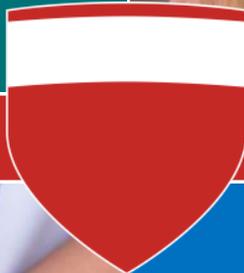


Long Term Care Facility Resource Guide



BUNCOMBE COUNTY
HEALTH & HUMAN SERVICES

AN OVERVIEW OF:

- Infection Prevention
- Communicable Diseases & Reporting
- Infestation Prevention
- Resources for administrators, caregivers and family members to keep residents safe

A MESSAGE FROM THE MEDICAL DIRECTOR

Buncombe County is home to a large number of long-term care facilities. The individuals that reside in these facilities are some of our most vulnerable citizens, and their health and safety is a priority for Buncombe County Health and Human Services.

Long-term care facilities are different from other healthcare settings in that persons who are often at increased risk of infections because of their age or health status are brought together in one setting and remain in the facility for extended periods of time. An atmosphere of community is fostered with residents sharing common eating and living areas, and participating in various facility-sponsored activities. Controlling transmission of infection in this setting can be a challenge.

To support the important work of protecting and promoting the health of residents of long-term care facilities, Buncombe County Health and Human Services created this guide. Our hope is that facility administrators and staff, as well as the families of facility residents, utilize this resource to better understand the essentials of infection prevention and disease outbreak management. Together, we can ensure the health and well-being of the residents of long-term care facilities, as well as those who care for them.



Dr. Jennifer Mullendore
Buncombe County Medical Director

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Medical Director
Buncombe County Health and Human Services



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COMMUNICABLE DISEASE REPORTING: IT'S THE LAW!

G.S. 131D-4.4B: "Guidelines for reporting suspected communicable disease outbreaks . G.S. 131D-4.4B requires the NC Department of Health and Human Services to develop guidelines prescribing the manner in which an adult care home is to report a suspected communicable disease outbreak within the facility to the local health department.

In accordance with this statute, the following guidelines have been developed for reporting of suspected communicable disease outbreaks within adult care homes:

The Adult Care Home Administrator or his/her designee must report all suspected communicable disease outbreaks to the local health department in which the facility is located. A suspected communicable disease outbreak is defined as any increase above expected in either:

- Illnesses among residents or staff with the same identified infectious cause (e.g. evidence of the same virus or bacteria found on laboratory testing), or
- Illnesses among residents or staff with the same or similar symptoms (e.g. vomiting and diarrhea or fever and cough) but no identified infectious cause.

Such reports must be made by phone within 24 hours of the time when the outbreak is reasonably suspected to exist.

You can visit www.epi.publichealth.nc.gov/cd to find reporting guidelines, forms, sample policies, case definitions and the NC Division of Public Health Communicable Disease Manual.

Physicians must report these diseases and conditions to the county local health department, according to the **North Carolina Administrative Code: 10A NCAC 41A.0101 Reportable Diseases and Conditions** (see below). Contact information for local health departments can be accessed at www.ncalhd.org/directors. If you are unable to contact your local health department, call the 24/7 pager for N.C. Communicable Disease Branch (919) 733-3419

10A NCAC 41A .0103 : DUTIES OF LOCAL HEALTH DIRECTOR: REPORT COMMUNICABLE DISEASES

(c) Whenever an outbreak of a disease or condition occurs which is not required to be reported by 10A NCAC 41A .0101 but which represents a significant threat to the public health, the local health director shall give appropriate control measures consistent with 10A NCAC 41A .0200, and inform the Division of Public Health of the circumstances of the outbreak within seven days.



DISEASES AND CONDITIONS REPORTABLE IN NC WITHIN 24 HOURS

The initial report shall be made by telephone to the local health department, and the written disease report be made within 7 days.

Diseases in *BOLD ITALICS* should be reported immediately to local health department.

A-G

ANTHRAX

BOTULISM, FOODBORNE

BOTULISM, INTESTINAL (INFANT) BOTULISM, WOUND

Campylobacter infection

Chancroid

Chikungunya

Cholera

Cryptosporidiosis

Cyclosporiasis

Diphtheria

E.coli infection, shiga toxin-producing

Foodborne disease: Clostridium perfringens.

Foodborne: staphylococcal

Foodborne disease: other/unknown

Foodborne poisoning: ciguatera

Foodborne poisoning: mushroom

Foodborne poisoning: scombroid fish

Gonorrhea

Granuloma inguinale

H-N

Haemophilus influenzae, Invasive disease

Hemolytic-uremic syndrome (HUS)

HEMORRHAGIC FEVER VIRUS INFECTION

Hepatitis A

Hepatitis B, acute

HIV/AIDS

HIV

AIDS

Influenza virus infection causing death

Listeriosis

Measles (rubeola)

Meningococcal disease, invasive

Middle East respiratory syndrome (MERS)

Monkeypox

NOVEL INFLUENZA VIRUS INFECTION

O-U

Ophthalmia neonatorum

Pertussis (Whooping Cough)

PLAGUE

Poliomyelitis, paralytic

Rabies, human

Rubella

Salmonellosis

S. aureus with reduced susceptibility to vancomycin

SARS coronavirus infection

Shigellosis

SMALLPOX

Syphilis primary

secondary

early latent

late latent

late with clinical manifestations

congenital

Tuberculosis

TULAREMIA

Typhoid Fever, acute

V-Z

Vaccinia

Vibrio infection, other than cholera & vulnificus

Vibrio vulnificus

Zika



IMMUNIZATIONS FOR STAFF & RESIDENTS

As you can see, there is no shortage of communicable diseases. This underscores that the need for immunizations doesn't end when we become adults. Vaccinations help protect you, your facility, and your community from vaccine preventable disease outbreaks.

BUILD A SHIELD OF PROTECTION FOR YOUR RESIDENTS

- Require an immunization record (including month and year for each type of immunization) for each resident and staff member in the facility's health history documentation. This information is important when an vaccine-preventable illness occurs.
- Will unvaccinated residents and staff be allowed? Understand the risk if you do accept a resident or staff member who has not been immunized for a specific disease. If an unimmunized person comes in contact with a person infected with measles, for instance, public health may issue a mandatory 21 day quarantine.
- Know the facts about the diseases and educate your staff. Make sure your staff understand the risks and warning signs for vaccine-preventable illnesses and steps you can take to stop an outbreak.
- Consider tracking the percent of immunized residents and staff in your facility. This may be important information for individuals who are unable to be immunized; it helps them understand their potential risk exposure.

Call or visit our Immunization Clinic— we are here to help! We can pull immunization records for you or assist your staff in obtaining their most recent immunization records.

Buncombe County Immunization Clinic: (828) 250-5096

Hours of Operation: Monday-Friday 8 a.m.– 5 p.m. (Check-in by 4:30 p.m.)

No appointment is necessary!



HELPFUL RESOURCES

- Buncombe County: www.buncombecounty.org/immunize
- NC DHHS: www.immunize.nc.gov
- Centers for Disease Control & Prevention: www.cdc.gov/vaccines

Healthcare workers include physicians, nurses, emergency medical personnel, dental professionals and students, medical and nursing students, laboratory technicians, pharmacists, hospital volunteers, and administrative staff.



VACCINE RECOMMENDATIONS FOR HEALTHCARE WORKERS

Hepatitis B	<p>If you don't have documented evidence of a complete hep B vaccine series, or if you don't have an up-to-date blood test that shows you are immune to hepatitis B (i.e., no serologic evidence of immunity or prior vaccination) then you should:</p>
	<p>Get the 3-dose series (dose #1 now, #2 in 1 month, #3 approximately 5 months after #2).</p>
	<p>Get anti-HBs serologic tested 1–2 months after dose #3.</p>
Flu (Influenza)	<p>Get 1 dose of influenza vaccine annually.</p>
MMR (Measles, Mumps, & Rubella)	<p>If you were born in 1957 or later and have not had the MMR vaccine, or if you don't have an up-to-date blood test that shows you are immune to measles or mumps (i.e., no serologic evidence of immunity or prior vaccination), get 2 doses of MMR (1 dose now and the 2nd dose at least 28 days later).</p> <p>If you were born in 1957 or later and have not had the MMR vaccine, or if you don't have an up-to-date blood test that shows you are immune to rubella, only 1 dose of MMR is recommended. However, you may end up receiving 2 doses, because the rubella component is in the combination vaccine with measles and mumps.</p> <p>For HCWs born before 1957, see the MMR ACIP vaccine recommendations.</p>
Varicella (Chickenpox)	<p>If you have not had chickenpox (varicella), if you haven't had varicella vaccine, or if you don't have an up-to-date blood test that shows you are immune to varicella (i.e., no serologic evidence of immunity or prior vaccination) get 2 doses of varicella vaccine, 4 weeks apart.</p>
Tdap (Tetanus, Diphtheria, Pertussis)	<p>Get a one-time dose of Tdap as soon as possible if you have not received Tdap previously (regardless of when previous dose of Td was received).</p> <p>Get Td boosters every 10 years thereafter.</p> <p>Pregnant HCWs need to get a dose of Tdap during each pregnancy.</p>
Meningococcal	<p>Those who are routinely exposed to isolates of <i>N. meningitidis</i> should get one dose.</p>



INFLUENZA (FLU)

The flu is a vaccine-preventable respiratory illness caused by influenza viruses. It is easily spread and attacks the nose, throat, and lungs. It is more common during colder months, especially October through March. The flu virus spreads mainly by droplets made when people with the flu cough, sneeze, or talk. These droplets are inhaled by others. A person also may get the flu by touching a surface or object that has the flu virus on it and then touching their own mouth, eyes or nose.

HOW LONG IS A PERSON CONTAGIOUS?

Most people with the flu can infect others beginning 1 day before symptoms appear and up to 5 to 7 days after becoming sick.

HOW IS THE FLU DIAGNOSED?

It can be hard to know if you have the flu or another type of respiratory illness based only on symptoms. There are lab tests that can be done by your medical provider.

HOW SERIOUS IS THE FLU?

Flu is unpredictable, so it varies every year. Older people, especially those with certain chronic conditions (like asthma, diabetes, heart disease, or weakened immune systems) are at an increased risk of serious illness from the flu. Call your medical provider or go to the emergency department if you are having severe symptoms such as:

- Pain or pressure in the chest or abdomen
- Difficulty breathing / shortness of breath
- Confusion
- Sudden dizziness

HOW IS THE FLU TREATED?

Prevention is key, as there is no cure for influenza. The goal for treating the flu is to decrease how bad symptoms become and how long they last. Treatments can include medication to help with aches, fever, congestion and runny nose. Medical providers recommend plenty of rest and liquids. Antiviral treatment works best when started within the first 2 days of symptoms. However, these medications can still help when given after 48 hours to those that are very sick, such as those who are hospitalized, or those who have progressive illness.

RECOMMENDED TYPES OF TREATMENT

ANTI-VIRAL TREATMENT:

All long-term care facility residents who have confirmed or suspected influenza should receive anti-viral treatment immediately. Do not wait for lab confirmation to begin treatment.

Recommended dosing and duration is twice daily for 5 days.

Symptoms usually start 1 to 4 days after exposure to the flu virus.

Symptoms include:

- Fever (or feeling feverish/chills)
- Muscle or body aches
- Cough
- Sore throat
- Runny or stuffy nose
- Headaches

CHEMOPROPHYLAXIS TREATMENT:

All eligible residents in the entire long-term care facility (not just the currently impacted wards) should receive antiviral chemoprophylaxis. Priority should be given to residents living in the same unit or floor of the ill person. CDC recommends antiviral chemoprophylaxis for a minimum of 2 weeks, and continuing for at least 7 days after the last known case was identified. Chemoprophylaxis can be considered or offered to unvaccinated personnel who provide care to persons at high risk of complications.

GUIDELINES FOR MANAGING A FLU OUTBREAK

- Vaccination is key for residents and staff!
- One laboratory-confirmed (by PCR, rapid test or culture) influenza positive case along with other cases of respiratory infection in a unit of a long-term care facility means an influenza outbreak might be occurring. So 2 cases and there may be an outbreak!
- Test for influenza. Staff can use a line list to help organize and document the outbreak. The Outbreak Workbook Tool– Respiratory can be downloaded at <http://epi.publichealth.nc.gov/cd/lhds/manuals/cd/outbreak.html>.
- Implement Standard Precautions for flu: Wearing gloves and a gown, changing gloves and gowns between patients, performing hand hygiene between patients, etc.
- Implement Droplet Precautions such as placing ill residents in private rooms or cohorting ill residents, wearing a facemask, and communicating information with personnel about illness.

ADDITIONAL MEASURES TO REDUCE FLU TRANSMISSION AMONG RESIDENTS

- Have symptomatic residents stay in their own rooms as much as possible, including restricting them from common activities, and have their meals served in their rooms when possible.
- Limit the number of large group activities in the facility and consider serving meals in resident rooms if possible during an outbreak.
- Avoid new admissions or transfers to wards with symptomatic residents and limit visitation.
- Exclude ill persons from visiting the facility via posted notices. Consider restricting visitation by children during community outbreaks of influenza.
- Monitor staff absenteeism due to respiratory symptoms and exclude those with flu-like symptoms from work until at least 24 hours after they no longer have a fever.
- Restrict personnel movement from areas of the facility having illness to areas not affected by illness.
- Administer the current season's flu vaccine to unvaccinated residents and health care personnel as per current vaccination recommendations.

