GLAD YOU ASKED THE PEDIATRIC INFECTION PREVENTIONIST… AND THE ANSWERS

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Why do we do this? How can we make this work for families? That only works for adults. Kids are special. Kids are different.

LECTURE TOPICS

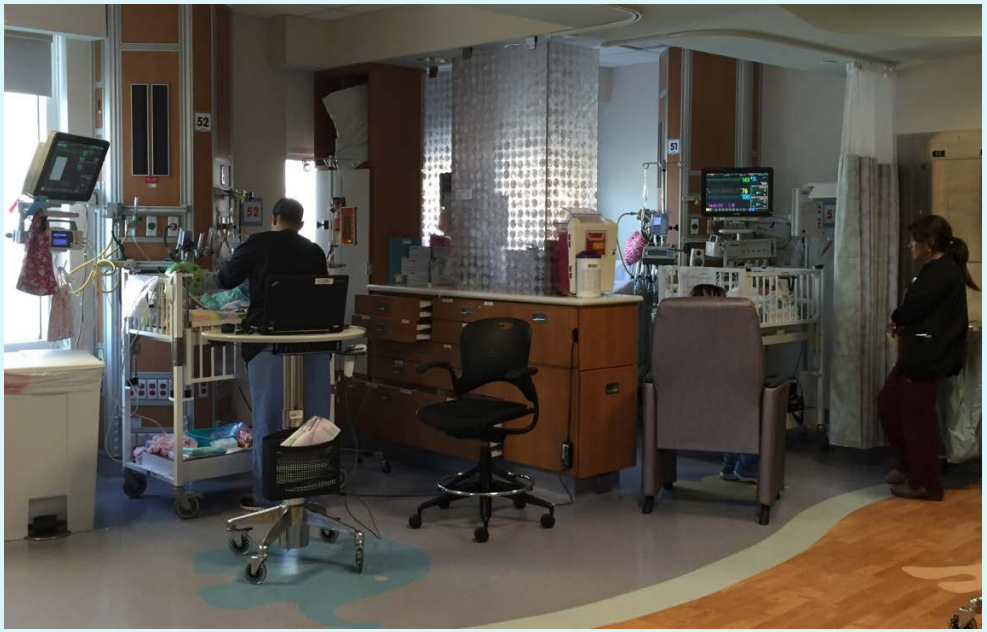
- Common infection prevention questions which are asked
- Importance of pediatric and maternal specific policies
- No conflicts of interests

A LITTLE ABOUT ME…

UNC Health Care's Pediatric Infection Preventionist
Pediatric Nurse Practitioner Student, UNC School of Nursing
NICU Nurse, Pediatric Critical Care Nurse

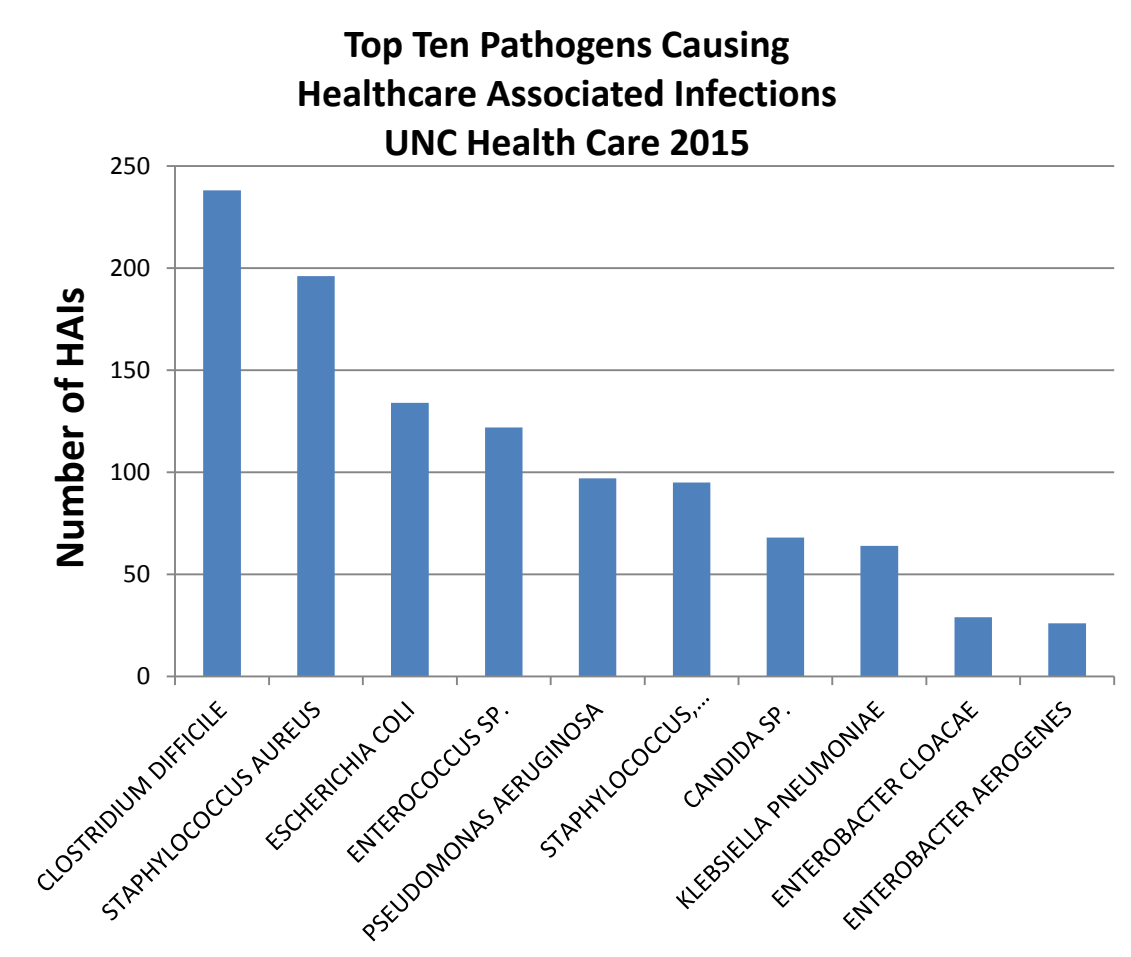
"WE JUST ADMITTED A PATIENT TO THE NICU WHOSE MOTHER HAS MRSA, WHAT SHOULD WE DO?"

- Do we have a policy that addresses this situation?
- Where should the baby be housed?
- Should the health care personnel (HCP) follow Contact Precautions? Should the parents?
- Should we do MRSA surveillance swabs on the baby? If so, when?



METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS

- Endemic in U.S. hospitals, accounts for 50-70% of nosocomial *S. aureus* infections;
- Continuing problem of community-associated strains
- Transmission
  - Close contact: direct or indirect
  - Environmental contamination linked to transmission



"WE JUST ADMITTED A PATIENT TO THE NICU WHOSE MOTHER HAS MRSA, WHAT SHOULD WE DO?"

- UNC Health Care has a policy to address this situation.
- Baby placed on Contact Precautions in isolation room
- No surveillance swabs are done

Appendix 9: MRSA in NCCC/NBN

Physicians need to:

- clearly express to the parents the risks to the infant (exposure to MRSA/ORSA from the family members may cause colonization, infection, and death)
- explain to the family that hand hygiene can help prevent colonization recurrence in the infant
- document this conversation in the infant's chart
- validate that the following precautions are understood and followed by the colonized visitors and the nursing staff
- maintain CPOE orders to keep the infant on Contact Precautions, as recolonization may occur after visitation

If the parent/MD assesses the benefits to outweigh the risks and they accept the risks, the following steps will be taken to protect the NCCC environment, other patients, visitors, and staff:

Nursing Staff need to:

- follow Contact Precautions while caring for the infant, as if they are known to be colonized
- follow and enforce optimal hand hygiene for anyone involved inside
- educate the family about MRSA/ORSA and Contact Precautions in NCCC
- enforce that the colonized visitors follow these recommendations:

Colonized family members need to:

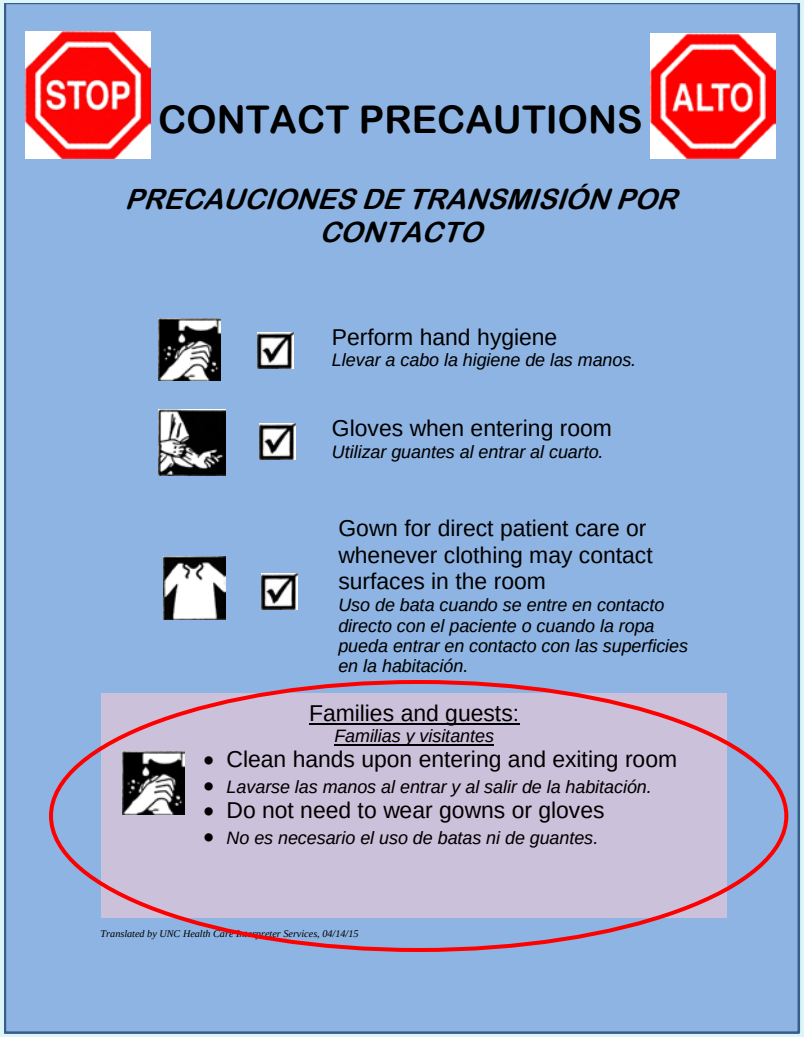
- wash their hands before touching the phone to gain access to NCCC
- visitation occurs only in the isolation room
- family members are not allowed to visit other patients in NCCC
- colonized family members will be encouraged to protect others by staying in the baby's isolation room until they are ready to go home for the day
- the colonized visitor will perform hand hygiene before touching the infant and before leaving the isolation room

Newborn Nursery Case:

- Colonized mother will be on Contact Precautions
- Baby will room in with mother
- Mother will be taught to perform hand hygiene before touching infant
- If infant needs to enter the Newborn Nursery, infant will be placed on Contact Precautions

"DO THE PARENTS HAVE TO WEAR GOWNS/GLOVES?"

- Families and guests/visitors do not have to wear gowns/gloves.
- Why?
  - Poor compliance
  - No guidance from CDC for guests
  - Visitors don't go from patient to patient
- Instead
  - Focus on hand hygiene
  - Clean In, Clean Out



STOP

CONTACT PRECAUTIONS

ALTO

PRECAUCIONES DE TRANSMISIÓN POR CONTACTO

☑ Perform hand hygiene
Llevar a cabo la higiene de las manos.

