The information in this manual reflects current guidelines and best practice and has been approved by the Fraser Health Infection Prevention & Control Committee.

On-line information on Infection Prevention & Control can be found at:

http://fhaweb/Programs+and+Services/Strategic+Services/Infection+Control/

Please remember!

Hand Hygiene is the simplest most effective measure for preventing health-care associated infections. Failure to perform appropriate hand hygiene is considered the leading cause of health-care-associated infections and spread of antibiotic resistant organisms and has been recognized as a substantial contributor to outbreaks.

Disclaimer

Refer to the on-line copy of this manual for the most recent revisions.
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IC1:0100  Use of This Manual

The prevention and control of infection within the hospital is everyone’s responsibility. The Infection Prevention & Control Manual serves as a resource to facilitate compliance with the Infection Prevention & Control Program. The manual contains routine practices and procedures based on national guidelines for disease control. These routine practices and procedures aim to prevent the development of new infections and to prevent the transfer of existing disease between patients, employees, and visitors.

Details on correct clinical techniques in nursing which assist in the prevention of infection are to be found in references such as Perry & Potter’s Clinical Nursing Skills and Techniques (e.g.: sterile dressing changes, catheterization, etc.).

This manual must be maintained by the person or delegate to whom it was issued. Maintenance includes the manual’s general repair and presentation as well as the immediate replacement of pages issued due to revisions.

1.0 SECURITY

The material contained in this manual must not be photocopied or passed to anyone who is not an employee of the Fraser Health Authority without prior approval from the Infection Prevention & Control Department.

2.0 TABLE OF CONTENTS

A Table of Contents is located at the front of the manual. By scanning the Table of Contents information can be located quickly and easily under each section.

3.0 CROSS REFERENCE

A cross reference of titles is located at the front of the manual. All titles are arranged in alphabetical order. By scanning the cross reference, specific information can be located quickly and easily throughout the manual.

4.0 PAGE LAYOUT

The manual name is located at the top of each page. The section heading is located below the manual name. The date each guideline was revised is located at the bottom of the page.
5.0 ELECTRONIC ACCESS

This manual is available on the Fraser Health Authority Intranet. Directions for access can be found under IC1:0200.

6.0 DEPARTMENTAL SPECIFIC GUIDELINES FOR INFECTION PREVENTION & CONTROL

Hospital services such as the Laboratory, Housekeeping, Food and Nutrition Services have written guidelines to help prevent the spread of infection in their own service manual.

7.0 SUGGESTIONS FOR REVISIONS

You are encouraged to make notes for suggestions to improve this manual, including information that should be inserted, deleted, repositioned, or rewritten. All suggestions are welcome and should be brought to the attention of the Infection Prevention & Control Department.

8.0 REVISIONS TO CONTENT

Fraser Health employees will be advised by email of changes to the manual. A new Table of Contents and copies of revised policies will be distributed to all those with a hard copy of this manual.
IC1:0200  Electronic Access

The Infection Prevention & Control Manual and Infection Prevention & Control Website can be accessed on the Fraser Health Authority (FHA) Intranet site (http://fhaweb/default.htm).

The Fraser Health Authority Intranet Home Page is the starting point to navigate to the Infection Prevention & Control Manual and Website.

To access the Infection Prevention & Control Manual electronically:

1) Click on Programs and Services
   Under the heading Strategic Services
   Click on Infection Control
   Click on Infection Control Manuals

   OR

2) Click on Tools and Resources
   Under the heading Clinical Support Tools
   Click on Infection Control Manuals

The Infection Prevention & Control Website provides quick access to information on the following topics:

- Contact information for the Infection Prevention & Control Team
- What’s new in Infection Prevention & Control
- Pamphlets on various Infection Prevention & Control topics
- Frequently asked questions or FAQs
- Links to other websites that have pertinent infection prevention & control and/or infectious disease information including Workplace Health
Infectious diseases are caused by a wide variety of microorganisms such as bacteria, viruses or fungi. Infectious diseases are spread when these microorganisms are transmitted from person to person, whether directly or indirectly.

1.0 THE CHAIN OF INFECTION

One of the basic concepts of infection control is the chain of infection. The progress of an infectious disease is from one link to the next along the chain. A basic example of this chain of infection is an infected patient cared for by a HCW who doesn’t wash his or her hands before caring for another patient.

The process of infection is reduced or stopped by breaking the chain at any point i.e. by using preventative and control measures specific to each link on the chain.

Hand Hygiene is the simplest most effective measure for preventing health-care associated infections. Failure to perform appropriate hand hygiene is considered the leading cause of health-care-associated infections and spread of antibiotic resistant organisms and has been recognized as a substantial contributor to outbreaks.

2.0 MODE OF TRANSMISSION

Mode of Transmission refers to how infectious agents are transmitted, and are classified as follows:

- contact
- droplet
- airborne
- vehicle
- vectorborne
3.0 CONTACT TRANSMISSION

Microorganisms from the patient’s skin or body substances may be transmitted to staff and other patients through breaks in hand hygiene and failure to clean shared equipment.

Direct contact is skin-to-skin contact. Indirect contact includes contact with inanimate objects in the patient’s environment that have been used or touched by the patient or caregiver. Uncontrolled diarrhea is one example where an infection could be spread via the contact route.

4.0 DROPLET TRANSMISSION

Disease may also be spread through droplets produced when a patient coughs or sneezes, or via splashing of fluids carrying the microorganism. Microorganisms could enter the body via droplet transmission through the eyes, nose or mouth, or by first contacting the skin and then being transferred to mucous membranes. Droplets generally travel 1 metre or less through the air. Colds are one example of a disease easily spread by droplets.

5.0 AIRBORNE TRANSMISSION

Airborne transmission occurs when microorganisms are carried by dust or other small particles floating in the air. These could spread to and infect someone in the same room, or by a ventilation system to someone elsewhere in the hospital. Microorganisms could enter the body by inhalation. Pulmonary tuberculosis is an example of a disease that could be spread via the airborne route.

6.0 VEHICLE TRANSMISSION

Vehicle transmission refers to a single contaminated source such as food, medication, intravenous fluid, blood, equipment, etc. which serves to transmit infection to multiple hosts. Vehicle transmission has been documented in outbreaks in the health care settings.

Control is affected by maintenance of safe food and medication handling standards and in appropriate decontamination of equipment. Food poisoning is the most common example of vehicle transmission.
7.0 VECTOR-BORNE TRANSMISSION

Vector-borne transmission is from reservoir to host via living intermediaries such as animals, insects or parasites e.g. mosquitoes are vectors for malaria. Appropriate hospital construction and maintenance, closed or screened windows, and proper housekeeping prevent transmission.

8.0 MULTIPLE ROUTE TRANSMISSION

Some microorganisms may be transmitted by more than one route, necessitating more than one type of transmission precaution, e.g. chicken pox (airborne/contact) or viral respiratory illness (droplet/contact).

9.0 CONTROL METHODS

Control methods related to the modes of transmission include (where appropriate):

- Hand hygiene
- Additional Precautions when required
- Ventilated rooms
- Patient roommate selection
- Disinfection and sterilization
- Safe food handling
Section IC2: PROGRAM ORGANIZATION
IC2:0100  Mission Statement and Responsibilities

The Infection Prevention & Control Department of the Fraser Health Authority is committed to promoting excellence in the principles and practices of infection prevention and control through education, communication, guidelines and public awareness.

The Infection Prevention & Control Department is responsible for the day-to-day operations of the Infection Prevention & Control Program within each hospital and hospital-affiliated long-term care facility.

A plan is developed and reviewed at regular intervals by Infection Prevention & Control personnel to include goals and objectives, establishment of priorities, and resource allocation.

The professional responsibilities of the Infection Prevention & Control Department can be divided into four categories:

1.0  SURVEILLANCE

- Identify outbreaks and case clusters, and conduct epidemiologic and special investigations as necessary
- Develop an effective and realistic surveillance program to monitor the incidence of health care associated infections
- Develop standardized definitions of health care associated infections and implement methods of information collection, analysis and reporting as per the recommendations of the Infection Prevention & Control Committee
- Collect health care associated infection data in a manner, which can be compared with established benchmarks, and to other institutions of similar services
- Report findings to the Infection Prevention & Control Committee and relevant departments so that current infection prevention & control guidelines can be changed or modified as necessary

2.0  EDUCATION AND COMMUNICATION

- Educate and inform all hospital staff on current Infection Prevention & Control guidelines and procedures outlined in the Infection Prevention & Control Manual
- Communicate pertinent health care associated infection data to appropriate personnel and departments
- Liaise with Public Health on issues related to communicable disease control
- Communicate with Infection Prevention & Control Departments of other hospitals
- Collaborate with Workplace Health on educational programs for staff
3.0 CONSULTATION SERVICES

- Provide information and guidance to hospital staff and physicians regarding Infection Prevention & Control guidelines and procedures and refer to appropriate external resources or institutions as necessary
- Collaborate with Workplace Health to assist in identification of health care workers exposed to a communicable disease
- Participate with community, regional, provincial and national agencies to help develop processes, which reduce the incidence of health care associated infections
- Liaise with community services as an information resource

4.0 DEVELOPMENT AND REVIEW OF POLICIES, GUIDELINES, AND PROCEDURES

- Develop and maintain written policies, guidelines and procedures for the Infection Prevention & Control Program
- Review guidelines and procedures developed by individual services that relate to infection prevention & control to ensure that the content is valid and acceptable

5.0 REFERENCES


IC2:0200 Terms of Reference

1.0 PURPOSE/MANDATE

Reporting to the Fraser Health Medical Advisory Committee through the Vice-President, Quality, the Fraser Health Infection Control/Communicable Diseases Coordinating Committee provides overall coordination of activities and functions of Infection Control and Communicable Diseases across the continuum of services within Fraser Health.

To achieve this purpose, the Committee

- Establishes strategies to plan, coordinate, and communicate initiatives related to hospital and community-based infection control and communicable disease management
- Establishes Regional Sub-Committees to coordinate and manage activities and report to the Coordinating Committee for the following areas:
  - Communicable Diseases
  - Hospital-based Infection Control
  - Home and Community-based Infection Control
- Oversees development of Fraser Health-wide strategies, objectives, and workplans to address priority issues related to all of the above
- Identifies, recommends, and oversees the effective and efficient use of resources to fulfill the responsibility of Fraser Health to ensure coordinated, evidence-based practice in Infection Control and Communicable Disease management
- Takes a leadership role in promoting evidence-based infection control practices and effective knowledge transfer throughout Fraser Health
- Develops and maintains linkages with external bodies such as the BC Centre for Disease Control, Health Canada, and others to ensure consistency with national and international best practices.
- Advises and makes recommendations to the Health Authority Medical Advisory Committee (HAMAC) on matters related to organization-wide infection control and communicable disease management.
- Receives and analyzes aggregate reports from the Sub-Committees to identify organization-wide wide infection control and communicable disease issues, and makes recommendations for a system-level approach to same
- Facilitates reporting and communication process between the Coordinating Committee and its Sub-Committees and other bodies within Fraser Health
- Evaluates the performance of the Coordinating Committee and its Sub-Committees in achievement of objectives and overall effectiveness.
IC2:0200 Terms of Reference

2.0 MEMBERSHIP

The Fraser Health Infection Control/Communicable Diseases Coordinating Committee is comprised of representatives from the following areas:

Core Membership
- Vice President, Quality
- Vice-President, Clinical Support, Health Protection and Systems Evaluation
- Chief Medical Health Officer
- Chief Nursing Officer and Leader, Professional Practice Advancement
- Director, Health Services
- Director, Workplace Health
- Director, Quality Improvement and Risk Management
- Director, Laboratories
- Director, Materiel Management
- Director, Housekeeping
- Director, Pharmacy Services
- Director, Protection Services
- Manager, Infection Control
- Representatives from:
  - Communicable Diseases
  - Infectious Diseases
  - Medical Microbiology
  - Home and Community Services
  - General Medical Practice (Primary Care)
  - Medical Directors, Long Term Care
  - BC Ambulance Service

Corresponding Members:
- Leadership Operations Committee

3.0 REPORTING

Reports to the Health Authority Medical Advisory Committee (HAMAC) through the Vice-President, Quality.

4.0 FREQUENCY OF MEETINGS

- Meetings will be scheduled on a quarterly basis or more frequently at the call of the Chair, with meeting segments dedicated to reports from each of the Sub-Committees.
IC2:0200  Terms of Reference

5.0 ADDENDUM FOR CLARIFICATION

1. There may be other *ad hoc* committees created with the HA wide Infection Control Committee to meet specific issues.

2. Local communities may wish to maintain a local Infection Control Committee for local needs but the policies created by the HA wide committee as outlined herein will apply across Fraser Health. Issues at the local area should be considered by the HA Infection Control Committee to assess generalizability across the Health Authority.

3. For serious outbreaks that may occur in the future, the HA wide Infection Control Committee will be involved and the chair of the committee will be expected to provide advice to managing the outbreak and/or nominating people who may be knowledgeable to do so.

APPROVED BY HAMAC ON: December 10, 2003

(December 2003)

Note: Terms of Reference to be reviewed in 2008
Section IC3: OPERATIVE FRAMEWORK
IC3:0100  Health Care Associated Infections

Definitions of health care associated infections are approved by the Fraser Health Infection Prevention & Control Coordinating Committee.

1.0 DEFINITIONS

The following are general criteria for health care associated infections:

- Information used to determine the presence and classification of infection involves various combinations of clinical findings and the results of laboratory and other diagnostic tests
- A physician’s diagnosis of infection derived from direct observation during surgery, endoscopy, and other diagnostic study or based on clinical judgment is an acceptable criteria for an infection
- The infection develops a minimum of 48 hours following admission or hospital procedure
- Infections may be endogenous (caused by patient’s own bacterial flora) or exogenous (acquired from an external source)
- The spread of infection to a different site is considered a new infection, even if the same organism is cultured
- The presence of a new organism cultured from the original site is considered a new infection if signs and symptoms of infection are present or continuing

2.0 DEFINITION OF INFECTION

The following are the criteria to meet the case definition of specific health care associated infections.

Bacteremia

**Primary Bacteremia** - Appears with no apparent underlying infection. It may also be related to the insertion of an intravascular device.

**Secondary Bacteremia** - Originates from another site of infection.
IC3:0100 Health Care Associated Infections

**Bacteremia (Primary bacteremia in an adult)**

Must meet one of the following criteria:
- Recognized pathogen isolated from blood culture and pathogen is not related to infection at another site
- One of the following: fever (>38°C), chills, or hypotension and any of the following:
  - Common skin contaminant isolated from two blood cultures drawn on separate occasions and organism is not related to infection at another site
  - Common skin contaminant isolated from blood culture from patient with intravascular access device and physician institutes appropriate antimicrobial therapy
  - Positive antigen test on blood and organism is not related to infection at another site

**Bacteremia (Primary Bacteremia in an infant ≤12 months age)**

Must have one of the following: fever (>38°C), hypothermia (<37°C), apnea, or bradycardia and any of the following:
- Common skin contaminant isolated from two blood cultures drawn on separate occasions and the organism is not related to infection at another site
- Common skin contaminant isolated from blood culture of a patient with an intravascular access device and the physician institutes appropriate antimicrobial therapy
- Positive antigen test on blood and the pathogen is not related to infection at another site

**Eye Infection (Conjunctivitis)**

Must meet one or more of the following criteria:
- Symptoms include pain, redness of conjunctiva or surrounding tissues
- Pathogen isolated from culture of purulent drainage
IC3:0100  Health Care Associated Infections

Gastrointestinal Infections

Must meet one of the following criteria:

- Acute onset of diarrhea (liquid stools for more than 12 hours) with or without nausea, vomiting, fever (>38°C) and no likely noninfectious cause e.g. diagnostic tests, therapeutic regimen, acute exacerbation of a chronic condition, psychologic stress

- Two of the following with no other recognized cause: nausea, vomiting, abdominal pain or headache and any of the following:
  - enteric pathogen isolated from stool culture or rectal swab
  - enteric pathogen detected by routine or electron microscopy examination
  - enteric pathogen detected by antigen or antibody assay on feces or blood
  - evidence of enteric pathogen detected by cytopathic changes in tissue culture (toxin assay)
  - diagnostic single antibody titer (IgM) or fourfold increase in paired serum samples (IgG) for pathogen

Reproductive Tract Infection (Endometritis)

Must meet one of the following criteria:

- Patient has organisms cultured from fluid or tissue from endometrium obtained during surgical operation, by needle aspiration, or by brush biopsy.
- Patient has at least two of the following signs or symptoms with no other recognized cause:
  - fever (>38°C), abdominal pain, uterine tenderness, purulent drainage from uterus

Postpartum endometritis is not considered an organ space surgical site infection if the amniotic fluid is infected at the time of admission or if the patient was admitted 48 hours after rupture of the membrane.
Respiratory Tract Infections (Pneumonia in patients > 12 months)

Must meet one of the following criteria:

- Patient has rales or dullness to percussion on physical examination of the chest and at least one of the following:
  - new onset of purulent sputum or change in character of sputum
  - organisms cultured from blood
  - isolation of pathogen from a specimen obtained by transtracheal aspirate, bronchial brushing or biopsy

- Patient has chest radiographic examination that shows new or progressive infiltrate, consolidation, cavitation or pleural effusion and at least one of the following:
  - new onset of purulent sputum or change in character of sputum
  - organisms cultured from blood
  - isolation of pathogen from a specimen obtained by transtracheal aspirate, bronchial brushing or biopsy
  - isolation of a virus or detection of viral antigen in respiratory secretions
  - histopathologic evidence of pneumonia

3.0 SURGICAL SITE INFECTIONS (SSI)

Superficial Incisional SSI

Occurs within 30 days of procedure and involves skin or subcutaneous tissue and one of the following:

- Purulent discharge
- Organism isolated from culture of aseptically obtained fluid or tissue from superficial incision
- At least one of the following signs and symptoms of infection: pain, tenderness, localized swelling, redness or heat and the incision is deliberately opened (unless the culture is negative)
- Diagnosis by surgeon

Note: The following do not meet the case definition for superficial incisional infection:

- stitch abscess
- infected episiotomy
- infected circumcision
- infected burn
Deep Incisional SSI

- Occurs within 30 days of procedure if NO implant or within one year if implant is in place and the infection appears to be related to operation and involves deep soft tissue (e.g. fascia/muscle) and at least one of the following is present:
  - Purulence from deep incision but not organ/space component
  - Deep incision dehiscence or probing of incision by surgeon when at least one of the following is present: fever (>38°C), localized pain, unless culture of incision is negative
  - Abscess or other evidence of infection involving deep incision found on examination during re-operation or x-ray exam
  - Diagnosis by a surgeon

Organ Space SSI

- Occurs within 30 days of procedure if NO implant or within one year of implant is in place and the infection appears to be related to operation and involves any part of the anatomy (other than the incision) opened or manipulated during the surgery and at least one of the following:
  - Purulence from a drain placed through a stab wound into the organ/space
  - Organisms from an aseptically obtained C&S of fluid or tissue in the organ/space
  - An abscess or other evidence of infection involving the organ/space that is found on direct examination, during re-operation, or by histopathological exam or x-ray exam
  - Diagnosis by a surgeon

NOTE: Infections involving both superficial and deep incision sites are classed as deep incisional surgical site infections.

When an organ/space infection drains through the incision and does not involve re-operation, it is considered a complication of the incision. It is therefore classed as a deep incisional infection.

Wound infections are a clinical diagnosis. Culture report interpretation should be discussed with the attending physician, the Infection Prevention & Control Practitioner and/or the Medical Microbiologist.
IC3:0100  Health Care Associated Infections

Urinary Tract Infections

Must meet one of the following criteria:

- One of the following: fever (>38°C), urgency, frequency, dysuria or suprapubic tenderness and a urine culture of \( \geq 10^5 \) colonies/ml urine with no more than two species of organisms
  
  OR

- Two of the following: fever (>38°C), urgency, frequency, dysuria or suprapubic tenderness and any of the following:
  - dipstick test positive for leukocyte esterase and/or nitrate
  - pyuria (\( \geq 10 \) white blood cells [WBC]/ml or \( \geq \) WBC/high-power field of unspun urine)
  - organisms seen on Gram stain of unspun urine
  - two urine cultures with repeated isolation of the same uropathogen with \( \geq 10^2 \) colonies/ml urine in non-voided specimens
  - urine culture with \( \leq 10^5 \) colonies/ml urine of single uropathogen in patient being treated with appropriate antimicrobial therapy
  - physician’s diagnosis
  - physician institutes appropriate antimicrobial therapy

4.0 OTHER

Other possible sites of health care associated infection must sometimes be considered. Application of the general principles outlined above will generally make classification of these infections possible. It must be re-emphasized that clinical impressions/diagnosis always supersede laboratory or radiological data.

5.0 REFERENCES


IC3:0200  Surgical Wound Classifications

The wound classification system was developed by the Center for Disease Control for use in surgical site infection surveillance. When used correctly is considered a reliable predictor of surgical site infection risk.

The following criteria will be used in Fraser Health to classify surgical wounds.

1.0  DEFINITIONS

Class 1 – Clean Wounds

- Uninfected operative wounds in which no inflammation is encountered and neither the respiratory, alimentary, genitourinary tract or oropharyngeal cavity is entered.
- Elective surgeries, primarily closed wounds and if necessary, drained with closed drainage.
- No break in aseptic technique during the operation.
- Operative wounds that follow non-penetrating (blunt) trauma are included in this category if they meet the criteria.

Examples: of Clean Surgery
- herniorrhaphy – ventral, inguinal, femoral, hiatal
- mammoplasty – augmentation or reduction
- mastectomy
- neurosurgery-elective
- orthopedic reconstructive procedures, hip nailings
- plastic surgery
- splenectomy
- thyroidectomy
- vagotomy-thoracic or abdominal approach
- vascular grafts
Class 2 – Clean-Contaminated Wounds

- Operative wounds in which the respiratory, alimentary, or genitourinary tract is entered under controlled conditions and without unusual contamination
- Specifically, operations involving the biliary tract, appendix, vagina, and oropharynx are included in this category provided no evidence of infection or major break in technique is encountered.
- Wounds are mechanically drained.
- Minor breaks in technique may occur.

Examples: of Clean Contaminated Surgery
- abdominal perineal resection
- appendectomy
- bowel resection
- caesarian section
- cholecystectomy-open or laparoscopic
- epididymectomy
- gastrectomy
- hysterectomy-vaginal, abdominal, Burch procedures
- lobectomy/pneumonectomy
- tracheostomy
- tubal ligation
- TUPR or Suprapubic Prostatectomy

Class 3 – Contaminated Wounds

- Open, fresh, accidental wounds or operations with major breaks in sterile technique.
- Incisions in which acute, nonpurulent inflammation is encountered.
- Operations involving entrance of the genitourinary or biliary tracts in the presence of infected urine or bile, or gross spillage from the gastrointestinal tract.
- Traumatic wounds less than 12 hours old.
IC3:0200  Surgical Wound Classifications

Examples: of Contaminated Surgery
- appendectomy-inflamed, no rupture, no pus
- bowel surgery – without bowel preparation
- burr holes following trauma
- compound fractures
- lacerations–fresh from a clean source
- removal of any prosthesis as a result of infection
- traumatic amputation

Class 4 – Dirty and Infected Wounds
- Includes old traumatic wounds (greater than 12 hours old) with retained devitalized tissue, foreign bodies, fecal contamination, delayed treatment from a dirty source.
- Involves existing clinical infection or perforated viscera.
- Acute bacterial inflammation where pus is encountered during the operation.
- This definition suggests that the organisms causing the post-operative infection was present in the operative field before the operation.

Examples: of Dirty Surgery
- abscess drainage
- amputation related to tissue necrosis
- bowel resection with perforation/peritonitis
- ruptured appendix
- traumatic wound more than 12 hours old from a dirty source

2.0 PROCEDURE

- All surgical procedures will be classified by the surgeon or designate, at the time of surgery and according to accepted criteria.
- Documentation shall be done on the operative report in the appropriate place.
- Documentation shall be done at the close of the procedure since events occurring during the procedure, or unsuspected operative findings may change the initial classification.
- Surgical infections will be categorized in statistical reports according to the procedure classification.
- Appropriate classification is essential in order for these statistics to reflect accurate information.
IC3:0200 Surgical Wound Classifications

3.0 REFERENCES


**IC3:0300  Flora of Specific Body Sites**

(This is not an all-inclusive list of organisms and pathogens.)

### Normal and Potentially Pathogenic Flora of Specific Body Sites

#### Skin (organisms commonly found on the skin)

<table>
<thead>
<tr>
<th>Normal Flora</th>
<th>Potential Pathogens, e.g. superficial skin/wounds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coagulase negative Staphylococci</td>
<td></td>
</tr>
<tr>
<td>Viridans group Streptococci</td>
<td></td>
</tr>
<tr>
<td>Non-haemolytic Streptococci</td>
<td></td>
</tr>
<tr>
<td>Corynebacterium species</td>
<td></td>
</tr>
<tr>
<td>Bacillus species</td>
<td></td>
</tr>
<tr>
<td>Acinetobacter species</td>
<td>Candida species</td>
</tr>
<tr>
<td>Micrococcus species</td>
<td>Enterobacteriaceae</td>
</tr>
<tr>
<td>Candida species</td>
<td>Pasteurella multocida</td>
</tr>
<tr>
<td>Peptostreptococcus species</td>
<td></td>
</tr>
<tr>
<td>Propionibacterium species</td>
<td></td>
</tr>
<tr>
<td>Moraxella species</td>
<td></td>
</tr>
</tbody>
</table>

#### Potential Pathogens, e.g. superficial skin/wounds

- *Staphylococcus aureus*
- β-haemolytic Streptococci (A,B,C,G)
- *Pseudomonas aeruginosa*
- Other non-fermenters
- *Candida species*
- *Enterobacteriaceae*
- *Pasteurella multocida*

#### Potential Pathogens, e.g. deep wounds

- above organisms listed
- Enterococcus
- *Streptococcus milleri* group
- *Eikenella corrodens*
- Anaerobes
- *Bacillus cereus*
- Corynebacterium species
- Coagulase neg Staphylococci
- Capnocytophaga species
- *Erysipelothrix rhusiopathiae*
- Mycobacterium (MOTT)

### Respiratory Tract

#### Normal oropharyngeal flora

<table>
<thead>
<tr>
<th>Normal Flora</th>
<th>Potential Pathogens, e.g. deep wounds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Viridans group Streptococci</td>
<td></td>
</tr>
<tr>
<td>Non-haemolytic Streptococci</td>
<td></td>
</tr>
<tr>
<td>Coagulase negative Staphylococci</td>
<td></td>
</tr>
<tr>
<td>Anaerobes</td>
<td></td>
</tr>
<tr>
<td>Neisseria species</td>
<td></td>
</tr>
<tr>
<td>Corynebacterium species</td>
<td></td>
</tr>
<tr>
<td>Micrococcus species</td>
<td></td>
</tr>
<tr>
<td>Stomatococcus species</td>
<td></td>
</tr>
<tr>
<td>Lactobacillus species</td>
<td></td>
</tr>
<tr>
<td>Enterococcus species</td>
<td></td>
</tr>
<tr>
<td>Bacillus species</td>
<td></td>
</tr>
<tr>
<td>Candida species</td>
<td></td>
</tr>
</tbody>
</table>

#### May be part of normal flora but may be potential pathogens in the lower respiratory tract.

- *Streptococcus pneumoniae*
- *H. influenzae/parainfluenzae*
- *Moraxella catarrhalis*
- *Staphylococcus aureus*
- β-haemolytic Streptococci (A,B,C,G)
- Enterobacteriaceae
- Pseudomonas and other GNB
- *Neisseria meningitidis*
- *C. pseudodiphteriticum*
# Flora of Specific Body Sites

## Urinary Tract

### Common Contaminants

<table>
<thead>
<tr>
<th>Lactobacillus</th>
<th>Corynebacterium species</th>
</tr>
</thead>
<tbody>
<tr>
<td>Viridans group Streptococci</td>
<td>Coagulase negative Staph</td>
</tr>
<tr>
<td>Non-haemolytic Streptococci</td>
<td><em>Gardnerella vaginalis</em></td>
</tr>
<tr>
<td>Neisseria species</td>
<td>Anaerobes</td>
</tr>
</tbody>
</table>

### Potential Pathogens

<table>
<thead>
<tr>
<th>Enterobacteriaceae (Escherichia coli, Klebsiella species)</th>
<th><em>Staphylococcus aureus</em></th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Staphylococcus saprophyticus</em></td>
<td><em>Candida species</em></td>
</tr>
<tr>
<td>Enterococcus</td>
<td><em>Haemophilus influenzae</em></td>
</tr>
<tr>
<td>β-haemolytic Streptococcus</td>
<td><em>Corynebacterium urealyticum</em></td>
</tr>
<tr>
<td>Pseudomonas species</td>
<td><em>Aerococcus species</em></td>
</tr>
</tbody>
</table>

## Genital Tract

### Normal Flora

<table>
<thead>
<tr>
<th>Lactobacillus</th>
<th>Corynebacterium species</th>
</tr>
</thead>
<tbody>
<tr>
<td>Viridans group Streptococci</td>
<td>β-haemolytic Strep (B,C,G)</td>
</tr>
<tr>
<td>Non-haemolytic Streptococci</td>
<td>Enterobacteriaceae</td>
</tr>
<tr>
<td>Enterococcus</td>
<td>Anaerobes</td>
</tr>
<tr>
<td>Coagulase negative Staphylococci</td>
<td><em>Candida species</em></td>
</tr>
<tr>
<td><em>Gardnerella vaginalis</em></td>
<td>Micrococcus species</td>
</tr>
</tbody>
</table>

### Potential Pathogens

<table>
<thead>
<tr>
<th>Candida sp.</th>
<th><em>Neisseria meningitidis</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>β-haemolytic Strep (Group A)</td>
<td>Pasteurella species</td>
</tr>
<tr>
<td><em>Staphylococcus aureus</em></td>
<td><em>Pseudomonas aeruginosa</em></td>
</tr>
<tr>
<td>Actinomyces</td>
<td></td>
</tr>
</tbody>
</table>

### Pathogens

<table>
<thead>
<tr>
<th><em>Neisseria gonorrhoeae</em></th>
<th>Chlamydia trachomatis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Herpes simplex</td>
<td>Trichomonas vaginalis</td>
</tr>
<tr>
<td>β-haemolytic Strep (Group B)</td>
<td>Listeria monocytogenes</td>
</tr>
<tr>
<td><em>Haemophilus influenzae</em></td>
<td>*</td>
</tr>
<tr>
<td>* in fetus / newborn</td>
<td>*</td>
</tr>
</tbody>
</table>
IC3:0300 Flora of Specific Body Sites

REFERENCES:


Surveillance, quality indicators and audit tools are used as a guide to assist in monitoring levels of care and support activities, against which objectives and standards are compared.

