

ROUTINE PRACTICES

Routine Practices are the foundation for preventing the transmission of microorganisms during patient/client/resident care in all healthcare settings. It is a comprehensive set of infection prevention and control (IP&C) measures developed for use in the routine care of **ALL PATIENTS at ALL TIMES in ALL HEALTHCARE SETTINGS**. Routine Practices aim to minimize or prevent healthcare-associated infections in all individuals in the healthcare setting including patients, Healthcare Workers (HCWs), other staff, visitors, contractors, and so on. Adherence to Routine Practices can reduce the transmission of microorganisms in all healthcare settings.

All HCWs (physicians, nurses, allied HCWs, support staff, students, volunteers and others) are responsible for complying with Routine Practices and for tactfully calling infractions to the attention of offenders. **No one is exempt from complying with Routine Practices.**

Consistent application of Routine Practices is expected for the care of all patients at all times across the continuum of care. Microorganisms may be transmitted from symptomatic and asymptomatic individuals, emphasizing the importance of adhering to Routine Practices at **all times for all patients in all healthcare settings**.

Individual components of Routine Practices are determined by a point of care risk assessment (PCRA). A PCRA is performed by HCWs to determine the appropriate control measures required to provide safe patient care (i.e., protect the patient from transmission of microorganisms) and to protect the HCW from exposure to microorganisms (e.g., from sprays of blood, body fluids, respiratory tract or other secretions or excretions and contaminated needles and other sharps). A PCRA includes an assessment of the task/care to be performed, the patient's clinical presentation, physical state of the environment and the healthcare setting.

Patients and visitors have a responsibility to comply with Routine Practices where indicated. Teaching patients and visitors basic principles (e.g., hand hygiene, use of PPE) is the responsibility of all HCWs.

Routine Practices include:

1. [Point of Care Risk Assessment](#)
2. [Hand Hygiene](#) (including Point of Care alcohol-based hand rub [ABHR])
3. [Source Control](#) (triage, early diagnosis and treatment, respiratory hygiene, spatial separation)
4. [Patient Accommodation, Placement, & Flow](#)
5. [Aseptic Technique](#)
6. [Personal Protective Equipment](#) (PPE)
7. [Specimen Collection](#)
8. [Sharps, Safety & Prevention of Bloodborne Transmission](#)
9. [Management of the Patient Care Environment](#)
 - Cleaning of the Environment
 - Cleaning & Disinfection of Non-Critical Patient Care Equipment
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1. POINT OF CARE RISK ASSESSMENT (PCRA)

- i. Prior to every patient interaction, all Healthcare Workers (HCWs) are responsible to assess the infectious risk posed to themselves and other patients, visitors, and HCWs by a patient, situation or procedure. Perform a Point of Care Risk Assessment (PCRA) before each patient interaction to determine the appropriate Routine Practices required for safe patient care.

The PCRA is an evaluation of the risk factors related to the interaction between the HCW, the patient and the patient's environment to assess and analyze their potential for exposure to infectious agents and identifies risks for transmission. Control measures are based on the evaluation of the risk factors identified.

HCWs should perform PCRA's before every interaction with a patient and apply control measures for their safety and the safety of patients and others in the environment.

A PCRA is performed when a HCW evaluates a patient and situation, including, but not limited to:

- Determine the possibility of exposure to blood, body fluids, secretions and excretions, non-intact skin, and mucous membranes and select appropriate control measures (e.g., personal protective equipment [PPE]) to prevent exposure
- Determine the need for Additional Precautions when Routine Practices are not sufficient to prevent exposure
- Determine the priority for single rooms or for roommate selection if rooms/spaces are to be shared by patients

- ii. How to Perform a PCRA

- When performing a PCRA, each HCW considers questions to determine risk of exposure and potential for transmission of microorganisms during patient interactions. Examples of such questions are:
 - What contact will the HCW have with the patient?
 - What task(s) or procedures(s) is the HCW going to perform? Is there a risk of splashes/sprays?
 - If the patient has diarrhea, is he/she continent? If incontinent, can stool be contained in a diaper or incontinent product?
 - Is the patient able and willing to perform hand hygiene?
 - Is the patient in a shared room?

- iii. Applying Control Measures Following the PCRA: The PCRA of the circumstances of the patient, the environment, and task to be performed determine the control measures required. Control measures may include:
- Hand hygiene (alcohol-based hand rub at point of care)
 - Patient placement and accommodation
 - Give priority to patients with uncontained wound drainage or uncontained diarrhea into a single room
 - Place a patient with suspected or confirmed airborne infection into an Airborne Infection Isolation Room (AIIR) with the door closed
 - Treatment of active infection
 - Roommate selection for shared rooms or for transport in shared ambulances (and other types of transportation e.g., air ambulances, taxis), considering the immune status of patients who will potentially be exposed to certain infections (e.g., measles, mumps, rubella, varicella)
 - Patient flow
 - Restrict movement of symptomatic patients within the specific patient care area/facility or outside the facility as appropriate for the suspected or confirmed microbial etiology
 - Work assignment, considering the immune status of HCWs who will potentially be exposed to certain infections (e.g., measles, mumps, rubella, varicella)
 - Personal protective equipment selection, applying PPE appropriate to the suspected or confirmed infection or colonization
 - Cleaning of non-critical patient care equipment and the patient environment
 - Handling of linen and waste
 - Restricting visitor access where appropriate
 - Reassessment of need for continuing or discontinuing Additional Precautions

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2. **HAND HYGIENE**

Hand hygiene (HH) is a general term referring to any action of hand cleaning. Hand hygiene relates to the removal of visible soil and removal or killing of transient microorganisms from the hands while maintaining the good skin integrity resulting from a hand care program. HH includes surgical hand antisepsis.

Hands of HCWs are the most common vehicle for the transmission of microorganisms from patient to patient, from patient to equipment and the environment, and from equipment and the environment to the patient. Transmission of organisms by hands of HCWs between patients can result in healthcare-associated infections (HAIs). During the delivery of health care, the HCW's hands continuously touch surfaces and substances including inanimate objects, patient's intact or non-intact skin, mucous membranes, food, waste, body fluids and the HCW's own body. With each hand-to-surface exposure a bidirectional exchange of microorganisms between hands and the touched object occurs and the transient hand-carried flora is thus continuously changing.

In healthcare settings, hand hygiene is the single most important way to prevent infections.

Hand hygiene is a core element of patient safety for the prevention of infections and the spread of antimicrobial resistance. There are two methods of performing hand hygiene:

Alcohol-Based Hand Rub (ABHR):

- Use of alcohol-based hand rub (ABHR) has been shown to reduce healthcare-associated infection rates
- ABHR is the preferred method for decontaminating hands. ABHR is faster and more effective than washing hands (even with an antibacterial soap) when hands are not visibly soiled. ABHRs:
 - Provide for a rapid kill of most transient microorganisms
 - Are not to be used with water
 - Contain emollients to reduce hand irritation
 - Are less time consuming than washing with soap and water
- Allow hands to dry completely before touching the patient or their environment/equipment for the ABHR to be effective and to eliminate the extremely rare risk of flammability in the presence of an oxygen-enriched environment or static electricity

Efficacy of ABHRs

- The efficacy of the ABHR depends on the quality of the product, the amount of product used, the time spent rubbing, and the hand surface rubbed
- ABHR should not be used with water, as water will dilute the alcohol and reduce its effectiveness
- ABHR should not be used after hand washing with soap and water as it will result in more irritation of the hands

ABHRs available for healthcare settings range in concentration from 60 to 90% alcohol. Concentrations higher than 90% are less effective because proteins are not denatured easily in the absence of water.