☑ Gloves when entering room
Utilizar guantes al entrar al cuarto.

☑ Gown for direct patient care or whenever clothing may contact surfaces in the room
Uso de bata cuando se entre en contacto directo con el paciente o cuando la ropa pueda entrar en contacto con las superficies en la habitación.

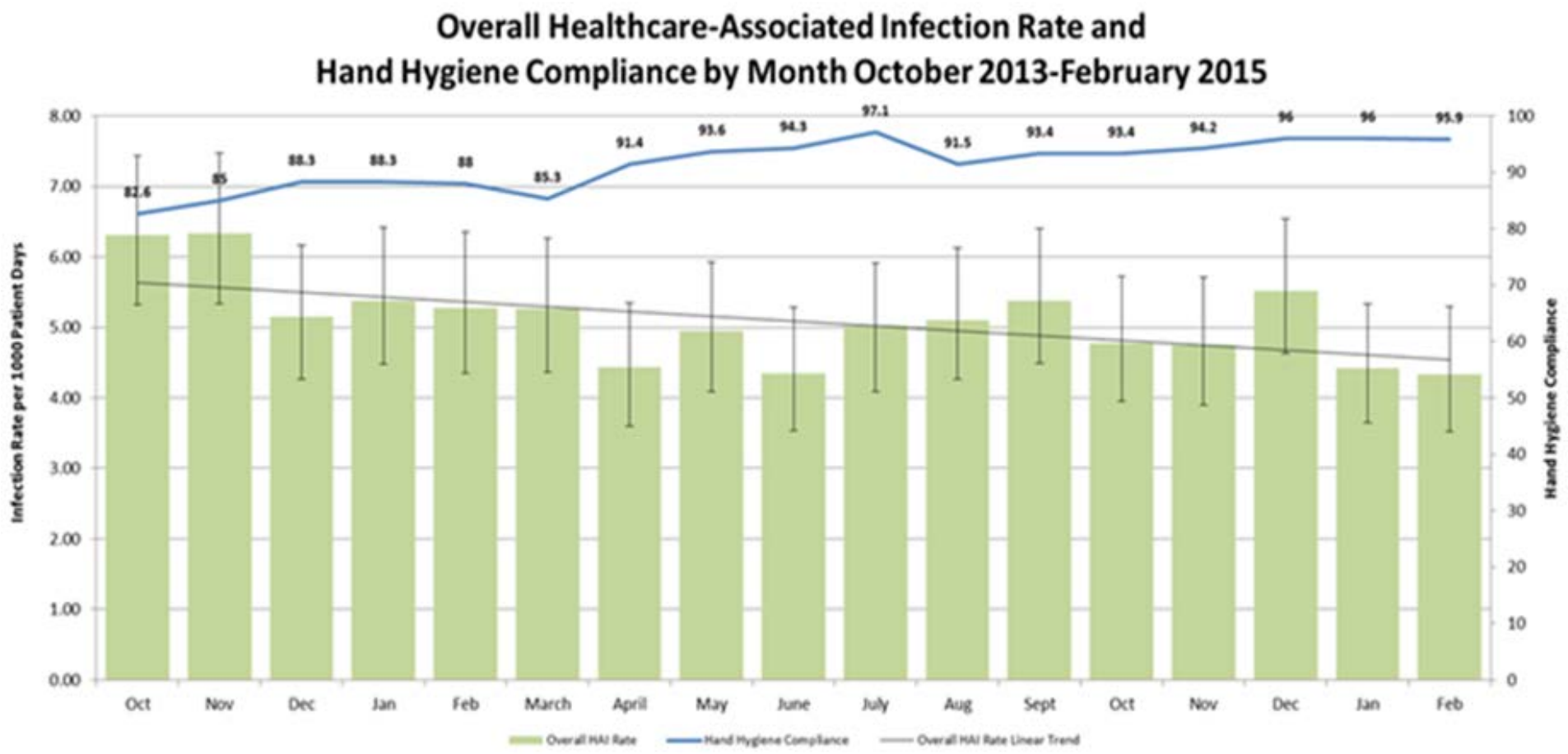
Families and guests:
Familias y visitantes

- Clean hands upon entering and exiting room
- *Lavarse las manos al entrar y al salir de la habitación.*
- Do not need to wear gowns or gloves
- *No es necesario el uso de batas ni de guantes.*

Translated by UNC Health Care Interpreter Services, 04/14/15

CLEAN IN, CLEAN OUT

- UNC's Hand Hygiene Program
- Teach 5 moments
- Observations of cleaning in and cleaning out
- First 17 months of program over 200,000 observations
- Focus on feedback
  - 50-60% of observations per month have compliment or reminder
- All staff do hand hygiene observations
- Compliance went from 86% to 97%
- Statistically decreased HAI


Overall Healthcare-Associated Infection Rate and
Hand Hygiene Compliance by Month October 2013-February 2015
Infection Rate per 1000 Patient Days
Hand Hygiene Compliance
8.00
7.00
6.00
5.00
4.00
3.00
2.00
1.00
0.00
100
90
80
70
60
50
40
30
20
10
0
82.6
85
88.3
88.3
88
85.3
91.4
93.6
94.3
97.1
91.5
93.4
93.4
94.2
96
96
95.9
Oct
Nov
Dec
Jan
Feb
March
April
May
June
July
Aug
Sept
Oct
Nov
Dec
Jan
Feb
Overall HAI Rate
Hand Hygiene Compliance
Overall HAI Rate Linear Trend

"I'M A PREGNANT NURSE AND I JUST TOOK CARE OF A PATIENT WITH PARVOVIRUS B-19, SHOULD I BE WORRIED?"

- Do we have a policy that addresses this?
- How should we council her?
- Is she at risk? Is her fetus?
- What questions do we need to ask her?

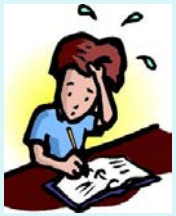
PARVOVIRUS B-19 REVIEW

Conditions	Usual Hosts
Erythema Infectiosum (fifth disease)	Immune competent children
Polyarthopathy Syndrome	Immune competent adults
Transient Aplastic Crisis	People with hemolytic anemia
Chronic Anemia	Immunocompromised hosts
Hydrops Fetalis/Congenital Anemia	Fetus (first 20 weeks)

TRANSMISSION OF PARVOVIRUS B-19

- Exposure to infected respiratory droplets (most common route of transmission)
- Percutaneous exposure to blood or blood products
- Vertically from mother to fetus

Infection Control Manual		
UNC HEALTH CARE	Policy Name	**Pregnant and Post-Partum Health Care Personnel: Recommendations from Infection Prevention and Hospital Epidemiology**
	Policy Number	**IC 0046**
	Date this Version Effective	**July 2013**
	Responsible for Content	**Hospital Epidemiology**



Quick Reference for Pregnant Healthcare Personnel

Chicken Pox (varicella zoster virus, VZV)*	• Follow airborne precautions: wear an N-95 mask for entry into room. • Follow Contact Precautions: wear gown & gloves when coming in contact with these patients or their environments. • **If past history for chicken pox is negative AND titer is negative AND HCP is not immunized (very rare)** exclude from interaction with infected patients.
Cytomegalovirus (CMV)*	• Follow standard precautions and practice strict hand washing. • A pregnancy precaution sign is NOT necessary and should NOT be used.
Herpes Simplex*	Disseminated HSV Infection • Follow Contact Precautions Mucocutaneous HSV • Follow Standard Precautions
Herpes Zoster (VZV) (Shingles)* • All Patients with Shingles require Contact Isolation • Patient Needs Airborne Isolation o For Immune Competent Patients: Disseminated Shingles (more than 3 dermatomes) o For Immune Compromised Patients: any number of dermatomes o Airborne isolation until zoster lesion(s) are dried and crusted	• Follow Contact Precautions for all patients with Herpes Zoster/Shingles • Follow Airborne isolation according to policy (listed on left) • **If past history for chicken pox is negative AND titer is negative AND HCP is not immunized (very rare)** exclude from interaction with infected patients. o This prevents acquiring Chickenpox
Parvovirus B19 (MMWR, 1989) (Fifth's Disease)	• Follow Droplet Precautions* • Place patient on Droplet Precautions as soon as Parvovirus testing is sent* • Report to Occupational Health for testing if exposed (worked with the patient without a surgical mask) • A pregnancy precaution sign is NOT necessary and should NOT be used
Tuberculosis*	• Practice Airborne Precautions for the duration of illness. • Practice Airborne & Standard Precautions for patients with extrapulmonary open draining lesions (wear gloves, N95 and any other appropriate PPE).
Influenza*	• Pregnant HCW should practice Droplet Precautions with all patients who may have URIs. • Any patient with s/s of URI should be placed on droplet and contact precautions until symptoms have resolved or results of RVP have returned. • All HCP must receive the flu vaccine

Did you know?

An Infection Prevention Newsletter

Pregnant Healthcare Personnel (HCP)

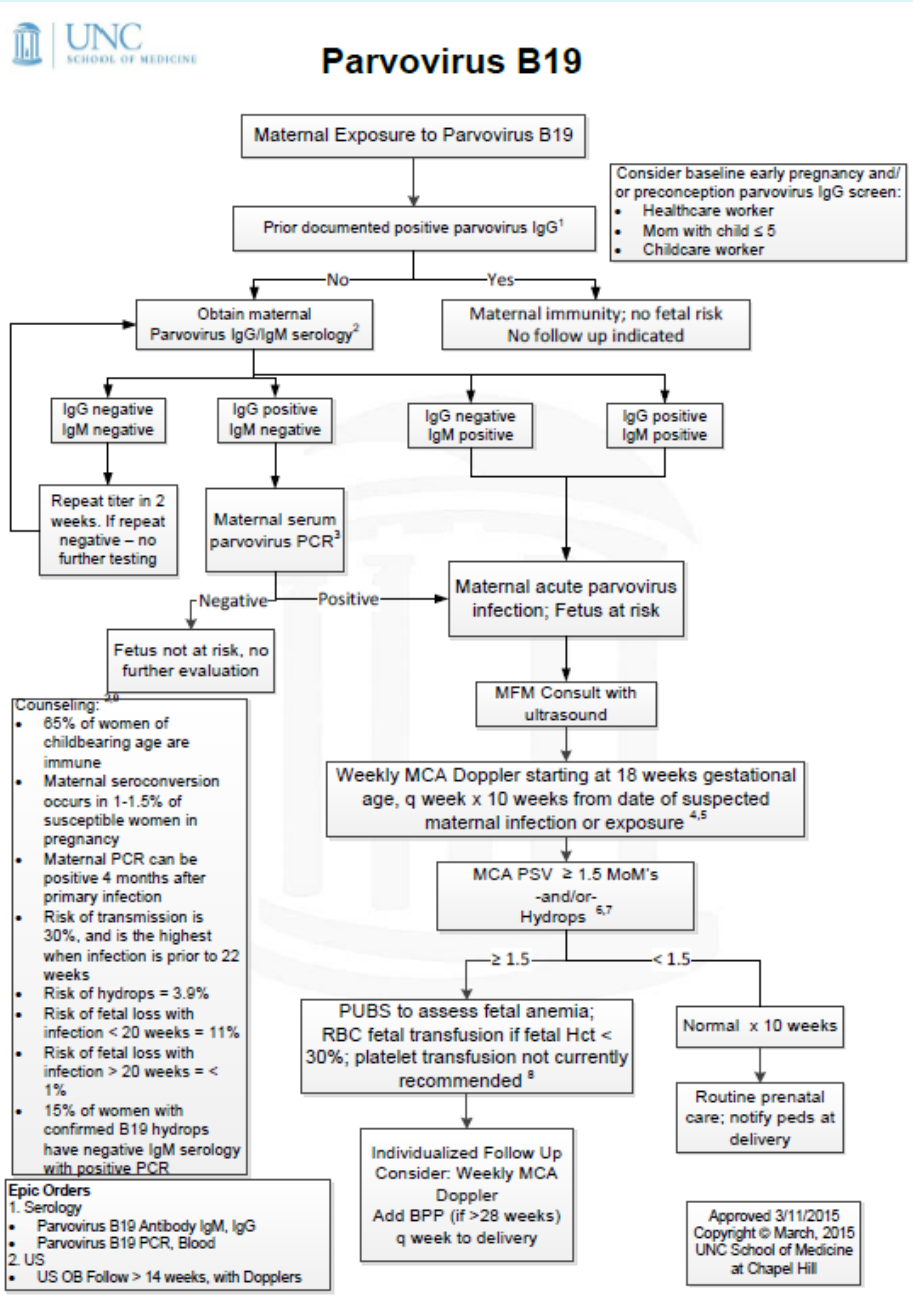
- There is a policy regarding pregnant HCP entitled Prevention of Infectious Diseases During Pregnancy: IC 0046.
- It highlights many concerns that pregnant HCP have regarding the risk of caring for patients with communicable diseases.
- There are no instances in which a "No Pregnant Health Care Personnel" sign should be hung on a patient's door.

