# 3.0 Infection Control

## Table of Contents

# 3.1 Preface

Most hearing healthcare providers receive limited, if any, infection control education during their training. Yet, as health care providers, we are exposed to risks, and expose our patients to potential risks each time we treat a patient or repair a hearing aid. HearPO is committed to comprehensive quality care by its providers including infection control. Enclosed you will find clear, descriptive guidelines for safeguarding your practice, your patients and yourself.

For additional information, questions, or suggestions applicable to HearPO's Infection Control Program, contact Director of Professional Relations at 1-800-920-4327 ~~extension 4205~~.

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# 3.2 Introduction

In the early 1980s, Human Immunodeficiency Virus (HIV-1) was identified as the cause of Acquired Immune Deficiency Syndrome (AIDS) and the concern over potential cross infection of healthcare professionals and patients became a catalyst for change across the healthcare field. This concern resulted in regulatory bodies, particularly the Occupational Safety and Health Administration (OSHA), enacting regulations that would provide healthcare employers and workers with guidelines on how to reduce the risk of being exposed to harmful, contagious diseases. It should be noted that while AIDS was the catalyst, the concept of infection control is significantly more comprehensive. That is, infection control deals with reducing the transmission of and exposure to all infectious diseases, from the common cold to tuberculosis and from cold sores to the Hepatitis B virus. All healthcare providers, must be diligent in their efforts to control the spread of infectious diseases within the context of their practice.

Hearing healthcare providers must take infection control particularly seriously for the following reasons:

- The patient population most often seen by a hearing healthcare provider is usually quite young or elderly. These patient groups, particularly the elderly, often include members with compromised immune systems, due in part to age, pharmaceutical preparations or underlying disease such as diabetes. Each patient's resistance capabilities are different from the next. For example, microorganisms that do not pose problems for the clinician or the first patient of the morning can, nevertheless, cause all sorts of problems for the second patient if that patient's resistance is compromised.

- The nature of hearing or otoscopic examination requires that the provider make contact with the patient and use objects like headphones, probe tips or specula that may contact several patients. Each contact — whether it is direct contact by touching or indirect with an object or surface — is an opportunity to spread organisms that may cause infection or disease. Simple, routine acts such as handling earmolds or hearing aids can put provider and subsequent patients at risk, particularly if the patient's immune system is compromised.

- As the hearing healthcare profession expands its scope of practice to include such procedures that can increase the potential for exposure to bodily fluids such as blood, mucous (drainage) or cerumen contaminated with either or both, there is increased risk of exposure to blood-borne pathogens such as HIV or hepatitis, as well. Also, providers will from time to time be asked to work with AIDS patients due to hearing changes attributable to AIDS, or the medications used to treat it. The risk of acquiring HIV from a patient via the administration of hearing services is very low. However, great care should be exercised to protect both patient and provider from opportunistic infections that may arise as a result of the AIDS patient's compromised immune system and, therefore, increased vulnerability.

Infection control is defined as, *"An organized effort to manage one's environment to minimize exposure to microorganisms that may make you or your patients sick."* (Kemp, Roeser, Pearson, Ballachanda, 1995.)

Regardless of the type of germ — bacteria, fungus, or virus — the goal is the same: *reduce or eliminate those opportunities for transmission of microorganisms from person-to-person.* Every provider should understand how individuals are exposed to microbes, what occurs during exposure, and how to reduce the potential for contact and transmission.

# How Microbes Are Transmitted

Two aspects of microbial transmission are critical. First, in order for transmission to occur, a vehicle (mode) of transmission must be available. In other words, the germ must find a way to get from where it is to where you are. Second, microbes must normally locate a cut, nick, body opening or other entrance (route) for their transmission.

