ADMINISTRATIVE MANUAL

Policy & Procedure

Title:	Infection Control – General Practices	**Number:**	AD 50-03
Section: **Sponsor:** **Author(s):**	Infection Control Director of Care Infection Control Lead	**Date Created:** **Last Date Approved:** **Next Review Date:**	July 3, 2008 July 7/11; Nov 24/16; Feb 2018 Feb 2021
Distribution:	All Staff & Volunteers	**Approval:**	CPAC/Leadership Team

STANDARD

DHW Long Term Care Facility Program Requirements, FINAL March 15, 2016

8.2 Systems and Processes are in place to minimize risk to residents, staff, volunteers, visitors and the home. An immunization program, is in place, that provides safe administration of vaccines, such as influenza, to interested residents and staff.

8.4 Infection Prevention and Control: Residents and staff are protected from exposures and transmissions of microorganisms and infection by knowledgeable staff and evidence-informed infection prevention and control strategies.

WEV Guiding Principle: SAFETY is paramount. We keep each other safe so no one gets hurt. We intervene to prevent injury.

RATIONALE

Eden Domain of Well-Being: Security – freedom from doubt, anxiety, or fear; safe, certain, assured

The Windsor Elms Village is committed to Infection Control evidence based practices in order to protect residents, staff, volunteers, and contracted individuals that work within the Home on a regular basis, from any contagious illness, such as influenza and noroviruses.

Influenza is a significant cause of death in Canada, especially amongst the elderly and frail. Many of the deaths due to influenza can be prevented through immunization. Influenza immunization is safe and effective and is the single most important way to prevent influenza-related complications and deaths.

Noroviruses are a group of viruses that cause vomiting and diarrhea.

POLICY

All staff, volunteers, and contracted individuals that work within the Home on a regular basis, must maintain compliance in infection control practices.

PROCEDURE

1. Public Health strongly recommends that all staff, volunteers, and contracted individuals that work within the Home on a regular basis, receive annual influenza immunization, during the influenza season (typically October to April).
   a. The Infection Control Nurse or delegate will initiate an immunization schedule as soon as vaccine (s) becomes locally available each Fall. Vaccine (s) will be offered, free of charge at a designated area within the Home, and at various times to ensure all receive an opportunity to be immunized. As well, educational materials will be readily available during immunization.

   b. Staff who decline influenza vaccination but have no medical contraindications will continue to be offered vaccine(s) in subsequent years.

   c. In the event of a severe influenza outbreak, it may become necessary to exclude non-immunized staff from work without pay.

   d. The Infection Control Nurse will maintain annual records of staff vaccination(s) status. Staff immunized at an off-site clinic or by their family physician must provide written documentation, including the date vaccine(s) was received. Off-site immunizations will not be reimbursed.

   e. Staff influenza immunization percentage rates will be posted in a public place on December 15th and March 1st as per licensing requirements.

   f. Persons carrying on activities in the facility that experience symptoms of infectious illness, must not work and must self-report their illness as soon as possible to their Neighborhood Manager/Department Head. Refer to Public Health recommendations.

   g. At the time of hiring or placement, staff/volunteers will be required to fill out an immunization form and acknowledge that they have reviewed and understand this policy, as well as discussing any concerns with their Neighbourhood Manager/Department Head as soon as possible.

   h. This policy will be reviewed annually by staff as required education.

2. **Staff Assignments During an Outbreak**: When there is a suspected outbreak in a household/neighborhood, attempts will be made to keep ‘exposed’ staff on a symptomatic household/neighborhood and ‘unexposed’ staff on a healthy household/neighborhood. Staff already booked for shifts/specific group assignments may be rotated or prevented from rotating to different households/neighborhoods depending on the needs of the home to contain the outbreak on one household/neighborhhood and prevent the spread to other household/neighborhoods. Each Neighborhood Manager/Charge RN will be responsible for ensuring that this process is followed in their respective areas as much as possible, once the Infection Control Nurse declares an outbreak is present.