Can I care for patients with Parvovirus B19 if I am pregnant?

- Yes. You must follow droplet precautions.
- If you have cared for a patient while pregnant and did not wear a surgical mask when interacting with this patient you must go to Occupational Health Services and be evaluated.
- Most people have been exposed to Parvovirus and are immune.
- The risk to your baby is only if you are not immune and become infected with Parvovirus.
- If you are asked to be evaluated in OHS by Hospital Epidemiology, they will draw your blood to see if you have had a past exposure or present illness.

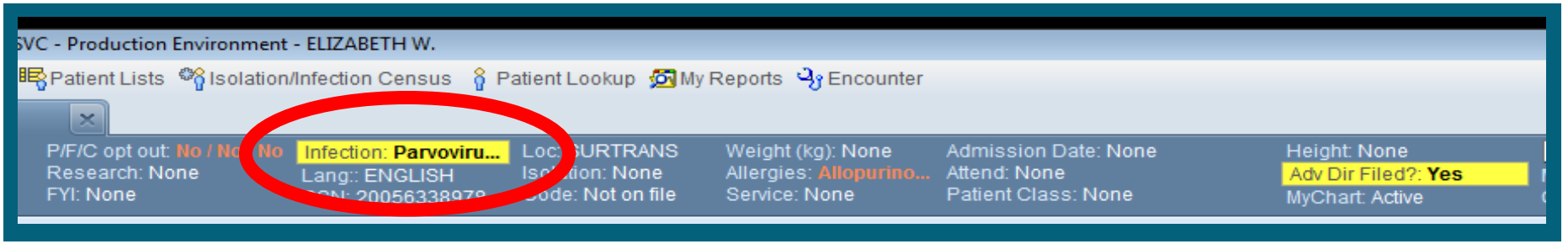
Can I care for patients who have CMV if I am pregnant?

- Yes. Pregnant healthcare personnel (HCP) can care for patients with CMV.
- All HCP should follow standard precautions when caring for patients with CMV.
- All HCP must practice strict hand hygiene when interacting with patients infected with CMV.
- Standard precautions will provide protection from acquiring CMV to all HCP of child bearing age.

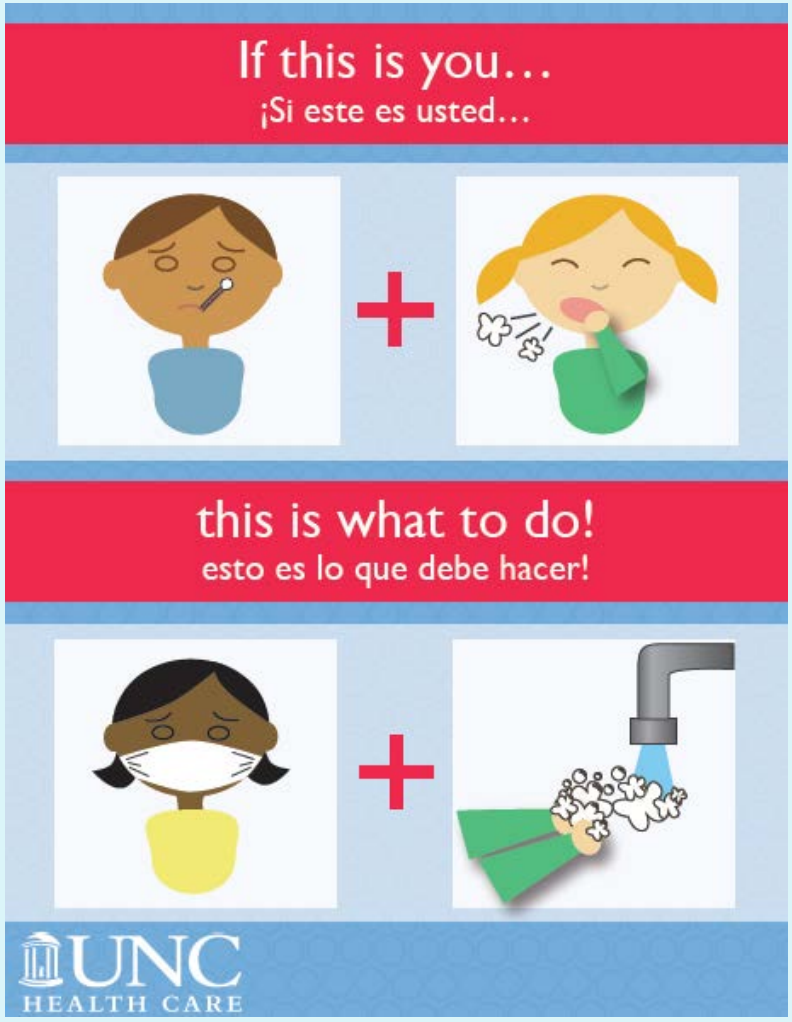


- Occupational Health Services (OHS) will draw blood for Parvovirus B-19 IgG and IgM
- OHS or Hospital Epidemiology will counsel regarding risk

Menard, K. (2015). Resources for Health Care Professionals. www.mombaby.org



- Reducing exposures from Parvovirus B-19
  - Education for HCP
  - Pregnancy counseling for HCP
  - Empiric droplet isolation when Parvovirus B-19 PCR is sent to lab
  - Documentation in EMR of chronically positive patients
  - Standard precautions and respiratory etiquette

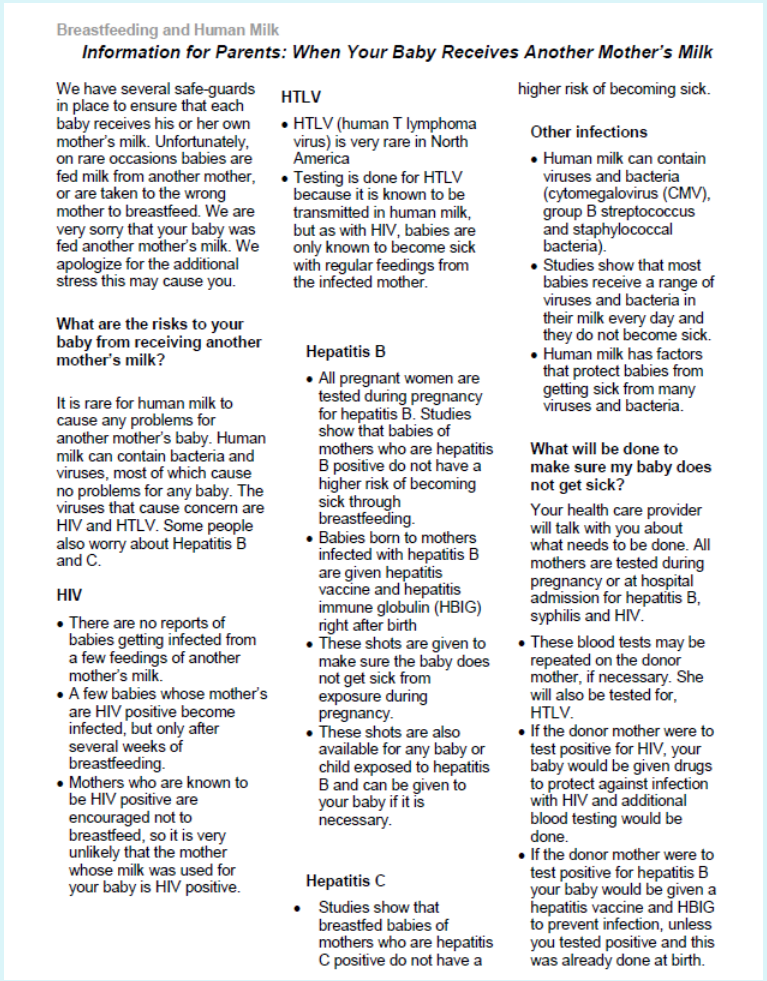


"WE JUST FED BABY A, BABY B'S BREAST MILK, WHAT SHOULD WE DO?"

- Do we have a policy that addresses this?
- How should we handle this situation?
- **How could this have happened?**

Administrative Manual		
UNC HEALTH CARE	Policy Name	**Patient to Patient Exposure to Bloodborne Pathogens and Human Breast Milk**
	Policy Number	**ADMIN 0240**
	Date this Version Effective	**Aug 2013**
	Responsible for Content	**Legal, Hospital Epidemiology**

- Policy which addresses this
- Follow check list
- Notification of involved parties
- Labs of "donor" mother
- Notification of both sets of parents



Breastfeeding and Human Milk

Information for Parents: When Your Baby Receives Another Mother's Milk

We have several safe-guards in place to ensure that each baby receives his or her own mother's milk. Unfortunately, on rare occasions babies are fed milk from another mother, or are taken to the wrong mother to breastfeed. We are very sorry that your baby was fed another mother's milk. We apologize for the additional stress this may cause you.

What are the risks to your baby from receiving another mother's milk?

It is rare for human milk to cause any problems for another mother's baby. Human milk can contain bacteria and viruses, most of which cause no problems for any baby. The viruses that cause concern are HIV and HTLV. Some people also worry about Hepatitis B and C.

HIV

- There are no reports of babies getting infected from a few feedings of another mother's milk.
- A few babies whose mother's are HIV positive become infected, but only after several weeks of breastfeeding.
- Mothers who are known to be HIV positive are encouraged not to breastfeed, so it is very unlikely that the mother whose milk was used for your baby is HIV positive.

HTLV

- HTLV (human T lymphoma virus) is very rare in North America
- Testing is done for HTLV because it is known to be transmitted in human milk, but as with HIV, babies are only known to become sick with regular feedings from the infected mother.

Hepatitis B

- All pregnant women are tested during pregnancy for hepatitis B. Studies show that babies of mothers who are hepatitis B positive do not have a higher risk of becoming sick through breastfeeding.
- Babies born to mothers infected with hepatitis B are given hepatitis vaccine and hepatitis immune globulin (HBIG) right after birth
- These shots are given to make sure the baby does not get sick from exposure during pregnancy.
- These shots are also available for any baby or child exposed to hepatitis B and can be given to your baby if it is necessary.

Hepatitis C

- Studies show that breastfed babies of mothers who are hepatitis C positive do not have a higher risk of becoming sick.