Hand wipes impregnated with antimicrobials or soap may be used to remove visible soil and/or organic material, but are not a substitute for alcohol-based hand rub or antimicrobial soap. This is because they are not as effective at reducing bacterial counts on HCWs hands. Hand wipes may ONLY be considered as an alternative to washing hands with plain soap and water (when hands are visibly soiled) in settings where a designated hand washing sink is not available or when the hand washing sink is not satisfactory (e.g., contaminated sink, sink used for other purposes, no running water, no soap). Follow use of wipes in this instance (when hands are visibly soiled) with an ABHR. Hands should be washed once a suitable sink is available.

At the present time, there is no evidence for the efficacy of non-alcoholic, waterless antiseptic agents in the healthcare environment. Non-alcoholic products have a quaternary ammonium compound (QAC) as the active ingredient, which has not been shown to be as effective against most microorganisms as ABHR or soap and water. QACs are prone to contamination by Gram-negative organisms. QACs are also associated with an increase in skin irritancy. Non-alcohol-based waterless antiseptic agents are not recommended for hand hygiene in healthcare settings and should not be used.

Hand washing:

Hand washing with soap and running water must be performed when hands are visibly soiled. Antimicrobial soap may be considered for use in critical care settings such as intensive care units and burn units but is not required and not recommended in other care areas. Bar soaps are not acceptable in healthcare settings except for individual patient personal use. In this case, the soap should be supplied in small pieces that are single patient use, and the bar must be stored in a soap rack to allow drainage and drying. It should be discarded on patient discharge.

Efficacy of Soaps

- *Plain soaps* act on hands by emulsifying dirt and organic substances (e.g., blood, mucous), which are then flushed away with rinsing. Antimicrobial agents in plain soaps are only present as a preservative
- *Antimicrobial soaps* have residual antimicrobial activity and are not affected by the presence of organic material
 - Disadvantages of antimicrobial soap include:
 - Antimicrobial soaps are harsher on hands than plain soaps and frequent use may result in skin breakdown; and
 - Frequent use of antimicrobial soap may lead to antibiotic resistance

Hand hygiene with correctly applied alcohol-based hand rub kills organisms in seconds. Hand hygiene with soap and water done correctly physically removes organisms.

Care Environments

The care environment is the space around a patient that may be touched by either the patient or the healthcare worker.

Two different environments:

- Healthcare environment/zone
 - Environment beyond the patient's immediate area. In a single room this is outside the room. In a multi-bed room this is everything outside the patient's bed area
- Patient environment/zone: the patient's area
 - In a single room this is everything in the patient's room
 - In a multi-bed room this is the area inside the patient's curtain
 - In an ambulatory setting, the patient environment is the area that may come into contact with the patient within their cubicle
 - In an Emergency department cubicle it is the patient stretcher and the equipment in close proximity used in the patient's care
 - In a nursery/neonatal and intermediate care setting, the patient environment includes the inside of the bassinette or isolette, the equipment outside the bassinette or isolette used for that infant (e.g., ventilator, monitor), as well as an area around the infant (i.e., within approximately 1 metre/ 3 feet)

If the patient bathroom is used for hand hygiene, avoid contamination of hands with potentially contaminated surfaces and objects.

Indications and Moments for Hand Hygiene during Health Care Activities

When should hand hygiene be performed? A hand hygiene indication points to the reason hand hygiene is necessary at a given moment. There may be several indications in a single care sequence or activity. Hand hygiene shall be performed before and after any direct contact with a patient or patient equipment, between procedures on the same patient, and before contact with the next patient.

While all indications for hand hygiene are important, there are some essential moments in healthcare settings where the risk of transmission is greatest and hand hygiene must be performed. Essential HH indications can be simplified into 4 moments for training:

THE 4 MOMENTS FOR HAND HYGIENE:

1. BEFORE INITIAL PATIENT/PATIENT ENVIRONMENT CONTACT

When? Clean your hands when entering a patient care environment

- Before entering the patient/treatment/exam room
- Before touching patient (e.g., shaking their hand, helping the patient move around)
- Before touching any object or furniture in the patient's environment (e.g., stretchers, wheelchairs, adjusting an IV, silencing a pump)

Why? To protect the patient and their environment from harmful microorganisms carried on your hands.

2. BEFORE ASEPTIC/CLEAN PROCEDURES

When? Clean your hands immediately before any aseptic procedure

- Performing invasive procedures
- Handling dressings or touching open wounds
- Preparing and administering medications
- Preparing, handling, serving or eating food
- Feeding a patient
- Shifts and breaks

Why? To protect the patient from harmful microorganisms, including his/her own microorganisms, entering his or her body.

3. AFTER BODY FLUID EXPOSURE RISK

When? Clean your hands immediately after an exposure risk to blood and body fluids, non-intact skin, and/or mucous membranes (and after glove removal).

- Contact with blood and body fluids
- Contact with items known or considered to be contaminated
- Procedures on the same patient where soiling of hands is likely, to avoid cross-contamination of body sites
- Oral care, wound care, patient toileting
- Removal of gloves
- Personal use of toilet or wiping nose/face
- Feeding a patient
- Before and after shifts and breaks

Why? To protect yourself and the healthcare environment from harmful patient microorganisms.

4. AFTER PATIENT/PATIENT ENVIRONMENT CONTACT

When? Clean your hands when leaving the patient/patient environment.

- After touching patient to assist with any tasks (e.g., helping a patient mobilize; giving a massage; taking pulse, blood pressure, chest auscultation, abdominal palpation) or
- After touching any object or furniture in the patient's environment (e.g., changing bed linen, perfusion speed adjustment, alarm monitoring, clearing the bedside or overbed table)

Why? To protect yourself and the healthcare environment from harmful microorganisms.

Risk is important in making decisions of when to clean hands. Immediately after (and immediately before) requires hand hygiene is possible at point of care. Hand hygiene with point of care alcohol-based hand rub (ABHR) is the standard of care expected of all HCWs, in all healthcare settings. Busy HCWs need access to hand hygiene products where patient/patient environment contact is taking place. Providing ABHR at the point of care (e.g., within arm's reach) is an important system support to improve hand hygiene. Point of care refers to the place where three elements occur together:

- The patient
- The healthcare worker
- Care potentially involving contact is taking place

The point of care (POC) concept refers to a hand hygiene product (e.g., alcohol-based hand rub) which is easily accessible to HCWs by being as close as possible, e.g., within arm's reach (as resources permit) to where patient contact is taking place. Point of care products should be available at the required moment, without leaving the patient environment. This enables HCWs to quickly and easily fulfill the 4 Moments for Hand Hygiene. Point of care can be achieved in a variety of methods. (e.g., ABHR attached to the bed, wall, equipment carried by the HCW).

Focusing on a single patient, the healthcare setting is divided into two virtual geographical areas: the patient environment/zone and the healthcare environment/zone. The term "patient zone" refers to the space that contains the patient, as well as the immediate surroundings and inanimate surfaces in contact with the patient (e.g., bed rails, bedside tables, bed linens, infusion tubing, and other medical equipment). It further contains surfaces frequently touched by HCWs within the vicinity of the patient (e.g., monitors, buttons and knobs, and other 'high frequency' touch surfaces within the patient zone). The patient zone and thus the POC extend beyond the bedside in a hospital room. The model assumes that the patient flora rapidly contaminates the entire patient zone, but that it is being cleaned between patient admissions. The POC occurs within the patient zone.

