## STANDARD PRECAUTIONS GUIDELINE

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<tr>
<td>02</td>
<td>Dr Nuala O’Connell</td>
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<td>Consultant: Microbiologist</td>
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<td>09/10</td>
<td>Heads of Disciplines: Nursing Support Service Management General Services Management Heads of Departments Infection Prevention &amp; Control team</td>
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1.0 POLICY STATEMENT
This guideline applies to best practice amongst Healthcare Workers in caring for all patients within the hospital environment.

2.0 PURPOSE
- To prevent the spread of cross infection.
- To uphold standards of safe practice.
- To protect both healthcare staff and every individual in their care at all times from the transmission of infection during care/hazardous procedures whether the risk is known or unknown.
- To ensure maximum protection of patients, visitors and staff without the need to divulge the individual’s diagnosis or other information that may be confidential.
- To ensure evidence based research underpins best practice.

3.0 SCOPE
The practices and procedures that are described in this guideline are to be used by all healthcare staff, bank/agency & contracted services involved in patient care to protect the patient and the individual providing care.

4.0 LEGISLATION/OTHER RELATED POLICIES


SAFETY, HEALTH AND WELFARE AT WORK ACT (2005)

5.0 GLOSSARY OF TERMS AND DEFINITIONS
5.1 Glossary of Definitions
Standard Precautions are evidence based clinical work practices published by the Centre of Disease Control (CDC) in 1996 and updated in 2007 that prevent transmission of infectious agents in healthcare settings. Standard precautions are a set of activities which must be used for all patients cared for within all healthcare settings. They are designed to prevent the transmission of microorganisms between patients even when the source of infection is not known. We do not always know which patients have microorganisms that can cause infection. Standard Precautions are designed for use with ALL patients who present in the EVERY healthcare setting (CDC 2003).

Personal Protective equipment (PPE) refers to a variety of Infection Prevention and Control barriers and respirators used alone, or in combination, to protect mucous membranes, skin, and clothing from contact with recognized and unrecognised sources of infectious agents in healthcare settings.

5.2 Glossary of Terms / Abbreviations
(BBV) Blood Borne Virus
(CDC) Centre of Disease Control
(C. diff) Clostridium difficile
(ED) Emergency Department
(ESBLs) extended spectrum beta-lactamases
6.0 ROLES AND RESPONSIBILITIES

It is the responsibility of Department heads to ensure that healthcare staff who report to them adhere to this guideline. All healthcare workers who are involved in patient care have a responsibility to observe the precautions outlined in these guidelines at all times. Healthcare workers (HCWs) have a professional responsibility to ensure that protective clothing is worn appropriately.

All healthcare workers have responsibilities to conform and respect all aspects of health and safety legislation. Managers have a key responsibility to ensure their department functions within the parameters of legislation and that staff are trained and assessed in these issues. All healthcare workers have a responsibility to ensure that they follow instructions, in accordance with local policy and not place themselves or others in danger (Safety, Health and Welfare Act 2005). It is the responsibility of all HCWs to ensure that they avail of Infection Prevention and Control education and training and have access to Infection Prevention and Control guidelines and policies.

7.0 STANDARD PRECAUTIONS GUIDELINE

Transmission of infections in health care facilities can be prevented and controlled through the application of basic Infection Prevention and Control precautions which can be grouped into standard precautions, which must be applied to all patients at all times, regardless of diagnosis or infectious status, and additional (transmission-based) precautions which are specific to modes of transmission-airborne, droplet and contact (please refer to the Infection Prevention and Control Isolation Guideline, 2010 for further information).

Treating all patients in the health care facility with the same basic level of standard precautions involves work practices that are essential to provide a high level of protection to patients, health care workers and visitors.

Universal blood and body fluid precautions is a concept that emerged in the 1980s, with protective clothing being one of a range of measures to prevent exposure to blood-borne viruses such as human immunodeficiency virus (HIV) (UK Health Departments 1990, Centre for Disease Control (CDC) 1988, CDC 1987). The term was replaced by Standard Precautions in 2007 which is now used to describe the application of a range of Infection Prevention and Control practices to prevent exposure to, and transmission of, a wide range of micro-organisms in healthcare settings. Standard precautions, or routine Infection Prevention and Control practice, also include hand hygiene, the safe disposal of clinical waste, decontamination of equipment and the environment, and the safe disposal of sharps (Wilson 2001).

This guideline offers advice to healthcare workers on Standard Precautions. It is important to emphasise that this guideline can only offer protection if used consistently.
and appropriately. Please refer to the ICNA/ Health Promotion Unit Standard Precautions Poster in your area.