1.0 DEFINITIONS

**Surveillance** – systematic methods for identifying and tracking the rates of specific infections and may be concurrent, retrospective or focused.

**Indicators** – are quantitative measures.

**Audits** – an examination of records, and/or activities to check for their accuracy.

2.0 PROCEDURE

Indicators will be developed on an annual basis and determined using high risk, high cost, high volume or unusual occurrences.

The following are examples which may be monitored for acute care patients:

- Surgical site infections
- Pneumonia, including post operative, non-postoperative, ventilator-associated
- Central line infections
- Bloodstream infections
- Maternal and newborn infections
- Gastrointestinal infections, e.g. *Clostridium difficile*
- Antibiotic resistant organisms (AROs)

The following are examples, which may be monitored for long-term care patients:

- Soft tissue infections
- Urinary tract infections
- Respiratory tract infections
- Eye infections
- Gastrointestinal infections

An infection rate is determined using both a numerator (number of cases which meets the definition of health care associated infection) and a denominator (number of patients/patients at risk for this type of infection).
Data for the numerators may be determined from the following:

- Review of microbiology reports
- Review of antibiotic orders for patients in hospital ≥ 48 hours
- Written/verbal reports from hospital staff and physicians
- Coding during review of hospital records by health record staff
- Chart reviews by Infection Prevention & Control staff

Data for the denominator may be determined from statistics collected by:

- Finance, e.g. number of patient/resident days
- OR clerical staff, e.g. number surgical procedures
- ICU e.g. number of ventilator days
- Health Records

Reports will be prepared and presented on a regular basis to the Infection Prevention & Control Committee.
IC3:0500 Notification and Follow Up of Communicable Diseases

Infection Prevention & Control will alert Public Health and Workplace Health of patients identified as harboring a reportable communicable disease where follow-up of exposed contacts may be required. Contacts may include patients, health care workers and first responders such as ambulance personnel, police and firefighters.

1.0 PROCEDURE

Infection Prevention & Control will provide names of exposed patients to the family physician and/or Public Health in a timely manner. Instructions for recommended follow-up will be given as required.

Infection Prevention & Control will alert Workplace Health when follow-up of exposed health care workers may be required. Workplace Health will identify any exposed first responders and provide the information to the local Health Unit.

2.0 REFERENCES


Section IC4: ROUTINE PRACTICES
IC4:0100  Hand Hygiene

1.0  PRACTICE GUIDELINE

Hand hygiene is the single most important procedure for the prevention of infection and shall be practised by all employees and medical staff.

Specialty areas such as the operating room and food services may have unit specific hand hygiene standards which exceed this guideline.

3.0  DEFINITIONS

Hand Antisepsis

Hand antisepsis refers to application of an antiseptic agent to the hands to reduce the amount of microbial flora. Hand antisepsis is performed using an alcohol hand sanitizer or antimicrobial soap.

An alcohol hand sanitizer is the preferred agent for hand antisepsis. However, an antimicrobial soap may be used as an alternative in certain situations (ie. intolerance to alcohol hand sanitizer).

The advantages of an alcohol hand sanitizer compared to antimicrobial soap are increased efficacy in reducing hand contamination, ease of use, and the ability to have it accessible at the point of care. These products also contain emollients which cause less skin irritation and dryness than antimicrobial or plain soap.

Routine Hand Washing

Routine hand washing refers to using plain soap to wash hands.

3.0  INDICATIONS FOR HAND HYGIENE

Hand antisepsis is recommended before and after routine patient care.

Hand antisepsis

• Before and after providing any direct patient care
• Before and after using gloves
• Before performing invasive procedures (e.g. dressing changes, catheter insertion, catheter care, IV insertion or IV site manipulation)
• When moving from a contaminated body site to a clean body site during direct patient care
• After handling contaminated equipment
• After contact with blood, body fluids, secretions, dressings, etc.
• When arriving and leaving the work area
IC4:0100 Hand Hygiene

**Note:** When hands are visibly soiled or when caring for patients with infectious gastroenteritis, wash hands with plain soap before using alcohol hand sanitizer OR wash hands with antimicrobial soap.

Alcohol hand sanitizer is available in all areas of the hospital. An antimicrobial soap is available in clinical areas as an alternative for those individuals who are sensitive to alcohol hand sanitizer.

For recommendations on placement of Alcohol Gel, Antimicrobial Soap and Plain Soap, see IC4:0100 Appendix A.

**Routine Hand Washing**

Routine hand washing is indicated:
- After using the washroom
- Before eating
- After 5 to 6 applications of an alcohol hand sanitizer to remove residual emollients

A plain soap will be supplied in all washrooms, at clinical sinks, and in food services.

**Other Aspects of Hand Hygiene**
- Staff providing direct patient care shall not wear artificial fingernails or extenders
- Staff shall keep fingernails short (less than 3 mm) and clean to prevent the spread of infection
- Staff shall not wear chipped nail polish, as bacteria may become trapped along the edges
- Staff providing direct patient care shall wear a minimum amount of hand jewelry. Hand jewelry should be removed prior to performing hand hygiene.

**4.0 PROCEDURE**

**Alcohol Hand Sanitizer**
- Take a dime size amount of the product in the palm
- Spread the product to cover all surfaces of both hands, including nail beds, web spaces, thumbs, and the back of the hands
- Rub hands together for 15 seconds or until dry

**Hand Washing with Soap (Antiseptic or Plain)**
- Wet hands under a steady flow of warm water
- Apply an adequate amount of the appropriate soap, ie. one pump from the dispenser
- Use friction to wash all surfaces of both hands, including web spaces, thumbs, and the back of the hands
- Rub nail beds against the opposite palm
- Wash for a minimum of 15 seconds
IC4:0100  Hand Hygiene

- Rinse thoroughly and dry hands with clean paper towel
- Use paper towel to turn off taps
- Discard paper towel
- See IC4:0100 Appendix A for illustrated technique.

5.0 REFERENCES

Association for Professionals in Infection Control & Epidemiology Inc.  (Oct. 2002). Guideline for Hand Hygiene in Health Care Settings.


IC4:0100 Appendix A: Hand Hygiene Illustrated Technique

1. Wet hands.

2. Add 1 pump of soap to the palm.

3. Rub hands together to create a lather.

4. Interface fingers while rubbing palms together then rub soap over L. dorsum, repeat with L. palm over R. dorsum.

5. Work knuckles of L. hand into R. palm then knuckles of R. hand into L. palm.


8. Rinse well in the same manner as washing.

9. Pat dry hands with paper towel. Turn taps off with the paper towel.
IC4:0100 Appendix B: Recommendations on the Placement of Alcohol Gel, Antimicrobial Soap and Plain Soap Within The Acute Care Hospital

<table>
<thead>
<tr>
<th>Area</th>
<th>Alcohol Gel</th>
<th>Plain Soap</th>
<th>Antimicrobial Soap</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public areas</td>
<td>√</td>
<td>√</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Washrooms</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Kitchens</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>General patient rooms</td>
<td>√</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*High risk areas</td>
<td>√</td>
<td></td>
<td>√</td>
<td>Where space permits hang both plain and antimicrobial</td>
</tr>
<tr>
<td>Dirty utility</td>
<td>√</td>
<td></td>
<td>√</td>
<td>Where space permits hang both plain and antimicrobial</td>
</tr>
<tr>
<td>Nursing stations</td>
<td>√</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic areas</td>
<td>√</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Areas not specifically identified</td>
<td>√</td>
<td></td>
<td></td>
<td>Discuss with Infection Prevention &amp; Control</td>
</tr>
</tbody>
</table>

*High Risk Areas: This will vary from hospital to hospital depending on the services offered, but could include: ICU, CCU, ER, Maternity, Nursery and Isolation.

- It is recommended that those sinks requiring antimicrobial soap be identified in consultation with Infection Prevention & Control, PCC/Supervisor and Housekeeping.
- Develop a method of marking the sinks designated for antimicrobial soap (e.g., red dot). This will help to ensure clear direction for housekeeping staff.
- When an alternate soap or alcohol gel is required, Infection Prevention & Control shall be consulted prior to the use of the replacement product.
IC4:0200    Routine Practices

1.0 PRACTICE GUIDELINE

Routine Practices are designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection.

Routine Practices are applied during the care of all patients all the time, regardless of their presumed infection status, and when handling soiled equipment.

In addition to Routine Practices, patients with specific communicable diseases may require Additional Precautions (Section IC5).

2.0 DEFINITIONS

Routine Practices apply to activities where there is a possibility of contact with:

- Blood
- Body substances, fluids, secretions, and excretions (except tears and perspiration)
- Non-intact skin
- Mucous membranes

3.0 PROCEDURE

- Use personal protective equipment (PPE) to reduce the risk of exposure to blood and body fluids.
- Assess the task to be performed and choose the appropriate barrier(s) to prevent exposure to these body fluids e.g. gloves, masks, gowns, aprons, and eyewear.
- Handle all biological samples as potentially infectious.
- Maintain appropriate immunization status e.g. Hepatitis B, Influenza.
- Hand hygiene is required before and following all direct contact with patients and following contact with specimens and contaminated equipment.
- The following guidelines pertain to personal protection only. Aseptic techniques (sterile gown, masks, drapes, etc.) or other additional precautions may need to be followed according to the specific procedure.
IC4:0200  Routine Practices

Legend for the following guideline:
X - Worn at all times
S - Worn if soiling likely
sp - Worn if splashing likely

* Mask
Refers to Procedure Mask
unless otherwise specified

<table>
<thead>
<tr>
<th>PROCEDURE</th>
<th>GLOVES</th>
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</thead>
<tbody>
<tr>
<td>Administration of Medication – oral</td>
<td></td>
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<td></td>
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<tr>
<td>Arterial Punctures</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Arteriograms</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Artificial rupture of membranes</td>
<td>X</td>
<td>X</td>
<td>S</td>
<td></td>
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<tr>
<td>Aspiration of urine from foley</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Fingerstick/heelsticks</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Autopsy</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td>Bathing patients with open wounds</td>
<td></td>
<td></td>
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<tr>
<td>Barium enema</td>
<td>X</td>
<td></td>
<td>S</td>
<td></td>
</tr>
<tr>
<td>Biopsy (percutaneous – bone, liver, skin, cervix)</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
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<tr>
<td>Bladder Irrigation (emptying solution)</td>
<td>X</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Bleeding time</td>
<td>X</td>
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<tr>
<td>Blood pressure</td>
<td></td>
<td></td>
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<tr>
<td>Blood product administration</td>
<td>X</td>
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<td></td>
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<tr>
<td>Bone Marrow collection</td>
<td></td>
<td></td>
<td></td>
<td>sp</td>
</tr>
<tr>
<td>Bronchoscopy - Diagnostic (performing/assisting)</td>
<td></td>
<td></td>
<td>X</td>
<td>(N95 respirator)</td>
</tr>
<tr>
<td>Calibration of body-fluid contaminated equipment</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central Lines V.A.D.s</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Changing Diapers / Incontinence pads</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clean catch urine M.S.U.</td>
<td>X</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Cleaning blood spills</td>
<td>X</td>
<td></td>
<td></td>
<td>S</td>
</tr>
<tr>
<td>Cleaning patient equipment</td>
<td>X</td>
<td></td>
<td>sp</td>
<td>X</td>
</tr>
<tr>
<td>Condom Catheter (placement)</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colostomy care</td>
<td>X</td>
<td></td>
<td></td>
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</table>
### IC4:0200 Routine Practices

<table>
<thead>
<tr>
<th>PROCEDURE</th>
<th>GLOVES</th>
<th>MASK*/EYEWEAR</th>
<th>GOWN/APRON</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NON-STERILE</td>
<td>STERILE</td>
<td></td>
</tr>
<tr>
<td>Cough: Care for undiagnosed patient with cough</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decubitus care</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delivering patient food</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dipstick urine test</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Dialysis (peritoneal) – discarding fluid</td>
<td>X</td>
<td>sp</td>
<td>S</td>
</tr>
<tr>
<td>Dressing – wet (not fresh wound) Wet to dry, changing of</td>
<td>X</td>
<td>sp</td>
<td>S</td>
</tr>
<tr>
<td>Endoscopy – G.I.</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Endotracheal suctioning</td>
<td>X</td>
<td>sp</td>
<td>S</td>
</tr>
<tr>
<td>Enemas</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environmental cleaning: general areas (Follow WHMIS Guidelines)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environmental Cleaning: patient care areas</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeding Infants, children, adults</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foley catheter (perineal care)</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastrostomy feeding</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heparin lock (inserting, drawing blood, removing)</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intubation/Extubation</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Injections: I.M., S.C., I.D.</td>
<td></td>
<td></td>
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<tr>
<td>Intravenous therapy: insertion, site care</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>I.V. piggyback medication</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Linen-handling: soiled</td>
<td>X</td>
<td></td>
<td>S</td>
</tr>
<tr>
<td>Lumbar puncture</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mouth care</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nasogastric tube: Irrigation &amp; removal</td>
<td>X</td>
<td>sp</td>
<td>S</td>
</tr>
<tr>
<td>Ortho Surgery: Sawing, drilling, suction, irrigation</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Ostomy care</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peri-care</td>
<td>X</td>
<td></td>
<td>S</td>
</tr>
<tr>
<td>Pin care: Orthopedic</td>
<td>X</td>
<td></td>
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</tr>
</tbody>
</table>
## IC4:0200 Routine Practices

<table>
<thead>
<tr>
<th>PROCEDURE</th>
<th>GLOVES</th>
<th>MASK*/EYEWEAR</th>
<th>GOWN/APRON</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placenta: Handling, cord blood specimen</td>
<td>X</td>
<td>sp</td>
<td>S</td>
</tr>
<tr>
<td>Plumbing repairs: Drains, sewer lines</td>
<td>X</td>
<td>sp</td>
<td>S</td>
</tr>
<tr>
<td>Postmortem care</td>
<td>X</td>
<td>sp</td>
<td>S</td>
</tr>
<tr>
<td>Rectal medications</td>
<td>X</td>
<td>sp</td>
<td></td>
</tr>
<tr>
<td>Repairing clogged toilets/sinks maintenance</td>
<td>X</td>
<td>sp</td>
<td>S</td>
</tr>
<tr>
<td>Specimen handling: Direct contact with blood/body fluids</td>
<td>X</td>
<td>sp</td>
<td></td>
</tr>
<tr>
<td>Temperature: Rectal</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tracheotomy care: Routine</td>
<td>X</td>
<td>X</td>
<td>S</td>
</tr>
<tr>
<td>Trauma patients: E.R., O.R.</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Tube feeding</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Vaginal deliveries: Physician role</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Vaginal deliveries: Nursing role</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Vaginal exams: obstetric</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaginal exams: non – obstetric</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Venipuncture</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wound cleaning: fresh operative wound</td>
<td>X</td>
<td>sp</td>
<td>X</td>
</tr>
<tr>
<td>Wound cleaning: Irrigation, packing</td>
<td>X</td>
<td>sp</td>
<td>X</td>
</tr>
<tr>
<td>Wound suction, emptying</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 4.0 REFERENCES


IC4:0300  Gloves

1.0  PRACTICE GUIDELINE

Gloves shall be worn when there is anticipated direct contact with blood, body substances or tissue, mucous membranes, non-intact skin or when handling items or surfaces soiled with blood or body substances.

Gloves are single use and must be changed between patients.

Sterile gloves are required for all invasive procedures, when contact with sterile sites, tissues or body cavities are anticipated.

Latex and non-latex medical gloves are available for use in all patient care areas. Nitrile gloves are available to health care workers with latex sensitivities or allergies and for the care of patients with latex sensitivities. It is the responsibility of the health care worker to select the appropriate glove. Contact Workplace Health for more information on glove selection or if experiencing any skin problems related to glove use.

2.0  PROCEDURE

To Don Gloves:

- Perform hand hygiene
- Select the appropriate glove
- Don gloves prior to any potential contact with body substances, mucous membranes, non-intact skin or contaminated objects
- If wearing a long sleeved gown, pull the gloves over the cuff of the sleeves

To Remove Gloves:

- Remove and discard gloves immediately after completing procedure
- Wash hands after removing gloves
- Disposable gloves are not used for the care of more than one patient
- If gloves are punctured or leak they are immediately removed, hand hygiene is performed and a new pair of gloves put on
- First glove: pinch outside of cuff and roll glove off hand inside out
- Second glove: pinch inside of cuff and roll glove off hand inside out
- Always perform hand hygiene after removing gloves.
IC4:0300   Gloves

Selection of Appropriate Non-sterile Gloves

Latex Gloves

Disposable latex medical gloves shall be worn during procedures where contact with visible blood is anticipated, during procedures of long duration, or where tactile sensitivity is required.

Examples include:

- IV starts
- phlebotomy
- laboratory procedures
- handling saturated dressings
- contact with unbathed newborns
- pericare of maternity patients
- cleaning up a blood spill
- sorting soiled laundry

Staff with sensitivities to latex gloves should contact Workplace Health to discuss alternatives.

Vinyl Gloves

Vinyl gloves are suitable choice for most contacts with mucous membranes, body secretions, and soiled equipment unless visible blood is present. Examples include:

- routine care of isolated patients
- pericare
- oral suctioning
- handling condom drainage systems
- handling lightly soiled dressings
- enemas
- mouthcare
- contact with non-intact skin
- handling general waste
- emptying catheter bags

Nitrile Gloves

Nitrile gloves are to be used in the same situations as latex gloves. Nitrile gloves are recommended for:

- Latex-sensitive staff with the recommendation of Workplace Health
- procedures where contact with certain chemicals is anticipated e.g. glutaraldehyde, formalin
- care of latex-sensitive patients
IC4:0300  Gloves

No Gloves

Unless the patient is on Contact Precautions, gloves are not required for:

- back rubs
- feeding
- contact with tears or perspiration
- changing beds
- transporting patients
- passing out medications
- handling food trays

Gloves are not to be worn for activities that do not pose a risk for the health care worker, such as:

- charting
- computer keyboarding
- using telephones

4.0 REFERENCES


1.0 PRACTICE GUIDELINE

All staff shall wear long-sleeved gowns or moisture-resistant aprons when it is likely that clothing may be soiled with body substances. The choice of protective garment depends on the anticipated level of contamination. For some procedures, moisture-resistant or moisture-proof gowns are indicated. Long-sleeved isolation gowns shall be worn while caring for an individual who requires Contact Precautions. Sterile gowns are worn during invasive procedures where contact with sterile sites, tissues or body cavities are anticipated. Gowns are single-use and must be changed between patients.

2.0 PROCEDURE

To Don a Gown:
• Perform hand hygiene
• Put on a clean gown and tie strings at back of neck
• Overlap the back of the gown and tie waist ties at the side

To Remove a Gown:
• Untie waist ties
• Remove gloves and perform hand hygiene
• Untie neckties, and allow gown to fall from shoulders
• Grasp the inside of the cuff and pull each sleeve inside-out while removing the gown
• Roll gown, handling only the inside
• Place cloth gown in linen hamper
• Place disposable gowns in general waste
• Perform hand hygiene

3.0 REFERENCES


IC4:0500  Masks

1.0  PRACTICE GUIDELINE

Procedure masks (and protective eyewear) are required during procedures that are likely to generate aerosols, splashing of blood or body substances. Procedure masks are required to be worn by health care workers when caring for patients on Droplet Precautions and are to be worn by patients on Droplet and Airborne Precautions while they are outside their room. Procedure masks shall be worn for invasive procedures to prevent the transmission of microbes from the care provider into the sterile field. A high filtration (N95 respirator) mask shall be worn to enter the room of patients suspected of having illnesses that are spread by the airborne route. Health care workers must be fit tested annually for the N95 respirator. Fit testing is done by Workplace Health.

2.0  PROCEDURE

Perform hand hygiene.

Applying a procedure mask:

- For procedure masks with two ties, fasten the top tie near the top of the head, and the second tie on the back of the neck. Some medical procedure masks have ear loops instead of ties.
- Lightly pinch the metal nose band to secure the seal around the nose
- Masks should be changed before each new procedure
- Do not leave the mask hanging around your neck for re-use

Applying a N95 respirator:

- There are various styles available, the primary ones being cup shaped and tri-fold.
- Use the style and size of N95 for which you’ve been fit tested.
- All N95s are secured with two elastic straps
- Place the first strap at the back of the head, near the top
- Place the second strap at the base of the neck, underneath any hair
- Lightly mold the metal noseband to secure the seal around the nose
- Check the seal by performing a user seal check.
- Refer to the “Instructions for Fitting: N95 Style Respirators” developed by Workplace Health.
Removing a procedure mask or N95 respirator

- Perform hand hygiene
- For procedure masks, untie strings (or remove ear loops), handling only the strings/loops
- For N95 respirators, remove strap at base of neck first then back of head second
- Discard procedure mask/N95 respirator in waste receptacle
- Perform hand hygiene
- All masks (including N95 respirators) are single-use only.

3.0 REFERENCES


CSA Standard Z94.4-02. Selection, Use and Care of Respirators, 2002.
IC4:0600  Protective Eyewear

1.0  PRACTICE GUIDELINE

Protective eyewear, goggles or face shields are required when it is reasonably anticipated that the eyes may be splashed with blood or a body substance.

Protective eyewear, goggles or face shields shall be worn when within 1 meter of patients suspected of having diseases that are transmitted by the droplet route. Prescription eyewear does not provide adequate protection.

2.0  PROCEDURE

Selecting Protective Eyewear
- There are various options available, including goggles and face shields

Cleaning Protective Eyewear
- Reusable protective eyewear may be safely cleaned in the unit/department with soap and water
- Discard disposable eyewear and eyewear with scratched or damaged lenses in general waste

3.0  REFERENCES


IC4:0700  Donning/Doffing PPE

1.0 PRACTICE GUIDELINE

The health care worker will don (apply) and doff (remove) personal protective equipment (PPE) in a safe manner that prevents exposure to the infectious agent and prevents contamination of the environment. Head covers and booties are used in very limited situations.

2.0 PROCEDURE

Apply PPE in the ante room if available or in the hallway if there is no anteroom. Determine what type of PPE is required and apply in the order described below.

Head Cover

- Head covers are used in very limited situations to decrease the potential exposure of bioburden from the environment. i.e. May be worn in conjunction with Powered Air Purifying Respirators for decontamination of chemically contaminated patients.
- If head covers are to be worn, don head cover.

Booties

- Booties are used in very limited situations where soiling of footwear is a concern. The low risk of contamination and the higher risk of injuries from falls preclude recommending their routine use.
- Don booties
- Perform hand hygiene

Applying a procedure mask

- For masks with two ties, fasten the top tie near the top of the head, and the second tie on the back of the neck.
- Some procedure masks have ear loops instead of ties.
- Lightly pinch the metal nose band to secure the seal around the nose.

Applying an N95 respirator

- Contact Workplace Health if you require fit testing
- Use the style and size for which you have been fit tested
- Refer to the “Instructions for Fitting: N95 Style Respirators” developed by Workplace Health.

Protective Eyewear or Face Shield

- Select the appropriate protective eyewear or face shield for the task
Donning/Doffing PPE

- Don protective eyewear or face shield and adjust to improve fit

Gown
- Select the appropriate gown for the task e.g. cloth, moisture-resistant or moisture-proof.
- Put on a clean gown and tie strings at back of neck
- Overlap the back of the gown and tie waist at the side

Gloves
- Select the appropriate glove.
- Don gloves.
- If wearing a long sleeve gown, pull the gloves over the cuff of the sleeves.

DOFF PPE IN THE FOLLOWING MANNER:

Inside the room:

Booties
Remove booties (if applicable) and discard

Gloves
- Untie waist ties of gown
- Remove gloves and perform hand hygiene

Gown
- Remove hand from sleeves without touching outside of gown
- Roll gown, handling only the inside
- Place cloth gown in linen hamper. Place disposable gown in general waste.
- Perform hand hygiene

Outside the room (in anteroom or in the hallway if no anteroom available):

Head Cover
- Remove head cover (if wearing) and discard
- Perform hand hygiene
IC4:0700  Donning/Doffing PPE

Protective Eyewear or Face Shield
- If protective eyewear is re-usable, apply clean gloves to remove and then disinfect the protective eyewear
- Remove gloves and perform hand hygiene
- If protective eyewear is disposable, discard in waste and perform hand hygiene

Procedure Mask / N95 Respirator
- Perform hand hygiene
- For procedure masks, untie strings (or remove ear loops), handling only the strings/loops
- For N95 respirators, remove strap at base of neck first then back of head second
- Discard procedure mask/N95 respirator in waste receptacle
- Perform hand hygiene
- All masks (including N95 respirators) are single-use only.

3.0 REFERENCES


IC4:0800  Aerosol Generating Procedures

1.0  PRACTICE GUIDELINE

Staff should follow Routine Practices with the use of appropriate personal protective wear for any procedures that involve droplets/aerosolization with all patients (with or without respiratory symptoms).

Factors that increase infectivity include the frequency of coughing and sneezing, the concentration of infectious organisms in the respiratory fluid and the severity of illness.

Procedures that generate aerosols can increase the risk of transmission with the potential to generate a high volume of droplets over a wide radius (i.e. greater then 1 meter). Additional precautions will be required for specific respiratory outbreaks e.g. N95 respirator during an Influenza Pandemic.

2.0  DEFINITIONS

Aerosol: A very small droplet nuclei of moisture that may carry microorganisms. The aerosolized droplets can be light enough to remain suspended in the air for short periods of time which facilitates inhalation.

Aerosol Generating Procedures: An aerosol generating procedure is a medical or surgical procedure that involves manipulation of a patient’s airway in a manner that may stimulate coughing and/or promote the generation of aerosols, e.g. nebulized therapies, use of bag-valve mask to ventilate a patient, endotracheal intubation, sputum induction, open airway suction, non-ventilated ventilation (CPAP, BIPAP) and bronchoscopy.

3.0  PROCEDURE

Limit HCW’s in the room to only those necessary to perform an aerosol generating procedure. Wear an N95 respirator, appropriately fit-tested and user seal checked and eye protection for patients known or suspected to have an airborne infection. Refer to IC8:0300 for information on management of patients known or suspected to have Tuberculosis.

