



Creutzfeldt - Jakob Disease Procedure

Procedure Number

CHC-IC-0050

Version Nos:

3

1. Purpose

This Procedure outlines the steps to be taken to protect West Coast District Health Board (WCDHB) healthcare workers and patients from potential iatrogenic (induced in a patient as a result of medical treatment) and nosocomial transmission of Creutzfeldt - Jakob disease (CJD) from specimens collected from or items used on patients with *known* or *suspected* CJD (see Appendix 1 for definition)

2. Application

This Procedure is to be followed by all Healthcare Staff at West Coast District Health Board

3. Definitions

Creutzfeldt - Jakob Disease (CJD) is rare, degenerative and fatal brain disorder that causes a rapid progressive dementia, visual deterioration and associated pyramidal and extra pyramidal disturbances. The pathogenic agent of CJD is neither a virus nor bacteria but a pathogen consisting of protein known as “prion” defined as “*proteinaceous infectious particle*” Four prion diseases occur in humans: Creutzfeldt – Jakob disease (CJD), Gerstmann-Straussler-Scheinker syndrome, Kuru and Fatal Familial Insomnia.

CJD disease can afflict anyone and affects both men and women of diverse ethnic backgrounds usually between the ages of 50-75 years, but with a new variant form of CJD (v CJD) this has identified a much younger population primarily in the United Kingdom. The incubation period can vary from months to decades but once symptoms develop about 90% of patients die within 6 months. At time of writing the only proven manner for contracting CJD from an infected person has been through iatrogenic transmission, an unintended consequence of a medical procedure using contaminated human matter or surgical instruments. E.g. corneal implants, dura mater grafts, contaminated surgical instruments, implantation of electrodes into the brain, and injection of natural human growth hormone derived from cadaveric patients.

4. Responsibilities

For the purposes of this Procedure:

The **Clinical Nurse Specialist - Infection Control** is required to:

- oversee all aspects of this Procedure

WCDHB Clinical Staff Members are required to:

- ensure they abide by the requirements of this Procedure;

5. Resources Required

This Procedure requires:

- PPE (Masks, gowns, gloves (nitrile) and protective eyewear)
- Specimen Sealable Containers
- Yellow Infectious Waste Bags
- Single Hospital Room



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6. Process

- 1.00 Standard Precautions are to be utilised for all patients with known or suspected CJD. As with all patients, perform hand hygiene before and after patient contact and when gloves removed. Because CJD-contaminated material can lead to deadly nosocomial transmission, the National Institute of Neurological Disorders and Stroke (NINDS) advises that “the most important safety rule is to avoid self-induced injury from instruments used in the course of examination” It is also recommended to avoid contact between contaminated material and non-intact skin.
- 1.01 Masks, gowns, gloves and protective eyewear should be worn if exposure of mucous membrane or skin to blood or other material that is potentially infectious is anticipated.
- 1.02 A single room is recommended for patients admitted to a WCDHB Health Care Facility.
- 1.03 Blood and Body Fluid may be disposed of in a Sanitary Sewer System. Regulated medical waste (i.e. bulk blood, pathological waste, and sharps) is disposed of in the same manner as other regulated medical waste.
- 1.04 Cleaning of cutlery, plates, cups etc may be handled as normal. There is **NO** evidence that CJD can be transmitted via saliva.
- 1.05 Laundering may be as normal except when contaminated with blood or CSF. Linen and clothes soiled with blood or CSF are to be incinerated.
- 1.06 Blood, tissue or CSF specimens are to be collected into sealable containers. Standard Precautions apply. Container is to be labelled clearly with patient details and risk status.
- 1.07 Ward materials (linen, swabs etc) contaminated with blood, CSF or other bodily wastes should be placed in yellow infectious waste bags and sent for incineration. Needles and other sharp articles should be placed in appropriate biohazard containers for incineration.

2.00 High Risk” Post Mortems

- 2.01 The Auckland & Canterbury District Health Boards are the two national sites for performing “high risk” post mortems examinations including those where CJD is suspected. Cases of suspected CJD are reported to the New Zealand CJD Registry at the Department of Preventive and Social Medicine at the University of Otago.
- 2.02 It is recommended that the deceased patient be placed in a body bag prior to transportation.