3. **Handwashing or Hand Sanitizing**: All staff are expected to practice thorough hand washing or hand sanitizing which are the most important and basic techniques in preventing and controlling the spread of infection. (See Appendix B: How To Handrub and How to Handwash)

   The instances when hand hygiene should be performed during the delivery of care have been simplified into 4 key moments: (see Appendix C: Your 4 Moments for Hand Hygiene)

Moment 1: Before initial resident/resident environment contact
Moment 2: Before aseptic procedures
Moment 3: After body fluid exposure risk
Moment 4: After resident/resident environment contact.

Other instances when hands of staff should be cleaned include, but are not limited to: Before and after eating, after using the washroom, after sneezing or coughing, after smoking, before and after recreational activities, before and after outings of the LTC facility, before and after contact with animals.

4. **Point of Care Risk Assessment (PCRA):** The PCRA is an assessment of the interaction between staff, the resident, and/or the resident's environment to determine the potential for exposure to infectious agents. Before each interaction, staff should do a PCRA to determine the appropriate intervention to prevent the transmission of microorganisms. Key things to assess when conducting a PCRA are: condition of the resident; the resident environment; the nature of the interaction. (See Appendix D: Point of Care Risk Assessment)

5. **Personal Protective Equipment (PPE):** Refers to the barriers worn by staff to minimize exposure to body fluids. The barriers include gloves, gown, masks, and facial protection which will be made available to protect staff. Staff will be educated yearly on the manner in which the PPEs are put on and removed to minimize the risk of self contamination. (See Appendix E: Recommended Steps for Putting on Personal Protective Equipment/Steps for Taking Off Personal Protective Equipment)

6. **Staff Surveillance (Respiratory and Enteric)**: The Scheduler will assist the Neighborhood Manager/Department Head with tracking staff illnesses on the Respiratory or Enteric Line Listing-Staff. This form will be submitted to the Infection Control Nurse at the first of each month. If there is more than 2 staff in the neighborhood/department at one time presenting with similar symptoms then the Neighborhood Manager/Department Head needs to report staff illnesses to the Infection Control Nurse promptly. Continue to fill out the surveillance form.

7. **Shared Equipment and Supplies:** All shared items are cleaned and disinfected between resident use. Follow current guidelines around cleaning and disinfecting. The Infection Control Nurse/Charge RN/delegate will request enhanced cleaning in affected areas when outbreaks occur using appropriate products (example: Virox) for common touch surfaces.

8. **Auditing:** There will be practice audits completed quarterly on hand hygiene practices, point of care assessments and personal protective equipment usage.

APPENDICES

Appendix A: Resident Outbreak Management Guidelines
Appendix B: How To Handrub and How to Handwash
Appendix C: Your 4 Moments for Hand Hygiene
Appendix D: Point of Care Risk Assessment
Appendix E: Recommended Steps for Putting on Personal Protective Equipment/Steps for Taking Off Personal Protective Equipment

REFERENCES

Standards and Practice Guidelines – IPCNS and other Nova Scotia Standards & Guidelines

Infection Prevention and Control: Guidelines for Long Term Care Facilities June 2015
Infection Prevention and Control Nova Scotia (IPCNS), Department of Health and Wellness

APPENDIX A: Resident Outbreak Management Guidelines

Resident Outbreak Management Guidelines

Purpose:
The Staff Care Partners knows the roles and responsibilities of each member and communicates appropriately for Outbreak Management.

Procedure:

The Nurse in the affected household will be responsible to initiate the following policy. The Infection Control Coordinator(Assistant Director of Care) or delegate (Charge RN) is to be contacted as soon as possible.

1. When residents develop specific symptoms (respiratory/enteric) which meets the case criteria (refer to line listing) then that resident needs to be confined to their room until symptoms improve or resolve. Respiratory recommendation is 7 days from start of symptoms and enteric is 48 hours after last symptom.

Suspect a **respiratory outbreak** when 2 or more residents in the same household develop symptoms of respiratory illness within 72hrs of each other: Fever*, sudden onset or increased cough and one or more of the following- sore throat, arthralgia, myalgia, prostration. *Note fever may not be prominent in residents over 65.

Suspect an **enteric outbreak** when 3 or more residents in the same household develop within 1-3 days: 2 or more episodes of vomiting or 3 or more episodes of diarrhea within 24hr period.