Wear procedure mask and eye protection for other patients with a respiratory infection undergoing an aerosol generating procedure.
Respiratory Therapy considerations to reduce the risk of aerosolization include the use of:

- metered dose inhalers instead of nebulizers
- when high concentrations of oxygen are required, a non-re-breather mask that allows filtration of exhaled gases (ideally a low flow high oxygen concentration mask with hydrophobic submicron filter) may be used
- limit the duration of the procedure if possible (e.g. sedation during intubation)
- assemble all needed equipment in the patient’s room before starting the procedure
- clean/disinfect all contaminated surfaces and equipment and discard or place in the appropriate container for transport to sterile processing department before leaving the room and before removal of the PPE

4.0 PROCEDURE SPECIFIC CONSIDERATIONS

Intubation, Extubation and Bronchoscopy

- Wear N95 respirator and eye protection for bronchoscopy and for intubation and extubation of patients known or suspected to have an airborne infection.
- Perform bronchoscopy in a negative pressure room
- Wear procedure mask and eye protection for routine intubation and extubation.
- If procedure performed in an area where patient cannot be isolated, such as a resuscitation area, curtains must be drawn and all non-essential persons should leave the area or must be at least 1 meter from the patient.
- Perform intubation in a manner that minimizes aerosolization of droplets. If the medical condition permits, consider sedation with or without paralysis.
- Pre-connect the ventilator and in-line suction in advance of intubation, if possible, to reduce time needed for bag ventilation.
- Minimize staff exposure by limiting re-entry to the room until the room has been cleaned.

Mechanical Ventilation

- Follow Airborne precautions when caring for patients with known or suspected airborne infections such as Tuberculosis
- Use Routine practices when caring for other patients on mechanical ventilators operating with a closed system
- Wear procedure mask and eye protection if the integrity of the system is to be breached (e.g. open suctioning, filter changes).
- Use ventilators with built in hydrophobic submicron filters in the expiratory circuit when able. If this is not possible, place a disposable filter in the expiratory circuit of the ventilator.
- Disposable filters and disposable ventilator circuits must be bagged, sealed, and then placed in a biohazardous bag/container for disposal
IC4:0800  Aerosol Generating Procedures

- Use heated wire circuits on both the inspiratory and expiratory limbs of the ventilator circuits. A heat moisture exchanger (HME) or HME/filter may be preferred at the discretion of the Respiratory therapist.
- Manual Resuscitation Bags:
  - Place a hydrophobic sub micron filter between the endotracheal tube and the bag or on the expiratory exhaust component of the bag
  - Bag and seal manual ventilation equipment and then place in a clean plastic bag for cleaning or disposal.

**Sputum Induction**
- Wear an N95 respirator and eye protection for known or suspect airborne infection such as tuberculosis
- Procedure mask with eye protection is to be worn in all other situations

**CPAP/ BIPAP**
- Wear an N95 respirator and eye protection for known or suspect airborne infection such as tuberculosis
- Wear a procedure mask and eye protection for patients on CPAP or BIPAP with a respiratory infection.
- Manage the patient in a private room or pull the curtains around the patient’s bedspace.

**Open Suctioning**
- Wear an N95 respirator and eye protection for known or suspect airborne infection such as tuberculosis
- Wear procedure mask and eye protection in all other situations

5.0  REFERENCES

Provincial Infectious Diseases Advisory Committee (PIDAC). (August 2006). Preventing Respiratory Illness.


1.0 PRACTICE GUIDELINE

- Reusable equipment and medical devices shall be cleaned and re-processed between patient use according to infection risk categories in Spaulding’s Classification and the manufacturer's instructions for the reprocessing of these items.
- All soiled equipment will be handled in a manner such that the contaminants are confined and contained during transport and cleaning.
- All staff responsible for reprocessing critical, semi critical and non-critical items must be appropriately trained.

2.0 DEFINITIONS

Critical Items
Equipment/device that enters sterile body sites or vascular system will be cleaned followed by sterilization before reuse. Critical items include items such as surgical instruments, obstetrical equipment, rigid scopes, bronchoscopes, dressing and suture sets.

Semi-Critical Items
Equipment/device that has come in contact with non-intact skin or mucous membranes but do not penetrate them will be cleaned followed by minimum of high-level disinfection before re-use. Semi-critical items include laryngoscope blades, respiratory therapy equipment, vaginal ultrasound probes.

Non-Critical Items
Equipment/device that touches only intact skin and not mucous membranes, or does not directly touch the client/patient/resident will be cleaned followed by a low-level disinfection (sanitizing) process before re-use. Non-critical items include patient room furnishings, bedpans, IV pumps, BP apparatus, stethoscopes, wheelchairs, stretchers, dishes, etc.

Sterilization processes destroy all microbial life including spores. The process includes steam, ethylene oxide, peracetic acid, and hydrogen peroxide plasma.

High-level disinfection processes destroy bacteria, most viruses and fungii but not spores. The process includes pasteurization and the use of liquid disinfectants such as 7% hydrogen peroxide, ortho-phthalaldehyde (OPA) and 2% glutaraldehyde. The use of OPA and glutaraldehyde is restricted to areas that are properly ventilated.
Low-level disinfection processes destroy most bacteria, some viruses and fungi but not TB or spores. This is for routine cleaning of non-critical items. The process includes the use of hospital-grade disinfectant cleaners, dishwashers and utensil washers.

3.0 PROCEDURE

- Refer to CSA Standards.
- Follow written departmental policies for specific cleaning regimes and record keeping as per Fraser Health guidelines.
- Apply Personal Protective Equipment (PPE) before handling and cleaning of soiled equipment.
- Cleaning and reprocessing of equipment is a multi-step process.
- Visible soil, body fluids and/or organic material must first be removed. This is done by rinsing or washing with a detergent or enzymatic cleaner.
- Equipment and devices must then be sterilized or disinfected at the appropriate level according to the infection risk categories.
- Consult Sterile Processing Department (SPD) for any questions.
- See IC4:0900 Appendix A Reprocessing Patient Care Equipment Policy

4.0 REFERENCES

Canada, Ministry of Health, Health Authorities Branch. (March 2007) Best Practice Guides for the Cleaning, Disinfection and Sterilization of Medical Devices in Health Authorities.


Canadian Standards Association (March 2000). Decontamination of Reusable Medical Devices (Z314.8-00).

IC4:1000  Sharps Handling and Disposal

1.0 PRACTICE GUIDELINE

It is the responsibility of all health care workers and medical staff to safely dispose of their sharps directly into a designated puncture proof sharps container at the point of use. Sharps include but are not limited to:
- Needles
- Scalpels
- Syringes with needles
- Razors

2.0 PROCEDURE

- Safety devices must be activated prior to disposal in sharps disposal container
- Discard all needles, syringes, blades, razors, scalpels, lancets and stylettes in a puncture-resistant sharps disposal container.
- The puncture-resistant sharps disposal container must be located at the point of use. It must be of sufficient size and with the dimensions required to hold the types of sharps generated in that area.
- Look first before discarding a sharp. Never put something into the sharps container “blind”.
- If there is no sharps container in the room e.g. paediatrics, psychiatry, one is brought in for immediate use and then removed.
- Do not recap, bend, or unscrew any needle by hand prior to disposal.
- Do not overfill a sharps container. The container is to be closed and replaced when the sharps reach the “full” line, which is several inches below the top.
- Do not use force to place an item into a sharps container
- Do not attempt to retrieve an item from a sharps container.
- Do not leave sharps on suturing, intravenous or other procedure trays.
- Do not discard waste such as I.V. bags, tubing or alcohol swabs into a sharps container.

Note:

Surgeons in the operating room or physicians in diagnostic areas will pass their sharps into a neutral zone where the assistant will take final responsibility for disposal of the sharp.
IC4:1000 Sharps Handling and Disposal

When medications are being injected into an intravenous line in small amounts over time from the same syringe, a needless device or safety engineered hollow bore needle should be used. If blunt fill needles are not available, use the one-handed method of recapping:

- Lay the needle cap on a flat surface
- Keep free hand away from cap
- Using only one hand, advance needle into cap
- Carefully tighten cap onto needle by holding the base of the cap

4.0 REFERENCES


IC4:1100 Laundry Handling

1.0 PRACTICE GUIDELINE

Soiled linen shall be handled and transported in a manner in which contaminants are confined and contained. Clean linen that has been dropped on the floor is considered soiled.

2.0 PROCEDURE

Soiled Linen

- Bring laundry hamper as close to work area as possible
- Wear gloves to handle visibly soiled linen
- Wear gown or apron if soiling of the employee’s uniform/clothing is likely
- Ensure that linen is free of biomedical waste, sharps, instruments, and patient’s personal belongings before placing in laundry bag
- Roll linen carefully and place in laundry bag. Avoid shaking linen
- Close linen bags when 2/3 full
- Laundry personnel shall wear gloves and moisture-resistant cover gowns to sort soiled laundry
- In areas where recyclable plastic laundry bags are in use, wet or dry soiled laundry is placed in the plastic bags
- In areas where cloth laundry bags are normally used, wet laundry which may soak through a cloth bag, should be placed in a plastic bag first
- Double bagging of laundry from isolation rooms is not required

Egg crate and Spenco Mattresses
These mattresses must be covered with plastic or vinyl covering prior to use

Personal Laundry

- Staff are discouraged from laundering patient’s clothing in the utility rooms on the nursing units.
- Family members should take patient’s clothing home for laundering

Clean Linen

- Clean linen is transported to the clinical areas in delivery carts that are covered
- Clean linen is transported separately from soiled linen
IC4:1100  Laundry Handling

3.0  REFERENCES


1.0 PRACTICE GUIDELINE

Unit staff will remove any visible blood or body fluids from food trays before the trays are returned to Food and Nutrition Services. Food service workers who dismantle soiled trays are to wear personal protective equipment.

2.0 PROCEDURE

Meal delivery to patients on Routine Precautions:
- Gloves are not required for routine delivery or pick up of food trays
- Hand hygiene is to be practiced when there is hand contact with contaminated surfaces in a patient's room (e.g. clearing patient equipment from bedside table before setting down food tray)

Meal delivery to patients on Additional Precautions:
- Patients isolated in a multi-bed room will have their tray delivered and removed in the usual manner
- Patients isolated in a private room (e.g. Airborne or Strict Precautions) will have their tray delivered and removed by their care provider in the following manner:
  - Food service workers will notify unit staff of the tray’s arrival.
  - Food service workers (where applicable) will deliver the tray to the nurse’s station or outside patient room or other designated location as per local practice.
  - Unit staff will deliver the tray to the patient.
  - Unit staff will remove the tray from the room and place directly on the food service cart.
  - If the food service cart has left the unit, either leave the tray in the room until the next tray pick up or, follow the usual practice for late food trays.

Note: Disposable dishes are not necessary for patients with any type of communicable disease.

3.0 REFERENCES

IC4:1300  Specimen Handling and Transport

1.0 PRACTICE GUIDELINE

Specimens will be transported in a manner that will limit the risk of exposure to blood and body substances.

2.0 PROCEDURE

Transport of Specimens within Facilities
- specimen container will have a secure lid
- specimen container will not be soiled on the outside
- if the outside of the container is visibly contaminated it should be cleaned with a disinfectant
- specimen container will be sealed in a plastic bag and/or secured in a caddy
- Blood or body fluid aspirates shall not be transported in a syringe with needle attached. Please refer to the Laboratory Manual regarding transport of fluid aspirates.
- Specimens must be labeled appropriately and sent to the laboratory as soon as possible.

Transport of Specimens between Facilities
Ministry of Transportation regulations will be observed when transporting specimens between laboratories. Information about the Transport of Dangerous Goods (TDG) is available in the Laboratory

3.0 REFERENCES


IC4:1400  Personal Care Supplies

1.0  PRACTICE GUIDELINE

Personal care supplies such as lotions, creams, soaps, razors, combs, etc., shall be designated to one patient, labelled where possible with the patient’s name and not shared with other patients. At the time of discharge, these items shall be sent with the patient or discarded.

2.0  REFERENCES

1.0 PRACTICE GUIDELINE

The goal of screening for Respiratory Illnesses (RI) in the emergency setting is to recognize suspect cases of infectious RI and implement appropriate control measures to prevent further spread.

Routine Precautions, notably hand hygiene and respiratory etiquette for staff, patients and visitors should be adhered to prevent transmission of infectious respiratory organisms.

Emerging (e.g. H5N1 Avian Influenza) or re-emerging respiratory infections (e.g. SARS) require special consideration and additional control measures. Severity of symptoms and a travel history or contact with someone with severe symptoms and/or travel history are indicators to follow Strict Precautions.

2.0 DEFINITION

Case definition for Respiratory Infection (RI)
Prior to laboratory confirmation of infection by a particular organism, the following case definition should be used to identify possible cases of RI:

- New or worsening cough and
- Fever >38°C, or a temperature that is abnormal for that individual
- Additional symptoms may include myalgia, runny nose, sore throat, headache

Note: Young children, the elderly, the immuno-compromised, or those taking medications such as steroids, NSAIDS or ASA may not develop a fever or may have a lowered temperature as a result of the infection.

3.0 RESPIRATORY ETIQUETTE

Encourage all patients and visitors to practice respiratory etiquette.

This includes:

- Perform hand hygiene after coughing, sneezing or using tissues.
- Use disposable, single use tissues for wiping noses.
- Cover nose and mouth when sneezing and coughing (even when this is due to allergies or chronic illness).
- Keep hands away from the mucous membranes of the eyes and nose.
IC4:1500 Prevention of Transmission of Infectious Respiratory Illnesses (RI) in Emergency Room Settings

4.0 PROCEDURE

For patients who meet case definition of Respiratory Illness:

- Ask patient to don a procedure mask to reduce the likelihood of transmission of the infection to others.
- If unable to tolerate a mask the person should be asked to remain in a separate area or at least one metre away from others.
- The health care worker will don appropriate personal protective equipment.
- Droplet Precautions stipulate that facial protection should be worn when within one metre of a coughing patient to prevent exposure to respiratory infections transmitted primarily by large droplets.

When there is a suspect case of emerging or re-emerging respiratory infection the patient should be moved to a negative pressure private room and placed on Strict Precautions (See IC5:1000).

Notify Infection Prevention & Control and the Medical Health Officer.

Areas of Emerging and re-emerging respiratory infections can be obtained from: http://www.phac-aspc.gc.ca/h5n1/index.html

5.0 REFERENCES

Section IC5: ADDITIONAL PRECAUTIONS
IC5:0100  Additional Precautions

1.0  PRACTICE GUIDELINE

- The goal of Additional Precautions is to supplement Routine Practices in interrupting the route of transmission of microorganisms from one person to another via the airborne, droplet or contact route. Additional Precautions are designed for patients who are diagnosed with or are suspected of having an infectious microorganism, and are to be implemented in addition to Routine Practices.
- Patients with identical symptoms may be infected by different organisms with different routes of transmission e.g. acute respiratory infections may be spread by large droplets alone (whooping cough) or large droplets and direct and indirect contact (respiratory viruses).
- Once the need for Additional Precautions has been identified, the patient’s room will be marked with an Isolation Precautions sign. Some examples of such signs would be “Airborne Precautions”, “Droplet Precautions”, or “Droplet Contact Precautions”.
- The Medical staff, Nursing staff or Infection Prevention & Control initiates isolation precautions when a patient is suspected or diagnosed of having an infectious process requiring isolation precautions in addition to Routine Practices.
- Additional Precautions are followed by all staff and visitors until the infectious process has subsided or is ruled out.
- Certain infections require more than one type of precaution.
- Patient access to diagnostic tests and treatment should not be denied because of isolation precautions.
- Patients requiring Additional Precautions are isolated using the appropriate precautions as listed below:
  - Routine Practices – applied to all patients at all times. (Refer to section IC4)
  - Airborne Precautions – applies to patients with diseases spread by the airborne route.
  - Droplet Precautions – applies to patients with diseases spread by the droplet route.
  - Contact Precautions – applies to patients with diseases spread by direct contact with the patient or the patient’s environment.
  - Droplet Contact Precautions – applies to patients with diseases spread by direct contact with the patient or the patient’s environment and spread by the droplet route.
### IC5:0200  Additional Precautions by Clinical Presentation

#### Transmission Characteristics and Empiric Precautions by Clinical Presentation: Recommendations for Acute Care Centres

<table>
<thead>
<tr>
<th>Clinical findings</th>
<th>Potential pathogens</th>
<th>Empiric precautions</th>
<th>Infective material</th>
<th>Route of transmission</th>
<th>Duration of precautions</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abscess</td>
<td>Staphylococcus aureus, Streptococcus gr.A, many other bacteria</td>
<td>Major: Contact Minor: Routine</td>
<td>Pus</td>
<td>Direct and indirect contact</td>
<td>Duration of drainage</td>
<td>Major = drainage not contained by dressing.</td>
</tr>
<tr>
<td>Bronchiolitis</td>
<td>Respiratory syncytial virus (RSV), parainfluenza virus, influenza, adenovirus</td>
<td>ADULT: Routine PAEDIATRIC: Droplet and Contact</td>
<td>Respiratory secretions</td>
<td>Large droplet and direct and indirect contact</td>
<td>Duration of illness</td>
<td>May cohort if infected with same virus. Minimize exposure of immunocompromised patients, children with chronic cardiac or lung disease, neonates.</td>
</tr>
<tr>
<td>Burns, infected</td>
<td>See abscess</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Cellulitis</td>
<td>Haemophilus influenza type b in non-immune child &lt;5 years of age; Streptococcus pneumoniae, Streptococcus gr. A, Staphylococcus aureus, other bacteria</td>
<td>Droplet if Haemophilus influenza type b is possible cause, otherwise Routine</td>
<td>Respiratory secretions</td>
<td>Large droplet, direct contact</td>
<td>Until 24 hours of appropriate antimicrobial therapy received unless Haemophilus influenzae type b ruled out</td>
<td></td>
</tr>
<tr>
<td>Cellulitis</td>
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<tr>
<td>Periorbital or other with intact skin</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Common cold</td>
<td>Rhinovirus, RSV, parainfluenza, influenza, adenovirus, coronavirus</td>
<td>ADULT: Routine PAEDIATRIC: Droplet and Contact</td>
<td>Respiratory secretions</td>
<td>Large droplet and direct and indirect contact</td>
<td>Duration of illness</td>
<td>May cohort if infected with same virus. Minimize exposure of immunocompromised patients, children with chronic cardiac or lung disease, neonates.</td>
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</tbody>
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## IC5:0200  Additional Precautions by Clinical Presentation

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<tbody>
<tr>
<td>Conjunctivitis</td>
<td>Adenovirus, enterovirus, chlamydia, gonococcus, other bacteria</td>
<td>ADULT: Routine</td>
<td>Eye discharge</td>
<td>Direct and indirect contact</td>
<td>Until viral etiology ruled out; duration of symptoms if viral</td>
<td>Routine if non-viral.</td>
</tr>
<tr>
<td>Cough, fever, acute upper respiratory tract infection</td>
<td>Rhinovirus, RSV, parainfluenza, influenza, adenovirus, coronavirus, pertussis, mycoplasma</td>
<td>ADULT: Routine</td>
<td>Respiratory secretions</td>
<td>Large droplet, direct and indirect contact</td>
<td>Duration of illness or until infectious etiology ruled out</td>
<td>May cohort if infected with same virus. Minimize exposure of immunocompromised patients, children with chronic cardiac or lung disease, neonates. Consider fever and asthma in child &lt;2 years old as viral infection.</td>
</tr>
<tr>
<td>Cough, fever, pulmonary infiltrates in person at risk for tuberculosis</td>
<td>Mycobacterium tuberculosis</td>
<td>Airborne</td>
<td>Respiratory secretions</td>
<td>Airborne</td>
<td>Until tuberculosis ruled out or Until patient has received at least two weeks of effective treatment and is clinically improved, and three sputa taken 24 hours apart are negative for AFB. Until negative sputum culture if multi-drug resistant tuberculosis</td>
<td>See Guidelines for Preventing the Transmission of Tuberculosis in Canadian Health Care Facilities and Other Institutional Settings</td>
</tr>
<tr>
<td>Croup</td>
<td>Parainfluenza, influenza, RSV, adenovirus</td>
<td>ADULT: Routine</td>
<td>Respiratory secretions</td>
<td>Large droplet, direct and indirect contact</td>
<td>Duration of illness or until infectious cause ruled out</td>
<td>May cohort if infected with same virus. Minimize exposure of immunocompromised patients, children with chronic cardiac or lung disease, neonates.</td>
</tr>
</tbody>
</table>
### Additional Precautions by Clinical Presentation

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</tr>
</thead>
<tbody>
<tr>
<td>Decubitus ulcer, infected Dermatitis</td>
<td>Many (bacteria, virus, fungi)</td>
<td>Contact</td>
<td>Skin exudates</td>
<td>Direct and indirect contact</td>
<td>Until infectious etiology ruled out</td>
<td>If compatible with scabies take appropriate precautions pending diagnosis.</td>
</tr>
<tr>
<td>See abscess</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Desquamation, extensive</td>
<td>Staphylococcus aureus</td>
<td>Contact</td>
<td>Skin exudates</td>
<td>Direct and indirect contact</td>
<td>Until skin exudates contained or infection ruled out</td>
<td></td>
</tr>
<tr>
<td>See abscess</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrhea</td>
<td>Several bacteria, viruses, parasites</td>
<td>ADULT: Routine*</td>
<td>Feces</td>
<td>Direct and indirect contact (fecal/oral)</td>
<td>Until normal stools or infectious etiology ruled out</td>
<td>*Consider Contact precautions for incontinent adults if feces cannot be contained or for adults with poor hygiene who contaminate their environment.</td>
</tr>
<tr>
<td>Acute diarrhea of likely infectious cause</td>
<td></td>
<td>PAEDIATRIC: Contact</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suspected Clostridium difficile diarrhea</td>
<td>Clostridium difficile</td>
<td>Contact for adults and children</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encephalitis</td>
<td>HSV, enterovirus, arbovirus</td>
<td>ADULT: Routine*</td>
<td>Feces, respiratory secretions</td>
<td>Direct and indirect contact (fecal/oral)</td>
<td>Until specific etiology established or until enterovirus ruled out</td>
<td>*May be associated with measles, mumps, varicella, Mycoplasma pneumoniae, Epstein-Barr virus (EBV). If so, take appropriate precautions for associated disease.</td>
</tr>
<tr>
<td>Endometritis</td>
<td>Streptococcus group A; many other bacteria</td>
<td>Routine</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Epiglottitis</td>
<td>Haemophilus influenzae type b; Streptococcus gr A, Staphylococcus aureus</td>
<td>ADULT: Routine</td>
<td>Respiratory secretions</td>
<td>Large droplet, direct contact</td>
<td>Until 24 hours of appropriate antimicrobial therapy received unless Haemophilus influenzae type b ruled out</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>PAEDIATRIC: Droplet if Haemophilus influenzae type b is possible cause, otherwise Routine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Erysipelas</td>
<td>Streptococcus gr A</td>
<td>Routine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### IC5:0200 Additional Precautions by Clinical Presentation

<table>
<thead>
<tr>
<th>Clinical findings</th>
<th>Potential pathogens</th>
<th>Empiric precautions</th>
<th>Infective material</th>
<th>Route of transmission</th>
<th>Duration of precautions</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever of unknown origin, fever without focus (acute)</td>
<td>Enterovirus (June-December)</td>
<td>ADULT: Routine* PAEDIATRIC: Contact</td>
<td>Feces, respiratory secretions</td>
<td>Direct or indirect contact (fecal/oral)</td>
<td>Duration of illness or until enteroviral infection ruled out</td>
<td>*If findings suggest a specific transmissible infection, take precautions for that infection pending diagnosis.</td>
</tr>
<tr>
<td>Food poisoning</td>
<td>Bacillus cereus, Clostridium perfringens, Staphylococcus aureus, Salmonella, Vibrio parahaemolyticus, Escherichia coli O157 and others</td>
<td>ADULT: Routine* PAEDIATRIC: Contact if Salmonella or Escherichia coli O157 suspected, otherwise Routine</td>
<td>Feces if Salmonella or Escherichia coli O157</td>
<td>Foodborne; or direct and indirect contact (fecal/oral) if Salmonella or Escherichia coli O157</td>
<td>Until Salmonella or Escherichia coli O157 ruled out</td>
<td>*Consider Contact precautions for incontinent adults if stool cannot be contained or for adults with poor hygiene who contaminate their environment if Salmonella or Escherichia coli O157 suspected.</td>
</tr>
<tr>
<td>Furuncles See abscess</td>
<td>Staphylococcus aureus</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Gas gangrene</td>
<td>Clostridium spp.</td>
<td>Routine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gastroenteritis See diarrhea</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Gingivostomatitis</td>
<td>HSV</td>
<td>Routine</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Guillain-Barre syndrome</td>
<td>Associated with many infections*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>*Take precautions as appropriate for known or suspected associated infection.</td>
</tr>
<tr>
<td>Hand, foot and mouth disease</td>
<td>Enterovirus</td>
<td>ADULT: Routine PAEDIATRIC: Contact</td>
<td>Feces, respiratory secretions</td>
<td>Direct and indirect contact (fecal/oral)</td>
<td>Duration of illness</td>
<td></td>
</tr>
<tr>
<td>Hemolytic-uremic syndrome</td>
<td>May be associated with E.coli O157</td>
<td>ADULT: Routine* PAEDIATRIC: Contact</td>
<td>Feces</td>
<td>Direct and indirect contact (fecal/oral)</td>
<td>Until E. coli O157 ruled out. * Consider Contact precautions for incontinent adults if stool cannot be contained or for adults with poor hygiene who contaminate their environment.</td>
<td></td>
</tr>
</tbody>
</table>
### IC5:0200  Additional Precautions by Clinical Presentation

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<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemorrhagic fever acquired in appropriate endemic</td>
<td>Ebola, Lassa, Marburg, and others*</td>
<td>Contact plus Droplet</td>
<td>Blood and bloody body fluids</td>
<td>Direct and indirect contact; possibly airborne if pneumonia</td>
<td>Duration of illness or until hemorrhagic fever virus ruled out</td>
<td>Local public health authorities or regional officer of health and LCDC should be notified immediately. *Refer to Canadian Contingency Plan for Viral Hemorrhagic Fevers and Other Related Diseases</td>
</tr>
<tr>
<td>area</td>
<td>HAV, HBV, HCV, HEV, EBV and others</td>
<td>ADULT: Routine*</td>
<td>Feces; blood and certain body fluids</td>
<td>Direct and indirect contact (fecal/oral) for hepatitis A, E</td>
<td>For 7 days after onset of jaundice or until hepatitis A ruled out</td>
<td>*Consider Contact precautions for incontinent adults if stool cannot be contained or for adults with poor hygiene who contaminate their environment unless hepatitis A ruled out.</td>
</tr>
<tr>
<td>Hepatitis of unknown etiology</td>
<td>Enterovirus</td>
<td>ADULT: Routine</td>
<td>Feces, respiratory secretions</td>
<td>Direct and indirect contact (fecal/oral)</td>
<td>Duration of illness</td>
<td></td>
</tr>
<tr>
<td>Herpangina</td>
<td>ADULT: Routine*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impetigo</td>
<td>Streptococcus grA, Staphylococcus aureus</td>
<td>Contact if extensive*</td>
<td>Skin exudates</td>
<td>Direct and indirect contact (fecal/oral)</td>
<td>Until 24 hours of effective antimicrobial therapy</td>
<td>*Not covered by dressings</td>
</tr>
<tr>
<td>See abscess</td>
<td>Unknown</td>
<td>Routine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kawasaki disease (Mucocutaneous lymph node syndrome)</td>
<td>Bacterial: Neisseria meningitidis, Haemophilus influenzae type b, Streptococcus</td>
<td>ADULT: Droplet if possibly Neisseria</td>
<td>Respiratory secretions</td>
<td>Large droplet</td>
<td>Until 24 hours of appropriate antibiotic therapy received</td>
<td>*Paediatrics: precautions for both bacterial and viral until etiology established</td>
</tr>
<tr>
<td></td>
<td>pneumoniae, Streptococcus groupB, Listeria monocytogenes, E.coli and other Gram</td>
<td>meningitidis otherwise Routine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>negative rods</td>
<td>PAEDIATRIC: Droplet*</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Tuberculosis</td>
<td>Routine*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>*Rule out associated pulmonary tuberculosis.</td>
</tr>
<tr>
<td>Viral: enterovirus</td>
<td>Adult: Routine* PAEDIATRIC: Contact*</td>
<td>Feces, respiratory secretions</td>
<td>Direct or indirect contact</td>
<td>Until enterovirus ruled out</td>
<td></td>
<td>*May be associated with measles, mumps, varicella, HSV. If so, take appropriate precautions for associated disease.</td>
</tr>
<tr>
<td>Fungus</td>
<td>Routine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Necrotizing enterocolitis</td>
<td>Unknown, probably many organisms</td>
<td>Routine*</td>
<td>Probable contact</td>
<td>Duration of illness</td>
<td></td>
<td>*Unknown if transmissible. Take precautions if outbreak suspected.</td>
</tr>
<tr>
<td>Osteomyelitis</td>
<td>Haemophilus influenza type b possible in non-immune infant &lt;2 years of age, Staphylococcus aureus, other bacteria</td>
<td>ADULT: Routine PAEDIATRIC: Droplet if Haemophilus influenzae type b possible; otherwise Routine</td>
<td>Respiratory secretions</td>
<td>Direct and indirect contact; large droplets</td>
<td>Until 24 hours of effective antimicrobial therapy unless Haemophilus influenzae type b ruled out</td>
<td></td>
</tr>
<tr>
<td>Otitis, draining</td>
<td>See abscess</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharyngitis</td>
<td>Streptococcus gr A, viral, Corynebacterium diphtheriae</td>
<td>ADULT: Routine* PAEDIATRIC: Droplet and Contact</td>
<td>Respiratory secretions</td>
<td>Direct and indirect contact; large droplets</td>
<td>Duration of illness; if Streptococcus grA until 24 hours of antibiotic therapy received</td>
<td>*If diphtheria suspected see IC5:0300</td>
</tr>
<tr>
<td>Pleurodynia</td>
<td>Enterovirus</td>
<td>ADULT: Routine PAEDIATRIC: Contact</td>
<td>Feces, respiratory secretions</td>
<td>Direct and indirect contact (fetal/oral)</td>
<td>Duration of illness</td>
<td></td>
</tr>
</tbody>
</table>
# IC5:0200 Additional Precautions by Clinical Presentation