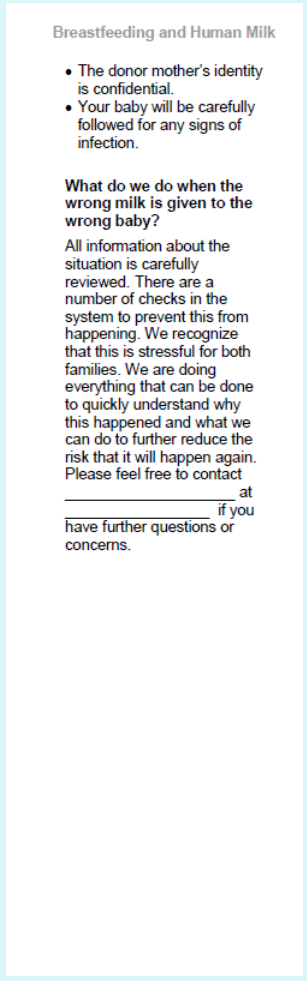
Other infections

- Human milk can contain viruses and bacteria (cytomegalovirus (CMV), group B streptococcus and staphylococcal bacteria).
- Studies show that most babies receive a range of viruses and bacteria in their milk every day and they do not become sick.
- Human milk has factors that protect babies from getting sick from many viruses and bacteria.

What will be done to make sure my baby does not get sick?

Your health care provider will talk with you about what needs to be done. All mothers are tested during pregnancy or at hospital admission for hepatitis B, syphilis and HIV.

- These blood tests may be repeated on the donor mother, if necessary. She will also be tested for, HTLV.
- If the donor mother were to test positive for HIV, your baby would be given drugs to protect against infection with HIV and additional blood testing would be done.
- If the donor mother were to test positive for hepatitis B your baby would be given a hepatitis vaccine and HBIG to prevent infection, unless you tested positive and this was already done at birth.



Breastfeeding and Human Milk

- The donor mother's identity is confidential.
- Your baby will be carefully followed for any signs of infection.

What do we do when the wrong milk is given to the wrong baby?

All information about the situation is carefully reviewed. There are a number of checks in the system to prevent this from happening. We recognize that this is stressful for both families. We are doing everything that can be done to quickly understand why this happened and what we can do to further reduce the risk that it will happen again. Please feel free to contact _____ at _____ if you have further questions or concerns.

- ✓ Follow the checklist
- ✓ Review each exposure in root cause analysis format
- ✓ Learn and improve from each exposure

Patient to Patient Exposure to Bloodborne Pathogens and Human Breast Milk

Appendix 1: Worksheet for Human Milk Exposure

Human Milk Exposure Follow-Up Protocol Checklist	Person Responsible to Complete:
Oversight of the completion of this Checklist-Protocol	Nurse Manager of the unit where the exposure occurred
Notify Charge Nurse, Nurse Manager and/or Nursing Supervisor of infant's exposure to another mother's human milk. Provide the following information: • Exposed infant's name and UNC Medical Record # • Exposed infant's mother's name (and UNC Medical Record # if she has	RN assigned to the infant or first to discover incident
Inform the Immunology Lab (#966-4058) that a Human Milk Exposure has occurred and the source mother's lab work will be ordered, obtained and sent	Hospital Epidemiology-Infection Control Preventionist
Notify Hospital Epidemiology during daytime hours by paging the Infection Control Preventionist @ 123-7427 or call Hospital Operator: #64131 and ask for on-call Infection Control Nurse. Provide the following information to the Infection Control Nurse: • Exposed infant's name and UNC Medical Record # • Exposed infant's mother's name (and UNC MR#) • Source mother's name (and UNC MR # if she has one)	RN assigned to the infant or first to discover incident
Phone message to Risk Management #63041 Inform Risk Management (#63041) of need for source mother's lab costs to be covered-provide name and MR#	involved (includes NFS staff if their handling/labeling of the human milk was involved)
Inform the Immunology Lab (#64058) that a Human Milk Exposure has occurred and the source mother's lab work will be ordered, obtained and sent to the Immunology lab as soon as it is available. Follow any instructions for proper and prompt movement of the sample to the lab (e.g., tubing blood samples to Tube Station #82-Immunology Lab) Request they perform the lab tests as quickly as possible and call the Infection Control Preventionist to inform him/her, if the blood sample does not arrive as expected.	Hospital Epidemiology-Infection Control Preventionist.

Patient to Patient Exposure to Bloodborne Pathogens and Human Breast Milk

and Handling Nursing Policy).
2. Explain next steps-lab tests that will be obtained.
3. HIV testing done per Requesting Human Immunodeficiency Virus (HIV) Antibody or Antigen Testing Hospital Administrative Policy 0029.

whose milk was misappropriated (Utilize Lactation Consultant to assist if needed)

samples to Tube Station #82-Immunology Lab). Request they perform the lab tests as quickly as possible and to call the Infection Control Nurse to inform him/her, if the blood sample does not arrive as expected.

Laboratory tests bundled in paper order or EMR order bundle, so nothing is missed.

Directions for Obtaining Bloodborne Disease Screening Labs After a Human Milk Exposure:	Person Responsible to Complete:
1. UNC INPATIENT Source Mother: **When the source mother is currently a UNC inpatient,** order required lab tests via CPOE, **click on Micro, click on Common, click on *Human Milk Exposure***	Source mother's OR Exposed infant's Medical Care Provider places CPOE order. Phlebotomy obtains required lab samples, tubing them to Tube Station #82-Immunology Lab. NOTE: If there is any problem having the inpatient source mother's lab work drawn, please contact the Phlebotomy Supervisor on call.
2. OUTPATIENT Source Mother: **2A. When the source mother already has a UNC Medical Record number, but is no longer an inpatient:** Labs ordered via **requisition form:** ***Human Milk Exposure*** 1. Obtain Human Milk Exposure **requisition form** from the hospital intranet. (This form is available on the hospital intranet under McClendon Labs.) 2. Provide completed Human Milk Exposure requisition form to the source mother. 3. Direct source mother to Phlebotomy Lab Draw Department with the **requisition form.** 4. Phlebotomy obtains the blood samples and sends them to the Immunology lab. **2B. When the source mother does not have a UNC medical record number:** Labs ordered via **requisition form:** ***Human Milk Exposure*** 1. Obtain and complete a Human Milk Exposure **requisition form** from the hospital intranet. (This form is available on the hospital intranet under McClendon Labs.) 2. Nursing will escort the source mother to the Hospitals' Registration Department with the completed **requisition form** for her lab work. 3. The registration staff will provide the source mother with a Medical Record number/card and a case assignment for her lab work. 4. The nurse will obtain a copy of the source mother's MR # and provide this number to the exposed infant's Medical Care Provider, Nurse Manager and Infection Control Nurse. 5. The source mother will be escorted to Phlebotomy. 6. Phlebotomy obtains the blood samples and sends them to the Immunology lab, tubing them to Tube Station #82-Immunology Lab. NOTE: If the source mother does not have transportation from home to the hospital contact Risk Management.	Source mother's OR Exposed infant's Medical Care Provider Phlebotomy obtains required lab samples, tubing them to Tube Station #82-Immunology Lab. NOTE: If there is any problem having the source mother's lab work drawn, please contact the Phlebotomy Supervisor on call. Phlebotomy obtains required lab samples, tubing them to Tube Station #82-Immunology Lab. NOTE: If there is any problem having the source mother's lab work drawn, please contact the Phlebotomy Supervisor on call and the Infection Control Preventionist on call.
Inform Risk Management of source mother's lab results.	Hospital Epidemiology-Infection Control Preventionist

UNIVERSITY OF NORTH CAROLINA HOSPITALS
101 Manning Drive
Chapel Hill, North Carolina 27514
Human Milk Exposure Orders
MIM #1183

Medicare will only pay for services that it determines to be reasonable and necessary under section 1862(a)(1) of the Medicare Law. When ordering tests for which Medicare reimbursement will be sought, physician should order only those individual tests that are necessary for the diagnosis and treatment of a patient, rather than for screening purposes.

HUMAN MILK EXPOSURE

Microbiology/Immunology Laboratory orders

LABORATORY MUST BE CONTACTED BEFORE COMPLETING THIS REQUISITION, CALL 966-4053

INSTRUCTIONS:

1. The patient **MUST** have a UNC Health Care medical record number.
2. The patient **MUST** be escorted to Patient Registration and have a stay created for the current day.
3. There is **NO CHARGE** to the patient for this testing.
4. The patient should present this requisition to any Phlebotomy Services Blood Collection outpatient location.
5. The phlebotomist will process the request on the current stay and account code for the patient.
6. UNC Health Care administration will assure that **NO CHARGES** are billed to the patient for this testing.
7. Send the blood specimens and the requisition to tube station #82.

Positive results are to be reported to the ordering physician and Risk Management immediately.

		Date /Time and Location of Exposure		
Attending MD:		**Date**	**Time**	**Location**
Attending MD ID #:				
Attending MD Pager #:		MM/DD/YY	HH:MM	UNIT

Test Code	Order these tests on Breast Milk Exposure Source Patients
8055	HIV Antibodies (post-exposure rapid test) EHHIV-HIV Ag/Ab Combo Assay
8056	HBsAG – Hepatitis B Surface Antigen
8422	HTLV 1/2 Antibodies
9068	Syphilis Serology

Minimum Specimen required:

Two 5mL SST Tubes, full.

Ordering MD:	
Ordering MD ID #:	
Ordering MD Pager #:	

I certify that all tests ordered are medically necessary.

Physician's signature and ID number	Date: Time:	Transcribed By	Checked by:

Chart Location: Provider Orders

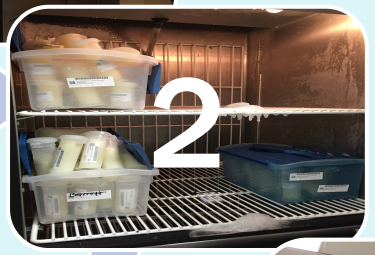
EXAMPLES OF HUMAN MILK EXPOSURES

- Baby A getting formula, Baby B getting human milk (HM)
  - Baby A got Baby B's HM
- Baby A Miller transferred to PICU and discharged, Baby B Miller transferred to PICU and back transferred to NICU
  - Baby A Miller's frozen milk back transferred to NICU with Baby B Miller which was transferred into secondary containers and fed to Baby A for a day

PREVENTION OF HUMAN MILK EXPOSURES

- Centralized breastmilk preparation
  - Quantities for 12 hours worth of feedings prepared twice daily
  - Orders generated and auto printed daily from EMR
  - Each feeding is pre-made
  - Only 1 patient's HM is prepared and fortified at a time
  - Each bottle is double checked to label
- Breastmilk bar code system
  - Replaces 2 person double check
  - Variety of systems from just barcode scanning at point of feeding to barcode scanning from entry into health care system

Steele, C., & Bixby, C. Breastfeeding Medicine 2014; 9 (9): 426-429



- ✓ Each baby has own bin in freezer and refrigerator
- ✓ Only 1 baby's milk is removed at a time
- ✓ Milk is double checked from each container prior to putting in another container

- ✓ Systems scan at each point in the process
- ✓ Reduce the chance of errors

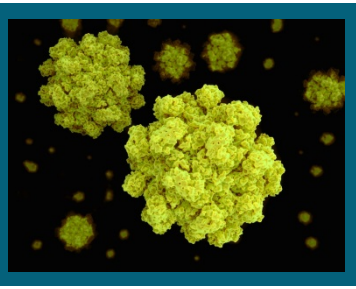
"ON THE CHILD PSYCHIATRIC UNIT, 3 OF 8 PATIENTS ARE HAVING NAUSEA AND VOMITING. WHAT SHOULD WE DO?"

- Is this a problem?
- Do we have a policy to address this?
- How should we handle this?

IS THIS A PROBLEM?