Notify the Infection Control Coordinator by calling Ext 226 and leave a message or by sending an email.
*Notify Public Health # 481- 5824 CDC intake nurse on call if reporting an Outbreak during business hours. Notify Medical Officer of Health by phoning NSHA locating:902-473-2222 for after hours or on the weekend and notify the Director on Call that an outbreak is presenting.

2. If an outbreak (as above) is present within the household then the household doors will be closed and all residents encouraged to remain within their household and not participate in activities outside of that area until outbreak is resolved. **NOTE: if there is the ability to close one house (house doors and spa doors) and ensure the affected residents remain within that house to prevent further spread then this could be a consideration.**

3. A sign will be posted on the household entrances indicating the presence of an outbreak of illness symptoms e.g., cough or diarrhea and advising hand washing and protective equipment needed when visiting.

4. To enhance communication between all staff, a sick picture sign will be attached to the resident's door when symptoms present requiring confinement.

5. All cases of illnesses (Respiratory or Enteric) need to be recorded on the surveillance forms in each house report book. Copies found in the Infection Control binder with a yellow spine and cover in each nursing office.

6. Contact measures are initiated based on the outbreak and the Point of Care Risk Assessment. Refer to sequence chart for donning and removing of personal protective equipment (PPEs).

7. **The Infection Control Nurse <u>may</u> place increase limitations if there is a confirmed outbreak e.g., Influenza, Norwalk, elsewhere in the Home or community or if affected residents do not understand about staying in their rooms to prevent the spread i.e. NH may be confined instead of just a household.**

8. Public Health may also direct the Home from continuing social programs which combines the residents from each Neighborhood.

9. Therapeutic Care Partners will be discouraged from interacting directly with residents within the affected household, e.g., PT, PTA, OT and PDT to minimize the spread to other households and neighborhoods. Exceptions may be made for urgent situations and with collaboration with the Nurse.

10. Depending on the extent of the outbreak, personal care may need to be minimized due to time constraints, e.g., baths, nail cutting.

11. All staff care partners will assist in encouraging fluid to affected residents.

12. Depending on the number of ill residents and the availability of staff, additional staffing may be put in place to assist in managing basic care.

    - Keep line listing for residents updated <u>each shift</u> (Enteric or Respiratory)

    - RSAs will be responsible to call the central kitchen by 10:00am to advise if changes are needed for the dinner meal. RSAs will also call in the afternoon in preparation for supper by 3pm. Additional soup, jello, sandwiches may be required.

    - RSAs will focus extra cleaning, using antiviral wipes(i.e. Virox), to frequent touch surfaces such as bedrails, over bed tables, door knobs, remotes, call bell, bath rooms (taps and levers) of affected residents. The Charge RN may increase housekeeping staffing to meet the needs of increased cleaning throughout the household.

    - The Nurses will collaborate with their household teams during shift huddle to discuss the plan for that affected household for that shift.

    - Staff may be rotated from houses or NHs to minimize further outbreak. Staff from healthy households/neighborhoods may need to be moved to the ill households/neighborhoods in order to avoid staff from the ill

households/neighborhoods being moved to the healthy households/neighborhoods.

- There will be no restrictions made for visitors except to limit visits to that resident only, excluding symptomatic visitors from visiting, and enforcing hand washing before and after visiting and using protective equipment as applicable. Closing a facility to visitors provides limited benefit in reducing transmission of symptoms; however it may become necessary due to attempts to further prevent the spread of the virus.

- The Medical Officer of Health will make the decision when the outbreak is declared over and households/Neighborhoods can be opened.

Nurse Responsibility:

1. Initiate & review line listing each shift.
2. Isolate affected residents to their rooms.
3. Post sick sign on the affected resident's door and on the household doors in the affected area. Close the household doors.
4. Contact Public Health if an outbreak is suspected on off hours or during the weekend. Leave a message for the Infection Control Coordinator.
5. Send specimens based on the outbreak type. Put outbreak # on the requisition.
   Enteric-Stool for viral, C&S and O&P
   Respiratory-Nasopharyngeal swab (Nasal swabs will not be accepted)
6. Discuss outbreak management during household shift huddles and report status to NH Manager at Daily Status.
7. Check for & request as needed that additional personal protective equipment is available in the neighborhood.