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7. Precautions And Considerations

- ➔ Standard Precautions are to be utilised for all patients with known or suspected CJD
- ➔ Blood and Body Fluid may be disposed of in a Sanitary Sewer System.
- ➔ Ward materials (linen, swabs etc) contaminated with blood, CSF or other bodily wastes should be placed in yellow infectious waste bags and sent for incineration.
- ➔ It is unlikely that a post mortem examination would be requested by the clinical team managing the patient without supporting clinical evidence being available from specialist neurologist

8. References

- Yale New Haven Hospital Infection Control Policy (2002)
- World Health Organisation (WHO): The revision of the vCJD Case Definition, 17 May 2001
- Collie, et al. Clinical Radiology 2001;56:726=739
- Ministry of Health New Zealand Advice document March 2010

9. Related Documents

- WCDHB Infection Control Policy and Procedure Manual
- United Kingdom Department of Health: “Transmissible spongiform encephalopathy agents: safe working and the prevention of infection” June 2003
- <http://www.dh.gov.uk/ab/ACDP/TSEguidance/index.htm>
- Australian Government Department of Health and Aging “Infection control guidelines for the prevention of transmission of infectious diseases in the health care setting” part 4 section 31 1995
- <http://www.health.gov.au/internet/main/publishing.nsf/content/icg-guidelines-index.htm>
- CDC Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare settings 2007
- <http://www.cdc.gov/ncidod/dhqp/pdf/isolation2007.pdf>
- Communicable Disease Control Branch IC service South Australia as cited Appendix 1, 1-6 (2004)

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10. Guidelines

These guidelines are taken from the NHS Leicestershire County and Rutland Trust and have been recommended as a reference guide by the New Zealand Ministry of Health in March 2010

These guidelines provide information to reduce the risk of transmission of Transmissible Spongiform Encephalopathy (TSEs), including Creutzfeldt-Jakob disease (CJD) and Variant (v) CJD, from patients suffering from TSE to other patients or staff within the hospital setting and reduce the risk of transmission of TSE agents, including CJD and vCJD, from asymptomatic patients who may be incubating a TSE to other patients or staff within a hospital setting.

The following guideline identifies the principles relating to the identification, treatment and subsequent infection control management of patients with a TSE, their environment and equipment used in their treatment or management.

1.1 Method of transmission

- There is no evidence that TSEs have been, or can be spread from person to person by close contact. However because TSEs are rare diseases about which information is incomplete, it is sensible to apply Standard Precautions when dealing with patients when a diagnosis or differential diagnosis of TSE is being considered
- Although there have been no confirmed cases of transmission to humans as a result of occupation, neurosurgeons and those undertaking post mortems may be at risk. Nerve and Lymphoid tissue from patients with TSE is the only likely source of infection. Therefore the most at risk procedures on known/highly suspected patients are those where the central nervous system or lymphoid tissue is breached. e.g. performing a lumbar puncture, performing neurosurgery, operating on the eye, appendectomy or tonsillectomy.
- Decontamination of instruments used in invasive procedures for patients who may potentially have TSEs **cannot** be achieved by a single passage through an autoclave, as this does not inactivate TSE agents (prions). The Importance of thorough cleaning and physical removal of organic matter from all instruments is emphasised. Washer disinfectors must conform to and be validated against the HTM2030, with an emphasis on ensuring that the machine's cleaning process is effective

1.2 Diagnosis and Treatment

- Diagnosis is usually made clinically; there are currently no widely available laboratory tests for humans TSEs, although the diagnosis can be confirmed by examination of brain tissue after death. Brain biopsy may be used in investigating cases of suspected TSE but may not be definitive in establishing diagnosis.
- There are no proven specific treatment available

1.3 Notification of a Case of CJD or vCJD

- Cases of suspected CJD are reported to the New Zealand CJD Registry at the Department of Preventive and Social Medicine at the University of Otago.
- All suspected or known cases of CJD or vCJD must be faxed on the Notifiable Diseases form to Community and Public Health Greymouth



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- In the event that a patient has been identified as having CJD of any type and it is known or suspected that they have had a surgical /endoscopic procedure the Infection Prevention and Control Team must be notified to instigate follow up investigations.

1.4 General Infection Control Precautions

- It is the responsibility of the Consultant/General Practitioner caring for the patient or carrying out our investigative procedures, to ensure that an assessment to determine risk of TSEs is undertaken (appendix 1)
- Within WCDHB facilities patients are nursed in a single room and Standard Precautions apply.

