TITLE:	Isolation Precautions – Standard/Transmission/MDRO Based Precautions – Infection Prevention	NUMBER: 8727-006
ORIGINATING DEPT:	Infection Prevention	PAGE: 1 of 14

SCOPE:

All Columbia Memorial Hospital (CMH) programs and services.

GENERAL POLICY STATEMENT:

All patients are screened for risk factors related to transmission of communicable illness and appropriate precautions are put in to place to prevent the transmission of communicable illness from patient to patient or patient to staff.

PURPOSE:

To reduce cross-contamination of organisms among patients, from patient to healthcare provider, and healthcare provider to patient.

SKILL LEVEL:

All personnel.

SUPPORTIVE DATA:

The spread of infection requires three elements: (1) a source of infecting micro-organisms, (2) a susceptible host, and (3) a means of transmission for the organism.

There are five main routes of transmission: (1) Contact - involves direct body surface to body surface contact; (2) Droplet - droplet generation (larger than 5 micron in size) during coughing, sneezing, talking, and suctioning; (3) Airborne - dissemination of airborne nuclei (smaller than 5 micron in size) of evaporation; (4) Common vehicle; and (5) Vector borne.

Isolation Precautions are comprised of Standard Precautions to be practiced for all patients and Transmission Based Precautions for specific patient groups. Personal Protective Equipment (PPE) may include, but is not limited to, gloves, gowns, goggles and masks.

DEFINITIONS:

MRSA	Staph aureus resistant to oxacillin (methicillin and nafcillin).
VRE	Vancomycin-resistant enterococcus – an enterococcus resistant to vancomycin.
CRE	Carbapenem Resistant Enterobacteriaceae
C. difficile	Clostridium Difficile. While C. difficile is not resistant to multiple pharmaceuticals it is grouped as an MDRO related to its transmission principals and increased risk of illness.
VRSA	vancomycin-resistant staph aureus
ASC	Active Surveillance Culture (or Active Surveillance Screening)
PPE	Personal Protective Equipment
ESBL	Extended Spectrium Beta Lactamase Resistant (E. coli, Klebsiella, Pseudomonas)

MDRO	Multidrug resistant organism
Colonization or "carrier"	This state is defined as the isolation of the organism from a site without signs or symptoms of infection. MRSA carriage occurs in the nares, skin, mucous membrane, and other body sites. VRE carriage occurs in the bowel and urinary tract.
Infection	Is present when the organism is isolated from a body site with accompanying signs and symptoms of infection.

PROCEDURE:

Organizational Policy:

I. Standard Precautions

A. Personal Protection Equipment (PPE) will be worn if contact or possibility of contact with mucous membranes, non-intact skin, body fluids (except sweat), blood or contaminated equipment may exist.

B. Hands will be washed with soap and water when hands are visibly contaminated or dirty, after use of restroom, after / before eating, after coughing, etc. Refer to Hand Hygiene Procedures - Infection Prevention (#8727-001).

C. Hands will be decontaminated with an alcohol based cleanser in the following situations: (Refer to Hand Hygiene Procedures - Infection Prevention (#8727-001).

1. Before patient contact
2. Before wearing sterile gloves for placement of invasive device
3. After contact with patient's intact skin
4. After contact with blood or body fluids, excretions, mucous membranes, or intact skin, and hands are not visibly soiled (soap and water indicated here)
5. When moving from contaminated site to clean body site during patient care
6. After contact with inanimate objects in the immediate vicinity of the patient after removing gloves

D. A private room is important to prevent direct /indirect contact transmissions when the source patient has poor hygienic habits, contaminates the environment or cannot be expected to assist in maintaining infection control precautions. When a private room/private toilet facility is not available, it is important to consider the mode of transmission of the infecting pathogen and provide adequate supplies to prevent transmission.

E. Patient care equipment/articles will be handled appropriately:

1. Critical equipment (enter sterile tissues) will be sterilized or disinfected after use according to manufacturer's guidelines.
2. Semi critical (touches mucous membranes), sterilized or disinfected after use according to manufacturer's guidelines.

3. Non-critical equipment (touches intact skin) if soiled with body fluids, will be cleaned and disinfected between patient contact with a hospital approved disinfectant.
4. Single Use patient items are used on only one patient and disposed of as appropriate based on our Lab Chemical and Biohazard Plan (#7070-2874).

F. All linen will be processed/handled to avoid the transfer of micro-organisms using standard precaution techniques and through use of appropriate personal protective equipment.