# Modes of Transmission

There are 4 main modes of transmission. These are: **Contact, Vehicle, Airborne, and Vector borne.**

**1. Contact** transmission is the most important and frequent means of transmission in the healthcare setting. Contact transmission can be divided into three subgroups: **Direct Contact, Indirect Contact, and Droplet Contact.**

- **Direct Contact** – Involves the direct, physical transfer of organisms between a susceptible host and an infected or colonized person. In the context of hearing health, direct contact transmission would occur when the provider touches the patient's ear with an unwashed (colonized) hand. Organisms on the provider's hand would quickly be transferred to the patient's (host) ear.

- **Indirect Contact –** Involves personal contact of the susceptible host with a contaminated, intermediate object that is usually inanimate, e.g., instruments, specula, hearing aid, earmolds, probe tips, probe microphone tubes or surfaces.

- **Droplet Contact** – As we talk, breathe cough or sneeze, droplets of moisture are expelled from our respiratory tract. These droplets carry microorganisms which are then "caught" by the mucous membrane linings of the susceptible hosts' eyelids, nose and mouth. Droplet transmission is a problem in hearing healthcare because the provider is often very close to the patient's face, for example, during an otoscopic examination.

2. **Vehicle** transmission applies to diseases transmitted by contaminated items:
    - Food, such as in salmonellosis.
    - Water, such as legionellosis.
    - Blood or body substances such as Hepatitis B or HIV.

It should be noted that while cerumen is not typically considered an infectious body substance per se, it may become infectious if the cerumen is contaminated by blood, mucous (drainage) or other bodily fluids or substances. Because of its color and viscosity, it is difficult to determine by visual inspection if cerumen is contaminated with blood (particularly, dried blood) or mucous. Consequently, cerumen and objects contaminated with cerumen should be handled very carefully and hands thoroughly washed afterward.

3. **Airborne** transmission occurs by dissemination of either droplet nuclei (residue of evaporated droplets that may remain suspended in the air for long periods of time), or dust particles in the air containing the infectious agents. These organisms can be widely dispersed by air currents before being inhaled by or deposited on the susceptible host.

Airborne contamination is constantly showering surfaces and uncovered objects, thereby contributing to indirect contact transmission. Besides normal airborne contamination, providers should be aware of situations that increase their risk of exposure to airborne contaminants. For example, working with a buffer or grinder casts microorganisms into the air that can be inhaled, or land in eyes, noses or mouths.

4. **Vector borne** transmission is when an animal or insect carries the pathogen and infects the susceptible host.

A good infection control program attempts to block these modes of transmission. For example, to block a great deal of **direct contact** transmission, a provider will carefully wash his/her hands between patients. To control **indirect contact**, objects like specula and probe tips will be disinfected or disposed of between patient contacts.

(Adapted from Infection Control for the Professions of Audiology and Speech Language Pathology, Kemp R.J., Roeser R.J., Pearson M.S., Ballachanda B.P., Iles Publications: 1995.)