The healthcare zone contains all surfaces outside the patient zone of the patient, i.e., all other patients and their patient zones and the healthcare facility environment. Conceptually, the healthcare zone is contaminated with microorganisms that might be foreign and potentially harmful to individual patients, either because they are multi-resistant or because their transmission might result in exogenous infection.

Two moments for hand hygiene may sometimes fall together. Typically this occurs when going from one patient to another without touching any surface outside the corresponding patient zones. Naturally, a single hand hygiene action will cover the two moments for hand hygiene.

Techniques

Using an Alcohol-Based Hand Rub (ABHR)

- Ensure hands are visibly clean (if soiled, follow hand washing steps)
- Remove hand and arm jewellery; if a watch is worn, it must be worn above the wrist and fit snugly; clothing or other items that impede frequent and effective hand hygiene should be removed; a simple and practical solution allowing effective hand hygiene is for HCWs to wear their rings around their neck on a chain as a pendant
- Apply one to two full pumps of product onto one palm; the volume should be such that 15 seconds of rubbing is required for drying
- Spread product over all surfaces of hands, concentrating on finger tips, between fingers, back of hands, and base of thumbs; these are the most commonly missed areas; and
- Continue rubbing hands until product is dry; this will take a minimum of 15 seconds if sufficient product is used. **Hands must be fully dry** before touching the patient or the care environment/equipment for the ABHR to be effective and to eliminate the extremely rare risk of flammability in the presence of an oxygen-enriched environment.

Using Soap and Water

- Remove hand and arm jewellery; if a watch is worn, it must be worn above the wrist and fit snugly; clothing or other items that impede frequent and effective hand hygiene should be removed or pushed back; a simple and practical solution allowing effective hand hygiene is for HCWs to wear their rings around their neck on a chain as a pendant
- Wet hands with warm (not hot or cold) water; hot or cold water is hard on the hands, and will lead to dryness
- Apply liquid or foam soap
- Vigorously lather all surfaces of hands for a minimum of 15 seconds; removal of transient or acquired bacteria requires a minimum of 15 seconds of mechanical action; pay particular attention to finger tips, between fingers, backs of hands and base of the thumbs; these are the most commonly missed areas
- Using a rubbing motion, thoroughly rinse soap from hands; residual soap can lead to dryness and cracking of skin
- Dry hands thoroughly by blotting hands gently with a paper towel; rubbing vigorously with paper towels can damage the skin
- Turn off taps with paper towel to avoid recontamination of the hands. If hand air dryers are used in non-clinical areas, hands-free taps are required
- DO NOT use ABHR immediately after washing hands, as skin irritation will be increased

Factors that Reduce Effectiveness of Hand Hygiene

Condition of the Hands

The condition of the hands and the presence of hand adornments can influence the effectiveness of hand hygiene. Intact skin is the body's first line of defence against bacteria; therefore careful attention to hand care is an essential part of the hand hygiene program. The presence of dermatitis, cracks, cuts or abrasions can trap bacteria and compromise hand hygiene. Dermatitis also increases shedding of skin squames (cells) and, therefore, shedding of bacteria.

Nails

Long nails are difficult to clean, can pierce gloves and harbour more microorganisms than short nails. Keep natural nails clean and short. The nail should not show past the end of the finger.

Nail Polish

Studies have shown chipped nail polish or nail polish worn longer than four days can harbour microorganisms that are not removed by hand washing, even with surgical hand scrubs. Freshly applied nail polish does not result in increased numbers of bacteria around the nails. Fingernail polish, if worn, must be fresh and in good condition.

Artificial Nails or Nail Enhancements

Artificial nails and nail enhancements are not to be worn by direct care providers (refer to WRHA Policy 20.70.010, Dress Code, and WRHA Policy 90.00.060, Routine Practices for Reducing the Risk of Infection Transmission).

Acrylic nails harbour more microorganisms and are more difficult to clean than natural nails. Artificial nails and nail enhancements have been implicated in the transfer of microorganisms and in outbreaks, particularly in neonatal nurseries and other critical care areas. Surgical site infections and hemodialysis-related bacteremias have been linked to artificial nails. Artificial nails and nail enhancements are also associated with poor hand hygiene practices and result in more tears to gloves.

Rings, Hand Jewellery and Bracelets

Hand and arm jewellery hinder hand hygiene. Rings increase the number of microorganisms present on hands and increase the risk of tears in gloves. Arm jewellery, including watches, should not interfere with, or become wet when performing hand hygiene.

Rings and bracelets should not be worn by direct care providers. If watches and other wrist jewellery are present, remove or push up above the wrist before performing hand hygiene.

Other Impediments to Effective Hand Hygiene

Long sleeves should not interfere with, or become wet when performing hand hygiene.

Hand Drying (paper towel, air dryers)

Effective hand drying is important for maintaining hand health. Considerations include:

- Disposable paper hand towels provide the lowest risk of cross-contamination and should be used for drying hands in clinical practice areas
- Cloth drying towels must not be used unless a new towel is used for each episode
- Towel dispensers must be mounted such that access to them is unobstructed and splashing or dripping onto adjacent wall and floor surfaces is minimized

- Towel dispenser design should be such that only the towel is touched during removal of towel for use
 - Towels hanging from the dispenser should not hang directly into a garbage can
- Hot-air dryers, including jet air dryers, must not be used in clinical areas as warm air currents dry hands slowly and can be used by only one individual at a time. This results in lines and the temptation to dry hands on clothing
 - Where hot-air dryers are used in non-clinical areas, hands-free taps are required
 - If hot-air dryers are used in non-clinical areas, there must be a contingency for power interruptions

Lotions and Creams

- HCWs must use facility approved lotions compatible with products and gloves in use
- Hand lotion bottles shall not be reused
- Barrier Creams: unlike hand lotions, which penetrate the skin via pores, barrier creams are adsorbed to the skin and are designed to form a protective layer that is not removed by standard hand washing. Barrier creams may actually be harmful as they trap agents beneath them, ultimately increasing risk for either irritant or allergic contact dermatitis. Furthermore, inappropriate barrier cream application on HCW hands may exacerbate irritation rather than provide benefit.

Dispensers

- Products must be dispensed in a disposable pump/squirt container that is not topped-up, to prevent contamination
- Do not add soap or hand rub to a partially empty dispenser
- If reusable dispensers are utilized they must be emptied, washed and air-dried prior to refilling

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3. SOURCE CONTROL

These measures are used to contain microorganisms from dissemination from an infectious source. Individuals with symptoms require direction at the point of initial encounter in any healthcare setting (e.g., triage in emergency departments; acute assessment settings; and reception and waiting areas in emergency departments, outpatient clinics and physician offices) and in strategic places (e.g., elevators, cafeterias) within ambulatory and inpatient settings. Source control measures may include but are not limited to:

- Signage at healthcare setting entrances for early recognition of symptoms
- Separate entrances/waiting areas
- Spatial separations
- Physical barriers for acute assessment
- Early identification, diagnosis and treatment of infection
- Respiratory etiquette/hygiene
- Hand hygiene
- Patient placement (e.g., patient care areas, single rooms/Airborne Infection Isolation Rooms [AIIRs])

Respiratory Etiquette/Respiratory Hygiene

Respiratory hygiene refers to a combination of measures designed to minimize the transmission of respiratory pathogens. These 'source control' measures are targeted to all individuals with symptoms of respiratory infection starting at the initial encounter in a healthcare setting and maintained throughout every encounter in the setting (e.g., pre-hospital triage, triage in emergency departments, reception and waiting areas in emergency departments and ambulatory clinics, and in strategic places such as elevators and cafeterias).

