Staff health and the management of work-related infection risks

Contents

Policy

The risk of transmission of infections between clinical staff and patients is minimised by prompt investigation, advice and implementation of appropriate infection prevention and control measures.

Purpose

To identify work-related infection risks and institute appropriate preventative measures to prevent the further transmission of infectious diseases.

The latest version of this document is available on the CDHB intranet/website only. Printed copies may not reflect the most recent updates.

Scope/Audience

All CDHB staff excluding food service staff

For food service staff, refer to the CDHB Food Service Food Control Plan Exclusion for Sickness policy

Associated documents

CDHB IPC Policy, Blood/Body Fluid Exposure

CDHB IPC Policy, Guidelines for the Control of Multidrug Resistant Organisms

CDHB Wellbeing Health & Safety Intranet Pages

CDHB IPC Intranet Guidelines - Staff Health

CDHB Food Service Food Control Plan

1. Work Restrictive Conditions

Work restrictions may be enforced or recommended for CDHB clinical staff that have been exposed to or infected with the following infectious diseases. For further advice contact the Infection Prevention and Control Service.

Disease	Relieve from Direct Patient Contact	Partial Work Restriction/ Precaution to Take	Duration	Pregnancy of Healthcare worker (HCW)
Chicken Pox (Varicella- zoster)				
Active	Yes		Until all lesions dry and crusted (usually 5 days).	
Post exposure – unknown immune or reported non-immune status	**Discuss with IP&C** Usually from 8th day post exposure through to 21st day if non-immune	Varicella zoster immunity **MUST** be checked by blood test.		Relieve from direct patient contact if not immune
Conjunctivitis (Infectious)	Yes		Until discharge ceases	

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Disease	Relieve from Direct Patient Contact	Partial Work Restriction/ Precaution to Take	Duration	Pregnancy of Healthcare worker (HCW)
Cytomegalovirus (CMV)	No			Apply Droplet Precautions for prolonged or frequent exposure to aerosolized urine or respiratory secretions
Gastroenteritis (viral or unknown)	Yes	During an outbreak of gastroenteritis, staff will not be able to return to work until 48 hours after symptoms have resolved.	If not during an outbreak, until HCW's symptoms have resolved for 24 hours. For further advice contact Occupational Health	
Campylobacter with symptoms	Yes	Notifiable disease to Community & Public Health (C&PH).	Until HCW asymptomatic for 48 hours	
Salmonella	Yes		Until HCW's asymptomatic for 48 hours	
Yersinia	Yes	Notifiable disease to C&PH.	HCW's – until asymptomatic for 48 hours.	
Diphtheria	Yes		Until antimicrobial therapy completed and two negative screens 24 hours apart.	
Enteroviral infections (Coxsackie viruses, Echoviruses, Enteroviruses, Polioviruses)	No	HCW's should not care for infants, new-borns and immunocompromised patients and their environment.	Until HCW's symptoms resolve.	
Group A Streptococcal infection	Yes		Until 24 hours after appropriate antibiotic treatment is commenced.	
Hepatitis A	Yes		Until 7 days after onset of jaundice.	

Disease	Relieve from Direct Patient Contact	Partial Work Restriction/ Precaution to Take	Duration	Pregnancy of Healthcare worker (HCW)
Hepatitis B	Consultation with Occupational Health is required if staff are performing exposure prone procedures.	HCW's must use Standard Precautions for procedures that involves potential/actual trauma to tissues, or contact with mucous membrane or non-intact skin of the health care worker.	Until advised by medical practitioner in consultation with Occupational Health.	
Hepatitis C	Consultation with Occupational Health is required if staff are performing exposure prone procedures.	HCW's must use Standard Precautions for any procedure that involves potential/actual trauma to tissues or contact with mucous membranes or non-intact skin of the health care worker.	Until advised by medical practitioner in consultation with Occupational Health.	
Herpes Simplex - Genital - Hand (herpetic whitlow) - Orofacial (cold sores)	 No Yes Requires consultation with Infection Prevention and Control Team in high risk areas	 HCW's should not care for high risk* patients. Consult with Infection Prevention and Control Team.	 Until lesions heal. Until lesions heal	
Human Immunodeficiency Virus (HIV)	Consultation with Occupational Health is required if staff are performing exposure prone procedures.	HCW's must use Standard Precautions for any procedure that involves potential/actual trauma to tissues or contact with mucous membranes or non-intact skin of the health care worker.		