1.5 Spillages

- All body fluid spillages must be dealt with promptly in accordance with the Cleaning and Disinfectant Policy. **All cleaning tools (including mop heads if used) should be disposed of as clinical waste**

1.6 Specimens

- Biopsy and lumbar puncture samples from patients identified in Appendix 1 should only be carried out by trained staff aware of the hazards involved.
- Blood, biopsy and lumbar puncture samples must be identified as a high-risk specimen and placed into a biohazard bag. When sending these samples to the Laboratory, the Laboratory should be telephoned in advance.

1.7 Endoscopy

- All staff must and should follow Standard Precautions at all times
- A tracking system must be in place that will trace instruments back to all patients who have undergone endoscopic procedure, including flexible endoscopes and associated equipment.
- Invasive Endoscopy procedures where there is potential contamination with lymphoid tissue include:
 - Endoscopy with biopsy
 - Endoscopy and any use of diathermy(e.g. snare polypectomy, sphincterotomy)
 - Endoscopy and dilation – only when a balloon used for dilation is withdrawn back up into the endoscope
 - Endoscopy and argon plasma coagulation
 - Endoscopic ultrasound and biopsy
- At risk patients should have the procedure carried out with the oldest scopes as these will be destroyed
- Flexible endoscopes must be incinerated after use if used on a patient known to have TSE for an invasive endoscopy procedure (as bullet pointed above in 1.7)
- Flexible endoscopes used on patients with suspected TSE for procedures outlined in bullet points above must be manually cleaned, then reprocessed on their own in an automated endoscope reprocessor (AER) then quarantined until the diagnosis has been confirmed or refuted (see appendix 5)
- If confirmed scopes must be incinerated, if refuted they can be reprocessed and re-used.
- The decision to reuse the scope can only be made by the Director of Infection Prevention and Control or Consultant in Communicable Disease Control. (CCDC) there must be documentation in the patient's medical record indicating that the patient is no longer deemed a risk for TSEs prior to decontamination procedures being commenced for equipment reuse.



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- Following the procedure the environment including floors – horizontal surfaces must be decontaminated with Precept.
- Patients identified as high risk for TSEs (haemophilia patients and patients who have received high doses of Intravenous Immunoglobulin) **should not** under-go invasive endoscopic procedures (as outlined in above 1.7 bullet points) unless absolutely necessary.

1.8 Theatres

- An operative procedure should only be performed if there is no reasonable alternative.
- The tracking system in place will trace trays back to all patients who have had a surgical procedure.
- In preparation:
 - The patient should be placed at the end of the list where possible
 - The following staff must be informed of the decision to operate; the CNM theatre, CSD team leader, and the Laboratory.
 - Equipment should be kept to a minimum
 - Only the Minimum number of healthcare personnel required should be involved
- At risk Patients (Appendix1) involving procedures on high to medium risk tissue (Appendix 2)
- The following single use protective wear clothing should be worn and disposed of as clinical waste
 - Liquid repellent operation gown, over a plastic apron
 - Nitrile gloves
 - Mask
 - Goggles or Visor
 - Footwear should be protective (i.e. surgical boots)
 - Maintain a one way flow of instruments
 - Avoid using power-tools wherever possible
 - Use single-use disposable instruments, drapes and equipment where possible (if reusable dispose of as clinical waste)

1.9 Reusable Instruments (High and medium risk tissue)

- In the event of a confirmed diagnosis of TSE all instruments must be incinerated after use.
- Instruments used on patients with suspected TSE must be cleaned then quarantined (Appendix 3 and 4) until the diagnosis have been confirmed or refuted. If confirmed instruments must be incinerated (as above), if refuted they can be reprocessed and re-used.

2.0 Complex Instruments

- Some expensive items of instruments, such as drills, may be prevented from being contaminated by using shields, guards or coverings, so that the entire items do not need to be destroyed. The drill bit, other parts in contact with high-risk tissue and the protective coverings must then be disposed of as infected waste.
- The decision to reuse equipment can only be made by the Director of Infection Prevention and Control or CCDC. There must be documentation in the patients medical record indicating that the patient is no longer deemed a risk for TSE prior to decontamination procedures being commenced for equipment reuse.



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3.0 Maternity

- In the event that an “at risk” patient becomes pregnant, no additional precautions above Standard Precautions need to be taken during the pregnancy or delivery of the baby and placenta.

4.0 Dentistry

- The risks of transmission from dental instruments are thought to be very low provided optimal standards of Infection control and decontamination are maintained.
- Standard Infection Control Precautions must be followed at all times for instruments and staff.
- There is no reason why any at risk patient should be refused dental treatment.