Respiratory hygiene involves educating and encouraging all individuals (patients, HCWs and visitors) who have the physical and cognitive abilities to do so, to practice respiratory hygiene. Specific measures may include instructional signs, education programs and provision of materials for respiratory hygiene (e.g., tissues, plastic lined waste receptacles, alcohol-based hand rub [ABHR]).

Encourage respiratory hygiene for patients and accompanying individuals who have signs and symptoms of an acute respiratory infection (manifested by new or worsening cough, shortness of breath and fever), beginning at the point of initial encounter in any healthcare setting. Respiratory hygiene includes:

- Covering the mouth and nose against a sleeve/shoulder during coughing or sneezing
- Using tissues to contain respiratory secretions to cover the mouth and nose during coughing or sneezing, with prompt disposal of these into a hands-free waste receptacle.
- Wearing a mask when coughing or sneezing.
- Turning the head away from others when coughing or sneezing.
- Maintaining a spatial separation of two metres/six feet between patients symptomatic with an acute respiratory infection and those who do not have symptoms of a respiratory infection. If this cannot be achieved, the patients must be at least one metre/three feet apart and the symptomatic patient must wear a mask. One metre/three feet may be sufficient for young children and others whose cough is not forceful enough to propel the droplets as far as two metres/six feet.

Family and HCWs with signs/symptoms of respiratory illness should not come to the hospital.

Triage

i. *Emergency rooms and acute assessment settings*

- Post signs to direct patients with symptoms of acute infection (e.g., cough, fever, vomiting, diarrhea, coryza, rash, conjunctivitis) to specific waiting areas
- Ensure a physical barrier (e.g., plastic partition at triage desk) is located between infectious sources (e.g., patients with symptoms of a respiratory infection) and others
- Place patients who are likely to contaminate the environment directly into a single examining room whenever possible
 - Patients with gastrointestinal (acute diarrhea/vomiting) illness
 - Patients with respiratory infections. These patients should be placed either directly into an examining room or an airborne infection isolation room, as indicated by the respiratory infection suspected. Place a mask on these patients until isolated or spatial separation is achieved
 - Patients with excessive bleeding or body fluid drainage into a single examining room whenever possible

ii. *Ambulatory settings*

- If possible, identify patients with symptoms of an acute infection when scheduling appointments for routine clinic visits and request they defer routine clinic visits until symptoms of the acute infection have subsided
- Inform patients who cannot defer their routine clinic visit (i.e., those that require assessment of symptoms/condition) to follow hand hygiene and/or respiratory hygiene recommendations appropriate for their symptoms. Direct these patients into an examining room as soon as they arrive and/or schedule their appointment for a time when other patients are not present
- Post signs at clinic entrances reminding symptomatic patients to perform hand hygiene and/or respiratory hygiene appropriate for symptoms

Early Diagnosis and Treatment

Ensure symptomatic patients are assessed in a timely manner and that any potential communicable infection is considered (e.g., tuberculosis, norovirus, RSV, pertussis).

Spatial Separation

Appropriate spatial separation and spacing requirements are necessary to decrease exposure to microorganisms for patients and visitors in clinical and waiting areas. A two metre/six feet spatial distance between a coughing/sneezing infected source (e.g., symptomatic individual with acute respiratory illness) and an unprotected susceptible host (e.g., patients, HCWs, visitors, contractors) is recommended to prevent the transmission of droplet borne infectious particles. In inpatient facilities, a single room with in-room designated toilet and sink is preferable, as it may be difficult to maintain the recommended spatial separation of two metres/six feet between patients.

If two metres/six feet cannot be achieved, patients must be at least one metre/three feet apart and the symptomatic patient must wear a mask. One metre/three feet may be sufficient for young children and others whose cough is not forceful enough to propel the droplets as far as two metres/six feet.

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4. PATIENT ACCOMMODATION, PLACEMENT, & FLOW

Accommodation of inpatients in single rooms facilitates IP&C activities. Single rooms with a private toilet, designated patient hand washing sink and designated staff hand washing sink may reduce opportunities for cross transmission between patients, particularly when the patient has poor hygiene, contaminates the environment or cannot comply with IP&C measures because of age or decreased cognitive abilities.

When availability of single rooms is limited, priorities for placement of patients in single rooms are determined by the PCRA. Priority for single rooms goes to patients:

- Requiring Additional Precautions
- Identified as high risk for transmission of microorganisms (e.g., stool incontinence, uncontained secretions)
- Identified as being at higher risk of acquisition and adverse outcomes resulting from transmission of microorganisms (e.g., immunosuppression, open wounds, indwelling catheters)

When single rooms are not available and rooms must be shared, factors to be considered with shared rooms include:

- Selecting appropriate roommates
- Avoiding placing patients at high risk of complications should they become infected in rooms with patients with transmissible infections, diarrhea or open wounds
- Delineating the boundary of the potentially contaminated patient area within the shared room (e.g., draw privacy curtain around patient)
- Preventing transmission risks through sharing of sinks and toilets
- Assessing activities of the roommates and their visitors

Patient flow refers to patient transfer/transport within and outside of the facility, and patient activity. There is a potential for exposure to and transmission of microorganisms as a result of patient activity and transport due to inadvertent contact with other patients, patient care items and environmental surfaces. *Patients should not be transported between patient care units, departments or facilities unless medically essential.* Frequent patient transfers should be avoided as this increases the number of interactions with staff and other patients, providing opportunities for transmission to occur. The HCW, including bed/accommodation co-ordinators, are responsible for selecting the most appropriate accommodation based on the PCRA and for prioritizing use of single rooms and AIIRs if these are scarce. When in doubt regarding accommodation, consult IP&C.

Avoid transfer of patients within facilities unless medically indicated. When Additional Precautions are necessary, patients should leave their rooms for medically necessary purposes only. Communication between the transporting area and the receiving area is important to ensure consistency of precautions and to decrease unnecessary waiting time in public areas. Apply source control measures (e.g., requesting patient to perform hand hygiene before leaving their room, cover skin lesions, wear a mask).

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5. **ASEPTIC TECHNIQUE**

Aseptic technique, sometimes referred to as sterile technique, refers to practices designed to render the patient's skin, medical supplies and surfaces as maximally free from microorganisms. These practices are required when performing procedures that expose the patient's normally sterile sites (e.g., intravascular system, spinal canal, subdural space, urinary tract) to minimize contamination with microorganisms).

Components of aseptic technique involve the following:

- Preparing the patient's skin with an antiseptic
- Hand hygiene, preferably with alcohol-based hand rub (ABHR), or if not accessible, an antimicrobial soap
- Sterile gloves
- Gowns
- Masks, where required, to prevent microorganisms carried in the HCW's nose and mouth from contaminating the sterile field
- Sterile drapes, used to prevent transferring microorganisms from the environment to the patient while the procedure is being performed
- Maintaining a sterile field

Infections may result from failure to use proper skin antisepsis prior to injection of medications, vaccines or venipuncture. Chlorhexidine in alcohol inactivates microorganisms on the skin more effectively than most other antiseptics and is the preferred antiseptic for skin preparation prior to insertion of central venous catheters and pulmonary artery catheters.

Transmission of hepatitis B and hepatitis C virus has followed the reuse of needles and/or syringes for withdrawing from multi-use vials.