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<th>Infective material</th>
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<th>Duration of precautions</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumonia</td>
<td>Viruses, pertussis, Mycoplasma, Streptococcus pneumoniae, Haemophilus influenzae type b, Staphylococcus aureus, Streptococcus grA, Gram negative enteric rods, Chlamydia, Legionella, Pneumocystis, fungi</td>
<td>ADULT: Routine PAEDIATRIC: Droplet and Contact</td>
<td>Respiratory secretions</td>
<td>Large droplets, direct and indirect contact</td>
<td>Until etiology established, then as for specific organism; no special precautions for Gram negative pneumonia unless MRO</td>
<td>May cohort if infected with same virus. Minimize exposure of immunocompromised patients, children with chronic cardiac or lung disease, neonates.</td>
</tr>
<tr>
<td>Pseudomembranous colitis</td>
<td>Clostridium difficile</td>
<td>Contact</td>
<td>Feces</td>
<td>Direct and indirect contact (fecal/oral)</td>
<td>Until normal stools</td>
<td></td>
</tr>
<tr>
<td>Rash compatible with scabies</td>
<td>Ectoparasite</td>
<td>Contact if extensive, otherwise Routine plus gloves and gown for direct patient contact</td>
<td>Mite</td>
<td>Direct and indirect contact</td>
<td>If confirmed, until 24 hours of appropriate therapy</td>
<td>See scabies, IC5: 0300</td>
</tr>
<tr>
<td>Rash (maculopapular) with fever and coryza</td>
<td>Measles</td>
<td>Airborne</td>
<td>Respiratory secretions</td>
<td>Airborne</td>
<td>If confirmed, until 4 days after onset of rash</td>
<td>See Measles, IC5: 0300</td>
</tr>
<tr>
<td>Rash (petechial/purpuric) with fever</td>
<td>Neisseria meningitidis</td>
<td>ADULT: Droplet if Neisseria meningitidis suspected otherwise Routine PAEDIATRIC: Droplet</td>
<td>Respiratory secretions</td>
<td>Large droplets, direct contact</td>
<td>If N. meningitidis confirmed, until 24 hours of appropriate antibiotic therapy received</td>
<td></td>
</tr>
</tbody>
</table>

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Revised: February 26, 2008
### IC5:0200  Additional Precautions by Clinical Presentation

<table>
<thead>
<tr>
<th>Clinical findings</th>
<th>Potential pathogens</th>
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<th>Infective material</th>
<th>Route of transmission</th>
<th>Duration of precautions</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rash (vesicular) with fever</td>
<td>Varicella</td>
<td>Airborne and Contact</td>
<td>Respiratory secretions, skin exudates</td>
<td>Airborne, direct and indirect contact</td>
<td>If confirmed, until all lesions are dry</td>
<td>See Chickenpox, IC5: 0300</td>
</tr>
<tr>
<td>Reye's syndrome</td>
<td>May be associated with viral infection, especially influenza, varicella</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Precautions as for known or suspected associated viral infection</td>
</tr>
<tr>
<td>Scalded skin syndrome</td>
<td>See Staphylococcus aureus, Table 7</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Septic arthritis</td>
<td>Haemophilus influenzae type b possible in non-immune infant &lt;5 years of age; Staphylococcus aureus, Streptococcus pneumoniae, Streptococcus gr A, other bacteria</td>
<td>ADULT: Routine PAEDIATRIC: Droplet if Haemophilus influenzae type b possible; otherwise Routine</td>
<td></td>
<td></td>
<td>Until 24 hours of appropriate antimicrobial therapy received unless Haemophilus influenzae type b ruled out</td>
<td></td>
</tr>
<tr>
<td>Skin infection</td>
<td>See abscess</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Toxic shock syndrome</td>
<td>Staphylococcus aureus, Streptococcus gr A</td>
<td>Routine*</td>
<td></td>
<td></td>
<td></td>
<td>*See abscess if drainage or skin exudates.</td>
</tr>
<tr>
<td>Urinary tract infection</td>
<td>Many</td>
<td>Routine unless MRO</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vincent's angina, Trench mouth</td>
<td>Multiple bacteria</td>
<td>Routine</td>
<td></td>
<td></td>
<td></td>
<td>Usually normal flora.</td>
</tr>
<tr>
<td>Wound infection (see abscess)</td>
<td></td>
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</tr>
</tbody>
</table>
## IC5:0300 Additional Precautions by Organism

### Transmission Characteristics and Precautions by Specific Etiology: Recommendations for Acute Care Centres

<table>
<thead>
<tr>
<th>Microorganism</th>
<th>Clinical presentation</th>
<th>Precautions</th>
<th>Infective material</th>
<th>Route of transmission</th>
<th>Incubation period</th>
<th>Period of communicability</th>
<th>Duration of precautions</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actinomycosis (Actinomyces sp.)</td>
<td>Cervicofacial, thoracic or abdominal infection</td>
<td>Routine</td>
<td></td>
<td></td>
<td>Variable</td>
<td>Not person-to-person</td>
<td></td>
<td>Normal flora; infection usually secondary to trauma.</td>
</tr>
<tr>
<td>Adenovirus Respiratory strains</td>
<td>Respiratory tract infection</td>
<td>ADULT: Routine</td>
<td>Respiratory secretions</td>
<td>Large droplets; direct and indirect contact</td>
<td>2-14 days</td>
<td>Until symptoms cease</td>
<td>Duration of illness</td>
<td>Different strains responsible for respiratory and gastrointestinal disease. Minimize exposure of immunocompromised patients, children with chronic cardiac or lung disease, neonates.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PAEDIATRIC:</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Contact</td>
<td></td>
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</tr>
<tr>
<td>Conjointivitis</td>
<td></td>
<td>ADULT: Routine</td>
<td>Eye discharge</td>
<td>Direct and indirect contact</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td>PAEDIATRIC:</td>
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<td></td>
<td></td>
<td>Contact</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Enteric strains</td>
<td>Diarrhea</td>
<td>ADULT: Routine</td>
<td>Feces</td>
<td>Direct and indirect contact</td>
<td>3-10 days</td>
<td>Until symptoms cease</td>
<td>Until normal stools</td>
<td>Consider Contact precautions for incontinent adults if stool cannot be contained or for adults with poor hygiene who contaminate their environment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PAEDIATRIC:</td>
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<tr>
<td></td>
<td></td>
<td>Contact</td>
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<td></td>
</tr>
<tr>
<td>Amebiasis (Entamoeba histolytica)</td>
<td>Dysentery</td>
<td>ADULT: Routine</td>
<td>Feces</td>
<td>Direct and indirect contact</td>
<td>Days to weeks</td>
<td>Duration of cyst excretion</td>
<td>Duration of illness</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Abscess</td>
<td>PAEDIATRIC:</td>
<td>Feces, pus</td>
<td>Direct and indirect contact (fecal/oral)</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Contact</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anthrax (Bacillus anthracis)</td>
<td>Skin lesions, pneumonia</td>
<td>Routine</td>
<td>Lesion drainage</td>
<td></td>
<td>1-7 days</td>
<td>Not person-to-person</td>
<td></td>
<td>Acquired from infected animals and animal products.</td>
</tr>
<tr>
<td>Antimicrobial Resistant Organisms</td>
<td>Infection or colonization of any body site</td>
<td>Contact*</td>
<td>Infected or colonized secretions, excretions</td>
<td>Direct and indirect contact</td>
<td>Variable</td>
<td>Variable</td>
<td>As directed by ICP</td>
<td>Includes MRSA, VRE, resistant Gram negative rods and other organisms as per ICP *See IC6</td>
</tr>
<tr>
<td>(ARO / MRO)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Microorganism</td>
<td>Clinical presentation</td>
<td>Precautions</td>
<td>Infective material</td>
<td>Route of transmission</td>
<td>Incubation period</td>
<td>Period of communicability</td>
<td>Duration of precautions</td>
<td>Comments</td>
</tr>
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<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Arthropod borne virus* (arboviruses)</td>
<td>Encephalitis, fever, rash</td>
<td>Routine</td>
<td>Insectborne</td>
<td>Variable 3-21 days</td>
<td>Not person-to-person</td>
<td></td>
<td></td>
<td>*Several hundred different viruses, most limited to specific geographic areas; in North America: California, St.Louis, Western equine, Eastern equine and Powassan encephalitis viruses and Colorado tick virus are most frequent.</td>
</tr>
<tr>
<td>Ascariasis (Ascaris lumbricoides) (roundworm)</td>
<td>Usually asymptomatic</td>
<td>Routine</td>
<td></td>
<td>4-8 weeks</td>
<td>Not person-to-person</td>
<td></td>
<td></td>
<td>Ova must hatch in soil to become infective.</td>
</tr>
<tr>
<td>Aspergillosis (Aspergillus spp.)</td>
<td>Skin, lung, wound or central nervous system infection</td>
<td>Routine</td>
<td></td>
<td>Variable</td>
<td>Not person-to-person</td>
<td></td>
<td></td>
<td>Spores in dust; infections in immunocompromised patients may be associated with construction.</td>
</tr>
<tr>
<td>Astrovirus</td>
<td>Diarrhea</td>
<td>ADULT: Routine*</td>
<td>Feces</td>
<td>Direct and indirect contact (fecal/oral)</td>
<td>3-4 days</td>
<td>Duration of illness</td>
<td>Until normal feces</td>
<td>*Consider Contact precautions for incontinent adults if feces cannot be contained or for adults with poor hygiene who contaminate their environment</td>
</tr>
<tr>
<td>Blastomycosis (Blastomyces dermatitidis)</td>
<td>Pneumonia, skin lesions</td>
<td>Routine</td>
<td></td>
<td>30-45 days</td>
<td>Not person-to-person</td>
<td></td>
<td></td>
<td>Acquired from spores in soil.</td>
</tr>
<tr>
<td>Botulism (Clostridium botulinum)</td>
<td>Flaccid paralysis; cranial nerve palsies</td>
<td>Routine</td>
<td>Foodborne</td>
<td>Variable</td>
<td>Not person-to-person</td>
<td></td>
<td></td>
<td></td>
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<th>Duration of precautions</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Brucellosis (Brucella sp.)</td>
<td>Undulant or Mediterranean fever</td>
<td>Routine</td>
<td></td>
<td></td>
<td>Weeks to months</td>
<td></td>
<td></td>
<td>Acquired from contact with infected animals or from infected food.</td>
</tr>
<tr>
<td></td>
<td>Draining lesions</td>
<td>Contact*</td>
<td>Drainage from open lesions</td>
<td>Possibly direct contact</td>
<td>Rare cases of person-to-person transmission</td>
<td>Duration of drainage</td>
<td>*Contact precautions required only if wound drainage cannot be contained by dressings.</td>
<td></td>
</tr>
<tr>
<td>Burkholderia cepacia</td>
<td>Exacerbation of chronic lung disease in patients with cystic fibrosis</td>
<td>Routine</td>
<td></td>
<td></td>
<td>Variable</td>
<td></td>
<td></td>
<td>Do not place in the same room as a patient with cystic fibrosis (CF) who is not infected or colonized with Burkholderia cepacia. Contacts with CF patients in the health care facility who are not colonized or infected with B. cepacia should be minimized. Persons with CF who visit or provide care and are not infected or colonized with B. cepacia may elect to wear a mask when within 1 metre of a colonized or infected patient who is coughing or undergoing chest physiotherapy.</td>
</tr>
<tr>
<td>Calicivirus (Calicivirus, Norwalk, other small round structural viruses)</td>
<td>Diarrhea</td>
<td>ADULT: Routine* PAEDIATRIC: Contact</td>
<td>Feces</td>
<td>Direct and indirect contact (fecal/oral)</td>
<td>12 hours to 4 days</td>
<td>Duration of excretion</td>
<td>Until normal feces</td>
<td>*Consider Contact precautions for incontinent adults if feces cannot be contained or for adults with poor hygiene who contaminate their environment.</td>
</tr>
<tr>
<td>Campylobacter jejuni</td>
<td>Diarrhea</td>
<td>ADULT: Routine* PAEDIATRIC: Contact</td>
<td>Feces</td>
<td>Direct and indirect contact (fecal/oral)</td>
<td>1-7 days</td>
<td>Duration of excretion</td>
<td>Until feces normal</td>
<td>*Consider Contact precautions for incontinent adults if stool cannot be contained or for adults with poor hygiene who contaminate their environment. Treatment with effective antibiotic shortens period of infectivity.</td>
</tr>
</tbody>
</table>
## IC5:0300  Additional Precautions by Organism

<table>
<thead>
<tr>
<th>Microorganism</th>
<th>Clinical presentation</th>
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<th>Duration of precautions</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Candidiasis (Candida sp.)</td>
<td>Many</td>
<td>Routine</td>
<td>Variable</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cat Scratch Disease Bartonella henselae (formerly Rochalimaea henselae)</td>
<td>Fever, lymphadenopathy</td>
<td>Routine</td>
<td>7-62 days</td>
<td>Not person-to-person</td>
<td>Acquired from animals (cats and others).</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Chancroid (Haemophilus ducreyi)</td>
<td>Genital ulcers</td>
<td>Routine</td>
<td>Sexually transmitted</td>
<td>3-10 days</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chickenpox (varicella-zoster virus)</td>
<td>Fever with vesicular rash</td>
<td>Airborne and contact</td>
<td>Lesion drainage, respiratory secretions</td>
<td>10-21 days</td>
<td>2 days before rash and until skin lesions have crusted</td>
<td>Until all lesions have crusted and dried</td>
<td>Roommates and caregivers should be immune to chickenpox. Susceptible high-risk contacts should receive VZIG as soon as possible, latest within 96 hours of exposure. VZIG may extend the incubation period to 28 days. Airborne precautions should be taken with neonates born to mothers with varicella onset &lt;5 days before delivery.</td>
<td></td>
</tr>
<tr>
<td>Susceptible contact</td>
<td>Airborne</td>
<td>Respiratory secretions</td>
<td>Potentially communicable during last 2 days of incubation period</td>
<td>From 8 days after first contact until 21 days after last contact with rash (28 days if given VZIG)</td>
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</tr>
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<tbody>
<tr>
<td>Chlamydia trachomatis</td>
<td>Genital tract; neonatal conjunctivitis, pneumonia; trachoma</td>
<td>Routine</td>
<td></td>
<td>Sexually transmitted; mother-to - newborn</td>
<td>Variable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cholera (Vibrio cholerae 01)</td>
<td>Diarrhea</td>
<td>ADULT: Routine* PAEDIATRIC: Contact</td>
<td>Feces</td>
<td>Direct and indirect contact (fecal/oral)</td>
<td>1-5 days</td>
<td>Duration of shedding</td>
<td>Until normal feces</td>
<td>*Consider Contact precautions for incontinent adults if stool cannot be contained or for adults with poor hygiene who contaminate their environment.</td>
</tr>
<tr>
<td>Clostridium difficile</td>
<td>Diarrhea, pseudo-membranous colitis</td>
<td>Contact</td>
<td>Feces</td>
<td>Direct and indirect contact (fecal/oral)</td>
<td>Variable</td>
<td>Duration of shedding</td>
<td>Until normal feces for 72 hours</td>
<td>Bacterial spores persist in the environment. Pay special attention to cleaning.</td>
</tr>
<tr>
<td>Clostridium perfringens</td>
<td>Food poisoning</td>
<td>Routine</td>
<td>Foodborne</td>
<td>6-24 hours</td>
<td>Not person-to-person</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Found in normal gut flora, soil. Infection related to devitalized tissue.</td>
</tr>
<tr>
<td>Coccidioidomycosis (Coccidioides immitis)</td>
<td>Pneumonia, draining lesions</td>
<td>Routine</td>
<td></td>
<td></td>
<td>1-4 weeks</td>
<td>Not person-to-person</td>
<td>Acquired from spores in soil, dust.</td>
<td></td>
</tr>
<tr>
<td>Colorado tick fever</td>
<td>See arbovirus</td>
<td>Fever</td>
<td>Routine</td>
<td>Tickborne</td>
<td>3-6 days</td>
<td>Not person-to-person</td>
<td>Acquired from spores in soil, dust.</td>
<td></td>
</tr>
<tr>
<td>Congenital rubella</td>
<td>See Rubella</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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*Consider Contact precautions for incontinent adults if stool cannot be contained or for adults with poor hygiene who contaminate their environment.
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<tr>
<td>Coronavirus</td>
<td>Common cold</td>
<td>ADULT: Routine PAEDIATRIC:</td>
<td>Respiratory secretions</td>
<td>Direct and indirect contact. Possible</td>
<td>2-4 days</td>
<td>Until symptoms cease</td>
<td>Duration of illness</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Droplet and Contact</td>
<td></td>
<td>large droplet</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coronavirus causing Severe Acute</td>
<td>Severe respiratory infection with possible associated gastrointestinal manifestations</td>
<td>Strict</td>
<td>Respiratory secretions,</td>
<td>Primarily droplet via respiratory</td>
<td>3-10 days</td>
<td>Not yet completely</td>
<td>At least until 21 days from</td>
<td>Public Health and Infection Prevention &amp; Control should be notified</td>
</tr>
<tr>
<td>Respiratory Syndrome (SARS)</td>
<td></td>
<td></td>
<td>feces, urine</td>
<td>secretions or body fluids. Possible</td>
<td></td>
<td>completely understood.</td>
<td>onset of symptoms. To be discussed with Infection Prevention &amp; Control.</td>
<td>immediately of any suspect cases.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>indirect spread by fomites</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coxsackievirus</td>
<td>See Enterovirus</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creutzfeldt-Jakob disease</td>
<td>Chronic encephalopathy</td>
<td>Routine*</td>
<td>Central nervous system</td>
<td>Months to years</td>
<td></td>
<td></td>
<td></td>
<td>*Special precautions for neurosurgical procedures and autopsy and</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>tissues</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>handling deceased body. Refer to Health Canada Infection control</td>
</tr>
<tr>
<td>Cryptococcosis</td>
<td>Pneumonia, meningitis, adenopathy</td>
<td>Routine</td>
<td></td>
<td>Unknown</td>
<td></td>
<td>Not person-to-person</td>
<td></td>
<td>guidelines for health care workers for Creutzfeldt-Jakob disease in</td>
</tr>
<tr>
<td>(Cryptococcus neoformans)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Canada.</td>
</tr>
</tbody>
</table>

Comments:
- *Special precautions for neurosurgical procedures and autopsy and handling deceased body. Refer to Health Canada Infection control guidelines for health care workers for Creutzfeldt-Jakob disease in Canada.
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<tr>
<td><strong>Cryptosporidiosis</strong></td>
<td>Diarrhea</td>
<td>ADULT: Routine* PAEDIATRIC: Contact</td>
<td>Feces</td>
<td>Direct and indirect contact (fecal/oral)</td>
<td>2-14 days</td>
<td>From onset of symptoms until several weeks after resolution</td>
<td>Until symptoms cease</td>
<td>*Consider Contact precautions for incontinent adults if feces cannot be contained or for adults with poor hygiene who contaminate their environment.</td>
</tr>
<tr>
<td><strong>Cysticercosis</strong></td>
<td>Cysts in various organs</td>
<td>Routine</td>
<td>Ova in feces</td>
<td>Direct contact (fecal/oral)</td>
<td>Months to years</td>
<td>Transmissible only if patient has Taenia solium adult tapeworm in gastrointestinal tract (see Tapeworm).</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cytomegalovirus</strong></td>
<td>Usually asymptomatic; congenital infection, retinitis, disseminated infection in Immunocompromised host</td>
<td>Routine</td>
<td>Saliva, genital secretions, urine</td>
<td>Sexual contact, direct contact</td>
<td>Unknown</td>
<td>Requires intimate direct personal contact for transmission</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dengue</strong></td>
<td>Fever, arthralgia, rash</td>
<td>Routine</td>
<td>Mosquito-borne</td>
<td>3-14 days</td>
<td>Not person-to-person</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dermatophytosis</strong></td>
<td>See Tinea</td>
<td>Routine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diphtheria</strong></td>
<td>Cutaneous (characteristic ulcerative lesion)</td>
<td>Contact</td>
<td>Lesion drainage</td>
<td>Direct or indirect contact</td>
<td>2-5 days</td>
<td>If untreated, 2 weeks to several months</td>
<td>Until two cultures* from skin lesions are negative</td>
<td>*Cultures should be taken at least 24 hours apart and at least 24 hours after cessation of antimicrobial therapy.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Droplet</td>
<td>Nasopharyngeal secretions</td>
<td>Large droplets, direct contact</td>
<td>2-5 days</td>
<td>Until two cultures* from both nose and throat are negative</td>
<td>If culture facilities not available, precautions should be taken until at least 2 weeks of appropriate therapy. Close contacts should be given antibiotic prophylaxis.</td>
<td></td>
</tr>
</tbody>
</table>

*Revised: February 26, 2008*
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<tbody>
<tr>
<td>Ebola</td>
<td>Hemorrhagic fever</td>
<td>Contact plus Droplet (Contact plus Airborne if pneumonia)</td>
<td>Blood and bloody body fluids, respiratory secretions</td>
<td>Direct and indirect contact; possibly airborne if pneumonia</td>
<td>2-21 days</td>
<td>Unknown, possibly several weeks</td>
<td>Until symptoms resolve</td>
<td>Local public health authorities or regional officer of health and LCDC should be notified immediately. Refer to Canadian Contingency Plan for Viral Hemorrhagic Fevers and Other Related Diseases Special precautions for handling of deceased body.</td>
</tr>
<tr>
<td>Echinococcosis (Hydatidosis) (Echinococcus granulosis, Echinococcus multilocularis)</td>
<td>Cysts in various organs</td>
<td>Routine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Acquired from contact with infected animals.</td>
</tr>
<tr>
<td>Echovirus (see enterovirus)</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Enterobiasis (Enterobius vermicularis), (oxyuriasis, pinworm)</td>
<td>Perianal itching</td>
<td>Routine</td>
<td>Ova in perianal region</td>
<td>Direct contact</td>
<td>1-2 months</td>
<td></td>
<td>Close household contacts may need treatment.</td>
<td></td>
</tr>
<tr>
<td>Enterococcus species (Vancomycin resistant only) See Vancomycin resistant enterococcus</td>
<td></td>
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<tr>
<td>Enteroviral infections</td>
<td>Acute febrile illness, aseptic meningitis,</td>
<td>ADULT: Routine</td>
<td>Feces, respiratory</td>
<td>Direct and indirect</td>
<td>3-6 days</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Echovirus, coxsackievirus, poliovirus, enterovirus</td>
<td>encephalitis, pharyngitis, herpangina, rash, pleurodynia</td>
<td>PAEDIATRIC: Contact</td>
<td>secretions</td>
<td>contact</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Conjunctivitis</td>
<td>Adult: Routine</td>
<td></td>
<td>Eye discharge</td>
<td>Direct and indirect</td>
<td>24-72 hours</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>PAEDIATRIC: Contact</td>
<td></td>
<td></td>
<td>contact</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Epstein Barr virus</td>
<td>Infectious mononucleosis</td>
<td>Routine</td>
<td></td>
<td></td>
<td>30-50 days</td>
<td></td>
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<tr>
<td>Erythema infectiosum</td>
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<td></td>
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<tr>
<td>See Parvovirus B19</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Escherichia coli (pathogenic strains)</td>
<td>Diarrhea, hemolytic-uremic syndrome, thrombotic thrombocytopenic purpura</td>
<td>ADULT: Routine</td>
<td>Feces</td>
<td>Direct and indirect</td>
<td>10 hours to</td>
<td>Duration of shedding</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>PAEDIATRIC: Contact</td>
<td></td>
<td></td>
<td>contact (fecal/oral)</td>
<td>8 days</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>German measles</td>
<td>See Rubella</td>
<td></td>
<td></td>
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*Consider Contact precautions for incontinent adults if feces cannot be contained or for adults with poor hygiene who contaminate their environment.
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<tr>
<td>Giardia (Giardia lamblia)</td>
<td>Diarrhea</td>
<td>ADULT: Routine* PAEDIATRIC: Contact</td>
<td>Feces</td>
<td>Direct and indirect contact (fecal/oral)</td>
<td>1-4 weeks</td>
<td>May persist for months</td>
<td>Until normal feces</td>
<td>*Consider Contact precautions for incontinent adults if feces cannot be contained or for adults with poor hygiene who contaminate their environment.</td>
</tr>
<tr>
<td>Gonococcus (Neisseria gonorrhoeae)</td>
<td>Ophthalmia neonatorum, gonorrhea, arthritis, pelvic inflammatory disease</td>
<td>Routine</td>
<td>Mother-to-newborn Sexually transmitted</td>
<td>2-7 days</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Granuloma inguinale (Donovanosis) (Calymmatobacterium granulomatis)</td>
<td>Painless genital ulcers, inguinal ulcers, nodules</td>
<td>Routine</td>
<td>Sexually transmitted</td>
<td>8-20 days</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haemophilus influenzae type b (invasive disease)</td>
<td>Pneumonia, epiglottitis, meningitis, bacteremia, septic arthritis, cellulitis</td>
<td>ADULT: Routine PAEDIATRIC: Droplet</td>
<td>Respiratory secretions</td>
<td>Large droplets, direct contact</td>
<td>Variable</td>
<td>Most infectious in the week prior to onset of illness and during the illness until treated</td>
<td>Until 24 hours of appropriate antibiotic therapy has been received</td>
<td>Close contacts &lt;48 months old and who are not immune may require chemoprophylaxis. Household contacts of such children should also receive prophylaxis.</td>
</tr>
<tr>
<td>Hantavirus</td>
<td>Fever, pneumonia</td>
<td>Routine</td>
<td>Rodents</td>
<td>Variable</td>
<td></td>
<td>Not person-to-person</td>
<td></td>
<td>Infection acquired from rodents.</td>
</tr>
<tr>
<td>Helicobacter pylori</td>
<td>Gastritis, ulcer</td>
<td>Routine</td>
<td>Unknown</td>
<td>Unknown</td>
<td></td>
<td></td>
<td></td>
<td>Disinfection of gastroscopes</td>
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| **Hepatitis A, E** | Hepatitis, anicteric acute febrile illness | ADULT: Routine*  
PAEDIATRIC: Contact | Feces | Direct and indirect contact (fecal/oral) | A: 15-50 days  
E: 15-60 days | A: Two weeks before to 1 week after onset of symptoms; shedding is prolonged in the newborn.  
E: fecal shedding at least 2 weeks | 1 week after onset of symptoms; duration of hospitalization if newborn | *Consider Contact precautions for incontinent adults if feces cannot be contained or for adults with poor hygiene who contaminate their environment. Post-exposure prophylaxis indicated for non-immune contacts with significant exposure to hepatitis A if within 2 weeks of exposure. |
| **Hepatitis B, C, D and other unspecified non-A, non-B** | Hepatitis, often asymptomatic | Routine | Blood and certain other body fluids* | Mucosal or percutaneous exposure to infective body fluids | Weeks to years | From onset of infection | | *Refer to Preventing the Transmission of Bloodborne Pathogens in Health Care and Public Services Settings For occupational exposures, contact Workplace Health |
| **Herpes simplex** | Encephalitis | Routine | Skin or mucosal lesions; possibly all body secretions and excretions | Direct contact | Birth to 6 weeks of age | Duration of illness | Contact precautions are also indicated for infants delivered vaginally (or by C-section if membranes have been ruptured more than 4-6 hours) to women with active genital HSV infections, until neonatal HSV infection has been ruled out. |
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<th>Incubation period</th>
<th>Period of communicability</th>
<th>Duration of precautions</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mucocutaneous disseminated or primary and extensive</td>
<td>Contact</td>
<td>Skin or mucosal lesions</td>
<td>Direct contact</td>
<td>2 days to 2 weeks</td>
<td>While lesions present</td>
<td>Until lesions resolve</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Herpes zoster Disseminated</td>
<td>Vesicular skin lesions</td>
<td>Airborne and Contact</td>
<td>Vesicle fluid, respiratory secretions</td>
<td>Airborne, direct and indirect contact</td>
<td>Until all lesions have crusted and dried</td>
<td>Until all lesions have crusted and dried</td>
<td></td>
<td>Room-mates and caregivers should be immune to chickenpox. Susceptible high-risk contacts should be given VZIG as soon as possible, latest within 96 hours of exposure. For susceptible contacts airborne precautions should begin 8 days after first exposure to rash and continue until 21 days after last exposure (28 days if VZIG given).</td>
</tr>
<tr>
<td>Herpes Zoster Localized: Immunocompromised host</td>
<td>Vesicular skin lesions in dermatomal distribution</td>
<td>Airborne and Contact</td>
<td>Vesicle fluid</td>
<td>Direct and indirect contact, airborne</td>
<td>Until all lesions have crusted and dried</td>
<td>Until 24 hours after antiviral therapy started; then as for localized zoster in normal host</td>
<td></td>
<td>Localized zoster may disseminate in immunocompromised host if not treated.</td>
</tr>
<tr>
<td>Herpes Zoster Localized: Normal host</td>
<td>Vesicular skin lesions in dermatomal distribution</td>
<td>Routine*</td>
<td>Vesicle fluid</td>
<td>Direct and indirect contact, possibly airborne</td>
<td>Until all lesions have crusted and dried</td>
<td>Until all lesions have crusted and dried</td>
<td></td>
<td>*Consider Airborne and Contact for cases of extensive localized zoster that cannot be covered, in situations where there are varicella susceptible patients.</td>
</tr>
<tr>
<td>Histoplasmosis (Histoplasma capsulatum)</td>
<td>Pneumonia, lymphadenopathy, fever</td>
<td>Routine</td>
<td>Variable</td>
<td>Not person-to-person</td>
<td></td>
<td></td>
<td></td>
<td>Acquired from spores in soil.</td>
</tr>
</tbody>
</table>
## IC5:0300 Additional Precautions by Organism