G. No special precautions are needed for dishes, glasses, cups, and utensils.

H. Routine and upon discharge cleaning will be based on the department cleaning schedule and national guidelines. Personnel will follow appropriate Transmission Based Precautions as necessary for daily and discharge cleaning.

I. Infectious or regulated waste is to be placed in the appropriate red bag lined stericycle container for pickup by Environmental Services.

II. Initiation of Transmission Based Precautions (See Table I for further information)

Transmission Based Precautions are for patients documented or suspected to be infected with highly transmissible or epidemiologically important pathogens in which additional precautions beyond standard precautions are required.

Inpatients placed in Transmission Based Precautions will be identified by placing the appropriate isolation sign on the patient door, dependent on the type of isolation. When transport is necessary the receiving department will be notified of Isolation Precautions.

All visitors of patients in Transmission Based Precautions will be evaluated by the staff nurse prior to entering the patient's room to determine immunity to the identified organism, as applicable, or educated to use of required Personal Protective Equipment.

Transmission based education sheets will be provided to patients and visitors as appropriate. All visitors and family members will be expected to comply with isolation precautions. In the case that families or guests refuse compliance the House Supervisor or Infection Preventionist should be immediately notified. The House Supervisor or Infection Preventionist will meet with the family or guests and explain rationale for isolation implementation and provide education and reinforce expectation to follow CMH policies and procedures.

Nursing staff are responsible for documentation of initiation of Transmission Based Precautions on the patient’s Electronic Medical Record (EMR) and placement of signage and isolation card at patient’s door.

Removal of isolation precautions may only occur if the patient meets the requirements for removal based on CDC expectations OR CMH Organizational policy. See Chart 3 of this policy. A complete

listing of all organisms and isolation precautions can be found on the hospital intranet, CMHtv, Department under Infection Prevention. This listing provides guidance related to isolation discontinuation.

In an emergency situation, patient and staff safety is the priority. Staff will don appropriate Personal Protective Equipment while maintaining patient safety.

Transmission based precautions may be combined based on mode of transmission of the identified organisms or presenting symptoms. (i.e., RSV in a pediatric patient – Droplet/Contact precautions should be initiated; C. difficile positive patient- Contact/ Enteric precautions should be initiated.)

A. Empiric Conditions
It may not be possible to prospectively identify all patients based on organisms needing Transmission Based Precautions, certain syndromes/conditions carry high risk, warranting the addition of enhanced precautions before a definitive diagnosis is developed.

Chart 1

TYPE OF ISOLATION	CONTACT (C)	DROPLET (D)	AIRBORNE (A)
Empiric conditions	Acute diarrhea; Diarrhea in an adult of three or more episodes a day for more than two days - in patient with antibiotic or oral corticosteroid use in past four weeks. Respiratory infections in infants and children; history of infection or colonization with multidrug resistant organisms; abscess or draining wound that cannot be covered; Skin, wound or urinary tract infection in patient with recent stay in facilities where multidrug resistance is prevalent; *Cellulitis that is actively draining; Adult or Pediatric patient with any perineal/rectal soft tissue infection;* hospitalization at a hospital outside the Pacific Northwest or internationally within the last six months.	Meningitis Petechiae/ecchymosis rash with fever (N. Meningitis); persistent cough during pertussis activity as notified by Infection Preventionist; ILI (Influenza like illness symptoms); RSV or any pediatric child with active cough.	Vesicular rash (varicella); Macupapullar rash with fever (measles); Cough/fever/upper lobe infiltrate in HIV negative or low risk HIV infection (Tb); Cough/fever/pulmonary infiltrate in HIV infected or high risk HIV infected patient (Tb)
Room	Door may remain open. Private bathroom or co-host similar organisms.	Door may remain open. Private bathroom or co-host similar organisms.	Negative pressure; external ventilation; private bathroom; door must remain closed. ED triage; MS 122; CCU 125-2; endoscopy suites.
Mask	Not unless anticipated splash.	Yes, if within three (3) feet of patient.	PAPR on inpatient unit N95 for ED/Urgent Care and visitors
Gloves	Yes	Only if soiling anticipated.	Only if soiling anticipated.
Gown	Yes	Only if soiling	Only if soiling

		anticipated.	anticipated.
Patient Transport	Limited. Be cautious of cross contamination.	Limited. If necessary, mask patient.	Limited. If necessary, mask patient.
Outpatient Procedure (Urgent/ED/Primary Care)	Prompt placement into single patient room; Staff should don gown/gloves for assessment when risk of contamination with blood/body fluids or uncontained wounds.	Prompt placement into single patient room; Staff should don mask upon entering room.	Mask patient with surgical/single loop mask. Prompt placement into single patient room/negative air pressure. Staff should don N95 or PAPR respiratory as appropriate.