**ALL health care workers in ALL situations involving the care of patients or contact with the environment must use Standard Precautions.**

### 7.1 The Spread of Infection

The spread of infection requires three elements:

**Infection Elements**

- **Source of microorganism**
- **Susceptible host or body site**
- **Means of transmission**

**Means of Transmission**

An infectious agent may be transmitted by contact (direct or indirect); droplets or by being airborne (inhalation of respiratory particles.)

The purpose of Standard Precautions is to break the chain of infection focusing particularly but not exclusively on the mode of transmission, portal of entry and susceptible host sections of the chain.

Aseptic technique and antibiotic prophylaxis while not components of Standard Precautions are other key practices used to break the Chain of Infection at the infectious agent, reservoir and portal of exit sections of the chain.

Because most people with blood borne viral infections such as HIV and HBV do not have symptoms, nor can they be visibly recognised as being infected, Standard Precautions
are designed for the care of all persons—patients and staff—regardless of whether or not they are infected. Standard Precautions require that health care workers assume that the blood and body substances of all patients are potential sources of infection, regardless of the diagnosis, or presumed infectious status.

Standard Precautions apply to blood and all other body fluids, secretions and excretions (except sweat), non-intact skin and mucous membranes. Their implementation is meant to reduce the risk of transmitting microorganisms from known or unknown sources of infection (e.g., patients, contaminated objects, used needles and syringes, etc.) within the healthcare setting. Applying Standard Precautions has become the primary strategy to preventing nosocomial infections in hospitalised patients. Placing a physical, mechanical or chemical barrier between microorganisms and an individual is a highly effective means of preventing the spread of infections (i.e. the barrier serves to break the disease transmission cycle).

The following actions create protective barriers for preventing infections in patients and are necessary for the care of all patients and healthcare workers. These provide the means for implementing Standard Precautions.
Infection Prevention and Control practices can be grouped in two categories:
• Standard precautions
• Additional (transmission-based) precautions.

Standard Precautions are intended to be applied to the care of all patients in all healthcare settings, regardless of the suspected or confirmed presence of an infectious agent. Implementation of Standard Precautions constitutes the primary strategy for the prevention of healthcare-associated transmission of infectious agents among patients and healthcare personnel (Refer to Appendix I).

7.2 All Patients/staff
Consider every patient or staff as potentially infectious and susceptible to infection.

7.3 Cover all cuts and abrasions
• Apply a waterproof dressing
• Ensure all healthcare workers (who are potentially in contact with blood, body fluids or human tissue) are immunized against Hepatitis B infection.

7.4 Hand Hygiene
• Hand Hygiene the most important procedure for preventing cross contamination (Person to person or contaminated object to person).
• Perform hand hygiene before and after patient contact, after contact with blood, body fluids, excretions, secretions, mucous membranes, broken skin or contaminated items and after gloves have been removed.
• Alcohol-based hand rubs/gels may be used as an alternative to hand washing if hands are visibly clean. Refer to the Mid-Western Regional Hospitals guideline on Hand hygiene (2010) for further advice.

7.5 Gloves
• Wear gloves on both hands before touching broken skin, mucous membranes, blood or other body fluids, or soiled instruments and contaminated waste materials—or before performing invasive procedures.

7.6 Personal Protective Equipment (PPE)
• Personal protective equipment should be chosen according to the risk of exposure. Health care workers should assess whether they are at risk of exposure to blood, body fluids excretions or secretions and choose their items of personal protective equipment according to this risk.

• Personal protective equipment (PPE) for healthcare personnel
PPE refers to a variety of barriers and respirators used alone or in combination to protect mucous membranes, airways, skin, and clothing from contact with infectious agents. The selection of PPE is based on the nature of the patient interaction and/or the likely mode(s) of transmission. A suggested procedure for donning and removing PPE that will prevent skin or clothing contamination is presented in Guideline for Isolation Precautions (2010). Designated containers (waste bins) for used disposable PPE should be placed in a location that is convenient to the site of removal to facilitate disposal and containment of contaminated materials. Hand hygiene is always the final step after removing and disposing of PPE.

- **Use physical barriers:** (protective goggles, face masks and aprons) if splashes and spills of any body fluids (secretions and excretions) are likely e.g., cleaning instruments and other items. Change PPE between patients.