5.0 Care of the Deceased

- The deceased patient must be placed into a body bag prior to transporting to the mortuary and normal procedures for bodies where there is a known infection risk must be followed.
- In all cases, discuss with Consultant Histopathologist, regarding post mortem examination.
- Embalming should be avoided in confirmed or suspect cases.
- The Auckland & Canterbury DHBs are the two national sites for performing “high risk” post mortems examinations, including those where TSE is suspected.
- In the event of a confirmed diagnosis of TSE all instrument must be incinerated after use.

6.0 Education and Training

- The annual Infection Prevention and Control audit programme ensures that a range of infection prevention and control practices are audited in both community and primary care.
- When a specific education or training need is identified, infection control staff will ensure the relevant training and education is made available to the appropriate staff.



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Appendix 1

CATEGORISATION OF PATIENTS BY RISK

Patients should be categorised as follows, in descending order:

1. Symptomatic patients	<p>1.1 Patients who fulfil the diagnostic criteria for definite, probable or possible CJD or vCJD</p> <p>1.2 Patients with neurological disease of unknown aetiology who do not fit the criteria for possible CJD or vCJD, but where the diagnosis is actively considered.</p>
2. Asymptomatic patients at risk from familial forms of CJD linked to genetic mutations	<p>2.1 Individuals who have been shown by specific genetic testing to be at significant risk of developing CJD or other prion disease.</p> <p>2.2 Individuals who have had a blood relative known to have a genetic mutation indicative of familial CJD</p> <p>2.3 Individuals who have or have had two of more blood relatives affected by CJD or other prion disease.</p>
3. Asymptomatic patients identified as potentially at risk due to iatrogenic exposures##	<p>3.1 Recipients of hormone derived from human pituitary glands, <i>e.g.</i> growth hormone, gonadotrophin. In the UK, cadaver-derived human growth hormone was banned in 1985 but use of human-derived products may have continued in other countries.</p> <p>3.2 Individuals who have received a graft of <i>dura mater</i>: (people who underwent neurosurgical procedures or operations for a tumour or cyst of the spine before August 1992 may have received a graft of <i>dura mater</i>, and should be treated as at risk, unless evidence can be provided that <i>dura mater</i> was not used)</p> <p>3.3 Patients who have been contacted as potentially at risk including individuals considered to be ##</p> <p>a) at risk of CJD/vCJD due to exposure to certain instruments used on a patient who went on to develop CJD/vCJD, or was at risk of CJD;</p> <p>b) at risk of vCJD due to receipt of blood components or plasma derivatives;</p> <p>c) at risk of CJD/ vCJD due to receipt of tissues /organs</p> <p>d) at risk of vCJD due to the probability they could have been the source of infection for a patients transfused with their blood who was later found to have vCJD.</p>

##NB: A decision on the inclusion of corneal graft recipients in the “iatrogenic at risk” category is pending completion of a risk assessment (NHS)

** The CJD Incidents Panel, which gives advice to the local team on what action needs to be taken when a patient, who is diagnosed as having, or found to be at risk of , CJD or vCJD, underwent surgery or donated blood, organs or tissues before CJD/vCJD was identified, will identify contacts who are potentially at risk.



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Appendix 2

Tissue Infectivity

vCJD

Tissue Infectivity
High: <ul style="list-style-type: none">• Brain• Spinal Cord• Posterior eye Medium: <ul style="list-style-type: none">• Lymphoid tissue• Anterior eye• Olfactory epithelium

CJD other than variant CJD

Tissue Infectivity
High <ul style="list-style-type: none">• Brain• Spinal Cord• Posterior eye Medium <ul style="list-style-type: none">• Anterior eye• Olfactory epithelium



