Biosecurity Policy

Biosecurity is a set of preventive measures designed to reduce the risk of transmission of infectious diseases. To better understand how these practices can be best implemented, it is important to know how infections begin and are transmitted and what measures can be taken to prevent them.

Goals for Davies Veterinary Specialists Infection Control Group

1) Protect staff and clients from exposure to zoonotic disease agents.

2) Create an environment where patient care can be optimized by minimizing the risk of nosocomial infection.

3) Demonstrate appropriate infection control and disease surveillance practices.

4) Provide advice to staff and clients regarding the control and prevention of infectious diseases in animals and humans.

5) Protect operational capabilities at Davies Veterinary Specialists

Davies Veterinary Specialists Infection Control Group will:

1) Develop policies and procedures for Biosecurity at DVS. The policies and procedures should model best practice, be cost efficient and be achievable within the operating structures of DVS.
a) The policies and procedures should explicitly address:
i) Control of nosocomial infection
ii) Control of animal-to-human and human-to-animal infections
iii) Passive and active surveillance
iv) Systematic and regular reporting of results of surveillance.
2) Manage implementation of biosecurity procedures to ensure compliance and adherence to best practice.
3) Provide advice to staff pertaining to biosecurity. The committee will be the primary resource information and advice on biosecurity associated with clinical activities.
4) Report on its activities to the rest of the hospital
5) Promote biosecurity in veterinary facilities to the veterinary profession.
6) Develop staff expertise in biosecurity.

Infection Control Principles

The following principles have guided the development of all infection control policies. These precautions help prevent disease transmission from staff to patient, patient to patient and patient to staff.
1) **Optimize hygiene** through the use of standard precautions including hand washing, proper attire and barrier protection, minimizing unnecessary contact with patients, appropriate disposal of infectious materials and proper cleaning and disinfection.

2) **Break transmission** cycles by understanding routes of disease transmission, creating barriers to direct and indirect transmission of infectious agents for patients with differing risks for contagious disease transmission, and effective use of hygiene protocols. This includes consideration of traffic patterns and kennelling of patients, as well as traffic patterns of staff and visitors within DVS.

3) **Target and refine infection control procedures** through surveillance and other investigative procedures.

4) **Enhance education and awareness** regarding nosocomial and zoonotic disease risks through optimizing communication about the purpose for these guidelines and procedures.

Optimizing Hygiene

Hand hygiene is the single most important factor affecting the risks of transmitting contagious organisms. Effective hand hygiene kills or removes microorganisms on the skin while maintaining hand health and skin integrity (i.e. prevents chapping and cracking of skin). Sterilization of the hands is not the goal of routine hand hygiene - the objective is to reduce the number of microorganisms on the hands, particularly the number of microorganisms that are part of the transient microflora of the skin, as these include the majority of opportunistic pathogens on the hands. These transient microbes may be picked up by contact with a patient, another person, contaminated equipment, or the environment.

There are **two methods** of removing/killing microorganisms on hands: washing with soap and running water or using an alcohol-based hand sanitizer. **Alcohol-based hand sanitizers** are not effective against certain pathogens, including bacterial spores (e.g. clostridial spores) and *Cryptosporidium spp*. Alcohol is also not as effective against non-enveloped viruses (e.g. canine parvovirus, feline panleukopenia virus) as it is against most other microbes. Nonetheless, alcohol-based hand sanitizers may be useful even if alcohol-resistant pathogens like *Clostridium difficile* are present. The improved hand hygiene compliance seen with alcohol-based hand sanitizers and their efficacy against other pathogens are important aspects of infection control. **Washing hands with soap and running water** can decrease the number of **all** organisms on the hands via the physical process and mechanical action of hand washing.

