

INFECTION PREVENTION AND CONTROL Policy

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PREAMBLE

1. Routine Practices are the Public Health Agency of Canada's (PHAC) minimum standards of infection prevention and control (IPAC) practice to prevent the spread of Microorganisms that cause infection in all health care settings.
2. The need for Additional Precautions (i.e. contact, droplet, and **airborne**) combined with Routine Practices is determined based on the route of spread of Microorganisms that are known or suspected.

POLICY STATEMENTS

1. All Staff must follow Routine Practices and Additional Precautions in all health care settings and at all times to reduce the spread of Microorganisms that cause infection to patients, Staff, visitors and volunteers.
2. Clinical Care Providers will complete a Point-of-Care Risk Assessment (PCRA) before any interaction with patients or their environments.
3. Clinical Care Providers will implement Airborne Precautions based on results of a PCRA. IPAC must be notified. A confirmed infectious diagnosis is not necessary. Refer to the [Disease Index/Transmission Based Summary Table](#) for guidance on routes of transmission and type of precautions to be utilized.
4. Airborne Precautions must only be discontinued in consultation with IPAC.
5. Airborne Precautions must be communicated to all members of the health care team providing care, and upon transfer of the patient to receiving unit/department/ facility or Emergency Health Services (EHS).
6. When initiating Airborne Precautions for suspected outbreak situations, IPAC or the Administrator for the facility (after hours) must be notified. Refer to policy IPC-CD-001 [Outbreak Management](#).
7. The first person to suspect/identify a notifiable disease or condition must notify public Health per "[It's the Law Reporting Notifiable Diseases and Conditions](#)".
8. Environmental controls such as: Personal Protective Equipment (PPE), accommodations, and additional environmental cleaning must be put in place for all patients requiring Additional Precautions.

CLINICAL PRACTICE GUIDELINES

1. Source Control
 - 1.1 Place Airborne Precautions notification in/on the patient's health care record as per facility protocol and document usage in the health care record.
2. Patient Accommodation, Placement and Flow
 - 2.1 Place patients suspected of having an airborne Infection directly into an Airborne Infection Isolation Room (AIIR) with the doors and windows

closed. See [Appendix B](#) for Airborne Infection Isolation Rooms in NSHA. These are sometimes referred to as Negative Pressure rooms

- 2.2 The AIIR should have an in-room toilet, sink and bathing facility for the patient.
- 2.3 Arrange for dialysis patients to receive dialysis in an AIIR.
- 2.4 Arrange for patients with suspect/confirmed pulmonary/laryngeal tuberculosis or emerging respiratory Infections who require bronchoscopy to have the procedure done and be recovered in an AIIR. See [Appendix E](#) for more detail.
- 2.5 Ensure pressure differentials are checked using visual indicators (smoke tubes or flutter strips) or portable manometers if a centralized monitoring system is not available. Contact Engineering Services to check pressure differentials:
 - 2.5.1 **Prior** to placing a patient requiring Airborne Precautions in an AIIR
 - 2.5.2 **Daily** when the room is being used for Airborne Precautions.
- 2.6 Engineering Services must make every effort notify the IPAC department (or after hours – the on-call Administrator for the facility) if the room’s Negative Pressure falls outside the standard values for the maintenance of Negative Pressure as per Canadian Standards Association (CSA) (HVAC Z317.2) standards.
- 2.7 If an AIIR is unavailable:
 - 2.7.1 Place the patient in a single room, with dedicated toileting facilities;
 - 2.7.2 Ensure the patient keeps a surgical mask on;
 - 2.7.3 Keep the doors and windows closed and
 - 2.7.4 Arrange for transfer of the patient to a unit/facility with an available AIIR as soon as medically stable for transport.
- 2.8 Cohorting must only be done in consultation with IPAC.
- 2.9 Place an Airborne Precautions sign on the patient’s door and any other additional areas as per the facilities procedures.
- 2.10 Patient Transport:
 - 2.10.1 Patients on Airborne Precautions are to leave their room for medically essential purposes only.
 - 2.10.2 Place a surgical mask on the patient (if tolerated) when patient leaves the room. Allow the patient to remove the mask once in an AIIR. Patients do not wear respirators (N95).