- **Facial Protection:** use of mask, visor or goggles when splashing is anticipated. Masks are used for three primary purposes in healthcare settings:

  1. placed on healthcare personnel to protect them from contact with infectious material from patients e.g., respiratory secretions and sprays of blood or body fluids, consistent with Standard Precautions and Droplet Precautions;
  2. placed on healthcare personnel when engaged in procedures requiring sterile technique to protect patients from exposure to infectious agents carried in a healthcare worker’s mouth or nose, and
  3. placed on coughing patients to limit potential dissemination of infectious respiratory secretions from the patient to others (i.e., Respiratory Hygiene/Cough Etiquette).

- **Masks** may be used in combination with goggles to protect the mouth, nose and eyes, or a face shield may be used instead of a mask and goggles, to provide more complete protection for the face. The eye protection chosen for specific work situations (e.g., goggles or face shield) depends upon the circumstances of exposure, other PPE used, and personal vision needs. Personal eyeglasses and contact lenses are NOT considered adequate eye protection. Removal of a face shield, goggles and mask can be performed safely after gloves have been removed, and hand hygiene performed. The ties, ear pieces and/or headband used to secure the equipment to the head are considered “clean” and therefore safe to touch with bare hands. The front of a mask, goggles and face shield are considered contaminated.

- **Plastic Aprons/Fluid Repellent Gown**
  For contact with infected patients, excretions, contaminated equipment or materials. Isolation gowns are used as specified by Standard and Transmission-Based Precautions, to protect the HCW’s arms and exposed body areas and prevent contamination of clothing with blood, body fluids, and other potentially infectious material. The need for and type of isolation gown selected is based on the nature of the patient interaction, including the anticipated degree of contact with infectious material and potential for blood and body fluid penetration of the barrier.

  - Change PPE between each patient.
  - Hand hygiene is always the final step after removing and disposing of PPE.

### 7.7 Sharps

- The prevention of sharps injuries has always been an essential element of Standard Precautions. These include measures to handle needles and other sharp devices in a manner that will prevent injury to the user and to others who may encounter the device during or after a procedure.
  - Adoption of work practices that minimize risk of injury.
  - Assemble sharps box correctly, do not overfill.
  - Position sharps box in a safe place close to point of use.
  - Discard all sharps/sharp items in a sharps box immediately after use.
• Do not re-cap, bend, disassemble or break needles.
• The user is responsible for disposing of sharps.
• Refer to the Infection Prevention & Control Occupational Exposure Management including Sharps Policy and Procedure, 2010.

7.8 Sharps Injury/Splash of Blood
• Encourage the puncture site to bleed
• Wash area with water
• Apply waterproof dressing
• Identify source patient (if appropriate)
• Notify head of department/person in charge
• Record incident/accident on appropriate form
• Refer to local policies on sharps injury for further advice.
• For splashes of blood/body fluids which occur to eyes, nose, mouth or broken skin. Wash immediately with water or a normal saline solution and proceed as outlined above. (Refer to the Infection Prevention & Control Occupational Exposure Management including Sharps Policy and Procedure 2010)

7.9 Management of Blood Spills
• Wear appropriate personal protective equipment (PPE), such as gloves, disposable plastic apron.
• Decontaminate all blood spills with a Chlorine based disinfectant or suitable alternative (Spill Kits are available in each area).
• Follow the manufacuter's instructions and follow local policy.

7.10 Medical Devices/Patient Care Equipment
• Ensure medical devices labeled as “Single Use Only” are not reprocessed or reused.

This Symbol means “Singe Use Only”

• Ensure “Reusable Equipment” is appropriately decontaminated between patients. Appropriate decontamination of healthcare equipment must be in line with Infection Prevention and Control principles and manufacturer’s instructions. Refer to Infection Prevention and Control Guidelines for Cleaning and Disinfection of Equipment and the Environment, (2010), for further advice.

7.11 Environmental Cleaning & Decontamination
• Ensure all environmental surfaces, particularly those in contact with patients are routinely cleaned with detergent and water (and disinfected when required). Please refer and follow local Infection Prevention and Control policies and procedures on cleaning and decontamination e.g. Guidelines for Cleaning and Disinfection of Equipment and the Environment, (2010), for further advice.

7.12 Waste & Laundry
• Segregate all healthcare risk and non-risk waste in appropriate bag/container such as:
  ▪ Risk waste in appropriate clinical waste stream.
  ▪ Non-risk waste in clear or black bags.
  ▪ Please refer to local Infection Prevention and Control waste management guideline, 2010, for further guidance.
  ▪ Place soiled, fouled or infected linen in an alginate or water soluble bag before placing in a laundry bag.
  ▪ Please refer to the local Infection Prevention and Control linen/laundry guideline, (2010) for further guidance.
7.13 Additional (Transmission-Based) Precautions

Additional (transmission-based) precautions are taken while still ensuring standard precautions are maintained.

