PURPOSE

This policy has been developed to minimize the transmission of infectious diseases within Company-owned or managed facilities, to prevent transmission of infection to staff and patients after exposure and provide a guideline for return to work after an exposure or communicable disease in the interest of patient and Team Member/other safety. This policy applies to persons providing services to the Company in any capacity (e.g., Team Members [hourly, salaried, full-time, part-time, temporary, on-call, or PRN], students, volunteers, and persons employed by an organization that contracts with the Company). These persons are herein referred to for the purpose of this policy as "Team Members/others" For the treatment of Team Members exposed to bloodborne pathogens see Exposure to Blood & Body Fluids policy (refer to the policy "Exposure to Blood and Body Fluids-HIV/Hepatitis" for information on follow-up for Team Member exposure to bloodborne pathogens).

POLICY

A. Team Members/others will immediately report any exposures to infectious diseases or communicable disease to his/her team leader/supervisor or manager immediately following the exposure, so that the risk of infection or contagion on the job may be evaluated. This includes diseases which according to the U.S. Centers for Disease Control and Prevention (CDC) may be transmitted through day to day casual contact or workplace exposure.

   1. In the event that the particular disease or condition the Team Member/other has been exposed to would subject other Team Members/others or patients to a risk of infection, the Team Member/other will be referred to Employee Health.
   2. The Team Member/other may be placed on administrative leave during such evaluation, if such a leave would be medically effective, according to nationally recognized infection control guidelines, in preventing the further spread of the disease or condition with the Company.

B. Team Members/others who perform or assist with exposure-prone invasive procedures on patients and who are infected with the Human Immunodeficiency Virus (HIV) or hepatitis B virus (HBeAg +) will report their infection to their team leader/supervisor or manager and may not perform exposure-prone invasive procedures on patients unless they appear before an expert review panel consisting of the Regional Vice President, the Clinical Vice President, Employee Health, and anyone else deemed appropriate and necessary.

   1. The panel will specify under what circumstances the Team Member/other may perform or assist with the procedures.1
   2. An exposure prone procedure is any invasive procedure that, in the reasonable determination of the Infection Control Committee, relying upon nationally recognized infection control guidelines, poses a direct and significant risk of transmission of HIV or hepatitis B. Generally, exposure-prone invasive procedures include oral, cardiothoracic, colorectal, obstetric/gynecologic, general surgery, orthopedic, cardiac, and trauma services during which there is a digital palpation of a needle tip in a body cavity or the simultaneous presence of the Team Member's/other's fingers and a needle or other sharp instrument or object in a poorly visualized or highly confined anatomic site.

3. Direct patient care Team Members/others who perform exposure-prone invasive procedures on patients and are aware or become aware during the course of their employment that they are infected with HIV or hepatitis B virus (HBeAg +) must notify his/her team leader/supervisor or manager immediately.
4. Direct patient care Team Members/others who wish to ascertain their HIV status will be referred to the local health department or their private medical provider for confidential testing.

C. Team Members/others with conjunctivitis, febrile rash, diarrhea, exudative lesions, weeping dermatitis, or other communicable disease must notify his/her team leader/supervisor or manager immediately and shall refrain from direct patient care as recommended by Employee Health and published guidelines (refer to Procedure the condition resolves and until cleared to return to work by a physician.

D. Team Members returning to work after sustaining an on-the-job injury and/or on medical leave must submit a physician's statement reflecting a release to return to work (see policy: “Early Return to Work”).

E. Failure to timely report any infection or exposure as set forth above may result in discipline, up to and including immediate termination. The Company reserves the right to require cooperation with medical investigations and inquiries whenever a job-related exposure occurs.

1 U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (1991, July 12). Recommendations for Preventing Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Patients During Exposure-Prone Invasive Procedures. *MMWR* 40 (RR-3).