- 2.10.3 If the patient must be transported and cannot wear a surgical mask, plan the transport to limit the exposure of other individuals (i.e. no waiting in the reception areas.)
- 2.10.4 Control access to elevator while in use for patient on Airborne Precautions (i.e. do not allow other people to travel on the same elevator with the patient and transport Staff).
- 2.10.5 Schedule tests and procedures to minimize exposure risk to others.
- 2.10.6 Staff must wear a N95 respirator for transport of patients on Airborne Precautions. Respirator is not required if the patient diagnosis is measles or varicella and the transporting Staff have documented immunity.
- 2.10.7 Advise the receiving area that the patient requires Airborne Precautions.

3. Personal Protective Equipment (PPE)

- 3.1 Provide a supply of PPE outside the room.
- 3.2 Wear an N95 respirator when:
 - 3.2.1 There is a suspicion/confirmation of airborne infection.
 - 3.2.2 Irrigating tuberculosis sites or wounds (may cause aerosols).
 - 3.2.3 Performing or assisting with Aerosol Generating Medical Procedures (AGMP) on patients with signs and symptoms of severe acute respiratory syndrome (SARS), tuberculosis, or other emerging respiratory infections. Refer to [Appendix D](#)- Strategies to Reduce Aerosol Exposure When Performing Aerosol-Generating Medical Procedures (AGMP).

Exception to respirator mask: health care workers who have documented immunity to varicella and rubeola (measles) can enter rooms of patients with these infections without a mask.

- 3.3 Fit Testing of health care workers for respirators is required by law every 2 years to ensure the respirator make and model fits the wearer without leakage around the facial seal. Health care workers are to use only those respirators for which they have been Fit Tested.
- 3.4 Health care workers are recommended to remain clean shaven in area of the respirator seal to ensure facial seal.
- 3.5 Change the N95 respirator whenever it is damp or soiled.

Note: N95 respirators are a single use item. They are discarded immediately after use- when removed from the face.

- 3.6 When leaving the room, close the door, clean hands, remove the N95 Respirator outside the room, discard immediately into a dedicated garbage receptacle, and clean your hands again.
4. Management of the Patient Care Environment:
 - 4.1 Place a laundry hamper in the single room as close to the exit door as possible or at the bedside of patients in shared accommodations.
 - 4.2 Special handling of linen is not indicated.
 - 4.3 Place a waste receptacle inside the patient room close to the door for PPE disposal.
 - 4.4 Patient Care Equipment:
 - 4.4.1 Where possible, provide single use disposable or dedicated equipment for the patient. If disposable or dedicated equipment is not possible, clean and disinfect between patients as per Routine Practices.
 - 4.5 Cleaning of the Patient Care Environment:
 - 4.5.1 When precautions are discontinued or the patient is moved, terminal cleaning and disinfecting of room/bedspace, bathroom and changing of privacy curtains must be done.
 - 4.5.2 Keep the Airborne Precaution sign in place following discharge/transfer of the patient.
 - 4.5.3 Keep the doors and windows closed.
 - 4.5.4 Room must remain closed for the required amount of time to clear airborne particles, prior to Staff entering without a N-95 Respirator or for use by another patient.
 - 4.5.5 The length of time is dependent on the level of ventilation in the room, expressed as air changes per hour (ACH). See [Appendix C](#). Contact Engineering Services to ascertain the number of ACH.
 - 4.6 Contact IPAC for further information/direction.
5. Patient/Family/Visitors Education:
 - 5.1 Educate patients, their visitors, families, and caretakers about the Airborne Precautions being used, the duration, as well as the prevention of Airborne Transmission of infection to others. Document education provided in the health care record.