Chart 2

Organism Related Empiric Precautions and Active Surveillance Culturing Requiring Contact Isolation h/o= history of						
	MRSA	C. difficile	ESBL	VRE	CRE	COVID19
Signs/Symptoms	• h/o MRSA infection or colonization. • Opening draining wound. • Cellulitis that has an open draining wound. • h/o drug abuse within the past six months. • *Adult/Pediatric patient with any perineal/rectal soft tissue infection.*	• h/o C. difficile infection within the past six months with current symptoms of diarrhea three or more times a day for more than two days; • Diarrhea in patient with antibiotic or oral corticosteroid use in past four weeks.	• h/o previous ESBL infection.		Hospitalized within less than six months from a hospital located outside the Pacific Northwest or Internationally.	Fever or chills Cough Shortness of breath or difficulty breathing Fatigue Muscle or body aches Headache New loss of taste or smell Sore throat Congestion or runny nose Nausea or vomiting Diarrhea
Active Surveillance Culture to be performed	Yes • Nasal • Perineum/Anal • Any open lesions/wound *nasal only for scheduled	Yes, if diarrhea present • Stool C. Difficile culture.	Yes, repeat culture for previous site of infection.		Yes; perirectal culture	For all symptomatic patients admitted; all presurgical cases

	presurgical ASC					
Isolation	Contact	Contact - Enteric	Contact	Contact	Contact	Airborne Plus

B. Airborne Precautions
1. Patient with known/ presumed airborne organisms or that may become airborne with aerosol generating procedure should be placed in a private room that has:
   a. Monitored negative air pressure.
   b. Minimum of six (6) air exchanges per hour.
   c. External ventilation. The room door should remain closed at all times.
   NOTE: These rooms include 122, 125-2, ED triage and endoscopic suites.
2. Patient should be immediately masked with yellow looped eared or surgical mask until patient can be placed in negative pressure isolation room.
3. Respiratory protection (PAPR or N95 if approved) and eyewear (full faceshield or gasket goggles) is required when entering the room of a patient with known or suspected infection with an airborne organism. Outpatient clinical areas, i.e. Emergency Room, will utilize the N95 mask. Inpatient staff will utilize the PAPR respirator.
4. Family/visitors are required to wear an N95 disposable mask when entering the patient's room. Nursing staff is responsible for educating family/visitors to proper use of respirators.
5. Patient transport should be limited. If transportation is necessary, a surgical mask will be placed on the patient.

C. Droplet
1. Patient should be placed in a private room with a private bathroom or bedside commode available. Special ventilation is not required. Door to room may remain open if patient activity is kept three feet from doorway.
2. Surgical or yellow loop eared masks will be worn when working within three feet of the patient.
3. Eyewear is encouraged if patient is actively coughing, sneezing, etc.
4. Patient transport should be limited. If transportation is necessary, a surgical mask or yellow loop mask will be placed on the patient.
5. Masks are to be utilized when performing any splash generating procedures (examples: wound irrigation, oral suctioning/intubation).

D. Contact
Inpatient Policy:
1. Patient will be placed in a private room with a private bathroom or bedside commode. If a bedside commode is used implement bedside commode bag and pads.
2. A yellow taped "hot box" will be placed at the patient's doorway, marked as three feet wide set approximately two feet in from the door. This identified "hot box" area marks an area in which staff may enter into the room without donning personal protective equipment.
3. Gown and gloves will be worn when entering the patient's room past the "hot box" area. Gown and gloves will be removed before leaving the patient's environment. After glove removal and hand washing, staff need to ensure that hands do not touch potentially contaminated

environmental surfaces or items in the patient's room to avoid transfer of micro-organisms. Staff will hand sanitize immediately after leaving patient's room.

