of infection.

Table of Contents

II. Rationale

A variety of diagnostic and therapeutic services are provided to outpatients that may have an associated risk of infection. This risk can be minimized by strict adherence to the infection n control guidelines included in this policy.

III. Policy

A. Infection Control Practices for Outpatient Care Services Clinic

1. Personnel

   a. Personnel should adhere to guidelines established by the Hospitals' Occupational Health Service (OHS). Refer to the policy: "Infection Control and Screening Program: Occupational Health Service."

   b. Healthcare personnel (HCP) should adhere to all applicable personnel guidelines in the Infection Control Policy: "Infection Control Guidelines for Adult and Pediatric Inpatient Care."

c. Hand hygiene will be performed in accordance with the Infection Control Policy: "Hand Hygiene and Use of Antiseptics for Skin Preparation."

i. Artificial nails and applications are prohibited for clinical staff.

ii. Nails should be kept short, neat and groomed and should not extend beyond the fingertips.

d. Pregnant personnel may be at increased risk in terms of maternal/fetal infections when attending to patients with certain communicable diseases. Please refer to the Infection Control Policy: IC 0046 Pregnant and Post-Partum Health Care Personnel.

e. Personnel should be familiar with the principles of asepsis outlined in the Infection Control Policy: "Cleaning, Disinfection, and Sterilization of Patient Care Items."

f. The Exposure Control Plan for Bloodborne Pathogens and the Tuberculosis Control Plan will be followed. These policies are located on the Infection Control website and the Intranet @ Work.

2. Infection control education, including OSHA-required education for Bloodborne pathogens and TB, is required annually via LMS.

3. Regulated Medical Waste Disposal

a. Regulated medical waste must be disposed of within the guideline outlined in the Infection Control Policy: IC 0054 Guideline for Disposal of Regulated Medical Waste.

B. Isolation Precautions

1. Detailed information regarding Standard Precautions, Contact Precautions, Droplet Precautions, and Airborne Precautions may be found in the Infection Control: Isolation Precautions Policy. Due to the nature of patient care provided in the UNCH Outpatient Care Services locations, the following modifications should be followed in addition to the applicable general isolation policies.

a. When patients with suspected or known communicable diseases are transported to other departments, the receiving department must be notified of the patient's impending arrival so that appropriate isolation/precaution guidelines can be followed.

b. Hemodialysis and CF Clinic will follow their own infection control policies regarding management of patients**.** Please refer to the Infection Control Policy: IC 0012 Patients with Cystic Fibrosis and the Infection Control Policy: IC 0016 Dialysis Unit.

c. Clinic staffs that perform duties for inpatients and outpatients must be familiar with inpatient isolation policies, door signs, and proper use of personal protective equipment (PPE).

2. Standard Precautions

a. Use Standard Precautions for the care of all patients.

b. Standard Precautions apply to: 1) blood; 2) all body fluids, secretions, and excretions except sweat, regardless of whether or not they contain visible blood; 3) non-intact skin; and 4) mucous membranes. Standard Precautions are designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection in hospitals.

c. Principles of Standard Precautions:

i. Safe Injection Practices

a) The following recommendations apply to the use of needles, cannulas that replace needles, and where applicable intravenous delivery system.

b) Whenever possible, use of single-dose vials is required. Please refer to the Administrative Policy: Admin 0104 Medication Management: Use of Multi-Dose Vials/Pens of Parenteral Medications and Vaccines in Acute Care and Ambulatory Care Environments.

c) Use aseptic technique to avoid contamination of sterile injection equipment.

d) Do not administer medications from a syringe to multiple patients, even if the needle or cannula on the syringe is changed. Needles, cannulae and syringes are sterile, single-use items; they should not be reused for another patient or to access a medication or solution that might be used for a subsequent patient.

e) Use fluid infusion and administration sets (i.e., intravenous bags, tubing, 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.

f) Use single-dose vials for parenteral medications whenever possible.

g) Do not administer medications from single-dose vials or ampules to multiple patients or combine or save leftover contents for later use.

h) If a multidose vial is approved for use and must be used, both the needle or cannula and syringe used to access the multidose vial must be a new sterile needle or cannula and syringe with each access.

i) Do not keep multidose vials in the immediate patient treatment area and store in accordance with the manufacturer's recommendations; discard if sterility is compromised or questionable.

j) Do not use bags or bottles of intravenous solution as a common source of supply for multiple patients.

ii. Infection control practices for special lumbar puncture procedures:

a) Wear a surgical mask when placing a catheter or injecting material into the spinal canal or subdural space (i.e., during myelograms, lumbar puncture and spinal or epidural anesthesia).

iii. Patient Placement

a) Place a patient who contaminates the environment or who does not (or cannot be expected to) assist in maintaining appropriate hygiene or environmental control in a private room or exam room

iv. Hand Hygiene

a) Refer to the Infection Control Policy: IC 0024 Hand Hygiene and Use of Antiseptics for Skin Preparation for full details regarding hand hygiene in all patient care areas.

b) Perform hand hygiene after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn.

c) Perform hand hygiene immediately after gloves are removed, between patient contacts, and when otherwise indicated to avoid transfer of microorganisms to other patients or environments

d) It may be necessary to perform hand hygiene between tasks and procedures on the same patient to prevent cross-contamination of different body sites.

v. Personal Protective Equipment:

a) Gloves

- Hand hygiene must be performed before donning clean or sterile gloves. Wear nitrile gloves when touching blood, body fluids, secretions, excretions, non-intact skin, rashes and contaminated items.
- Perform hand hygiene and put on clean gloves before touching mucous membranes and/or non-intact skin.
- Change gloves between tasks and procedures on the same patient after contact with material that may contain a high concentration of microorganisms.
- Remove gloves promptly after use and perform hand hygiene before touching items and environmental surfaces and before going to another patient to avoid transfer of microorganisms to other patients or environmental surfaces.

b) Mask, Eye Protection, Face Shield:

- Wear a mask and eye protection or a face shield to protect mucous membranes of the eyes, nose, and mouth during procedures and patient-care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, and excretions.

c) Gowns

- Wear a gown to protect skin and to prevent soiling of clothing during procedures and patient-care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, or excretions.
- Select a gown that is appropriate for the activity and amount of fluid likely to be encountered. Fluid-resistant gowns are available for use (e.g., blue plastic gowns). A non-fluid resistant gown (i.e., isolation gown) may be worn in all other procedures not requiring a fluid-resistant or sterile gown.
- Carefully remove a soiled gown so clothes are not contaminated. Gowns should be removed promptly when no longer needed and should be properly disposed of. Disposable gowns may not be used more than once.

vi. Patient Care Equipment

a) Handle used patient-care equipment soiled with blood, body fluids, secretions, and excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and transfer of microorganisms to other patients and environments.

b) Ensure that reusable equipment is not used for the care of another patient until it has been cleaned and reprocessed appropriately.

c) Ensure that single use items are discarded properly and used for only one patient.

vii. Linen

a) Handle, transport, and process used linen soiled with blood, body fluids, secretions, excretions in a manner that prevents skin and mucous membrane

exposures and contamination of clothing and that avoids transfer of microorganisms to other patients and environments.

b) Soiled laundry will be bagged in linen bags that prevent soak-through and/or leakage of fluids to the exterior. If the outside bag becomes wet or soiled it must be double bagged into a second linen bag.

d. Respiratory Hygiene/Cough Etiquette

i. Provide surgical masks to all patients with symptoms of a respiratory illness. Provide instructions on the proper use and disposal of masks.

ii. For patients who cannot wear a surgical mask, provide tissues and instructions on when to use them (i.e., when coughing, sneezing, or controlling nasal secretions), how and where to dispose of them, and the importance of hand hygiene after handling this material.

iii. Provide hand hygiene materials in waiting room areas, and encourage patients with respiratory symptoms to perform hand hygiene

iv. Designate an area in the waiting room where patients with respiratory symptoms can be segregated (ideally by at least 3 feet) from other patients who do not have respiratory symptoms.

v. Place patients with respiratory symptoms in a private room (preferred) or cubicle or exam room as soon as possible for further evaluation.

vi. Implement use of surgical or procedure masks by health care personnel during the evaluation of patients with respiratory symptoms.

vii. Consider the installation of Plexiglas barriers at the point of triage or registration to protect health care personnel from contact with respiratory droplets.

viii. If no barriers are present, instruct registration and triage staff to remain at least 3 feet from unmasked patients and to consider wearing surgical masks during respiratory infection/flu season.

ix. Continue to use Droplet Precautions to manage patients with respiratory symptoms until it is determined that the cause of symptoms is not an infectious agent that requires precautions beyond Standard Precautions.

3. Airborne Precautions

a. In addition to Standard Precautions, patients with known or suspected tuberculosis (TB), chicken pox, disseminated shingles, or measles are placed in Airborne Precaution isolation. If possible, patients requiring airborne precautions should have appointments rescheduled until they are no longer considered contagious or should be seen only in clinical sites with airborne isolation rooms.

b. Airborne Precautions in outpatient clinics are implemented as follows:

i. Placement of the patient in an exam room with the door closed or a separate waiting area apart from other patients (as soon as possible in a room meeting airborne isolation requirements).

ii. Give the patient a surgical mask and instruct them to keep their mask on.

iii. Give the patient tissues to use for covering coughs and sneezes.

iv. Health Care Personnel will wear N95 respirators when entering the exam room. If an N95 is not available or the healthcare worker is not fit tested a surgical mask should be worn.

c. Please refer the Airborne Isolation Rooms List for the most recent listing of areas on-campus and off-campus locations that have airborne infection isolation rooms (negative pressure rooms).

d. Chicken pox, disseminated shingles, herpes zoster, measles

   i. Patients with known or suspected chicken pox, disseminated Herpes Zoster (≥3 dermatomes), or measles should be placed on Airborne Precautions in a negative pressure room.

   ii. If a negative pressure room is not available, the patient should be seen only in clinical sites with airborne isolation rooms. Alternatively, and only when necessary, patients with suspected airborne infections should be seen at the end of the day when no other patients are in the clinic.

   iii. If a patient with chicken pox can be seen outside the facility or can be rescheduled at a time when they are no longer infectious (i.e. all lesions dried and crusted), that would be preferable.

   iv. Caregivers should be immune to measles and chicken pox.

   v. Patients with Chickenpox or Measles should don a mask on entry into the facility and should not use the main entrance, if possible.

   vi. Place the patient in an exam room immediately. Keep the door closed.

   vii. After the patient leaves the clinic, keep the exam room door **closed for 3 ½ hours if the room is *NOT* a negative pressure room.** If a HEPA filter has been utilized during the patient's care, the room needs only be closed for 30 minutes after the patient leaves.

   viii. Rooms ***with*** negative pressure should be kept closed for 30 minutes after the patient leaves.

   ix. After the appropriate "closed" time has elapsed, clean all surfaces with an EPA-registered disinfectant/detergent (e.g. MetriGuard, Sani-Wipes) before using the room for another patient.

e. Tuberculosis

   i. Please refer the Infection Control Policy: IC 0060 Tuberculosis Control Plan for full details regarding TB control.

      a) Patients with signs and symptoms suggestive of tuberculosis should be evaluated promptly to minimize time spent in outpatient care waiting areas. Such patients should have Airborne Precautions applied while the diagnostic evaluation is being conducted. It will be the responsibility of the clinic director or an attending level physician to designate clinic personnel who will be responsible for determining whether.

      b) Airborne precautions should be implemented as described in this section.

      c) The patient should be referred immediately to the Pulmonary, Pediatric Specialty or Infections Disease Clinic for evaluation for active tuberculosis.

      d) Patient Check-In / Waiting Process:

         - Front line personnel (front desk, information and front door staff) should identify patients with symptoms (see below) that may indicate potential tuberculosis, and immediately notify the charge nurse.

- Front line personnel should note if there are comments associated with the appointment regarding the patient having symptoms/conditions that indicate that the patient may have tuberculosis. These patients should be brought to the attention of nursing personnel for further assessment.
- Front line personnel should offer surgical masks and tissues to all patients with coughs and encourage the patient to cover his/her mouth and nose with a tissue when coughing or sneezing. Nursing staff should be notified of patients who are coughing excessively.
- Patients with known or suspected active pulmonary tuberculosis should be given a surgical mask to wear and placed in an exam room immediately.
- Patients who have respiratory symptoms and report any of the following high-risk situations should be brought immediately to the attention of the nursing staff for further evaluation.

e) Medical conditions that may indicate tuberculosis include a cough for more than three weeks, especially if any of the following are present:

- Profound fatigue
- Unintentional weight loss
- Night sweats
- Fevers
- Hemoptysis (bloody sputum)
- Anorexia (loss of appetite)

f) Historical facts which increase the risk of pulmonary tuberculosis:

- Exposure to others with active tuberculosis
- History of a positive skin test (TST)
- History of therapy with anti-tuberculosis drugs
- HIV infection
- Immigrants from countries in Africa, Asia or South America
- Migrant farm workers
- Persons who are or have recently been incarcerated
- Homeless individuals

g) Nursing Assessment:

- Nursing personnel (if not available, a physician) are responsible for evaluating patients who display symptoms or signs of active tuberculosis or are at high risk for active tuberculosis.
    - Nursing Assessment: Nursing personnel (if not available, a physician) are responsible for evaluating patients who display symptoms or signs of active tuberculosis or are at high risk for active tuberculosis.
    - Nursing personnel should immediately assess patients with symptoms suggestive of tuberculosis when notified by front line personnel. Patients should be removed from the waiting area and placed in an exam room

with the door closed (preferably in a room meeting TB isolation requirements-Airborne Precautions room with negative pressure and out exhaustion).

- If the room does not meet OSHA TB standards, i.e., it is not a negative pressure room, then the patient should be provided with a surgical mask and shown how to wear the mask properly (i.e., it must cover nose and mouth). Staff will don an N95 respirator if available and staff has been fit tested. If staff is not fit-tested for an N95 respirator, then a tightly fitting surgical mask must be worn
- Arrangements should be made to transfer the patient ***as soon as possible*** to a UNCH facility with airborne isolation rooms or the local health department for further evaluation. See referral section below.
- If the patient leaves the room for any reason (e.g., to obtain a chest radiograph) he/she must wear the surgical mask.
- Rooms used by suspect TB patients that are *not* airborne isolation rooms (i.e., negative pressure) and in which there was *not* a HEPA filter in place during the patient's visit, should be closed for a minimum of 3 ½ hours after the suspect patient leaves. Normal terminal cleaning can be performed in this room *after* the 3 ½ hour closed time.
- If a HEPA filter has been utilized for the duration of the patient's visit, the room needs only be closed for 30 minutes after the patient leaves.
- Nursing personnel should notify the physician as rapidly as feasible, that the patient may have active tuberculosis.