- We expect to see no cases of gastroenteritis in these patients.
- Did they admit with this gastroenteritis? Or was this health care associated?
- **Are there any staff members who are sick?**
- Are the patients isolated? If so, which type of isolation?
- Are they in shared rooms?
- **When were the last symptoms for each patient/staff member?**
- **Can we send lab (stool samples) testing for confirmation of norovirus?**
- Are we seeing anything else like this in the system?
- Could this be food poisoning?
- Was any food brought in from outside the hospital?
- Did the patients have contact with any other staff/area we may need to notify?

NOROVIRUS



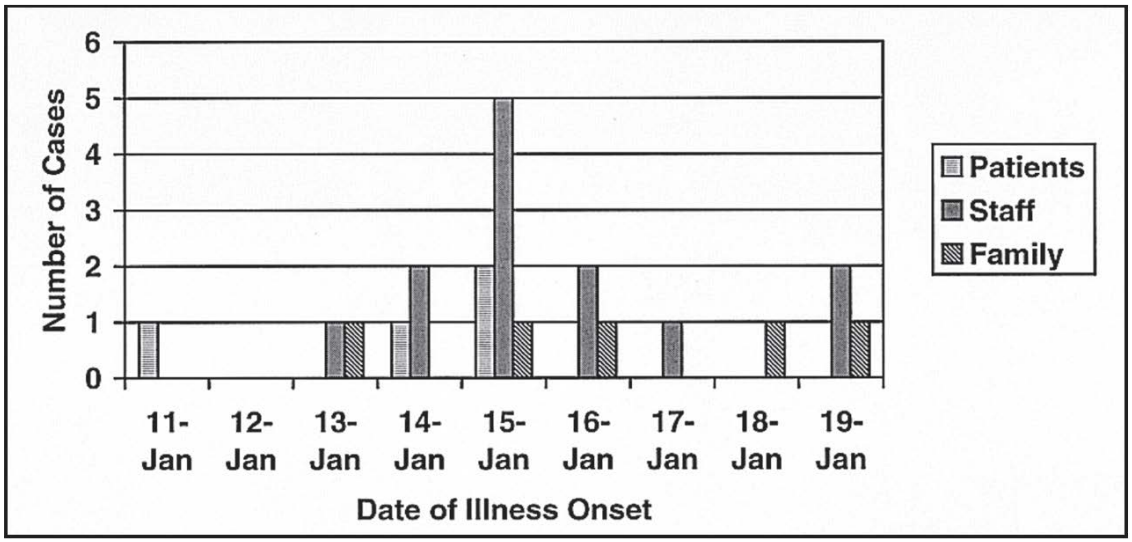


FIGURE 1. Outbreak curve based on the day of disease onset.

- Non-enveloped virus
- Low infectious dose
- Prolonged asymptomatic shedding
- Environmental stability
- Not readily killed by alcohol based hand rubs

Weber, D. J., et al. (2005). ICHE 26(10); 841-843

WHY IN PSYCHIATRIC AND REHABILITATION UNITS?

- In US almost all patients housed in single rooms; most patients too ill to walk in halls
- Patients in these type of units spend substantial time with each other outside of their rooms
  - Group therapy
  - Rehabilitation training
- Patients eat together in common area
- HCP eat with patients
- Proper use of HH may be difficult to achieve amongst patients

POLICY

Appendix 11: Infection Control Recommendations for Multiple Patients/Healthcare Personnel with Signs/Symptoms of Gastroenteritis

The following measures will be implemented to prevent the spread of gastroenteritis:

I. Patients
- A. Patients with symptoms of gastroenteritis (for example, 3 or more loose stools in 24 hours; vomiting and diarrhea) will be placed on strict Enteric-Contact Precautions. Notify Infection Control (6-1638) if additional cases occur.
- B. Enteric-Contact Precautions require:
  1. Private room with Enteric-Contact Precautions sign prominently displayed outside room.
  2. Patient is restricted to the room; however may leave the room for essential purposes (e.g., radiology tests, surgical procedure). Patient should not attend group activities until Enteric Precautions are discontinued.
  3. Hand hygiene will be performed using soap and water (i.e., chlorhexidine) rather than alcohol-containing foam; a 15 second handwash is required:
     a. before and after contact with the patient or the patient's environment
     b. before donning gloves and after glove/gown removal
  4. All staff will wear gloves upon room entry, even if they are not intending to touch anything. A gown is required for direct contact with the patient and when clothing may contact equipment/surfaces in the room. Equipment will be dedicated to the room, if possible. If equipment must be shared, it must be cleaned thoroughly with a 1:10 solution of bleach and water (expires in 30 days) prior to use by another patient.
  5. Visitors should be assessed for signs/symptoms of gastroenteritis. Medical and nursing personnel should exclude visitors with signs/symptoms of communicable disease until cleared by their personal physician or healthcare facility personnel.
  6. Visitors will be taught compliance with Enteric-Contact Precautions and monitored for adherence.
  7. Patients will be assisted with hand hygiene before eating and after use of the bathroom.
  8. Patients should remain on Enteric-Contact Precautions until:
     C. difficile – symptoms have resolved and patient has completed antibiotic therapy
     Norovirus – until the patient is 48 hours after symptoms have resolved
     Rotavirus – until no longer symptomatic and remains asymptomatic for 48hours
- C. Patient Placement
  1. Ideally, do not transfer symptomatic patients to an unaffected nursing unit until at least 48 hours after symptoms have ended.
  2. Ideally, cohort symptomatic patients by location (e.g., one unit or one area of a unit) and with designated staff for the ill patients.
- D. In certain outbreak situation additional enhanced precautions may be necessary (e.g. closure of a unit) at the discretion of Hospital Epidemiology.

- ✓ **Enteric Contact Precautions for symptomatic patients**
- ✓ **All routine cleaning with bleach for entire unit until 48 hours after last patient is symptomatic and no further cases amongst staff**
- ✓ **Hand hygiene with soap and water**

I. Staff
- A. Staff with symptoms of gastroenteritis will not be allowed to work (i.e., will be on sick leave) until asymptomatic for 48 hours.
- B. Staff will not eat or drink on the unit.
- C. Staff will perform hand hygiene with soap and water and in accordance with the Infection Control Policy IC 0024: Hand Hygiene and Use of Antiseptics for Skin Preparation. Gastroenteritis is spread by the fecal-oral route; thus hand hygiene is essential before eating and after using the bathroom.

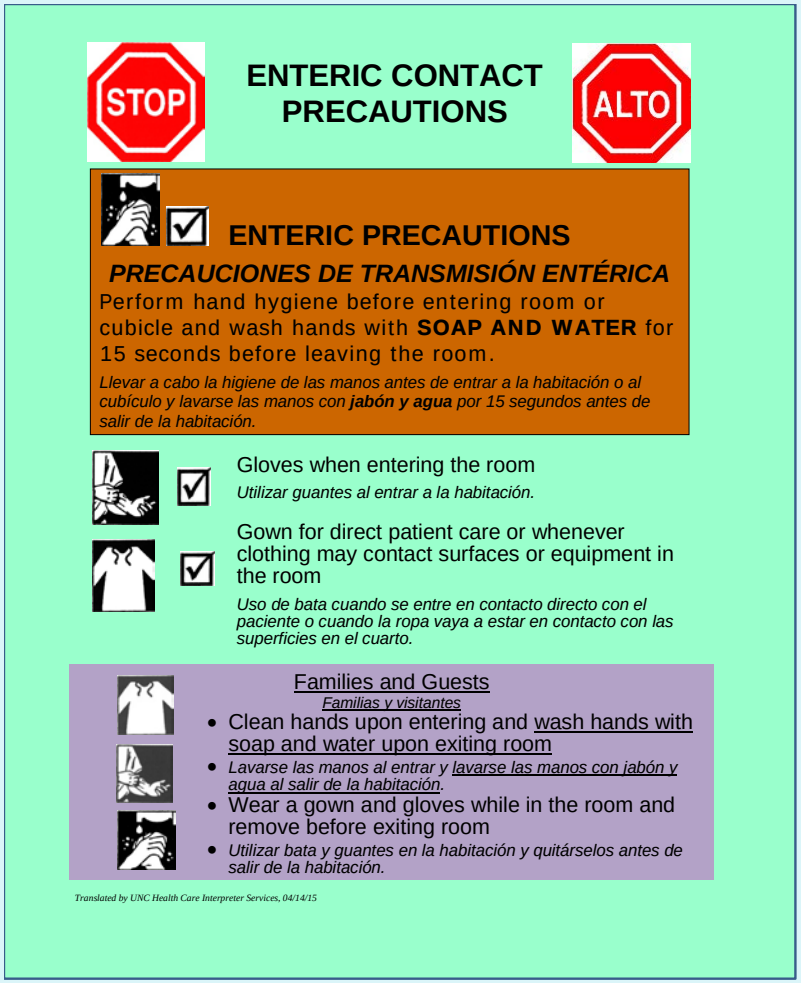
II. Housekeeping
- A. Gloves and gown should be worn to clean Enteric-Contact Precautions rooms.
- B. Norovirus
  1. Environmental Services will perform a thorough cleaning of the patient's room with a 1:10 solution of bleach and water.
  2. For outbreaks (e.g., ≥3 patients on a nursing unit overlapping in time), all routine daily cleaning by Environmental Services should be done with 1:10 bleach solution for the entire unit, until 48 hours after last patient is symptomatic and there are no further cases among staff or patients.
- *C.* *C. difficile* and Rotavirus
  1. Terminal cleaning of the room will be done using 1:10 bleach and water.
  2. Additional cleaning may be indicated for outbreaks and as directed by Hospital Epidemiology.

ADDITIONAL CONTROL MEASURES

- Symptomatic patients placed on Enteric Contact Precautions until resolution of symptoms for 48 hours
  - Symptomatic patients should not be transferred to another unit unless medically indicated
- **Entire unit placed on Enteric Contact Precautions**
  - Anyone entering the unit must gown and glove while on the unit to see or visit patients
  - Remove gown and gloves and perform hand hygiene with soap and water upon leaving the unit
- Any new patients who develop symptoms will be placed on Enteric Contact Isolation
  - Notify Hospital Epidemiology of any newly symptomatic patients
  - GI Pathogen Panel for any symptomatic patients
- Notify Hospital Epidemiology of any staff who become symptomatic and date symptoms started
  - Symptomatic staff should be symptom-free for **48 hours** before returning to work
- Screen all visitors for GI symptoms
- **Close unit to admissions**
  - Unit should remain closed until signs/symptoms of the last patient identified with diarrhea has resolved and an additional 48 hours have passed with no new cases of GI symptoms
  - Do not transfer patients out of unit unless medically indicated.
- EVS to perform twice daily bleach cleaning on the unit, particularly on shared or common areas on the unit, such as the Dayroom
- **Patients should not be transferred to another unit unless medically indicated**
- **No floating of unit staff to other units or staff from other units affected unit**

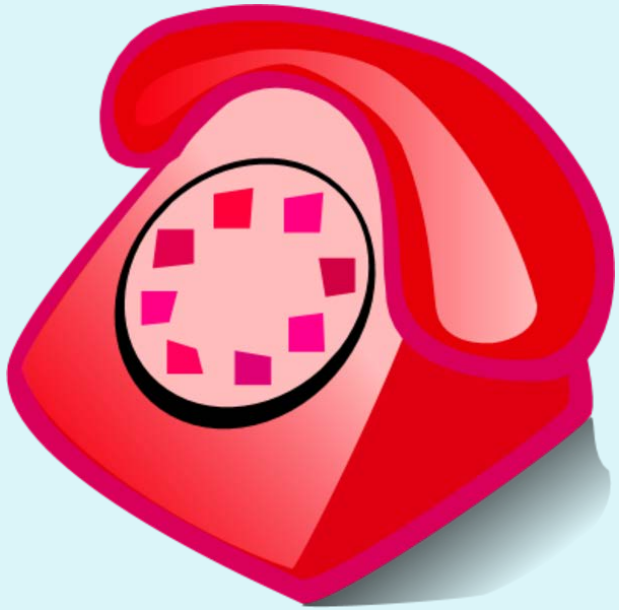
ENTERIC PRECAUTIONS

- Healthcare personnel (HCP) and Visitors
  - Wear gown/gloves
  - Hand hygiene with soap and water
- All equipment cleaned with bleach
- Daily and terminal cleaning with bleach
- Terminal room disinfection with ultraviolet (UV) light treatment
  - E.g. Tru-D, UVDI



"I THINK THE DAD OF MY NEWBORN PATIENT HAS CHICKEN POX, WHAT SHOULD WE DO?"