- 5.2 Instruct visitors to wear the same PPE as health care providers unless it is determined the visitor already has had prolonged exposure to the patient or if immune to the specific disease/condition for which the patient is on Airborne Precautions. (e.g. patient has TB and family has already had exposure and is determined not to be infectious). The medical team and IPAC may need to be consulted to assist in this determination.

6. Management of Visitors:

- 6.1 If patient is on Airborne Precautions, visitors should be limited to members of the person's household. Visitors should be instructed to speak with a nurse before entering the patient room.

7. Intubated and Ventilated patients:

- 7.1 Ensure a bacterial filter is on the endotracheal tube to prevent Contamination of the ventilator and the ambient air.
- 7.2 Perform endotracheal suctioning using a closed suction apparatus.

8. Operating Room:

- 8.1 Postpone elective procedures until the patient is non-infectious.
- 8.2 If surgery is required while on precautions, book procedures at the end of the day's schedule, if possible. Room will require appropriate time for recommended air exchanges as per [Appendix C](#).
- 8.3 Patients will be recovered in an AIIR.

9. Duration of Precautions:

- 9.1 Always consult the IPAC department before discontinuing Airborne Precautions

Note: Duration of precautions varies according to the extent or stage of the disease and the treatment received.

10. Discharge/Transfer (and Terminal Cleaning):

- 10.1 Keep the Airborne Precautions sign in place following discharge/transfer of a patient on Airborne Precautions.
- 10.2 Keep the doors and windows closed.
- 10.3 Sufficient time should be allowed for the air to be free of airborne Microorganisms. The length of time is dependent on the level of ventilation in the room, expressed as air changes per hour (ACH). See [Appendix C](#).
- 10.4 If entering the room during these respective time periods, wear an N95 Respirator (inclusive of Environmental services Staff performing the terminal clean).

11. Handling of Deceased Bodies:

- 11.1 Use Airborne Precautions while in the patient room until appropriate time has elapsed to remove airborne contaminants i.e. performing post mortem care.

12. Modifications to Airborne Precautions in Long-Term Care:

- 12.1 Airborne Precautions should be followed as above.

13. Modifications of Airborne Precautions for Ambulatory Care/Primary Care/Outpatient settings:

- 13.1 If notified that the patient has an airborne illness, schedule the visit at a time to minimize exposure of other patients (such as at the end of the day).
- 13.2 Direct patients with suspected airborne infection to put a surgical mask on upon entry to the facility.
- 13.3 Place patients known or suspected to have airborne infection directly into an AIIR (if available). The patient not required to wear a mask while in room.
- 13.4 If AIIR not available, place the patient into a single room; ensure the patient keeps the surgical mask on and the door remains closed.
- 13.5 Upon discharge, allow sufficient time for the air changes before using the room for another patient.

14. Modifications of Airborne Precautions for Home Care:

- 14.1 Develop a system to screen patients and family members prior to home care visits to identify patients or family members with known or suspected Infection that requires Airborne Precautions (e.g. infectious tuberculosis, measles, varicella or Disseminated Herpes Zoster).

Note: Home care agencies consult with Public Health to determine if the patient is infectious for pulmonary/laryngeal tuberculosis and requires Airborne.

DISEASE INDEX/TRANSMISSION BASED SUMMARY TABLE

[Annapolis Valley](#)

[Cape Breton](#)

[Central Zone](#)

[Guyborough Antigonish Strait](#)

[Colchester](#)

[Cumberland](#)

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[South Shore](#)

[South West](#)

REFERENCES

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RELATED DOCUMENTS

Learning Module

[Routine Practices and Additional Precautions](#)

Policies

[IPC-CD-001 Outbreak Management](#)

[IPC-RP-001 Routine Practices and Additional Precautions](#)

[IPC-RP-005 Routine Practices](#)

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[IPC-RP-010 Contact Precautions](#)

[IPC-RP-015 Droplet Precautions](#)

Patient Teaching Pamphlet

NSHA Preventing the Spread of Infections- Routine Practices and Additional Precautions