There are three categories of Transmission-Based Precautions:

- Contact Precautions
- Droplet Precautions
- Airborne Precautions.

Transmission-Based Precautions are used when the route(s) of transmission is (are) not completely interrupted using Standard Precautions alone.

7.13.1 Airborne Precautions

Airborne Precautions prevent transmission of infectious agents that remain infectious over long distances when suspended in the air (e.g., rubeola virus [measles], varicella virus [chickenpox], M. tuberculosis, and possibly SARS-CoV) (refer to The Infection Prevention & Control Guideline on Isolation Precautions (2010).

The preferred placement for patients who require Airborne Precautions is in an airborne infection isolation room. In settings where Airborne Precautions cannot be implemented due to limited engineering resources (e.g., physician offices), masking the patient, placing the patient in a private room (e.g., office examination room) with the door closed, and providing N95 or higher level respirators or masks if respirators are not available for healthcare personnel will reduce the likelihood of airborne transmission. Healthcare personnel caring for patients on Airborne Precautions wear a mask or respirator, depending on the disease-specific recommendations that is donned prior to room entry. Whenever possible, non-immune HCWs should not care for patients with vaccine-preventable airborne diseases (e.g., measles, chickenpox, and smallpox).

7.13.2 Droplet Precautions

Droplet Precautions are intended to prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions. Because these pathogens do not remain infectious over long distances in a healthcare facility, special air handling and ventilation are not required to prevent droplet transmission. Infectious agents for which Droplet Precautions are indicated are found in The Infection prevention & Control Isolation Precautions Guideline (2010) and include B. pertussis, influenza virus, adenovirus, rhinovirus, N. meningitides, and group A streptococcus (for the first 24 hours of antimicrobial therapy).

A single patient room is preferred for patients who require Droplet Precautions. When a single-patient room is not available, consultation with infection control personnel is recommended to assess the various risks associated with other patient placement options (e.g., cohorting, keeping the patient with an existing roommate) Healthcare personnel wear a mask (a respirator is not necessary) for close contact with infectious patient; the mask is generally donned upon room entry. Patients on Droplet Precautions who must be transported outside of the room should wear a mask if tolerated and follow Respiratory Hygiene/Cough Etiquette.

7.13.3 Contact Precautions

Contact Precautions are intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, which are spread by direct or indirect contact with the patient or the patient’s environment as described in The Infection Prevention & Control Guidelines for Isolation Precautions (2010).

The application of Contact Precautions for patients infected or colonised with Multi Drug Resistant Organisms (MDRO) is described in the Infection prevention & Control Isolation Precautions Guideline 2010). Contact Precautions also apply where the presence of excessive wound drainage, fecal incontinence, or other discharges from the body suggest an increased potential for extensive environmental contamination and risk of
transmission. A single-patient room is preferred for patients who require Contact Precautions. When a single-patient room is not available, consultation with infection control personnel is recommended to assess the various risks associated with other patient placement options (e.g., cohorting, keeping the patient with an existing room mate).

7.13.4 Syndromic And Empiric Applications Of Transmission-Based Precautions

Diagnosis of many infections requires laboratory confirmation. Since laboratory tests, especially those that depend on culture techniques, often require two or more days for completion, Transmission-Based Precautions must be implemented while test results are pending based on the clinical presentation and likely pathogens. Use of appropriate Transmission-Based Precautions at the time a patient develops symptoms or signs of transmissible infection, or arrives at a healthcare facility for care, reduces transmission opportunities.

While it is not possible to identify prospectively all patients needing Transmission-Based Precautions, certain clinical syndromes and conditions carry a sufficiently high risk to warrant their use empirically while confirmatory tests are pending, See Appendix II. Clinical syndromes or conditions warranting empiric transmission-based precautions in addition to standard precautions pending confirmation of diagnosis, for further detail, Refer to Appendix III for advice on Infection Control Guideline for Prioritisation for Isolation of Patients in the Emergency Department. Note – the febrile returning traveller should be assessed for presence of infectious diseases endemic to the region they have come from. If in doubt, contact a member of the Infection Prevention and Control Team.

7.13.5 Inability To Isolate A Patient Appropriately

Due to the lack of side rooms it is often necessary to prioritise which infectious patient most urgently required single room isolation. The prioritisation of infectious patients for isolation depends on the route of infection (which determines infectiousness) and the extent of potential consequences of spread of infection (ability to infect staff as well as patients, severity of infection, availability of treatment or prophylaxis).

Patients with infections that spread via airborne droplet nuclei are a major priority to isolate.