| DISEASE | AGENT | POTENTIAL TRANSMISSION DANGER | INCUBATION PERIOD | POTENTIAL OUTCOME |
|---|---|---|---|---|
| **Acquired Immune Defiency Syndrome (AIDS)** | Virus | Blood to Blood contact. Blood enters via something as simple as chapped hands. | Average 8 years | Death |
| **Chicken pox** | Virus | Blood, saliva or mucous (ear drainage);provide therapy for infected, sub-clinical child. | 10-21 days | conjunctivitis, shingles, encephalitis |
| **Common cold** | Virus | Blood, saliva, mucous; infected patient sneezes on counter. Receptionist touches counter, touches nose, then breathes on others in the office. | 48-72 hours | temporary disability |
| **Cytomegalovirus** | Virus | Blood, saliva, mucous; handling toys that infected child put in mouth. | 2-8 weeks | Birth defects, death |
| **Hepatitis A** | Virus | Oral, fecal; failure to wash hands after using restroom. | 2-7 weeks | Disability, liver damage |
| **Hepatitis B** | Virus | Blood, saliva, mucous; microparticles of cerumen containing dried blood lands in eyes or are inhaled while cleaning hearing aid. | 6 weeks -6 months | chronic carrier, chronic disability, death |
| **Herpes zoster (Shingles)** | Virus | Blood, saliva, mucous; Make contact with vesicle (blister). | 6-10 weeks | Disability |
| **Infectious mononucleosis** | Virus | Blood, saliva, mucous; contact with infected's saliva or ear drainage. | 4-7 weeks | temporary disability |
| **Infectious meningitis** | Virus or bacteria | Blood, saliva, mucous; contact with infected's saliva, or ear drainage. | 2-10 days | temporary disability |
| **Influenza** | Virus | Saliva, mucous, respiratory droplets (moisture particles from the lungs); provide service for infected patient. | 1-3 days | temporary disability, death |
| **Legionellosis** | Bacteria | Respiratory droplets; otoscopic examination requires that practitioner's face comes close to patient's face. | 2-10 days | temporary disability, death |
| **Measles (German) Measles (Rubella)** | Virus | Saliva, mucous; Contact saliva or drainage of infected. | 9-11 days | congenital defects, temporary disability, encephalitis |
| **Mumps** | Virus | Respiratory droplets. | 14-25 days | temporary disability, sterility (men) |
| **Otitis externa** | Bacteria fungus | Saliva, mucous, blood, contact with microbes; handle ITEs with bare hands, transferring fungus or bacteria from one patient to the next. | | itching, pain, swelling |
| **Pediculosis (head lice)** | Lice | Lice transported from scalp via combs and hats; head phones could potentially transfer lice from child to child. | eggs hatch in 7-10 days | temporary discomfort, itching and scratching |
| **Pneumonia** | Virus Bacteria | Blood, respiratory droplets. | varies with organism | temporary disability, death |
| **Staphylococcus infection** | Bacteria | Saliva, mucous, contact with staph colony; audiologist handles ear mold or speculum prior to Disinfecting. | 4-10 days | skin lesions, death |
| **Streptococcus Infection** | Bacteria | Saliva, blood, mucous, respiratory droplets; same as above. | 1-3 days | heart and kidney problems, death |
| **Tuberculosis** | Bacteria | Respiratory droplets, saliva. | up to 6 months | disability, death |

# 3.3 Infection Control Procedures

Infection control in any setting revolves around controlling exposure between people and the environment in which they work. This section includes specific recommendations and protocols that you can incorporate into your own infection control plan. Keep in mind that there is no one correct infection control plan. Rather, these procedures can be useful if you adapt them to your particular practice. These recommendations and their corresponding protocols are divided into two groups:

- Procedures designed to control exposure from the environment.
- Procedures designed to protect the provider and patient from human sources of infection.

## Environmental Infection Control and General Housekeeping Practices

Environmental infection control requires cleaning, disinfecting and sometimes sterilizing items or surfaces that are reused. These terms are not arbitrarily selected to describe products or procedures. Rather, each term has a specific legal meaning as defined by the Environmental Protection Agency (EPA). It is important to understand the differences between these terms. For example, a product that only cleans cannot be called a disinfectant; likewise, a disinfectant cannot be called a sterilant, unless it has been demonstrated to meet the legal requirements of a sterilant.

### Cleaning

Cleaning means that gross contamination is removed but germs are not necessarily killed. Cleaning is an important precursor to disinfecting or sterilizing because gross contamination must first be removed before these procedures will be effective.

### Disinfection

Disinfection means killing germs. There are various levels of disinfection depending on how many and which germs are killed. There are many brands of sprays, wipes, and ultrasonic solutions available for disinfection. For example, there are household disinfectants that kill a very limited number of germs and hospital grade disinfectants that kill a wide variety of microbes. In healthcare settings, the use of *hospital grade* disinfectants is recommended.