4. Patient transport/movement will be limited to essential purposes only. Maintain precautions to minimize the risk of transmission to other patients and contamination of environmental surface. If transport is necessary, the following practices will be followed:
    a. Notify receiving department of contact based precautions.
    b. Stretcher or wheelchair should be made up with clean linen and/or pillow. Soiled bed linens should be placed in linen bag in patient's room.
    c. Don gown and gloves. After assisting the patient into wheelchair or stretcher, remove gown and gloves and hand sanitize.
    d. Assist patient to perform hand sanitizing prior to leaving the room.
    e. The patient should wear a clean gown; use impervious dressings to cover the affected area when infectious skin lesions or drainage is present.
    f. Don clean gloves prior to transferring patient to destination.
    g. Remove covering from stretcher, wheelchair or any equipment patient has come in contact with hospital approved disinfectant.
    h. Remove gown, gloves and sanitize hands.
5. Non-critical patient care items should remain in the patient's room or cleaned and disinfected before use by another patient with hospital approved disinfectant.
6. Patients placed in contact precautions who are identified as having a respiratory infection with a multidrug resistant organism (i.e., MRSA, etc.) should also be placed in Droplet Precautions.
7. Patient ambulation should be limited and occur for patients requiring therapeutic ambulation only. The following criteria will be met before a patient can ambulate outside the room with staff:
    a. Skin lesions will be covered, with drainage contained by an impervious dressing.
    b. Staff will follow contact precautions until leaving the room with the patient.
    c. Upon leaving, if potential contact with the patient could occur, staff should don a clean gown and gloves after leaving the room.
    d. The patient will wear a clean gown and hospital issued robe when leaving the room for ambulation. If the patient has respiratory symptoms they will wear a surgical mask during ambulation.
    e. The patient will only ambulate outside the room if accompanied by staff, family or friends.
    f. The patient will not be allowed to enter other patient's rooms or public areas (i.e. cafeteria, wait in lobbies).

E. Enteric Precautions
    1. Staff will perform soap and water wash only upon exiting the patient's room.
    2. All semi-critical patient equipment must be wiped with bleach wipes after patient use for patients placed in enteric precautions.
    3. Daily and discharge patient room cleaning will be completed utilizing appropriate hospital approved disinfectants.

F. Standard Plus
    1. Staff will donn face mask and eyewear (either full faceshield or gasket goggles) upon entry to

patients room.
2. Eyewear will be disinfected using hospital approved disinfectant each time eyewear is removed.

G. Airborne Plus
1. Staff will donn gown, gloves, eyewear (either full faceshield or gasket goggles) and N95 or PAPR upon entering patients room who are placed in Airborne Plus.
2. Patients should be placed in an airborne isolation room.
3. Eyewear will be disinfected using hospital approved disinfectant each time eyewear is removed.

H. MDRO Related Practices in the Surgical Environment
1. Please refer to CMH Policy Management of MDRO/MRSA Patients in OR/PACU (#7020.088).

I. MDRO Related Practices in the Home Care Environment
1. Please refer to CMH Policy Infection Prevention Measures - Hospice (#7490.5000).

III. Discontinuation of Transmission Based Precautions

1. Discontinuation of Transmission Based Precautions must be based on the organism and its response to treatment.
2. Refer to organism specific isolation guidelines for specific instructions found on CMHtv – Departments tab – Infection Prevention
3. Discontinuation of MDRO specific organisms will be based on the following algorithm.

Chart 3

Requirements to Be Met Prior to Discontinuation of MDRO Related Isolation	
Risk Criteria	Criteria to meet BEFORE Removal of Isolation
MRSA Known infection or history of colonization	Negative Acute Surveillance Culture (ASC) nasal and perirectal swab and lack of any signs or symptoms of infection including: • Temperature below 99° F or 37.2° C for a minimum of three days. • White Blood Cell (WBC) within normal range. • Absence of signs of infection including cough, sputum production, pain with urination, frequent urination or flank pain. **notify Infection Prevention of negative ASC cultures*
Presence of an open, draining wound and/or diagnosis of skin or soft tissue infection at admission	Documentation of a negative ASC nasal swab, negative wound culture for MRSA or any other MDRO AND evidence of healing of any previous wound or skin infection (no

	drainage is present) **see personal hygiene and environmental discontinuation requirements below*
C. difficile	Completion of Metronidazole or oral vancomycin for seven days and resolution of symptoms (no diarrhea and no abdominal pain). Patients with colostomy or ileostomy should remain in isolation until discharge. **see personal hygiene and environmental discontinuation requirements below*
ESBL	Completion of appropriate antibiotic therapy for 72 hours and two negative cultures from site specified for organism/infection • If the original positive site was Cerebrospinal Fluid (CSF), Blood or healed wound substitute a rectal or oral swab for the previous positive site. Enterococcus organisms should always include rectal swab. **see personal hygiene and environmental discontinuation requirements below*
VRE	Completion of appropriate antibiotic therapy for 72 hours. Two negative cultures greater than 48 hours apart. Culture site should be the original site plus a rectal swab. If the original site was CSF, Blood or healed surgical site a rectal swab only can be completed. **See personal hygiene and environmental discontinuation requirements below.*
CRE	Maintain isolation until patient is discharged **See personal hygiene and environmental discontinuation requirements below*
COVID 19	Asymptomatic patient – 2 negative cultures greater than 24 hours apart Symptomatic- Mild to Moderate Illness- at least 10 days since symptom onset and improving symptoms with 24 hours since last fever; Severe to Critical Illness- at least 20 days since symptom onset and improving symptoms with 24 hours since last fever

NOTE: Personal Hygiene/Environmental Discontinuation Requirements: All patients currently in Contact Isolations that meet isolation discontinuation criteria must complete a Chlorhexidine (CHG) shower/or wipes as appropriate and terminal room clean as part of the discontinuation protocol.