Recommendations for Injection Safety include:

- Never administer medications from the same syringe to more than one patient, even if the needle is changed
- Consider a syringe or needle contaminated after it has been used to enter or connect to a patient's intravenous infusion bag or administration set
- Do not enter a vial with a syringe or needle which has been previously used
- Never use medications packaged as single use vials for more than one patient
- Assign medications packaged as multi-use vials to a single patient whenever possible
- Do not use bags or bottles of intravenous solution as a common source of supply for more than one patient

Aseptic Technique for Invasive Procedures and Handling Injectable Products:

- Perform hand hygiene, preferably with alcohol-based hand rub (ABHR) prior to opening supplies
 - When ABHR is not accessible, perform hand hygiene with antimicrobial soap and water
- Open tray and supplies only when ready to use to ensure a sterile field
- Perform hand hygiene prior to applying PPE, as indicated by the specific procedure
- Prepare the patient's skin with an appropriate antiseptic before performing an invasive procedure
- Use the appropriate size drape when a drape is required, to maintain a sterile field
- Do not administer medications or solutions from single dose vials, ampules or syringes to multiple patients or combine leftover contents for later use
- Use a sterile, single use disposable needle and syringe for each medication/fluid withdrawal from vials or ampules
- Clean the stoppers or injection ports of medication vials, infusion bags, etc., with alcohol before entering the port, vial or bag
- Use single dose medication vials, prefilled syringes, and ampules in clinical settings. If the product is only available as multi-dose vials, see *multi-dose vials below

*When a product is only available for purchase in multi-dose vials:

- Restrict the multi-dose vial to single patient use whenever possible
- Prepare syringes from multi-dose vials from a centralized medication preparation area (i.e., do not take multi-dose vials to the patient)
- Store the multi-dose vial to restrict access (e.g., in a secure location away from patient bedside and where access is restricted, such as a medication room or locked cart)
- Use a sterile, single use needle and syringe each time the multi-dose vial is entered
 - Do not re-enter the multi-dose vial with a previously used needle or syringe
- Label the multi-dose vial with date of first opening
- Inspect the multi-dose vial for clouding or particulate contamination prior to each use and discard multi-dose vial if clouding or particulate contamination present
- Discard the multi-dose vial if sterility or product integrity is compromised

Single Patient Multi-Use Devices:

- Assign single patient multi-use devices (e.g., glucose sampling devices, finger stick capillary blood sampling devices) to only one patient. If not feasible to assign glucose meters to individual patients, clean and disinfect before use between patients.

Injecting Material and Placing a Catheter into the Spinal Canal or Subdural Space:

- Use aseptic technique including a mask and sterile gloves (e.g., during lumbar puncture, myelogram, and spinal or epidural anesthesia)

Insertion of Central Venous Catheters:

- Use maximal aseptic barriers as outlined in Aseptic Technique for Invasive Procedures and Handling Injectable Products (above), in addition to a cap, mask, long sleeved sterile surgical gown, sterile gloves, and a large full body sterile drape
- Prepare the skin with chlorhexidine in alcohol or an equal alternative for inserting any central venous catheter or pulmonary catheter

Insertion of Peripheral Venous Catheters or Peripheral Arterial Lines:

- Perform hand hygiene, prepare the skin with an antiseptic and wear clean disposable gloves

Storage, Assembly or Handling Components of Intravenous Delivery Systems:

- Use intravenous bags, tubing and connectors for one patient only and dispose appropriately after use
- Consider a syringe, needle or cannula as contaminated once it has been used to enter or connect to one patient's intravenous infusion bag or administration set and do not reuse
- Do not assemble sterile components until time of need with the exception of the emergency department, operating room, or intensive care unit where it may be essential to maintain one system primed and ready for emergency use. If so, store the primed system in a clean and dry area secure from tampering and label with the date of priming. Replace if not used within 2 hours
- Store sterile intravenous equipment components in a clean, dry and secure environment

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6. PERSONAL PROTECTIVE EQUIPMENT (PPE)

PPE should not be relied on as a stand-alone primary prevention program. Focusing only on availability and use of various PPE will result in suboptimal protection of all persons, including patients, HCWs and other staff. PPE provides a physical barrier between the uninfected and an infectious agent/infected source, and protects the user from exposure to bloodborne and other microorganisms (e.g., sprays of blood, body fluids, respiratory tract or other secretions or excretions).

Appropriate PPE must be available for use by patients, HCWs, visitors, contractors, and others, to prevent exposure to an infectious agent/infected source. Effective and appropriate use of PPE is reliant on the user's adherence and competence. HCWs should determine what PPE is needed by assessing the risk of exposure to blood, body fluids, secretions and excretions, mucous membranes, or non-intact skin during patient care interactions. The PCRA identifies hazards and enables the HCW to select PPE compatible with the hazard likely to be encountered during the patient care interaction. The selected PPE should maximize protection, dexterity and comfort.

Appropriate and proper use of PPE includes:

- Point of Care Risk Assessment (PCRA) to determine need for PPE
- Correct technique for putting on and taking off PPE
- Correct technique when wearing PPE (e.g., not contaminating self)
- Discard into designated receptacles immediately after use, followed by hand hygiene, preferably with alcohol-based hand rub (ABHR)

Following the PCRA, PPE for the appropriate application of Routine Practices may include:

- Gloves
- Gowns
- Facial protection
 - Masks (procedure or surgical)
 - Eye protection (safety glasses or goggles or face shields)
Does NOT include prescription or fashion glasses
 - Masks with visor attachment

Performing a point of care risk assessment to determine whether PPE is necessary is also important to avoid overreliance on PPE, misuse or waste. Over-reliance on PPE may result in a false sense of security. Misapplication or incorrect removal of PPE can result in inadvertent exposure of the user or patient to infectious agents or contamination of the patient's environment.

Refer to:

- Appendix 4, Personal Protective Equipment Options
- Appendix 5, Personal Protective Equipment Putting it On in 5 Easy Steps; and
- Appendix 6, Personal Protective Equipment Taking it Off in 6 Easy Steps

i. *Gloves*

The use of gloves is not a substitute for hand hygiene, but an additional measure of protection. For Routine Practices, glove use is dependent on a risk assessment of the patient, the environment and the interaction. Gloves are not required for routine patient care activities when contact is limited to a patient's intact skin. Available gloves for patient care include procedure and surgical (i.e., sterile) gloves.



Gloves are used to reduce the transmission of microorganisms from one patient to another or from one body site to another, and to reduce the risk of exposure of the user to blood, body fluids, secretions and excretions, mucous membranes, draining wounds or non-intact skin and for handling items or touching surfaces visibly or potentially soiled. **Hand hygiene is ALWAYS necessary after the removal of gloves.** Gloves may have microscopic holes, or hands may become contaminated during glove removal.

Wear gloves as determined by the Point of Care Risk Assessment:

- For anticipated contact with blood, body fluids, secretions and excretions, mucous membranes, draining wounds or non-intact skin (including skin lesions or rash)
- For handling items or touching surfaces visibly or potentially soiled with blood, body fluids, secretions or excretions
- While providing direct care if the user has an open cut or abrasions on the hands

Appropriate Glove Use:

- Perform hand hygiene prior to putting on gloves for tasks requiring clean, aseptic or sterile technique
- Put gloves on directly before contact with the patient or just before the tasks or procedure requiring gloves
- Wear disposable procedure or surgical gloves or reusable utility gloves for cleaning the environment or medical equipment
- Remove gloves and perform hand hygiene immediately after patient care activities. If gloves are still indicated, replace with a clean pair
- Remove gloves and dispose into a hands-free waste receptacle immediately following their intended use. Do not reuse single use gloves. Do not clean gloves with alcohol-based hand rub or wash for reuse
- Perform hand hygiene following the removal of gloves, before leaving the patient's environment and before touching environmental surfaces
- Do not use the same pair of gloves for the care of more than one patient
- Do not double glove

Single use gloves must never be washed. Washing affects integrity and has not been shown to be effective in removing inoculated microorganisms.

ii. *Long Sleeved Gowns and Other Apparel*

Long sleeved gowns are worn for Routine Practices as indicated by the risk assessment, to protect uncovered skin and clothing during procedures and patient care activities likely to produce soiling or generate splashes or sprays of blood, body fluids, secretions or excretions.