Infection Control Coordinator

1. Review line listings with the Nurse in the affected households.
2. Report to Public health that an outbreak is occurring and then report daily status by faxing updated line listing on a daily basis throughout the week. An outbreak # will be issued.
3. General Communication throughout the Home- daily updates as well as when new information presents via email
4. Discuss outbreak management at daily Leadership Team huddles.
5. Look at external programs- daycare etc. and community programs. Homewide program may need to be suspended. Director of Therapeutic Services will be notified.
6. Notify local hospital and local LTC facilities about any outbreak.
7. Notify Department of Health- resident transfers, moving in and respites may be put on hold during the outbreak.
8. Notify Medical Director and notification to family physicians.
9. Post signs on main entrances.
10. Ensure availability of sick signs for doors.
11. Check to see if additional personal protective equipment, specimen containers/swabs and/or other supplies are needed to be ordered for the Home.
12. Notify all above stakeholders, as mentioned above, when outbreak is over.

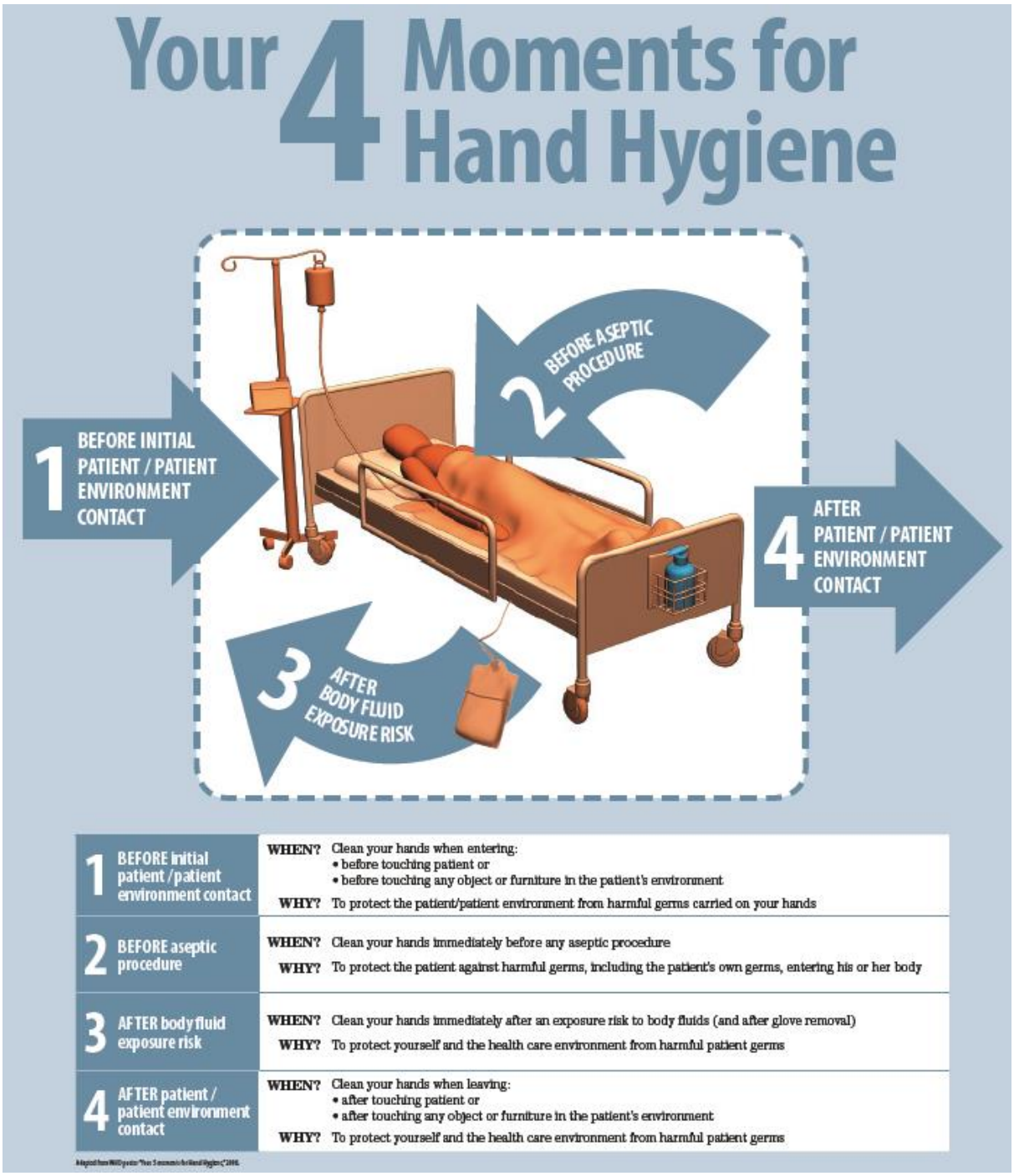
APPENDIX B: How to HANDRUB

Source: http://www.publichealthontario.ca/en/eRepository/how-to-handrub.pdf

How To Handwash

Source: http://www.publichealthontario.ca/en/eRepository/how-to-handwash.pdf

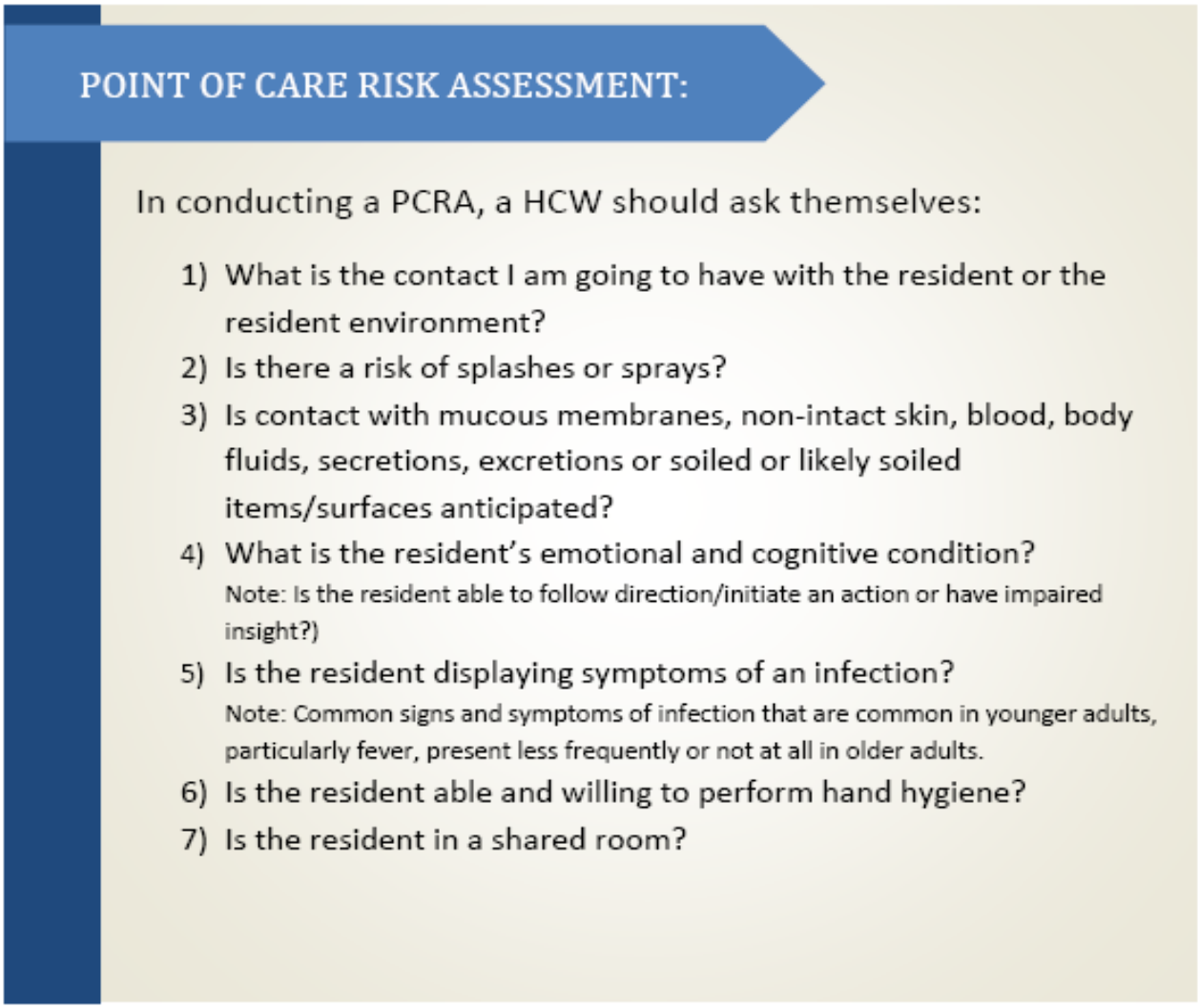
APPENDIX C: Your 4 Moments of Hand Hygiene