- Patients waiting for an inpatient bed should not wait in the admitting office but be placed in an appropriate Airborne Isolation room in clinic until a bed becomes available. Alternatively, patients should be sent to the ED to wait for admittance if the clinic is closed.
- Referral to Pulmonary Medicine, Infectious Disease Clinic, or Pediatric Specialty Clinic.
  - All patients suspected or known to have tuberculosis should be referred to their local health department for free treatment. When active TB has been ruled out or appropriately treated, then they can continue care at UNC outpatient clinics.
  - Pulmonary Clinic, Pediatric Specialty of the Infection Disease Clinic: Patients at high risk for HIV infection are to be sent to the Infectious Disease Clinic. Patients seen in the Family Practice Center with either known or suspected TB should be referred to the ID Clinic or Pulmonary Disease Clinic for evaluation until proven noninfectious. Patients under the age of 19 years should be referred to the Pediatric Specialty Clinic.
  - Infectious Disease Clinic: page the Infectious Disease Fellow on call at 216-0626 Infectious Disease Clinic is located on the first floor of UNC Memorial Hospital.
  - Pulmonary Medicine Clinic: call Hospital Operator 984-974-1000, and ask for a pulmonary consult.

- Pediatric Specialty Clinic: call 984-974-1401 for appointments or call the Hospital Operator at 984-974-1000 and ask for the on-call Pediatric Infectious Disease Consultant.

- Additional Considerations for Selected Areas: Ambulatory Surgery Center: Patients with known or suspected TB will not be operated on in the Ambulatory Surgery Center.

4. Contact Precautions
   a. There are few data on the risk of multidrug-resistant organism (MDRO) transmission in the ambulatory setting. In most cases, adherence to Standard Precautions is sufficient to prevent cross-transmission. However, cross-transmission has occurred. Due to the concern for cross-transmission of MDROs, some UNCH outpatient care clinics choose to follow Contact Precautions for patients colonized/infected with MDROs.
   b. In addition to standard precautions, the following guidelines are intended to assist the clinician when managing outpatients with MDROs who receive care in clinics that utilize Contact Precautions.
      i. Place the patient in an exam room or cubicle as soon as possible.
      ii. A disposable isolation gown and exam gloves should be worn by all staff that have direct contact with the patient. Gown and gloves should be removed and hand hygiene performed when leaving the exam room.
      iii. Exam room patient's care equipment (e.g., exam table, computers) should be disinfected using a Sani Cloth or Metriguard before use for another patient.
      iv. Some diagnostic and treatment areas (e.g., GI Procedures, Interventional Radiology) see both inpatients and outpatients. In these areas, staff should follow Contact Precautions for inpatients when indicated. For all other patients (inpatients that do not require Contact Precautions and outpatients), Standard Precautions are followed.
      v. The pediatric infusion room will utilize contact precautions for those patients who require Contact Precautions due to an MDRO. When the patient needs to leave the area (e.g. to utilize the bathroom), they will wear clean clothing or a clean hospital gown and perform hand hygiene. There are criteria that must be met in order for contact precaution patients to be allowed to leave their contact isolation area in the Isolation Policy in the section on Contact Precautions.
5. Droplet Precautions
   a. In addition to Standard Precautions, patients with known or suspected communicable diseases spread through the droplet route are placed on Droplet Precautions isolation.
   b. These diseases include but are not limited to:
      i. Influenza (flu)
      ii. Epiglottitis due to *Haemophilus influenza*
      iii. Meningitis due to *Neisseria meningitides* or *Haemophilus influenza*
      iv. Mumps
      v. Pertussis (whooping cough)
      vi. And many others

c. If possible, these patients should have appointments rescheduled until they are no longer considered contagious.

d. If this is not medically feasible, the patient should ideally be scheduled as the last case of the day.

e. The patient should not be allowed to linger in the waiting area with other patients/staff. A surgical mask should be placed on the patient upon arrival at the clinic. Every effort should be made to place the patient in an exam room as soon as they arrive at the clinic.

f. Healthcare personnel should wear a surgical mask when entering the patient's exam room or when working within 3 to 6 feet of the patient.

g. To transport patients under Droplet Precautions, notify area to which patient is being transported of impending arrival and of any special precautions to be used to prevent transmission of infection. Have the patient wear a surgical mask during transport.

C. Communicable Disease Reporting

1. Personnel should know which diseases are reportable to the Public Health Department and encourage physician compliance (refer to the UNCHC Administrative Policy: Reporting of Communicable Diseases). Additional information and forms may be obtained online from UNC Health Care's Infection Control Intranet website.

D. Cleaning Routines and Cleaning Agents

1. Cleaning Agents

   a. Surfaces should be cleaned with an EPA-registered, hospital-approved disinfectant detergent (e.g., MetriGuard, Sani-Cloths), 70% alcohol or a 1:10 bleach solution (effective for 30 days). MetriGuard requires a one minute contact time for effectiveness.

   b. Cleaning Routines

      i. Intravenous poles and lamps should be cleaned with an EPA registered, hospital-approved disinfectant detergent (e.g., MetriGuard, Sani-Cloths), 70% alcohol, or a 1:10 bleach solution on a routine basis and when visibly soiled. Mayo stands should be disinfected after each use with an EPA-registered disinfectant.

      ii. Electronic thermometers will be equipped with two probes (rectal-red or oral-blue) and disposable hard-plastic sheaths. A new plastic sheath should be used for each temperature. The cord, probe, and unit should be thoroughly cleansed routinely (i.e., weekly) and when visibly soiled with an EPA-registered disinfectant detergent, 70% alcohol, or a 1:10 bleach solution. Rectal electronic thermometers should have the probe handle cleaned after each use. Ear (tympanic membrane) thermometers are equipped with a probe and disposable, plastic probe covers. A new plastic cover should be used for each temperature. The unit, including the end of the probe, should be cleaned routinely and when visibly soiled with 70% alcohol.

      iii. EKG cables should be wiped with an EPA-registered disinfectant detergent between each patient

      iv. Patient care equipment (e.g., reusable blood pressure cuffs, wall mounted otoscopes) should be cleaned with an EPA registered disinfectant detergent (e.g., MetriGuard or Super Sani-Cloths) routinely, when obviously soiled, and after use for patients requiring Contact Precautions. Disposable cuffs are for one patient only and must be discarded after each use.

v. Exam tables, recliners and short-term use beds should be cleaned routinely, (i.e., weekly), when visibly soiled, and after use for patients requiring Contact Precautions. In cases of symptomatic diarrheal diseases, these items should be cleaned with a bleach-based disinfectant such as Sani-Cloth bleach wipes.

vi. Pediatric scales should be cleaned daily, when visibly soiled and after patients with signs and symptoms of gastroenteritis. In cases of symptomatic gastroenteritis, pediatric scales should be cleaned with a bleach-based disinfectant.

vii. Shared equipment such as measuring tools shall only have contact with intact skin or wounds covered with clean dressings. This equipment shall be cleaned between each use with an EPA-registered, hospital-approved disinfectant (e.g., Sani Cloths).

viii. Change cubicle curtains on a routine basis and when visibly soiled.

E. General Guidelines

1. BCG Bladder Installations

   a. BCG bladder installations are performed to provide palliative treatment to patients who have superficial bladder carcinomas. BCG is a biologically active material and should be managed with caution. The procedure must be strictly followed and care exercised to eliminate the possibility of exposure to the substance by employing the appropriate personal protective equipment. (Refer to Appendix 1).

2. Computers

   a. Computers located at the nurses' station (e.g. clinical workstation) should be managed in a clean manner. Gloves must be removed and hands washed after providing patient care and prior to use of computer equipment.

   b. Computers used for patient care activities include mobile units and computers permanently located in the patient care areas. These computers have no direct contact with the patient. Mobile units should be used with clean hands. The computers should not be taken into the rooms of patients who are on Contact Isolation. If the computer is taken into the room, it must be disinfected prior to use for another patient. Mobile computers should be disinfected on a regular basis (e.g. weekly) and when visibly soiled. The keyboard and mouse should be wiped with an EPA-registered disinfectant detergent disposal cloth. The surface should appear visibly wet and allowed to air dry. Touch screens should be cleaned according to the manufacturer’s instructions for cleaning.

   c. Computers that are permanently installed in exam rooms should be cleaned on a routine basis (i.e., weekly), when visibly soiled, and by Environmental Services during terminal cleaning. An EPA-registered disinfectant detergent for environmental surfaces (e.g., Metriguard or Sani-Cloths) should be used.

3. Cystic Fibrosis

   a. For guidelines for patients with Cystic Fibrosis, refer to the Cystic Fibrosis Infection Control Policy.

4. Dressings

   a. Wound care/dressing changes should be done using aseptic technique utilizing the appropriate PPE as described by standard precautions. Dressing materials should be sterile.

   b. Please note the universal symbol on packaging for single patient use. If this symbol is present, the item may only be used for one patient.

5. Ophthalmology (see Appendix 4 for equipment disinfection routines)
    a. Management of Patients with Conjunctivitis:
        i. When a patient is discharged from the “red eye room,” the following general cleaning practices should be done.
        ii. All equipment is properly cleaned and disinfected. If the equipment cannot be immediately cleaned after use, the used equipment should be placed in the middle of the desk pad.
        iii. Close the exam room door to let others know that this room is not clean.
        iv. Change the tissue paper on the slit lamp and wipe the entire slit lamp, headrest and handlebars with a 1:10 bleach solution or 70% alcohol.
        v. Wipe all horizontal surfaces (i.e., counter tops, exam chairs) with an EPA-registered disinfectant such as Sani Cloths or Metriquard.
    b. Eye Drops in Ophthalmology
        i. Eye drops must be used as prescribed on the label. If an eye drop is labeled as “single patient use” or “single use only”, it cannot be used on multiple patients. A multidose eye drop may be used on more than one patient with the following exceptions:
            a) If used on a conjunctivitis patient, it must be discarded after use.
            b) If there is any suspicion that the bottle has been contaminated (e.g., the tip has touched a patient's eyelashes or eye), it should be discarded after a single use.
            c) If there is any sign that the fluid in the bottle is no longer safe to use (e.g. turbidity, color change, unusual odors, etc.), then it should not be used.
    c. Procedures in Ophthalmology
        i. For noninvasive ophthalmology procedures performed in the Ophthalmology Clinic, personnel must perform hand hygiene and don sterile gloves. For ophthalmology procedures performed in Day Op, personnel must adhere to the Perioperative Services Infection Control Policy.
        ii. ERG Electrodes (electroretinography)
            a) Clean with a 50/50 mix of regular Tide detergent and distilled water (do not use tap water).
            b) Following cleaning, the electrodes should be disinfected using 1:10 bleach solution (10% bleach, 90% distilled water) for 5 minutes. Use of a simple kitchen timer is highly recommended. If time exceeds 5 minutes, the silver coating will turn brown, and eventually black. Rinse immediately and thoroughly after soaking in bleach with distilled water.
6. Equipment
    a. Atomizers
        i. After each use, the single use, disposable atomizer cap or tip is discarded and the atomizer is thoroughly wiped with an alcohol pad. Every 30 days or sooner if indicated, the atomizers are washed in enzymatic detergent, rinsed, and steam sterilized.
    b. ENT Equipment

i. Only single use, disposable ear and nasal specula are used in speech therapy. Ear irrigations should be performed using sterile solutions.

c. Glucometers

i. The glucometer and its case are maintained in a visibly clean manner at all times. The glucometer should be cleaned after each use and when visibly soiled using a Super Sani Cloth wipe following manufacturer's instructions for cleaning. The glucometer should be stored in a designated clean area (e.g., nurses' station).

d. Gynecological Equipment

i. Fitting diaphragms should be washed in detergent, completely immersed in 70% alcohol for at least 20 minutes and allowed to dry. Alternatively, they may also be cleaned with an enzymatic detergent (e.g., Valsure) according to manufacturer's instructions for use and steam sterilized.

ii. Cryosurgery probes will be high-level disinfected with 2% glutaraldehyde for a minimum of 20 minutes. Any portion of the probe that could have mucous membrane contact (the probe stem) should be disinfected by wrapping with a cloth soaked in the glutaraldehyde for a minimum of 20 minutes. Ensure the wrapped probe stem is placed in a covered basin during this process. After disinfection, the probe tip and probe stem should be rinsed with sterile water or tap water and dried before use. In order to prevent damage to the electrical component, this may have to be accomplished using several water-soaked cloths. If tap water is used, rinse or wipe down with alcohol as the final step.

iii. Vaginal ultrasound probes should be cleaned and high level disinfected following the infection control policy "Cleaning, Disinfection and Sterilization of Patient-Care Items"

iv. Reusable vaginal speculae should be cleaned with an enzymatic detergent (e.g. Valsure) according to manufacturer's instructions for use. After soaking in enzymatic detergent according to manufacturer's instructions, use a clean cloth or brush to wash the instruments then rinse with water and allow to air dry prior to packaging for sterilization.

iv. In order to retrieve supplies when a sterilizer malfunctions (i.e. biological indicator turns positive), vaginal specula should be individually wrapped in peel packs. An internal and external chemical indicator should be used with each peel pack and the date and/or load number should be written on the package. After sterilization, the speculae should be stored in a manner that prevents contamination. Vaginal speculae labeled single use only (disposable) must be discarded after use.

e. Hand Center, Splinting Tank/Whirlpool

i. Water in the splinting tanks should be emptied weekly, the tank cleaned and refilled with tap water.

ii. The hydrocolator tanks are cleaned and maintained according to manufacturer's instructions.

iii. The whirlpool is cleaned and disinfected after each patient use. The procedure for disinfecting the whirlpool is as follows: Fill whirlpool with cold water. Add 200 ml. of 5.25% sodium hypochlorite (liquid house hold bleach). This achieves 1000 ppm of available chlorine. Allow to stand for 2-3 minutes with hose detached and completely submerged in whirlpool. Agitate whirlpool for 2 minutes. Empty. Reattach hose to drain.

f. Respiratory Care Equipment

i. All equipment is cleaned and disinfected as outlined in the Pulmonary Function Laboratory Infection Control Policy.

ii. Clean respiratory equipment (e.g., manual ventilation bags, oxygen tubing, laryngoscope blades, etc.) should be used for each patient.