BASIC FLU PREVENTION SHOULD BE TAKEN SERIOUSLY

- Get a flu shot every fall when it becomes available.
- Cover your cough/sneeze with a tissue. Throw the tissue in the trash afterwards and wash your hands.
- Wash your hands often with soap and water, if not available, alcohol-based hand rub may be used.
- Stay home if you're sick! Your fever should be gone for 24 hours without the use of fever reducing medicine before you return to school, work or other activities outside your home.
- Clean and disinfect frequently touched objects and surfaces.



HELPFUL RESOURCES

Guidance for individuals and healthcare providers:

<http://epi.publichealth.nc.gov/cd/diseases/flu.html>

Weekly flu reports (under statistics):

<http://flu.nc.gov/>

Influenza-associated death definition and criteria for diagnosis:

http://epi.publichealth.nc.gov/cd/lhds/manuals/cd/casedefs/INFLUENZA_ADULT_DEATH_CD.pdf

Vaccinating healthcare personnel, best practices for community, guidance for influenza outbreaks in LTCFs, guidance on antiviral use:

<http://www.cdc.gov/flu/toolkit/long-term-care/index.htm>

Flu Outbreak in Facilities:

<http://www.cdc.gov/flu/professionals>

How to manage a flu outbreak in your facility:

www.cdc.gov/flu/professionals/infectioncontrol/ltc-facility-guidance

Standard Precautions & Droplet Precautions for flu:

http://www.cdc.gov/hicpac/2007IP/2007ip_part3.html#a



PNEUMONIA

The major types of pneumococcal disease are pneumonia (lung infection), bacteremia (blood infection), and meningitis (infection of the covering of the brain and spinal cord). Less severe illnesses include ear and sinus infections.

PNEUMOCOCCAL PNEUMONIA

Pneumococcal pneumonia is the most common form of pneumococcal disease in adults. It is estimated that about 900,000 Americans get pneumococcal pneumonia each year and about 5-7% die from it.

Most pneumococcal deaths in the United States are in adults. Yet about 67 million adults at increased risk remain unvaccinated, leaving them vulnerable. Vaccination is the safest, most effective way to protect yourself.

PREVENTION

The best way to prevent pneumococcal disease is by getting vaccinated.

Pneumococcal vaccines help protect against some of the more than 90 types of pneumococcal bacteria.

The pneumococcal **conjugate vaccine** (PCV13 or Prevnar 13[®]) protects against the 13 types of pneumococcal bacteria that cause most of the severe illness in children and adults. PCV13 is recommended in all adults 65 years or older.

The **pneumococcal polysaccharide vaccine** (PPSV23 or Pneumovax 23[®]) protects against 23 types of pneumococcal bacteria. It is recommended for all adults 65 years or older.

It is also important to get an influenza vaccine every year because having the flu increases your chances of getting pneumococcal disease.

ANTIBIOTICS

Since it's not common for people to develop an infection after being exposed to someone with a pneumococcal infection, prophylactic (preventative) antibiotics are not recommended for contacts of patients with such infections.

PREVIOUS INFECTION

Because there are more than 90 known pneumococcal serotypes (strains or types) that cause disease, a previous pneumococcal infection will not protect you from future infection. Therefore, pneumococcal vaccines are still recommended for children and adults who have had pneumococcal disease in the past.

SYMPTOMS OF PNEUMOCOCCAL PNEUMONIA (LUNG INFECTION):

- Fever and chills
- Cough
- Rapid breathing or difficulty breathing
- Chest pain

Older adults with pneumococcal pneumonia may experience confusion or low alertness, rather than the more common symptoms listed here.



SHINGLES (HERPES ZOSTER)

Shingles is a painful skin rash, often with blisters. It is caused by the Varicella Zoster virus, the virus that causes chickenpox. Only someone who has had chickenpox can get shingles. The virus stays in your body and can reappear many years later to cause shingles.

Shingles is most common in people age 50 and older, and those with a weakened immune system.

COMPLICATIONS FROM SHINGLES

The most common complication of shingles is post-herpetic neuralgia (PHN). People with PHN have severe pain in the area where they had the rash, even after the rash goes away. This pain usually stops in a few weeks or months, but can last for years.

Shingles can also affect the eye which can lead to problems with vision, including blindness.

Shingles cannot be passed from one person to another. However, the virus that causes shingles can cause chickenpox in someone

who has never had chickenpox. The virus is spread by direct contact with fluid from shingles blisters. The risk of someone with shingles spreading the virus is low if the rash is covered.

People with shingles should keep the rash covered. Do not touch or scratch the rash and wash their hands often.

Once the shingles rash has crusted over, the person is no longer contagious. Until the rash develops crusts, a person with shingles needs to avoid contact with:

- Pregnant women who have never had chickenpox or the chickenpox vaccine
- Premature or low birth weight infants
- People with weakened immune systems

There is no need to exclude if the rash is covered and dry. If the rash is exposed and weeping, they should be excluded from work or group activities.

TREATMENT:

Antiviral medicines can decrease how long a case of shingles lasts and how severe it is. To be effective, these medicines must be started as soon as possible after the rash starts. Pain medicine, wet compresses, calamine lotion and oatmeal baths may help treat pain and itching.

PREVENTION:

Get immunized! The CDC recommends that people 50 years and older get the shingles vaccine. Even if you have had shingles, you can still get the shingles vaccine to help prevent getting shingles again.

Painful skin rash usually on one side of the face or body that lasts 2 to 4 weeks

Before the rash starts, people often have pain, itching or tingling in the same area

Other symptoms: fever, headache, chills & upset stomach



NOROVIRUS (THE STOMACH BUG)

Norovirus is a highly contagious virus, commonly referred to as “the stomach bug.” Each year, norovirus causes 56,000 to 71,000 hospitalizations and 570 to 800 deaths, mostly in young children and the elderly.

Norovirus can spread quickly in enclosed places like nursing homes and cruise ships. It spreads through direct contact with an infected person, eating food or drinking liquids that are contaminated with norovirus, touching objects that have norovirus on them and then putting your fingers in your mouth, or sharing utensils or cups with people who are infected with norovirus.

People with norovirus illness shed billions of virus particles in their stool and vomit and can easily infect others. You are contagious from the moment you begin feeling sick and for the first few days after you recover. Norovirus can stay on objects and surfaces and still infect people for days or weeks and can survive some disinfectants.

There is no vaccine to prevent norovirus and no drug to treat it. Antibiotics will not help with norovirus illness because antibiotics do not work on viruses. When you have norovirus illness, drink plenty of liquids to prevent dehydration.

NOROVIRUS SYMPTOMS:

- Symptoms range from asymptomatic to acute-onset vomiting; watery, non-bloody diarrhea with abdominal cramps; and nausea.
- Myalgia, malaise, and headache may also be present, lasting 24 to 60 hours.
- Symptoms can cause severe illness in the elderly due to pre-existing conditions and/or progression towards dehydration.

NOROVIRUS OUTBREAK PREVENTION:

- Proper hand hygiene: Staff, residents and visitors should wash their hands with soap and water for at least 15 seconds after using the toilet, changing diapers, and before eating, preparing, or handling food. Soap and water are still the best defense against norovirus.
- Wash fruits and vegetables and cook seafood thoroughly. Noroviruses are relatively resistant and can survive temps as high as 140°F and quick steaming processes that are often used for cooking shellfish. Food that might be contaminated with norovirus should be thrown out. Keep sick infants and children out of areas where food is being handled and prepared.
- When you are sick, do not prepare food or care for others for at least 2 to 3 days after you recover. Exclude ill staff from work until 48 hours after last symptom resolves. Please remind ill staff that they should not report to work in any other facility during this period. This applies to sick workers in schools, childcares, and other places where they may expose people to norovirus.
- Clean and disinfect contaminated surfaces. Utilize a bleach-based disinfectant for non-porous surfaces. The minimum concentration that is effective against norovirus is 1000 parts per million (ppm). The maximum concentration effective against norovirus is 5000

parts per million (ppm) and should be considered when surfaces are more porous and or difficult to clean.

- Wash laundry thoroughly: Immediately remove and wash clothes or linens that may be contaminated with vomit or stool (feces). Handle soiled items carefully without agitating them and wear rubber or disposable gloves while handling soiled items. Wash your hands after, and wash the items with detergent at the maximum available cycle length, then machine dry them.



ADDITIONAL CONTROL MEASURES TO DECREASE SPREAD OF NOROVIRUS:

- Keep ill persons away from well persons and restrict ill patients to private rooms when possible
- Observe contact isolation precautions
- Visitors should be aware of illness in the facility and should avoid visiting while symptomatic. Consider restricting visitors to a single-entry point, and monitor compliance with contact isolation precautions. Administrators should consider posting signage.
- Restrict admissions and transfers until outbreak is over (i.e., no new cases for at least 96 hours)
- Consider canceling group activities until 96 hours after last case started feeling ill
- Environmental health should review food service/disinfection practices and pay particular attention to staff hand washing and ice machines
- Outbreak control measures can stop once the outbreak is declared over- after 96 hours have passed with no new illnesses. The local health department will clear facilities to discontinue outbreak control measures.



HELPFUL RESOURCES

- As you are testing for gastrointestinal illness, you may use this a list to help organize and document the outbreak. A copy of this list can be found in the *Helpful Resources* section on page 51.
- The Outbreak Workbook Tool– GI can be downloaded at <http://epi.publichealth.nc.gov/cd/lhds/manuals/cd/outbreak.html>.
- CDC Norovirus Website: www.cdc.gov/norovirus
- Norovirus Line List: <https://www.cdc.gov/hai/pdfs/norovirus/229110-A-NoroLineList508.pdf>

MRSA (Methicillin-resistant Staphylococcus aureus)

MRSA is Methicillin-resistant Staphylococcus aureus, a potentially dangerous type of staph bacteria that is resistant to certain antibiotics and may cause skin and other infections. Recognizing the signs and receiving treatment for MRSA skin infections in the early stages reduces the chances of the infection becoming severe. MRSA is spread by:

- Direct contact with another person's infection.
- Sharing personal items, such as towels or razors, that have touched infected skin.
- Touching surfaces or items, such as used bandages, contaminated with MRSA.

WHAT ARE THE SIGNS AND SYMPTOMS?

Most staph skin infections, including MRSA, appear as a bump or infected area on the skin that may be:

- Red
- Swollen
- Painful
- Warm to the touch
- Full of pus or other drainage
- Accompanied by a fever

**PREVENT A MRSA INFECTION FROM SPREADING IN FACILITIES:****GLOVING**

- Wear gloves (clean nonsterile gloves are adequate) when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, not-intact skin, or potentially contaminated intact skin (e.g., of a patient incontinent of stool or urine) could occur. Remove gloves after contact with a patient and/or the surrounding environment (including medical equipment) using proper technique to prevent hand contamination.
- Throw gloves away after contact with patient and immediately wash hands.

WASH HANDS

- Wash hands after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn.
- Wash hands immediately after gloves are removed, between patient contacts, and when otherwise indicated to avoid transfer of microorganisms to other patients or environments.
- It may be necessary to wash hands between tasks and procedures on the same patient to

prevent cross-contamination of different body sites.

MOUTH, NOSE, EYE PROTECTION

- Use PPE to protect the mucous membranes of the eyes, nose and mouth during procedures and patient-care activities that are likely to generate splashes or sprays of blood, body fluids, secretions and excretions.
- Select masks, goggles, face shields, and combinations of each according to the need anticipated by the task performed.

GOWNING

Wear a gown that is appropriate to the task, to protect skin and prevent soiling or contamination of clothing during procedures and patient-care activities when contact with blood, body fluids, secretions, or excretions is anticipated.

HANDLING PATIENT EQUIPMENT, INSTRUMENTS, DEVICES, AND LAUNDRY

- Handle used patient-care equipment soiled with blood, body fluids, secretions, and excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and transfer of microorganisms to other patients and environments.
- Ensure that reusable equipment is not used for the care of another patient until it has been appropriately cleaned and reprocessed and that single-use items are properly discarded.
- Clean and disinfect surfaces that are likely to be contaminated with pathogens, including those that are in close proximity to the patient (e.g., bed rails, over bed tables) and frequently-touched surfaces in the patient care environment (e.g., door knobs, surfaces in and surrounding toilets in patients' rooms) on a more frequent schedule compared to that for other surfaces (e.g., horizontal surfaces in waiting rooms).
- Handle, transport, and process used linen to avoid contamination of air, surfaces and persons.

CONTACT PRECAUTIONS

CDC recommends contact precautions when the facility (based on national or local regulations) deems MRSA to be of special clinical and epidemiologic significance. The components of contact precautions may be adapted for use in non-hospital healthcare facilities, especially if the patient has draining wounds or difficulty controlling body fluids.