[Replacing the Following District Health Authority Policies/Version History](#)

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Appendix A - Definitions

Additional Precautions	Further precautions based on the method of transmission (i.e. contact, droplet, airborne) that are necessary when routine practices alone may not be enough to interrupt transmission of an infectious agent.
Aerosol- Generating Medical Procedures (AGMP):	<p>Any procedure carried out on a patient that can induce the production of aerosols of various sizes, including droplet nuclei. Examples:</p> <ul style="list-style-type: none">• Bronchoscopy procedures• Non-invasive positive pressure ventilation (BIPAP, CPAP)• Endotracheal intubation• Respiratory/airway suctioning• High-frequency oscillatory ventilation• Tracheostomy care• Chest physiotherapy• Aerosolized or nebulized medication administration• Diagnostic sputum induction
Airborne Infection Isolation Room (AIIR)	An airborne isolation room (also referred to as a negative pressure room- definition below) is a single room used to isolate persons with suspicious or confirmed airborne infectious diseases.
Airborne Precautions	Used in addition to routine practices when a patient has or is suspected of having an illness transmitted by small airborne droplet nuclei that remain suspended in air and may be inhaled by others (e.g. tuberculosis).
Airborne Transmission	Airborne transmission: occurs when airborne particles remain suspended in the air, travel on air currents and are then inhaled by others who are nearby or who may be some distance away from the source patient, in a different room or ward (depending on air currents) or in the same room that the patient has left, if there have been insufficient air changes. Control of airborne transmission requires control of air flow through

special ventilation systems and the use of respiratory protection.

Clinical Care Provider	Any person who delivers clinical care to a client, patient or resident.
Contamination	The presence of an infectious agent on hands or a surface. This may include: clothing, bedside items or equipment, medical or surgical instruments, or other inanimate objects
Disseminated Herpes Zoster	Rash can be more widespread and affect three or more dermatomes. This condition is called, disseminated zoster. This generally occurs in people with compromised or suppressed immune systems. (CDC, 2014).
Fit Testing	Tests the seal between the respirators face piece and your face.
Infection	Entry and multiplication of an infectious agent in the tissues of a host leading to a response from the host's immune system. Infection may or may not lead to clinical disease.
Microorganisms	A bacteria, virus, fungi, protozoan, or prion capable of causing diseases (infection) in a source or a host.
N-95 Respirator	Disposable, respiratory protective device that filters inspired air of particles greater than or equal to 1 micron in size with a filter efficiency of greater than 95%, and provides a tight facial seal.
Negative Pressure	The volume of air exhausted from the room is greater than the volume being drawn in. The pressure in the room is less than that of surrounding areas. Therefore, air is drawn into the room and does not escape into the hallway or adjacent areas. With negative pressure, air should be exhausted directly to the outside. Negative pressure is created in order to contain contaminated airborne particles.
Patient Care Environment	Area in close proximity to the patient including objects and surfaces (e.g. bedside table, IV pole, chairs, etc.).

Personal Protective Equipment (PPE)	Clothing or equipment used for protection against hazards (e.g. masks, N95 respirators, gowns, gloves, eye protection).
Point of Care Risk Assessment	An activity where clinical care providers evaluate the likelihood of exposure to an infectious agent for a specific interaction, with a specific patient, in a specific environment, under available conditions and choose the appropriate actions/PPE needed to minimize exposure.
Routine Practices	Routine practices are infection prevention and control (IPAC) practices for use in the routine care of all patients at all times in all healthcare settings and are determined by the circumstances of the patient, the environment and the task to be performed
Staff	Unless specifically limited in a specific Policy, refers to all employees, physicians, learners, volunteers, board members, contractors, contract workers, franchise employees, and other individuals performing work activities within the NSHA.