iii. Patients receiving lung volume measurements through a peak flow meter will be given a new disposable mouthpiece. The screen should be removed and cleaned weekly and when visibly contaminated by immersion in 70% alcohol. The outside of the Peak Flow Meter will be routinely cleaned with alcohol. If the flow meter used does not have a removable filter, the entire device must be exposed to a complete high level disinfection cycle according to the Infection Control Policy: IC 0008 Cleaning, Disinfection and Sterilization of Patient-Care Items. This shall include testing the chemical's minimum effective concentration with the appropriate test strips, proper soak times, rinsing, and drying.

iv. Disposable airways are preferred. If a non-disposable airway is used, it should be cleaned and steam sterilized.

v. Maxi-mist machines should be wiped with an EPA-registered disinfectant detergent after each use. The tubing is disposable.

vi. Disposable nebulizers should be used in the clinic setting and are to be discarded after patient use. If medication needs to be diluted with saline or water prior to administration, please use only sterile water or saline.

g. Pulse Oximeter Probe

i. Disinfect with 70% alcohol or an EPA-registered disinfectant/detergent routinely, e.g., weekly, when visibly soiled, and after use by a patient on Contact Precautions.

h. Speech/Wellness Flowhead

i. The flowhead is used to measure oral flow rates. Wipe the interior and membrane with an alcohol swab and then spray/atomize alcohol onto the membrane and let it dry. Reusable nose clips will be disinfected with alcohol. Single-use nose clips are disposed of after patient use.

i. Procedure Carts

i. Procedure carts should be set-up as needed as close to the start of the procedure as possible.

ii. During times procedure carts are not in use, items should be securely stored in cart drawers. As always, medication and sharps must be secure.

iii. Sterile endoscopes and instruments must remain in their protective wrap until ready for use.

j. Urology Prostate Biopsy Ultrasound Probe

i. Fully disposable prostate biopsy equipment is highly preferred.

ii. After each procedure, the biopsy probe should be disassembled (needle guide removed from the probe). .

iii. The probe and needle guide should be cleaned with an enzymatic or instrument detergent (e.g., Valsure) taking care to flush all lumens, then rinsed with tap water prior to high-level disinfection (HLD).

iv. After cleaning, the ultrasound probe and needle guide, shall be exposed to a complete high level disinfection cycle according to the Infection Control Policy: IC

0008 Cleaning, Disinfection and Sterilization of Patient-Care Items. This shall include testing the chemical's minimum effective concentration with the appropriate test strips, proper soak times, rinsing, and drying.

v. While soaking in the chemical used for high level disinfection, the lumen of the needle guide and probe channel should be flushed with the high level disinfecting chemical (e.g., OPA, glutaraldehyde) to assure the inner components will be appropriately high level disinfected.

vi. Following HLD, the probe and lumens should be rinsed thoroughly with sterile water and air-dried.

a) Tap water followed by an alcohol rinse may be used rather than sterile water.

b) Flushing air through the lumens will facilitate the drying process.

c) The probe must be dry prior to storage.

7. IV Therapy

a. IV catheter-associated infections are a serious complication of IV therapy. Strict adherence to aseptic technique is required for the insertion, maintenance and removal of IV lines. Personnel working with intravenous catheters must comply with the Infection Control Policy: The Prevention of Intravascular Catheter-Related Infections.

b. Stopcocks

i. Stopcocks should not be used in ambulatory care facilities.

ii. Stopcocks may be used by appropriate healthcare personnel in the Ambulatory Surgery Center in the Ambulatory Care Center as follows

a) Prep all ports with alcohol or povidone-iodine and let dry prior to access.

b) Stopcock ports must be covered with a sterile cap at all times except during access, such as drawing blood or IV fluid administration.

c) Use a new sterile cap after each removal. Never reuse an old cap.

d) Flush stopcock immediately if blood is seen in the port of the stopcock.

e) No blood cultures should be drawn from the stopcock (refer to Nursing Policy: Blood Cultures).

8. Medications

a. Hand hygiene should be performed before preparing medications.

b. Aseptic technique must be used when entering a medication vial. Cleanse the rubber diaphragm of the medication vial with alcohol before inserting needle into the vial. Use a sterile syringe with needle or a sterile vial adaptor for each access. Avoid touch contamination of the vial adaptor prior to penetrating the rubber diaphragm. Vial adaptors are intended for single patient use only and may not be used for multiple patients.

c. The medication preparation areas shall be clean, uncluttered and functionally separate. These areas should be cleaned routinely, e.g., daily, with an approved EPA-registered disinfectant (e.g., MetriGuard, Super Sani- Cloths).

d. Medications should not be prepared within 3 feet of a sink unless a splashguard is present.

9. Nourishments

a. Eating and drinking of nourishments by clinical service personnel is prohibited in clinical areas and other potentially contaminated areas. Personnel should not consume foods brought in for patients.

10. Plants

a. Plants and flowers are not allowed in treatment /procedure areas or areas in which patient care supplies are stored. Personnel must perform hand hygiene after handling plants or changing water.

11. Preoperative Showers

a. Pre-surgical patients will be given instructions and supplies for pre-operative showers. Patients will be instructed to bathe or shower with an antiseptic agent (e.g., 4% chlorhexidine gluconate [CHG]) the night before and morning of surgery with particular attention to the operative site.

b. Follow manufacturer's recommendations for exceptions, such as head/neck surgery patients and pediatric patients (not for use on infants <1000 grams in weight).

c. Patients scheduled for surgery on the face, head, eyes, ears, nose and mouth are candidates for a pre-operative shower or bath with CHG, but they must be informed they should not use the CHG on mucous membranes of the eyes or ears. Please obtain an order for CHG shampoo if this is the case.

12. Refrigerators

a. Food, medications and specimens shall be refrigerated separately. The refrigerator should be clearly identified as a nourishment, medication or specimen refrigerator and cleaned routinely.

b. Open juice containers should be discarded if contamination or spoilage is suspected. Food brought into a clinic from patients should not be homemade and must be prepackaged by an outside facility (e.g., grocery store, bakery).

c. All refrigerator/freezers containing medications should be monitored. A 24 hour minimum/maximum temperature logging thermometer should be used in all refrigerators and freezers that are not under constant supervisions (i.e. overnight and on weekends). Temperatures should be monitored and recorded at least daily to ensure temperatures are in the proper range. Records should be maintained for three years for vaccine refrigerators and 90 days for non-vaccine refrigerators.

d. Vaccines must be stored according to the NC Immunization Guidelines for Safe Vaccine Storage. Refrigerator/freezer temperatures must be monitored and recorded according to the same guidelines.

e. Specimen refrigerators must display a BIOHAZARD label. Refrigerated laboratory kits/reagents cannot be stored in a specimen refrigerator

f. Ideally, refrigerated laboratory kits/reagents should be stored in a separate refrigerator. Alternatively, they may be stored in a medication refrigerator if stored separately, such as in a drawer, separate labeled container or section within the refrigerator.

13. Reuse of Single Use Items/Devices

a. Disposable equipment shall not be reused. Refer to the Reuse of Single Use Devices Infection Control Policy.

14. Service Animals

a. For guidelines for service animals in ambulatory care, refer to the Service Animal Policy available online.

15. Skin Preparation
    a. Procedures in which the skin is punctured/incised should be performed using meticulous aseptic technique. For acupuncture, EMG, and other procedures that involve the skin being penetrated with a needle, the skin should be prepped with alcohol prior to needle insertion. For further information on preparation of a patient's skin for non-surgical and surgical procedures, refer to the Hand Hygiene and Use of Antiseptics for Skin Preparation Infection Control Policy.
16. Specimen Transport
    a. Laboratory specimens should be collected properly and transported in containers that do not leak.
    b. If laboratory specimens are transported via the ACC shuttle bus, the outside of the container and the requisition must not be contaminated.
    c. Specimens should be transported in a container designated with a BIOHAZARD label.
    d. Specimens from hospital-based clinics may be transported via the Computerized Tube System (CTS). Specific packaging instructions for specimens and other guidelines for CTS specimen transport are located in the Administrative Policy 0173: Usage of the Computerized Tube System.
17. Sterile Solutions and Supplies (NaCl, Sterile Water)
    a. Sterile pour (irrigation) solutions are single-patient use and any unused portion must be discarded immediately after use.
18. Supplies, Storage
    a. Storage on floors is not allowed.
    b. Clean patient care items may be stored in the dirty utility room only when contained within an enclosed cabinet.
    c. Patient care items may not be stored in cabinets under sinks due to the increased likelihood of water contamination. The only items that may be stored under sink cabinets are trash bags, cleaning agents (no hand hygiene products or paper towels) and, battery disposal bins, equipment recycling bins (e.g. Pulse-ox) unused sharps safety containers.
    d. Patient care supplies must be stored at least 3 feet from a sink unless a splashguard is present.
19. Surgical Site Infection/Post-Operative Surgical Site Infection Surveillance
    a. Hospital Epidemiology should be notified in the event a surgical site infection is identified or suspected in the outpatient setting. Report the patient's name, medical record number and date of surgery to the Hospital Epidemiology department. Staff directory is online.
20. Toys
    a. Items to be used by younger children (who have a tendency to put things in their mouth) should be made of a cleanable material.
    b. Used cleanable toys (e.g. non porous items such as plastic blocks, etc) and tables are cleaned with an EPA-registered hospital disinfectant (e.g., Sani Cloths) on a routine

basis (e.g. weekly), after use on a patient on contact precautions and when visibly soiled. If the EPA- registered disinfectant contains bleach, accelerated hydrogen peroxide or quaternary ammonium compounds, the toy should be rinsed or wiped with tap water and dried following the use of the disinfectant.

c. Non-cleanable toys (e.g., porous items such as puzzles, cardboard, books, etc.) should not be used unless they are intended to be given to a single patient.

d. New toys brought into the playroom do not need to be sterilized or disinfected.

e. Cleanable toys used by a patient on Enteric Isolation precautions should be cleaned with a bleach solution (i.e. bleach wipes or 1:10 bleach solution) and then rinsed or wiped with tap water before being returned to the playroom for use by other children.

f. Books and magazines in waiting areas are allowed.

21. Ultrasound Gel

a. Bottles of ultrasound gel should not be topped off or refilled. The bottle should be used until empty and then discarded. It is preferable to use unit dose packets of ultrasound gel.

b. Care must be taken to avoid allowing the nozzle of US gel bottles to touch non-intact skin or contaminated surfaces. If contamination is suspected, discard the bottle.

c. Sterile ultrasound gel is used in surgical settings requiring a sterile field. Only sterile gel should be used on and in close proximity to mucous membranes (e.g., vaginal procedures), broken skin, and wound dressings.

22. Utility Rooms

a. Doors to dirty utility rooms should remain closed at all times.

23. Visitation

a. Visitors with communicable infectious diseases should not accompany patients to the Outpatient Care setting.

24. Water Features

a. Water features are discouraged in healthcare settings. Designs that call for water features must be approved prior to acquisition by Hospital Epidemiology. No tabletop waterfalls/water gardens are allowed in patient care areas.

b. Fish Tanks/ Beta fish in Peace Lily arrangements are not allowed in clinical areas (e.g. nursing stations, any patient care areas). Fish tanks are allowed in certain areas, such as recreation therapy, reception areas and waiting rooms, with the following strict precautions.

i. The tank is completely enclosed to prevent patients having direct access to the water and fish (e.g., enclosed area with observation window, freestanding tank with solid, affixed top.

ii. They are not managed by health care workers but by a contracted service provider.

F. High Level Disinfection and Sterilization

1. All high level disinfection and sterilization activities must be in compliance with and according to the Cleaning, Disinfection and Sterilization Infection Control Policy.
2. The sterilization competency for outpatient care sites is yearly. See appendix 2.
3. The high level disinfection competency for all areas is yearly.

a. All personnel with high level disinfection responsibilities must attend the "High Level Disinfection at UNCH" workshop. This class is offered approximately every month. Contact Judie Bringhurst at judie.bringhurst@unchealth.unc.edu in the Hospital Epidemiology department for more information and class dates.

b. Endoscopes must be cleaned and disinfected according to the Endoscope Infection Control Policy.

G. Environmental Services and Waste Management

1. Housekeeping services to on-campus clinics are provided by UNC Environmental Services staff. Community-Based Clinics' and non-hospital clinics' services are sometimes contracted with an outside agency. These services should be consistent with guidelines provided in the Environmental Services Infection Control Policy.

   a. General Hospital Waste

      i. Solid waste from all patient rooms including isolation precautions rooms may be placed in a regular trash receptacle and discarded with the general hospital waste. Any trash bag that is torn should be double bagged.

      ii. Regular trash bags are generally white and display a BIOHAZARD label.

      iii. Small volumes (<20 ml) of blood and blood products from nursing units and outpatient clinics will be disposed of in trash receptacles and discarded with general hospital waste.

         - Blood and body fluids in amounts greater than 20ml may be discarded by carefully pouring the fluid down a clinical sink (hopper) or toilet.
         - Blood and body fluids in amounts greater than 20ml that cannot be safely discarded by pouring into a hopper or toilet must be tightly capped and will be disposed of in the regulated medical waste container.

      iv. Empty bulk blood and blood product containers (e.g., bags and bottles) and tubing may be disposed of in a regular trash receptacle.

      v. Hand washing sinks should never be used for disposal of blood or body fluids.

      vi. Hand washing sinks should never be used for disposal of used IV fluids since it is recognized that these fluids contain any pathogens that may have been present in the patient who received the fluids. Used IV fluids should be disposed of in a hopper.

   b. Regulated Medical Waste

      i. Regulated medical waste includes sharps disposal containers that are full and properly closed, Pleurevacs, evacuated containers, and materials used in the preparation and administration of antineoplastic drugs including gloves, gowns and other trace contaminated items. These wastes are placed in a red trash bag located in an appropriate area. Refer to the Regulated Medical Waste Infection Control Policy and the Environmental Health and Safety Policy: Handling and Disposal of Hazardous Drugs.

      ii. Blood and other bodily fluids should be discarded in a dirty sink or hopper, toilet, or using a vacuum-assisted evacuation system (e.g. Saf-T-Pump) and not in a sink intended for hand washing.

2. Sharps Disposal Containers

a. It is the responsibility of every employee to ensure sharps are disposed of appropriately. Sharps disposal containers are located in exam rooms, procedure rooms, on medicine carts and selected high-use areas.

b. Needles, syringes and sharp edged items (e.g., glass vials, capillary tubes, and glass slides) will be disposed of in these rigid, puncture-proof containers.

c. Sharps disposal containers will be affixed to prevent the container from tipping over.

d. Needles will not be cut or recapped after use.

e. Clinics should check the sharps disposal containers on a daily basis and change when contents have reached the "full" mark on the container, or when 75% full.

f. Full sharps containers will have the top locked and the container will then be placed in red bag waste. Nursing personnel are responsible for monitoring and changing sharps containers as needed.