## Sterilization

Sterilization means killing 100-percent of vegetative microorganisms and their endospores, 100-percent of the time. When challenged, many microbes, will revert to a spore form of life that is much more resistant than the vegetative form. If the spore is not killed, it may become vegetative again and cause disease. The best sterilization technique is heat under pressure in an autoclave. Unfortunately most implements used by hearing healthcare providers would melt in such sterilizers. Also, these chambers are quite expensive to buy and maintain. Consequently, "cold sterilization" with chemicals may work best for hearing healthcare providers. Cold sterilization is accomplished by soaking instruments in 2% glutaraldehyde (Procide, Wavicide, Cidex) for ten hours; 2% glutaraldehyde is currently the only chemical approved for sterilization. Glutaraldehyde solutions are good for use and re-use for 14 or 28 days, depending on the solution. It is extremely important to investigate the scope and ability of chemical disinfectants prior to use. For example, contrary to popular belief, bleach is a disinfectant — not a sterilant.

## When to Disinfect

Disinfection is acceptable on "non-critical" items, i.e. those items that do not touch blood or other infectious substances. Remember to clean first, then disinfect. Non-critical items in a hearing healthcare setting might include earmolds, ITEs, headphones, specula or any object or surface that is not contaminated with blood, drainage or cerumen that contains either substance. All of these items should be disinfected before handling or re-use, but sterilization is not required.

Surfaces in work areas should be disinfected regularly. Routine disinfection should be performed on repair benches where earmolds and hearing aids are cleaned or patient "touch" surfaces such as the examination chair arm rests, and the reception counter. Headphones should also be disinfected regularly.

Waiting room toys and motivation devices must be disinfected frequently. Toys should be nonporous and easily disinfected. Plastic materials are easier to maintain than painted wood or metal surfaces. Because children invariably place toys in their mouths, great care should be taken when handling objects covered with saliva. Always thoroughly wash hands after contacting a potentially infectious item, or wear gloves while cleaning up.

Research has shown that ordinary objects touched by patients are often contaminated with *staphylococci*, bacteria that can cause serious, sometimes deadly infections. In one study of physicians' stethoscopes, 26 of 29 carried the organism. Research data worldwide confirm that the incidence of infection with resistant strains of staphylococci is rising. Because the organism is spread primarily on the hands of healthcare workers, rates of infection can be cut significantly by infection control measures within offices and other treatment facilities.

### When to Sterilize

Critical items — those that may contact blood or mucous — require sterilization. Cerumen, while not an infectious substance per se, often contains dried blood or drainage. If there is visible blood in or on cerumen, then that cerumen is a potentially infectious substance, and the instruments contacting it must be pre-cleaned and then sterilized. One difficulty is that the nature of cerumen, its color and viscosity, make it very difficult for the clinician to determine whether blood, particularly dried blood, is present. For this reason, instruments like curettes used in cerumen removal, impedance probe tips, and otoscopic specula should be sterilized after use when visibly contaminated with cerumen, ear drainage or blood. Remember to clean first using an ultrasonic cleaner, disinfectant towelette, or cleaning brush, then sterilize the instruments in an autoclave or 2% glutaraldehyde.

## Controlling the Human Source of Infection

### Medical History

If feasible, the availability of a patient's full medical history can assist in reducing potential exposure. For example, identifying a case of *shingles* (Herpes zoster) while taking a medical history would alert the provider to be wary about a strange-looking sore. Identifying a patient taking an anti-coagulant (blood thinner; one brand is Cumodin, the generic name is warfarin), would warn the practitioner of a greater potential for blood. It may be impractical to ascertain medical histories in group settings like schools or industry. Still, when possible, a medical history should be taken.

### Hand Washing

As previously mentioned, hand washing is critical to any infection control program. Ideally, hands should be washed before and after seeing each patient. This sometimes can present a challenge to providers who may not have convenient access to a sink. An anti-microbial "no-rinse" hand wash may be used effectively for this situation. These products are very helpful, and most have an alcohol base which dissipates quickly with no need for drying with a towel. Alcohol is an example of a germicide used both as a disinfectant for skin and inanimate objects. However, other germicides may not serve this dual purpose. It is important to be aware of a germicide's ingredients and properties and whether it is suitable for use on human skin.