When there are insufficient side rooms to isolate all patients who ought to be isolated, a risk assessment should be performed for each patient taking into consideration:

- Probable route of transmission
- Whether the infection is sporadic, endemic or epidemic
- Degree of antibiotic resistance
- Susceptibility of other patients
- Dispersal characteristics of the particular patient

When faced with a competing need for isolation facilities, please place patients in single rooms in the order of priority indicated in the table in Appendix IV (Prioritising use of single-bedded rooms for isolation of common infections).

Other infections may take precedence; seek advice from the Infection Prevention and Control Team (IP&CT).

The need for isolation in these categories overrides that needed for ‘dignity and privacy’. It may be necessary to remove a patient from isolation to accommodate another patient with a higher priority for isolation; in this event please contact the IP&CT.
Please refer to local Infection Prevention and Control Isolation guideline 2010, for details on IP&C isolation precautions.

7.14 RISK ASSESSMENT

Various factors need to be considered when assessing risk as required by the COSHH Regulations (COSHH 1999).

The key factors are:
- Hazard identification e.g. whether a blood-borne virus (BBV) may be present
- What effect the BBV may have
- Where the BBV is present, e.g. blood or blood-stained body fluids
- Ways in which the employee may be exposed, e.g. direct contact or a sharps injury
- Estimate of exposure, i.e. number and range of sources and frequency of contact.

8.0 IMPLEMENTATION PLAN

8.1 This guideline will be implemented by Heads of Disciplines, Nursing Support Service Management, General Services Management, Heads of Departments and the Infection Prevention & Control Team in the Mid-Western Regional Hospitals.

8.2 The Heads of Disciplines and Heads of Departments are responsible to ensure that this guideline is available/brought to the attention to staff who report to them in their areas of responsibility.

8.3 Staff have a responsibility to read this guideline and sign the Signature Sheet (Refer to Appendices).

8.4 The Infection Prevention and Control Team will provide education and training sessions to relevant staff as part of the implementation process of this guideline.

8.5 The receipt sheet should be returned to the infection Prevention and Control secretary.

8.6 The Infection Prevention & Control team will be responsible for maintaining guideline receipt sheets from all Wards/Departments. It is the responsibility of Heads of Disciplines and Heads of Departments to maintain records locally.

9.0 REVISION AND AUDIT.

9.1 The Guideline will be reviewed by the Infection Prevention and Control Team and updated as necessary and at least every 2 years.

9.2 An audit will be undertaken within one year of issue.
10.0 REFERENCES/ BIBLIOGRAPHY


Centres for Disease Control CDC (2003) Infection Control for Viral Haemorrhagic Fevers In the African Health Care Setting, Annex 1 Standard Precautions for Hospital Infection Control.


Infection Control Nurses Association (ICNA) Protective Clothing, Principles and Guidance (2002) Fitwise, Drumcross Hall, Bathgate, EH48 4JT


Mid Western Regional Hospitals (MWRHs) (2010); Policy on Healthcare Risk Waste and its Segregation & Disposal within the HSE Mid-West Area.

Mid Western Regional Hospitals (MWRHs) (2010); Guideline for the Handling and Segregation of Linen.
Mid Western Regional Hospitals (MWRHs) (2010); Guidelines for Isolation Precautions.

Mid Western Regional Hospitals (MWRHs) (2010); Guidelines for Cleaning and Disinfection of Equipment and the Environment.

Mid Western Regional Hospitals (MWRHs) (2010); Hand Hygiene Guideline.


Oireachtas SAFETY, HEALTH AND WELFARE AT WORK ACT (2005) www.oireachtas.ie/viewdoc Accessed on 24/05/10


### APPENDIX I Recommendations For The Application Of Standard Precautions For The Care Of All Patients In All Healthcare Settings