3. Volunteer Organizations (MedWorld)

   a. MedWorld is a volunteer organization that collects and recycles medical supplies for developing countries. Areas participating in MedWorld must follow certain guidelines for disposable items designated for collection. These guidelines are located in the Regulated Medical Waste Infection Control Policy.

IV. References

Heroux DL, Garris J, Nathan J, et. Al. Ambulatory Care Infection Control Manual. Seattle: Group Health Cooperative businesses, 1993

Rutala WA. APIC Guideline committee, APIC guideline for selection and use of disinfectants. Am J Infect Control 1996;24:313-342

Goodman RA, Solomon SL. Transmission of infectious disease in outpatient health care settings. JAMA 1991;265-2377-2380

Rice R, Jorden JU. Implementing an infection control program for the community-based healthcare facility. JONA 1992;22:18-2

Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings http://www.cdc.gov/ncidod/dhqp/pdf/isolation2007.pdf

V. Reviewed/Approved by

Hospital Infection Control Committee

VI. Original Policy Date and Revisions

Revised on Dec 2004, Feb 2007, Feb 2010, Mar 2013, Mar 2014, Mar 2017, June 2017_{rev}

Appendix 1: BCG Bladder Instillation

BCG is a biologically active material and should be managed with caution. The procedure must be strictly followed and care exercised to eliminate the possibility of exposure to the substance.

POLICY:

RN's perform BCG bladder instillation according to a physician's order. In case of inadvertent exposure, nurse performing BCG instillation should contact Occupational Health Service (6-4480) as soon as possible. Exposure is defined as aerosol formation without persons in room wearing masks.

PURPOSE:

To provide palliative treatment of superficial bladder carcinomas

EQUIPMENT:

For instillation:

A. BCG mixture
B. Catheter tray with 14 French catheter
C. Syringe – 60 cc
D. Lidocaine, 2% Urojet – for males
E. Protective gear:
    1. mask
    2. gloves
    3. goggles
    4. gown

PRE-PROCEDURE:

A. Obtain U/A on each visit
    1. If positive, send for C&S – delay treatment for one week.
    2. If documented sterile pyuria, proceed with bladder instillation with physician approval.
    3. If negative, proceed with bladder instillation.
B. Review patient symptoms and discuss any questionable symptoms with physician
C. Complete check-in: blood pressure, temperature, weight (in kg.), and pulse.
D. Bring the patient to the examination room and inform him you will be dressed in protective gear and explain why. Give the patient one of two attached instruction sheets to read.
E. Review instructions with the patient. Remind the patient to retain the BCG mixture for two hours and to follow the decontamination procedure, etc. (see attached)
F. Document the treatment on the appropriate form.
G. Upon completion of the procedure, utilizing appropriate personal protective equipment, personnel should dispose of the urine in the following manner:
    1. Urine voided after instillation should be poured into a toilet or hopper.
    2. Disinfect the urine by adding an equal volume of undiluted household bleach.
    3. Allow to stand for 15 minutes before flushing.

PROCEDURE:

A. Place blue chux pad on counter of medication area.
B. Mix BCG as directed. Discard materials in red biohazard bag and clean area with alcohol.
C. Transfer BCG mixture via chem block vent to 50 cc vial of preservative-free saline.
    Attach 60 cc syringe to chem block and withdraw BCG.

Appendix 2: Sterilization Competency for Ambulatory Care/Community-Based Centers

Signature: _____Date:_____

Print name: _____Title:_____

COMPETENCY CRITERIA: Circle appropriate outcome measure.

Date: Initials:	Met	Not Met	Has read the Cleaning, Disinfection, and Sterilization Infection Control Policy.
	Met	Not Met	Knows biological monitoring of steam sterilizers is done on a weekly basis.
	Met	Not Met	States the "recall procedure" if a positive biological indicator is detected (from Cleaning, Disinfection and Sterilization Policy).
	Met	Not Met	Assures item is appropriately clean and dried prior to packaging for sterilization.
	Met	Not Met	Affixes a chemical indicator to the outside of each package to verify steam sterilization (or uses a package with an integrated chemical indicator on it) and labels package with date or load number.
	Met	Not Met	Places a chemical indicator inside each package to verify steam penetration.
	Met	Not Met	Knows how to interpret the chemical and biological indicators for steam, ETO and Hydrogen Peroxide Plasma sterilization (those that apply to your clinic).
	Met	Not Met	Knows the location of the chemical and biological monitoring record. Assures all results are recorded and stored in an organized manner. (Must be retrievable for 5 years).
	Met	Not Met	Documents the following: date or load number and content, exposure time and temperature, results, and operator by name or initials.
	Met	Not Met	Cleans the sterilizer according to sterilizer manufacturer instructions and document results.
	Met	Not Met	Checks package for tears, moisture, and unbroken seal prior to use.
	Met	Not Met	Checks the internal and external package indicators for change in color to determine steam sterilization prior to use.

I certify that this individual has met all competencies for sterilizer use.

Signature: _____ Date: _____

Print Name: _____ Title: _____

Appendix 3: Ophthalmology Clinic – Red-Eye Log

Date: ___________

Patient Name	MR Number	Date of Visit	Clinic Visit or Surgery Within Last 30 Days?		Date of Previous Visit or Surgery
			Yes	No	

* If two or more patients within a 30 day period have red-eye and have had clinic visits or surgery during the previous 30 days, notify Hospital Epidemiology at (984) 974-7500.

Appendix 4: Eye Equipment Cleaning Chart

Eye Equipment	Cleaning/Disinfection	Frequency
Slit lamp, occluder	1:10 diluted bleach solution or 70% alcohol	After patient use
Tonopen	Entire unit wiped with 70% alcohol; new tip cover for each patient	After patient use
Applanation tonometer tip	Put tip in 1:10 bleach solution for at least 5 minutes, flush with tap water 15-20 seconds, air dry or tissue dry	After patient use
Laser/Gonio lenses	Soak in 1:10 bleach solution for 10 minutes, rinse thoroughly with 3 cycles of tap water, air dry	After patient use
20,28,60,90 lenses	Wipe with 70% alcohol or soak in 1:10 bleach solution	After patient use, when visibly soiled, or weekly basis
Pac Scan 3000	Soak tips in 1:10 bleach solution for 5 minutes, rinse with tap water, air dry	After patient use
Sonomed Master Vu 12MHz B-Scan Probe	Wipe with 70% alcohol	After patient use
QTI Scan 1000	Wipe with 70% alcohol	After patient use
Blood pressure cuffs Treatment room bed	Clean with a disinfectant detergent (e.g., MetriGuard, , or Sani-Cloths)	Weekly, when visibly soiled, or after a patient on Contact Precautions

Revised 12/09

Appendix 5: Sequences for Putting On (donning) and Taking Off (doffing) PPE used for Protection from Blood and Body Fluids

SEQUENCE FOR DONNING PERSONAL PROTECTIVE EQUIPMENT (PPE)

The type of PPE used will vary based on the level of precautions required; e.g., Standard and Contact, Droplet or Airborne Infection Isolation.

1. GOWN
- Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back
- Fasten in back of neck and waist

2. MASK OR RESPIRATOR
- Secure ties or elastic bands at middle of head and neck
- Fit flexible band to nose bridge
- Fit snug to face and below chin
- Fit-check respirator

3. GOGGLES OR FACE SHIELD
- Place over face and eyes and adjust to fit

4. GLOVES
- Extend to cover wrist of isolation gown

SECUENCIA PARA PONERSE EL EQUIPO DE PROTECCIÓN PERSONAL (PPE)

El tipo de PPE que se debe utilizar depende del nivel de precaución que sea necesario; por ejemplo, equipo Estándar y de Contacto o de Aislamiento de infecciones transportadas por gotas o por aire.

1. BATA
- *Cubra con la bata todo el torso desde el cuello hasta las rodillas, los brazos hasta la muñeca y dóblela alrededor de la espalda*
- *Átesela por detrás a la altura del cuello y la cintura*

2. MÁSCARA O RESPIRADOR
- *Asegúrese los cordones o la banda elástica en la mitad de la cabeza y en el cuello*
- *Ajústese la banda flexible en el puente de la nariz*
- *Acomódesela en la cara y por debajo del mentón*
- *Verifique el ajuste del respirador*

3. GAFAS PROTECTORAS O CARETAS
- *Colóquesela sobre la cara y los ojos y ajústela*

4. GUANTES
- *Extienda los guantes para que cubran la parte del puño en la bata de aislamiento*

USE SAFE WORK PRACTICES TO PROTECT YOURSELF AND LIMIT THE SPREAD OF CONTAMINATION
- Keep hands away from face
- Limit surfaces touched
- Change gloves when torn or heavily contaminated
- Perform hand hygiene

UTILICE PRÁCTICAS DE TRABAJO SEGURAS PARA PROTEGERSE USTED MISMO Y LIMITAR LA PROPAGACIÓN DE LA CONTAMINACIÓN
- *Mantenga las manos alejadas de la cara*
- *Limite el contacto con superficies*
- *Cambie los guantes si se rompen o están demasiado contaminados*
- *Realice la higiene de las manos*

SEQUENCE FOR REMOVING PERSONAL PROTECTIVE EQUIPMENT (PPE)

Except for respirator, remove PPE at doorway or in anteroom. Remove respirator after leaving patient room and closing door.

1. GLOVES
- Outside of gloves is contaminated!
- Grasp outside of glove with opposite gloved hand; peel off
- Hold removed glove in gloved hand
- Slide fingers of ungloved hand under remaining glove at wrist
- Peel glove off over first glovet
- Discard gloves in waste container

2. GOGGLES OR FACE SHIELD
- Outside of goggles or face shield is contaminated!
- To remove, handle by head band or ear pieces
- Place in designated receptacle for reprocessing or in waste container

3. GOWN
- Gown front and sleeves are contaminated!
- Unfasten ties
- Pull away from neck and shoulders, touching inside of gown only
- Turn gown inside out
- Fold or roll into a bundle and discard

4. MASK OR RESPIRATOR
- Front of mask/respirator is contaminated — DO NOT TOUCH!
- Grasp bottom, then top ties or elastics and remove
- Discard in waste container

SECUENCIA PARA QUITARSE EL EQUIPO DE PROTECCIÓN PERSONAL (PPE)

Con la excepción del respirador, quítese el PPE en la entrada de la puerta o en la antesala. Quítese el respirador después de salir de la habitación del paciente y de cerrar la puerta.

1. GUANTES
- *¡El exterior de los guantes está contaminado!*
- *Agarre la parte exterior del guante con la mano opuesta en la que todavía tiene puesto el guante y quíteselo*
- *Sostenga el guante que se quitó con la mano enguantada*
- *Deslice los dedos de la mano sin guante por debajo del otro guante que no se ha quitado todavía a la altura de la muñeca*
- *Quítese el guante de manera que acabe cubriendo el primer guante*
- *Arroje los guantes en el recipiente de deshechos*

2. GAFAS PROTECTORAS O CARETA
- *¡El exterior de las gafas protectoras o de la careta está contaminado!*
- *Para quitárselas, tómelas por la parte de la banda de la cabeza o de las piezas de las orejas*
- *Colóquelas en el recipiente designado para reprocesar materiales o de materiales de deshecho*

3. BATA
- *¡La parte delantera de la bata y las mangas están contaminadas!*
- *Desate los cordones*
- *Tocando solamente el interior de la bata, pásela por encima del cuello y de los hombros*
- *Voltee la bata al revés*
- *Dóblela o enróllela y deséchela*

4. MÁSCARA O RESPIRADOR
- *La parte delantera de la máscara o respirador está contaminada — ¡NO LA TOQUE!*
- *Primero agarre la parte de abajo, luego los cordones o banda elástica de arriba y por último quítese la máscara o respirador*
- *Arrójela en el recipiente de deshechos*

PERFORM HAND HYGIENE IMMEDIATELY AFTER REMOVING ALL PPE

EFECTÚE LA HIGIENE DE LAS MANOS INMEDIATAMENTE DESPUÉS DE QUITARSE CUALQUIER EQUIPO DE PROTECCIÓN PERSONAL

Outpatient Care Infection Prevention Survey Checklist with Answers 2018

The Standards	How to Achieve the Standards
1. Infection Control Policies and Procedures	
a. At least 1 staff has attended the Outpatient .0206 SPICE education.	NC requires at least one clinical person from every clinic that performs invasive procedures to attend this training. Contact Infection Prevention for more information.
b. Staff can articulate the procedure for reportable diseases.	Certain suspected or confirmed communicable diseases are to be reported to the local health department by the patient's physician-of-record. Reporting Of Communicable Diseases policy IC 0063. See Hospital Epidemiology's Did You Know "Reporting Communicable Diseases."
c. Staff can articulate the process for reporting suspected or identified infections related to procedures or surgeries performed at your facility or at **an outside facility.**	Hospital Epidemiology should be notified in the event a surgical site infection is identified or suspected in the outpatient setting. Report the patient's name, medical record number and date of surgery to the Hospital Epidemiology department. Staff directory is online. Ambulatory Care Clinical Services policy IC 0002.
STANDARD PRECAUTIONS: Includes hand hygiene, PPE, respiratory etiquette, isolation	
Aseptic technique is used when performing invasive procedures including injections, foley catheter insertion, central line dressing changes, biopsies, joint injection/aspiration, etc.	
2. Hand Hygiene - Clean Hands Save Lives! You are encouraged to participate in Clean In, Clean Out. Ask Infection Prevention for details.	
a. Artificial fingernails, including gel and shellac polish are not allowed on healthcare professionals.	Hand Hygiene and Use of Antiseptics for Skin Preparation - Policy IC 0024.
b. Soap and paper towels are available.	Paper towels must be accessible and maintained clean and dry. Hospital grade soap and approved alcohol based sanitizer must be available. No refilling of soap dispensers or sanitizer dispensers.
c. Hospital grade alcohol based hand sanitizer is used as appropriate.	Sinks in dirty utility rooms and other areas used for decontaminating equipment or disposal of potentially contaminated items cannot be used for hand hygiene.[2]
d. Staff can explain and/or staff is observed performing hand hygiene per Hand Hygiene and Use of Antiseptics for Skin Preparation policy IC 0024.	Staff performs hand hygiene: Before and after every patient contact, even if gloves are worn; Before and after an invasive procedure such as insertion of IV catheter or surgical procedure even if gloves are worn; After contact with blood or body fluids or non-intact skin even if gloves are worn; After contact with used contaminated equipment or soiled environmental surfaces even if gloves are worn.[2]
e. Hand hygiene is performed prior to donning and after removing gloves.	Hand hygiene is performed prior to donning gloves, prior to direct contact with patients and after removing gloves.[2]
f. Appropriate lotions are available.	Hand lotions/creams must be compatible with both the antimicrobial agent and use of nitrile gloves.[2]
3. Personal Protective Equipment (PPE)	
a. Staff dons and removes gloves at appropriate opportunities.	Wear gloves for procedures that might involve contact with blood or body fluids and when handling potentially contaminated patient equipment; Remove soiled gloves before moving to next task.
b. Additional PPE (i.e. gown, mask, face shield) is available and used if possible exposure to blood and/or bodily fluids is anticipated.	PPE should be matched to the patient's symptoms and the health care personnel's tasks. For example, wear a surgical mask to manage patients with respiratory symptoms and wear a gown to protect yourself from blood, body fluids and other potentially infectious material.[1]