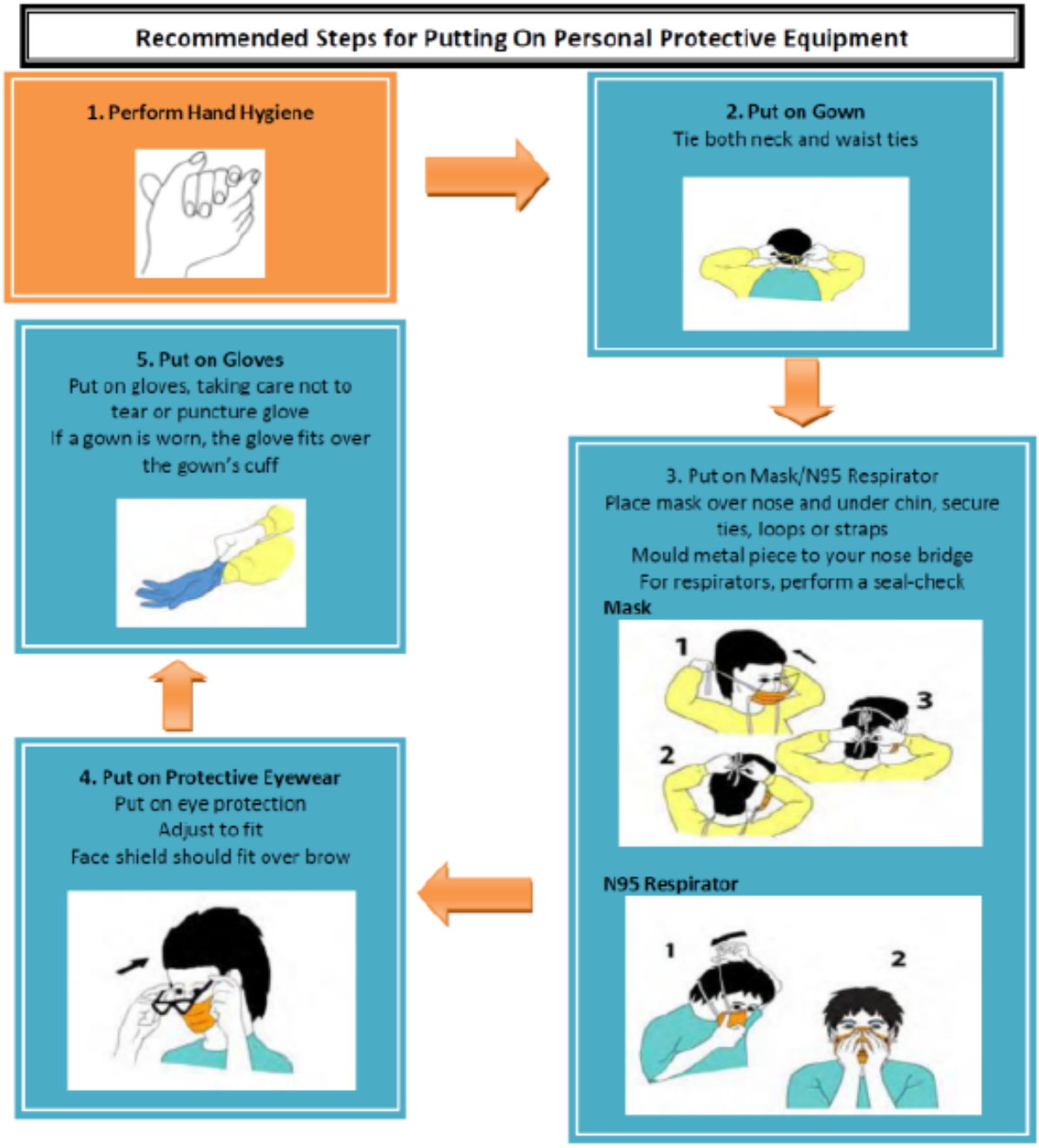
1	BEFORE initial patient / patient environment contact	**WHEN?** Clean your hands when entering: • before touching patient or • before touching any object or furniture in the patient's environment **WHY?** To protect the patient/patient environment from harmful germs carried on your hands
2	BEFORE aseptic procedure	**WHEN?** Clean your hands immediately before any aseptic procedure **WHY?** To protect the patient against harmful germs, including the patient's own germs, entering his or her body
3	AFTER body fluid exposure risk	**WHEN?** Clean your hands immediately after an exposure risk to body fluids (and after glove removal) **WHY?** To protect yourself and the health care environment from harmful patient germs
4	AFTER patient / patient environment contact	**WHEN?** Clean your hands when leaving: • after touching patient or • after touching any object or furniture in the patient's environment **WHY?** To protect yourself and the health care environment from harmful patient germs