IV. Decolonization Protocol

a. Decolonization protocols will only be utilized based on CMH approved protocols listed below OR after consultation with Infection Prevention Epidemiologists with approval by the CMH Infection Preventionist and CMH Infection Prevention (IP) provider.
b. Presurgical Screening and decolonization will be conducted on all total hip, total knee and total shoulder surgical cases, per CMH Policy Prevention of Surgical Site Infections. All positive cultures will be treated with five days prior to operative date with Mupiricin intranasally. Patients who are unable to start treatment at five days pre-operatively will begin treatment as soon as possible, up to first day post operatively.
c. Prenatal screening and decolonization will be initiated for patients identified with previous MRSA colonization .
    i. Any patient with previous MRSA colonization or infection with have screening conducted through completion of a nasal and perineal/rectum swab (Active Surveillance Cultures) after 36 weeks.
    ii. If MRSA is identified on the Active Surveillance Culture (ASC) then the patient will be offered the opportunity to complete a decolonization protocol, see attachment A.
    iii. Patients who test MRSA ASC positive and defer the decolonization protocol will be notified by the provider that they and their baby will be placed on contact isolation procedures during any admission to CMH including prenatal, labor and delivery and postpartum.
    iv. Decolonization will be initiated upon positive MRSA identification.
d. All Critical Care patients with indwelling central lines and/or ventilator in place will be screened for MRSA colonization through completion of a nasal and perineal/rectal swab.
    i. If MRSA is identified on the ASC then the patient will begin a decolonization protocol to include CHG and nasal decolonization, see policy.
e. Pediatric decolonization will be offered for any pediatric patient who has had a precious MRSA infection, significant medical history that puts the patient at increased risk of MRSA infection reoccurs (i.e. spina bifida, cerebral palsy), or a household member of their family who has a history of MRSA.
    i. Hibiclens cleansing to under arms, groin and diaper areas three times a week for four weeks.
    ii. Bleach baths (1 tspn to each gallon of water) for any pediatric patient without open skin breakdown, twice a week for four weeks.
    iii. Mupiricin nasal treatment two times a day for five days.

V. Patient Education

a. All patients identified as having an MRSA, ESBL or C. difficile infection will be provided patient education “living with” booklets by their name or clinic representatives.
b. All patients placed in transmission based precautions will be provided with the appropriate transmission based education handout by the nurse initiating isolation precautions.

VI. MDRO Notification Protocols

a. The presence of an identified MDRO is noted on the CMH microbiology report. All MDRO initial positive cultures will be phoned to the appropriate inpatient nursing unit by laboratory personnel.
b. MDRO presence is charted on the CMH Transfer form, Skilled Nursing Facility Transfer Form, and

Medix transport notification form. All receiving facilities will receive verbal notification of an MDRO during the hand off process.

c. When internal transport of an MDRO positive patient is necessary the receiving department will be notified of the MDRO status during handoff.
d. CMH Infection Prevention implements MDRO status within the patient/chart problem list based on monthly MDRO positive culture results as provided by CMH Laboratory services. MDRO alert removal can only be completed by the IP or designee after patient has met clinical requirements for alert removal for MDRO status, Attachment B.

VII. Initiation of MDRO Prevalence and Intensive Analysis

Monthly monitoring for MDRO incidence is performed by the CMH Infection Preventionist. Benchmarks and thresholds for MDRO incidence are established annually within the CMH Infection Prevention Annual Program Plan. When thresholds are met, the CMH Infection Preventionist is responsible for developing a corrective action plan that is approved by the CMH Infection Prevention Provider, Director of Quality and Vice President of Clinical Services.

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ATTACHMENTS:

Patient MRSA Decolonization algorithm

Removal of MDRO Identification / Alert System

KEY WORDS:

IP, Isolation, precautions, MDRO, decolonization, MRSA, VRSA, VISA, ESBL, VRE, CRE, ESBL, Transmission based

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