The Standards	How to Achieve the Standards
c. Surgical masks are worn when placing a catheter or injecting material into the spinal canal or subdural space (i.e., during myelograms, lumbar puncture and spinal or epidural anesthesia).	See reference 1.
4. Respiratory Hygiene/Cough Etiquette	
a. Respiratory etiquette signs are posted in the waiting areas with instructions to patients.	Reception areas and waiting rooms must have alcohol-based hand rub, tissues, masks (pediatric and adult as appropriate), trash receptacle and the relevant sign posted. [1]
b. Hand sanitizer, surgical masks, tissues are available.	
c. Patients with respiratory symptoms are placed in a private room (preferred) or cubicle or exam room as soon as possible for further evaluation.	
5. Isolation	
a. Staff are able to articulate isolation policies (for TB, chickenpox, respiratory illnesses).	See reference 1.
b. Staff are able to state how patients would be managed that have a known resistant organism (e.g. MRSA, VRE, C. difficile, draining wound or rash).	
6. Storage of Supplies	
a. Clean and sterile supplies and equipment are stored appropriately and are protected from contamination and/or tampering.	Clean and sterile supplies must be stored in a manner to prevent contamination. Bins used to store items must be clean upon inspection. Items should be removed from shipping cartons before storage to prevent contamination with soil/debris that might be on the cartons. Outer shipping boxes should not be left in clinical areas due to risk of environmental contamination. Supplies should be stored in plastic, washable containers; storage in cardboard is discouraged.
b. Sterile supplies/instruments set up ahead of time are protected from contamination or tampering.	If sterile supplies and instruments are set-up, if appropriate, ahead of time, they should be protected from contamination and/or tampering.
c. Patient care supplies stored at least 36" from a sink or there is a protective barrier (splash guard) to prevent splash contamination.	On the counter top, all items should be an adequate distance (36") from sink or there must be a splash guard installed next to sink.
d. No storage under sinks except for clean sharps containers, clean trash bags, detergents and cleaning agents (NO hand soaps).	To prevent water damage and/or contamination, only chemicals and reagents that do not react with each other or with water can be stored under sinks.
e. Supplies stored on shelves and off floors. Bottom shelf is at least 8" above the floor. Bottom shelf is a solid material.	Must be 8" off floor. Must be 24" from the ceiling. Items should be removed from shipping cartons before storage to prevent contamination.
f. Supplies are within expiration date.	Sterile items must be clean, within date and properly stored. There should be no open steri-strips or opened packing strip bottles. These items are for single patient use. Supplies should be stocked and rotated "first in, first out" so oldest items are used first.

The Standards	How to Achieve the Standards
g. There is clear separation of clean and dirty activities.	Clean items/areas are clearly separated from dirty items. Need either separate clean/dirty rooms or the designated utility room must flow from clean to dirty.
h. Items labeled as "single use only" are not reused.	Items labeled as single use include: steri-strips, bottles of gauze packing, ultrasound gel, lubricating gel. Individual packets of US gel are preferred. Reuse of Single Use Devices (SUDs) Policy IC 0058 follows the FDA labeled guidelines that prohibit the reuse of SUDs except for rare departures.
7. Risk Analysis	
a. Types of procedures performed and services provided are appropriate for the physical space of the site as well as for the skill level and competency of staff.	New construction or renovations are in compliance with Infection Control standards. Infection Control is consulted prior to initiating new procedures or obtaining new equipment.
8. Medication Management	
a. Medications must be separated by type and dosage.	All medications be stored separated by type and dosage in labeled, plastic, washable bins.
b. Medications are secured.	Secured means that medications are under the direct visual field of health care personnel at all occupied times -- or -- under lock and key.
c. Medications are stored appropriately.	Ideally, medications are stored in a medication grade refrigerator. Topical and internal medications are to be stored to prevent possible cross contamination and medication errors. Chemicals (e.g. nail polish remover, betadine) are not to be stored adjacent to medications. Medication Management: Use Of Multi-Dose Vials/Pens Of Parenteral Medications In Acute Care and Ambulatory Care Environments policy ADMIN 0104.
d. Requirements for storage and use of NC state supplied vaccines are met.	See the NC State immunization website for details: http://www.immunize.nc.gov
e. Irrigation solutions (saline/sterile water) are single patient use	Irrigation solutions (bottles of sterile water, acetic acid, saline, etc.) are single use and must be discarded after use. Betadine or other solutions poured into a secondary container must be labeled with the name of the solution and hazard information (if any) from the primary label or SDS. These solutions, once poured into a secondary container are single use and must be discarded immediately after use.
f. Medications are within date	No expired medications. Multi-dose vials of injectable medications expire according to drug manufacturer's FDA-approved labeling and UNCH Medication Management policy.[3]
g. Medications requiring special care after initial use are stored/labeled appropriately	Special care meds include meds requiring refrigeration or meds not kept at room temp for longer than manufacturer's recommendation, meds with a shorter usage period as stated on the vial label by pharmacy or manufacturer (e.g. specific ophthalmic solutions, insulin-varies by manufacturer and type).
9. Medication Refrigerators and Freezers	
a. Refrigerators and freezers are large enough to properly store medications.	Ideally, medications are stored in a medication grade refrigerator. Refrigerators and freezers must be large enough to store the year's largest inventory of medications.
b. Refrigerators and freezers well maintained and clean.	Clean and well maintained. No expired medications. Store patient food, medications, and specimens in separate labeled refrigerators.

<table>
<tr><th>The Standards</th><th>How to Achieve the Standards</th></tr>
<tr><td>c. Medication refrigerator temperatures maintained between 36-46 degrees F (2-8 degrees Celsius).
Note: Clinics with state-supplied vaccines should use the NC state refrigerator and freezer logs available at http://www.immunize.nc.gov/providers/index.htm</td><td rowspan="2"><table><tr><th></th><th>Fahrenheit</th><th>Celsius</th></tr><tr><td>Medication Freezer</td><td>5° to -13°</td><td>-15° to -25°</td></tr><tr><td>Medication Refrigerator</td><td>36° to 46°</td><td>2° to 8°</td></tr></table></td></tr>
<tr><td>d. Medication freezer maintained below 5 degrees F (below -15 degrees Celsius).</td></tr>
<tr><td>e. An appropriate means to check medication in event of a power outage is in place.</td><td>All areas will have a reliable and traceable method of monitoring temperatures in all medication refrigerators and freezers. Staff demonstrate how to verify the Min/Max temperatures and how to clear the memory if relevant. Minimum and maximum temperatures shall be routinely checked and action taken for out-of-range temperatures. For remote monitoring, staff are identified to receive alerts and pull reports. For power outages of less than two hours, leave doors to refrigerators and freezers closed. Proper storage temperatures will be maintained for at least 2 hours if doors are not opened. In the event of a power outage lasting longer than two hours, call the Pharmacy Support Service during normal working hours. If no answer, call the Inpatient Pharmacy.</td></tr>
<tr><td colspan="2">ONE NEEDLE: ONE SYRINGE: ONE PATIENT: ONE TIME</td></tr>
<tr><td colspan="2">10. Safe Injection Practices</td></tr>
<tr><td>a. Medications are prepared safely</td><td>Medications/injections are prepared using aseptic technique in a clean area away from contamination or contact with blood, body fluids or contaminated equipment. Maintains a clean, uncluttered, and functionally separate area for medication preparation. Needles and syringes are discarded immediately after use. NEVER dismantle dirty needles or syringes where medications are prepared. Maintain separation of clean and dirty activities.</td></tr>
<tr><td>b. Single dose vials are never used as multi-dose vials.</td><td>Single dose vials should be used whenever possible and discarded immediately after use.[3]</td></tr>
<tr><td>c. If multi-dose vials must be used for more than one patient, they should be kept and accessed in a dedicated medication prep area (e.g., nurses station) / medication room), away from immediate patient treatment areas.</td><td>Examples of immediate patient treatment areas include exam rooms, operating and procedure rooms, anesthesia and procedure carts, and patient rooms or bays.</td></tr>
<tr><td>d. Fluid infusion and administration sets (IV bags, tubing, and connectors) are used for one patient only and discarded after use.</td><td>Bags of IV fluids are ALWAYS single use.[3]</td></tr>
<tr><td>e. IV fluids are spiked and primed at time of use.</td><td>IV fluids are spiked and tubing is primed immediately prior to use. Preoperative areas (PCS), GI procedures, and outpatient infusion areas are allowed to spike and prime IV sets up to 96 hours. Spiked and primed IV set-ups must be secured until used.</td></tr>
<tr><td>f. Patient's skin is prepped with an approved prep before IV placement.</td><td>Approved skin prep agents are alcohol or chlorhexidine gluconate (CHG).[2]</td></tr>
</table>

The Standards	How to Achieve the Standards
g. Single dose medications or infusates are used for only one patient and not collected or combined (bags of IV fluids are ALWAYS single use).	No combining of "left-overs" from single dose vials. No flushes drawn from bulk sources such as bags of IV fluids.
h. Multi-dose medication vials used for more than one (1) patient are always entered with a new needle and new syringe.	Medication vials used for more than one patient must be labeled as "multi-dose" by the drug manufacturer. Multi-dose vials to be used for more than one patient are kept in a centralized medication area and do not enter the immediate patient treatment area (e.g., exam room, operating room, patient room/cubicle).[1,3]
i. Multi-dose and single dose vials are managed consistent with current Safe Injection Practices guidelines.	The safest practice is to enter a single-dose or single-use vial only once to prevent inadvertent contamination of the vial and infection transmission. Single-dose or single-use vials should be used for a single patient and a single case/procedure/injection. Therefore, they should require only a single entry into the vial. If the single-dose or single-use vial will be entered more than once for a single patient as part of a single procedure, it should be with a new needle and new syringe, and the vial must be discarded at the end of the procedure and not stored for future use. https://www.cdc.gov/injectionsafety/providers/provider_faqs_singlevials.html https://www.cdc.gov/injectionsafety/providers/provider_faqs_multivials.html
j. The rubber septum on a medication/infusate vial is disinfected with alcohol prior to piercing the septum.	Disinfect all rubber septums with a robust wipe with alcohol whether or not the vial has just been opened.
k. Needles and syringes are used for only one patient.	NEVER, NEVER, NEVER re-use needles or syringes.
l. Medications or infusates that are packaged as prefilled syringes are used for only one patient.	Pre-filled syringes are ALWAYS single dose.
m. Hand hygiene is performed before preparing medications.	See Reference 2.
n. Injectable medications are drawn up at start of each procedure, unless otherwise approved by policy.	Any injectable medication drawn from a single dose vial must be injected within an hour of drawing up. Compliance with USP 797 **prohibits** "pre-drawing" injectable medications from a single dose vial unless done under a hood which meets ISO class 5 conditions.
o. Needles and syringes are discarded intact in an appropriate sharps container after use.	Safety devices are deployed; needles should not be removed from syringes.
p. Flushes are not drawn from a bulk container.	Bags of IV fluids are ALWAYS single use. Manufacturer pre-filled syringes, i.e., sterile saline, heparin, are used for IV flushes.
q. Appropriate safety devices are in use. Exceptions have an approval from Hospital Epidemiology.	OSHA regulation requires sharps safety devices to be used unless not appropriate or effective.
r. Sharps are secured.	"Secured" means that sharps (e.g., needles, scalpel blades) are under the direct visual field of health care personnel at all occupied times -- or -- under lock and key.[1]
11. Linens	
a. Linens are stored appropriately	Clean linen must be stored in designated area to prevent contamination from traffic and to reduce risk of linen falling on floor.[1]

The Standards	How to Achieve the Standards
b. Linens are laundered according to UNC Infection Control's Laundry and Linen Service policy	Clean linen must be kept covered if not in a closet, drawer, or cabinet. Laundry and Linen Service policy IC 0034.
c. Soiled linens are handled and stored appropriately.	See Reference 1.
12. Surface Disinfection	
a. Toys are disinfected per UNCH policy.	Toys should be restricted to only those that are non-porous and easily cleaned. Washable toys/sand tables are cleaned with soap and water or surface disinfectant (i.e., Sani-Cloths) and rinsed with tap water on a routine basis (e.g. weekly) and when visibly soiled. Plush toys are to be new and given to the individual patient to take home.[1]
b. Non-critical items and surfaces are cleaned routinely, (i.e., weekly).	Non-critical items are those that come into contact with intact skin. Single use disposable BP cuffs are to be used for one patient and discarded after use. Environmental Services policy IC 0020.
c. Expiration dates: spray surface disinfectants, e.g., Metriguard.	Ensure spray disinfectants are not past the manufacturer's expiration dates stamped on the original container.
d. Patient care equipment (e.g., blood pressure cuffs, wall mounted otoscopes, etc.) should be cleaned with an EPA registered disinfectant detergent (e.g., (No Suggestions)®, Super Sani Cloths) once a week, when obviously soiled, and after use for patients requiring Contact Precautions.	Cleaning supplies are in their proper place. Only hospital grade approved germicidals are to be used for cleaning surfaces in the healthcare environment. Exam tables, recliners and short-term use beds should be cleaned weekly, when visibly soiled, and after use for patients requiring Contact Precautions.
e. Areas identified as nursing responsibility are cleaned appropriately.	Some examples include medication storage areas, electrical equipment.
f. Point-of-care devices are cleaned according to policy.	Medical equipment that involves potential cross transmission must be cleaned according to policy; glucometers must be cleaned between every patient with a hospital grade approved disinfectant.
g. Point-of-care control solutions and test strips are dated with open/expiration dates.	
Instrument Reprocessing	
All reusable equipment is high-level disinfected or sterilized according to manufacturer's instructions and/or evidence-based guidelines and according to UNC Cleaning, Disinfection, and Sterilization of Patient-Care Items policy.	
****Please continually reassess all instruments being sent for sterilization to see if any of them can be switched to disposables****	
All elements in the instrument reprocessing sections are consistent with the UNCH Cleaning, Disinfection, and Sterilization Policy, IC 0008	
13. Instrument Decontamination/pre-cleaning	
a. Items are thoroughly pre-cleaned and decontaminated with enzymatic detergent according to manufacturer instructions and/or evidence-based guidelines prior to high level disinfection or sterilization.	Staff can demonstrate understanding of manufacturer's instructions for use.
b. Enzymatic detergents.	Must be accurately measured following the manufacturer's instructions on the label.
c. Enzymatic detergents.	Must have measuring tools, e.g., cups, basins, tubs, sinks.