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<tbody>
<tr>
<td>Hookworm (Necator americanus, Ancyclostoma duodenale)</td>
<td>Usually asymptomatic</td>
<td>Routine</td>
<td></td>
<td></td>
<td>4-6 weeks</td>
<td>Not person-to-person</td>
<td></td>
<td>Larvae must hatch in soil to become infectious.</td>
</tr>
<tr>
<td>Human herpesvirus 6 (HHV-6) See Roseola</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human immunodeficiency virus (HIV)</td>
<td>Asymptomatic; multiple clinical presentations</td>
<td>Routine</td>
<td>Blood and certain other body fluids*</td>
<td>Mucosal or percutaneous exposure to infective body fluids</td>
<td>Weeks to years</td>
<td>From onset of infection</td>
<td></td>
<td>*Refer to Preventing the Transmission of Bloodborne Pathogens in Health Care and Public Services Settings For occupational exposures, contact Workplace Health</td>
</tr>
<tr>
<td>Human T-cell leukemia virus, human T-lymphotropic virus (HTLV-I, HTLV-II)</td>
<td>Asymptomatic</td>
<td>Routine</td>
<td>Blood and certain other body fluids*</td>
<td>Mucosal or percutaneous exposure to infective body fluids</td>
<td>Weeks to years</td>
<td>From onset of infection</td>
<td></td>
<td>*Refer to Preventing the Transmission of Bloodborne Pathogens in Health Care and Public Services Settings For occupational exposures, contact Workplace Health</td>
</tr>
<tr>
<td>Influenza</td>
<td>Respiratory tract infection</td>
<td>ADULT: Droplet and Contact PAEDIATRIC: Droplet and Contact</td>
<td>Respiratory secretions</td>
<td>Large droplets, direct and indirect contact (possibly airborne)</td>
<td>1-3 days</td>
<td>7 days (shedding may be longer in infants)</td>
<td>For duration of illness</td>
<td>If private room is unavailable, consider cohorting patients during outbreaks. Patient should not share room with high risk patients. Minimize exposure of immunocompromised patients, children with chronic cardiac or lung disease, neonates.</td>
</tr>
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<tr>
<td>Lassa fever</td>
<td>Hemorrhagic fever</td>
<td>Contact plus Droplet (Contact plus Airborne if pneumonia)</td>
<td>Blood and bloody body fluids, respiratory secretions, possibly urine and stool</td>
<td>Direct and indirect contact (possibly airborne if pneumonia)</td>
<td>6-21 days</td>
<td>Until 3-9 weeks after onset</td>
<td>Duration of viral shedding</td>
<td>Local public health authorities or regional officer of health and LCDC should be notified immediately. Refer to Canadian Contingency Plan for Viral Hemorrhagic Fevers and Other Related Diseases Special handling of deceased body.</td>
</tr>
<tr>
<td>Legionella (Legionella spp)</td>
<td>Pneumonia</td>
<td>Routine</td>
<td>2-10 days</td>
<td>Not person-to-person</td>
<td></td>
<td></td>
<td></td>
<td>Acquired from contaminated water.</td>
</tr>
<tr>
<td>Leprosy (Hansens disease) (Mycobacterium leprae)</td>
<td>Chronic disease of skin, nerves, nasopharyngeal mucosa</td>
<td>Routine</td>
<td>Nasal secretions</td>
<td>Direct contact</td>
<td>One to many years</td>
<td></td>
<td></td>
<td>Transmitted between persons only with very prolonged extensive close personal contact. Household contacts should be given prophylaxis.</td>
</tr>
<tr>
<td>Leptospirosis (Leptospira sp.)</td>
<td>Fever, jaundice, aseptic meningitis</td>
<td>Routine</td>
<td>2-26 days</td>
<td>Not person-to-person</td>
<td></td>
<td></td>
<td></td>
<td>Acquired from contact with animals.</td>
</tr>
<tr>
<td>Lice (pediculosis) (Pediculus humanus, Phthirus pubis)</td>
<td>Scalp or body itch, itchy rash</td>
<td>Contact gloves for direct patient contact only</td>
<td>Louse</td>
<td>Direct and indirect contact</td>
<td>6-10 days</td>
<td>Until effective treatment to kill lice and ova</td>
<td>Until 24 hours after initiation of appropriate treatment</td>
<td>Apply pediculicides as directed on label. If live lice found after therapy, repeat. Head lice: Wash headgear, combs, pillow cases, towels with hot water or dry clean or seal in plastic bag and store for 10 days. Body lice: As above, for all exposed clothing and bedding.</td>
</tr>
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<td>Microorganism</td>
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</tr>
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</table>
| Listeriosis (Listeria monocytogenes)        | Fever, meningitis
Congenital or neonatal infection                                                  | Routine           | Foodborne          | Mother-to-fetus or newborn | Mean 21 days       |                           |                         | Health care associated outbreaks reported in newborn nurseries.          |
| Lyme disease (Borrelia burgdorferi)         | Fever, arthritis, rash, meningitis                                                     | Routine           | Tickborne          | Rash: 3-31 days            | Not person-to-person |                         |                         |                                                                          |
| Lymphocytic choriomeningitis virus          | Aseptic meningitis                                                                    | Routine           | Sexually transmitted | Variable                  |                   | Not person-to-person      |                         |                                                                          |
| Lymphogranuloma venereum (Chlamydia trachomatis) | Genital ulcers, inguinal adenopathy                                                  | Routine           | Sexually transmitted | Variable                  |                   | Not person-to-person      |                         | Acquired from contact with rodents.                                      |
| Malaria (Plasmodium sp.)                    | Fever                                                                                 | Routine           | Blood              | Mosquito-borne             | Variable           | Not normally person-to-person |                         | Can be transmitted via blood transfusion.                                |
| Marburg virus                               | Hemorrhagic fever
(Contact plus Airborne if pneumonia)                                                   | Contact plus Droplet; Blood and bloody body fluids; respiratory secretions | Direct and indirect contact; possibly airborne if pneumonia | 3-9 days       | Duration of virus shedding | Until symptoms resolve | Local public health authorities or regional officer of health and LCDC should be notified immediately. Refer to Canadian Contingency Plan for Viral Hemorrhagic Fevers and Other Related Diseases
Special handling of deceased body. |
### IC5:0300  Additional Precautions by Organism

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</tr>
</thead>
<tbody>
<tr>
<td>Measles (Rubeola)</td>
<td>Fever, coryza, maculopapular skin rash</td>
<td>Airborne</td>
<td>Respiratory</td>
<td>Airborne</td>
<td>7-18 days</td>
<td>5 days before onset of rash; duration of illness in immunocompromised patients</td>
<td>4 days after start of rash; until 4 days after onset of rash (longer in immunocompromised patients)</td>
<td>Only immune personnel and caretakers should enter the room. Immunoprophylaxis is indicated for susceptible contacts. Precautions should be taken with neonates born to mothers with measles infection at delivery.</td>
</tr>
<tr>
<td>Susceptible contact</td>
<td>Airborne</td>
<td>Airborne</td>
<td>Respiratory</td>
<td>Airborne</td>
<td>Potentially communicable during last 2 days of incubation period</td>
<td>From 5 days after first exposure through 21 days after last exposure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Melioidosis (Pseudomonas pseudomallei)</td>
<td>Pneumonia, fever</td>
<td>Routine</td>
<td>Variable</td>
<td>Unknown</td>
<td>Variable</td>
<td>Unknown</td>
<td>Organism in soil in South-East Asia. Rare cases of person-to-person transmission.</td>
<td></td>
</tr>
<tr>
<td>Meningococcus (Neisseria Meningitidis)</td>
<td>Meningococcalia, meningitis, pneumonia</td>
<td>Droplet</td>
<td>Respiratory</td>
<td>Large droplet, direct contact</td>
<td>Usually 2-10 days</td>
<td>Until 24 hours of effective therapy has been received</td>
<td>Until 24 hours of appropriate antibiotic therapy received</td>
<td>Close contacts may require chemoprophylaxis.</td>
</tr>
<tr>
<td>Methicillin resistant S. aureus (MRSA)</td>
<td>Infected or colonized secretions, excretions</td>
<td>Contact</td>
<td>Direct and</td>
<td>Variable</td>
<td>Variable</td>
<td>See IC6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Molluscum contagiosum</td>
<td>Umbilicated papules</td>
<td>Routine</td>
<td>Contents of papules</td>
<td>Direct contact</td>
<td>2 weeks to 6 months</td>
<td>Unknown</td>
<td>Requires intimate direct personal contact for transmission.</td>
<td></td>
</tr>
</tbody>
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<tbody>
<tr>
<td>Mucormycosis</td>
<td>Skin, wound, rhinocerebral infection</td>
<td>Routine</td>
<td></td>
<td>Unknown</td>
<td>Not person-to-person</td>
<td>Until 9 days after onset of swelling</td>
<td></td>
<td>Acquired from spores in dust, soil.</td>
</tr>
<tr>
<td>(phycomycosis; zygomycosis) (Mucor, Zygomycetes)</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td>Swelling of salivary glands, orchitis</td>
<td>Droplet</td>
<td>Saliva</td>
<td>Large droplets, direct contact</td>
<td>12-25 days</td>
<td>2 days before to 9 days after onset</td>
<td>Until 9 days after onset of swelling</td>
<td>Droplet precautions for exposed susceptible patients should begin 10 days after first contact and continue through 26 days after last exposure.</td>
</tr>
<tr>
<td>Mycobacterium non-tuberculosis (atypical) (Mycobacterium avium complex)</td>
<td>Lymphadenitis; pneumonia; disseminated disease in immunocompromised host</td>
<td>Routine</td>
<td></td>
<td>Unknown</td>
<td>Not person-to-person</td>
<td></td>
<td></td>
<td>Acquired from soil, water, animal, reservoirs.</td>
</tr>
</tbody>
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</tr>
</thead>
</table>
| Mycobacterium tuberculosis    | Confirmed or suspected pulmonary, laryngeal                 | Airborne*         | Respiratory        | Airborne              | Weeks to years      | While organisms in sputum | Until patient has received two weeks of effective therapy, is improving clinically, and has three consecutive negative sputum smears collected at least 24 hours apart. If multi-drug resistant tuberculosis, until culture negative | *Refer to Guidelines for Preventing the Transmission of Tuberculosis in Canadian Health Care Facilities and Other Institutional Settings
Tuberculosis in young children is rarely contagious
Assess visiting family members for cough.                                                                                                                                                                                                                     |
| (also Mycobacterium africanum, Mycobacterium bovis) |                                                              |                   |                    |                       |                   |                           |                                                                                         |                                                                                                                                                                                                  |
Avoid procedures that may generate aerosols from drainage.                                                                                                                                                                                                     |
|                               | PPD skin test positive with no evidence of current pulmonary disease | Routine           |                    |                       |                   |                           |                                                                                         |                                                                                                                                                                                                  |
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<tr>
<td>Mycoplasma pneumoniae</td>
<td>Pneumonia</td>
<td>ADULT: Routine</td>
<td>Respiratory</td>
<td>Large droplets, direct contact</td>
<td>1-4 weeks</td>
<td>Unknown</td>
<td>Duration of illness</td>
<td></td>
</tr>
<tr>
<td>Neisseria gonorrhoeae</td>
<td></td>
<td>See Gonococcus</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Neisseria Meningitidis</td>
<td></td>
<td>See Meningococcus</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Nocardiosis (Nocardia sp.)</td>
<td>Fever, pulmonary or</td>
<td>Routine</td>
<td></td>
<td></td>
<td>Unknown</td>
<td>Not person-to-person</td>
<td></td>
<td>Acquired from organisms in dust, soil.</td>
</tr>
<tr>
<td></td>
<td>CNS infection</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Norwalk agent</td>
<td>Skin lesions</td>
<td>Routine</td>
<td>Variable</td>
<td>Not person-to-person</td>
<td></td>
<td></td>
<td></td>
<td>Acquired from infected animals.</td>
</tr>
<tr>
<td></td>
<td>See Caliciviruses</td>
<td></td>
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<tr>
<td>Orf (poxvirus)</td>
<td></td>
<td></td>
<td>Variable</td>
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</tr>
<tr>
<td>Parainfluenza virus</td>
<td>Respiratory tract</td>
<td>ADULT: Routine</td>
<td>Respiratory</td>
<td>Direct and indirect contact, large droplets</td>
<td>2-6 days</td>
<td>1-3 weeks</td>
<td>Duration of illness</td>
<td>May cohort if infected with same virus. Minimize exposure of immunocompromised patients, children with chronic cardiac or lung disease, neonates.</td>
</tr>
<tr>
<td></td>
<td>infection</td>
<td>PAEDIATRIC: Contact and Droplet</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Parvovirus B-19</td>
<td>Erythema infectiosum</td>
<td>Fifth disease: Routine</td>
<td>Respiratory</td>
<td>Large droplets, direct contact</td>
<td>4-21 days</td>
<td>Fifth disease: no longer infectious by the time the rash appears</td>
<td>Aplastic crisis: see comments</td>
<td>For patients with transient aplastic or erythrocyte crisis, precautions should be maintained for 7 days. For immunosuppressed patients with chronic infection, maintain for duration of hospitalization.</td>
</tr>
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<td>Pediculosis</td>
<td></td>
<td></td>
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<tr>
<td>See lice</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Pertussis (Bordetella pertussis)</td>
<td>Whooping cough, non specific respiratory tract infection in infants</td>
<td>Droplet</td>
<td>Respiratory secretions</td>
<td>Large droplets</td>
<td>6-20 days</td>
<td>Up to 3 weeks after onset of paroxysms if not treated</td>
<td>Until 3 weeks after onset of paroxysms if not treated; or until 5 days of appropriate antibiotic therapy received</td>
<td>Close contacts may need chemoprophylaxis.</td>
</tr>
<tr>
<td>Phycomycosis</td>
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<td></td>
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<tr>
<td>See Mucormycosis</td>
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<td></td>
</tr>
<tr>
<td>Pinworms</td>
<td>Routine</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>See Enterobias</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Plague (Yersinia pestis)</td>
<td>Bubonic (lymphadenitis)</td>
<td>Routine</td>
<td></td>
<td></td>
<td>2-6 days</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumocystis carinii</td>
<td>Pneumonia in immunocompromised host</td>
<td>Routine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Ensure room-mates not immunocompromised.</td>
</tr>
</tbody>
</table>

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<tr>
<td>Poliomyelitis See Enterovirus</td>
<td>Flaccid paralysis</td>
<td>Contact</td>
<td>Feces, respiratory secretion</td>
<td>Direct and indirect contact</td>
<td>3-21 days</td>
<td>Duration of shedding up to 6 weeks</td>
<td>Until 6 weeks from onset of illness or feces culture negative</td>
<td>Close contacts who are not immune should receive immunoprophylaxis.</td>
</tr>
<tr>
<td>Pseudomonas cepacia See Burkholderia cepacia</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Psittacosis (Chlamydia psittaci) (ornithosis)</td>
<td>Pneumonia, fever</td>
<td>Routine</td>
<td></td>
<td></td>
<td>7-14 days</td>
<td>Not person-to-person</td>
<td></td>
<td>Acquired from contact with infected birds.</td>
</tr>
<tr>
<td>Q Fever (Coxiella burnetii)</td>
<td>Pneumonia, fever</td>
<td>Routine</td>
<td></td>
<td></td>
<td>14-39 days</td>
<td>Not person-to-person</td>
<td></td>
<td>Acquired from contact with infected animals or from raw milk.</td>
</tr>
<tr>
<td>Rabies</td>
<td>Rabies</td>
<td>Routine</td>
<td>Saliva</td>
<td>Mucosal or percutaneous exposure to saliva</td>
<td>5 days to several months</td>
<td>Person-to-person not documented</td>
<td></td>
<td>Acquired from contact with infected animals. Post-exposure prophylaxis recommended for percutaneous or mucosal contamination with saliva of rabid animal or patient.</td>
</tr>
<tr>
<td>Rat bite fever Streptobacillus moniliformis; Spirillum minus</td>
<td>Fever, arthralgia</td>
<td>Routine</td>
<td></td>
<td></td>
<td>S. moniliformis 3-21 days; S. minus 7-21 days</td>
<td>Not person-to-person</td>
<td></td>
<td>S. moniliformis: rats and other animals, contaminated milk. S. minus: rats, mice only.</td>
</tr>
</tbody>
</table>
### IC5:0300 Additional Precautions by Organism

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<tr>
<th>Microorganism</th>
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<th>Duration of precautions</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory syncytial virus (RSV)</td>
<td>Respiratory tract infection</td>
<td>ADULT: Routine</td>
<td>Respiratory</td>
<td>Direct and indirect contact, large</td>
<td>2-8 days</td>
<td>Until symptoms cease</td>
<td>Duration of symptoms</td>
<td>May cohort if infected with same virus. Minimize exposure of immunocompromised patients, children with chronic cardiac or lung disease, neonates.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PAEDIATRIC: Contact and Droplet</td>
<td>secretions</td>
<td>droplets</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rhinovirus</td>
<td>Respiratory tract infection, common cold</td>
<td>ADULT: Routine</td>
<td>Respiratory</td>
<td>Direct and indirect contact, possibly</td>
<td>2-3 days</td>
<td>Until symptoms cease</td>
<td>Duration of illness</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>PAEDIATRIC: Contact and Droplet</td>
<td>secretions</td>
<td>large droplets</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rickettsialpox</td>
<td>Fever, rash</td>
<td>Routine</td>
<td>Miteborne</td>
<td></td>
<td>9-14 days</td>
<td>Not person-to-person</td>
<td></td>
<td>Transmitted by mouse mites.</td>
</tr>
<tr>
<td>Rickettsia akari</td>
<td></td>
<td>Routine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ringworm</td>
<td></td>
<td>Routine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>See Tinea</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Rocky Mountain spotted fever</td>
<td>Fever, petechial rash, encephalitis</td>
<td>Routine</td>
<td>Tickborne</td>
<td></td>
<td>2-14 days</td>
<td>Not person-to-person</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rickettsia rickettsii</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Roseola Infantum</td>
<td>Rash, fever</td>
<td>Routine</td>
<td>Saliva (presumed)</td>
<td>Direct contact</td>
<td>9-10 days</td>
<td></td>
<td>Transmission requires intimate direct personal contact.</td>
<td></td>
</tr>
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<tbody>
<tr>
<td>Rotavirus</td>
<td>Diarrhea</td>
<td>ADULT: Routine* PAEDIATRIC: Contact</td>
<td>Feces</td>
<td>Direct and indirect contact</td>
<td>1-3 days</td>
<td>Duration of illness</td>
<td>Duration of illness, minimum of 7 days**</td>
<td>*Consider Contact precautions for incontinent adults if feces cannot be contained or for adults with poor hygiene who contaminate their environment. ** Prolonged fecal shedding may occur in immunocompromised patients after recovery; Contact precautions for duration of hospitalization may be justified.</td>
</tr>
<tr>
<td>Roundworm</td>
<td>See Ascariasis</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Rubella</td>
<td>Acquired</td>
<td>Fever, maculopapular rash</td>
<td>Droplet</td>
<td>Respiratory secretions</td>
<td>14-21 days</td>
<td>Few days before to 7 days after onset of rash</td>
<td>Until 7 days after onset of rash</td>
<td>Droplet precautions should be maintained for exposed susceptible patients for 7 days after first contact through to 21 days after last contact.</td>
</tr>
<tr>
<td>Rubella</td>
<td>Congenital</td>
<td>Congenital rubella syndrome</td>
<td>Droplet and contact</td>
<td>Respiratory secretions, urine</td>
<td>Direct and indirect contact; large droplets</td>
<td>Prolonged shedding in respiratory tract and urine; can be up to one year</td>
<td>Until one year of age, unless nasopharyngeal and urine cultures done after 3 months of age are negative</td>
<td></td>
</tr>
<tr>
<td>Rubeola</td>
<td>See Measles</td>
<td></td>
<td></td>
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<tbody>
<tr>
<td>Salmonella (including Salmonella typhi)</td>
<td>Diarrhea, enteric fever, typhoid fever</td>
<td>ADULT: Routine* PAEDIATRIC: Contact</td>
<td>Feces</td>
<td>Contact (fecal/oral), foodborne</td>
<td>Diarrhea: 6-72 hours; enteric fever: 3-60 days</td>
<td>Variable</td>
<td>Until normal feces</td>
<td>*Consider Contact precautions for incontinent adults if feces cannot be contained or for adults with poor hygiene who contaminate their environment.</td>
</tr>
<tr>
<td>Scabies (Sarcoptes scabiei)</td>
<td>Itchy skin rash</td>
<td>Contact*</td>
<td>Mite</td>
<td>Direct and indirect contact</td>
<td>4-6 weeks. If re-infected, 1-4 days.</td>
<td>Until 24 hours after initiation of appropriate therapy</td>
<td>Until 24 hours after initiation of appropriate therapy</td>
<td>*For extensive or Norwegian (crusted) scabies only. For typical scabies, use gloves and gown for direct patient contact only; otherwise, Routine. Apply scabicide as directed on label. Wash clothes and bedding in hot water, dry clean or seal in a plastic bag, and store for 1 week. Household contacts should be treated.</td>
</tr>
<tr>
<td>Schistosomiasis (bilharziasis) (Schistosoma sp.)</td>
<td>Diarrhea, fever, itchy rash Hepatospleno-megaly, hematuria</td>
<td>Routine</td>
<td>Unknown</td>
<td>Not person-to-person</td>
<td>Contact with larvae in contaminated water.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shigella</td>
<td>Diarrhea</td>
<td>ADULT: Routine* PAEDIATRIC: Contact</td>
<td>Feces</td>
<td>Direct and indirect contact (fecal/oral)</td>
<td>1-7 days</td>
<td>Usually 4 weeks if not treated</td>
<td>Until normal feces</td>
<td>*Consider Contact precautions for incontinent adults if feces cannot be contained or for adults with poor hygiene who contaminate their environment. Treatment with effective antibiotic shortens period of infectivity.</td>
</tr>
<tr>
<td>Shingles</td>
<td>See Herpes zoster</td>
<td></td>
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<tr>
<td>Small round-structured viruses See Caliciviruses</td>
<td>Skin lesions, disseminated</td>
<td>Routine</td>
<td></td>
<td></td>
<td>Variable</td>
<td>Not person-to-person</td>
<td></td>
<td>Acquired from spores in soil, on vegetation.</td>
</tr>
<tr>
<td>Sporotrichosis</td>
<td>Wound or burn infection, skin infection, impetigo, scalded skin syndrome (Ritters disease)</td>
<td>Minor: Routine Major: Contact</td>
<td>Drainage, skin exudates</td>
<td>Direct or indirect contact</td>
<td>Variable</td>
<td>As long as organism is in the exudate/drainage</td>
<td>Until drainage resolved or contained by dressings</td>
<td>Major = drainage not contained by dressings.</td>
</tr>
<tr>
<td>Staphylococcus aureus If methicillin-resistant, see ARO / MRO If vancomycin-resistant, see ARO / MRO</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumonia</td>
<td>Routine*</td>
<td>Possibly droplet</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>*Transmissibility and need for masks controversial. Consider mask for close contact until 24-48 hours of antibiotic received.</td>
<td></td>
</tr>
<tr>
<td>Toxic shock syndrome</td>
<td>Routine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Streptococcus gr A (Streptococcus pyogenes)</td>
<td>Wound or burn infection, skin infection, impetigo, cellulitis, necrotizing fasciitis, myositis, endometritis</td>
<td>Minor: Routine* Major: Contact*</td>
<td>Drainage, skin exudates</td>
<td>Direct and indirect contact</td>
<td>Variable</td>
<td>As long as organism is in the exudate/drainage</td>
<td>Until 24 hours of appropriate antibiotic therapy received</td>
<td>Major = drainage not contained by dressings. Chemoprophylaxis may be indicated for close contacts of patients with invasive disease or toxic shock syndrome (controversial). *Need for masks controversial. Consider using Droplet precautions for all patients with invasive disease until 24 hours of antibiotic received.</td>
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<tr>
<td><em>Streptococcus gr A</em> (Streptococcus pyogenes)</td>
<td>Pneumonia</td>
<td>ADULT: Routine PAEDIATRIC: Droplet</td>
<td>Respiratory secretions</td>
<td>Large droplets, direct contact</td>
<td>Variable</td>
<td></td>
<td></td>
<td>*Need for masks controversial. Consider using droplet precautions for all patients with invasive disease until 24 hours of antibiotic received.</td>
</tr>
<tr>
<td>Scarlet fever, pharyngitis</td>
<td></td>
<td>ADULT: Routine PAEDIATRIC: Droplet</td>
<td>Respiratory secretions</td>
<td>Large droplets</td>
<td>2-5 days</td>
<td>10-21 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toxic shock syndrome</td>
<td></td>
<td>Routine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Streptococcus gr B</em> (Streptococcus agalactiae)</td>
<td>Sepsis, meningitis</td>
<td>Routine</td>
<td></td>
<td></td>
<td>Variable</td>
<td></td>
<td></td>
<td>Normal flora.</td>
</tr>
<tr>
<td><em>Streptococcus pneumoniae</em></td>
<td>Multiple</td>
<td>Routine</td>
<td></td>
<td></td>
<td>Variable</td>
<td></td>
<td></td>
<td>Normal flora.</td>
</tr>
<tr>
<td>Strongyloides (Strongyloides stercoralis)</td>
<td>Usually asymptomatic</td>
<td>Routine</td>
<td>Larvae in feces</td>
<td>Unknown</td>
<td>Rarely transmitted person-to-person</td>
<td></td>
<td></td>
<td>Infective larvae in soil. May cause disseminated disease in immunocompromised patient.</td>
</tr>
<tr>
<td><em>Syphilis</em> (Treponema pallidum)</td>
<td>Genital, skin or mucosal lesions, disseminated disease</td>
<td>Routine</td>
<td>Genital secretions, lesion exudates</td>
<td>Sexual Mother-to-fetus or newborn</td>
<td>10-90 days</td>
<td></td>
<td></td>
<td>Requires intimate direct personal contact for transmission.</td>
</tr>
<tr>
<td>Tapeworm Taenia saginata, Taenia solium Diphyllobothrium latum</td>
<td>Usually asymptomatic</td>
<td>Routine</td>
<td>Foodborne</td>
<td>Variable</td>
<td>Not transmissible person-to-person</td>
<td></td>
<td></td>
<td>Consumption of larvae in raw or undercooked beef or pork or raw fish; larvae develop into adult tapeworms in gastrointestinal tract.</td>
</tr>
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<tr>
<td>Hymenolepsis nana</td>
<td></td>
<td></td>
<td>Ova in feces</td>
<td>Direct contact (fecal/oral)</td>
<td>2-4 weeks</td>
<td>While ova in feces</td>
<td></td>
<td>Acquired from spores in soil which germinate in wounds, devitalized tissue.</td>
</tr>
<tr>
<td>Tetanus Clostridium tetani</td>
<td>Tetanus</td>
<td>Routine</td>
<td></td>
<td></td>
<td>2 days – 2 months</td>
<td>Not person-to-person</td>
<td></td>
<td>May be acquired from animals, close person-to-person contact, shared combs, brushes, sheets.</td>
</tr>
<tr>
<td>Tinea (dermatophytes) Trichophyton</td>
<td>Ringworm, athletes foot, pityriasis versicolor</td>
<td>Routine</td>
<td>Organism in skin or hair</td>
<td>Direct contact</td>
<td>Unknown</td>
<td>While lesion present</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malassezia furfur</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Toxocariasis (Toxocara canis, Toxocara cati)</td>
<td>Fever, wheeze, rash, eosinophilia</td>
<td>Routine</td>
<td>Ova in dog/ cat feces</td>
<td>Unknown</td>
<td>Not person-to-person</td>
<td></td>
<td>Acquired from contact with dogs, cats.</td>
<td></td>
</tr>
<tr>
<td>Toxoplasmosis (Toxoplasma gondii)</td>
<td>Asymptomatic or fever, lymphadenopathy; retinitis, encephalitis in immuno-compromised host; congenital infection</td>
<td>Routine</td>
<td></td>
<td>7-21 days</td>
<td>Not person-to-person except mother-to-fetus</td>
<td></td>
<td>Acquired by contact with infected felines or soil contaminated by felines, consumption of raw meat, contaminated raw vegetables or contaminated water.</td>
<td></td>
</tr>
<tr>
<td>Trachoma</td>
<td></td>
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<tr>
<td>Trichinosis  (Trichinella spiralis)</td>
<td>Fever, rash, diarrhea</td>
<td>Routine</td>
<td></td>
<td></td>
<td>1-2 weeks</td>
<td>Not person-to-person</td>
<td></td>
<td>Acquired from consumption of infected meat.</td>
</tr>
<tr>
<td>Trichomoniasis (Trichomonas vaginalis)</td>
<td>Vaginitis</td>
<td>Routine</td>
<td></td>
<td>Sexually transmitted</td>
<td>4-28 days</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trichuriasis (whipworm) (Trichuris trichiura)</td>
<td>Abdominal pain, diarrhea</td>
<td>Routine</td>
<td></td>
<td>Unknown</td>
<td></td>
<td>Not person-to-person</td>
<td></td>
<td>Ova must hatch in soil to be infective.</td>
</tr>
<tr>
<td>Tuberculosis See Mycobacterium tuberculosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tularemia (Francisella tularensis)</td>
<td>Fever, lymphadenopathy, pneumonia</td>
<td>Routine</td>
<td></td>
<td></td>
<td>1-21 days</td>
<td>Not person-to-person</td>
<td></td>
<td>Acquired form contact with infected animals.</td>
</tr>
<tr>
<td>Typhoid / paratyphoid fever See Salmonella</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Typhus fever (Rickettsia typhi, Rickettsia prowazekii)</td>
<td>Fever, rash</td>
<td>Routine</td>
<td></td>
<td>Insectborne</td>
<td>6-14 days</td>
<td></td>
<td>Endemic – fleas. Epidemic – lice.</td>
<td></td>
</tr>
<tr>
<td>Vancomycin-resistant enterococcus (VRE)</td>
<td>Infection or colonization of any body site</td>
<td>Contact</td>
<td>Infected or colonized secretions, excretions</td>
<td>Direct and indirect contact</td>
<td>Variable</td>
<td>Duration of colonization</td>
<td>As directed by ICP</td>
<td>See IC6</td>
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<tr>
<td>Vancomycin-resistant Staphylococcus aureus (VRSA)</td>
<td>Infection or colonization of any body site</td>
<td>Contact</td>
<td>Infected or colonized secretions, excretions</td>
<td>Direct and indirect contact</td>
<td>Variable</td>
<td>Duration of colonization</td>
<td>As directed by ICP</td>
<td>Local public health authorities or regional officer of health and LCDC should be notified immediately. See IC6</td>
</tr>
<tr>
<td>Varicella/See Chickenpox</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vibrio parahaemolyticus</td>
<td>Diarrhea, wound infections</td>
<td>Routine</td>
<td>Foodborne</td>
<td>Diarrhea: 5-92 hours</td>
<td>Probably not person-to-person</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>West Nile Virus</td>
<td>Fever, headache, malaise, arthralgia or myalgia, occasionally nausea and vomiting, conjunctivitis, photophobia and rash.</td>
<td>Routine</td>
<td>Not person to person</td>
<td>Usually 1-3 days</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whipworm/See Trichuriasis</td>
<td></td>
<td></td>
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<tr>
<td>Whooping cough/See Pertussis</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Yersinia enterocolitica; Y. pseudo-tuberculosis</td>
<td>Diarrhea</td>
<td>ADULT: Routine* PAEDIATRIC: Contact</td>
<td>Feces</td>
<td>Direct and indirect contact, foodborne</td>
<td>1-14 days</td>
<td>Duration of excretion in stool</td>
<td>Until normal feces</td>
<td>*Consider Contact precautions for incontinent adults if feces cannot be contained or for adults with poor hygiene who contaminate their environment.</td>
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<tr>
<th>Microorganism</th>
<th>Clinical presentation</th>
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<th>Infective material</th>
<th>Route of transmission</th>
<th>Incubation period</th>
<th>Period of communicability</th>
<th>Duration of precautions</th>
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**REFERENCES:**