PATIENT PLACEMENT

In patient placement in hospitals and LTCFs, when single-patient rooms are available, assign priority for these rooms to patients with known or suspected MRSA colonization or infection. Give highest



priority to those patients who have conditions that may facilitate transmission, e.g., uncontained secretions or excretions.

- When single-patient rooms are not available, cohort patients with the same MRSA in the same room or patient-care area.
- When cohorting patients with the same MRSA is not possible, place MRSA patients in rooms with patients who are at low risk for acquisition of MRSA and associated adverse outcomes from infection and are likely to have short lengths of stay.
- In general, in all types of healthcare facilities it is best to place patients requiring Contact Precautions in a single patient room.

GLOVING

- Wear gloves whenever touching the patient's intact skin or surfaces and articles in close proximity to the patient (e.g., medical equipment, bed rails).
- Don gloves upon entry into the room or cubicle.

GOWNING

- Put gown on before entry into the room or cubicle.
- Remove gown and perform hand hygiene before leaving the patient-care environment.
- After gown removal, ensure that clothing and skin do not contact potentially contaminated environmental surfaces that could result in possible transfer of microorganism to other patients or environmental surfaces.

PATIENT TRANSPORT

- In acute care hospitals and long-term care and other residential settings, limit transport and movement of patients outside of the room to medically-necessary purposes.
- When transport or movement in any healthcare setting is necessary, ensure that infected or colonized areas of the patient's body are contained and covered.
- Remove and dispose of contaminated PPE and perform hand hygiene prior to transporting patients on Contact Precautions.
- Clean PPE to handle the patient before arrival at the transport destination.

PATIENT-CARE EQUIPMENT, INSTRUMENTS, AND DEVICES

In acute care hospitals and long-term care and other residential settings, use disposable noncritical patient-care equipment (e.g., blood pressure cuffs) or implement patient-dedicated use of such equipment.

- If common use of equipment for multiple patients is unavoidable, clean and disinfect such

DISINFECTION AFTER A MRSA INFECTION

When MRSA skin infections occur, cleaning and disinfection should be performed on surfaces that are likely to contact uncovered or poorly covered infections. If you have any questions about sanitizing for MRSA, please do not hesitate to contact the HHS Communicable Disease team at (828) 250-5109. We are here to help!

equipment before use on another patient.

- In home care settings, limit the amount of non-disposable patient-care equipment brought into the home of patients on Contact Precautions.

Whenever possible, leave patient-care equipment in the home until discharge from home care services.

If noncritical patient-care equipment (e.g., stethoscope) cannot remain in the home, clean and disinfect items before taking them from the home using a low- to intermediate-level disinfectant. Alternatively, place contaminated reusable items in a plastic bag for transport.

ENVIRONMENTAL MEASURES

Ensure that rooms of patients on Contact Precautions are prioritized for frequent cleaning and disinfection (e.g., at least daily) with a focus on frequently-touched surfaces (e.g., bed rails, overbed table, bedside commode, lavatory surfaces in patient bathrooms, doorknobs) and equipment in the immediate vicinity of the patient.

GROUP ACTIVITIES

It is extremely important to maintain the patients' ability to socialize and have access to rehabilitation opportunities. Infected or colonized patients should be permitted to participate in group meals and activities if draining wounds are covered, bodily fluids are contained, and the patients observe good hygienic practices.

WHAT IF I SUSPECT A MRSA SKIN INFECTION?

Cover the area with a bandage and contact your healthcare professional. It is especially important to contact your healthcare professional if signs and symptoms of an MRSA skin infection are accompanied by a fever.

HOW ARE MRSA SKIN INFECTIONS TREATED?

Treatment for MRSA skin infections may include having a healthcare professional drain the infection and, in some cases, prescribe an antibiotic. Do not attempt to drain the infection yourself – doing so could worsen or spread it to others. If you are given an antibiotic, be sure to take all of the doses (even if the infection is getting better), unless your healthcare professional tells you to stop taking it.



HELPFUL RESOURCES

CDC: www.cdc.gov/mrsa



STREPTOCOCCAL INFECTION

Group A Streptococcus (group A strep) is a bacterium that can cause noninvasive and invasive disease. When most people think of “strep,” it is in relation to pharyngitis (“strep throat”), impetigo, or some other everyday non-invasive manifestations of disease caused by the group A streptococcus (GAS), *Streptococcus pyogenes*. **Invasive GAS infections** are far more deadly than the more common non-invasive forms and include septicemia, puerperal sepsis, pneumonia, necrotizing fasciitis, and streptococcal toxic shock syndrome.

Two forms of invasive GAS disease are particularly severe. Necrotizing fasciitis, which can be caused by bacteria other than GAS (e.g., *Vibrio vulnificus*, *Clostridium perfringens*), usually starts at a site of trauma and progresses rapidly from a painful erythematous area to a petechial, vesicular lesion with subcutaneous necrosis possibly extending into skeletal muscle tissue; case-fatality ratios can exceed 20%.

Streptococcal toxic shock syndrome (STSS) is different from TSS caused by the *Staphylococcus*. Like necrotizing fasciitis, it commonly begins at the site of seemingly minor trauma and progresses rapidly as the patient becomes febrile. The site suddenly becomes very painful and hypotension ensues. Fatality ratios with invasive GAS disease can exceed 50%.

Early symptoms of necrotizing fasciitis & STSS include fever, severe pain & swelling, redness of the wound, generalized red rash, fever, dizziness, confusion, and stomach pain.

Transmission: The bacteria live in the nose and throat. When someone who is infected coughs or sneezes, the bacteria travel in small droplets of water called respiratory droplets. You can get sick if you breathe in those droplets, if you touch something that has the droplets on it and then touch your mouth, nose, or eyes, or if the droplets contaminate an open wound.

Treatment: Group A streptococcus bacteria can be treated with common antibiotics such as Penicillin, for both mild and severe disease. Rapid treatment is important to reduce the risk of death. Supportive care in an intensive care unit and sometimes surgery are necessary. Unfortunately, even appropriate therapy does not prevent death in every case.

Prevention: respiratory etiquette and good hand hygiene, especially after coughing and sneezing, after caring for persons with wounds or sore throats, before preparing food and before eating. All wounds should be kept clean and bandaged. Wounds should be watched for possible signs of infection including increasing redness, swelling, and pain at the wound site.

Isolation: People with strep throat should avoid work or school until they have been on antibiotics for 24 hours.

Notification: **Even ONE case of invasive group A strep is mandated to be reported to your local health department for investigation.**

C. diff (CLOSTRIDIUM DIFFICILE)

What is Clostridium difficile infection?

Clostridium difficile [pronounced Klo-STRID-ee-um dif-uh-SEEL], also known as “*C. diff*” [See-dif], is a germ that can cause diarrhea. Most cases of *C. diff* infection occur in patients taking antibiotics.

The elderly and people with certain medical problems have the greatest chance of getting *C. diff*. *C. diff* spores can live outside the human body for a very long time and may be found on things in the environment such as bed linens, bed rails, bathroom fixtures, and medical equipment. *C. diff* infection can spread from person-to-person on contaminated equipment and on the hands of doctors, nurses, other healthcare providers and visitors.

There are antibiotics that can be used to treat *C. diff*. In some severe cases, a person might have to have surgery to remove the infected part of the intestines. This surgery is needed in only 1 or 2 out of every 100 persons with *C. diff*.

Common symptoms of a *C. diff* infection include:

- Watery diarrhea
- Fever
- Loss of appetite
- Nausea, belly pain and tenderness

C. DIFF PREVENTION STEPS FOR PROVIDERS INCLUDE:

1. Clean hands with soap and water before and after caring for every patient. This can prevent *C. diff* and other germs from being passed from one patient to another.
2. Carefully clean rooms and medical equipment that have been used for patients with *C. diff* with a cleaning solution that is known to be effective against *C. diff*.
3. Use Contact Precautions to prevent *C. diff* from spreading to other patients. Contact Precautions mean:
 - Whenever possible, patients with *C. diff* will have a single room or share a room only with someone else who also has *C. diff*. Patients on Contact Precautions are asked to stay in their rooms as much as possible.
 - Healthcare providers will put on gloves and wear a gown over their own clothing while taking care of patients with *C. diff*.
 - Visitors may also be asked to wear a gown and gloves.
 - When leaving the room, providers and visitors remove their gown and gloves and clean their hands with soap and water.



HELPFUL RESOURCES

C. diff Consumer Fact Sheet: https://nhqualitycampaign.org/files/Factsheet_for_Consumer_Infections.pdf

INFECTION PREVENTION

Infection control and prevention is a set of practices designed to reduce transmission of communicable diseases among patients, health care workers, and visitors in a variety of health care settings. Such practices include hand hygiene, use of personal protective equipment, environmental cleaning and disinfection, waste management, cough etiquette, and other engineering and work practice controls that help reduce infectious disease transmission. A high quality infection control program is essential for long-term care facilities to ensure the safety of residents and staff.

According to **10A NCAC 41A .0206** each health care organization that performs invasive procedures shall implement a written infection control policy. To prevent transmission of HIV, hepatitis B, hepatitis C and other bloodborne pathogens, the health care organization shall ensure that health care workers in its employ or who have staff privileges are:

- Trained in the principles of infection control
- Trained in the practices required by the policy
- Compliant with the policy

Additionally, the health care organization shall designate one on-site staff member for each noncontiguous facility to direct these activities. The designated staff member in each health care facility shall complete a course in infection control approved by the Department.

INFECTION CONTROL TRAINING

The NC Statewide Program for Infection Control and Epidemiology (NCSPICE) has approved infection control courses approved by the NC Department of Health and Human Services (NCDHHS). These courses are available online at www.spice.unc.edu

Another useful resource is the ASK SPICE feature on the NCSPICE website. NCSPICE is an excellent source for infection control answers, information, and resources. NCSPICE will make every effort to respond to inquiries within 24 hours.

SAFE INJECTION PRACTICE:

Safe injection practices are a set of measures taken to perform injections in an optimally safe manner for patients, healthcare personnel, and others

Reference available on Infection Prevention in *Helpful Resources* section:
Health Care Associated Infections: What Patients can do. - Pg. 52

Safe injection practices include:

- Proper infection control practices and maintaining aseptic technique during the preparation and administration of injected medications (e.g., perform hand hygiene).
- Never administer medications from the same syringe to more than one patient, even if the needle is changed.
- Never enter a vial with a used syringe or needle.
- Do not use medications packaged as single-dose or single-use for more than one patient.
- Do not use bags of intravenous solution as a common source of supply for more than one patient.
- Limit use of multi-dose vials and dedicate them to a single patient whenever possible.
- Always use facemasks when injecting material or inserting a catheter into the epidural or subdural space.



What is aseptic technique? Aseptic technique refers to the manner of handling, preparing, and storing of medications and injection equipment/supplies (e.g., syringes, needles and IV tubing) to prevent microbial contamination.

What is a single-dose or single-use vial? A single-dose or single-use vial is a vial of liquid medication intended for parenteral administration (injection or infusion) that is meant for use in a single patient for a single case/procedure/injection. Single-dose or single-use vials are labeled as such by the manufacturer and typically lack an antimicrobial preservative. Single-dose or single-use vials cannot be used for more than one patient. There have been multiple outbreaks resulting from healthcare personnel using single-dose or single-use vials for multiple patients.

What is a multi-dose vial? A multi-dose vial is a vial of liquid medication intended for parenteral administration (injection or infusion) that contains more than one dose of medication. Multi-dose vials are labeled as such by the manufacturer and typically contain an antimicrobial preservative to help prevent the growth of bacteria. The preservative has no effect on viruses and does not protect against contamination when healthcare personnel fail to follow safe injection practices.

How can healthcare personnel ensure that injections are performed correctly?

Designate someone to provide ongoing oversight for infection control issues who also assists with written control policies, training, and quality assurance assessments.

Why is improving antibiotic prescribing practices important for nursing homes?

Nursing home residents have a higher risk of colonization with bacteria for many reasons. The presence of invasive devices such as urinary catheters and feeding tubes, wounds, and conditions that affect the bladder (e.g., diabetes or stroke) can all lead to colonization. Difficulties in separating colonization of bacteria from true illness in frail or older adults can lead to the over-use of antibiotics, which in turn drives antibiotic resistance.

What can my nursing home do to improve antibiotic stewardship?

Nursing homes can implement the following:

- > **Leadership commitment:** Demonstrate support and commitment to safe and appropriate antibiotic use.
- > **Accountability:** Identify leaders who are responsible for promoting and overseeing antibiotic stewardship activities at the nursing home.
- > **Drug expertise:** Establish access to individuals with experience or training in improving antibiotic use.
- > **Action:** Take at least one new action to improve the way antibiotics are used in the facility.
- > **Tracking:** Measure how antibiotics are used and the complications (e.g., *C. difficile* infections) from antibiotics in the facility.
- > **Reporting:** Share information with healthcare providers and staff about how antibiotics are used in the facility.
- > **Education:** Provide resources to healthcare providers, nursing staff, residents and families to learn about antibiotic resistance and opportunities for improving antibiotic use.