The Standards	How to Achieve the Standards
d. Enzymatic detergents.	Basins, cups, tubs and sinks must be marked with increments of water and enzymatic detergent.
e. Enzymatic detergents.	Must have simple digital timer for enzymatic soak time. Check product label for required soak times. For example, items decontaminated in Valsure must be soaked for at least 2 - 5 minutes and must have that period of time validated by a timer.
f. Transporting used (dirty) equipment to instrument reprocessing area.	All used and dirty equipment/devices that are bound for sterilization, HLD, or decontamination must be transported from **point of use** in a leak-resistant, rigid or non-rigid container marked "biohazard" such as a plastic basin with a lid or a biohazard bag. Sharps must be transported from **point of use** in a puncture-resistant container.
g. Manufacturer's instructions for cleaning and/or disinfection for every item reprocessed.	There must be hard copies or readily available electronic copies of device/equipment manufacturer's instructions for cleaning, disinfection and/or sterilization on site.
14. High Level Disinfection	
a. Medical instrument and devices are visually inspected for residual soil and re-cleaned as needed before high level disinfection.	
b. HLD equipment (e.g., AER) is maintained according to manufacturer instructions and/or evidence-based guidelines.	AERs are maintained and logs kept of maintenance of AERs strictly in accordance with manufacturer's IFUs.
c. Chemicals used for HLD are prepared according to manufacturer instructions, UNC infection control policy, and evidence-based guidelines.	Only Infection Control-approved HLDs such as Cidex glutaraldehyde, Rapicide glutaraldehyde, Rapicide PA, Resert may be used.
d. Chemicals used for HLD are documented to have been prepared and replaced according to manufacturer instructions and/or evidence-based guidelines	All labels on all HLD products must be read and instructions followed.
e. HLD expiration date must be affixed to original containers and secondary containers.	Note that HLD expiration dates vary depending on the specific HLD chemical in use: Example: when glutaraldehyde (Cidex®) is opened/activated on September 5, the 14 day use-life (or expiration date) is September 19. Example: when Resert (Revital-Ox)® is poured out of the gallon into your secondary container on September 5, the 21 day use-life (or expiration date) is September 26. Check all HLD chemical and test strip labels for correct information.
f. Equipment is high-level disinfected according to manufacturer's instructions and/or evidence-based guidelines and according to UNC Cleaning, Disinfection, and Sterilization of Patient-Care Items policy.	Cleaning, Disinfection, and Sterilization of Patient-Care Items - IC 0008
g. Containers of HLD chemicals must be labeled with chemical name, hazard information and expiration date.	The name of product as shown on the original container label must be affixed to the secondary container. Hazard information may be obtained from the original product container or from the product's SDS. Actual expiration date after original container is opened must be shown on the container into which the chemical is poured, known as the "secondary" container.

The Standards	How to Achieve the Standards
h. Items that undergo HLD are dried before re-use.	A wet instrument is NEVER ready to use on a patient.
i. HLD logs are in order.	There must be an entry on your HLD log for **every day of the month**. If your HLD is not used on a day, indicate that on your log by the date and the words "not used on this day" written on the line to the right of the initials and date. Draw a line through the remainder of that day's entry. There is no need to log the temperature or test the solution on days it is not used.
j. HLD logs are in order.	You must document the temperature of your HLD chemical in the appropriate column on the log once a day on days it is used.
k. HLD logs are in order.	Keep only one sheet immediately available, i.e., in your notebook or on the clipboard. Older sheets should be stored separately but available if asked for. As always, these logs must be kept for 5 years.
l. Chemicals used for HLD are tested for minimum effective concentration (MEC) before each and every use according to manufacturer instructions.	All HLD test strips instruct to test HLD chemicals before each and every use. If the HLD chemical is used 15 times a day, there must be 15 entries on the HLD log.
m. Expiration dates: HLD test strip bottles must be dated when opened and when expiring.	Use a permanent marker (i.e., Sharpie) and write "opened" and "exp" for these dates. It's OK to use the areas supplied by the test strip manufacturer on some bottles for the correct expiration date.
n. Quality control testing of HLD test strips.	**Cidex® brand** test strips require quality control activities when opening a new bottle of test strips. This activity includes testing 3 strips in full-strength solution and 3 in half-strength solution. **FULL DETAILS are in the instructions that came with your test strips.**
o. Quality control testing of HLD test strips.	**Resert (Revital-Ox)®** brand test strips require quality control activities only when opening a bottle of test strips from a **new lot number**. When appropriate, this activity includes testing 3 strips in a full-strength solution and 3 strips in a half-strength solution. **FULL DETAILS are in the instructions that came with your test strips and must be followed.**
p. Quality control testing of HLD test strips.	**Comply® 3M brand** test strips do not require any quality control activities as do Cidex® brand test strips and Resert® brand strips.
q. Individuals with HLD responsibilities have attended the HLD class.	Class is offered monthly by the Infection Prevention Department. Contact Infection Prevention for details.
r. Individuals with HLD responsibilities have the ability to interpret color differences.	Individuals performing HLD have attestation whether or not they are color blind on file at the clinic. Clinics are responsible for keeping this protected health information in a HIPAA-compliant manner.
s. Colonoscopes and bronchoscopes.	Must be stored without any circular arrangement (no "loops") of the insertion tube. A mild "S" shape is acceptable. Ends of the colonoscope or bronchoscope must be hanging free and not touching the bottom of the scope cabinet or any other container.
15. Sterilization	
a. Autoclaves: chemical and biological indicators are used appropriately.	Internal chemical indicators must be used in each package to be sterilized; the chemical indicator must be examined before the contents are used.
b. Biological indicators run at least weekly.	Biological indicators are to be run at least weekly and must be used with each load containing implantable devices.
c. Sterilization logs accurate and up to date.	The required sterilization log must be used for all counter-top and clinic-based sterilizers.

The Standards	How to Achieve the Standards
d. Sterilizer maintenance logs must be accurate and up to date.	Logs of at least weekly, monthly, and periodic maintenance must be kept.
e. Sterile packages are inspected for integrity and compromised packages are reprocessed.	Instruments in torn, wet, or damaged sterilization pouches must be re-sterilized.
e. Sterilization equipment (e.g., sterilizers, ultrasonic cleaners, washer/disinfectors) is maintained according to manufacturer instructions and/or evidence-based guidelines.	Sterilizer manuals must be onsite and reviewed by all staff using the sterilizer.
16. Trophon	
a. Cleans probe with the appropriate Sani Cloth. Probe is dry prior to commencing the HLD process.	Cleans hands, wear gloves.[4]
b. Cartridge date changed and expiration date is on log.	Cartridges expire 30 days after installing in the Trophon.
c. Cartridge is not expired.	Cartridges expire 30 days after installing in the Trophon.
d. Chemical indicators are not expired.	Only Trophon chemical indicators may be used.
e. Chemical indicators (CI) are used for every HLD cycle.	Only Trophon chemical indicators may be used.
f. Chemical indicators are stored in a clean/dry area, out of direct heat/UV light.	Chemical indicators expire on manufacturer's stamped expiration date.
g. Disinfected probes are stored and covered with an unused peel pouch, separate from where they are disinfected.	High-level disinfected vaginal probes or rectal probes that are ready-to-use must be covered with a peel pack "sleeve". The sleeve should have a second label from the Trophon cycle in which it was high-level disinfected.[4]
h. Log is complete for disinfection cycle: Pass/Fail; All boxes checked, date and initials present.	The prescribed log must be used for all Trophon cycles.[4]
17. General Decontamination/HLD/Sterilization	
a. Proper PPE is worn when processing dirty equipment.	Water-proof or water-resistant gown, disposable gloves (nitrile if performing HLD activities), and full face protection must be worn when processing dirty instruments.
b. Competencies are maintained for cleaning, disinfection and sterilization processes.	Records of staff training must be documented. HLD competency is evaluated at commencement of employment and at least yearly thereafter.
c. HLD, decontamination, and /or sterilization is performed in appropriate environment.	HLD, decontamination and/or sterilization may not be performed in a patient care area.
e. Areas used for cleaning or disinfection flow from dirty to clean.	There must be clear separation between clean and dirty areas of these rooms. It may be helpful to place a line of demarcation between these areas in your room.
f. There is a procedure in place for identification and recall of inadequately sterilized or high level disinfected instruments.	UNC Infection Prevention department must be notified immediately if there is a suspected/known HLD or sterilization failure: 984-974-7500.

<table>
<tr><th>The Standards</th><th>How to Achieve the Standards</th></tr>
<tr><td>g. After sterilization or high level disinfection, devices and instruments are stored in a designated clean area so sterility/cleanliness is not compromised.</td><td>Sterilized and high-level-disinfected items should not be stored in instrument processing areas.</td></tr>
<tr><td>h. There is a distinct separation strategy in place to clearly differentiate dirty, not-ready-to-use instruments from clean, ready-to-use instruments.</td><td>High-level disinfected vaginal probes or rectal probes that are ready-to-use may be covered with a peel pack "sleeve." Flexible endoscopes of any type (ENT, cystoscopes, hysteroscopes, etc.) should use a tagging system: a green tag means "ready to use and clean," and a red tag means "dirty" and must be high-level disinfected before use on the next patient. Consult with Infection Prevention for guidance.</td></tr>
<tr><td colspan="2">18. General Issues</td></tr>
<tr><td>a. Areas free of dust, dirt, soil, trash, odors, clutter and hazards (fixtures, walls, ceilings, floors).</td><td>Ceiling tiles all intact, clean, dry and no stains.</td></tr>
<tr><td>b. Areas and furnishings are in good repair.</td><td>Paint intact, cabinet doors functioning properly, no rips, holes, or cracks in vinyl upholstery.</td></tr>
<tr><td>c. Exam tables/procedure chairs are not ripped or torn.</td><td>Unable to be properly cleaned/disinfected.</td></tr>
<tr><td>e. Staff food and drinks are placed in appropriate areas.</td><td>Stored away from patient care areas and in compliance with NC OSHA blood borne pathogen regulations.</td></tr>
<tr><td colspan="2">19. Nourishment Refrigerator</td></tr>
<tr><td>a. Nourishments and medications are stored separately.</td><td>Patient nourishments are to be single-serving, individually sealed portions. Patient food refrigerator temperatures are must monitored and documented routinely on the appropriate refrigerator log.
<table>
<tr><th></th><th>Fahrenheit</th><th>Celsius</th></tr>
<tr><td>Food Freezer</td><td>Below 0°</td><td>Below -17°</td></tr>
<tr><td>Food Refrigerator</td><td>41° or less</td><td>7° or less</td></tr>
</table></td></tr>
<tr><td>b. Nourishments are within date.</td><td>Expiration date should be visible on all food/medication.</td></tr>
<tr><td>c. Nourishment refrigerator does not contain specimens, culture media and/or medications.</td><td>Medications and food must be stored in separate refrigerators with all items within date and not stored with specimens.</td></tr>
<tr><td>d. Ice chests and ice machines are maintained according to national and North Carolina state guidelines.</td><td>Machines that automatically dispense ice are preferred. Periodic cleaning and maintenance must be per the manufacturer's instructions and be documented. After cleaning, rinse all surfaces of the ice machine with tap water and wipe dry. Ice machines shall be cleaned on a regular schedule such that they are kept free of scum, rust, mold or other contamination. Ice machines shall be maintained in good repair and shall be protected from the elements, splash, drip, dust, vermin, other contamination. Ice machines which are accessible to patients or the public shall provide ice through automatic ice dispensing equipment which prevents the contamination of stored ice. 1A NCAC 18A.1314.</td></tr>
<tr><td>e. Food refrigerators are clearly marked "staff" or "patient" food as appropriate.</td><td>Infection Control Guidelines for Adult and Pediatric Inpatient Care Policy IC 0030. Guidelines for Infection Control in Nutrition and Food Services Policy IC 0039</td></tr>
<tr><td colspan="2">20. Lab Refrigerators</td></tr>
</table>

<table>
<tr><th>The Standards</th><th>How to Achieve the Standards</th></tr>
<tr><td>a. Specimen and culture media are stored separately from food and medications.</td><td>Medications and food must not be stored with specimens.</td></tr>
<tr><td>b. Specimens and lab regents are stored appropriately.</td><td>Laboratory reagents and specimens must be stored separately from medications.</td></tr>
<tr><td>c. Specimen refrigerator temperature monitoring.</td><td>To maintain integrity of specimens for testing.[1]
<table>
<tr><th></th><th>Fahrenheit</th><th>Celsius</th></tr>
<tr><td>Specimen Freezer</td><td>5° to -4°</td><td>-15° to -20°</td></tr>
<tr><td>Specimen Refrigerator</td><td>36° to 46°</td><td>2° to 8°</td></tr>
</table></td></tr>
<tr><td>d. Specimen refrigerators must display a BIOHAZARD label.</td><td>OSHA regulation.</td></tr>
<tr><th colspan="2">21. References</th></tr>
<tr><td colspan="2">1. Ambulatory Care Clinical Services policy IC 0002</td></tr>
<tr><td colspan="2">2. Hand Hygiene and Use of Antiseptics for Skin Preparation policy IC 0024</td></tr>
<tr><td colspan="2">3. Medication Management: Use Of Multi-Dose Vials/Pens Of Parenteral Medications In Acute Care and Ambulatory Care Environments policy ADMIN 0104</td></tr>
<tr><td colspan="2">4. Cleaning, Disinfection, and Sterilization of Patient-Care Items policy IC 0008</td></tr>
<tr><td colspan="2">CMS Infection Control Worksheet for Ambulatory Surgical Centers. https://www.cms.gov</td></tr>
<tr><td colspan="2">Injection Safety. https://www.cdc.gov/injectionsafety/index.html</td></tr>
<tr><td colspan="2">Compounding Standards USP 797</td></tr>
</table>

Appendix 7: Sterilization Competency for UNCH Table Top Sterilizers
(from Ambulatory Care Clinic Services Infection Control Policy: IC0002)

Signature: _____Date:_____

Print name: _____Title:_____

COMPETENCY CRITERIA: Circle appropriate outcome measure.