IC5:0400  Bed Selection for Additional Precautions

1.0  PRACTICE GUIDELINE

Selection of private rooms for isolation is based on risk of transmission. Patients known to be infected with the same organism may be cohorted. If beds are urgently needed, a patient requiring Contact or Droplet Precautions may be isolated in a multi-bed room until a private room is available. Consult Infection Prevention & Control when there is a conflict as to the greatest need for private room placement.

Priority 1: Patients requiring Airborne Precautions or Strict Precautions, e.g. Pulmonary Tuberculosis, Chickenpox or SARS.

Note: When negative pressure isolation measures cannot be instituted at the facility, procedures will be followed to transfer the patient to a facility with a negative pressure isolation room.

Priority 2: Patients requiring Contact and/or Droplet Precautions, e.g, Clostridium difficile, Meningitis, Pertussis, Influenza, MRSA infections

Note: The priority for a private room for diseases spread by the Contact or Droplet route will depend on the infectious agent, the presenting symptoms of the patient and the potential for environmental contamination

Priority 3:
- Patients with known MRSA and/or VRE colonization/infection with risk factors for transmission
- Patients with known MRSA and/or VRE colonization and do not have risk factors for transmission
- Patients who are being screened for MRSA and/or VRE and have risk factors for transmission
- Patients who are being screened for MRSA or VRE and do not have risk factors for transmission

Note: If there are no private rooms available, place the patient in a multi-bed room on Contact Precautions until a private room is available. Select room mates who are at low risk for acquiring MRSA or VRE, i.e. intact skin, no invasive devices.
IC5:0500 Airborne Precautions

1.0 PRACTICE GUIDELINE

Airborne Precautions are used for patients known or suspected to have diseases transmitted by inhalation of airborne particles. Examples of such diseases include but are not limited to:

- Red Measles
- Varicella (including disseminated zoster)
- Tuberculosis-pulmonary

Certain infections require more than one type of precaution. i.e Chickenpox (Airborne/Contact).

When negative pressure isolation measures cannot be instituted at the facility, procedures will be followed to transfer the patient to a facility with a negative pressure isolation room.

2.0 DEFINITION

Airborne transmission refers to dissemination by aerosolization. Organisms are contained in droplet nuclei (small airborne particles < 5 μm), that result from evaporation of large droplets that remain suspended in the air for long periods of time.

3.0 PROCEDURE

Room Setup

- Negative Pressure Isolation Room required. See: Negative Pressure Rooms (IC5:0600)
- Private room with negative air pressure (minimum 6 air exchanges per hour)
- Remove unnecessary equipment, furnishings and supplies from room
- Ensure room is equipped with appropriate supplies such as waterless antiseptic hand cleanser, gloves, dedicated stethoscope, dedicated BP cuff
- Place laundry hamper and waste containers within the room by the door if possible
- Place Airborne Precautions sign outside room on closed door

Door

- The door to the room and anteroom (if available) must remain closed except to enter and exit.
- Follow any posted directions to maintain negative pressure eg. open/closed bathroom door.
- The door should remain closed for approximately one hour after the discharge of a patient requiring Airborne precautions.
IC5:0500  Airborne Precautions

N95 respirator
- All individuals who enter the room must wear a N95 respirator.
- N95 respirators must be worn for all entries into the room and for one hour after the room has been vacated.
- N95 respirators are single use only and must be discarded after each use.
- The N95 respirator must be applied and removed in the hallway or in the anteroom if available
- For care of patients with Varicella, a N95 respirator is not required if the health care worker has known immunity.
- Health care workers must be fit tested annually for the N95 respirator. This is done by Workplace Health.

Eyewear
Follow Routine Practices.

Gloves
Follow Routine Practices.

Gowns
Follow Routine Practices.

Hand Hygiene
Before and after direct contact with patient and after touching contaminated articles.

Contaminated Equipment
Follow Routine Practices.

Patient Transport/Discharge
- Limit transport of patient to essential purposes only.
- Patient must wear procedure mask during transport.
- If patient is unable to wear mask ensure staff escorting or treating the patient do so.
- Patient must not be left in waiting area, but must go directly to diagnostic treatment area.
- Alert the receiving department/unit/facility of the patient’s isolation requirements at the time of booking an appointment and/or when arranging transport/transfer.
- The amount of time required for complete replacement of air in an isolation room depends on the number of air exchanges per hour. For example, a room with seven
Airborne Precautions

Air changes per hour would require 60 minutes for complete air exchange. Therefore, an individual entering such a room must wear an N95 respirator if entering the room within 60 minutes after the patient has left.

Healthcare Workers
- Ensure that anyone that is not immune to the disease is wearing an N95 respirator prior to entering the room.
- Whenever possible assign only immune staff to care for the patient with the disease in question. i.e. chickenpox

Visitors
- Visitors should wear N95 respirator

4.0 REFERENCES


1.0 PRACTICE GUIDELINE

All patients identified as requiring airborne precautions will be accommodated in a room under negative pressure relative to the hallway. All negative pressure rooms will be exhausted directly out-of-doors away from any air intake vents. In some locations, exhaust air may also be HEPA-filtered or passed by ultraviolet lights. When negative pressure is required, the door to the room and ante room shall remain closed except to enter and leave the room.

2.0 DEFINITIONS

In most areas of the hospital, air moves from patient care and procedure rooms into the hallway. Air may or may not be re-circulated within the building.

Patients suspected or known to have infections spread by the airborne route require accommodation in a negative pressure room. These infections include:

- *Mycobacterium tuberculosis* (pulmonary), both suspected and known cases.
- Chickenpox (Varicella)
- Measles (Rubeola)
- Disseminated Herpes Zoster
- SARS

3.0 PROCEDURE

- Admit patient to a negative pressure isolation room as soon as possible.
- Request Plant Services to verify the ventilation status of negative pressure room.
- Plant Services will verify ventilation status of negative pressure room every 6 months.

Follow any instructions posted including:

- silencing and resetting the alarm
- directions for adjusting dials (used to open exhaust vents)
- special instructions regarding the bathroom door
- closing windows
- keeping the door to the room closed
- When a negative pressure room is unavailable at the facility, arrangements are to be made for transferring patients with suspected or known airborne spread diseases to a facility with an available negative pressure room.

**Note:** The amount of time required for complete replacement of air in an isolation room depends on the number of air exchanges per hour. For example, a room with seven
IC5:0600  Negative Pressure Rooms

Air changes per hour would require 60 minutes for complete air exchange. Therefore, an individual entering such a room within 60 minutes after the patient has left, must wear an N95 respirator.

4.0 REFERENCES


Droplet Precautions are used for patients known or suspected to have disease transmitted by large particle droplets of sputum or mucous which do not remain suspended in the air. Examples of such disease include but are not limited to:

- Invasive Haemophilus influenzae type B disease in infants and young children, including: meningitis, pneumonia, epiglottitis, and sepsis
- Invasive Meningococcal disease, including: meningitis, pneumonia, sepsis and conjunctivitis
- Pertussis
- Streptococcal pharyngitis, pneumonia, or scarlet fever in infants and young children
- Mumps
- Rubella (German Measles)

Certain infections require more than one type of precaution eg Influenza (Droplet/Contact)

Droplet transmission is a form of contact transmission, and refers to large droplets, > 5μm in diameter, generated from the respiratory tract of the source patient during coughing, sneezing, or during procedures such as suctioning or bronchoscopy. These droplets are propelled for a short distance (<1 metre) through the air and deposited on the nasal, oral mucosa, or conjunctiva of another person.

Room Setup
- A single room is preferred.
- When unavailable, place patient in a multi-bed room and maintain a distance of at least one metre between patients.
- Remove unnecessary equipment, furnishings and supplies from room
- Ensure room is equipped with appropriate supplies such as waterless antiseptic hand cleanser, gloves, dedicated stethoscope, dedicated BP cuff
- Place laundry hamper and waste containers within the room by the door if possible

Door
May remain open.

Procedure Mask
Procedure mask must be worn when within one metre of patient.
IC5:0700 Droplet Precautions

Eyewear
Protective eyewear or a face shield must be worn when within one metre of patient.

Gloves
Follow Routine Practices.

Gown
Follow Routine Practices.

Hand Hygiene
- Before and after direct contact with patient and after touching contaminated articles.
- After removal of personal protective equipment.

Contaminated Equipment
Follow Routine Practices.

Patient Transport/Discharge
- Limit transport of patient to essential purposes only.
- Patient must wear procedure mask during transport.
- If patient is unable to wear mask, ensure staff transporting or treating patient do so.
- Patient must not be left in waiting area, but must go directly to diagnostic treatment area.
- Alert the receiving department/unit/facility of the patient’s isolation requirements at the time of booking an appointment and/or when arranging transport/transfer.

Health care Workers
- Whenever possible assign only immune staff to care for the patient with the disease in question.
- A mask is not needed if the health care worker has immunity to rubella or mumps when caring for a patient with those respective diseases.

4.0 REFERENCES


Contact Precautions are used for patients known or suspected to have disease transmitted by direct patient contact or by contact with items in the patient’s environment. Examples of such diseases include but are not limited to:

- Antibiotic Resistant Organisms (AROs)
- *Clostridium difficile*
- Undiagnosed diarrhea
- Undiagnosed major draining wound

Direct contact transmission occurs when transfer of microorganisms results from direct contact between an infected or colonized individual and a susceptible host.

Indirect contact involves passive transfer of microorganisms to a susceptible host by an intermediate object such as contaminated hands, contaminated instruments, or inanimate objects in the patient’s immediate environment.

**Room Setup**

- A private room is preferred.
- Remove unnecessary equipment, furnishings and supplies from room
- Ensure room is equipped with appropriate supplies such as waterless antiseptic hand cleanser, gloves, dedicated stethoscope, dedicated BP cuff
- Place laundry hamper and waste containers within the room by the door if possible
- Patients with the same infection may be cohorted, or may be cared for in rooms shared with appropriately selected roommates.
- When sharing a room with non-infected patients, ensure ability to delineate the boundary of the potentially contaminated patient area, risks from sharing of sinks and toilets, and controls on the activities of the room-mates and their visitors. Consult Infection Prevention & Control.

**Door**

May remain open.

**Procedure Mask**

Follow Routine Practices.
IC5:0800  Contact Precautions

Eyewear
Follow Routine Practices.

Gloves
- Wear gloves for all patient contact and/or contact with the patient’s environment.
- Change gloves immediately after contact with body substances or secretions.
- Remove gloves before leaving patient room or bed space.

Gown
- Wear gown if it is anticipated that your clothing or forearms will have direct contact with the patient, environmental surfaces, or items in the room.
- Remove gown before leaving patient room or bed space.

Hand Hygiene
- Before and after providing care, after removing gloves, and after touching contaminated articles.
- After removal of personal protective equipment.

Contaminated Equipment
Dedicate equipment for patient care or clean with disinfectant before removing from patient room or bed space.

Patient Transport/Discharge
- Limit transport of patient to essential purposes only.
- Patient must not be left in waiting area, but must go directly to diagnostic treatment section.
- Alert the receiving department/unit/facility of the patient’s isolation requirements at the time of booking an appointment and/or when arranging transport/transfer.

4.0 REFERENCES

1.0 PRACTICE GUIDELINE

Droplet/Contact Precautions are used for patients known or suspected to have diseases transmitted by both direct and indirect contact, as well as respiratory secretions. Examples of such diseases include but are not limited to:

- Paediatric patients:
  - Viral respiratory disease including bronchiolitis, pneumonia, croup, and RSV
- Adults and Children:
  - Influenza
  - Noro Virus

2.0 DEFINITIONS

Contact Transmission

- Direct contact transmission occurs when transfer of microorganisms results from direct contact between an infected or colonized individual and a susceptible host.
- Indirect contact involves passive transfer of microorganisms to a susceptible host by an intermediate object such as contaminated hands, contaminated instruments, or inanimate objects in the patient’s immediate environment.

Droplet Transmission

- Droplet transmission is a form of contact transmission, and refers to large droplets > 5μm in diameter, generated from the respiratory tract of the source patient during coughing, sneezing, or during procedures such as suctioning or bronchoscopy.
- These droplets are propelled for a short distance (<1 metre) through the air and deposited on the nasal, oral mucosa, or conjunctiva of another person.

3.0 PROCEDURE

Room Setup

- A single room is preferred, when unavailable, place patient in a multi-bed room and maintain a distance of at least one metre between patients.
- Remove unnecessary equipment, furnishings and supplies from room
- Ensure room is equipped with appropriate supplies such as waterless antiseptic hand cleanser, gloves, dedicated stethoscope, dedicated BP cuff
- Place laundry hamper and waste containers within the room by the door if possible

Door

May remain open.
IC5:0900  Droplet/Contact Precautions

Procedure Mask
Procedure mask worn when within one metre of patient.

Eyewear
Protective eyewear or a face shield must be worn when within one metre of patient.

Gloves
- Wear gloves for all patient contact and/or contact with the patient’s environment.
- Change gloves after contact with body substances or secretions.
- Remove gloves before leaving patient room or bed space.

Gown
- Wear gown if it is anticipated that your clothing or forearms will have direct contact with the patient, environmental surfaces, or items in the room.
- Remove gown before leaving patient room or bed space.

Hand Hygiene
- Before and after providing care, after removing gloves, and after touching contaminated articles.
- After removal of personal protective equipment.

Contaminated Equipment
Dedicate equipment for patient care, or clean with disinfectant before removing from patient room or bed space.

Patient Transport/Discharge
- Limit transport of patient to essential purposes only.
- Patient must wear procedure mask during transport.
- If patient is unable to wear mask ensure staff transporting or treating patient do so.
- Patient must not be left in waiting area, but must go directly to diagnostic treatment section.
- Alert the receiving department/unit/facility of the patient’s isolation requirements at the time of booking an appointment and/or when arranging transport/transfer.

4.0 REFERENCES

IC5:1000  Strict Precautions

1.0  PRACTICE GUIDELINE

Strict Precautions are used for patients with undiagnosed severe respiratory symptoms with a travel history or close contact with a symptomatic person from an identified zone of emergence or reemergence of Severe Acute Respiratory Syndrome (SARS) or a novel influenza virus such as Avian Influenza H5N1 within a specified time frame.

These are supplementary or extraordinary infection control techniques.

2.0  PROCEDURE

General Directives for All Health Care Workers

Staff Self Monitoring

- Primary care staff who provide ongoing care to patients admitted for probable Severe Acute Respiratory Syndrome (SARS) or other severe respiratory illness of potential public health concern must monitor themselves for symptoms of severe respiratory illness on a daily basis before coming to work. This must include a daily temperature before coming to work.
- Staff with a febrile respiratory illness or those who become unwell during a shift, should immediately notify their supervisor or designate and follow up with Workplace Health during regular business hours.
- Staff who develop any symptoms will be instructed to stay at home and contact Workplace Health. Upon arriving at work, staff should also have their temperature taken at the beginning of each shift and should be queried regarding symptoms.
- Monitoring should continue until ten days after the last contact with the patient.

Hand Hygiene

- Alcohol hand cleanser may be used in place of soap and water for hand hygiene if hands are not visibly soiled.
- Hand hygiene should not be done in the patient washroom. If the patient washroom must be used for hand hygiene, avoid contamination of hands from contaminated surfaces or objects.
- All staff must perform hand hygiene before performing invasive procedures, feeding patients or preparing, handling, serving or eating food, before and after direct contact with a patient, after contact with body fluids or items known or likely to be contaminated with body fluids, and after removing gloves and other protective equipment.
Personal Protective Equipment (PPE)

- Everyone must wear the following Personal Protective Equipment (PPE): N95 respirator, goggles or eye/face shield, gloves and gown before entering the room.
- An eye/face shield is sufficient protection in situations where aerosolization is not anticipated.
- Goggles and full face shield must be worn when performing high risk aerosol generating procedures.
- Staff who are required to wear an N95 respirator for isolation must be fit-tested by a certified fit-tester (Workplace Health and/or site designated staff) prior to working in these areas.
- N95 respirators are to be discarded after one use in direct care situations. They can be worn for up to 4 hours in non-direct care situations unless soiled, wet or crushed.
- Powered Air Purifying Respirators (PAPRs) shall be used by health care workers for close encounters with patients with probable or confirmed SARS or highly pathogenic novel influenza viruses where visualization is critical, such as intubations and bronchoscopies.
- PAPRs are also indicated for an individual who has failed all N95 respirator fittings.
- Aerosol generating respiratory procedures should be limited to those deemed absolutely medically essential.

Room Setup

- Private room with negative air pressure (minimum 6 air exchanges per hour).
- Remove unnecessary equipment, furnishings and supplies from room.
- Ensure room is equipped with appropriate supplies such as waterless antiseptic hand cleanser, gloves, dedicated stethoscope, dedicated BP cuff.
- Place laundry hamper and waste containers within the room by the door if possible.

Donning and Doffing PPE

- See IC5:1000 Appendix A “Donning and Doffing Personal Protective Equipment (PPE)”

Before Entering the Patient Room

- Perform hand hygiene.
- Apply a long sleeved gown.
- Wear moisture resistant isolation gown if there is potential for moist contamination.
- Wear regular isolation gown if contact does not involve potential for moist contamination.
- Apply N95 respirator.
- Apply goggles and/or eye/face shield. Note: Goggles and full face shield must be worn when performing high risk aerosol generating procedures e.g. sputum induction, uncontrolled intubation, use of nebulizer.
- An eye/face shield is sufficient protection in situations where aerosolization is not anticipated.
IC5:1000  Strict Precautions

- Apply one pair of non-sterile medical examination gloves (gloves should cover the sleeve cuff of gown)
- While in the Patient Room:
  - Do not touch your face. Prevent the risk of facial contamination.
  - If gloves become visibly soiled during care, remove and perform hand hygiene and replace with new gloves.

To exit the Patient Room
- Remove and dispose of gloves and gown while in the room.
- Perform hand hygiene
- Use paper towel to exit to hallway (or anteroom if present).
- If eyewear is to be reused, apply gloves to remove eyewear and then disinfect. Remove gloves.
- Perform hand hygiene.
- If eyewear is disposable, remove and dispose of eyewear.
- Perform hand hygiene.
- Remove N95 respirator carefully using straps (prevent contaminating face).
- Perform hand hygiene.
- Use paper towel to exit anteroom (if present).

Patient Care Equipment
- Refer to Section IC4:0900 Reprocessing Contaminated Equipment & Devices
- All patient care equipment must be cleaned following the Health Canada recommendations published in Infection Control Guidelines Hand Washing, Cleaning, Disinfection and Sterilization in Health Care (1999)
- Soiled patient care equipment should be handled in a manner that prevents exposure of skin and mucous membranes, and contamination of clothing and the environment
- Equipment that is visibly soiled should be cleaned promptly with soap and water, detergents or enzymatic cleaners
- Disposable equipment should be used as much as possible (e.g. thermometer)
- Empty bed pans and urinals by carefully pouring and rinsing contents into toilet. Avoid aerosol generation and do not clean using hoses or hoppers

Dishes/Linen/Waste Handling
- Routine Practices should be applied when handling dishes, linen and waste
- Disposable dishes are not required.
- Dishes should be returned directly to food services
- Linen should be transported from the patient's room in closed laundry bags. Wet items must be contained
- Double bagging is not required
IC5:1000 Strict Precautions

Visitors
- Restrict visitors. Allow only for compassionate reasons
- Instruct visitors re: nature of illness and reason for infection prevention & control precautions
- Visitors to wear the same PPE as recommended for health care workers
- Provide instruction in the appropriate use of PPE and hand hygiene

Patient Transport/Discharge
- Patients should be out of their rooms for essential purposes only
- Patients should wear procedure mask during transport
- If unable to keep mask on child, use tissue to cover the child’s nose and mouth. An isolette can be used for infant transport
- Notify receiving area prior to transport
- Transport personnel should wear an N95 respirator, eye protection, gown and gloves and remove all PPE on completion of transport
- Choose the shortest and least populated route for transport within a facility. Use a dedicated elevator
- Alert the receiving department/unit/facility of the patient’s isolation requirements at the time of booking an appointment and/or when arranging transport/transfer.
- The amount of time required for complete replacement of air in an isolation room depends on the number of air exchanges per hour. For example, a room with seven air changes per hour would require 60 minutes for complete air exchange. Therefore, an individual must wear an N95 respirator if entering such a room within 60 minutes after the patient has left.

3.0 REFERENCES


Before Entering the Patient Room:
- Perform hand hygiene.
- Apply gown
- Apply N95 respirator
- Apply protective eyewear
- Apply one pair of non-sterile medical examination gloves (gloves should cover the sleeve cuff of gown)

Before exiting the Patient Room:
- Remove gloves and gown
- Perform hand hygiene

Use paper towel to exit to hallway (or anteroom if provided):
- If eyewear is to be reused:
  - Apply gloves to remove eyewear and then disinfect.
  - Remove gloves.
- Perform hand hygiene.
- If eyewear is disposable:
  - Remove and dispose of eyewear.
- Perform hand hygiene.
- Remove N95 respirator
- Perform hand hygiene.
- Use paper towel to exit anteroom (if present).
IC5:1100  Immunocompromised Patients

1.0 PRACTICE GUIDELINE

Immunocompromised patients will be treated in a manner to prevent infections from endogenous and exogenous sources. Severely immunocompromised patients are preferably placed in a private room. The decision to place a patient in a private room due to an immunocompromised condition should be made by the attending physician in consultation with Infection Prevention & Control. Immunocompromised patients are managed by Routine Practices. Protective equipment such as gowns, gloves and masks are not indicated beyond what is used for Routine Practices. Protective Environment designed rooms are not currently available at any site in Fraser Health.