DVS staff with patient contact should be 'bare below the elbows', maintain short fingernails, no nail varnish and wear minimal jewellery on their hands in order to minimize contamination and improve cleanability of hands. A single plain band is permitted as a ring. *See Bare below the elbow and personal hygiene policy.*

Hands should be washed:

1) Before and after handling each patient

2) After touching blood, body fluids, secretions, excretions and contaminated items, whether or not gloves are worn

3) Immediately after gloves are removed

4) Between tasks and procedures on the same patient to prevent cross-contamination of different body sites

5) After handling laboratory specimens or cultures

6) After general environmental cleaning

7) Before lunch, eating, or leaving work for the day

8) Before and after using the toilets

PPE is available in all areas of the practice and should be worn where a protocol or standard operating procedure (SOP) advises its use. Employees are advised to consider the task to be undertaken and whether it is necessary to use personal protective equipment (PPE) in order to carry out that task safely. Much of the PPE is disposable and staff should check that they are disposing of any PPE in accordance with DVS waste segregation and disposal. Where PPE is not disposable and single use, staff should check the correct protocol with regard to proper cleaning and disinfection.

- Disposable nitrile gloves, blue gloves for general use and purple for handling cytotoxic drugs
- Plastic aprons
- Thumb loop protector gowns, offer waterproof protection to the arms
- Safety glasses

- Fluid resistant respirator masks (FFP3) stored in sterile services for use during instrument cleaning where harmful aerosols may be created. In addition these masks are used for handling patients with zoonotic conditions where aerosols are likely to be inhaled
- Protective glasses/ masks with eye shield for surgeon/assistant use during surgical procedures
- Heat resistant gauntlets, for use during unloading of autoclaves
- Radiation protection- lead gowns, lead sleeves, thyroid protector
- Hard hats for use in loft areas with low beams and when working at height
- Ampoule breakers to prevent injury whilst opening glass ampoules
- Needle safe devices to allow one handed recapping of needles

For preparation and administration of chemotherapy:

- Glove box isolator for preparation of drugs (includes use of latex gloves)
- Splash shield eye protectors
- High filtration masks

Breaking Transmission Cycle
Routes of Disease Transmission
Many disease agents can survive for extended periods of time in the air, on surfaces and in organic material. Pathogenic disease agents can be spread from animal-to-animal, animal-to-human or even human-to-animal, through inhalation, oral consumption, direct contact with nasal or ocular mucosal surfaces, and indirect contact. Transmission can also be via fomites or vectors. Awareness of these routes of disease transmission can help prevent transmission and therefore mitigate any potential effects. Cleaning and disinfection of premises, equipment, and vehicles will play a vital part in the control of disease transmission, along with personal hygiene. All staff should be aware of the protocols for cleaning and disinfection and should take an active part in the process. *See cleaning and disinfection protocols for each department.* Those patients categorised as infectious should have orange bags for their waste. *See Waste Disposal Regulations.*

• ***Aerosol transmission*** occurs when infectious agents contained in aerosol droplets are passed between susceptible species. Most pathogenic agents do not survive for extended periods of time within the aerosol droplets and as a result, close proximity of infected and susceptible animals is required for disease transmission. The greater the distance between animals, the less likely transmission will occur. Aerosol transmission may occur through close contact of animals and/or humans. Infectious agents may be freshly aerosolized (as in a sneezing cat with feline respiratory virus), may be re-aerosolized by high-pressure washing or on dust particles by air currents. Temperature, relative humidity and ventilation play important roles in aerosol transmission of pathogens.

• ***Oral transmission*** involves exposure to infectious agents by the gastrointestinal route. This also can occur inadvertently through inhalation of aerosolized material and subsequent swallowing of materials through the nasopharynx. Contaminated environmental objects include equipment such as food and water dishes, and any other items an animal could lick or chew. Feed and water contaminated with faeces or urine are frequently the cause of oral transmission of disease agents. In people, oral contact with contaminated hands is commonly part of the transmission cycle for oral-faecal agents, which exemplifies the need for excellent hand hygiene among

personnel working around animals. Appropriate handling and segregation of patients with diarrhoea will help control the spread of potentially infective organisms in faeces as will proper cleaning and disinfecting of food and water dishes.