Disease	Relieve from Direct Patient Contact	Partial Work Restriction/ Precaution to Take	Duration	Pregnancy of Healthcare worker (HCW)
Influenza	Yes	Contact with influenza does not incur work restrictions	For a minimum of 72 hours after onset of ~~from the~~ first symptoms and ~~.~~should stay off work for at least 24 hours after resolution of fever. For further advice consult Occupational Health.	
Lice (Head/Pubic)	No			
Measles Active Post exposure	Yes. immune-compromised personnel, consult with IP&C Team	 Refer to Occupational Health Team for vaccination	Until at least 5 days after the rash appears.	
Meningococcal infections	Yes	(see chart below)	Until 24 hours after start of appropriate antibiotic therapy.	Rifampicin and Ciprofloxacin prophylaxis not recommended during pregnancy
Mumps **Post exposure**	Yes		Until 5 days after onset of parotitis. From 12-26 days after exposure	
Pertussis (Whooping Cough) Active Post-exposure (asymptomatic)	Yes No - advise post exposure prophylaxis		From the beginning of the catarrhal stage through the third week after onset of paroxysms or until 5 days after start of effective antimicrobial therapy.	
Rubella Active	Yes		Until 7 days after the rash appears.	
Post exposure	Susceptible personnel,	Refer to Occupational	Serology recommended	Relieve from

Disease	Relieve from Direct Patient Contact	Partial Work Restriction/ Precaution to Take	Duration	Pregnancy of Healthcare worker (HCW)
	consult with IP&C Team.	Health Team for vaccination	otherwise from 7-21 days after exposure.	direct patient care
Scabies	Yes	(see chart below)	24 hours after effective treatment.	
Post exposure	No	Consider prophylaxis, discuss with IP&C		
Shingles (zoster) Active	Dependant on site of lesions - consult with IP&C Team.	Appropriate barrier protective i.e. cover lesions. Personnel should not care for high risk* patients	Until lesions have crusted and no further eruption of new lesions	
Post exposure				Relieve from direct patient contact if not immune
Staphylococcus aureus (skin lesions)	Yes		Until lesions have resolved.	
TB (Pulmonary)	Yes (refer NZ TB Guidelines, 2010)	(see chart below)	Until treated and identified as non-infectious by medical specialist	
Upper respiratory tract infections	Yes – when working with high risk patients	Personnel should not care for high risk* patients.	Until acute symptoms resolve.	

***High risk patients are those in the following categories:**

- Burns
- Intensive Care Unit
- Neonatal nurseries
- Birthing Unit
- Paediatric/CHOC
- Transplant/BMTU
- Immuno-suppressed patients
- Operating Theatre

2. Follow up of staff contact with infectious disease

Community and Public Health, Occupational Health and Infection Prevention & Control all have a role in the follow up of staff who have had unprotected exposure to the following infectious diseases.

Disease	Exposure risk	Follow up
Pulmonary TB	>8 hours (cumulative) without Airborne Precautions in place	Department manager to send exposed staff member details to Occupational Health. Patient contact names to be forwarded to Community and Public health.
Meningococcal disease	Health care personnel including ambulance staff, exposed to the patient during mouth-to-mouth resuscitation or unprotected contact during endotracheal intubation or the patient coughed in their face or prolonged close exposure without adequate protection e.g. surgical mask	Staff names to be forwarded to the IP&C team who will refer to Infectious Diseases and forward to community and public health. Prophylactic treatment of contacts should ideally be given within 24 hours of notification of a case, however can be given up to 14 days post contact For clearance of nasopharyngeal N. meningitidis from contacts refer to Pink Book and search under 'meningitis'.
Scabies	Close contact with a patient diagnosed with scabies without Contact Precautions in place	Names to be forwarded to Occupational Health Service. If topical treatment is offered, this will be organised by the departmental manager.
Blood borne viruses	Blood and body fluid exposure incident	Refer CDHB IPC BBFE policy

3. MRSA screening and follow up for CDHB employees

3.1 Pre-employment screening

Prior to employment with Canterbury District Health Board hospitals, a negative MRSA screen from Canterbury Health Laboratories or West Coast DHB laboratories is required from the following:

- All prospective clinical staff members who will be working in CDHB facilities
- Staff who have previously worked in or been admitted to another healthcare facility (within NZ or overseas)

The negative screen must be:

- From Canterbury Health or West Coast DHB Laboratories
- Recent (within two weeks) and should be taken at the end of previous employment
- Sighted by the Clinical Line Manager, prior to commencing clinical duties*****

A prospective employee, who comes to Canterbury DHB with a recent clear screen from outside the Canterbury area, will require a re-screen via Canterbury Health Laboratory on employment.

In situations where no clearance results are available, the Infection Prevention and Control Service may assess the risk and allow the employee to start work while awaiting results of clearance swabs.

3.2 Re-screening

- Following initial pre-employment testing, re-screening is usually not required for existing staff unless epidemiologically indicated i.e. contact screening or outbreak situation.
- Staff returning from long term leave (≥12 months), which has involved employment in or admission to a healthcare facility other than Canterbury or West Coast DHB's.
- Existing staff that have regular clinical contact in DHBs outside of Canterbury and West Coast DHB's must provide 6 monthly MRSA screens. The staff member's manager will monitor compliance
- Existing staff who have regular clinical contact in healthcare facilities listed on the CDHB NZ MDRO cross infection list must provide 6 monthly MRSA screens while that facility remains a cross infection risk.
- Existing staff who work overseas in a healthcare facility for a temporary period of time while still in employment with CDHB must submit MRSA swabs on return to a CDHB facility.