When hand washing facilities are used, the skin must be washed by rubbing vigorously to clean hands, wrists and lower forearms. The use of a medical-grade, liquid antibacterial soap that contains emollients to protect the hands from drying out is recommended. Medical-grade, antibacterial soap is gentler than household antibacterial soaps because they are designed for people who wash their hands more frequently than the average person. Bar soap is a great breeding ground for germs and should be avoided.

## Gloves

All audiometric procedures, including hearing screenings performed by hearing healthcare providers, should begin with a thorough inspection of the ear, surrounding facial area and scalp. An otoscopic inspection of the outer ear region and ear canal should be conducted, confirming that the skin is intact and there is no blood or ear drainage present. After completing this inspection, a determination can be made whether gloves are necessary. Gloves should be worn whenever the patient has a draining ear, blood is present, sores or lesions are evident on the ear or scalp, or when a medical history indicates an infectious disease.

Gloves should be worn when the *risk* of encountering infectious substances is high. Gloves are necessary during cerumen management and occasionally while taking real ear measurements. Gloves should be worn when cleaning up spills of infectious waste and while disinfecting a contaminated area. Gloves should be properly disposed of after use with each patient, and hands should be washed immediately after removing gloves. Gloves should be disposed of in the regular trash, unless grossly contaminated with blood or other potentially infectious substance.

## Protective Apparel

Safety glasses and disposable masks are necessary when there is risk of potentially infectious material splashing or splattering, or when either provider or patient is at risk of airborne contamination. Cerumen removal by irrigation may require use of protective apparel if the splash of the irrigation is significant. Also, safety glasses and a mask should be worn when working with a grinding or buffing wheel to reduce the chance of microorganisms and particles of plastic from being inhaled or landing in the eyes. Also, masks should be worn in the presence of tuberculosis patients or immuno-compromised individuals who may be at risk from droplet contact.

## Vaccination

One of the most effective forms of controlling infection is through vaccination. Measles, mumps, rubella, tetanus, influenza, tuberculosis, small pox, polio, pertussis (Whooping Cough), Diphtheria, Hepatitis A and Hepatitis B are all preventable through vaccination. Vaccinations should be seriously considered by hearing healthcare professionals.

## Waste Management

Waste (gloves, wipes, paper towels etc.) contaminated with blood or ear drainage, or cerumen containing blood or ear drainage can be placed in the regular trash, unless the blood or mucous is present in significant amounts. Materials containing significant amounts of blood should be disposed of in impermeable bags labeled with the symbol for biohazard. There is no need for biohazard bags for a little earwax, rather, biohazard bags should be used for large amounts of visible blood and the materials used to clean it up. Such waste should be picked up by a waste hauler licensed for medical waste disposal.

When placing lesser contaminated waste in the regular trash, an attempt should be made to separate it from the rest of the trash to minimize the chance of clean-up personnel making casual contact with it. This can be accomplished by placing the waste in small plastic bags or wrapping it in paper. Any instrument like X-ACTO blades or needles must be disposed of in a “sharps” container that cannot be penetrated and is labeled as a biohazard. Again, these containers are to be handled by a licensed waste disposal company.

# Sources

Breathnach AS, Jenkins DR, Pedler SJ. Stethoscopes as possible vectors of infection by staphylococci. *British Medical Journal* Dec. 19, 1992;305:1573.

Wenzel RP, Nettleman MD, Jones RN, Pfaller MA. Methicillin-resistant staphylococcus aureus: Implications for the 1990s and effective control measures. (Proceedings of conference on nosocomial infections). *American Journal of Medicine* Sept. 16, 1991;91:2215.