<table>
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<tr>
<th>Component</th>
<th>Recommendations</th>
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<tbody>
<tr>
<td><strong>Hand Hygiene</strong></td>
<td>• After touching blood, body fluids, secretions, excretions &amp; contaminated items</td>
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<td>• Immediately after removing gloves</td>
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<td>• Between patient contacts</td>
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<td>• Between tasks and procedures on the same patient.</td>
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<td></td>
<td>• Alcohol based hand rubs/gels should only be used if hands are visibly clean.</td>
</tr>
<tr>
<td><strong>Personal Protective Equipment (PPE)</strong></td>
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</tr>
<tr>
<td>Gloves</td>
<td>• When touching blood, body fluids, secretions, excretions &amp; contaminated items</td>
</tr>
<tr>
<td></td>
<td>• For touching mucous membranes and non-intact skin.</td>
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<tr>
<td></td>
<td>• Change gloves between tasks on the same patient after contact with material, which may contain a high concentration of microorganisms.</td>
</tr>
<tr>
<td></td>
<td>• Change gloves before going to another patient. Always conduct hand hygiene to avoid transfer of microorganisms to other patients.</td>
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<tr>
<td></td>
<td>• During procedures and patient-care activities when contact of clothing/exposed skin with blood/body fluids, secretions, and excretions is anticipated.</td>
</tr>
<tr>
<td>Mask, eye protection, goggles, face shield</td>
<td>• During procedures and patient care activities likely to generate splashes or sprays of blood, body fluids, secretions, especially suctioning, endotracheal intubation</td>
</tr>
<tr>
<td>Gown</td>
<td>• During procedures and patient care activities when contact of clothing/exposed skin with blood/body fluids, secretions and excretions is anticipated.</td>
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<tr>
<td></td>
<td>• Select a gown that is appropriate for the activity and amount of fluid likely to be encountered.</td>
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<tr>
<td></td>
<td>• Remove soiled gown as promptly as possible.</td>
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<tr>
<td></td>
<td>• Hand Hygiene: Wash hands or use Alcohol based hand rubs/gels if hands are visibly clean.</td>
</tr>
<tr>
<td>Soiled patient-care equipment</td>
<td>• Handle in a manner that prevents transfer of microorganisms to other and to the environment; wear gloves if visibly contaminated; perform hand hygiene.</td>
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<td></td>
<td>• Ensure medical devices labeled as “Single Use Only” are not reprocessed or reused.</td>
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<td></td>
<td>• This symbol ✂ means “Single Use Only”</td>
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<tr>
<td></td>
<td>• Ensure “Reusable Equipment” is appropriately decontaminated between patients.</td>
</tr>
<tr>
<td>Environmental Control</td>
<td>• Develop procedures for routine care, cleaning and disinfection of environmental surfaces, especially frequently touched surfaces in patient-care areas.</td>
</tr>
<tr>
<td>Textiles &amp; laundry</td>
<td>• Handle, transport and process linen in a manner that prevents transfer of micro-organisms to others and to the environment</td>
</tr>
<tr>
<td>Needles &amp; other sharps</td>
<td>• Do not recap, bend, break, or hand manipulate used needles.</td>
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<td></td>
<td>• Use safety features when available.</td>
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<tr>
<td></td>
<td>• Place used sharps in an approved sharps container.</td>
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<tr>
<td>Patient Resuscitation</td>
<td>• Use mouthpiece, resuscitation bag other ventilation devices to prevent contact with mouth and oral secretions.</td>
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### Patient Placement

- Prioritise for single-patient room if patient is at increased risk of transmission, is likely to contaminate the environment, does not maintain appropriate hygiene, or is at increased risk of acquiring infection or developing adverse outcomes following infection.
- If a private room is unavailable, consult with the Infection Control Team regarding patient placement or other alternatives.

### Respiratory hygiene/cough etiquette

**Respiratory hygiene/cough etiquette**

(source containment of infectious respiratory secretions in symptomatic patients, beginning at initial point of encounter e.g., triage and reception areas in emergency departments and physician offices)

- Instruct symptomatic persons to cover mouth/nose when sneezing/coughing; use tissues and dispose in non-touch receptacle; observe hand hygiene after soiling of hands with respiratory secretions; wear surgical mask if necessary or maintain spatial separation > 3 feet if possible.

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**Note:**

During aerosol-generating procedures on patients with suspected or proven infections transmitted by respiratory aerosols (e.g., SARS), wear a fit-tested N95 or higher respirator in addition to gloves, gown, and face/eye protection.
**APPENDIX II Clinical Syndromes Or Conditions Warranting Empiric Transmission-Based Precautions In Addition To Standard Precautions Pending Confirmation Of Diagnosis**

<table>
<thead>
<tr>
<th>Clinical Syndrome or Condition</th>
<th>Potential Pathogens</th>
<th>Empiric Precautions (Always includes Standard Precautions)</th>
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<tbody>
<tr>
<td><strong>DIARRHOEA</strong></td>
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<tr>
<td>Acute diarrhea with a likely infectious cause in an incontinent or diapered patient</td>
<td>Enteric pathogens</td>
<td>Contact Precautions (paediatrics and adult)</td>
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| **MENINGITIS**                |                     |                                                            |
| Neisseria meningitidis Enteroviruses M. tuberculosis | Droplet Precautions for first 24 hrs of antimicrobial therapy; mask and face protection for intubation Contact Precautions for infants and children Airborne Precautions if pulmonary infiltrate Airborne Precautions plus Contact Precautions if potentially infectious draining body fluid present |