2.0 DEFINITIONS

- Immunocompromised patients: Those patients who have neutropenia (absolute neutrophil count < 500 cells/mm³), leukemia, lymphoma, HIV with CD4 count < 200, or patients on cytotoxic chemotherapy or high dose steroids (i.e. > 40mg of Prednisone or its equivalent: >160mg hydrocortisone/day).
- Severely Immunocompromised: Immunocompromised patients who are identified as high-risk patients have the greatest risk for infection and include persons with severe neutropenia (i.e., absolute neutrophil count of < 500 cells/mm³ for > 1 week), recipients of allogeneic hemopoietic stem-cell transplant (HSCT), and those who receive the most intensive chemotherapy such as patients with childhood myelogenous leukemia.
- Protective Environment: Rooms designed to prevent acquisition of infections from the environment are recommended for patients who are recipients of allogeneic hemopoietic stem-cell transplants (HSCT). These rooms have special environmental controls such as HEPA filtration of incoming air, directed room airflow and positive room air pressure relative to the corridor.
IC5:1100 Immunocompromised Patients

3.0 PROCEDURE

- Ensure meticulous attention to hand hygiene before giving care and between tasks
- Consistently follow Routine Practices for all immunocompromised patients
- Post a reminder sign advising visitors not to enter if ill or potentially infectious (IC5:1100 Appendix A)
- Minimize exposure to other patients with transmissible infections
- Schedule appointments when traffic is at a minimum and avoid long waits in other departments
- A private room is preferred for patients who are severely immunocompromised
- Do not accommodate a severely immunocompromised patient in a room under negative pressure unless they have a co-existing communicable disease requiring Airborne Precautions
- Staff and visitors with infections should not enter room
- Educate patient on hand hygiene and provide with a personal waterless hand antiseptic
- Fresh or dried flowers, potted plants and animals are not allowed in the room of patients who are severely immunocompromised
- Bottled water may be requested.
- Bottled water is provided by Food and Nutrition Services and must meet a recommended standard established by Fraser Health Environmental Health Services

4.0 REFERENCES


IC5:1200 Initiating and Discontinuing Additional Precautions

1.0 PRACTICE GUIDELINE

Additional Precautions are initiated and maintained when a patient is suspected of or diagnosed with an infectious process requiring isolation precautions in addition to Routine Practices.

Additional Precautions will be discontinued when the risk of transmission no longer exists.

2.0 PROCEDURES

Initiating Additional Precautions
Determine the category of precautions required. See Selection of Additional Precautions by Clinical Presentations (IC5:0200) or Selection of Additional Precautions by Organism (IC5:0300).

Ensure the patient is accommodated in a room appropriate for the precautions and post the appropriate isolation sign.
Document initiation and purpose of precautions in the patient kardex and health record.
Provide educational material to the patient where available.

Educate patient and family on the following:
- what to expect of staff
- duration of precautions
- activity restrictions
- visitor restrictions
- hand hygiene

Isolation Room Preparation
Remove unnecessary equipment
- Determine what equipment needs to be in the room, example: stethoscope, thermometer, I.V. pole, linen and garbage containers
- Assemble required equipment
- Ensure isolation cart/supply cupboard is properly stocked. Supplies/equipment may include the following:
  - alcohol hand sanitizer
  - gowns
  - gloves
  - procedure mask and/or N95 respirator
  - eyewear/face shield
  - disposable thermometers
  - disinfectant wipes
IC5:1200  Initiating and Discontinuing Additional Precautions

**Signage**
Post appropriate isolation precaution sign on closed door (for Airborne, Strict) or on door frame (for Contact, Droplet)

**Discontinuing Additional Precautions**
- Document in the patient kardex and health record when the precautions are discontinued
- Call Housekeeping for “Isolation-Discharge Clean” if required. For example when Contact Precautions are discontinued

**Airborne Precautions**
Airborne Precautions must be maintained when entering the room for one hour after discharge of patient.

**Contact and Droplet Precautions**
- Label and place medications kept in the patient’s room in a clear plastic bag and transport to pharmacy for disposal.
- Discard the top two items and leave the remaining disposable patient care items if these are in a secure container which can be cleaned. Eg paper towels, gloves, blue pads.
- Request an “Isolation-Discharge Clean” when the patient is discharged before a definitive diagnosis has been made.
- Notify Housekeeping that a double “Isolation-Discharge Clean” is required after discharge of a VRE positive patient.
IC5:1300 Patient Transport/Transfer

1.0 PRACTICE GUIDELINE

Patients on Additional Precautions should leave their room for essential purposes only and shall be transported in a manner that limits the potential transmission of infection to others.

2.0 PROCEDURE

- Alert the receiving department/unit/facility of the patient’s isolation requirements at the time of booking an appointment or when arranging transport/transfer.
- Determine if procedure can be done in patient’s room.
- Schedule the patient to allow for minimum contact with the public during transit and to avoid waiting in holding areas.
- Schedule the patient’s appointment in the diagnostic/treatment area to allow for equipment to be cleaned following the procedure, e.g. for “Contact Precautions”.
- Ensure that the person transporting the patient is aware of the isolation precautions.

Airborne Precautions and Droplet Precautions
- Patient to wear a procedure mask during transport if able to tolerate.
- Staff escorting or treating the patient must wear appropriate facial protection.

Contact and Droplet/Contact Precautions
- Drape a clean sheet over stretcher/wheelchair, covering rails, armrests and handles
- Do not transport patient in their own bed unless unavoidable
- Staff to wear clean gown and gloves
- Patient to perform hand hygiene and wear clean patient gown or outer clothing
- Patient to wear a procedure mask if they have a productive cough
- Transfer patient to wheelchair or stretcher, cover patient with clean sheet
- Avoid touching wheelchair handles, stretcher bumpers and side rails with contaminated gloves
- Before leaving room, transport personnel are to remove their contaminated isolation gown, gloves and perform hand hygiene
- Obtain chart, if required, ensure chart is not contaminated by patient handling
- Take clean gown and gloves if expected to help transfer patient in diagnostic area
- Transport patient in an empty elevator whenever possible
- Notify receiving unit of patient’s arrival
- Repeat procedure when patient is returned to unit
- Place a Contact Precautions sign on used stretcher or wheelchair and notify Housekeeping that cleaning is required
- Ensure stretcher/wheelchair and transfer board are cleaned prior to reuse
IC5:1300 Patient Transport/Transfer

4.0 REFERENCES


BC Centre for Disease Control. (May 2001). *British Columbia Guidelines for Control of Antibiotic Resistant Organisms (ARO’s).*

IC5:1400  Patient Discharge with Communicable Disease

1.0  PRACTICE GUIDELINE

Measures will be taken to limit the potential transmission of infection to at-risk members of the community when patients with communicable diseases are discharged into the community. For patients with reportable communicable illnesses, the local Public Health Unit shall be notified as soon as possible of the patient’s illness and be involved in discharge planning, where applicable.

2.0  PROCEDURE

Patient and Family Education
Patient and family education will be provided to all patients regarding the type of infection, the mode of transmission and measures to prevent close contacts from becoming infected

Notifying Other Agencies/Facilities
When a patient is discharged to the care of another facility/agency, the receiving facility must be informed of the patient’s infection and isolation requirements prior to transport.
1.0 PRACTICE GUIDELINE

To limit the potential transmission of infection within the hospital and community, visitor restrictions shall be applied to patients requiring Additional Precautions:

- Visitor will be restricted to two at a time.
- Children under 12 years of age are discouraged from visiting patients on isolation unless there are exceptional circumstances.

2.0 PROCEDURE

- Post signage directing visitors to speak to the nurse before entering the isolation room.
- Instruct visitors about hand hygiene and the use of appropriate protective attire.
- Provide visitors with fact sheets appropriate to specific infectious disease

Note: If visitors are non-compliant with isolation measures and contamination of the environment poses a risk of transmission to other patients, the designated security service for the hospital may be contacted to escort the visitor from the building.
Section IC6:
ANTIBIOTIC RESISTANT ORGANISMS (AROs)
IC6:0100  ARO Screening, Isolation and Specimen Collection

1.0 PRACTICE GUIDELINE

All admitted patients will be assessed for Antibiotic Resistant Organisms (AROs) screening using the guidelines below.

MRSA Screening is required for:
- All patients who have been in a health care facility for greater than 48 hours in the past three months
- All patients identified as an MRSA contact

VRE Screening is required for:
- All patients who have been in a health care facility for greater than 48 hours in the past three months
- All patients identified as a VRE contact

Screening may not be required for those patients re-admitted to the same facility unless identified as a contact or directed to do so by Infection Prevention & Control.

All patients known to be colonized/infected with MRSA and/or VRE will be placed on Contact precautions on admission.

Contact precautions may be discontinued at the discretion of Infection Prevention & Control.
### Isolation Precautions and Accommodation Requirements

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Contact Precautions (Yes/No)</th>
<th>Private Room/Cohort (Yes/Preferred/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients with known MRSA infection</td>
<td>Yes</td>
<td>Yes *</td>
</tr>
<tr>
<td>Patients with known MRSA and/or VRE colonization who have risk factors for transmission</td>
<td>Yes</td>
<td>Preferred</td>
</tr>
<tr>
<td>Patients with known MRSA and/or VRE colonization and do not have risk factors for transmission</td>
<td>Yes</td>
<td>Preferred</td>
</tr>
<tr>
<td>Patients who are being screened for MRSA and/or VRE and have risk factors for transmission</td>
<td>Yes</td>
<td>Preferred</td>
</tr>
<tr>
<td>Patients who are being screened for MRSA or VRE and do not have risk factors for transmission</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

* If there are no private rooms available, place the patient in a multi bed room on Contact Precautions until a private room is available. Cohorting is an option for patients colonized/infected with the same organism.

Accommodation for patients with VRE infection will be assessed on an individual basis by Infection Control.

Patients who develop risk factors for transmission of MRSA or VRE must be reassessed for accommodation and Contact Precautions.

### 2.0 DEFINITIONS

**Screening:** Refers to assessing admitted patient’s history of greater than 48 hour stay at a health care facility in the past 3 months, assessing for risk factors and testing for the presence of antibiotic resistant organisms.

**Facility:** Includes acute care, residential care and in-patient rehabilitation centers.

**Risk factors for transmission of MRSA include the following:**
- Open draining wounds
- Ostomies
- Productive cough
- Desquamating skin conditions
- Drains
Risk factors for transmission of VRE include the following:
- Diarrhea
- Open draining wounds
- Ostomies

Contact: a patient identified as being exposed to a known MRSA or VRE positive patient for greater than 48 hours during a current or previous admission.
- If exposed on current admission – screening will occur at a minimum of 48 hours from the initial exposure and will be repeated in one week if the patient is still in the hospital.
- If exposed on previous admission – screen on re-admission only.

3.0 PROCEDURE
- Determine the screening requirements.
- Initiate any isolation requirements.
- Explain the specimen collection procedure to patient. A handout is available.

Materials Required:
- standard sterile culture swabs with transport media
- sterile saline or sterile water without preservative

MRSA Screening - Specimens required include:
- anterior nares (swab both nares with one sterile swab)
- groins (swab both groins with one sterile swab)
- combined neck/groin swab for neonates (0-3 months)
AND ANY TWO of the following if present;
- open, draining wounds
- ostomy sites
- invasive device sites such as tubes, drains, catheters
- sputum (if productive cough)

Order Entry/Requisition(s):
- indicate specific source of specimen
- specify as an "MRSA Screen". Do not send as a routine culture.
IC6:0100  ARO Screening, Isolation and Specimen Collection

VRE Screening - Specimens required include:
- rectal, perianal, colostomy or ileostomy
- perianal swab to be taken instead of rectal swab for patients with the following conditions:
  - Acute coronary condition
  - Neutropenia (neutrophil count <0.7 x 10^9/L)

Order Entry / Requisition(s)
- indicate specific source of specimen
- specify as a “VRE Screen”. Do not send as a routine culture

Procedure for Rectal Swab
- patient to lie on side with legs flexed at hip
- spread buttocks to expose anus
- swab may be lubricated with a small amount of sterile water or saline
- insert swab 2 to 3 cm in adults or 1 cm in infants. Do not introduce swab too far due to risk of perforating rectal mucosa
- gently rotate swab
- place swab in transport media, label, and forward to laboratory with completed order entry / requisition(s)

Procedure for Perianal Swab
- patient to lie on side with legs flexed at hip
- spread buttocks to expose anus
- swab may be lubricated with a small amount of sterile water or saline
- gently rotate the swab around the anus to obtain specimen
- place swab in transport media, label, and forward to laboratory with completed order entry/requisition(s)
4.0 REFERENCES


BC Centre for Disease Control. (May 2001). *British Columbia Guidelines for Control of Antibiotic Resistant Organisms (AROs).*

IC6:0200  ARO Contact Precautions

1.0 PRACTICE GUIDELINE

Contact Precautions will be applied for
- Patients who are known to be infected or colonized with an ARO
- Patients identified as requiring MRSA or VRE screening and have risk factors for MRSA or VRE transmission

Antibiotic resistant organisms (AROs) include but are not limited to:
- Methicillin-resistant *Staphylococcus aureus* (MRSA)
- Vancomycin-resistant Enterococcus (VRE)

Infection Prevention & Control may expand this practice guideline at their discretion during outbreak situations.

2.0 DEFINITIONS

For definitions of risk factors for transmission of MRSA and VRE see IC6:0100.

3.0 PROCEDURE

Room Placement
- See ARO Screening, Isolation and Specimen Collection (IC6:0100).
- Patients with known MRSA infection – a private room is recommended.
  The door may remain open unless patient has a desquamating skin condition.
- Patients with MRSA may be cohorted (roomed) with other patients with MRSA.
- Patients with VRE may be cohorted (roomed) with other patients with VRE.
- Patients colonized with MRSA only OR VRE only *should not* be roomed with patients who are colonized with both MRSA and VRE.

Signage
- Place Contact Precautions sign on the door frame or wall beside the entrance to room.
- If patient is in a multi-bed room place a second sign at bedside.

Specimens
- See ARO Screening, Isolation and Specimen Collection (IC6:0100).
IC6:0200 ARO Contact Precautions

Hand Hygiene
- All health care workers, volunteers and visitors shall perform hand hygiene before entry and upon leaving the patient room.
- Alcohol hand sanitizer may be used, provided hands are not visibly soiled and the patient does not have infectious gastroenteritis.
- Visibly soiled hands must be washed either by using an antimicrobial soap containing 2% chlorhexidine gluconate or with plain soap and water followed by alcohol hand sanitizer.
- Do not re-contaminate hands prior to leaving the room.

Gloves
- All personnel must wear gloves for direct contact with the patient, the patient’s equipment, furniture, or personal care items.
- Remove gloves and wash hands before leaving the patient’s environment and before contact with any other patient or surface.

Gowns
- Full-length long sleeve gowns must be worn for all direct contact with the patient, body fluids, or furniture and equipment in the room.
- Gowns are to be used only once and then discarded before leaving the patient’s environment.

Procedure Mask/Protective Eyewear
Procedure mask and protective eyewear are required as per Routine Practices, such as when in close contact with a patient who has a productive cough or is undergoing a procedure that could generate droplets.

Patient Care Equipment
Prior to admitting an ARO positive patient into a room, remove all unnecessary equipment and supplies. Necessary equipment e.g. transfer belt, sling and patient care items must be dedicated for the patient’s exclusive use.

Shared equipment must be cleaned with a hospital-approved disinfectant before being used on another patient.

Equipment Cleaning
Avoid setting non-dedicated equipment down while in room. If unavoidable, set item down on a paper towel.
IC6:0200  ARO Contact Precautions

Cleaning an Item
- perform hand hygiene and don gloves
- whenever possible place item on a flat surface on a fresh paper towel
- wet cloth with disinfectant cleaner
- wipe all surfaces touched by patient or care provider
- discard paper towel and gloves
- perform hand hygiene

Televisions
Those responsible for setting up TV sets in patient rooms will request assistance from unit staff. The TV set will be cleaned before it is removed from an isolation room.

Housekeeping
On discharge of an ARO positive patient, notify Housekeeping that a “Isolation-Discharge Clean” is required.

Linen and Garbage
Bag linen and garbage in the patient’s room.
Handle as per Routine Practices.

Food Trays
Remove tray from patients’ room and place directly on food service cart.
Handle as per Routine Practices.

Patient Care Activities
Nursing care for patients with an ARO should be carried out in their own room.

Bathing
Patients with MRSA and/or VRE may be given a tub bath or shower using a common tub.

Patients with MRSA and/or VRE may use 2% chlorhexidine gluconate (with 4% isopropyl alcohol) as the soap of choice provided their skin is intact.
Routine disinfection procedures for cleaning the tub between patients are adequate.
IC6:0200  ARO Contact Precautions

Mobilization
- Isolation precautions do not preclude the patient from receiving optimum care and treatment.
- Patients may leave their room for essential purposes (e.g., mobilization therapy, treatment).
- Patients are restricted from common patient areas such as patient lounges, unit kitchenettes, and other patients’ rooms.
- Gowns and gloves are not routinely required to be worn by ARO colonized patients when out of their room.
- Ensure that the following measures are taken prior to the patient leaving the room:
  - Infected or colonized wounds are covered with a dry dressing.
  - Patient has performed hand hygiene with either an alcohol hand sanitizer or 2% chlorhexidine gluconate skin antiseptic soap.
  - Patient to wear a procedure mask if they have a productive cough and are unable to control their secretions. Apply mask over colonized tracheostomy if tolerated.
  - If the patient is incontinent, ensure that incontinent device is dry and secure.
  - Mobility aids such as a wheelchair, walker, cane, etc. must be wiped down with a hospital approved disinfectant daily and before being used by another patient.

Visitors
- Visitors must report to the nursing station before entering room.
- Visitors must be informed of the importance and technique of hand hygiene before and after any patient visitation.
- Visitors must be informed of the importance and the technique of donning and doffing PPE.
- Visitors providing direct care to patients with MRSA or VRE are required to gown and glove.

Transfer to Another Department or Facility
Alert the receiving department/unit/facility of the patient’s isolation requirements at the time of booking an appointment and when arranging transport/transfer. See Patient Transport / Transfer (IC5:1300).

Chart Identification
The patient’s record will be flagged with an ARO Critical Care Indicator (CCI).
IC6:0200 ARO Contact Precautions

4.0 REFERENCES


BC Centre for Disease Control. (May 2001) *British Columbia Guidelines for Control of Antibiotic Resistant Organisms (AROs).*


IC6:0300  ARO Decolonization

1.0 PRACTICE GUIDELINE

Routine decolonization of patients with MRSA is not recommended at this time. However, in some instances, MRSA decolonization may be of specific benefit. This protocol is not intended for pre-operative prophylaxis.

There is no decolonization protocol for VRE.

If MRSA Decolonization is considered:

- Consult with Infection Prevention & Control to determine if the patient is an appropriate candidate for the MRSA decolonization protocol.
- Decolonization for MRSA should not be attempted under the following conditions:
  - MRSA positive urine with foley catheter in situ
  - MRSA positive sputum or endotracheal aspirate
  - Patient has open wounds larger than the size of a quarter
  - Patient has an ostomy
  - Patient is on antibiotics
- MRSA decolonization should not be attempted more than twice as resistance to Mupirocin may develop.
- MRSA decolonization is not appropriate for neonates.

2.0 DEFINITIONS

Colonized: Laboratory cultures indicate the presence of an antibiotic resistant organism at one or more sites, but the patient does not have any symptoms of active infection.

Infected: Laboratory cultures indicate the presence of an antibiotic resistant organism at one or more sites, and the patient has symptoms of an active infection at the site(s).

Decolonization Protocol: A set of interventions that reduce the number of antibiotic resistant organisms on the patient’s skin and mucosal surfaces thereby reducing the number of organisms being shed into the environment. These interventions will reduce the possibility of transmitting the organism from the affected patient to other patients. Decolonization therapy may or may not result in eradicating the MRSA.
IC6:0300 ARO Decolonization

3.0 PROCEDURE

For patients with VRE and those who are not appropriate candidates for MRSA decolonization the following treatments may reduce the colony counts:

- Use of 2% chlorhexidine gluconate (CHG) (with 4% alcohol) antiseptic soap applied to a wet wash cloth as a daily body wash
- Use of aqueous chlorhexidine gluconate 0.05% (1:2000) skin antiseptic to cleanse wound sites at dressing change

Decolonization Protocol
Consult Infection Prevention & Control prior to initiating decolonization protocol.

Bathing
- The patient with MRSA is to be bathed daily with whole body washes (and shampoo where feasible) for 7 days using 2% CHG (with 4% alcohol) antiseptic soap.
- Apply soap directly onto a moist washcloth.
- Special attention should be paid to all skin folds such as axillae, inframammary folds, inguinal folds, and perineum.

Wound Care
Aqueous chlorhexidine gluconate 0.05% (1:2000) skin antiseptic will be used for routine cleaning of any wounds or insertion/exit sites such as tubes, drains, and catheters. This is used daily for 7 days.

Mupirocin Ointment (Bactroban®)
With a physician’s order, Mupirocin ointment will be applied for 7 days to the following areas:
- Nares: apply to the rim of anterior nares three times a day
- All insertion sites (drains, IV lines, catheters, pin sites): apply daily or when doing routine dressing change
- Wounds less than the size of a quarter: apply three times a day or when doing routine dressing change
- Mupirocin must not be applied to large denuded areas as it contains polyethylene glycol (PEG) that will be absorbed.
- If MRSA is resistant to Mupirocin, use Polysporin® in the same manner.
IC6:0300  ARO Decolonization

Follow-up Specimens

- Stop decolonization protocol for 48 hours prior to collecting follow-up specimens.
- Obtain three sets of specimens 48 hours apart from the following sites:
  - Rim of anterior nares (one swab for both sides)
  - Bilateral groins (one swab for both sides)
  - Sputum (if patient has a productive cough)
  - Open wounds

Note: If any follow up swabs are reported by Microbiology as positive for MRSA, stop collection of any follow-up specimens and notify Infection Prevention & Control.

Discontinuation of Contact

If all three sets of follow-up cultures are negative, Contact Precautions may be discontinued after consultation with Infection Prevention & Control.

- Call Housekeeping for Isolation-Discharge clean
- Send home personal belongings
- Use 2% CHG (with 4% alcohol) antiseptic soap weekly as the soap of choice for bathing the patient. Schedule the bath following collection of routine screening swabs
- Repeat MRSA screening swabs 48 hours following completion of any subsequent antibiotic therapy
- If patient remains in hospital, repeat MRSA screening at one month
**IC6:0300  ARO Decolonization**

### 4.0 REFERENCES


Section IC7: SEVERE RESPIRATORY INFECTIONS (SRIS) (currently under development)
Section IC8: OTHER INFECTIONS/CONDITIONS AND OUTBREAK MANAGEMENT
IC8:0100  Exposure of Infant to Non-Maternal Breast Milk

1.0 PRACTICE GUIDELINE

Breast milk is a body fluid and management of accidental exposure to it requires similar follow-up as is done with a blood exposure. This protocol will be initiated for any incident where an infant is inadvertently fed breast milk from a source other than the biological mother or a screened and previously agreed to surrogate.

Any incidents involving exposure of infant to non-maternal breast milk must be reported to Infection Prevention & Control as soon as possible once the error is recognized.

2.0 DEFINITIONS

“Exposed” infant: The infant who received the incorrect breast milk.

Source mother: The mother whose breast milk was given to the incorrect infant.

3.0 PROCEDURE

The Source Mother

- The source mother will be approached by her family doctor or another designated physician to explain the incident and the follow-up necessary. Consent from the source mother for testing of blood as per the flow sheet on page three of this document and for a review of test results obtained during the pregnancy will be obtained.

- In the event that the source mother is known but not available, it is possible to obtain maternal blood screening results through the Provincial Laboratory. As well, blood specimens are stored at the Provincial Laboratory for up to 18 months on all women who have recently undergone maternal screening.

- Discussion with the source mother regarding testing will include the need to release test results (but not her identity) to the “exposed” infant’s parents. Confidentiality of the source mother will be preserved. This discussion will be documented by the physician in the “exposed” infant’s chart and in the source mother’s chart if she is an inpatient.

The “Exposed” Infant and Parents

- Parents of the exposed infant will be informed by the attending physician/pediatrician immediately and counseled regarding possible risks to the infant from the exposure.

- The exposed infant will receive hepatitis B vaccine immediately and if the source mother is positive for HBsAg, the “exposed” infant will also receive Hep B immunoglobulin (HBIG) as soon as possible.

- If the source mother is known HIV positive or is at high risk for having HIV, a decision will be made immediately regarding giving the “exposed” infant anti-HIV prophylaxis as it should be initiated within 1 to 2 hours after the exposure, consult one of the following resources:
IC8:0100 Exposure of Infant to Non-Maternal Breast Milk

- Centre for Excellence in HIV/AIDS, Physician’s Hotline: 1-800-665-7677
- The Pediatric Infectious Diseases Team at BC Children’s Hospital: 604-875-2161 (paging)

- The exposed infant’s mother will be advised to have the same tests as the possible source mother in order to provide baseline results, which are necessary to determine origin of disease in the unlikely event that any disease has been transmitted because of the breast milk exposure. If the exposed infant’s mother declines investigation, this will be documented in the infant’s chart.

- If the source mother refuses testing by any or all the tests, then the exposed infant will be followed up with the appropriate corresponding tests for hepatitis B, hepatitis C, HIV, and CMV.

4.0 DOCUMENTATION

- The paediatrician will document the incident and discussion with both sets of parents on each of the mother’s charts and on the “exposed” infant’s chart.

- Lab reports of test results will be placed in the charts of those who have submitted the samples.

- The source mother’s chart number (PIN), but not her name, will be included in the incident documentation recorded in the exposed infant’s chart.

- If the source mother is not a patient in the hospital, an arrangement will be made to have her test results available and recorded and paired with the exposed infant’s results in order to determining the need for follow-up with the exposed infant.
### 5.0 FLOW DIAGRAM

#### PART 1: TESTING

**IS TESTING ACCEPTED?**

- **YES:** testing accepted by both mothers
  - Obtain serology on both the source and the "exposed" infant's mother for: HBsAg; HIV; HCV; CMV; HTLV 1/2; VDRL
  - Have source mother's physician inspect her breasts in regards to abscesses or lesions and provide a signed report
  - Explain that if infant becomes ill, the infant's mother will be considered a source of the illness unless proven to be free of disease
  - Obtain serology on both the source and the "exposed" infant's mother for: HBsAg; HIV; HCV; CMV; HTLV 1/2; VDRL

- **NO:** Source mother refused
  - Arrange follow-up testing of "exposed" infant

- **NO:** "exposed" infant's mother refused
  - Explain that if infant becomes ill, the infant's mother will be considered a source of the illness unless proven to be free of disease

#### PART 2: FOLLOW-UP OF SEROLOGY

<table>
<thead>
<tr>
<th>HBsAg</th>
<th>HIV</th>
<th>HCV</th>
<th>CMV</th>
<th>HTLV 1/2</th>
<th>VDRL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source mother</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>&quot;Exposed&quot; infant's mother</td>
<td>-</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

**ACTION**

- **HBIG Plus HB Vaccine for Infant**
- **Counsel parents re: prophylaxis**
- **Counsel**
- **Counsel**
- **Counsel**
- **Prophylaxis**

**LEGEND:**
- CMV = cytomegalovirus
- EBM = expressed breast milk
- HBIG = hepatitis B immune globulin
- HBsAg = hepatitis B surface antigen
- HCV = hepatitis C virus
- HIV = human immunodeficiency virus
- HTLV 1/2 = human T-cell leukemia/lymphotrophic virus
- VDRL = Venereal Disease Research Lab (syphilis serology)

**Referral to Infectious Diseases doctor.**

Follow-up testing of infant as required.

Complete documentation on charts.
IC8:0100 Exposure of Infant to Non-Maternal Breast Milk

6.0 REFERENCES


IC8:0200  Neisseria meningitidis Infections

1.0 PRACTICE GUIDELINE

Health Care workers will take appropriate measures to prevent secondary cases of meningococcal disease.