What can I do to improve use of antibiotics and prevent the spread of germs?

- > Get smart about antibiotics by reviewing the information at the link below and ask the right questions about any antibiotic prescription. <https://www.cdc.gov/antibiotic-use/>
- > Be informed about how your nursing home stops the spread of germs among residents and works to improve antibiotic prescribing practices.
- > Protect yourself by getting vaccines for flu and pneumonia and encourage others around you to do the same.
- > Avoid visiting when you feel ill to protect residents from germs which may be spread in the community.
- > Insist nursing home staff and visitors always clean their hands before touching or caring for your wound or catheter.
- > Know what else you can do to prevent the spread of germs (e.g., cover your cough).

References Available on Antibiotic Stewardship in *Helpful Resources* section:

Checklist for Core Elements of Antibiotic Stewardship in Nursing Homes - pg. 47

Assessment of Current CDI Prevention Activities: Antibiotic Stewardship - pg. 49

DIABETES CARE:

- Wear gloves during fingerstick glucose monitoring and during any other procedure that involves potential exposure to blood or body fluids. Change gloves between patient contacts. Change gloves that have touched potentially blood-contaminated objects or fingerstick wounds before touching clean surfaces. Perform hand hygiene (i.e., hand washing with soap and water or use of an alcohol-based hand rub) immediately after removal of gloves and before touching other medical supplies intended for use on other residents.
- Provide a full hepatitis B vaccination series to all previously unvaccinated LTC staff persons whose activities involve contact with blood or body fluids. Check and document post-vaccination titers one to two months after completion of the vaccination series.
- Provide staff members who assume responsibilities involving percutaneous procedures with infection control training that includes practical demonstration of aseptic techniques and instruction regarding reporting exposures or breaches. Direct annual retraining to all staff members who perform procedures that involve exposure to blood or body fluids.
- Never reuse needles, syringes, or lancets
- Restrict use of fingerstick capillary blood sampling devices to individual patients. Consider selecting single-use lancets that permanently retract upon puncture. Glucometers should be assigned to individual patients. If a glucometer that has been used for one patient must be reused for another patient, the device must be cleaned and disinfected.

BASICS / STANDARD PRECAUTIONS

Standard precautions are a set of infection control practices used to prevent transmission of diseases that can be acquired by contact with blood, body fluids, non-intact skin (including rashes), and mucous membranes. Standard Precautions combine the major features of Universal Precautions and Body Substance Isolation and are based on the principle that all blood, body fluids, secretions, excretions except sweat, non-intact skin, and mucous membranes may contain transmissible infectious agents. These measures are to be used when providing care to all individuals, whether or not they appear infectious or symptomatic.

- Standard precautions include: hand hygiene; use of PPE (personal protective equipment such as gloves, gown, mask, eye protection, or face shield) depending on the anticipated exposure; and safe injection practices
- The application of Standard Precautions during patient care is determined by the nature of the HCW-patient interaction and the extent of anticipated blood, body fluid, or pathogen exposure. For some interactions (e.g., performing venipuncture), only gloves may be needed; during other interactions (e.g., intubation), use of gloves, gown, and face shield or mask and goggles is necessary.
- Education and training on the principles and rationale for recommended practices are critical elements of Standard Precautions because they facilitate



appropriate decision-making and promote adherence when HCWs are faced with new circumstances. The CDC has created hand hygiene and standard precaution courses for health care workers.

- Standard Precautions are also intended to protect patients by ensuring that healthcare personnel do not carry infectious agents to patients on their hands or via equipment used during patient care.

HAND HYGIENE:

- Alcohol-based hand sanitizers are the most effective products for reducing the number of germs on the hands of healthcare providers. Antiseptic soaps and detergents are the next most effective and non-antimicrobial soaps are the least effective.
- When hands are not visibly dirty, alcohol-based hand sanitizers are the preferred method for cleaning your hands in the healthcare setting. Soap and water are recommended for cleaning visibly dirty hands.

PROTECT YOURSELF



WASH YOUR HANDS

- 1 Use soap & water
- 2 Count to 30
- 3 Wash off soap
- 4 Dry with paper towel
- 5 Use towel to turn off faucet

WHEN TO WASH HANDS WITH SOAP AND WATER:

- When hands are visibly dirty
- After known or suspected exposure to *Clostridium difficile* if your facility is experiencing an outbreak or higher endemic rates
- After known or suspected exposure to patients with infectious diarrhea during norovirus outbreaks
- If exposure to *Bacillus anthracis* is suspected or proven
- Before eating
- After using a restroom



HELPFUL RESOURCES

These links provide more information regarding safe injection practices and diabetes care.

Remember, Communicable Disease RNs from your local health department are always available to come out to your facility at your request for training specific to safe injection practices.

www.dhs.wisconsin.gov/ic/precautions.htm

www.cdc.gov/infectioncontrol/guidelines/isolation/precautions.html

www.cdc.gov/infectioncontrol/guidelines/isolation/appendix/standard-precautions.html

www.cdc.gov/handhygiene/providers/training/index.html

www.oneandonlycampaign.org

<https://www.cdc.gov/longtermcare/pdfs/factsheet-core-elements-what-you-need-to-know.pdf>

<https://www.cdc.gov/longtermcare/pdfs/factsheet-core-elements-creating-culture-improve-use.pdf>

TUBERCULOSIS TESTING FOR HEALTHCARE WORKERS

There are two types of testing for TB in health care workers and long term care residents. Do you know the frequency of TB testing? Health care facilities have different TB testing requirements. Facilities should conduct staff TB testing based on risk classification.

Risk classification	Frequency of testing
Low	Baseline; then test if TB exposure occurs
Medium	Baseline, then annually
Potential ongoing transmission	Baseline, then every 8–10 weeks until evidence of transmission has ceased

To determine the risk classification for your facility, review the infection control guidelines and complete the Tuberculosis (TB) Risk Assessment Worksheet at https://www.cdc.gov/tb/publications/guidelines/pdf/appendixb_092706.pdf (PDF - 195k).

Baseline Testing

A baseline test should be given prior to employment. The result of this test can be compared with later tests (due to potential exposure or as part of annual testing) to help determine if recent TB transmission has occurred in the facility.

Annual or Serial Testing

You may need to test for TB on a regular basis. To standardize the interpretation of results, the same test should be used for the baseline and the later tests.

For more information see:

<https://www.cdc.gov/tb/topic/testing/healthcareworkers.htm#tabs-1155957-2>

Baseline Testing: Two-Step Test

Two-step testing with the Mantoux tuberculin skin test (TST) should be used for baseline or initial testing. Some people with latent TB infection have a negative reaction when tested years after being infected. The first TST may stimulate or boost a reaction. Positive reactions to subsequent TSTs could be misinterpreted as a recent infection.

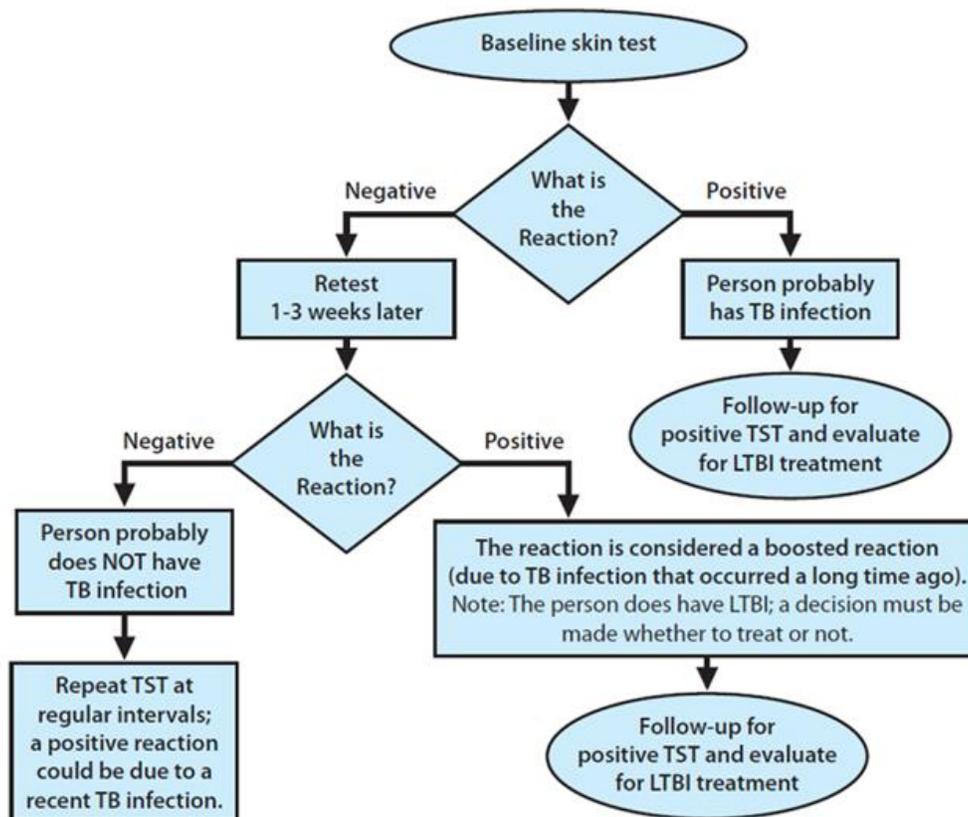


STEP 1

- Administer first TST following proper protocol
- Review result
 - Positive — consider TB infected, no second TST needed; evaluate for TB disease.
 - Negative — a second TST is needed. Retest in 1–3 weeks after first TST result is read.
- Document result

STEP 2

- Administer second TST 1-3 weeks after first test
- Review results
 - Positive — consider TB infected and evaluate for TB disease.
 - Negative — consider person not infected.
- Document result



HEAD LICE DETECTION & CONTROL

Head lice are parasitic insects that can be found on the head, eyebrows, and eyelashes of people. Head lice feed on human blood several times a day and live close to the human scalp. Head lice are not known to spread disease. Head lice are spread by direct contact with the hair of an infested person.

Anyone who comes in head-to-head contact with someone who already has head lice is at greatest risk. It is uncommon for lice to be spread by contact with clothing (such as hats, scarves, coats) or other personal items (such as combs, brushes, or towels) used by an infested person.

TO KEEP LICE IN CHECK:

- Look closely at the hair and head under a good light.
- Look for tiny tan or gray insects and tiny white oval eggs, called nits. These may be attached to the base of the hair and are hard to remove.
- Check resident at least three times a week for two weeks, even if you do not find them initially.



REMEMBER:

- Lice multiply very fast. If you find lice, you must treat the live bugs and remove as many of the nits or eggs as you can.
- To prevent the spread of lice, do not share combs, brushes, towels, or clothes with others.

If a resident needs treatment:

- Use lice treatment shampoo on resident, following your institution's protocol and following shampoo directions.
- Follow the directions for removing lice and nits on the fact sheet provided in the back of this booklet.
- Not all nits are killed with one treatment. Repeat treatment according to the directions on the label.



HELPFUL RESOURCES

We have provided a Head Lice Fact Sheet in the back of this booklet that you can provide to patients, staff or families in the event of a head lice issue at your facility.

Human scabies is caused by an infestation of the skin by the human itch mite which burrows into the upper layer of the skin where it lives and lays its eggs. The most common symptoms of scabies are intense itching and a pimple-like skin rash. Scabies can spread rapidly in crowded conditions where close body contact is frequent. Institutions such as nursing homes, extended-care facilities, and prisons are often sites of scabies outbreaks. An infested person can transmit scabies, even if they do not have symptoms, until they are successfully treated and the mites and eggs are destroyed.

The characteristic itching and rash of scabies can be absent in many debilitated, immunocompromised, institutionalized, or elderly persons, leading to frequent misdiagnosis and delayed or inadequate treatment and continued transmission. Scabies often is not recognized until it begins to appear among staff and less debilitated patients at the institution.

A scabies outbreak suggests that transmission has been occurring for several weeks to months — thus increasing the likelihood that some infested staff or patients may have had time to spread scabies, including to other facilities. Measures to control scabies in an institution depend on how many cases are diagnosed or suspected, how long infested persons have been at the institution while undiagnosed and/or unsuccessfully treated, and whether any of the cases are crusted (Norwegian) scabies.

CLINICAL FEATURES:

Severe itching, especially at night, is the earliest and most common symptom of scabies. A pimple-like “scabies rash” is common. Itching and rash may affect much of the body or be limited to common sites such as the armpit, penis, nipple, elbow, buttocks, shoulder blades and in between fingers. The local health department should be notified of any outbreak that may have community implications, including possible spread by patients or staff to other institutions.