Appendix B - Airborne Isolation Rooms NSHA

Central Zone			
Halifax Infirmary (HI)			
Location	Room #	Location	Room #
3 IMCU	3625	Recovery	5614
3 IMCU	3628	6.2	6214
Emergency	3675	CCU	6863
Emergency	3682	7.1	7114
Emergency	3615	7.2	7214
Minor Procedures	4541	Dialysis	1217
Minor Procedures (recovery)	4539	7.3	7334
4.1	4114	7.4	7414
4.2	4214	8.1	8114
5.1	5104	8.2	8214
5.2	5206	8.3	8314
HI Recovery	5438	8.4	8414
6.1	6134		
Victoria General (VG)			
Location	Room #	Location	Room #
MSICU	2057	MSICU	2063
Dartmouth General (DGH)			
Location	Room #	Location	Room #
Emergency	2832	Dialysis	1222
Cobequid			
Location	Room #	Location	Room #
Cobequid ED	2046	Cobequid ED	2064
Northern Zone			
Aberdeen Regional Hospital			

Location	Room #	Location	Room #
Fifth floor (ALC unit)	524	ICU	Bed 7
Fourth floor Medical unit	424	Ortho/Oncology day unit	286 - 1
Fourth floor Surgical unit	483	Maternal Child unit	183
Fourth floor Surgical unit	459		
Colchester East Hants Health Centre			
Location	Room #	Location	Room #
Inpatient Psychiatry	D1-731	Medical Specialty Unit	E3-814
Inpatient Psychiatry	D1-730	Medical Specialty Unit	E3-822
Women and Children's Unit	D2-712	Medical Specialty Unit	E3-823
Medical Unit	D3-718	Emergency Department	C1-322
Medical Unit	D3-707	Emergency Department	C1-321
Medical Unit	D3-706	Intensive Care Unit	C2-317
Medical Surgical Unit	E2-818	Intensive Care Unit	C2-314
Medical Surgical Unit	E2-819	Intensive Care Unit	C2-451
Dialysis	A2-041	Endoscopy Procedure Room #1	C2-478
Ambulatory Care	A1-065		

Lillian Fraser Memorial Hospital			
Location	Room #	Location	Room #
	105		
Cumberland Regional Health Care Centre			
Location	Room #	Location	Room #
Emergency department	OBS 5	ICU	Room 159
Medical unit	Room 124	Surgical Unit	Room 220
Medical unit	Room 125		
Western Zone			
Annapolis Valley Health			
Location	Room #	Location	Room #
Medical A unit VRH	213	ER VRH	TRC
Medical A unit VRH	214	ER VRH	CC6
Day Surgery VRH (bronchoscopy room)	Room 3232		
South Shore Health			
Location	Room #	Location	Room #
Mat/Child	4128		
Queens General Hospital			
Location	Room #	Location	Room #
Medical unit	2102	Medical unit	2106
Yarmouth Regional Hospital			
Location	Room #	Location	Room #

ICU	Room 301	Pre-Natal Clinic (not active inpatient Unit)	Room 211
3 South	Room 324		Room 407 (Currently not in Service)
Emergency Department			
Eastern Zone			
Cape Breton Regional			
Location	Room #	Location	Room #
ICU	4	Peds	4190
ICU	5	Peds	4194
CCU	1	Pain Clinic	3029-1 (Exam room 16)
CCU	2	Emergency Department (ED)	22
4A	4113	Emergency Department (ED)	16
4A	4114	Renal Dialysis Unit (RDU)	2431
4D	4165	Renal Dialysis Unit (RDU)	2461
4D	4168		
Northside General			
Location	Room #	Location	Room #
5E	539		

Inverness Consolidated Memorial Hospital			
Location	Room #	Location	Room #
Emergency Department	Non-operational	Renal Dialysis Unit (RDU)	Bed 1
Saint Martha's Regional Hospital			
Location	Room #	Location	Room #
Progressive Care	Room 2239	Renal Dialysis Unit (RDU)	Isolation Room #10
Day Surgery	Isolation Room #4	Emergency Department (ED)	Room #10

Appendix C - Time (in minutes) Required for Removal of Airborne Microorganisms based on Air Changes per Hour