Gowns include isolation gowns – reusable/disposable, fluid repellent, or sterile. The type of gown selected is based on the:

- Anticipated degree of contact with infectious material
- Potential for blood and body fluid penetration of the gown (fluid repellence when heavy liquid contamination is anticipated (e.g., operating theatre, dialysis)
- Requirement for sterility (e.g., operating theatre, central line insertion)

Appropriate Gown Use

- Perform hand hygiene before gowning



- Ensure gown is long enough to cover the front and back of the user, from the neck to mid-thigh and the sleeves no shorter than just above the wrist
- Put gown on with the opening at the back, with edges overlapping, thus covering as much clothing as possible
- Ensure cuffs of the gown are covered by gloves
- Tie the gown at the neck and waist
- Remove gown by undoing the neck and waist ties, starting with neck ties, and remove the gown without touching the clothing or agitating the gown unnecessarily; then turn the gown inside on itself, and roll it up
- Remove gown immediately after the indication for use and place in a hands-free waste receptacle (if disposable), or in a soiled linen bag (if reusable), and perform hand hygiene before leaving the patient's environment
- Remove wet gowns immediately to prevent a wicking action that facilitates the passage of microorganisms through the fabric
- Do not reuse gowns once removed, even for repeated contacts with same patient
- Do not wear the same gown between successive patients

There is no evidence the routine use of gowns for all patient care is beneficial in the prevention of healthcare-associated infections (HAIs), even in high risk units such as intensive care or haematopoietic stem cell transplant units. Universal gown use has had no effect on HAI rates in neonatal or paediatric ICUs or on rates of neonatal colonization on post-partum wards.

In the laboratory setting, wearing of laboratory coats is considered PPE. Outside of the laboratory, apparel such as uniforms, laboratory coats or scrub suits may be worn by HCWs for purposes of comfort, convenience or identity but do not have a role in the prevention of infection (i.e., they are not considered PPE).

For aesthetic purposes and professional etiquette, HCW apparel and uniforms should be clean. It is safe to launder HCWs uniforms at home. Adhere to organizational policy regarding the laundering of scrub suits and uniforms supplied by the organization.

Wear long sleeved cuffed gowns as determined by the Point of Care Risk Assessment:

- To protect uncovered skin
- To prevent soiling of clothing
- During procedures and patient care activities likely to soil clothing and/or generate splashes or sprays of blood, body fluids, secretions or excretions

iii. *Facial Protection*

Facial protection includes masks (procedure or surgical), eye protection (safety glasses or goggles or face shields), or masks with visor attachment.

Masks

Masks include procedure or surgical masks, and have several uses:

- To protect from sprays or splashes
- As a barrier for infectious sources
- As a barrier when performing aseptic/sterile procedures
- To protect susceptible hosts when within two metres/six feet of patients with respiratory signs/symptoms

The eye is an important portal of entry for some pathogens. Pathogens may be introduced into the eye directly via respiratory droplets generated during coughing or



suctioning, or by self-inoculation if the eyes are touched with contaminated fingers. Eyes may be protected through use of:

- Masks with visor attachment
- Safety glasses/goggles, or
- Face shields

The need for facial protection during routine patient care is determined by the risk assessment of the patient interaction and the task to be performed.

Interactions involving activities likely to generate coughing, splashes or sprays of blood, body fluids, secretions or excretions, and procedures that potentially expose the mucous membranes of the eyes, nose or mouth, require facial protection. Transmission of hepatitis C and HIV has been reported by splashes of blood to the mucous membranes of the face.

Users should *avoid touching their faces* with their hands during patient care. Wear facial protection (i.e., masks plus eye protection, face shields, or masks with visor attachment) as determined by the Point of Care Risk Assessment:

- To protect the mucous membranes of the eyes, nose and mouth during procedures and patient care activities likely to generate splashes or sprays of blood, body fluids, secretions or excretions including respiratory secretions
- When caring for a coughing/sneezing patient

Remove eye protection or face shields immediately after use and place promptly into a hands-free waste receptacle and perform hand hygiene.

- If eye protection or face shields are reusable, clean and disinfect as per organizational policy before reuse

When eye protection is required, wear eye protection over prescription or fashion glasses; prescription or fashion glasses alone are not adequate for eye protection.

Appropriate Use of Facial Protection

- Perform hand hygiene prior to applying facial protection
- Wear and discard facial protection appropriately to prevent self-contamination
- Ensure nose, mouth and chin are covered when wearing a mask
- Avoid self-contamination by not touching facial protection on its external surface during use and disposal
- Wear disposable eye protection or face shields only once to avoid self-contamination
- Remove facial protection carefully by the straps or ties
- Discard facial protection immediately after the intended use into a hands-free waste receptacle (i.e., dispose of as soon as removed from the face) and perform hand hygiene
- Do not dangle a mask around the neck when not in use; do not reuse mask
- Change the mask if it becomes wet or soiled (from the wearer's breathing or due to an external splash)
- Change the mask if breathing becomes difficult
- Do not position on head or around the neck for later use

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7. **SPECIMEN COLLECTION**

All clinical specimens are considered potentially infectious and shall be handled carefully to prevent contamination.

All specimens submitted to the laboratory for testing must be packaged in such a manner as to prevent spillage, breakage, or damage to the specimen itself, and/or to accompanying specimens. The safety of the environment, and the safety of all persons involved in the shipping, handling and receiving of these specimens must be ensured by preventing exposure to the contents of the shipment at any time.

Specimens and requisitions must be labelled to comply with receiving laboratory's acceptance policy.

Specimens shall be transported to the laboratory in sealable zipper storage bags (e.g., Ziploc®).

Each specimen must have its own requisition. Requisitions shall be placed in the exterior pouch of the sealable zipper storage bag (e.g., Ziploc®) for transport.

Consider Personal Protective Equipment when collecting specimens.

Perform hand hygiene immediately after specimen collection.

Process:

1. Assemble all supplies. When tourniquets are used, they must be single use, or safely left at the patient's bedside and used for the duration of his/her hospitalization, unless visibly soiled (in which case they shall be disposed).
2. Perform hand hygiene.
3. Apply appropriate PPE if required, or if splashing is anticipated.
4. Collect specimen per laboratory sample collection manuals, available at: <https://apps.sbggh.mb.ca/labmanualviewer/findPolicies.action>
5. Remove PPE. Perform HH.

Specimens will be rejected for analysis for the following reasons:

- Specimens that cannot be safely processed, i.e., specimens with needle attached
- Improperly transported specimens
- Improperly labelled specimens
- Improper specimen collection
- Samples that are inappropriate for the test requested

Specific rejection criteria exist depending on the specimen type; consult the laboratory for further information.

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8. SHARPS SAFETY & PREVENTION OF BLOODBORNE TRANSMISSION

The prevention of sharps injury and HCW exposure to bloodborne pathogens is a component of Routine Practices.