PROCEDURE

A. Chickenpox/Zoster

1. On hire, and pre-exposure, verify varicella immunity for Team Members who have no history of chickenpox (see policy: “Applicant Health Assessment”)..
2. Team Member exposure:
   - If the Team Member has a previous history of chickenpox disease, consider him/her immune and return to work.
   - If the Team Member has no history of chickenpox or cannot remember having the chickenpox, consider him/her susceptible to the disease.
     - Verify the source patient's diagnosis of chickenpox or herpes zoster (shingles).
     - Draw exposed Team Member's blood immediately for varicella serology.
     - Negative serology (no varicella antibody): Team Member must remain at home from day 10 to day 21 after the exposure; may return to work on day 21 if disease has not developed.
     - If chickenpox or zoster develops, Team Member should remain at home until all lesions are crusted and dry.

B. **Conjunctivitis**

1. Send Team Member with conjunctivitis home with instructions to contact physician for treatment.
2. The Team Member may return to work 24 hours after the start of effective therapy, evidenced by a decrease in symptoms. Restrict the Team Member from patient care until clear of infection.
3. Emphasize strict hand hygiene for the affected Team Member.

C. **Cytomegalovirus (CMV)**

1. No special means to prevent transmission to Team Members beyond Standard Precautions are required.
2. There is no post-exposure or return to work protocol.

D. **Hepatitis A**

1. Post-exposure to the feces of an infected person: refer to Emergency Room for serum immune globulin prophylaxis 0.02 ml/kg as soon as possible but within 2 weeks of exposure.
2. Return to work: 7 days after onset of jaundice or other symptoms of hepatitis

E. **Hepatitis B**

See the policy: “Exposure to Blood and Body Fluids.”

F. **Non-A, non-B hepatitis, hepatitis C**

See the policy: “Exposure to Blood and Body Fluids.”

G. **Herpes simplex**

1. Team Members with herpes labialis (cold sores) should not work with infants and immunocompromised patients.
2. Return to work:
   - Herpes labialis - no restriction.
   - Herpetic whitlow - when healed. Oral acyclovir may significantly reduce lost time from work.

H. **HIV / AIDS**

See the policy: “Exposure to Blood and Body Fluids.”

I. **Influenza**

1. Encourage yearly vaccination for all Team Members. (See policy: “*Influenza Vaccination*”).
2. Post-exposure (influenza A only): amantadine or rimantadine 100 mg twice daily as prophylaxis for 2- 5 days.
3. Return to work after illness when symptom-free and at least 5-7 days after initial symptoms.

J. **Measles, Mumps, and Rubella**

1. All susceptible Team Members should be vaccinated (see policy: "*Applicant Health Assessment*").
2. Post-exposure of susceptible persons:
   - Live virus vaccine should be given within 72 hours of exposure. Alternatively, immune globulin may be given within 72 hours to those for whom vaccine is contraindicated.
   - Immunocompromised individuals who cannot receive vaccine (other than HIV positive individuals who can receive vaccine) should receive immune globulin within 3 days of a documented exposure.
   - Susceptible pregnant Team Members exposed to rubella should be referred to their obstetrician for follow-up including testing for anti-rubella IgM which indicates acute infection.
   - Susceptible exposed Team Members must be excluded from work according to the following:
     Measles: exclude days 5-21 after exposure.
     Mumps: exclude days 5-26 after exposure.
     Rubella: exclude days 7-21 after exposure.
3. Return to work:
   - Measles: 7 days after rash appears.
   - Mumps: 9 days after onset of parotitis.
   - Rubella: 5 days after rash appears.

K. **Meningococcal**

1. An exposure is a direct contact with respiratory secretions (as with mouth-to-mouth resuscitation) or with cultures of the organism. Patients are infectious for 24-48 hours after initiation of appropriate antibiotic therapy.
2. Prophylactic antibiotic therapy:
   - Rifampin 600 mg twice daily orally for 2 days (not for pregnant women), or
   - Cipro 500-750mg orally X 1 dose (not for children or pregnant women), or
   - Ceftriaxone 250 mg IM or IV as a single dose.

   Note: percutaneous exposure to lab personnel requires penicillin prophylaxis.