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Appendix 4

Process for the Quarantining of Surgical and Endoscopic Instruments

ALL STAFF MUST WEAR DISPOSABLE NITRILE GLOVES, A DISPOSABLE IMPERVIOUS /PLASTIC GOWN, A MASK WITH INTEGRAL VISOR

1. After completion of a procedure on a patient with possible TSE, single-use instruments should be separated and disposed of by incineration. Re-usable instrument should be washed to remove gross soil.
2. Care should be taken to avoid splashing and generating aerosols, by holding instruments below the surface of the water in a sink into which water is running and draining continuously. Instruments should not be held directly under a flowing tap, as this is likely to generate splashes.
3. Staff (Operatives) should wear protective gloves and either a visor or goggles, and care must be taken to avoid penetrating injuries.
4. After washing, instruments should be placed on a disposable instrument tray and allowed to air dry.
5. Instruments to be put neatly into a clear plastic bag and folded closed (several bags may be required)
6. These bags will be placed in a yellow container, with the lid clipped in situ. The container is then sealed and placed in a large Biohazard bag before it leaves the theatre area.
7. The container must be labelled with the following details:
 - Patient Details including hospital number
 - Time, date and place of surgery
 - Type of surgery performed
 - List of contents
8. The container will then be placed in the designated safe area for quarantine in SSD/Endoscopy. The instruments will remain in this area until there is a diagnosis of Confirmed TSE; the instrumentation must be sent for incineration at high temperature
9. Negative pathology; the instruments will be decontaminated prior to reuse.
10. Negative and positive diagnosis must be confirmed by the Consultant Medical Microbiologist and Histopathologist prior to the instruments being sent for incineration or reprocessing. The decision to reuse instruments can only be made by the Director of Infection Prevention and Control or the Consultant in Communicable Disease Control. Documentation of the decision making process must be presented to SSD/Endoscopy prior to decontamination procedures being commenced for reuse of equipment.
11. It is the responsibility of the SSD/Endoscopy staff to safely store the quarantined equipment and a record made of the person responsible.
12. All procedures must be documented.



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13. The designated quarantine area will be clearly marked and kept locked at all times and CNM Theatre will hold the key.

Appendix 5

The Process for decontamination for endoscopes following use on a suspected or known CJD patient.

What endoscope should be used?

- When there is no designated endoscope for the patient any endoscope appropriate for the procedure should be decontaminated and prepared as per routine guidelines
- Should the patient be returning for a repeat procedure and have a designated endoscope this should be decontaminated and prepared as per routine guidelines

What precautions should be taken?

- Standard Precautions will be taken during the procedure including the use of PPE
- Any accessories required during the endoscopy process will be single use

What happens after the procedure is completed?

- Following the completion of the procedure the endoscopes will be leak tested and manually cleaned in the designated sink as per unit guidelines
- The sink could be lined with plastic sheeting as an additional precaution
- Any used accessories will be placed in the appropriate Sharps container or yellow clinical waste bag
- Following manual cleaning the scope will be disinfected in an AER and the sink cleaned with a powder sanitizer or precept
- The Sharps bin and yellow clinical waste bag will be closed and put for incineration as per WCDHB policy.
- All linen will be treated as infected linen as per WCDHB policy (Linen and clothes soiled with blood or CSF should be incinerated)

How is the endoscope disinfected?

- Once the manual cleaning process has been completed the endoscope must be disinfected in a AER
- If a single shot disinfectant is not in use in the department then fresh disinfectant must be put into the AER that is to be used for this endoscope
- The endoscope will complete a normal disinfection cycle but with an additional rinse and an alcohol flush. There should be no other equipment in the bath with this endoscope
- The endoscope will be removed from the AER on completion of this process and stored for routine re-use (if no invasive procedure has been carried out) or exclude from routine circulation and quarantined for this nominated patient if an invasive procedure has been performed.
- Following removal of the endoscope from the AER the disinfectant will be disposed of as per company guidelines and replaced by fresh disinfectant.
- The AER will run and empty cycle
- Following this empty cycle the disinfectant will be disposed of and again replaced by fresh disinfectant
- Any drain filter in the machine will be disposed of and replaced
- A self disinfect cycle will then be carried out



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- Following this process the AER is then ready for routine use

Routine Hospital/Nursing Home/Domiciliary Care – Specific Recommendations.

	Group 1 (High Risk)	Group 2 (Low Risk)
Infection Control Policy	All major hospitals should have procedures set in place to identify and manage high risk patients. Standard Precautions must also still apply.	Standard Precautions apply in addition to the extra precautions listed below.
Ward Accommodation	Hospital patients should be accommodated in single rooms.	
Specialist Nursing Requirements.	Isolation and barrier nursing are not required. Staff should, however be fully informed in the precautions required for the different risk groups.	
Eating Utensils	Cleaning of cutlery, plates, cups etc may be handled as normal. There is no evidence that CJD can be transmitted via saliva.	
Bath Towels And Face Washers	Patients should be allocated their own personal face washers and towels. If contaminated with blood, soaking in hypochlorite prior to normal laundering may add an extra margin of safety.	No special requirements. Wash according to normal laundering procedures.
Razors and Toothbrushes.	Razor and toothbrushes must not be shared. Dispose of old blades and brushes by incineration.	Razors and toothbrushes should not be shared.
Laundering of Normal Bed Linen and Clothes	Laundering may be as normal except when contaminated with blood or CSF. Linen and clothes soiled with blood or CSF should be incinerated. For this reason, it is advisable to use single use absorbent sheet covers wherever practical.	Wash linen and clothes according to normal laundering procedures.