| **RASH OR EXANTHEMS, GENERALIZED, ETIOLOGY UNKNOWN** | | |
| Petechial/ecchymotic with fever (general) - If positive history of travel to an area with an on going outbreak of VHF in the 10 days before onset of fever | Neisseria meningitides Ebola, Lassa, Marburg viruses | Droplet Precautions for first 24 hrs of antimicrobial therapy Droplet Precautions plus Contact Precautions, with face/eye protection, emphasizing safety sharps and barrier precautions when blood exposure likely. Use N95 or higher respiratory protection when aerosol-generating procedure performed |

| Vesicular | Varicella-zoster, herpes simplex, variola (smallpox), vaccinia viruses Vaccinia virus | Airborne plus Contact Precautions; Contact Precautions only if herpes simplex, localized zoster in an immunocompetent host or vaccinia viruses most likely |

| Maculopapular with cough, coryza and fever | Rubeola (measles) virus | Airborne Precautions |

<p>| <strong>RESPIRATORY INFECTIONS</strong> | | |
| Cough/fever/upper lobe pulmonary infiltrate in an HIV-negative patient or a patient at low risk for human immunodeficiency virus (HIV) infection | M. tuberculosis, Respiratory viruses, S. pneumoniae, S. aureus (MSSA or MRSA) | Airborne Precautions plus Contact precautions |</p>
<table>
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<tr>
<th>Cough/fever/pulmonary infiltrate in any lung location in an HIV-infected patient or a patient at high risk for HIV infection</th>
<th>M. tuberculosis, Respiratory viruses, S. pneumoniae, S. aureus (MSSA or MRSA)</th>
<th>Airborne Precautions plus Contact Precautions Use eye/face protection if aerosol-generating procedure performed or contact with respiratory secretions anticipated. If tuberculosis is unlikely and there are no AIIRs and/or respirators available, use Droplet Precautions instead of Airborne Precautions. Tuberculosis more likely in HIV-infected individual than in HIV negative individual</th>
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<tr>
<td>Cough/fever/pulmonary infiltrate in any lung location in a patient with a history of recent travel (10-21 days) to countries with active outbreaks of SARS, avian influenza</td>
<td>M. tuberculosis, severe acute respiratory syndrome virus (SARS-CoV), avian influenza</td>
<td>Airborne plus Contact Precautions plus eye protection. If SARS and tuberculosis unlikely, use Droplet Precautions instead of Airborne Precautions.</td>
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<tr>
<td>Respiratory infections, particularly bronchiolitis and pneumonia, in infants and young children</td>
<td>Respiratory syncytial virus, parainfluenza virus, adenovirus, influenza virus, Human metapneumovirus</td>
<td>Contact plus Droplet Precautions; Droplet Precautions may be discontinued when adenovirus and influenza have been ruled out</td>
</tr>
</tbody>
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### Skin or Wound Infection

<table>
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<tr>
<th>Skin or Wound Infection</th>
<th>Staphylococcus aureus (MSSA or MRSA), group A streptococcus</th>
<th>Contact Precautions Add Droplet Precautions for the first 24 hours of appropriate antimicrobial therapy if invasive Group A streptococcal disease is suspected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abscess or draining wound that cannot be covered</td>
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</table>

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

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

§ These pathogens include enterohemorrhagic Escherichia coli O157:H7, Shigella spp, hepatitis A virus, noroviruses, rotavirus, C. difficile.
APPENDIX III Infection Control Guideline For Prioritisation For Isolation Of Patients In The Emergency Department

Infection Control Guideline for Prioritisation for Isolation of Patients in the Emergency Department

Given the limitations of facilities for isolation in the Emergency Department, it is not uncommon that, all of the patients who should ideally be in single rooms cannot be accommodated in single rooms. This guideline is intended to provide general assistance in terms of prioritisation for single room accommodation when this situation arises. In all cases, every effort should be made to move patients who require admission from ED to appropriate in patient accommodation as quickly as possible.

Please refer to the “Guideline for Isolation Precautions” if necessary - Section 6 in the Infection Prevention & Control Manual.

Priority 1: The highest priority for isolation must be given to patients suspected of infection with agents that can be transmitted by the airborne route and that may be associated with serious disease. Examples include:

1. Patients with an undiagnosed acute febrile illness and a history of recent travel outside of the EU (especially if travel to a Viral Haemorrhagic Fever (e.g Congo-Crimean fever, Ebola fever, Lassa fever, Marburg fever, Endemic area etc).
2. Patient suspected to have tuberculosis (TB), measles, varicella-zoster virus (VZV) e.g chicken-pox, open / ophthalmic shingles, etc.
3. Patients who are vomiting and are suspected of having Norovirus infection during periods of high activity in the community.