ESTABLISH SURVEILLANCE AND FOLLOW CONTROL MEASURES:

- An institution-wide information program should be implemented to instruct all management, medical, nursing, and support staff about scabies, the scabies mite, and how scabies is and is not spread. Epidemiologic and clinical data should be reviewed to determine the extent of the outbreak and risk factors for spread. Establish an active program for early detection of infested patients and staff; unrecognized crusted scabies is frequently the source of institutional scabies outbreaks.
- Maintain a high index of suspicion that scabies may be the cause of undiagnosed skin rash; suspected cases should be evaluated and confirmed by obtaining skin scrapings; persons with crusted scabies may not show the characteristic symptoms of scabies such as rash and itching (pruritus).



- Screen all new patients and staff for scabies.
- Notify the local health department; notify other institutions to or from which infested or exposed patients may have transferred.
- Maintain ongoing surveillance for scabies among all patients and staff to identify new or unsuccessfully treated cases of scabies.
- Establish appropriate procedures for infection control and treatment.
- Maintain records with patient name, age, sex, room number, roommate(s) name(s), skin scraping status and result(s), and name(s) of all staff who provided hands-on care to the patient before implementation of infection control measures: symptoms can take up to 2 months to appear in exposed persons and staff.
- Use epidemiologic data about distribution of confirmed cases by building, room, floor, wing, occupation (for staff), dates of admission, and onset of scabies-like condition to determine: 1) levels of risk for patients, staff, and visitors; 2) extent of the outbreak (e.g. confined or widespread in the facility; and 3) temporal relationship among cases.
- Use contact precautions with protective garments (e.g. gowns, disposable gloves, shoe covers, etc.) when providing care to any patient with crusted scabies until successfully treated; wash hands thoroughly after providing care to any patient.
- Isolate patients with crusted scabies from other patients who do not have crusted scabies; consider assigning a cohort of caretakers to care only for patients with crusted scabies.
- Maintain contact precautions until skin scrapings from a patient with crusted scabies are negative; persons with crusted scabies generally must be treated at least twice, a week apart; oral ivermectin may be necessary for successful treatment.
- Limit visitors for patients with crusted scabies; visitors should use the same contact precautions and protective clothing as staff.
- Identify and treat all patients, staff, and visitors who may have been exposed to a patient with crusted scabies or to clothing, bedding, furniture or other items (fomites) used by such a patient; strongly consider treatment even in equivocal circumstances because controlling an outbreak involving crusted scabies can be very difficult and risk associated with treatment is relatively low.
- Offer treatment to household members (e.g. spouses, children, etc.) of staff who are undergoing scabies treatment.
- Treat patients, staff, and household members at the same time to prevent re-exposure and continued transmission.
- Staff generally can return to work the day after receiving a dose of treatment with permethrin or ivermectin; however, symptomatic staff who provide hands-on care to any patient may need to use



disposable gloves for several days after treatment until sure they are no longer infested.

- Use procedures that minimize risk of transmission of secondary bacterial infections that may develop with scabies.

ENVIRONMENTAL DISINFECTION

- Ensure bedding and clothing used by a person with crusted scabies is collected and transported in a plastic bag and emptied directly into washer to avoid contaminating other surfaces and items; machine wash and dry all items using the hot water and high heat cycles (temperatures in excess of 50°C or 122°F for 10 minutes will kill mites and eggs); ensure laundry personnel use protective garments and gloves when handling contaminated items.
- Attempt to ensure that all persons who receive treatment have the clothing and bedding they used anytime during the 3 days before treatment machine-washed and dried using the hot water and high heat cycles.
- Clean the room of patients with crusted scabies regularly to remove contaminating skin crusts and scales that can contain many mites.
- Thoroughly clean and vacuum the room when a patient with crusted scabies leaves the facility or moves to a new room.

COMMUNICATION

Establish procedures for identifying and notifying at-risk patients and staff who are no longer at the institution. Maintain an open and cooperative attitude between management and staff.



HELPFUL RESOURCES

Scabies in Institutional Settings: https://www.cdc.gov/parasites/scabies/health_professionals/institutions.html

BED BUG PREVENTION

Bed bugs can move from an infested site to a new home by traveling on furniture, bedding, luggage, boxes, and clothing. Although they typically feed on blood every five to ten days, bed bugs can be quite resilient; they are capable of surviving several months to a year without feeding.

Early detection is key to preventing a major bed bug infestation. When cleaning or changing bedding, be on the lookout for:

- rusty or reddish stains on bed sheets or mattresses caused by bed bugs being crushed.
- dark spots (about this size: •), which are bed bug excrement and may bleed on the fabric like a marker would.

To avoid new introductions of bed bugs into assisted living facilities and long-term care, consider a bed bug information sheet including information on how to avoid bringing bed bugs into the facility, and a prohibition on used or secondhand furniture or a requirement that furniture, luggage, and other personal items be inspected and declared free of bed bugs before coming into the facility.

CLEANING AND ORGANIZATION TO PREVENT BED BUG INFESTATIONS:

- In long-term care and assisted living facilities, regularly vacuum or steam clean areas prone to bed bugs (under and around beds, upholstered furniture, luggage racks, wall/floor junction, etc.)
- Reduce clutter, seal cracks, crevices and holes near beds, repair or replace peeling wallpaper or paint, and take other actions to reduce bed bug hiding places.

FOLLOW GOOD LAUNDRY HANDLING PRACTICES TO PREVENT BED BUGS:

- Keep carts in the hallway during room service.
- Keep clean and dirty laundry separate on carts and in processing room.
- Do not place dirty laundry in linen storerooms or linen closet or any room that contains clean linens.
- If dirty laundry is transported to an outside cleaning facility, do not use the same vehicle for clean linens unless clean and dirty laundry can be completely isolated from each other.

Please Note: Contact a professional exterminator if you suspect your facility has a bed-bug infestation. Do not try to treat bedbugs with pesticides on your own.



HELPFUL RESOURCES

EPA: www.epa.gov/bedbugs

CDC: www.cdc.gov/parasites/bedbugs

CLEANING & SANITIZING

Cleaners or detergents are products that are used to remove soil, dirt, dust, organic matter, and germs (like bacteria, viruses, and fungi). Cleaners or detergents work by washing the surface to lift dirt and germs off surfaces so they can be rinsed away with water. The same thing happens when you wash your hands with soap and water or when you wash dishes. Rinsing is an important part of the cleaning process. Use these products for routine cleaning of surfaces.

SANITIZERS VS. DISINFECTANTS

Sanitizers are used to reduce germs from surfaces but not totally get rid of them. Sanitizers reduce the germs from surfaces to levels that are considered safe.

Disinfectants are chemical products that destroy or inactivate germs and prevent them from growing. Disinfectants have no effect on dirt, soil, or dust. Disinfectants are regulated by the U.S. Environmental Protection Agency (EPA). You can use a disinfectant after cleaning for surfaces that have visible blood or drainage from infected skin.

HOW SHOULD CLEANERS AND DISINFECTANTS BE USED?

Read the label first. Each cleaner and disinfectant has instructions on the label that tell you important facts:

- How to apply the product to a surface
- How long you need to leave it on the surface to be effective
- If the surface needs to be cleaned first and rinsed after using
- If the disinfectant is safe for the surface
- Whether the product requires dilution with water before use
- Precautions you should take when applying the product, such as wearing gloves or aprons or making sure you have good ventilation during application

LAUNDRY

Routine laundry procedures, detergents, and laundry additives will all help to make clothes, towels, and linens safe to wear or touch. If items have been contaminated by infectious material, these may be laundered separately, but this is not absolutely necessary.

SURFACES TO CLEAN

Focus on surfaces that touch people's bare skin each day and any surfaces that could come into contact with uncovered infections. For example, surfaces such as chairs, end tables, remote controls, and all knobs/handles.

Use a targeted approach of cleaning frequently touched surfaces and any surfaces that have been exposed to infections.

Large surfaces such as floors and walls have not been directly associated in the spread of staph and MRSA.

SHARED EQUIPMENT

Shared equipment that comes into direct skin contact should be cleaned after each use and allowed to dry. Equipment used during group activities, all game pieces, and possibly writing utensils should all be cleaned according to the manufacturers' instructions to make sure the cleaner will not harm the item.



Cleaning keyboards and other difficult surfaces: Many items such as computer keyboards or handheld electronic devices may be difficult to clean or disinfect or they could be damaged if they became wet. If these items are touched by many people during the course of the day, a cleanable cover/skin could be used on the item to allow for cleaning while protecting the item. Always check to see the manufacturer has instructions for cleaning.

IS IT CLEAN?

Although in most situations you will not know if a surface has been cleaned, it's important to remember that most surfaces do not pose a risk of spreading MRSA. If cleaning procedures are unknown, take the appropriate precautions such as:

- Using barriers like a towel or clothing between your skin and the surface.
- Showering immediately after activities where you have direct skin contact with people or shared surfaces.
- Cleaning your hands regularly and keeping cuts and scrapes clean and covered with bandages or dressing until healed.

These precautions are especially important in LTCFs because of all the direct contact between staff and residents.

Which disinfectants should I use against MRSA?

Disinfectants effective against *Staphylococcus aureus* (staph) are most likely also effective against MRSA. These products are readily available from grocery stores and other retail stores. Check the disinfectant product's label on the back of the container. Most, if not all, disinfectant manufacturers will provide a list of germs on their label that their product can destroy. **NOTE:** Use disinfectants that are registered by the EPA (check for an EPA registration number on the product's label to confirm that it is registered).

FOOD SAFETY & SANITATION RESOURCES

FOOD PROTECTION FOR LONG TERM CARE FACILITIES:

- Food brought in by employees or visitors must be labeled with the employee's/resident's name and dated.
- Food that must be temperature controlled must be stored at or below 41°F.
- Thermometers required in all cooling units.
- Food stored off the floor. Store chemicals and medicines under/away from food products.
- Animals (other than service animals) are not permitted where food is stored, prepared, or served.

GENERAL:

- Employees must be in good health and free of any illness that may be transmitted by foods.
- Ensure all employees are properly trained on the Employee Health Hygiene Policy.
- Always wear clean outer clothing and proper hair restraints.
- Keep hands away from mouth, hair, and facial area.
- No eating or tobacco use is allowed while working with food or utensils.
- Bare hand contact with ready-to-eat food products is prohibited by law

HANDWASHING:

- Always wash hands in a designated handwashing sink using soap and warm water. Dry hands using a clean paper towel or hand dryer.

BATHROOMS/LAVATORIES

- No storage in toilet rooms.
- Bedpans/Urinals/Bedside Commodes shall be properly cleaned and disinfected. Disposable bedpan/urinals shall be labeled with the patient's name and dated and cleaned in soiled utility room. May be cleaned in patient's room if a toilet with a bedpan lug or spray arm is installed, may not be washed in a hand sink.
- Shower/bath facilities must be disinfected in between patients. Should be kept clean and in good repair.
- Hot water must be between 100-116°F.
- Hand-sinks are required in rooms where personnel may be exposed to bodily fluids, food is handled, sterile supply processing areas, medicine is dispensed and laundry rooms. Hands must be properly washed after handling soiled linen and before handling clean linen.
- Handwashing sinks are for handwashing only. Hand washing signs must be posted.

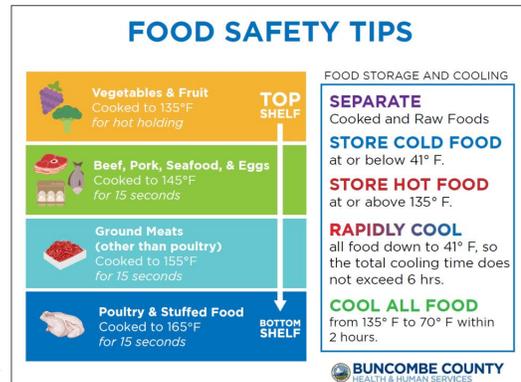
- Hands must be washed after using the toilet and before beginning your shift.
- Before working with food, clean equipment, utensils and single service articles
- Before and after wearing or changing disposable gloves
- After handling raw meats and animal products
- Before handling ready-to-eat foods
- After any activity that may contaminate hands
- As often as necessary to remove soil and contamination

FOOD STORAGE

- Store foods immediately upon receiving based on final cook temperatures.
- Date all ready-to-eat food products stored for more than 24 hours. Ready-to-eat food products must be used or discarded within 7 days, with day 1 being the day food was opened or discarded.
- Cold hold food at or below 41F.
- Hot hold food at or above 135F.
- Always store raw meats and raw shell eggs below any cooked foods, ready-to-eat foods and produce.
- Keep stored foods properly covered.

FOOD TEMPERATURES

- Cooking: Always cook foods thoroughly:
- Beef, Pork, Seafood: 145°F for 15 seconds
- Eggs (not for immediate service), Ground beef and foods containing ground beef: 155°F for 15 seconds
- Poultry, poultry stuffings, stuffed meats, 165°F for 15 seconds
- Reheat all previously prepared food products to 165°F for 15 seconds within a 2 hour time frame
- Cool foods rapidly by stirring frequently and using one of the following methods:
- Ice bath
- Transfer food to shallow pans
- Add ice to food
- Place in freezer lightly covered or not covered on top shelf
- Cool from 135°F to 70°F within in 2 hours AND then 70°F to 41°F, so the total time does not exceed 6 hours.
- If the food product has not reached 70° within the first 2 hours, products must be discarded.
- Use a thin probe thermometer to check food temperatures and re-calibrate using an ice bath, as necessary.