- What should we do?
- Do we have a policy?
- How should we approach this?
- Can you go and interview the dad?
- Does he have a history of Chicken Pox?
- Does he have a history of the vaccine?
- Has he had a known exposure?



YOU DECIDE TO INTERVIEW THE FATHER

- The father and 19 month old sibling are sitting in the room of the newborn/mother dyad
- Dad reports
  - He does not recall having the chicken pox
  - His mother can't remember if he had them
- Mom reports
  - 19 month old unvaccinated
  - Someone in church nursery had chicken pox 2 weeks ago
- EMR Review
  - Mom IgG negative for varicella
  - Newborn had hearing screen in Nursery 4 hours ago

YOU ARE CONVINCED…CHICKEN POX

CHILDREN VISITOR SCREENING FORM

UNC Hospitals reserve the right to revoke visitation for any length of time if the presence of a child on the Patient Care Area will interfere with or endanger patient care.

On this visit I affirm that _____ has had no known exposure to and has no signs or symptoms of contagious illness such as:
Name of Child

YES	NO	N/A	
☐	☐	☐	1. Fever+
☐	☐	☐	2. Cough, sore throat, or runny nose (cold symptoms)+
☐	☐	☐	3. Vomiting, diarrhea+
☐	☐	☐	4. Skin rash, boils+
☐	☐	☐	5. Conjunctivitis (pink eye)+
☐	☐	☐	6. At the discretion of the Unit Medical Director the exposure to measles, mumps, chickenpox, Pertussis (whooping cough), or zoster (shingles) in the past 3 weeks*
☐	☐	☐	7. At the discretion of the Unit Medical Director exposure to any contagious illness in the family, school, or other group activities within the last 3 weeks*
Interviewer:			Signature/relation to child:

*If yes, please consult with the patient's physician

+ If yes, please exclude from visiting.

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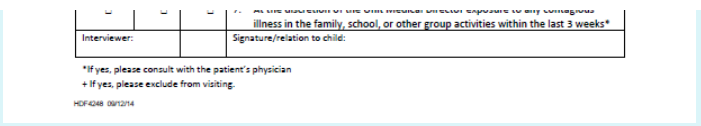
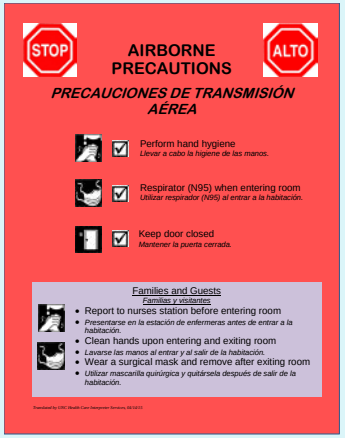


WHAT ABOUT MOM & BABY?

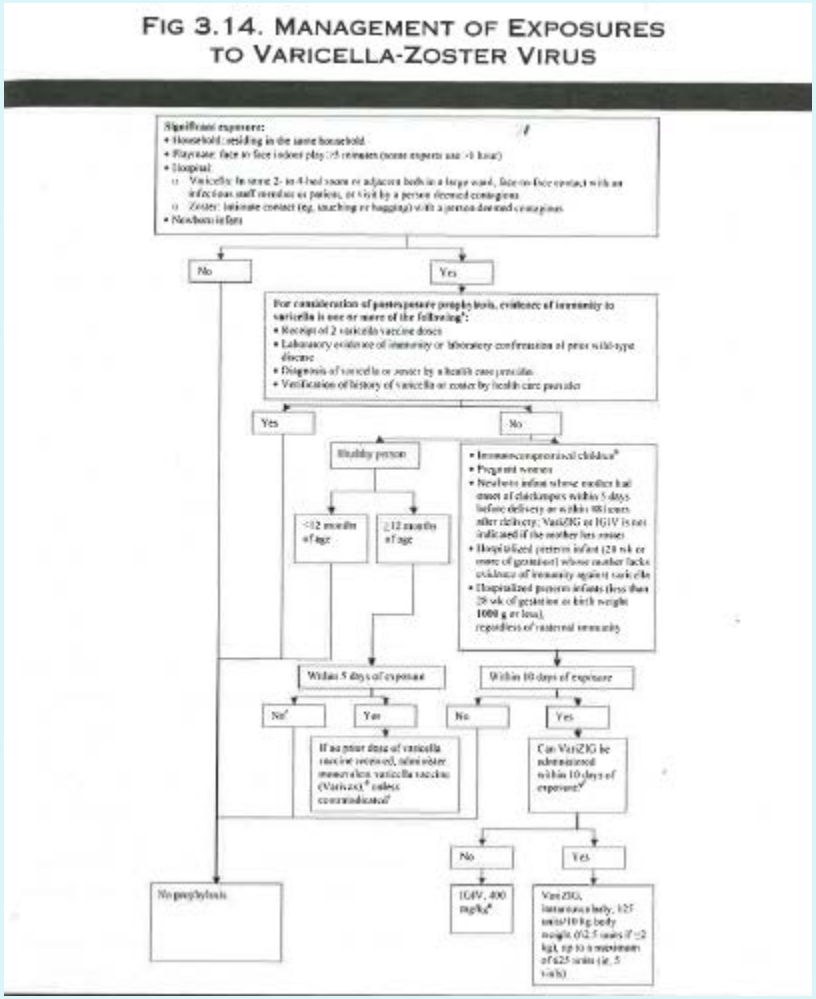
- **Pediatric ID consult for baby for treatment & post exposure prophylaxis**

Infectious Disease	Isolation Precautions Category for Baby	Air Pressure of Room	Placement Options for Baby	Comments
Varicella (in mother during hospital stay)	Airborne Precautions	Negative pressure room	Isolation room in NCCC, room in with mother in a private room (OB service), or private room on pediatric service.	Initiate Contact Precautions in addition to Airborne Precautions if lesions develop.
Varicella exposure (in mother)	Airborne Precautions	Negative	Same as above	Same as above



WHAT ABOUT ALL THE OTHER MOMS & BABIES?

- IgG/immunization review for all mothers who shared space and time on unit with this family
- If IgG negative – consult pediatric infectious disease for treatment recommendations



AAP. Red Book: 2015 Report of the Committee on Infectious Diseases

WHAT ABOUT THE HCP?

- Proof of immunity required upon employment
- If HCP does not have immunity, vaccine is required unless medically contraindicated
- 10,000 employees <30 not immunized or immune
- Vaccines/immunity are a condition of employment at UNC including Flu vaccine
  - Very few exceptions: religious exemptions, medical contraindications

"A 20 MONTH OLD IS ADMITTED TO THE WARD WITH A 4 WEEK HISTORY OF COUGH, WHAT TYPE OF ISOLATION DOES SHE NEED?"

- What are the physicians concerned about?
- Which policy address this?
- What is in the differential?
- What is in your infection prevention differential?
- What are your policies?

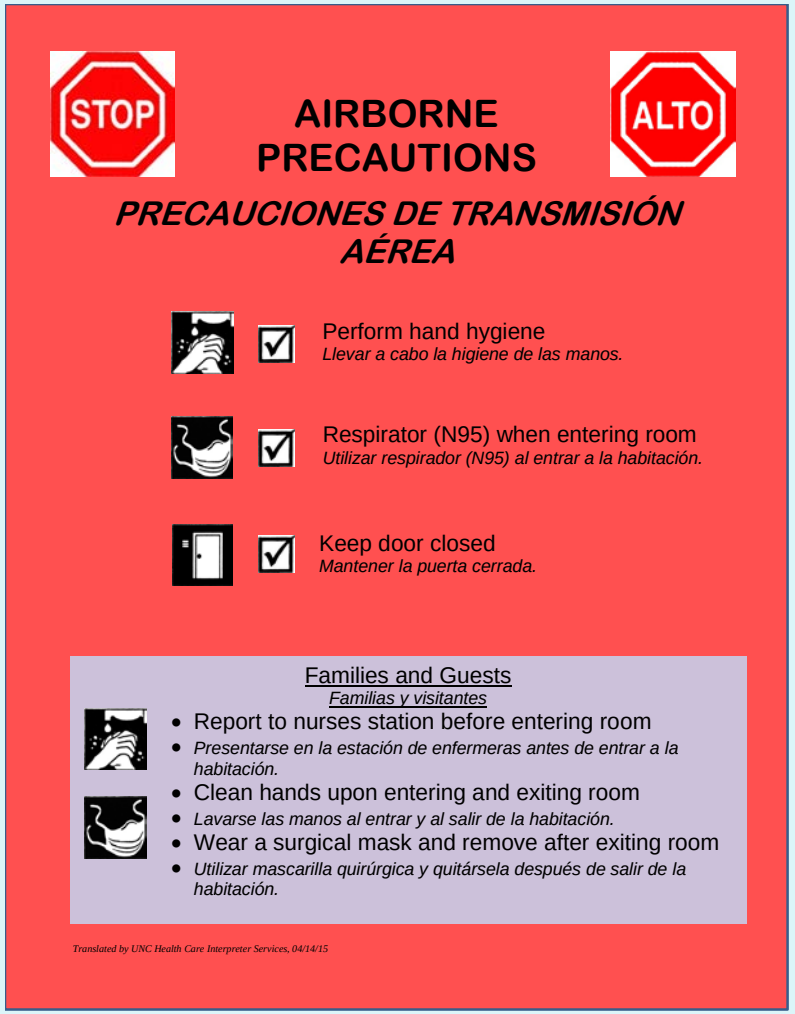
HISTORY & PHYSICAL

- Recent travel back from Africa where parents were working for the last six months
- Chest x-ray reveals suspicious lesion
  - Pneumonia?
  - Cannot exclude TB?

- Differential
  - Community acquired pneumonia
  - TB

INFECTION PREVENTION PLAN

- Airborne Isolation
  - Negative Pressure Room
  - N-95 respirators
- For pediatric patients parents/primary care givers must be ruled out for active pulmonary TB



RULING OUT PRIMARY CARE GIVERS FOR TB

- Symptom Screen

a. For patients ≤15 years of age diagnosed TB, **ALL** household members and close contacts must provide written verification of the absence of disease prior to visitation regardless of signs/symptoms of illness. Primary care givers (parents or legal guardians who live with the pediatric patient suspected of having pulmonary TB will be screened for symptoms of TB (e.g. cough for greater than 2 weeks fever, night sweats, hemoptysis, weight loss). Written verification they do not have TB is required if symptoms are present. It will be at the discretion of Hospital Epidemiology Medical Director and/or Peds ID Attending if screening will be required for the primary care givers without symptoms based on the the child's risk factors for TB.