L. **Parvovirus B19 (Erythema Infectiosum, Fifth Disease)**

1. An exposure results from contact with blood and respiratory secretions.
2. Pregnant personnel in the first half of pregnancy:
   - Test for evidence of prior infection (a positive IgG)
   - Refer susceptible pregnant Team Members to their obstetrician; follow for IgM response.
3. Follow non-pregnant Team Members for development of symptoms.
4. Return to work several days after symptoms resolve.

M. **Pediculosis (Lice)**

1. Exposure: direct contact with an infected person; for body lice and to a lesser extent for head lice, indirect contact with the patient's personal belongings, especially shared clothing and headgear.
2. Post-exposure: Treat only those infested with lice.
3. Return to work: 24 hours after application of an effective insecticide.

N. **Pertussis**

1. Consider providing Tdap immunizations for Team Members at risk of exposure.
2. Remove exposed Team Members from work at the first sign of any respiratory infection (incubation period is 6-20 days).
3. Consider the use of erythromycin (7 day) prophylaxis for exposed Team Members. Clarithromycin or azithromycin may be used as alternatives.
4. Return to work after illness:
   - With erythromycin treatment: 5 days after onset of therapy.
   - Without erythromycin treatment: 3 weeks after onset of symptoms or until the end of the cough, whichever comes first.

O. **Respiratory syncytial virus (RSV)**

1. RSV-infected Team Members or those with symptoms of upper respiratory infection should not work with infants or young children. Cohort patients and staff, limit visitors.
2. Send Team Members home when ill.
3. Return to work when symptoms resolve.

P. **Salmonella and Shigella**

1. If an outbreak of salmonella or shigella infection occurs, perform stool cultures on all individuals with contact exposure to infected patients or implicated fomites (i.e., prepared food).
2. Personnel with positive cultures (symptomatic or asymptomatic): follow with serial cultures until negative. Shigella infection should be treated with antibiotics; salmonella infection should not be treated with antibiotics.
   - Food handlers may not work until their stool cultures are negative.
   - Other Team Members may return to work when asymptomatic.

Q. **Scabies**

1. Exposure: prolonged direct skin-to-skin contact, incubation period is 1-4 weeks.
2. Treat Team Members who have had skin-to-skin contact with an infested individual.
3. Return to work the day after treatment.

R. **Skin Lesions (infected)**

1. Team Member with a draining lesion should not provide patient care.
2. b. Return to patient care when drainage ceases.

S. **Staphylococcus, including MRSA**

1. Team Member with a draining lesion should not provide patient care.
2. Return to patient care when drainage ceases.
3. Remove a culture-positive Team Member from work if linked to a hospital-acquired infection. If implicated in transmission of MRSA, they should be treated and culture-negative before returning to work.
4. If colonized with MRSA, but not linked to transmission, they do not require decolonization.

T. **Streptococcus Group A**

1. In the case of nosocomial infection with group A streptococcus, an investigation should be initiated to locate carriers. Pharyngeal, rectal, vaginal, and skin lesion cultures should be obtained.
2. Remove a culture positive Team Member from work if linked to the patient case.
3. Treat with oral or IM penicillin, or erythromycin for those with penicillin allergy.
4. Return to work when culture negative.

U. **Syphilis**

1. Evaluate any exposure individually to determine if therapy is necessary.
2. No work restriction.

V. **Tuberculosis**

(See policy: *TB Prevention and Control Plan*)

1. Exposure: close or casual contact to an infectious (sputum smear AFB positive) patient who is not Post-exposure: Check the Team Member's TB skin test at the time of exposure, then 8-10 weeks post exposure.
2. Converters should be treated according to the TB Prevention and Control Plan.
3. Return to work (active pulmonary TB) when sputum smear is negative, when on effective therapy, and when improved clinically.

REFERENCE

Centers for Disease Control and Prevention (1998). Guideline for infection control in healthcare personnel, American Public Health Association, Heymann, DL Ed. (2004). *Control of Communicable Diseases Manual*. APHA, Washington, DC.
Centers for Disease Control and Prevention, US Public Health Service;. Management of Multidrug-Resistant Organisms in Healthcare Settings. Available at: http://www.cdc.gov/ncidod/dhqp/pdf/ar/mdroGuideline2006.pdf