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Dentistry – Special Recommendations.

	Group 1 (High Risk)	Group 2 (Low Risk)
Standard Precautions	Adhere to Standard Precautions for all procedures, in addition to extra precautions set out below.	
Single Use Items	Wherever possible, single use items / equipment should be used.	
Staff Clothing	During all dental procedures, staff should wear masks, protective eye-wear, single use gloves and gowns.	
Procedures Involving Blood or Neurovascular Tissue	<p>Instruments contaminated with blood or neurovascular tissue should all be disposed of by incineration.</p> <p>Dental broaches and burns and other items which may have come into contact with blood and neurovascular tissue should also be disposed of by incineration.</p> <p>Continual use of reusable equipment is not advised, therefore reusable equipment should be discarded after use on a Group 1 patient.</p> <p>Contaminated hand pieces should be disposed of after use.</p>	<p>For procedures involving blood and neurovascular tissue, re-usable instruments should only be used when adequate decontamination procedures are available.</p> <p>Instruments may be decontaminated by:</p> <ul style="list-style-type: none"> - Autoclaving at 134°C (30 psi or 203kPa) for 18 minutes (holding time at temperature) or; - Six separate 3 minute cycles (total holding time 18 minutes) at 134°C (30 psi or 203kPa) or; - Soaking in 1-2 NaOH minimum 1 hour (NB only suitable for stainless steel instruments). <p>Use single use equipment wherever possible.</p> <p>Contaminated hand pieces should be autoclaved as above.</p> <p>Broaches, files etc. cannot be cleaned adequately and therefore must be disposed of after single use.</p>



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	Group 1 (High Risk)	Group 2 (Low Risk)
Needles / Syringes	Use single needles, syringes and anaesthetic cartridges only.	Single use needles, syringes and anaesthetic cartridges are recommended. Metal reusable local anaesthetic syringes should be autoclaved as for other stainless steel instruments or soaked in 1-2M NaOH (see above).
Collection of Specimens	Collect into a secure closing container and enclose in a plastic bag. The container must be labelled clearly with patient details and risk status.	Standard Precautions apply.
	Including a CJD risk alert to laboratory / other medical personnel.	
Disposal of Specimens	Disposal of all specimens should be by incineration.	Disposal of other specimens should follow Standard Precautions.
Other Articles used in Procedures	Use of reusable articles is not permitted. Swabs, dressings, linen, needles etc. used during operations must be disposed of by incineration.	Standard Precautions apply for disposal of other waste material.

Body And Blood Fluid Exposure

Follow West Coast DHB procedures, including the completion of the Blood / Serum Body Fluid Contact Report.

When exposure has been to Group 1 patients:

1. Needle sticks injury, contamination of broken skin or bites with exposure to blood, cerebrospinal fluid or tissue (especially brain).
 - Wash wound immediately with copious amounts of warm water, followed by irrigation with 0.5% sodium hypochlorite (1ml of Milton solution and 1ml of water). Milton; 1% sodium hypochlorite available in the Pharmacy / Emergency Drug Cupboard.
2. Mucous membrane contact, eg. Splashes into eye of blood / CSF.
 - Institute normal eye washing procedures with warm water.
3. Contamination of unbroken skin
 - Wash skin using detergent and copious amounts of warm water.
 - Avoid vigorous scrubbing.

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General Infection Control Guidelines.

The Standard Precautions which apply for the prevention of blood borne pathogens such as Hepatitis B C, and HIV should apply to the management of patients with known or suspected CJD and related diseases.

Because the clinical disease is sometimes difficult to diagnose and because of the known long incubation (preclinical) period, Standard Precautions should apply in a wide context to all persons with undiagnosed progressive neurological disease and to instruments and persons coming into direct contact with tissue related to the central nervous system.

Whenever possible, objects and surfaces which are potentially contaminated with infectious material should be disinfected with heat and/or chemicals, although no method currently available can guarantee complete decontamination.

Contaminated single use equipment, linen and such-like should be incinerated, as should all needles and sharps. The use of yellow infectious waste bags with the international biohazard symbol and the words ‘Medical Waste’ and ridged puncture proof containers is advised for containment of waste material prior to incineration