PROPER THAWING

Food shall be thawed:

- In a refrigerator that does not exceed 41°F
- Under potable running water that does not exceed 70°F as part of the cooking process
- In a microwave oven (only when food will be cooked immediately)

CLEANING AND SANITIZING

- A 3-compartment sink must be set up correctly:
- Pre-scrape, wash, rinse, sanitize and air dry. (Never towel dry dishes or utensils)
- Chemical sanitizing in the sink
- Chlorine 50ppm
- Quaternary Ammonia 200ppm
- Keep test strips available to test concentration of sanitizer
- Keep sanitizer in spray bottle or bucket mixed, labeled, and properly stored for use on equipment.

PATIENT CONTACT ITEMS

- Linens must be changed when soiled
- Laundry area and equipment kept clean. Linen disinfected in between use
- Mattresses must be clean, dry and odor free

MISCELLANEOUS

- Medication carts must be cleaned when visibly soiled.
- Reusable feeding syringes must be labeled with the patient's name and date.
- Ambient air temperatures must be between 65°F and 85°F.
- Indoor smoking of any product containing tobacco or other substances is restricted to dedicated smoking rooms.

BACK-UP WATER SUPPLY PLAN

You must notify Buncombe County Environmental Health at (828) 250-5016 if a water interruption lasts more than 4 hours.

PLAN MUST INCLUDE:

- 2 Liters of drinking water per person per day
- Recommended 25 Gallons per person/per day to replace bathing activities & flushing toilets.
- Relocating residents OR
- An alternative water source sufficient to provide for essential functions (food preparation, bathing, cleaning, dishwashing, laundry, hand washing, and disposal of bodily waste)



HELPFUL RESOURCES

We have provided a flyer in the back of this booklet that you can print and hang in your food preparation area. **Environmental Health can be reached at: (828) 250-5016** or visit:

<https://www.buncombecounty.org/eh>



SAFETY & HEALTH RESOURCES

EMERGENCY PREPAREDNESS COORDINATION

Purpose: To establish national emergency preparedness requirements to ensure adequate planning for both natural and man-made disasters, and coordination with federal, state, tribal, regional and local emergency preparedness systems. The following information will apply upon publication of the final rule:

Requirements will apply to all 17 provider and supplier types.

Each provider and supplier will have its own set of Emergency Preparedness regulations incorporated into its set of conditions or requirements for certification.

As of November 15, 2017 the final rule Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers requires that all affected Health Care providers and suppliers comply with new guidance.



Must be in compliance with Emergency Preparedness regulations to participate in the Medicare or Medicaid program. The below downloadable sections will provide additional information, such as the background and overview of the final rule and related resources.

The minimal elements of an effective Emergency Preparedness Program are:

- Risk Assessment and Planning
- Policies and Procedures
- Communications Plan
- Training and Testing

EMERGENCY PLAN

Develop an emergency plan based on a risk assessment and using an “all-hazards” approach, which will provide an integrated system for emergency planning that focuses on capacities and capabilities.

POLICIES AND PROCEDURES

Develop and implement policies and procedures based on the emergency plan and risk assessment that are reviewed and updated at least annually. For hospitals, Critical Access Hospitals (CAHs), and Long-Term Care (LTC) facilities, the policies and procedures must address the provision of subsistence needs, such as food, water and medical supplies, for staff and residents, whether they evacuate or shelter in place.

COMMUNICATION PLAN

Develop and maintain an emergency preparedness communication plan that complies with federal, state and local laws. Patient care must be coordinated within the facility, across healthcare providers, and with state and local public health departments and emergency management systems to protect patient health and safety in the event of a disaster.

TRAINING AND TESTING

Develop and maintain training and testing programs, including initial training in policies and procedures. Facility staff will have to demonstrate knowledge of emergency procedures and provide training at least annually. Facilities must conduct drills and exercises to test the emergency plan or participate in an actual incident that tests the plan.



HELPFUL RESOURCES

Emergency Preparedness Rule:

<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Emergency-Prep-Rule.html>

Knowledge Center: <https://www.healthcareready.org/programs/cms-emergency-preparedness-knowledge-center>



BUNCOMBE COUNTY VETERANS SERVICES

The Buncombe County Veterans Services Office offers assistance in a wide range of services to our nation's veterans, service members and their families. Make sure your residents are getting all the benefits they deserve by making sure they know what Buncombe County offers them.

BURIAL BENEFITS

Headstone and marker, Presidential Memorial Certificate (PMC), reimbursement of burial expenses and burial in a VA National Cemetery.

There is no time limit for claiming reimbursement of burial expenses for a service-related death. In other cases, claims must be filed within 2 years of the veteran's burial.

DISABILITY BENEFITS:

Disability Compensation & Disability Pension

EDUCATION AND TRAINING:

To access detailed information on these education and training programs offered to our nation's veterans and their families, please visit: www.benefits.va.gov/gibill/ and search for a program listed below.

- Montgomery GI Bill
- Veterans Educational Assistance Program (VEAP)
- Survivor's & Dependent's Educational Assistance

HEALTH CARE

The Veterans Administration provides a number of health care services including hospital, outpatient medical, dental, pharmacy and prosthetic services.

- Domiciliary, nursing home, and community-based residential care
- Sexual trauma counseling
- Specialized health care for women veterans
- Health and rehabilitation programs for homeless veterans
- Readjustment counseling
- Alcohol and drug dependency treatment

Medical evaluation for military service exposure, including Gulf War, Agent Orange, radiation, or other environmental hazards.

CONTACT VETERANS SERVICES

PHONE: (828) 250-5726

BUNCOMBE COUNTY VETERANS SERVICES OFFICE:

199 COLLEGE STREET, ASHEVILLE, NC 28801

WWW.BUNCOMBECOUNTY.ORG/VETERANS





BUNCOMBE COUNTY FAMILY JUSTICE CENTER

PREVENTING, RECOGNIZING AND RESPONDING TO SEXUAL ABUSE

Sexual abuse of residents in long term care facilities, assisted-living centers and nursing homes is a largely hidden problem. Preventing, recognizing and responding to sexual assault in adult care homes is essential to the safety and wellbeing of residents.

Sexual abuse and/or harassment may look like unwanted sexual attention or touching, unwanted sexual discussion, harassment, sexting, stalking, or threatening. Sexual abuse of residents may happen from staff or by other residents.

Data on sexual abuse in long-term care shows an increasing percentage of complaints that involve sexual abuse. This federal program has cataloged more than 20,000 complaints of sexual abuse at long term care facilities over 20 years and these numbers do not include resident on resident abuse.

PREVENTING:

Clearly and consistently communicate that all residents must be treated with dignity and respect which includes respecting sexual boundaries. Make clear that sexual harassment, abuse, unwanted sexual conversations and unwanted touching are never appropriate in your facility.

Provide specific training for direct care workers serving residents to learn about sexual assault, recognize it when indicated, and assist victims in gaining protection from further abuse. This training may be part of staff on-boarding or a stand-alone training. Our VOICE and Adult Protective Services can provide community trainings on preventing and responding to sexual abuse in adult care homes.

Provide information about healthy boundaries and consent to residents. Let residents know how they can express any concerns or report sexual abuse. Let residents know their concerns will be taken seriously. Our VOICE can provide trainings and information about consent and sexual assault prevention.

RECOGNIZING:

It's not always easy to identify when sexual abuse has occurred or is occurring. Most sexual abuse is perpetrated by someone the victim knows, this can create complex feelings about reporting the abuse. Sexual abuse can cause a range of emotions including, anger, embarrassment, hostility, guilt and fear.

Some of the signs that a victim of sexual abuse may show are:

- Nightmares or other sleep problems without explanation



- Mood swings, rage, anger, fear insecurity, hopelessness and/or despair
- Change in eating habits
- Develops a fear of certain people or places
- Depression, withdraw, lack of energy, fatigue
- May see increase in alcohol or substance use, self-harm
- Suicidal ideation

The experience of being sexually abused can have ongoing impacts on a victim's life. Survivors of sexual assault are 3 times more likely to have depression, 6 times more likely to suffer from PTSD, 13 times more likely to abuse alcohol, 26 times more likely to abuse drugs than someone who has not been sexually abused.

RESPONDING:

If you suspect someone has been sexually abused speak up; ask them if they feel safe or need support. If someone reports sexual abuse, take their concerns seriously. If you believe a vulnerable adult has been abused or neglected contact Adult Protective Services at 828-250-5800.

Showing support to a victim of sexual abuse can help keep them safe and help them heal. Support looks like listening to them, believing and validating their experience and reassuring them that it was not their fault. Empowering them to connect with resources like Our VOICE and the Family Justice Center who can help them heal.

Supportive statements include:

- > "I believe you."
- > "I'm sorry this happened to you."
- > "You are not alone."
- > "There are resources available to support you. "

Connect victims to Our VOICE and the resources at the Buncombe County Family Justice Center





HELPFUL RESOURCES

We have provided some resources that might be helpful to you as you seek to make your long term care facility the very best. The resources found in this section are for your use and can be copied and printed as needed.

COMMUNICABLE DISEASE OUTBREAKS:

Outbreak: Two linked cases of infectious disease may be sufficient to constitute an outbreak.

If you suspect an outbreak, it is important to notify/report to public health communicable disease at (828) 250-5109. We can help.

OUTBREAK WORKBOOK TOOL: LINE LISTS

A line list is a tool used for investigations of outbreaks. The line list is used to collect and organize important information about individual cases during the outbreak. The data fields on the spreadsheet are suggestions and can be modified to accommodate the needs of the current situation. Your communicable disease nurse can assist and support you through this process.

Acute Gastroenteritis / Norovirus Case Report Worksheet

Reporting facility: _____ Contact Name/Phone Number: _____ Estimated number of exposed patients during outbreak:

Street Address: _____ Unit: _____ Outbreak Identification Number (Health Dept. assigned): _____ Estimated number of exposed staff during outbreak:

1.	Patient/Staff Demographics				Case Location		Symptoms					Outcome			Diagnostics			
	Name	Unique ID (optional)	Patient (P) Staff (S)	Age	Sex (M/F)	Patients only: Room/Bed	Symptom onset date (m/d/yy)	Vomiting (Y/N)	Diarrhea (Y/N)	Bloody stools (Y/N)	Fever (Y/N)	Abdominal cramps (Y/N)	First symptom-free date (m/d/yy)	Died (Y/N/Unk)	Specimen(s) collected for diagnostics (Y/N/Unk)	Date of specimen collection (m/d/yy)	Lab Results	Location of stool specimen testing (H=HCF lab, C=contracted lab S=state lab, CD=CDC lab)
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CS# 216887-A

If required, REDACT Name column prior to faxing. FAX to local/state health department upon completion
<https://www.cdc.gov/hai/pdfs/norovirus/229110-A-NoroLineList508.pdf>

Nursing Home Modules

- 1) Antibiotic Resistant Bacteria – Gowns and Gloves (.73 CNE)**
- 2) Isolation Precautions – Gowns and Gloves (.63 CNE)**
- 3) Safe Injection Practices – The Technique (.86 CNE)**
- 4) Environmental Disinfection – PPP Infomercial (.55 CNE)**
- 5) UTI Prevention in Nursing Homes – Gowns and Gloves(.50 CNE)**
- 6) C. difficile Prevention in Nursing Homes – Gowns and Gloves (.50 CNE)**

THIS CONTINUING NURSING ACTIVITY WAS APPROVED BY THE NORTH CAROLINA NURSES ASSOCIATION, AN ACCREDITED APPROVER OF CONTINUING NURSING EDUCATION BY THE AMERICAN NURSES CREDENTIALING CENTER'S COMMISSION ON ACCREDITATION.

View all of the modules at the link below:

<http://spiceducation.unc.edu/nursing-home-modules/>



Checklist for Core Elements of Antibiotic Stewardship in Nursing Homes

The following checklist is a companion to the Core Elements of Antibiotic Stewardship in Nursing Homes. The CDC recommends that all nursing homes take steps to implement antibiotic stewardship activities. Before getting started, use this checklist as a baseline assessment of policies and practices which are in place. Then use the checklist to review progress in expanding stewardship activities on a regular basis (e.g., annually). Over time, implement activities for each element in a step-wise fashion.