Users of sharps require education and training about how to safely handle sharp devices to prevent injuries to themselves and to others who may encounter the device during or after procedures. Safety programs include a formal incident investigation for every sharp injury occurring in the work setting.

Use of safety engineered devices such as using protected needle devices, needle-free systems with self-sealing ports, and syringes with safety features, have been reported to reduce needlestick injuries. Their use has been identified as a priority in risk reduction strategies. Some models have demonstrated a risk for patients. Therefore careful consideration to both patients and health care workers should be taken when selecting safety engineered sharps devices. Refer to WRHA policy 20.20.020, Sharps, Safe Handling, Use and Disposal (including Safety-Engineered Needle (SEN) Exemption (<http://home.wrha.mb.ca/corp/policy/files/20.20.020.pdf>).

Do not recap used needles. Handle used needles and other sharp instruments with care to avoid injuries during disposal. Dispose of used needles and other used single use sharp items immediately into designated puncture-resistant containers readily accessible at the point of care.

Protect eyes, nose and mouth (using facial protection) when splashes with blood and/or body fluids are anticipated.

Perform first aid immediately if exposed to blood or body fluids:

- Thoroughly rinse the site of a percutaneous injury with running water and gently clean any wound with soap and water
- Flush mucous membranes of the eyes, nose, or mouth with running water if contaminated with blood, body fluids, secretions or excretions
- Thoroughly rinse non-intact skin with running water if contaminated with blood, body fluids, secretions or excretions

Report immediately to employer after first aid and seek immediate medical attention. Refer to WRHA Occupational and Environmental Safety and Health Operational Procedure, Blood and Body Fluid – Post Exposure Management (<http://www.wrha.mb.ca/professionals/safety/files/OP-BloodandBodyFluidExposure.pdf>).

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9. MANAGEMENT OF THE PATIENT CARE ENVIRONMENT

Cleaning of Environment

Minimize Environmental Contamination by:

- Refraining from taking the patient care record/chart into the patient room, cubicle or designated bed space in a shared room and perform hand hygiene after handling the record/chart
- Refraining from eating or drinking in areas where direct patient care is provided, at the nursing station, in medication rooms, in clean supply rooms, and in reprocessing or laboratory areas
- Dedicating non-critical medical equipment to a single patient
- Assigning responsibility and accountability for routine cleaning of patient care equipment
- Ensuring environmental cleaning follows a set procedure and frequency, and is documented and supervised by adequately trained dedicated personnel
- Ensuring surfaces are constructed of materials that can be easily cleaned at the point of use
- Increasing frequency of cleaning and disinfecting frequently touched surfaces. Clean and disinfect surfaces likely to be touched and/or used on a more frequent schedule compared to other surfaces. This includes surfaces in close proximity to the patient (e.g., bedrails, over bed tables, call bells) and frequently touched surfaces in the patient care environment such as door knobs, surfaces in the patient's bathroom and shared common areas for dining, bathing, toileting.
- Monitoring for adherence to recommended environmental cleaning practices
- Ensuring rooms/spaces are terminally cleaned following patient discharge and after discontinuing precautions
- Using facility approved cleaners and disinfectants

When continued transmission of selected microorganisms (e.g., norovirus, rotavirus, *C. difficile*) occurs, use of specific disinfectant products may need to be considered. In outbreak situations or when there is continued transmission, rooms of *C. difficile* infected patients should be decontaminated and cleaned with chlorine containing cleaning agents (at least 1,000 ppm) or other sporicidal agents.

Cleaning & Disinfection of Non-Critical Patient Care Equipment

Contamination of patient care equipment, items in the patient environment, as well as the patient's environment itself have been implicated in transmission of infection.

Clean and disinfect used or potentially contaminated items that have been in direct contact with a patient or in that patient's environment before use in the care of another patient.

Identify used non-critical patient care equipment and other items such as toys and electronic games, and do not allow use by another patient until these items are appropriately cleaned and disinfected.

Clean and disinfect non-critical patient care equipment dedicated to an individual patient according to a regular schedule.

Dedicate bedpans and commodes for single patient use and label appropriately. Clean and disinfect before use by another patient. The use of disposable bedpans is acceptable. Bedpan holders for disposable bedpans must be reprocessed following use.

Store sterile and clean supplies in a designated and separate clean dry area protected from dust. Do not store under sinks and/or near plumbing as leaks may occur.

Discard personal care items (e.g., tissues, lotions, soaps, razors) and disposable equipment such as containers used for blood collection or tourniquets left in the room following transfer, terminal cleaning or discharge.

Assign responsibility for regular cleaning of computer keyboards and horizontal computer cart surfaces utilized in the healthcare environment.

Ensure computer keyboards in patient rooms are cleaned during discharge or terminal cleaning, as well as after each use.

Consider computer keyboards and computer device technology used in the healthcare environment as contaminated. Clean hands after using keyboards and computer devices, *especially* before touching a patient, a patient environment or supplies.

Handling of Linen

Linen in healthcare facilities may become contaminated with pathogens but risk of disease is negligible.

Care should be taken in the handling of soiled linen to prevent dispersal of microorganisms. Handle soiled linen with a minimum of agitation to avoid contamination of air, surfaces and persons.

Handle soiled linen in the same way for all patients without regard to their infection status. Place soiled linen in an appropriate receptacle at the point of use.

Clean linen should be transported and stored in a manner to prevent inadvertent handling or contamination by dust, which may contain fungal spores harmful to immunocompromised patients.

Maintain separation of clean and soiled linen during transport and storage.

If laundry chutes are used, they should be properly designed, maintained, and used in a manner to minimize dispersion of aerosols from contaminated laundry.

Change patient bed linen regularly and when soiled, and following patient discharge.

Roll or fold heavily soiled linen to contain the heaviest soil in the centre of the bundle. Do not remove large amounts of solid soil, feces or blood clots from linen by spraying with water; use a gloved hand and toilet tissue then place into a bedpan or toilet for flushing.

Perform hand hygiene after handling soiled linen.

Wash reusable linen bags after each use; they may be washed in the same cycle as the linen contained in them.

In ambulatory care areas change linen following every patient treatment/procedure.

Handling of Waste

Most waste generated in healthcare settings is no more hazardous than household waste.

Waste receptacles should be conveniently located and, preferably, hands-free.

Contain and dispose of biomedical waste according to site policies.

Handling of Dishes

There are no indications for the use of disposable dishes other than when dishwashing equipment is non-functioning. No special precautions; Routine Practices are sufficient.

Handling of Deceased Bodies

Use Routine Practices properly and consistently applied for the routine handling of deceased bodies. There are no special requirements when handling deceased bodies. Adhere to provincial specified communicable disease regulations, available at Manitoba Health, *Public Health Act*, Dead Bodies Regulation

<http://web2.gov.mb.ca/laws/regs/pdf/p210-027.09.pdf>

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10. VISITOR MANAGEMENT AND EDUCATION

Visitors have been documented to transmit infections including tuberculosis, pertussis, and respiratory viruses in healthcare settings.

Visitors have a responsibility to comply with Routine Practices. All HCWs are responsible to teach patients and visitors basic principles, such as hand hygiene, respiratory hygiene, and use of PPE.

Visiting policies must balance the risk of transmission of infectious diseases and the promotion of patient and family centered care. Exclusion of those with signs and symptoms of transmissible infections should reduce this risk. For essential visits, the visitor with an infection should be instructed on measures to take to reduce the risk of transmission (e.g., wear a mask for a respiratory tract infection, perform appropriate hand hygiene, remain in the patient's room, avoid public areas, avoid contact with other patients or with patient care equipment).