Air Changes per hour (ACH)	Time (in minutes) required for removal of airborne microorganisms	
	99% Removal	99.9% Removal
2	138	207
4	69	104
6	46	69
12	23	35
15	18	28
20	14	21
50	6	8

Canadian Tuberculosis Standards (7th Edition). February 2014. Page 383

Example:

- General patient care/non-isolation rooms have 2-6 air changes per hour.
- You would use 2 air changes per hour (ACH) to calculate unless you know an exact number of ACH.
- You would need to leave the room closed for 207 minutes (approx. 3 hours and 30 minutes) to remove 99.9% of microorganisms before utilizing for a new patient.

Appendix D - Strategies to Reduce Aerosol Exposure When Performing Aerosol-Generating Medical Procedures (AGMP)

Apply the following strategies to reduce the level of aerosol exposure when performing AGMP for patients **with suspected or confirmed severe acute respiratory syndrome (SARS), tuberculosis and emerging respiratory infections.**

1. Limit AGMP to those that are medically necessary.
2. Anticipate and plan for AGMP.
3. Use appropriate patient sedation.
4. Limit the number of staff in the room when AGMP are performed.
5. Perform AGMP in airborne infection isolation rooms whenever feasible.
6. Maintain negative pressure.
7. Use single rooms (with the door closed and away from high risk patients if feasible), in settings where airborne infection isolation rooms are unavailable.
8. Ensure N95 respirators are worn by all staff present in the room during the procedure.
9. Use closed endotracheal suction systems wherever possible.

Note: When responding to a code (cardiac arrest) on a patient with an airborne infection who is not in an airborne infection isolation room, and if transfer to a single room or airborne infection isolation room is not feasible, pull the privacy curtain and ensure all staff in the room or within the privacy curtain area are wearing appropriate PPE. Remove visitors and other patients (if feasible).

Reference: Public Health Agency of Canada (2012). Routine Practices and Additional Precautions for Preventing the Transmission of Infection in Healthcare Settings.

Appendix E - Bronchoscopy in Suspect or Confirmed Pulmonary/Laryngeal TB patients (In-patients and Outpatients)

1. A patient with a diagnosis of suspected/confirmed pulmonary/laryngeal TB requiring bronchoscopy, must always be treated and recovered in an airborne isolation room and placed on Airborne Precautions in addition to Routine Practices.
 - 1.1. The booking physician notifies the Procedural department of the patient's status prior to the patient's arrival.
 - 1.2. On arrival to the Procedure area, place the patient in an airborne isolation room immediately.
 - 1.3. Place an Airborne Precaution sign on the door.
 - 1.4. Have the patient wear a surgical mask when travelling to and from the procedure area.
2. The patient must remain in the airborne infection isolation room until coughing has subsided and recovery is complete.
 - 2.1. Provide the patient with an adequate supply of tissues and instruct him/her in cough etiquette and proper disposal of the soiled tissues.
3. Complete cleaning and high level disinfection of the bronchoscope as per the recommended cleaning and disinfection procedures.

Bronchoscopy in Suspect or Confirmed Pulmonary/Laryngeal TB patients (In-patients and Outpatients)

District Health Authority Policies Being Replaced

Annapolis Valley

282.006 Routine Practices and Additional Precautions

Cape Breton

IC-I-30 Airborne Infection Precautions

Capital Health

IC 04-010 Airborne Infection Precautions

Colchester East Hants

115-003 Isolation and Precaution Guidelines

Guysborough Antigonish Strait

3-05 Additional Precautions- Airborne and Droplet

3-06 Additional Precautions & Patient Transportation

Pictou County Health

9-r-20 Routine Practices & Isolation Precautions

South Shore Health

IC-210-001 Infection Prevention and Control: Routine Practices and Additional Precautions

South West Health

600.115.1 Isolation Precautions Initiation and Discontinuing

Version History

Major Revisions (e.g. Standard 4 year review)	Minor Revisions (e.g. spelling correction, wording changes, etc.)
New to NSHA 2017-08-08	