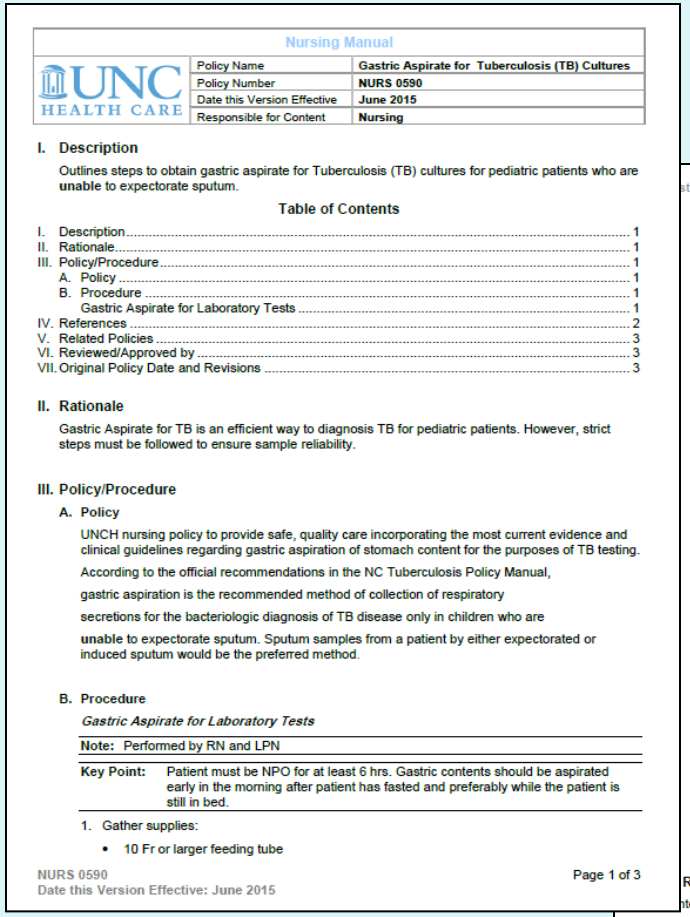
   i. Written verification should include: 1) absence of the following symptoms: persistent cough (≥ 3 weeks duration), hemoptysis, night sweats, weight loss and fever; 2) a negative Mantoux TST/IGRA read by a trained HCP; and 3) a negative chest radiograph if indicated.

are no longer infectious

a. For patients ≤15 years of age diagnosed TB, **ALL** household members and close

Orange County Health Department may assume responsibility for delivering and observing the administration of the antibiotics. This can be arranged by having the primary care giver's local health department contact the Orange County Health Department.

GASTRIC ASPIRATES



Nursing Manual

UNC HEALTH CARE

Policy Name	**Gastric Aspirate for Tuberculosis (TB) Cultures**
Policy Number	**NURS 0590**
Date this Version Effective	**June 2015**
Responsible for Content	**Nursing**

I. Description

Outlines steps to obtain gastric aspirate for Tuberculosis (TB) cultures for pediatric patients who are **unable** to expectorate sputum.

Table of Contents

II. Rationale

Gastric Aspirate for TB is an efficient way to diagnosis TB for pediatric patients. However, strict steps must be followed to ensure sample reliability.

III. Policy/Procedure

A. Policy

UNCH nursing policy to provide safe, quality care incorporating the most current evidence and clinical guidelines regarding gastric aspiration of stomach content for the purposes of TB testing.

According to the official recommendations in the NC Tuberculosis Policy Manual,

gastric aspiration is the recommended method of collection of respiratory

secretions for the bacteriologic diagnosis of TB disease only in children who are

unable to expectorate sputum. Sputum samples from a patient by either expectorated or induced sputum would be the preferred method.

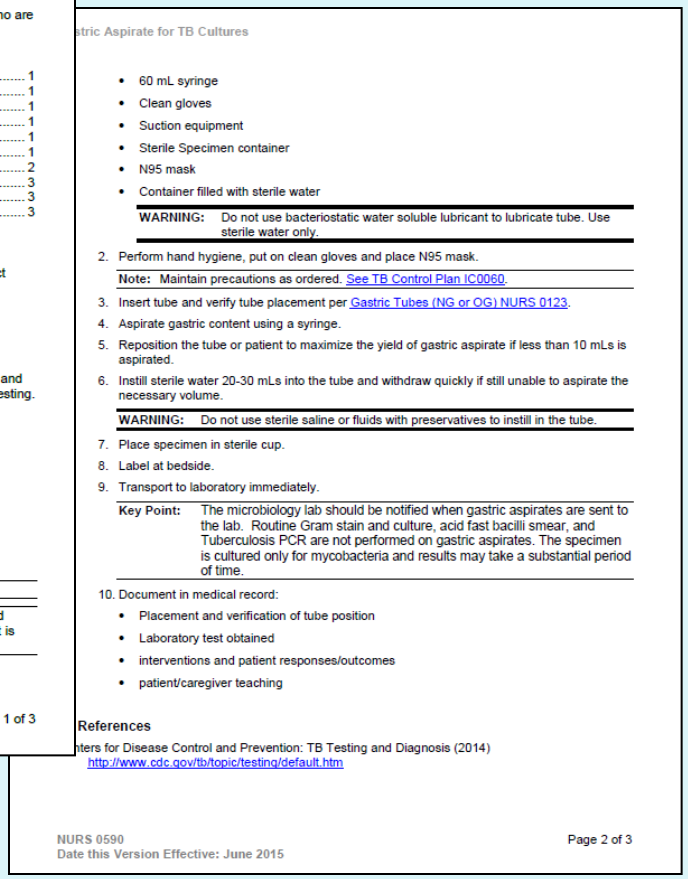
B. Procedure

Gastric Aspirate for Laboratory Tests

Note: Performed by RN and LPN

Key Point: Patient must be NPO for at least 6 hrs. Gastric contents should be aspirated early in the morning after patient has fasted and preferably while the patient is still in bed.

1. Gather supplies:
   - 10 Fr or larger feeding tube



- 60 mL syringe
- Clean gloves
- Suction equipment
- Sterile Specimen container
- N95 mask
- Container filled with sterile water

WARNING: Do not use bacteriostatic water soluble lubricant to lubricate tube. Use sterile water only.

2. Perform hand hygiene, put on clean gloves and place N95 mask.

Note: Maintain precautions as ordered. See TB Control Plan IC0060.

3. Insert tube and verify tube placement per Gastric Tubes (NG or OG) NURS 0123.
4. Aspirate gastric content using a syringe.
5. Reposition the tube or patient to maximize the yield of gastric aspirate if less than 10 mLs is aspirated.
6. Instill sterile water 20-30 mLs into the tube and withdraw quickly if still unable to aspirate the necessary volume.

WARNING: Do not use sterile saline or fluids with preservatives to instill in the tube.

7. Place specimen in sterile cup.
8. Label at bedside.
9. Transport to laboratory immediately.

Key Point: The microbiology lab should be notified when gastric aspirates are sent to the lab. Routine Gram stain and culture, acid fast bacilli smear, and Tuberculosis PCR are not performed on gastric aspirates. The specimen is cultured only for mycobacteria and results may take a substantial period of time.

10. Document in medical record:
    - Placement and verification of tube position
    - Laboratory test obtained
    - interventions and patient responses/outcomes
    - patient/caregiver teaching

References

ters for Disease Control and Prevention: TB Testing and Diagnosis (2014)
http://www.cdc.gov/tb/topic/testing/default.htm

- AFB smears not done on gastric aspirates
  - Low sensitivity
  - Risk of false positives from commensal organisms

"THE 4 YEAR OLD SIBLING OF MY PATIENT HAS A REALLY BAD COUGH, SHOULD HE BE HERE VISITING?"

- Do we have a policy that addresses this?
- Can he wear a mask?
- How should we approach this?

VISITOR SCREENING

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UNC HOSPITALS

CHILDREN VISITORS SCREENING FORM PATIENT

The purpose of this policy is to outline the visitation of children less than 12 years to patients at UNC Hospitals. Since children are often exposed to communicable diseases, the screening process available at each Patient Care Unit should be adhered to with each daily visit.

- The screening form is completed for each visit and expires after each 24 hour period of time.
- Visitation should occur during approved visiting hours, and children must be accompanied by a responsible adult at all times.
- Children under the age of 12 years will be screened and this form completed when visiting all intensive care units (CICU, MICU, CTICU, NSICU, SICU, PICU, NCCC), Burn Center, and Bone Marrow Transplant Unit, Labor and Delivery, PACU/OR and patients on Protective Precautions.
- Minors under the age of 12 should be screened for the presence within the past 24 hours of the following symptoms of illness: fever, cough, sore throat, runny nose, conjunctivitis (pink eye), vomiting, diarrhea, skin rashes or boils. If yes to any of the preceding, visitor should be excluded from visiting.
- At the discretion of the unit medical director visitors under the age of 12 may also be assessed for exposure to measles, mumps, chicken pox, zoster (shingles), pertussis (whooping cough) or any other contagious illness within their family, school or their community groups within the last 3 weeks. The unit medical director may opt to exclude visitors under the age of 12 who have been exposed to the preceding diseases.
- The responsible adult must sign this form indicating the child is free from illness or recent exposure (if being assessed per the Unit Medical Director).
- Children under the age of 12 will be restricted from visiting patients on isolation, including Droplet, Contact, and Airborne precautions. Exceptions can be made by a physician's order when the child is of sufficient size and age to properly wear the required personal protective equipment (PPE) and the parent/guardian has accepted responsibility for ensuring the child properly wears the personal protective equipment. Hands must be washed prior to and at the end of the visit. Small children cannot be relied upon to properly wear protective equipment without assistance. If there are questions about this exception, an infection control professional can be consulted at 919-966-1638 or through the hospital operator at 919-966-4131.

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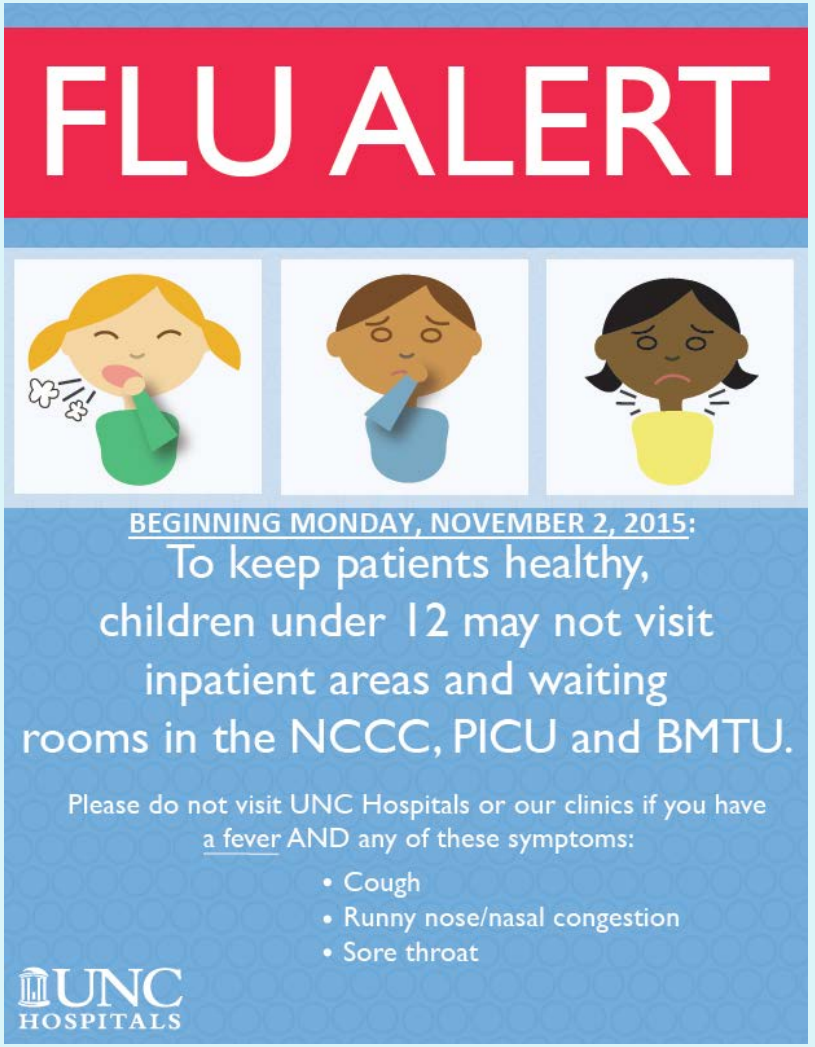
EXCLUSION OF CHILDREN VISITORS DURING COLD/FLU SEASON

- Exclusion of children visitors (<12)
  - Certain number of cases of RSV in high risk units (NICU, PICU, BMTU)
  - Certain number of cases of flu in all units
- Why?
  - Get sick more often
  - Can spread respiratory viruses for up to 2 days before showing any symptoms
  - Almost half of children with respiratory infections are asymptomatic, but can still transmit virus



"MY PATIENT'S SERVICE TERRIER IS JUMPING ALL OVER THE OTHER PATIENTS, WHAT SHOULD WE DO?"