# 3.4 Infection Control Protocols

## PROTOCOL #1 - Surface Disinfection

Surface disinfection is a two-step process. *First clean, then disinfect the contaminated surface.* Cleaning removes the gross contamination, disinfection kills the germs. Many products contain a cleaning agent compounded with a disinfectant and, as a result, these products may be used to both clean and disinfect. A fast and effective program of surface disinfection incorporates the following steps:

- Select a hospital-grade, EPA registered, disinfectant/cleaner (Audiologist's Choice® Earmold & ITE Disinfectant/Cleaner, Cavicide®, Audiologist's Choice® AudioWipes™).

- Spray surface with disinfectant/cleaner or wipe with AudioWipes™. Wipe away all gross contamination using a paper towel, or coarse brush if necessary.

- Spray (or wipe) the surface again, this time leaving it wet for the time specified on the label. It is during this dwell time that the germs are killed.

### Disinfecting Objects

Objects like specula, probe tips, etc., can be disinfected with a disinfectant towelette or in an ultrasonic machine if there are several to be disinfected. Objects such as headphones, which cannot be submerged, should be disinfected with a disinfectant towelette. AudioWipes™ that do not contain alcohol are a good choice.

## PROTOCOL #2 - Handling ITEs & Earmolds

Many times during an office visit, a patient removes an ITE or earmold from their ear and places it directly in a provider's or staff member's hand. This practice must be controlled, because the danger of spreading fungal and bacterial infections is extremely high, not to mention that the appliance may be covered with blood or ear drainage. A plan should be implemented to assure that the hearing instrument is disinfected prior to handling. One solution is to wear gloves to receive the aid, but if this seems impractical, try these simple alternatives:

- Receive the hearing aid or earmold in a disinfectant wipe (AudioWipes™, SaniCloth®). Once in the wipe, wipe the aid or earmold. This action will disinfect the hearing aid or earmold.

- Ask the patient to place the appliance in a bowl or a dish; then disinfect it with a wipe. This is an effective way to receive hearing aids or earmolds at the receptionist desk.

- Ask the patient to place the earmold in the ultrasonic cleaner containing a disinfectant solution.

Other things to consider about handling earmolds and ITEs:

- Always wear gloves when cleaning aids on the repair bench. The chance of encountering dried blood or mucous within cerumen found in the sound ports or on the hearing aid is very high.

- Sterilize the picks and probes used to clean the aid when encountering blood, drainage, or cerumen that contains either. Disinfect these tools even when blood, drainage or cerumen that contains either is not found.

- Never use a diagnostic stethoscope on an aid that has not been disinfected properly. Always disinfect the stethoscope using a disinfectant towelette prior to attaching it to another aid.

# PROTOCOL #3 – Office Toys

Office toys almost always end up in children's mouths and are common vectors for passing disease. The following information can be used to help control this problem and insure a safe environment for children:

- Always use nonporous, easily cleaned toys, preferably those that can get wet. This will allow the use of a spray disinfectant, or a disinfectant towelette.
- Disinfect these toys daily or on a routine basis. It is highly probable that the toy was placed in a child's mouth.
- Be careful when handling these toys and be sure to wash your hands thoroughly using an antibacterial soap after touching them. Wearing gloves to pick the toys up would be advisable.
- Replace old, broken, or worn-out toys. Avoid placing stuffed animals, small toys, and non-washable items in environments frequented by young children.

# PROTOCOL # 4 - Sterilization

Instruments that contact blood, ear drainage, or cerumen containing either are *critical* instruments and *must* be sterilized prior to reuse. Remember, gross contamination must be cleaned away first. If using heat sterilization, follow the manufacturer's guidelines. When using chemical sterilization with 2% glutaraldehyde, the following steps are recommended:

- Prepare the solution in a covered, plastic tray which is approved for use with glutaraldehyde. Wear gloves when handling the solution. Do not use glutaraldehyde in an ultrasonic cleaner as this will create fumes.

- Clean the instruments then submerge them. Ten (10) minutes for high level disinfection, ten (10) hours for sterilization.
- Remove instruments and rinse with water or wipe with a disinfectant towelette to remove the residual glutaraldehyde. Allow to air dry.
- Change the solution at least every twenty-eight (28) days or as instructed on the label or sooner if the solution becomes visibly soiled or viscous.