3.4 Contact Screening

The IP&C Service may request that clinical staff are screened for MRSA colonisation in the following situations:

- As part of an MRSA outbreak management plan
- As a result of prolonged exposure to a MRSA colonised or infected patient where inadequate infection prevention and control procedures were used

Contact screening results will not be sent to staff. However if a staff member has a positive result then the IP&C Service will make

contact with the staff member and manage the staff member's programme of decolonisation / clearance (refer 3.6 and 3.7).

In general patient contacts of an MRSA positive staff member do not require screening for MRSA. However in certain circumstances patient contact screening may be initiated by the IP&C Service.

3.5 MRSA screening swabs and procedure

A set of three swabs is required for clearance. A purple-top bacterial swab is used to sample the following sites:

- **Nasal Swab** (one swab for both nostrils)
  and
- **Groin Swab** (one swab for both sides)
  and
- **Perineum Swab** (natal cleft)
  and
- **Dermatitis / eczema/ wounds**

Specimen Collection Technique

Swabs will be tested for presence of MRSA only.

1. Moisten the swab using the transport media in the tube, directly before use.
2. Rub the pre-moistened swab over the indicated area(s) indicated above, several times.
3. Clearly label all specimens.
   - Name
   - Date of Birth
   - Site swabbed
4. Use one laboratory form per person for all swabs.
   Request: MRSA screen
   Charge cost to: Infection Prevention and Control Service
5. **<u>Ensure you fill in contact details asked for on the form</u>**
6. Place specimens and laboratory form in laboratory specimen bag and send to laboratory

3.6 Management of positive screen

A clinical employee found to be colonised with MRSA shall not commence/continue clinical contact until consultation between Infection Prevention and Control and management has taken place.

The staff member is required to commence decolonisation treatment.

The IP&C Service will manage the staff member's programme of decolonisation and follow up

A nationally recommended decolonisation regime is used (refer 3.7).

The staff member may be referred to Infectious Diseases if the initial decolonisation is not successful

3.7 Decolonisation treatment for staff

NB: Decolonisation must be discussed with the IP&C Service prior to commencing treatment.

The following decolonisation regime is used for 7 days. A programme for follow up swabs to establish clearance will be arranged in conjunction with the CNS IP&C.

Area	Substance	Procedure
Treatment of anterior nares (nose)	Mupirocin 2% ointment (Bactroban)	Apply to anterior nares (nostrils) 3 times daily (at entrance to the nose not the mucosa). Use clean cotton buds for each application.
Bodywash	Chlorhexidine Gluconate 2% Skin Cleanser (Microshield)	Use daily as soap for showering.
Shampoo*	Chlorhexidine Gluconate 2% Skin Cleanser (Microshield)	Use at least twice weekly as shampoo.

If the staff member is sensitive to any of the above products, the IPC service can advise on alternative treatments.

4. MRSA screening for clinical staff not employed by CDHB (honorary staff and student placements)

4.1 Indication for screening

The following groups must provide negative MRSA screening swabs results prior to undertaking clinical care or activities in a CDHB hospital facility:

- Honorary medical staff
- Nursing students
- Medical students
- Allied health students
- Paramedic students
- Military healthcare trainees
- Other healthcare training programme students
- Visiting healthcare professionals involved in direct patient care

It is the responsibility of the training programme co-ordinator/lead to check the results prior to the student commencing clinical care.

MRSA screening undertaken at CHL will be paid for under the IPC budget.

Refer section 3.5 for screening procedure

4.2 Re-screening for healthcare students and other visiting personnel

- Nursing/Midwifery students are re-screened as arranged between the Heads of School of Nursing/Midwifery, Ara Institute and Canterbury and West Coast District Health Board's Infection Prevention and Control Services.
- Medical students are re-screened on return from electives, as arranged through the Christchurch School of Medicine.
- Company representatives who visit the Operating theatre or who have clinical contact as part of their clinical teaching role must submit a MRSA clearance screen to the Infection Prevention and Control Service at six monthly intervals.

4.3 Management of positive pre-employment/placement screen of non-CDHB employees

The CDHB IPC Service does not undertake the decolonisation management of non-CDHB staff (exception is Otago University medical students).

Non-CDHB staff who have a positive pre-placement/employment MRSA screen should seek decolonisation advice from their respective institutions or GP.

The IPC Service provides guidance for external healthcare training organisations to ensure that decolonisation regimes meet the criteria required for clinical placement in a CDHB hospital facility. Contact the IPC Service for advice if required.

Measurement/Evaluation

Staff health records.

ICNet surveillance statistics

References

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7. Guidelines for Tuberculosis Control in New Zealand. 2010. Ministry of Health, Wellington.
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Policy Owner	CDHB Infection Prevention & Control Service
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