LEADERSHIP SUPPORT

ESTABLISHED
AT FACILITY

1. Can your facility demonstrate leadership support for antibiotic stewardship through one or more of the following actions? Yes No

If yes, indicate which of the following are in place (select all that apply)

- Written statement of leadership support to improve antibiotic use
- Antibiotic stewardship duties included in medical director position description
- Antibiotic stewardship duties included in director of nursing position description
- Leadership monitors whether antibiotic stewardship policies are followed
- Antibiotic use and resistance data is reviewed in quality assurance meetings

ACCOUNTABILITY

2. Has your facility identified a lead(s) for antibiotic stewardship activities? Yes No

If yes, indicate who is accountable for stewardship activities (select all that apply)

- Medical director
- Director or assistant director of nursing services
- Consultant pharmacist
- Other: _____

DRUG EXPERTISE

3. Does your facility have access to individual(s) with antibiotic stewardship expertise? Yes No

If yes, indicate who is accountable for stewardship activities (select all that apply)

- Consultant pharmacy has staff trained/is experienced in antibiotic stewardship
- Partnering with stewardship team at referral hospital
- External infectious disease/stewardship consultant
- Other: _____

ACTIONS TO IMPROVE USE

4. Does your facility have policies to improve antibiotic prescribing/use? Yes No

If yes, indicate which policies are in place (select all that apply)

- Requires prescribers to document a dose, duration, and indication for all antibiotic prescriptions
- Developed facility-specific algorithm for assessing residents
- Developed facility-specific algorithms for appropriate diagnostic testing (e.g., obtaining cultures) for specific infections
- Developed facility-specific treatment recommendations for infections
- Reviews antibiotic agents listed on the medication formulary
- Other: _____

5. Has your facility implemented practices to improve antibiotic use? Yes No

If yes, indicate which practices are in place (select all that apply)

- Utilizes a standard assessment and communication tool for residents suspected of having an infection
 - Implemented process for communicating or receiving antibiotic use information when residents are transferred to/from other healthcare facilities
 - Developed reports summarizing the antibiotic susceptibility patterns (e.g., facility antibiogram)
 - Implemented an antibiotic review process/"antibiotic time out"
 - Implemented an infection specific intervention to improve antibiotic use
- Indicate for which condition(s): _____

6. Does your consultant pharmacist support antibiotic stewardship activities? Yes No

If yes, indicate activities performed by the consultant pharmacist (select all that apply)

- Reviews antibiotic courses for appropriateness of administration and/or indication
- Establishes standards for clinical/laboratory monitoring for adverse drug events from antibiotic use
- Reviews microbiology culture data to assess and guide antibiotic selection

TRACKING: MONITORING ANTIBIOTIC PRESCRIBING, USE, AND RESISTANCE

7. Does your facility monitor one or more measures of antibiotic use? Yes No

If yes, indicate which of the following are being tracked (select all that apply)

- Adherence to clinical assessment documentation (signs/symptoms, vital signs, physical exam findings)
- Adherence to prescribing documentation (dose, duration, indication)
- Adherence to facility-specific treatment recommendations
- Performs point prevalence surveys of antibiotic use
- Monitors rates of new antibiotic starts/1,000 resident-days
- Monitors antibiotic days of therapy/1,000 resident-days
- Other: _____

8. Does your facility monitor one or more outcomes of antibiotic use? Yes No

If yes, indicate which of the following are being tracked (select all that apply)

- Monitors rates of *C. difficile* infection
- Monitors rates of antibiotic-resistant organisms
- Monitors rates of adverse drug events due to antibiotics
- Other: _____

REPORTING INFORMATION TO STAFF ON IMPROVING ANTIBIOTIC USE AND RESISTANCE

9. Does your facility provide facility-specific reports on antibiotic use and outcomes with clinical providers and nursing staff? Yes No

If yes, indicate which of the following are being tracked (select all that apply)

- Measures of antibiotic use at the facility
- Measures of outcomes related to antibiotic use (i.e., *C. difficile* rates)
- Report of facility antibiotic susceptibility patterns (within last 18 months)
- Personalized feedback on antibiotic prescribing practices (to clinical providers)
- Other: _____

EDUCATION

10. Does your facility provide educational resources and materials about antibiotic resistance and opportunity for improving antibiotic use? Yes No

If yes, indicate which of the following are being tracked (select all that apply)

- Clinical providers (e.g., MDs, NPs, PAs, PharmDs)
- Nursing staff (e.g., RNs, LPNs, CNAs)
- Residents and families
- Other: _____

Assessment of Current CDI Prevention Activities

Antibiotic Stewardship

December 28, 2016



Background/Rationale:

- Antibiotic stewardship refers to programs and activities that promote the appropriate selection and use of antibiotics.
- Stewardship activities include limiting the use of antibiotics when they are not needed, and minimizing the frequency, duration, and number of antibiotics prescribed.
- Stewardship can improve the outcomes for residents who need antibiotics and prevent the unintended consequences of antibiotic use such as side effects, the development of antibiotic resistant bacteria, and the replacement of normal bacteria with those which cause infections, such as *C. difficile*.
- Many residents with *C. difficile* infection (CDI) have had exposure to antibiotics within 28 days prior to the onset of symptoms.
- CDI risk increases with taking multiple antibiotics or taking long courses of an antibiotic.
- Antibiotic stewardship can be an effective prevention strategy for the reduction of CDI.

Current survey activities:

SECTION 1. KNOWLEDGE AND COMPETENCY		YES	NO	N/A
Q1	Do direct care personnel* understand how to recognize changes in a resident that might indicate a new infection or other concerning condition?			
Q2	Do direct care personnel understand how to communicate information to medical personnel* when a resident has a change that might indicate a new infection or other concerning condition?			
Q3	Do nursing personnel* receive any periodic training or education about appropriate antibiotic use?			
Q4	Are medical personnel given any resources to help guide decisions about when to suspect a resident has an infection or needs an antibiotic?			
Q5	Do residents and family receive education about appropriate antibiotic use?			
SECTION 2. INFECTION PREVENTION POLICIES AND INFRASTRUCTURE		YES	NO	N/A
Q1	Do direct care personnel document changes in a resident that might indicate a new infection or other concerning condition?			
Q2	Do nursing personnel communicate information to medical personnel when a resident has a change that might indicate a new infection or other concerning condition?			
Q3	Does your nursing home have a pharmacist or physician who provides guidance or expertise on antibiotic use?			
Q4	Does your nursing home use standardized order forms for antibiotic prescriptions including documentation of indication and anticipated duration of therapy?			
SECTION 3. MONITORING PRACTICES		YES	NO	N/A
Q1	Does the pharmacy service provide a monthly report of antibiotic use (e.g., new orders, number of days of antibiotic treatment) for the nursing home?			
Q2	Does your nursing home have a process to perform a follow-up assessment 3 days after a new antibiotic start to determine whether the antibiotic is still indicated and appropriate?			
Q3	Does your nursing home provide feedback on antibiotic prescribing practices to medical personnel?			
Q4	Does the laboratory provide your nursing home with a report of antibiotic resistance in bacteria identified from cultures sent from your nursing home (e.g., antibiogram)?			

*Direct care personnel – All persons interacting with and/or providing hands-on care for residents; Nursing personnel – All persons who provide nursing care to residents including implementing orders and documenting resident condition in the record; Medical personnel – All persons who provide and document medical assessments and care to residents including writing orders and prescriptions.

Assessment of Current CDI Prevention Activities

Appropriate Cleaning/Disinfection of Equipment and the Environment

December 28, 2016



Background/Rationale:

- *C. difficile* spores, surviving for a long time on objects and surfaces, play a role in the spread of *C. difficile* infections (CDI).
- Appropriate cleaning and disinfection of the environment and equipment is an essential strategy for reducing CDI.
- Spores can be found throughout a room like light switches, door knobs, and bedside tables.
- Nursing homes should have educational programs, policies and procedures that outline schedules and responsibilities for cleaning practices.
- Nursing homes should monitor adherence to procedures, evaluate effectiveness of cleaning, and keep staff informed of the results.

Current survey activities:

SECTION 1. KNOWLEDGE AND COMPETENCY				
		YES	NO	N/A
	General: Do direct care personnel* know			
Q1	Appropriate use of personal protective equipment when handling and disposing of soiled materials according to Standard Precautions?			
Q2	How to clean and disinfect equipment that is shared between residents?			
	Environmental services* personnel know			
Q3	How to use personal protective equipment (e.g., gowns, gloves) when cleaning a room of a resident with known CDI?			
Q4	The difference between cleaning and disinfection?			
Q5	To follow manufacturers' instructions for use of cleaners and disinfectants?			

This material was prepared by Telligon, National Nursing Home Quality Improvement Campaign Special Innovation Project contractor, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 11SOW-CO-NNHQIC- 10/16-031



SECTION 2. INFECTION PREVENTION POLICIES AND INFRASTRUCTURE				
		YES	NO	N/A
Q1	Is there a policy for using an EPA-registered disinfectant with a <i>C. difficile</i> sporicidal claim when cleaning the room of a resident with known CDI?			
Q2	Is there a process to communicate with environmental services personnel when a resident is suspected or known to have CDI?			
Q3	Are there procedures and schedules in place for daily cleaning and cleaning when a resident with CDI stops occupying a room (e.g., the resident moves, is discharged, or dies)?			
Q4	Are there policies and procedures in place for the cleaning and disinfection of all equipment used by residents with known CDI?			
Q5	Are the responsibilities for cleaning and disinfecting equipment used by residents with CDI well defined between direct care personnel and EVS personnel?			
Q6	If environmental services are provided by a contracting company, are those individuals aware of and following the nursing home's policies for cleaning and disinfecting the room of a resident with CDI?			
Q7	Are environmental services personnel available 24/7? If not, who is trained/ responsible for cleaning during the off hours and do they have access to the appropriate supplies?			
SECTION 3. MONITORING PRACTICES				
		YES	NO	N/A
Q1	Does your nursing home monitor the adequacy of room cleaning by EVS personnel on a regular basis?			
Q2	Is there a method to track room and equipment cleaning/disinfection according to schedule?			
Q3	Does your nursing home monitor that direct care personnel appropriately clean/disinfect equipment before using it for the next resident?			

* Direct care personnel – All persons interacting with and/or providing hands-on care for residents; Environmental services are also known as housekeeping services.

BE INFORMED. BE EMPOWERED. BE PREPARED.

6 WAYS TO BE A SAFE PATIENT

1

SPEAK UP.

Talk to your doctor about all questions or worries you have. Ask them what they are doing to protect you.

- ▶ If you have a catheter, ask each day if it is necessary.
- ▶ Ask your doctor how he/she prevents surgical site infections. Also ask how you can prepare for surgery to reduce your infection risk.



2

KEEP HANDS CLEAN.

Be sure everyone cleans their hands before touching you.



3

GET SMART ABOUT ANTIBIOTICS.

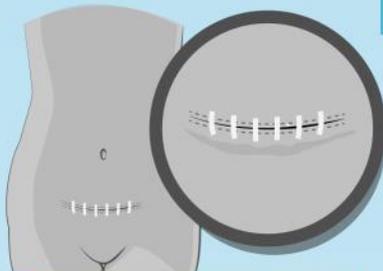
Ask if tests will be done to make sure the right antibiotic is prescribed.



4

KNOW THE SIGNS AND SYMPTOMS OF INFECTION.

Some skin infections, such as MRSA, appear as redness, pain, or drainage at an IV catheter site or surgery site. Often these symptoms come with a fever. Tell your doctor if you have these symptoms.



5

WATCH OUT FOR DEADLY DIARRHEA. (AKA *C. difficile*)

Tell your doctor if you have 3 or more diarrhea episodes in 24 hours, especially if you have been taking an antibiotic.



6

PROTECT YOURSELF.

Get vaccinated against flu and other infections to avoid complications.



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Assessment of Current CDI Prevention Activities

Hand Hygiene

December 28, 2016



Background/Rationale:

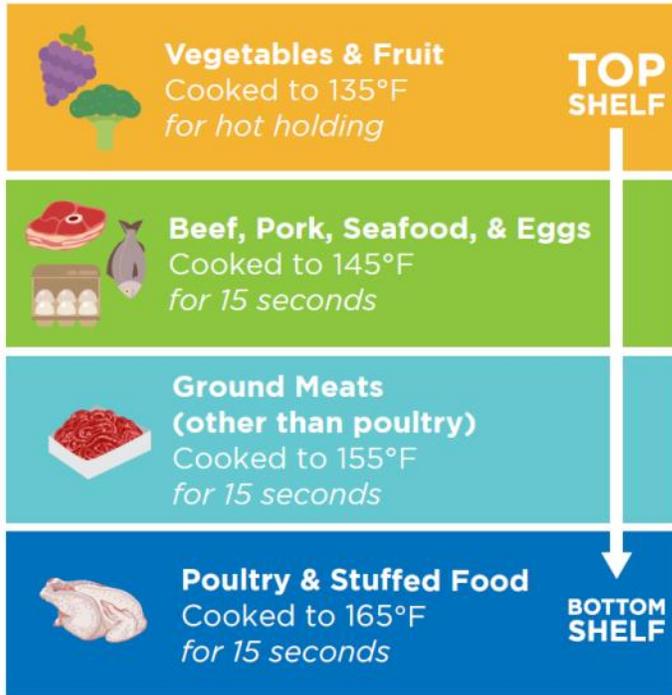
- Hand hygiene is the most important way to prevent the spread of bacteria which cause infections.
- Improving healthcare personnel adherence to hand hygiene practices can reduce both infections and the spread of antibiotic-resistant bacteria.
- Although most bacteria and viruses are effectively killed by alcohol-based hand rubs or washing with soap and water, C. difficile spores are not killed by alcohol hand rubs or removed by hand washing.
- Use of gloves in addition to hand hygiene is very important to prevent hand contamination from C. difficile. But, gloves are not a substitute for performing hand hygiene.
- Hand hygiene adherence among healthcare personnel remains disappointingly low; many studies report less than half of health care personnel perform appropriate hand hygiene.
- Proper hand hygiene must be understood by all people working in a healthcare facility.
- Effective hand hygiene programs must go beyond training to identify and address barriers to hand hygiene, including availability of and satisfaction with hand hygiene products.
- Providing feedback about hand hygiene performance can raise hand hygiene awareness and promote better adherence among healthcare personnel.