Priority 2: Spread of many infectious agents can be prevented by strict adherence to contact precautions, although, in practice this is difficult to implement for extended periods without single room isolation or cohorting of patients, particularly when the ED has a large number of patients on trolleys and limited toilet facilities.
Examples of such infections include those spread by droplet or contact routes and include:

1. Patients with diarrhoea (contact route mostly)
2. Patient droplet transmitted infections include:
   (a) Meningitis – both bacterial (e.g meningococcal) and viral (e.g mumps) or meningitis of unknown cause.
   (b) Influenza A & B or influenza –like illnesses*
   (c) Mumps
   (d) Rubella (including congenital)
   (e) Diphtheria (pharyngeal)
   (f) Parvovirus/Erythrovirus
   (g) Pertussis (whooping cough)
   (h) Respiratory Syncytial Virus (RSV)
3. Patients with discharging pyogenic infections
4. Patients infected with or colonized with meticillin-resistant Staphylococcus aureus (MRSA) and other antibiotic resistant organisms, e.g VRE, ESBLs, etc.
Notes:

1. *An Influenza-like illness is typically characterized by abrupt onset fever, myalgia, headache, shivers with and respiratory symptoms.

2. Note that in most cases when a single room is not available, most of the benefits of isolation can be achieved by rigorous adherence to physical separation, barrier precautions, hand hygiene and the wearing of a surgical mask by the patient if the patient has an influenza-like illness.
APPENDIX IV Priotising Use Of Single-Bedded Rooms for Isolation Of Common Infections

When faced with a competing need for isolation facilities, please place patients in single rooms in the order of priority indicated in the table below. Refer to IP&C Guidelines for further advice.

1. Viral Haemorrhagic fever
   - Pyrexia of unknown origin (PUO) from abroad (where viral haemorrhagic fever is not a concern)

2. Tuberculosis–pulmonary
   - Isolate on suspicion without laboratory confirmation.
   - Check duration of isolation with IP&CT as isolation no longer required if treated for more than 2 weeks.

3. Diarrhoea and/or vomiting–until an infectious etiology is ruled out
   - Clinically diagnosed (i.e. suspect), or laboratory proven viral cause (e.g. Norovirus, Clostridium difficile).
   - Norovirus - maintain isolation until patient is asymptomatic for 72 hours
   - C. difficile – maintain isolation until patient is asymptomatic for 48 hours and continue metronidazole or vancomycin treatment for 10 day course according to the antibiotic policy.
   - There is no need to send further samples to the laboratory to check for ‘clearance.

4. Chickenpox or shingles (Varicella Zoster Virus infection)
   - Chickenpox is spread by respiratory droplet, a patient is infectious for 48 hours before the onset of the rash and until the rash has dried and crusted
   - Shingles is infectious from direct contact with the rash. A patient whose rash is covered by clothes will be a lower infectious risk than a patient with VZV infection on the face which can't be covered.

5. MRSA Infection
   - Every effort must be made to isolate patients with active MRSA infection
   - Isolate if sputum positive with productive cough.
   - If skin positive and shedding due to condition such as eczema or psoriasis.
   - Patients with MRSA sepsis

6. Influenza
   - Clinically suspected or laboratory proven.
   - In immunocompetent people maintain isolation up to the 5th day from the onset of symptoms.
   - In immunocompromised people check duration of isolation with IP&CT.

7. Multi-resistant Acinetobacter/Pseudomonas
   - Contact IP&CT if patient needs to be removed from isolation.

8. Meningitis
   - Clinically suspected or laboratory proven.
   - Check with microbiologists for advice on management, investigation & infection control
   - Notify Public Health (061)483338

9. MRSA
   - If known MRSA positive upon admission, transfer, etc.
   - If diagnosed as colonised post MRSA screen.
   - If NOT MRSA screened prior to transfer from other health care organisation

10. Multi-resistant Gram-negative bacteria and VRE
   - Contact the Infection Control Team if patient needs to be removed from isolation.
   - VRE in patients with active diarrhea, Assess individual risks e.g. incontinence, diarrhoea
   - ESBL producing coliform infection in urine (ESBL+ E. coli, ESBL+ Klebsiella sp)
   - GRE (Glycopeptide Resistant Enterococci e.g. VRE)
APPENDIX V Signature Sheet

I have read, understand and agree to adhere to the attached Guideline

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