2.0 PROCEDURE

- Place patient with known or suspected meningococcal disease on “Droplet Precautions” until completion of 24 hours of effective antimicrobial therapy.
- Collect cultures of blood, CSF, etc. prior to starting antimicrobial therapy
  - Additional tests may be added at the discretion of Infectious Disease / Medical Microbiologist immediately or after the initial tests have been completed
  - Throat or nasopharyngeal swabs are not useful to determine need for prophylaxis
  - Send isolates to BCCDC Laboratory Services.

3.0 DEFINITION

Meningococcal disease includes invasive disease such as meningitis and septicemia as well as primary meningococcal pneumonia, primary meningococcal conjunctivitis and primary meningococcal urethritis.

Reporting and Consultation

Monday to Friday 0800 - 1540
- Notify Infection Prevention & Control whenever a patient is admitted with a suspicion of meningococcal disease. Infection Prevention & Control will inform Public Health and Workplace Health.

Outside regular business hours and on stat holidays
- Contact the Medical Microbiologist on call (604-231-4411).
- For BH call the operator and ask for the Pathologist on call.
  AND
- Notify the Medical Health Officer (Fraser Health Public Health On-Call Service at 604-527-4806) for contact follow-up.

Indications for Prophylaxis of Contacts

Chemoprophylaxis is offered to all persons having close contact with an invasive meningococcal disease case during the time when the case was infectious (7 days before onset of symptoms to 24 hours after the start of appropriate antibiotic treatment). If the date of onset of symptoms is unclear, consider the case infectious from 10 days prior to presentation.
Chemoprophylaxis of close contacts should be administered as soon as possible, preferably within 24 hours of case identification, but is still recommended up to 10 days after the last contact with an infectious case.

CLOSE CONTACTS are defined as:
- Household contacts of the case
- Contacts who share sleeping arrangements with the case (This is generally considered as sleeping arrangements in a residential setting).
- Contacts who have direct contamination of their nose or mouth with the oral/nasal secretions (eg. kissing on the mouth, shared cigarettes or ‘joints’, shared drinking bottles, eating utensils, toothbrushes, mouth guards or musical instrument mouthpieces).
- Children and staff in child care and preschool facilities.
- Contacts who have direct exposure to eye secretions of a case of primary meningococcal conjunctivitis.
- Airline passengers sitting immediately on either side of the case (but not across the aisle) when the total time spent on board the aircraft was at least 8 hours.

Advice to Close Contacts:
- Advise close contacts about the symptoms of invasive meningococcal disease and need for prompt medical attention if symptoms develop in spite of antibiotic chemoprophylaxis.
- Advise that public health (Workplace Health if hospital employee) will call if vaccine is indicated.

Health Care Worker Contacts include:
- Health Care Workers who have had intensive, unprotected contact without appropriate precautions (ie procedure mask and protective eyewear) with infected patients (eg. intubating, resuscitating or closely examining the oropharynx).
- Health Care Workers who have had unprotected contact as defined above should contact their local Occupational Health Nurse (OHN) first. If outside OHN hours, report to the nearest Fraser Health Emergency Department (Triage Nurse).

NOTE: Chemoprophylaxis is not recommended by BCCDC for emergency workers or health care contacts of cases, unless the contact’s nose or mouth has been directly contaminated with oral or nasal secretions or purulent discharge from the eye of a case of primary meningococcal conjunctivitis.

Contact Workplace Health for more information.
Situations in which contacts are NOT considered close contacts include:

- Casual contact: no history of direct exposure to index patient’s oral secretions [e.g. school or classroom contacts, workplace contacts, social contacts who are not close contacts and transportation contacts (except unique, prolonged close exposure as in the airline contact example above)].
- “Contact of a contact”, when the only exposure is to a high-risk contact and not a direct exposure to a confirmed case.

Prophylaxis

Prophylaxis is issued under the authority of the Fraser Health Medical Health Officer. Public Health is to be informed when a chemoprophylactic agent is provided for any close contact.

Chemoprophylaxis: Publicly funded chemoprophylaxis is available for close contacts through the public health units. Publicly funded chemoprophylaxis is not available at drug stores or through family physicians. Once informed, public health will arrange for appropriate and timely chemoprophylaxis of close contacts.

Immunoprophylaxis: In addition to chemoprophylaxis, the Medical health Officer may recommend that all close contacts be immunized with a serogroup-specific meningococcal vaccine. Immunization provides extended protection against invasive disease. Immunization is usually not recommended until the serogroup is determined. There is currently no licensed vaccine against serogroup B.

Responsibilities Regarding Chemoprophylaxis and Immunoprophylaxis

Public Health:

- Identify close contacts, with assistance of Infection Prevention & Control
- Screen close contacts and provide, or arrange for provision of, chemoprophylaxis
- Provide consultation and screening of close contacts who may present to the hospital for screening. Generally this can be done by phone. The contact will be directed where to obtain chemoprophylaxis, if indicated
- Inform contacts if vaccine is indicated and administer the appropriate meningococcal vaccine as immunoprophylaxis is indicated
Workplace Health:
- Identify health care workers including first responders who are potential close contacts
- Screen close contacts
- Arrange chemoprophylaxis and immunoprophylaxis if indicated
- Fax list of chemoprophylaxis recipients to public health (when arranged through hospital without public health involvement). The fax number for the appropriate public health office is provided when public health is informed of the case.

4.0 REFERENCES


IC8:0300  Pulmonary Tuberculosis

1.0 PRACTICE GUIDELINE

Patients known or suspected to have pulmonary or laryngeal Mycobacterium tuberculosis (MTB) are managed on Airborne Precautions.

2.0 PROCEDURE

- Follow Pulmonary Tuberculosis Algorithm (Appendix A) for assessment and isolation of known or suspect patients
- Consult physician and/or Infection Prevention & Control when other differential diagnosis’ are present
- Arrange for transfer of patient to a facility with a negative pressure isolation room if unavailable at current facility
- See IC5:0500 for Airborne Precautions
- See IC5:0600 Negative Pressure Rooms

3.0 PPD SKIN TEST

Purified Protein Derivative (PPD) is partially purified tuberculin and may be used to detect past exposure to or infection with MTB. It is not diagnostic of active disease and a negative result does not exclude the possibility of MTB.

Procedure to administer PPD skin test:
- Draw 0.1 ml of 5 TU PPD solution using a 1ml tuberculin syringe with a 26 or 27 gauge needle. Ensure there is no air in the needle.
- Select injection site on anterior surface of forearm, 3-4 finger widths below the bend of the elbow. Area should be free of lesions and apparent blood vessels.
- Cleanse injection site with alcohol and let dry
- Hold skin taut and position needle with bevel up, insert at 10 – 15 degree angle without aspirating
- Slowly inject the solution. A small bleb of approximately 6 – 10mm should form.
- If a bleb does not appear, repeat the skin test immediately at another site, preferably on the opposite arm or at least 2 inches from the first site.
- Withdraw needle, do not apply pressure, rub the site or cover with a bandage.
- Repeat tuberculin skin testing must not be done on the same site
- Record the site and date of the PPD injection in patient chart and flag Kardex to have skin test read in 48-72 hours
IC8:0300  Pulmonary Tuberculosis

Procedure to read PPD skin test:
- Reading should be done in good light with the forearm slightly flexed at the elbow
- Inspection should be made from the side view against the light
- Examine injection site 48 – 72 hours after administration
- Palpate the site gently to feel for the edges of induration (firmness)
- Mark edges of induration from side to side with a pen (ie. transverse or across arm - do not measure lengthwise)
- Measure edges of induration using a ruler calibrated in millimeters
- Record result in millimeters. If there is no induration, the result recorded is 0 mm.
- Notify physician of measurement of induration

4.0 REFERENCES


IC8:0300 Appendix A: Pulmonary Tuberculosis Algorithm

Indications for initiating Airborne Precautions for suspected pulmonary MTB.

**Signs and symptoms include:**
- A chest x-ray suggestive of active TB
- An Acid Fast Bacilli (AFB) positive sputum

**OR**

**Patient is in a high-risk group:**
- Foreign born from high prevalence countries (including China, Vietnam, Philippines, Korea, Hong Kong, Indian Subcontinent, Eastern Europe, Africa, Mexico).
- Canadian Aboriginals
- Previous history of TB
- Homeless or in a shelter
- In prison in the last two years
- HIV positive
- Substance abuse

**AND**

**Patient has two or more of the following symptoms:**
- Chronic cough of more than four weeks
- A non-resolving pneumonia
- Unexplained weight loss >10 lbs.
- Fever (longer than 1 week)
- Night sweats
- Hemoptysis

**If YES**

- Place patient on Airborne Precautions
- Notify Infection Control
- Ask for a physician to assess the patient

**Diagnostic tests that may be ordered by the physician to diagnose or rule-out MTB include:**
- A chest x-ray PA and lateral
- Sputum for AFB smear and culture x 3
- TB skin test

Another diagnosis may explain the patient’s symptoms, e.g. lung tumour

Consult Infection Control prior to discontinuing Airborne Precautions.
IC8:0400 General Outbreak Management

1.0 PRACTICE GUIDELINE

When an outbreak is suspected Infection Prevention & Control will take appropriate measures to control and contain the outbreak.

2.0 PROCEDURE

- Infection Prevention & Control will determine a case definition of infection and develop investigation plans (e.g. timely specimen collection, chart review, etc.).
- Infection Prevention & Control will notify the appropriate departments
- Control measures should be tailored to the situation and need to address the following:
  - Isolation: Implement appropriate Additional Precautions. Symptomatic patients may be confined to their rooms. Patients may be cohorted
  - Visitors and group activities: Consider restricting visitation if the pathogen causing the outbreak is also present in the community. Patient contact via group sessions may also need to be suspended
  - New admissions: Consider closing an area or restricting new admissions and transfers until the outbreak is over
  - Staff: Staff should be assigned to care for either infected or non-infected patients, and not care for both groups. Symptomatic staff should be restricted from work. Staff follow up is done by Workplace Health.
  - Environmental control: Review cleaning regimens and disinfectants to ensure practices are effective.
  - Education: Anticipate questions from staff, patients and visitors and provide written information
  - Communication: Infection Prevention & Control will send out regular updates to the appropriate departments. Media inquires will be directed to Communications.

Infection Prevention & Control will declare the outbreak over.
IC8:0500  Scabies Outbreak

1.0 PRACTICE GUIDELINE

The following procedures will be followed to investigate and manage suspected or known scabies cases and outbreaks in Fraser Health.

2.0 DEFINITIONS

**Typical Scabies:** An infection of the skin caused by a parasitic mite that burrows under the skin and lays eggs. Visible papules or vesicles with or without linear burrows may be present on the skin. The lesions commonly appear in the interdigital spaces, anterior surfaces of wrists and ankles, axillae, skin folds, genitalia, belt-line, and abdomen. Itching may be intense, especially at night.

**Norwegian Scabies:** A heavy infestation of scabies. The patient is highly contagious due to the large number of mites on the skin and particularly in patients who have a desquamating skin condition. The skin may have a darkened appearance with a flaky epidermis and crusted patches. Treatment of patients diagnosed with Norwegian scabies is coordinated through the consulting specialist. Several scabicide treatments may be required. Contact precautions must be maintained until the infestation is cleared.

**Scabies Case:** An individual who has scabies diagnosed by skin scrapings or based on the clinical decision of a dermatologist or a family physician with training and/or experience in scabies diagnosis and management.

If an outbreak is declared, a case may include any individual with onset of a new itchy, papular, vesicular rash, or linear burrows, and has had direct skin-to-skin contact with a confirmed case.

**Contact:** An individual who had direct skin-to-skin contact or has had contact with contaminated equipment with a case but has no skin lesions at the time of initial examination.

**Case definition of a Scabies Outbreak:** When three or more individuals on a single unit have been diagnosed with scabies including staff members.

3.0 TRANSMISSION

Transmission of scabies occurs from skin to skin contact with a symptomatic person. Within health care facilities, scabies is usually transmitted from symptomatic patients to staff. Then several weeks later, staff may begin to transmit scabies to their family members and patients. The goal in controlling a scabies outbreak is to treat symptomatic patients as well as any staff who have had direct contact with symptomatic patients, patients who receive care from symptomatic staff and family members of symptomatic staff.
3.0  PROCEDURE

MAKING A DIAGNOSIS OF SCABIES

Skin rash identified by care provider.

Unit staff will:
- Initiate Contact Precautions
- Contact physician to assess patient

Scabies is suspected

Skin scrapings to be collected by the physician. Consider a dermatology consult if Norwegian scabies is suspected.

New admission?

Yes

Consider scabies treatment of index case if scabies remains highly suspected

Observe other patients

No

Confirm diagnosis as other patients and staff may need to be treated

Scabies diagnosis is confirmed on same unit or facility

Unit staff will:
- Inform Infection Control
- Assess roommates for evidence of a rash
- Notify Workplace Health & Safety
- Information affected patients' family and provide information as necessary
IC8:0500  Scabies Outbreak

If other scabies cases are suspected:
- Alert other units if patient transfers have occurred or if staff have worked on other units
- Consult Infection Prevention & Control
- Infection Prevention & Control will determine if this is an outbreak.

4.0 RESPONSIBILITIES

Infection Prevention & Control
- Infection Prevention & Control will declare an outbreak and determine action plan.
- Perform contact tracing.
- Notify Workplace Health regarding known staff cases and potential staff exposures
- Ensure notification of exposed discharged patients. Include transfer units, facilities, Home Care Services and Family Physicians of discharged exposed discharged patients.

Medical Microbiologist
Depending on the extent of the outbreak, the Medical Microbiologist and Workplace Health will recommend that some or all of the following individuals be treated:
- Diagnosed cases among the patient population
- Close contacts to symptomatic patients
- Cases among staff, students, volunteers
- Staff who have had direct skin-to-skin contact with cases within six weeks prior to treatment of the cases
- Partners and household contacts of staff diagnosed as having scabies
- Health care workers from other care units/diagnostic/treatment areas who have had direct skin-to-skin contact with symptomatic patients within the previous six-week period
- Patients who have had direct skin-to-skin contact with symptomatic staff

Unit Manager or Delegate
- Inform Infection Prevention & Control as soon as possible if an outbreak is suspected.
- If Infection Prevention & Control declares an outbreak:
  - Initiate treatment of cases within 48 hours
  - Stop all transfer of patients in or out of the unit
  - Implement Contact Precautions of all patients until treatment of patients and health care workers is complete
  - Notify potentially exposed staff
  - Liase with Workplace Health
  - Notify families of patients
  - Notify Housekeeping for enhanced cleaning
IC8:0500 Scabies Outbreak

- Notify Pharmacy regarding amount of scabicide medication required for staff and patient treatment
- Limit visitors if possible
- Notify physicians of discharged or transferred patients regarding the outbreak
- Restrict group activities
- Determine if extra staff are required, and inform staffing office if necessary
- Arrange for extra laundry supply and pick-up
- Arrange for in-service education
- Consult with Workplace Health regarding contact tracing of exposed health care workers
- Ensure that a line list is kept of symptomatic patients
- Ensure that staff cases are treated before returning to work
- Encourage family members of staff cases are treated at the same time to be coordinated through their family physician.

Workplace Health

The Workplace Health Nurse will assess staff members and recommend treatment or medical referral as appropriate. She/he will coordinate with the unit Manager and Pharmacy regarding scabicide requirements for staff and contacts.

5.0 TREATMENT OF SCABIES
- Confirmed and suspect cases should be cared for using Contact Precautions
- A doctor’s order is required for all treatment.
- Follow the scabicide application instructions.
- For infants, young toddlers and geriatric patients the scalp, neck, temples and forehead may need to be included because these areas can be infested in these age groups. Contact with the eyes and mouth should be avoided. If this occurs, the eyes should be immediately flushed with water.
- Change patient gown. Bed linen must be changed before patient returns to bed after scabicide is removed.
- Place patient’s personal clothing in a clear plastic bag and secure the bag.
- Send personal clothing home with a relative/friend for laundering. Intimate articles of clothing should be washed by machine in the hot cycle for at least 10 minutes, tumbled in a hot dryer for at least 20 minutes, or bagged for 10 days. Placing items in the freezer will also kill mites. It is usually not necessary to clean outerwear or furniture. Dry cleaning will also kill the mites.
- Equipment such as slings and walking belts must be laundered.
- Discard creams, lotions, or ointments used prior to effective treatment.
- Scabies lesions should begin to disappear within 48 hours of treatment, turning from a pink/flesh tone to brown.
IC8:0500 Scabies Outbreak

- Carefully examine the patient for new lesions or burrows after seven days. Treatment of cases may be repeated in 7 – 10 days if considered necessary by the attending physician.
- Itching may persist for one to two weeks following treatment. The itchiness is a reaction to the organic material of the mite or sensitivity to the scabicide. It should not to be mistaken for treatment failure.

6.0 HOUSEKEEPING
- Routine Housekeeping procedures are generally adequate.
- Wipe vinyl furniture, bedside tables, overhead tables and wheelchairs with hospital approved disinfectant
- Vacuum upholstered furniture.

7.0 REFERENCES


Association for Professionals in Infection Control and Epidemiology. (2000) APIC Text of Infection Control and Epidemiology.
SCABIES OUTBREAK SURVEILLANCE

<table>
<thead>
<tr>
<th>Name</th>
<th>DOB</th>
<th>Room Number</th>
<th>Symptomatic (Y/N)/Date</th>
<th>Diagnosis Confirmed/Suspected*</th>
<th>Treatment Date/s</th>
<th>Notes</th>
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* Confirmed Diagnosis = positive skin scraping or diagnosis by Dermatologist
* Suspect Diagnosis = signs & symptoms of scabies and linked to confirmed case

Follow-up notification of discharged patient contacts is done by Infection Prevention & Control.

The following are to be notified:

1. Facilities that have received patient transfers.
2. Home Care Services that are providing services to discharged patients.
3. General Practitioner of discharged patients
IC8:0600  Gastroenteritis Outbreak

1.0  PRACTICE GUIDELINE

Outbreak measures will be initiated to prevent or reduce transmission when there is a suspected or confirmed outbreak of gastrointestinal illness on a unit.

The most common cause of gastroenteritis outbreaks in acute care facilities is the Norovirus, an enteric virus. In most cases, illness caused by the Norovirus is mild and self-limiting, but in elderly and/or chronically ill patients, serious dehydration may result.

2.0  DEFINITIONS

Gastroenteritis

At least one of the following must be met:

- 2 or more episodes of thick liquid or watery stool above what is normal for the patient or employee within a 24 hour period,
- 2 or more episodes of vomiting within a 24-hour period,
- 1 episode of thick liquid or watery stool AND 1 episode of vomiting within a 24 hour period;
- Both of the following:
  - lab confirmation of a known enteric pathogen; and at least 1 symptom compatible with gastrointestinal tract infection
  - nausea, vomiting, diarrhea, abdominal pain or tenderness

Viral Gastroenteritis

Gastroenteritis caused by a virus (e.g. Norovirus) usually presents as a self-limited, mild to moderate illness with symptoms of nausea, vomiting, non-bloody diarrhea, abdominal pain, muscle ache, headache, malaise, low grade fever, or a combination of these symptoms.

Gastroenteritis Outbreak

Three or more cases of gastroenteritis in patients or staff in a four day period.

When an outbreak is declared

- Post visitor restriction signs (IC8:0600 Appendix A)
- Provide visitors and staff with Norovirus fact sheet (IC8:0600 Appendix B)
- Review and post the Quick Reference Guide (IC8:0600 Appendix C)
- Follow outbreak control measures in Quick Reference Guide
- Collect and send specimens to BCCDC (IC8:0600 Appendix D/E)
- Maintain Surveillance records for patients and staff and forward daily to Infection Prevention & Control and Workplace Health (IC8:0600 Appendix F)
- Infection Prevention & Control will send notification of the outbreak (IC:0600 Appendix G/H)
3.0 REFERENCES


IC8:0700  Respiratory Illness Outbreak

Currently under development.
Section IC9: ENVIRONMENTAL HYGIENE
IC9:0100 Blood and Body Fluid Spills Cleanup

1.0 PRACTICE GUIDELINE

Blood or body fluid spills must be confined and contained until Housekeeping services provides clean-up.

2.0 PROCEDURE

- Cover the spill with paper towels and place a hazard sign in the immediate vicinity of the spill.
- Contact the Housekeeping Service for clean-up of blood and body fluid spills.

If no Housekeeping Services are available;
- Apply gloves and other PPE as needed
- Cover area with paper towel to soak up the spill
- Discard paper towels
- Clean area with hospital grade disinfectant
- Allow to air dry
- For large spills, use mop and bucket with hospital grade disinfectant
- Place mop head in plastic bag and place in laundry bag
- Remove gloves and gown
- Perform hand hygiene

3.0 REFERENCES


BCCDC. Blood and Body Fluid Exposure Management. May 2005

1.0 PRACTICE GUIDELINE

Pet visiting is permitted in acute care facilities in Fraser Health under the following conditions;
- Approved pet visitation program that is administered by Volunteer Services
- For compassionate reasons and in accordance with this document.

Service animals are permitted in Fraser Health facilities. However both service animals and personal pets are restricted from the following areas: surgical suites, isolation rooms, food preparation areas, medication and sterile supply areas. Turtles, reptiles, wild, stray or exotic animals are not permitted. In addition to the risk of infection through zoonotic transmission and organisms harbouried by the animal, other concerns about animals in acute care facilities including cleanliness and allergies must be considered.

2.0 DEFINITIONS

Service Animal: an animal that assists a person with disabilities such as sight, mobility, sound alert and seizure alert.

Volunteer Pet Visitation Program: Service provided by Volunteer Services. Volunteer Services has a policy outlining required standards for pets in the Pet Visitation Program. These pets are required to meet similar standards as outlined in this document. Visitation is not restricted to one patient. The encounter with patients is limited.

Personal pet: A pet with a close emotional bond to a patient

Zoonosis: the transmission of diseases between animals and humans.

Zoonotic risk of transmission: Animals can transmit infectious diseases to humans. Animals can become carriers of potential human pathogens, including antibiotic resistant organisms and could be responsible for cross-infection. The risk of zoonotic disease transmission is considered low.
3.0 PROCEDURE

For Personal Pet Visitation

- Prearrange the pet visit through the charge person on the unit
- Obtain permission from roommates prior to the visit
- Agree upon the time allotment of the visit before the visit
- Patient’s wounds must be covered. Avoid having the animal come in to contact with wounds and other areas of interrupted skin integument
- Tracheostomies must be covered
- Designate an escort to be responsible for all care of the visiting pet
- The pet escort must carry a record of current vaccination with pet and available on request by unit charge person/manager
- Pets should be clean and well groomed
- Pet must be in a carrier or on a short leash at all times
- Pet must interact only with patient
- If the pet is allowed on a patient’s bed, a barrier such as a towel or sheet is to be placed between the animal and the patient’s linen
- If the pet is allowed in ICU, guidance must be provided by the nurse regarding the best way for the pet to approach the patient and avoid disrupting equipment
- If any visiting pet causes a disturbance or interferes with the health, safety, treatment or well-being of the patients or staff, the designated escort will be asked to remove the pet from the facility
- Complete an Incident Report for any bites, scratches or punctures that occur as a result of the pet visit
- Hand hygiene must be carried out after contact with the pet

Contraindications to Pet Visits

- Pets are not permitted when it has been medically determined that a pet visit may be detrimental to the patient such as patients who are immunocompromised are at higher risk of acquiring an infection from organisms harbored by animals
- Pets are not permitted when patients, clients or staff have allergies to pets which affect their health or well-being
- Pets are not permitted if their presence will cause a disruption or create fear among patients, visitors or staff.
4.0 REFERENCES


Association for Professionals in Infection Control & Epidemiology Inc. (2005). Text of Infection Control and Epidemiology, Association for Professionals in Infection Control and Epidemiology Inc.
IC9:0300 Waste Management

1.0 PRACTICE GUIDELINE

All waste is handled in a safe manner such that contaminated materials will be confined and contained. All biomedical waste is identified and disposed of in accordance with the "Guidelines for the Management of Biomedical Waste in Canada".

2.0 DEFINITIONS

Biomedical Waste

Human Anatomical Waste
Human tissues, organs, and body parts, excluding teeth, hair, and nails.

Microbiology Laboratory Waste
Laboratory cultures, stocks or specimens of microorganisms, live or attenuated vaccines, human or animal cell cultures used in research, and laboratory material that has come into contact with any of these.

Human Blood and Body Fluid Waste
Human liquid blood or semi-liquid blood and blood products, items contaminated with blood or blood products that would release liquid or semi-liquid blood if compressed, body fluids visibly contaminated with blood, and body fluids removed in the course of surgery, treatment, autopsy, embalming or for diagnosis, excluding urine and faeces.

Sharps Waste
Clinical and laboratory materials consisting of needles, syringes, blades, or laboratory glass capable of causing puncture or cut.

General Waste

Soiled dressings, sponges, or disposable drapes, lavage tubes, casts, catheters, incontinent pads, diapers, sanitary napkins, disposable gloves, empty specimen containers, empty urinary drainage bags, empty IV bags, and non-bloody IV tubing

Note: for non-bloody IV tubing, please ensure that the spike remains in the IV bag.
3.0 PROCEDURE

Human Anatomical Waste
- Place in designated red bags/containers, securely tie shut and deliver to morgue or other designated area for refrigeration or freezing, until picked up for final disposal.

Microbiology Laboratory Waste
- Place in designated bags/containers and stored in designated area until picked up for incineration or autoclave before final disposal.

Human Blood and Bloody Fluid Waste
- Place in designated yellow bags or biomedical waste container and securely tie shut. This is picked up from the dirty utility rooms by Housekeeping.
- Biomedical Waste containers generally should not be found outside of designated collection areas (e.g. dirty utility rooms) except for sharps containers or where a patient is producing large amounts of waste matching the definition of biomedical waste.

Sharps Waste
- Do not recap needles
- Place contaminated sharps and similar waste in designated sharps containers.
- Do not overfill above fill line.

General Waste
Place in designated black garbage bags or recycling containers as appropriate.

Exception
- Reusable fluid-filled containers
- Carefully pour biomedical waste from reusable fluid filled containers into the sanitary sewer e.g., urine from catheter bags. Wear appropriate protective attire when splashing is anticipated.

4.0 REFERENCES


1.0 PRACTICE GUIDELINE

Prior to beginning the project, the individual(s) responsible for planning and organizing construction and renovation projects shall consult with Infection Prevention & Control and complete the Infection Control Construction Agreement for all Class III & IV projects and as required for Class I & II projects.

Plant Services shall ensure that all staff and all contractors follow the requirements stated in the Infection Control Construction Agreement.

2.0 PROCEDURE

Plant Services Manager or Designate:

- Determine the type and duration of the construction and special risk factors, for example disruption of water supply, dust generating activities.

- Consult Infection Prevention & Control to identify the population risk groups in the area adjacent to the construction.

- When heavier construction projects are undertaken in areas where high risk patient groups are accommodated, higher levels of precautions are required to minimize potential illness for the patient population.

- Give special consideration to transferring immunocompromised patients from areas adjacent to construction.

- Refer to the Matrix in IC9:0400 Appendix A to determine the Infection Prevention & Control Measures required to minimize risk of airborne/waterborne illness during construction.

- Complete the Infection Control Construction Agreement for any projects which require Infection Prevention & Control Measures for Class III, IV. Any additional requirements will be dated and initialed by the Contractor and Infection Prevention & Control prior to commencement of construction.

- Provide the original signed agreement to Infection Prevention & Control and copies to the Contractor, FH Plant Services and manager of the department where the construction activity will take place at the preconstruction meeting. (See IC9:0400 Appendix A).

- The general contractor is responsible for ensuring these guidelines are followed by all personnel: general and subcontractors working on the project.

- Ensure concurrent cleaning is done by the construction crew and followed by Housekeeping services.
3.0 REFERENCES


Hospital Infection Control (February 1997). Reduce dust and danger during construction. (pp.24:26)


Section IC10: HANDOUTS/PAMPHLETS/SIGNS
Various Infection Prevention & Control information handouts are available for patients, families and staff on-line through our website. To access these documents, go to:

http://fhaweb/Programs+and+Services/Strategic+Services/Infection+Control/Pamphlets/default.htm

**Isolation Precautions Signs**
- Airborne
- Contact
- Droplet
- Droplet contact
- Strict

**Immunocompromised Patient Sign**

**Information Pamphlets for Patients**
- Hand Hygiene
- CDAD
- MRSA
- VRE

**Information for Staff**
- Hand Hygiene
- Basics of Infection Control
- MRSA
- VRE
- ESBL
- How to remove gown and gloves
- Donning & Doffing PPE for Strict Precautions
- Guidelines for Glove Use