Current activities survey:

SECTION 1. KNOWLEDGE AND COMPETENCY				
		YES	NO	N/A
Q1	Does your facility have an annual hand hygiene training program for all healthcare personnel*?			
Q2	Can healthcare personnel describe situations when hand washing with soap and water is preferred over use of alcohol-based hand products?			
Q3	Does your nursing home assess healthcare personnel hand hygiene technique (i.e., they can do hand hygiene properly)?			
Q4	Does your nursing home assess healthcare personnel knowledge of indications for hand hygiene during resident care activities?			
Q5	Do residents and family members receive education about the importance of hand hygiene in prevention the spread of infections?			
SECTION 2. INFECTION PREVENTION POLICIES AND INFRASTRUCTURE				
		YES	NO	N/A
Q1	Does your nursing home have a written hand hygiene policy?			
Q2	Has your nursing home assessed the availability of hand hygiene products in all resident care areas*?			
Q3	Has your nursing home assessed healthcare personnel satisfaction with hand hygiene products available in all resident care areas?			
Q4	Does your nursing home utilize cues to action (e.g., posters, pamphlets, resident engagement) to enhance healthcare personnel and visitors awareness and performance of appropriate hand hygiene?			
SECTION 3. MONITORING PRACTICES				
		YES	NO	N/A
Q1	Does your nursing home monitor healthcare personnel adherence to hand hygiene at regular intervals?			
Q2	Does your nursing home have a process for providing feedback to healthcare personnel about hand hygiene performance?			

* **Healthcare personnel** - All paid and unpaid persons working in the healthcare setting; **Resident care areas** - Areas in the nursing home where direct resident care is provided (for example, resident rooms, common bathing room, therapy rooms, procedure/exam rooms, etc)

FOOD SAFETY TIPS



FOOD STORAGE AND COOLING

SEPARATE

Cooked and Raw Foods

STORE COLD FOOD

at or below 41° F.

STORE HOT FOOD

at or above 135° F.

RAPIDLY COOL

all food down to 41° F, so the total cooling time does not exceed 6 hrs.

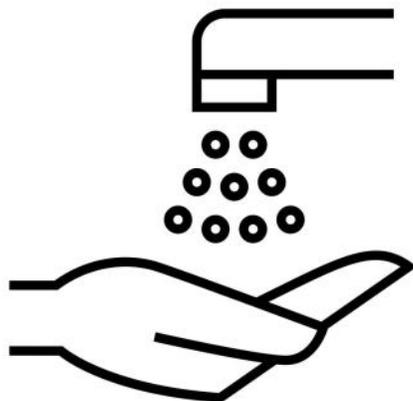
COOL ALL FOOD

from 135° F to 70° F within 2 hours.



BUNCOMBE COUNTY
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PROTECT YOURSELF

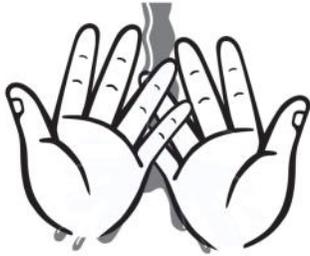


WASH YOUR HANDS

- 1 Use soap & water
- 2 Count to 30
- 3 Wash off soap
- 4 Dry with paper towel
- 5 Use towel to turn off faucet

Wash Your Hands!

¡Lávese Las Manos!



1 Wet Hands
Mójese las manos



2 Soap
Enjabónese



3 Wash for 20 seconds
Lávese las manos por 20 segundos



4 Rinse
Enjuáguese



5 Dry
Séquese las manos



6 Turn Off Water with Paper Towel
Cierre el grifo usando una toalla de papel

We can provide the *SPEAK UP* brochure to your facility upon request. Email us at hhscommunications@buncombecounty.org



If you suspect abuse or neglect of an elder or adult with disabilities

SPEAK UP AND CALL

IN BUNCOMBE COUNTY
828-250-5800

OTHER LOCAL AGENCIES THAT CAN HELP

Buncombe County Sheriff's Office 828-250-6670
 Asheville Police Department 828-252-1110
 Biltmore Forest Police Department 828-274-0822
 Black Mountain Police Department 828-419-9350
 Weaverville Police Department..... 828-645-5700
 Woodfin Police Department 828-253-4889

HENDERSON COUNTY

Social Services 828-694-6241
 Sheriff's Office 828-697-4596

MADISON COUNTY

Social Services 828-649-2711
 Sheriff's Office 828-649-2721

TRANSYLVANIA COUNTY

Social Services 828-884-3174
 Sheriff's Office 828-884-3188

If you have any reason to believe an elder or adult with disabilities is being abused, neglected, or exploited then you are required by NC law to make a report.



Guide for Reporting Abuse, Neglect and Exploitation of Adults with Disabilities

The NC law applies to adults with disabilities who might be abused, neglected or exploited and might be in need of protective services.

An adult with a disability is someone over 18 who is physically or mentally incapacitated.

Remember, if you see these signs
SPEAK UP!

- S**udden changes in behavior or finances
- P**hysical injuries, dehydration, or malnourishment
- E**xtrême withdrawal, depression or anxiety
- A**bsence of basic health care or necessities
- K**ept away from others
- U**nsanitary living conditions
- P**ersonal items or resources missing

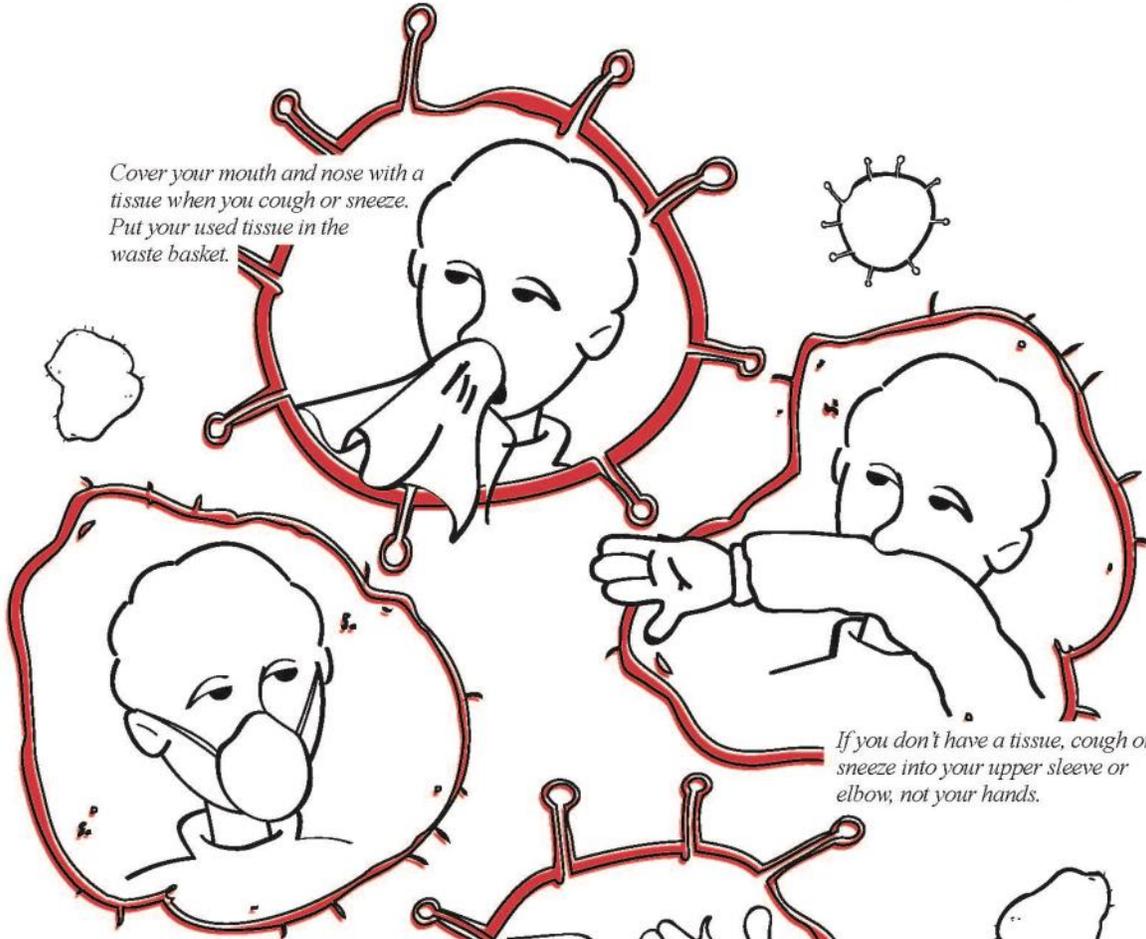
Please help protect vulnerable members of our community.



Cover Cough

— Stop the spread of germs that can make you and others sick! —

Cover your mouth and nose with a tissue when you cough or sneeze. Put your used tissue in the waste basket.



If you don't have a tissue, cough or sneeze into your upper sleeve or elbow, not your hands.

You may be asked to put on a facemask to protect others.



Wash hands often with soap and warm water for 20 seconds. If soap and water are not available, use an alcohol-based hand rub.



What are Head Lice?

Head lice are parasitic insects that can be found on the head, eyebrows, and eye-lashes of people. Head lice feed on human blood several time a day and live close to the human scalp. Head lice are not known to spread disease. Head lice are spread by direct contact with the hair of an infested person.

Anyone who comes in head-to-head contact with someone who already has head lice is at greatest risk. Spread by contact with clothing (such as hats, scarves, coats) or other personal items (such as combs, brushes, or towels) used by an infested person is uncommon.

You can help by doing this:

Look closely at the hair and head under a good light.

Look for tiny tan or gray insects and tiny white oval eggs, called nits. These may be attached to the base of the hair and are hard to remove.

Check resident at least three times a week for two weeks, even if you do not find them today.

For more information

Communicable Disease Control ~
828.250.5109

Remember:

- Head lice do not mean you are unclean.
- Head lice do not spread disease.
- Lice multiply very fast.
- If you find lice, you must treat the live bugs and remove as many of the nits or eggs as you can.

To prevent the spread of lice, residents must not share combs, brushes, towels, or clothes with others.

If resident needs treatment:

Use lice treatment shampoo on resident, following your institution’s protocol and following shampoo directions.

Follow the directions for removing lice and nits on the back of this page.

Not all nits are killed with one treatment. Repeat treatment according to the directions on the label.

Lice medicine

There are many products to treat lice. Check your institution’s protocol for which product to use.

Follow the directions on the label or use the medicine as a doctor or nurse tells you.

Do not use a cream rinse, conditioning shampoo or hair conditioner before you treat for lice. These keep the lice medicine from working well.

Step 1: Are there active lice? This means you see live lice crawling around in the hair. If yes, you will need to use a lice medicine or shampoo. Lice medicines are very harsh and should be used with care.

Step 2: Remove the lice and lice eggs, or nits, from the hair as best as you can and as instructed by the product used. Use a good light to help you see. Work on one section of hair at a time. Nits can be hard to remove but get as many of them as you can. Focus on the nits closest to the scalp. A fine-tooth comb works best or you can slide the nits off the hair between your fingernails. It also helps if the hair is damp. Flush any lice or nits down the toilet.

Step 3: Wash all combs, brushes, hairbands, or ribbons with lice shampoo with HOT water.

Step 4: Put on clean clothes after using or applying a lice treatment. Wash sheets, clothes, stuffed toys, towels and anything else that may have touched the head of the person with lice. Use HOT water.

Do you have things you can't wash? If yes, put them in a very hot dryer for 30 minutes or place them in a tightly closed plastic bag for 3 weeks. This will kill the lice and nits.

Step 5: Vacuum the furniture, mattresses & rugs. Vacuum the car(s) that the child has ridden in, particularly fabric upholstery.

Step 6: Wash your hands! Make sure to clean under your fingernails.

Step 7: Recheck for lice three times per week for three weeks. If any lice are found, repeat treatment beginning with Step 1 above.

If the problem continues, notify physician. A prescription treatment may be needed.

For more information

Communicable Disease Control ~
828.250.5109



HELPFUL CONTACTS:

**Questions, concerns or to report communicable disease in
Buncombe County:**

Communicable Disease Control:
(828) 250-5109

Buncombe County Immunization Clinic:
(828) 250-5096

**buncombecounty.org/hhs
(828) 250-5000**



BUNCOMBE COUNTY
HEALTH & HUMAN SERVICES