- Do we have a policy that addresses this?
- What are we legally allowed to do?
- What is the best way to approach this situation?

Administrative Manual		
UNC HEALTH CARE	Policy Name	**Service Animals**
	Policy Number	**ADMIN 0190**
	Date this Version Effective	**September 2013**
	Responsible for Content	**Hospital Epidemiology, Legal**

- ADA definition of service animal
  - Must perform task for benefit of individual with a disability (e.g. blind/low vision, alerting individuals to presence of allergens, assistance with mobility, helping persons with psychiatric and neurological disabilities by preventing or interrupting impulsive or destructive behaviors.
  - Does not include any animal used for provision of emotional support, well-being, comfort or companionship

- Identification of Service Animals
  - UNC Health Care personnel may ask the owner in a courteous manner what work or tasks the animal is trained to perform to verify the dog is a service animal defined under ADA and this policy

EXCLUSION OF SERVICE ANIMALS

- Exhibits aggressive behavior (e.g.. Snarling, biting, scratching or teeth baring)
- Excessively noisy (howling, crying, whining)
- Unable to contain bodily excretions
- Signs or symptoms of infection unless or until it has been evaluated by licensed veterinarian.
- Can't go
  - Invasive procedure areas where sterility is required
  - Protected units
  - Food and medication preparation areas
- Miniature horses will be evaluated on a case by case basis

SHEA EXPERT GUIDANCE

Animals in Healthcare Facilities: Recommendations to Minimize Potential Risks

Rekha Murthy, MD;[1] Gonzalo Bearman, MD, MPH;[2] Sherrill Brown, MD;[3] Kristina Bryant, MD;[4] Raymond Chinn, MD;[5] Angela Hewlett, MD, MS;[6] B. Glenn George, JD;[7] Ellie J.C. Goldstein, MD;[8] Galit Holzmann-Pazgal, MD;[9] Mark E. Rupp, MD;[10] Timothy Wiemken, PhD, CIC, MPH;[4] J. Scott Weese, DVM, DVSc, DACVIM;[11] David J. Weber, MD, MPH[12]

PURPOSE

Animals may be present in healthcare facilities for multiple reasons. Although specific laws regarding the use of service animals in public facilities were established in the United States in 1990, the widespread presence of animals in hospitals, including service animals to assist in patient therapy and research, has resulted in the increased presence of animals in acute care hospitals and ambulatory medical settings. The role of animals in the transmission of zoonotic pathogens and cross-transmission of human pathogens in these settings remains poorly studied. Until more definitive information is available, priority should be placed on patient and healthcare provider safety, and the use of standard infection prevention and control measures to prevent animal-to-human transmission in healthcare settings. This paper aims to provide general guidance to the medical community regarding the management of animals in healthcare (AHC). The manuscript has four major goals:

1. Review and interpret the medical literature regarding risks and evidence for animal-to-human transmission of pathogens in the healthcare setting, along with the potential benefits of animal-assisted activities in healthcare.
2. Review hospital policies related to AHC, as submitted by members of the SHEA Guidelines Committee.
3. Summarize a survey that assessed institutional AHC policies.
4. Offer specific guidance to minimize risks associated with the presence of AHC settings.

Recommendations for the safe oversight and management of AHC should comply with legal requirements and minimize the risk of transmission of pathogens from animals to humans when animals are permitted in the healthcare setting. Although little published literature exists on this topic, we provide guidance on the management of AHC in four categories: animal-assisted activities, service animals, research animals, and personal pet visitation. Institutions considering these programs should have policies that include well-organized communication and education directed at healthcare personnel (HCP), patients, and visitors. Appropriately designed studies are needed to better define the risks and benefits of allowing animals in the healthcare setting for specific purposes.

BACKGROUND

The Role of Animals in Healthcare Settings (AHC)

People come into contact with animals in a variety of settings including households (pets), occupational exposure (veterinarians, farmers, ranchers, and forestry workers), leisure pursuits (hunting, camping, and fishing), petting zoos, and travel to rural areas. Pet ownership is common in the United States. A national poll of pet owners revealed that in 2013–2014, 68% of US households included a pet with the number of households owning specific animals as follows: dogs 56.7 million, cats 45.3 million, freshwater fish 14.3 million, birds 6.9 million, small animals 6.9 million, reptiles 5.6 million, horses 2.8 million, and saltwater fish 1.8.[1]

Patients in healthcare facilities come into contact with animals for 2 main reasons: the use of animals for animal-assisted activities (animal-assisted activities encompass "pet therapy," "animal-assisted therapy," and pet volunteer programs) and the use of service animals such as guide dogs for the sight impaired. Other reasons for contact with AHC include the use of animals in research or education, and personal pet visits to their owners in the hospital (personal pet visitation). Risks to patients from exposure to animals in the healthcare setting may be associated with transmission of pathogens through

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d March 2, 2015

KEY POINTS

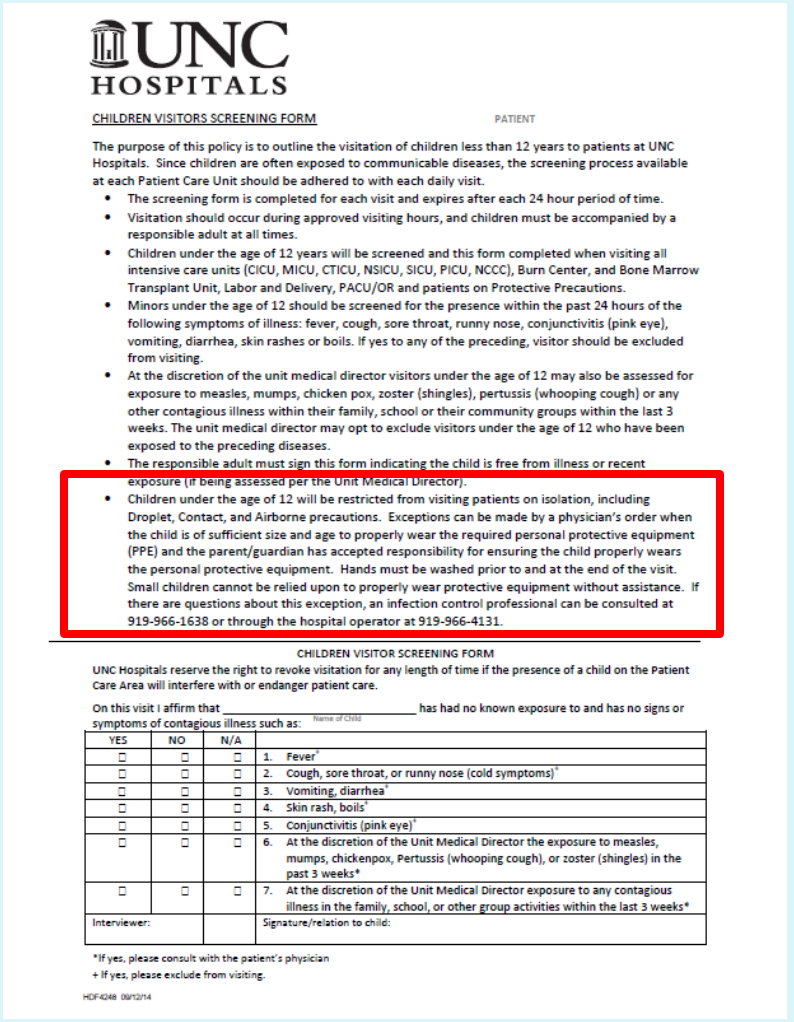
- Infection prevention in pediatrics is a challenge
- First steps involve policy review
- Importance of having policies which address pediatric concerns
- Ensure that patients are placed on appropriate precautions if needed

"MY PATIENT HAS RSV AND THE PARENTS KEEP BRINGING THE 4 MONTH OLD BABY TO VISIT, SHOULD THEY DO THAT?"

- Do we have a policy that addresses this?
- Is this safe?
- How should we address this?

"MY PATIENT HAS RSV AND THE PARENTS KEEP BRINGING THE 4 MONTH OLD BABY TO VISIT, SHOULD THEY DO THAT?"

- Children under 12 will be restricted from visiting patients on isolation precautions if they cannot wear the appropriately sized PPE
- A 4 month old cannot safely wear a mask
  - Excluded from visiting



UNC HOSPITALS

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- Children under the age of 12 years will be screened and this form completed when visiting all intensive care units (CICU, MICU, CTICU, NSICU, SICU, PICU, NCCC), Burn Center, and Bone Marrow Transplant Unit, Labor and Delivery, PACU/OR and patients on Protective Precautions.
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On this visit I affirm that _____ has had no known exposure to and has no signs or symptoms of contagious illness such as:
Name of Child

YES	NO	N/A	
☐	☐	☐	1. Fever*
☐	☐	☐	2. Cough, sore throat, or runny nose (cold symptoms)+
☐	☐	☐	3. Vomiting, diarrhea+
☐	☐	☐	4. Skin rash, boils+
☐	☐	☐	5. Conjunctivitis (pink eye)+
☐	☐	☐	6. At the discretion of the Unit Medical Director the exposure to measles, mumps, chickenpox, Pertussis (whooping cough), or zoster (shingles) in the past 3 weeks*
☐	☐	☐	7. At the discretion of the Unit Medical Director exposure to any contagious illness in the family, school, or other group activities within the last 3 weeks*
Interviewer:			Signature/relation to child:

*If yes, please consult with the patient's physician

+ If yes, please exclude from visiting.

HDF4248 09/12/14

"SOMEONE DONATED 15 STUFFED ANIMALS TO OUR UNIT, WE WOULD LIKE TO KEEP THEM IN THE PLAY AREA FOR EVERY CHILD TO USE, CAN WE?"

- Do we have a policy for this?
- Can they be cleaned? How?

NON WASHABLE TOYS

1. Toys
   a. Items to be used by younger children (who have a tendency to put things in their mouth) should be made of a washable material (e.g. vinyl, plastic). Used washable toys are cleaned with soap and water and rinsed with tap water or wiped with a 70% alcohol solution when soiled and at some frequency appropriate to the unit (e.g., 5 Children's – weekly).

   b. Non-washable toys (e.g., puzzles, stuffed animals, puppets, etc) may be used by the older children (i.e., children who do not place toys in their mouth). Non washable toys must be disposed of when soiled. New toys brought into the playroom do not need to be sterilized or disinfected.

   c. Toys that are not washable (e.g., puzzles, books, stuffed animals) should not be taken into the room of a patient on isolation precautions. Preferably, the child should have his own toys or be given toys he can keep. Washable toys used by a patient on isolation precautions should be washed with soap and water followed by 70% alcohol before being returned to the playroom for use by other children.

THANK YOU