Date: Initials:	Met	Not Met	Has read the Cleaning, Disinfection, and Sterilization Infection Control Policy.
	Met	Not Met	Knows biological monitoring of steam sterilizers is done at least weekly.
	Met	Not Met	States the "recall procedure" if a positive biological indicator is detected (from Cleaning, Disinfection and Sterilization Policy).
	Met	Not Met	Assures item is appropriately clean and dried prior to packaging for sterilization.
	Met	Not Met	Places a chemical indicator inside each package to verify sterilant (steam, hydrogen peroxide plasma) penetration.
	Met	Not Met	Places a chemical indicator on the outside of each package to verify processing.
	Met	Not Met	Knows how to interpret the chemical and biological indicators for steam, ETO and Hydrogen Peroxide Plasma sterilization (those that apply to your clinic).
	Met	Not Met	Knows the location of the chemical and biological monitoring record. Assures all results are recorded and stored in an organized manner. (Must be retrievable for 5 years).
	Met	Not Met	Documents the following: date or load number and content, exposure time and temperature, results, and operator by name or initials.
	Met	Not Met	Saves all sterilizer print outs in an organized fashion for 5 years.
	Met	Not Met	Cleans the sterilizer on a basis (e.g., weekly, monthly) in accordance with manufacturer recommendations and documents results.
	Met	Not Met	Checks all sterilized packages for tears, moisture, and/or unbroken seals prior to use.
	Met	Not Met	Checks the internal and external package indicators for change in color to determine steam sterilization prior to use.

I certify that this individual has met all competencies for sterilizer use.

Signature: _____ Date: _____

Print Name: _____ Title: _____

Appendix 8: UNCHC High Level Disinfection General Competency

UNCHC High Level Disinfection General Competency

I have read the UNCHC Safety Policy on Glutaraldehyde Control before presenting for competency review.

Circle appropriate outcome measure:			Competencies
Met	Not Met	N.A.	Verbalizes knowledge of cleaning and disinfecting solutions used, labeling, length of effective use life and soak times.
Met	Not Met	N.A.	Documents concentration of high-level disinfectant appropriately, following manufacturer's instructions for use (IFUs).
Met	Not Met	N.A.	Wears personal protective equipment, including gown, gloves, and appropriate face protection.
Met	Not Met	N.A.	Demonstrates initial gross decontamination of exterior of device and accessories. Wipes exterior of device with clean cloth soaked in detergent or enzymatic cleaner.
Met	Not Met	N.A.	If flexible endoscope, leak tests scope according to manufacturer's IFUs.
Met	Not Met	N.A.	Demonstrates the process of manual washing and brushing all channels, ports and valve covers with appropriately prepared detergent or enzymatic cleaner.
Met	Not Met	N.A.	If device has lumen(s), uses suction to fill channels with detergent or enzymatic cleaner.
Met	Not Met	N.A.	Brushes lip of biopsy port if processing scope. Uses appropriate cleaning tools for the device being cleaned, i.e., soft brushes, cloths, and processes cleaning tools appropriately.
Met	Not Met	N.A.	Uses suction to rinse lumens until fluid is clear, ends by suctioning air to clear fluid from lumens (or Scope Buddy) and rinses exterior of scope.
Met	Not Met	N.A.	Fills interior channels of any lumened instrument with high-level disinfectant and immerses completely to prevent air bubbles. Utilizes manufacturer's recommended immersion time for chemical used.
Met	Not Met	N.A.	Demonstrates the proper use of the automated endoscope reprocessor (AER) by completing manufacturer's competency form and training.
Met	Not Met	N.A.	Avoids contaminating clean and/or disinfected items with dirty hands or gloves.
Met	Not Met	N.A.	Rinses device with either sterile water, filtered water, or tap water. Uses three separate volumes of water for three one-minute rinses.
Met	Not Met	N.A.	If appropriate, uses forced air to dry the scope followed by alcohol to assist in drying.
Met	Not Met	N.A.	Demonstrates proper cleaning, high-level disinfection, rinsing and drying of all accessories.
Met	Not Met	N.A.	Demonstrates proper cleaning and sterilization of biopsy forceps and any instrument that enters normally sterile tissues.
Met	Not Met	N.A.	Labels or packages high level disinfected instruments to indicate disinfection has been done.
Met	Not Met	N.A.	Is able to state conditions indicating a device has not been disinfected (e.g., if not labeled or packaged, device is considered contaminated and requires high level disinfection prior to use).
Met	Not Met	N.A.	Properly stores devices, instruments, and/or scopes and their accessories in a clean location.
Met	Not Met	N.A.	Empties and disinfects water bottles on AERs according to manufacturer's IFUs and most current accepted guidelines and UNCH policy.
Met	Not Met	N.A.	Disinfects brushes if reusable; discards disposable brushes after use.
Met	Not Met	N.A.	Empties and cleans pans or sink as indicated.
Met	Not Met	N.A.	Removes personal protective gear and discards appropriately.
Met	Not Met	N.A.	Washes hands before leaving reprocessing room.

I certify that _____ has met the competencies necessary to perform the general duties of high level disinfection.

Name:_____ Date: _____

Signature: _____

North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch

Public Health
HEALTH AND HUMAN SERVICES

Confidential Communicable Disease Report—Part 1

NAME OF DISEASE / CONDITION

ATTENTION HEALTH CARE PROVIDERS:
Please report relevant clinical findings about this disease event to the local health department.

Patient's Last Name	First	**Middle**	Suffix	Maiden/Other	Alias

Birthdate *(mm/dd/yyyy)*	**Sex** ☐M ☐F ☐Trans.	**Parent or Guardian** *(of minors)*	**Medical Record Number**

Patient's Street Address	**City**	**State**	**ZIP**	**County**	**Phone** (_____) _____-_____

Age _____ **Age Type** ☐Years ☐Months ☐Weeks ☐Days

Race (check all that apply): ☐White ☐Black/African American ☐American Indian/Alaska Native ☐Native Hawaiian or Pacific Islander ☐Asian ☐Other ☐Unknown

Ethnic Origin ☐Hispanic ☐Non-Hispanic

Was patient hospitalized for this disease? (>24 hours) ☐Yes ☐No Date / /

Did patient die from this disease? ☐Yes ☐No

Is the patient pregnant? ☐Yes ☐No

Patient is associated with (check all that apply):
- ☐ Child Care (child, household contact, or worker in child care)
- ☐ School (student or worker)
- ☐ College/University (student or worker)
- ☐ Food Service (food worker)
- ☐ Health Care (health care worker)
- ☐ Correctional Facility (inmate or worker)
- ☐ Long Term Care Facility (resident or worker)
- ☐ Military (active military, dependent, or recent retiree)
- ☐ Travel (outside continental United States in last 30 days)

In what geographic location was the patient MOST LIKELY exposed?
- ☐ In patient's county of residence
- ☐ Outside county, but within NC - County: _____
- ☐ Out of state - State/Territory: _____
- ☐ Out of USA - Country: _____
- ☐ Unknown

CLINICAL INFORMATION

Is/was patient symptomatic for this disease? ☐Y ☐N ☐U
If yes, symptom onset date (mm/dd/yyyy): / /
SPECIFY SYMPTOMS:

If a sexually transmitted disease, give specific treatment details

1. Date patient treated:(mm/dd/yyyy) _____
   Medication _____
   Dosage _____
   Duration _____
2. Date patient treated:(mm/dd/yyyy) _____
   Medication _____
   Dosage _____
   Duration _____

DIAGNOSTIC TESTING

Provide lab information below and fax copy of lab results and other pertinent records to local health department.

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name—City/State
/ /						/ /	
/ /						/ /	
/ /						/ /	

Reporting Physician/Practice:
_____
Contact Person/Title: _____
Phone: (_____) _____–_____ Fax:(_____) _____– _____

Health Care Provider for this disease (if not reporting physician):
_____
Contact Person/Title: _____
Phone: (_____) _____– _____ Fax: (_____) _____– _____

LOCAL HEALTH DEPARTMENT USE ONLY

Initial Date of Report to Public Health:____/____/_____
Initial Source of Report to Public Health:
- ☐ **Health Care Provider (specify):**
  - ☐ Hospital
  - ☐ Private clinic/practice
  - ☐ Health Department
  - ☐ Correctional facility
- ☐ **Laboratory**
- ☐ **Other**

Is the patient part of an outbreak of this disease? ☐Yes ☐No

Outbreak setting: ☐ Household/Community (specify index case): _____
- ☐ Restaurant/Retail
- ☐ Child Care
- ☐ Long term care
- ☐ Healthcare setting
- ☐ Adult care home
- ☐ Assisted living facility
- ☐ Adult day care
- ☐ School
- ☐ Prison

Name of facility _____
Address of facility _____
_____

Diseases and Conditions Reportable in North Carolina

Physicians must report these diseases and conditions to the county local health department, according to the **North Carolina Administrative Code: 10A NCAC 41A.0101 Reportable Diseases and Conditions** (see below). Contact information for local health departments can be accessed at ***www.ncalhd.org/directors***. If you are unable to contact your local health department, call the 24/7 pager for N.C. Communicable Disease Branch ***(919) 733-3419.***

For diseases and conditions required to be reported within 24 hours, the initial report shall be made by telephone to the local health department, and the written disease report be made within 7 days. The reporting rules and disease report forms can be accessed at: ***http://epi.publichealth.nc.gov/cd/report.html***

Diseases in *BOLD ITALICS* should be reported immediately to local health department.

Reportable to Local Health Department Within 24 Hours

DISEASE/CONDITION

A-G

ANTHRAX
BOTULISM, FOODBORNE
BOTULISM, INTESTINAL (INFANT)
BOTULISM, WOUND
Campylobacter infection
Chancroid
Chikungunya
Cholera
Cryptosporidiosis
Cyclosporiasis
Diphtheria
E.coli infection, shiga toxin-producing
Foodborne disease: Clostridium perfringens
Foodborne: staphylococcal
Foodborne disease: other/unknown
Foodborne poisoning: ciguatera
Foodborne poisoning: mushroom
Foodborne poisoning: scombroid fish
Gonorrhea
Granuloma inguinale

H-N

Haemophilus influenzae, invasive disease
Hemolytic-uremic syndrome (HUS)
HEMORRHAGIC FEVER VIRUS INFECTION
Hepatitis A
Hepatitis B, acute
HIV/AIDS
HIV
AIDS
Influenza virus infection causing death
Listeriosis
Measles (rubeola)
Meningococcal disease, invasive
Middle East respiratory syndrome (MERS)
Monkeypox
NOVEL INFLUENZA VIRUS INFECTION

O-U

Ophthalmia neonatorum
Pertussis (Whooping Cough)
PLAGUE
Poliomyelitis, paralytic
Rabies, human
Rubella
Salmonellosis
S. aureus with reduced susceptibility to vancomycin
SARS coronavirus infection
Shigellosis
SMALLPOX
Syphilis
primary
secondary
early latent
late latent
late with clinical manifestations
congenital
Tuberculosis
TULAREMIA
Typhoid Fever, acute

V-Z

Vaccinia
Vibrio infection, other than cholera & vulnificus
Vibrio vulnificus
Zika

Reportable to Local Health Department Within 7 Days

DISEASE/CONDITION

A-G

Brucellosis
Chlamydial infection—laboratory confirmed
Creutzfeldt-Jakob Disease
Dengue
Ehrlichiosis, HGA (human granulocytic anaplasmosis)
Ehrlichiosis, HME (human monocytic or e. chaffeensis)
Ehrlichiosis, unspecified
Encephalitis, arboviral, WNV
Encephalitis, arboviral, LAC
Encephalitis, arboviral, EEE
Encephalitis, arboviral, other

H-N

Hantavirus infection
Hepatitis B, carriage
Hepatitis B, perinatally acquired
Hepatitis C, acute
Legionellosis
Leprosy
Leptospirosis
Lyme disease
Lymphogranuloma venereum
Malaria
Meningitis, pneumococcal
Mumps
Non-gonococcal urethritis

O-Z

Pelvic inflammatory disease
Psittacosis
Q fever
Rocky Mountain Spotted Fever
Rubella, congenital syndrome
Streptococcal infection, Group A, invasive
Tetanus
Toxic shock syndrome, non-streptococcal
Toxic shock syndrome, streptococcal
Trichinosis
Typhoid, carriage (Salmonella typhi)
Yellow fever

You may be contacted by the local health department for additional information about this case. Medical record information relevant to the investigation and/or control of a communicable disease is exempt from the HIPAA Privacy Rule (see 45 CFR 164.512(a)) and is permitted as an exception to confidentiality of records in NC State Law GS § 130 A-130.

North Carolina General Statute:

§130A-135. Physicians to report.

A physician licensed to practice medicine who has reason to suspect that a person about whom the physician has been consulted professionally has a communicable disease or communicable condition declared by the Commission to be reported, shall report information required by the Commission to the local health director of the county or district in which the physician is consulted.