Visitors could be at risk for serious diseases should they acquire the patient's infection (e.g., acquisition of a respiratory virus by a visitor with chronic lung disease, or exposure of a non-immune visitor to varicella), and should be capable of complying with the necessary precautions to prevent indirect transmission to other patients (e.g., hand hygiene, not sharing personal items).

Provide education to patients, their families and visitors regarding respiratory hygiene and hand hygiene.

Visitors with symptoms of acute infection (e.g., cough, fever, vomiting, diarrhea, coryza, rash, conjunctivitis) should not visit unless the visit is essential (e.g., parent, guardian or primary caretaker), in which case they should be instructed and supervised in precautions to take to minimize transmission of infection.

REFERENCES

1. Best Practices For Hand Hygiene In All Health Care Settings. (December 2010). Ontario Provincial Infectious Diseases Advisory Committee. Retrieved July 2, 2013 from: [Best Practices For Hand Hygiene In All Health Care Settings](#).
2. Hand Hygiene Practices In Health Care (draft). (2010). Public Health Agency of Canada.
3. Routine Practices and Additional Precautions: Preventing the Transmission of Infection in Health Care. (April 2012). Manitoba Health. Retrieved July 2, 2013 from: <http://www.gov.mb.ca/health/publichealth/cdc/docs/ipc/rpap.pdf>

APPENDIX I

PRINCIPLES OF ROUTINE PRACTICES AND ADDITIONAL PRECAUTIONS

1. Consistent application of Routine Practices is expected for the care of all patients at all times across the continuum of care.
2. Adherence to Routine Practices can reduce the transmission of microorganisms in all healthcare settings.
3. Individual components of Routine Practices are determined by a Point of Care Risk Assessment (PCRA) (i.e., an assessment of the task/care to be performed, the patient's clinical presentation, physical state of the environment and the healthcare setting).
4. Microorganisms may be transmitted from symptomatic and asymptomatic individuals, emphasizing the importance of adhering to Routine Practices at all times for all patients in all healthcare settings.
5. The primary goal of Infection Prevention and Control programs is to reduce the risk of acquiring a healthcare-associated infection (HAI) to a minimum level; zero risk is not attainable in every circumstance but should nevertheless be the ultimate goal. The consequences of cross-transmission of microorganisms must be balanced against the consequences (adverse effects and cost) of precautions taken.

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APPENDIX II: OVERVIEW OF HEALTHCARE WORKER CONTROL MEASURES TO REDUCE EXPOSURE TO AND TRANSMISSION OF INFECTIOUS AGENTS

ROUTINE PRACTICES

Routine Practices are the foundation for preventing the transmission of microorganisms during patient care in all healthcare settings. It is a comprehensive set of infection prevention and control (IP&C) measures developed for use in the routine care of **ALL PATIENTS** at **ALL TIMES** in **ALL HEALTHCARE SETTINGS**. Routine Practices aim to minimize or prevent healthcare-associated infections (HAIs) in all individuals in the healthcare setting including patients, healthcare workers (HCWs), other staff, visitors, contractors, and so on. Adherence to the following can reduce the transmission of microorganisms in all healthcare settings.

1. Point of Care Risk Assessment (PCRA)

Prior to every patient interaction, all HCWs are responsible to assess the infectious risk posed to themselves and other patients, visitors, and HCWs by a patient, situation or procedure. Perform a Point of Care Risk Assessment before each patient interaction to determine the appropriate Routine Practices required for safe patient care.

2. Hand Hygiene (HH)

Hand hygiene with point of care alcohol-based hand rub is the standard of care expected in all healthcare settings. Hand hygiene measures provided in Routine Practices must be adhered to by all staff at all times.

3. Patient Placement and Accommodation

Accommodation of in-patients in single rooms facilitates IP&C activities. Single rooms with a private toilet, designated patient hand washing sink and designated staff hand washing sink may reduce opportunities for cross transmission between patients, particularly when the patient has poor hygiene, contaminates the environment or cannot comply with IP&C measures.

In waiting rooms, maintain a spatial separation of two metres/six feet between patients symptomatic with an acute respiratory infection (manifested by new cough, shortness of breath and fever) and those who do not have symptoms of a respiratory infection. If this cannot be achieved, the patients must be at least one metre/three feet apart and the symptomatic patient must wear a mask. One metre/three feet may be sufficient for young children and others whose cough is not forceful enough to propel the droplets as far as two metres/six feet.

4. Patient Flow

Patient flow refers to patient transfer/transport within and outside of the facility, and patient activity. There is potential for exposure to and transmission of microorganisms as a result of patient activity and transport due to inadvertent contact with other patients, patient care items and environmental surfaces.

Patients should not be transported between patients care units, departments or facilities unless medically essential. Frequent patient transfers should be avoided as this increases the number of interactions with staff and other patients, providing opportunities for transmission to occur.

The healthcare worker, including bed/accommodation coordinators, are responsible for selecting the most appropriate accommodation based on the PCRA and for prioritizing use of single rooms and Airborne Infection Isolation Rooms if these are scarce. When in doubt regarding accommodation, consult your IP&C professional.

5. Aseptic Technique for Injections, Intravascular and other Invasive Procedures

Aseptic technique, sometimes referred to as sterile technique, refers to practices designed to render the patient's skin, medical supplies and surfaces as maximally free from microorganisms. These practices are required when performing procedures that expose the patient's normally sterile sites (e.g., intravascular system, spinal canal, subdural space, urinary tract) to minimize contamination with microorganisms.

6. Personal Protective Equipment (PPE)

Personal protective equipment are additional barriers (e.g., gloves, gowns, masks/respirators, facial protection) worn to protect from transmission of microorganisms and from exposure to bloodborne and other microorganisms (e.g., sprays of blood, body fluids, respiratory tract or other secretions or excretions).

Performing a risk assessment to determine whether PPE is necessary is also important to avoid over reliance on PPE, misuse or waste. Over-reliance on PPE may result in a false sense of security. Misapplication or incorrect removal of PPE can result in inadvertent exposure of the HCW or the patient to infectious agents or contamination of the environment.

7. Cleaning and Disinfection of Non-Critical Patient Care Equipment

Cleaning of shared patient care equipment prior to use on another patient can reduce transmission of microorganisms. Equipment that is frequently taken from one patient to the next should be cleaned before use on the next patient (e.g., stethoscope, oximeter, blood pressure cuffs, and glucometers).

Computers, Charts and Charting Stations: Consider computer keyboards used for patient care contaminated and clean hands after touching these items especially before touching a patient, a patient environment or supplies. Computer keyboards should be cleaned routinely with facility approved disinfectant.

8. Terminal Cleaning

Terminal cleaning refers to the process for cleaning and disinfection of patient accommodation which is undertaken upon discharge of any patient or on discontinuation of Additional Precautions. The patient room, cubicle, or bedspace, bed, bedside equipment and environmental surfaces and sinks and bathroom are thoroughly cleaned before another patient is allowed to occupy the space. The bed linens are removed before cleaning begins.

Discard all disposable items in the patient's room. Appropriately reprocess all reusable items in the room as required.

Clean bedside tables, bedrails, commodes, mattress covers and all horizontal surfaces in the room with a detergent/disinfectant.

Clean visibly soiled carpets (with patient's excretions, blood or body fluids) promptly.

Routine washing of walls, blinds, and window curtains is not indicated. These are cleaned if visibly soiled.

Privacy and shower curtains are changed.

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