Glutaraldehyde fumes may irritate the eyes and nose, and can cause respiratory problems. Persons who handle the chemical should wear rubber gloves and safety goggles. Good ventilation is necessary in cabinets and rooms where it is stored and where instruments cleaned with it are stored. Be sure to store it in a covered tray.

# PROTOCOL #5 – Hand Washing

The single, most important activity that limits the spread of infectious disease in the office is the regular and thorough washing of the hands. It is important to always wash hands before and after eating, adjusting contact lenses, handling waiting room toys, performing sterilization procedures, applying cosmetics or lip balm, smoking, or handling contaminated earmolds or ITEs.

Always wash your hands after removing gloves, contacting any potential or actual contamination, using the washroom, or completing the day's work. To safeguard against the spread of infectious diseases, follow these guidelines:

- Remove all rings and put them in a safe place away from drains. Microorganisms cannot be eliminated from skin beneath rings and growth is facilitated in warm, moist dark spaces such as exists under rings. Such colonization is a potential risk to the patient and the provider.

- Wash hands before and after each patient. When water is not available use a "no-rinse" antibacterial hand soap. When water is available, use a medical-grade, antibacterial soap containing emollients to protect hands from drying.

- Start the water and apply a liquid antibacterial soap. Lather up the soap, scrubbing your palms, the backs of your hands and up over your wrists onto your forearms for a minimum of ten seconds. Clean all surfaces, especially under fingernails and between fingers.

- Thoroughly rinse off the soap under running water.

- Use a paper towel to blot hands dry. Rubbing with the paper towel chafes the skin.

- Turn off the water using the paper towel — not your clean hand.

- Wash your hands after removing gloves. Use lotion as needed to keep hands from chapping. Avoid petroleum-based lotions, as these negatively affect latex gloves.

# PROTOCOL # 6 - Gloves

Follow these guidelines for proper use of gloves:

- Select latex (or vinyl if you or your patient shows sensitivity to latex) examination gloves making sure that they fit properly. Properly fitted gloves will fit tightly, like a second skin. This is important because loose fitting gloves make for frustration due to a lack of dexterity. This frustration is the main reason people stop wearing gloves.

- Always change gloves between patients. If a glove becomes torn or perforated in any way, replace it.

- If questioned about the use of gloves, explain that gloves are worn to protect patients and to provide the best in modern care. Most people expect gloves to be worn. Most other healthcare professionals wear gloves as a precautionary measure.

- Use the following procedure to remove gloves safely, making sure that the hands do not make contact with potentially infectious material.

    - First, peel off one glove from wrist to fingertip, then grasp it in the gloved hand. Next, using the bared hand, peel off the second glove from the inside, tucking the first glove inside the second glove as it is removed.
    - Wash hands thoroughly when completed.

# 3.5 HearPO Control Guidelines

In order to safeguard against the spread of infectious disease, HearPO providers must establish an Infection Control Program specific to their practice. By implementing an Infection Control Program, the practice will afford a safe environment for both patients and providers.

All HearPO providers must have an Infection Control Program on file. Programs must have protocols including description and frequency for the following:

- Surface disinfection
- Handling hearing aids and earmolds
- Disinfecting waiting room and motivational toys
- Sterilization
- Hand washing
- Use of gloves
- Work area restrictions
- Waste management.

Recommended supplies for an Infection Control Program include:

- Latex exam gloves in appropriate sizes
- Tuberculocidal disinfectant spray
- Tuberculocidal disinfectant wipes
- Ultrasonic machine cleaner/disinfectant concentrate
- Gluaraldehyde for sterilization
- Soaking trays
- Medical-grade, antibacterial liquid hand soap
- No-rinse hand disinfectant
- Safety goggles
- Paper towels
- Plastic bags
- Sealable plastic bags

**For inquiries or additional information, please contact Director of Professional Relations at 1-800-920-4327.**