North Carolina Administrative Code:

10A NCAC 41A.0101 Reportable Diseases and Conditions

(a) The following named diseases and conditions are declared to be dangerous to the public health and are hereby made reportable within the time period specified after the disease or condition is reasonably suspected to exist:

CHAPTER 41 - EPIDEMIOLOGY HEALTH

SUBCHAPTER 41A - COMMUNICABLE DISEASE CONTROL

SECTION .0100 - COMMUNICABLE DISEASE CONTROL

10A NCAC 41A .0101 REPORTABLE DISEASES AND CONDITIONS

(a) The following named diseases and conditions are declared to be dangerous to the public health and are hereby made reportable within the time period specified after the disease or condition is reasonably suspected to exist:

(1) acquired immune deficiency syndrome (AIDS) - 24 hours;
(2) anthrax - immediately;
(3) botulism - immediately;
(4) brucellosis - 7 days;
(5) campylobacter infection - 24 hours;
(6) chancroid - 24 hours;
(7) chikungunya virus infection - 24 hours;
(8) chlamydial infection (laboratory confirmed) - 7 days;
(9) cholera - 24 hours;
(10) Creutzfeldt-Jakob disease – 7 days;
(11) cryptosporidiosis – 24 hours;
(12) cyclosporiasis – 24 hours;
(13) dengue - 7 days;
(14) diphtheria - 24 hours;
(15) Escherichia coli, shiga toxin-producing - 24 hours;
(16) ehrlichiosis – 7 days;
(17) encephalitis, arboviral - 7 days;
(18) foodborne disease, including Clostridium perfringens, staphylococcal, Bacillus cereus, and other and unknown causes - 24 hours;
(19) gonorrhea - 24 hours;
(20) granuloma inguinale - 24 hours;
(21) Haemophilus influenzae, invasive disease - 24 hours;
(22) Hantavirus infection – 7 days;
(23) Hemolytic-uremic syndrome – 24 hours;
(24) Hemorrhagic fever virus infection – immediately;
(25) hepatitis A - 24 hours;
(26) hepatitis B - 24 hours;
(27) hepatitis B carriage - 7 days;
(28) hepatitis C, acute – 7 days;
(29) human immunodeficiency virus (HIV) infection confirmed - 24 hours;
(30) influenza virus infection causing death – 24 hours;
(31) legionellosis - 7 days;
(32) leprosy – 7 days;
(33) leptospirosis - 7 days;
(34) listeriosis – 24 hours;
(35) Lyme disease - 7 days;
(36) Lymphogranuloma venereum - 7 days;
(37) malaria - 7 days;
(38) measles (rubeola) - 24 hours;
(39) meningitis, pneumococcal - 7 days;
(40) meningococcal disease - 24 hours;
(41) Middle East respiratory syndrome (MERS) - 24 hours;
(42) monkeypox – 24 hours;
(43) mumps - 7 days;

(44) nongonococcal urethritis - 7 days;
(45) novel influenza virus infection – immediately;
(46) plague - immediately;
(47) paralytic poliomyelitis - 24 hours;
(48) pelvic inflammatory disease – 7 days;
(49) psittacosis - 7 days;
(50) Q fever - 7 days;
(51) rabies, human - 24 hours;
(52) Rocky Mountain spotted fever - 7 days;
(53) rubella - 24 hours;
(54) rubella congenital syndrome - 7 days;
(55) salmonellosis - 24 hours;
(56) severe acute respiratory syndrome (SARS) – 24 hours;
(57) shigellosis - 24 hours;
(58) smallpox - immediately;
(59) Staphylococcus aureus with reduced susceptibility to vancomycin – 24 hours;
(60) streptococcal infection, Group A, invasive disease - 7 days;
(61) syphilis - 24 hours;
(62) tetanus - 7 days;
(63) toxic shock syndrome - 7 days;
(64) trichinosis - 7 days;
(65) tuberculosis - 24 hours;
(66) tularemia – immediately;
(66) typhoid - 24 hours;
(67) typhoid carriage (Salmonella typhi) - 7 days;
(68) typhus, epidemic (louse-borne) - 7 days;
(69) vaccinia – 24 hours;
(70) vibrio infection (other than cholera) – 24 hours;
(71) whooping cough – 24 hours; and
(72) yellow fever - 7 days.

(b) For purposes of reporting, "confirmed human immunodeficiency virus (HIV) infection" is defined as a positive virus culture, repeatedly reactive EIA antibody test confirmed by western blot or indirect immunofluorescent antibody test, positive nucleic acid detection (NAT) test, or other confirmed testing method approved by the Director of the State Public Health Laboratory conducted on or after February 1, 1990. In selecting additional tests for approval, the Director of the State Public Health Laboratory shall consider whether such tests have been approved by the federal Food and Drug Administration, recommended by the federal Centers for Disease Control and Prevention, and endorsed by the Association of Public Health Laboratories.

(c) In addition to the laboratory reports for Mycobacterium tuberculosis, Neisseria gonorrhoeae, and syphilis specified in G.S. 130A-139, laboratories shall report:

(1) Isolation or other specific identification of the following organisms or their products from human clinical specimens:
  (A) Any hantavirus or hemorrhagic fever virus.
  (B) Arthropod-borne virus (any type).
  (C) Bacillus anthracis, the cause of anthrax.
  (D) Bordetella pertussis, the cause of whooping cough (pertussis).
  (E) Borrelia burgdorferi, the cause of Lyme disease (confirmed tests).
  (F) Brucella spp., the causes of brucellosis.
  (G) Campylobacter spp., the causes of campylobacteriosis.
  (H) Chlamydia trachomatis, the cause of genital chlamydial infection, conjunctivitis (adult and newborn) and pneumonia of newborns.
  (I) Clostridium botulinum, a cause of botulism.
  (J) Clostridium tetani, the cause of tetanus.
  (K) Corynebacterium diphtheriae, the cause of diphtheria.
  (L) Coxiella burnetii, the cause of Q fever.
  (M) Cryptosporidium parvum, the cause of human cryptosporidiosis.
  (N) Cyclospora cayetanesis, the cause of cyclosporiasis.
  (O) Ehrlichia spp., the causes of ehrlichiosis.

(P) Shiga toxin-producing Escherichia coli, a cause of hemorrhagic colitis, hemolytic uremic syndrome, and thrombotic thrombocytopenic purpura.
(Q) Francisella tularensis, the cause of tularemia.
(R) Hepatitis B virus or any component thereof, such as hepatitis B surface antigen.
(S) Human Immunodeficiency Virus, the cause of AIDS.
(T) Legionella spp., the causes of legionellosis.
(U) Leptospira spp., the causes of leptospirosis.
(V) Listeria monocytogenes, the cause of listeriosis.
(W) Middle East respiratory syndrome virus.
(X) Monkeypox.
(Y) Mycobacterium leprae, the cause of leprosy.
(Z) Plasmodium falciparum, P. malariae, P. ovale, and P. vivax, the causes of malaria in humans.
(AA) Poliovirus (any), the cause of poliomyelitis.
(BB) Rabies virus.
(CC) Rickettsia rickettsii, the cause of Rocky Mountain spotted fever.
(DD) Rubella virus.
(EE) Salmonella spp., the causes of salmonellosis.
(FF) Shigella spp., the causes of shigellosis.
(GG) Smallpox virus, the cause of smallpox.
(HH) Staphylococcus aureus with reduced susceptibility to vanomycin.
(II) Trichinella spiralis, the cause of trichinosis.
(JJ) Vaccinia virus.
(KK) Vibrio spp., the causes of cholera and other vibrioses.
(LL) Yellow fever virus.
(MM) Yersinia pestis, the cause of plague.

(2) Isolation or other specific identification of the following organisms from normally sterile human body sites:
(A) Group A Streptococcus pyogenes (group A streptococci).
(B) Haemophilus influenzae, serotype b.
(C) Neisseria meningitidis, the cause of meningococcal disease.

(3) Positive serologic test results, as specified, for the following infections:
(A) Fourfold or greater changes or equivalent changes in serum antibody titers to:
(i) Any arthropod-borne viruses associated with meningitis or encephalitis in a human.
(ii) Any hantavirus or hemorrhagic fever virus.
(iii) Chlamydia psittaci, the cause of psittacosis.
(iv) Coxiella burnetii, the cause of Q fever.
(v) Dengue virus.
(vi) Ehrlichia spp., the causes of ehrlichiosis.
(vii) Measles (rubeola) virus.
(viii) Mumps virus.
(ix) Rickettsia rickettsii, the cause of Rocky Mountain spotted fever.
(x) Rubella virus.
(xi) Yellow fever virus.
(B) The presence of IgM serum antibodies to:
(i) Chlamydia psittaci.
(ii) Hepatitis A virus.
(iii) Hepatitis B virus core antigen.
(iv) Rubella virus.
(v) Rubeola (measles) virus.
(vi) Yellow fever virus.

(4) Laboratory results from tests to determine the absolute and relative counts for the T-helper (CD4) subset of lymphocytes and all results from tests to determine HIV viral load.

(d) Laboratories utilizing electronic laboratory reporting (ELR) shall report:
(1) All positive laboratory results from tests used to diagnosis chronic Hepatitis C Infection, including the following:
(A) Hepatitis C virus antibody tests (including the test specific signal to cut-off (s/c) ratio);
(B) Hepatitis C nucleic acid tests;
(C) Hepatitis C antigen(s) tests; and
(D) Hepatitis C genotypic tests.
(2) All HIV genotypic test results, including when available:
(A) The entire nucleotide sequence; and
(B) The pol region sequence (including all regions: protease (PR)/reverse transcriptase (RT) and integrase (INI) genes, if available.)

History Note: *Authority G.S. 130A-134; 130A-135; 130A-139; 130A-141;*

Amended Eff. October 1, 1994; February 1, 1990;
Temporary Amendment Eff. July 1, 1997;
Amended Eff. August 1, 1998;
Temporary Amendment Eff. February 13, 2003; October 1, 2002; February 18, 2002; June 1, 2001;
Amended Eff. April 1, 2003;
Temporary Amendment Eff. November 1, 2003; May 16, 2003;
Amended Eff. January 1, 2005; April 1, 2004;
Temporary Amendment Eff. June 1, 2006;
Amended Eff. April 1, 2008; November 1, 2007; October 1, 2006;
Temporary Amendment Eff. January 1, 2010;
Temporary Amendment Expired September 11, 2011;
Amended Eff. July 1, 2013;
Temporary Amendment Eff. December 2, 2014;
Amended Eff. October 1, 2015;
Emergency Amendment Eff. March 1, 2016;
Temporary Amendment Eff. July 1, 2016;
Amended Eff. January 1, 2018; October 1, 2016;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 9, 2018.

Infection Control Training for Outpatient Healthcare Settings

Resource Links

https://spice.unc.edu/opt-resources

Module A: NC Laws Concerning Infection Prevention in Outpatient Settings

NC-law- Explication
http://spice.unc.edu/wp-content/uploads/2017/04/NC-law-explication.doc

NC Communicable Disease Control Laws-10A NCAC 41A
http://reports.oah.state.nc.us/ncac/title%2010a%20-%20health%20and%20human%20services/chapter%2041%20-%20epidemiology%20health/subchapter%20a/subchapter%20a%20rules.pdf

15A NCAC 13B.1200 Medical Waste Rules
https://files.nc.gov/ncdeq/Waste%20Management/DWM/SW/Programs%20and%20Planning/MedicalWaste/Section.1200.pdf

NC Sanitation Rules
http://ehs.ncpublichealth.com/docs/rules/294306-2-1300.pdf

People's Magazine Article on Kimberly Bergalis
http://people.com/archive/cover-story-a-life-stolen-early-vol-34-no-16/

CDC- updated 2012 Management of Hep B health care providers and students
https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6103a1.htm

Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposure to HBV, HCV, and HIV and Recommendations for Post exposure Prophylaxis
https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5011a1.htm

CDC Poster for Management of Occupational Blood Exposure to HBV, HCV or HIV
https://www.cdc.gov/hai/pdfs/hiv/occupational_exposure_hiv_08_11x17.pdf

Module B: Complying with OSHA Bloodborne Pathogen Standard

OSHA Bloodborne Pathogen Regulation 29CFR
https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051

Most frequently asked Question about the BBP standard
https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=INTERPRETATIONS&p_id=21010

Frequently asked questions about the needlestick safety act
https://www.osha.gov/needlesticks/needlefaq.html

Occupational Exposure to Bloodborne Pathgens; Needlestick and Other Sharps Injuries: final Rule
https://www.osha.gov/laws-regs/federalregister/2001-01-18

Module C: Epidemiology and Risk of Infection in Outpatient Settings

2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings
https://www.cdc.gov/infectioncontrol/pdf/guidelines/isolation-guidelines.pdf

APIC resource on glove use:
https://apic.org/For-Media/Announcements/Article?id=93e57b8e-8405-4c7e-ab10-c61099a51402

APIC resource on mask use:
https://apic.org/Resource_/TinyMceFileManager/consumers_professionals/APIC_DosDontsofMasks_hiq.pdf

APIC resource on respirator use:
https://apic.org/Resource_/TinyMceFileManager/consumers_professionals/APIC_DosDonts_Respirators_hiq.pdf

CDC-HICPAC Core IP Elements in all settings
https://www.cdc.gov/hicpac/pdf/core-practices.pdf

WHO- 2016 Guidelines on Core Components of IPC programs
http://apps.who.int/iris/bitstream/10665/251730/1/9789241549929-eng.pdf

Module D: Outbreak and Safe Injection Practices

Viral Hepatitis Outbreaks Reported to CDC
https://www.cdc.gov/hepatitis/outbreaks/healthcarehepoutbreaktable.htm

Endoscopy Center in Nevada Outbreak
http://www.southernnevadahealthdistrict.org/download/outbreaks/final-hepc-investigation-report.pdf

NJ Oncology Practice Outbreak
https://www.sciencedirect.com/science/article/pii/S0196655311000976

National One and Only Campaign
www.oneandonlycampaign.org

North Carolina One and Only Campaign
http://oneandonlycampaign.org/partner/north-carolina

CDC Preventing Unsafe Injection Practices
https://www.cdc.gov/injectionsafety/unsafepractices.html

APIC Position Paper on Safe Injection, Infusion, etc.
http://www.apic.org/Resource_/TinyMceFileManager/Position_Statements/2016APICSIPPositionPaper.pdf

Module E: Principles and Practices of Asepsis, Hand Hygiene and Environmental Issues

CDC PPE Sequence- 2 examples
http://www.cdc.gov/hai/pdfs/ppe/PPE-Sequence.pdf

WHO how to hand rub
http://www.who.int/gpsc/5may/How_To_HandRub_Poster.pdf

WHO how to handwash
http://www.who.int/gpsc/5may/How_To_HandWash_Poster.pdf?ua=1

CDC Guidelines for Hand Hygiene
https://www.cdc.gov/handhygiene/providers/guideline.html

CDC Guidelines for Environmental Infection Control in Health-Care Settings
https://www.cdc.gov/infectioncontrol/pdf/guidelines/environmental-guidelines.pdf

Module F: Principles of Disinfection and Sterilization and Module G: Application of Cleaning, Disinfection and Sterilization Principles in Outpatient Settings

CDC Guidelines for Disinfection and Sterilization in Healthcare Facilities 2008
https://www.cdc.gov/infectioncontrol/pdf/guidelines/disinfection-guidelines.pdf

FDA listing of cleared sterilants and high-level disinfectants with label claims for reprocessing reusable medical devices
http://www.fda.gov/cdrh/ODE/germlab.html

Association for the Advancement of Medical Instrumentation
http://www.aami.org/productspublications/index.aspx?navItemNumber=505

Additional Sites

Statewide Program for Infection Control and Epidemiology
https://spice.unc.edu/

NC Division of Public Health
http://epi.publichealth.nc.gov/