Before each interaction with a resident, the HCW should do a PCRA to determine the appropriate interventions to prevent the transmission of microorganisms. The answers to the following questions determine the types of controls or interventions which are required to provide safe care. Examples of interventions or controls include the use of PPE, a change in accommodation, dedicated equipment, increased cleaning or implementing additional precautions. It is important to note that the PCRA is an ongoing process integrated into the routine delivery of care.

Figure 3: Point of Care Risk Assessment



APPENDIX E: Recommended Steps for Putting on Personal Protective Equipment/Steps for Taking Off Personal Protective Equipment



Adapted from: Ontario Ministry of Health and Long-Term Care/Public Health Division/Provincial Infectious Diseases Advisory Committee; Toronto Canada; August 2009 (ISBN: 978-1-4249-9725-1) by **Infection Prevention & Control Services, IWK Health Centre, September 2010**

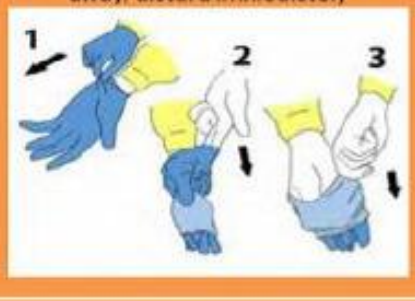
Recommended Steps for Taking Off Personal Protective Equipment

1. Remove Gloves

Remove gloves using a glove-to-glove/skin-to-skin technique

Grasp outside edge near the wrist and peel away, rolling the glove inside-out

Reach under the second glove and peel away, discard immediately



2. Remove Gown

Remove gown in a manner that prevents contamination of clothing or skin

Starting at the neck ties, the outer, 'contaminated', side of the gown is pulled forward and turned inward, rolled off the arms into a bundle, discarded immediately

3. Perform Hand Hygiene

4. Remove Protective Eyewear

Remove eye protection by handling ear loops, sides or back only

Discard into waste receptacle or into appropriate container to be sent for reprocessing

5. Remove Mask/N95 Respirator

Untie bottom tie then top tie, or grasp straps or ear loops, pull forward off the head, bending forward to allow mask/respirator to fall away from the face. Discard immediately into waste receptacle

Mask

N95 Respirator

6. Perform Hand Hygiene

N95 respirators must be removed outside patient room. All other PPE must be removed at doorway or in anteroom.

Last Revision October 24, 2014