• ***Direct contact transmission*** requires an animal or person to directly contact another infected animal or person. ***Indirect contact transmission*** occurs through contact with surfaces or materials that have been contaminated with a variety of substances (e.g., blood, discharge from wounds, saliva, nasal secretions or aerosolized respiratory droplets, genitourinary secretions, faecal material, etc). It is important to remember that patients in the hospital have a highly likelihood of being infected with contagious pathogens, and therefore surfaces throughout the facility have a high likelihood of being contaminated with infectious agents. As such, the most important method of reducing the potential for direct and indirect contact transmission is the segregation of infected animals and minimizing contact with them. Since not all infected animals show signs of illness, generalized efforts to decrease the likelihood of animals coming into direct contact and segregating patients in different populations eg. hospitalised patients and staff pets.

• ***Fomite transmission*****:** Fomites are objects that serve as intermediates in contact transmission cycles. Virtually any object can serve as a fomite, even a person acting as a caregiver. For example: a door knob, keyboard, telephone, clothing, thermometer, stethoscope, lead, brush, etc., are all items that can be contaminated with infectious agents and serve as an exposure source involved in contagious disease transmission. An important aspect of fomite transmission is that portable items can be contaminated near one patient and then be a source of transmission for patients or staff in other areas of the hospital. The most important means of controlling transmission by fomites is through proper cleaning and disinfection, use of barrier nursing precautions, separation of equipment, as well as the appropriate recognition and segregation of diseased animals.

• ***Vector transmission*** occurs when an insect or arthropod acquires a pathogen from one animal and transmits it to another. Fleas, ticks, flies and mosquitoes are common biological vectors of disease. The most effective means to prevent transmission of vector-borne is the elimination or reduction of the insect vector, or at a minimum, separation of the vector from the host.

Zoonotic Infections

While the risk of contracting a zoonotic disease among the general population is, on average, low, people that routinely have contact with animals have an increased risk of exposure to zoonotic disease agents. *See Zoonotic infections protocols and risk assessment for zoonoses.*

Notifiable Diseases

Notifiable' diseases are animal diseases that we are legally obliged to report to the Animal and Plant Health Agency (APHA), even if you only suspect that an animal may be affected. Fortunately, these diseases are very low in occurrence. *See Reporting of notifiable disease protocol*

5.11.2019 Danielle Banks

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The Veterinary Specialists

Categorising Patients

All patients should be categorised according to the following tier system. This will guide people as to where they should be kennelled, what PPE should be worn and how they should be nursed. Ultimately it is the responsibility of the clinician in charge to assess the risk of infection to other patients and assign a tier accordingly.

Tier Level	Definition	Examples	Where to house	PPE required
TIER 1	Patients at high risk for acquiring infection due to poor immune status.	Immunocompromised patients, unvaccinated patients, neonates	In regular wards – Pink beds	Handle these patients before Tier 2. Gloves and thumb loop required. Reverse barrier nursing to protect this patient.
TIER 2	Patients with no evidence of contagious disease.	Elective orthopaedic surgery	In regular wards – normal beds	No PPE required.
TIER 3	Patients that have infectious diseases that can be contained with barrier nursing alone.	Ringworm, Lepto, Giardia, Salmonellosis	In regular wards – Pink beds	Gloves and thumb loop required. Barrier nursing
TIER 4	Patients that are known or suspected to have highly contagious diseases Or a disease in which transmission to other patients may cause major/life threatening complications.	Parvo, distemper, kennel cough Antibiotic resistant infections	In Isolation	Peach Scrubs, gloves and thumb loop required. Barrier nursing

Tier 4 Plus	Patients that are known or suspected to have highly contagious diseases Or a disease in which transmission to other patients/people may cause major/life threatening complications.	Micobacterium bovis	Isolation or isolated consult room	Peach Scrubs, gloves and thumb loop required. A fitted mask (FFP3) may be required for inhaled zoonotic diseases. Barrier nursing

Danielle Banks 15.10.2019

Updated 26.03.2020 DB

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Isolation Protocol

Should the patient be in a life threatening situation, it may be necessary to break protocols. This will be at the discretion of the member of the staff, but must not involve putting yourself at risk.

Animals will be admitted to isolation if the categorised as Tier 4/Tier 4 Plus or at the discretion of the clinician in charge of the case.

PPE (Personal Protective Equipment)

- Anybody working within isolation should be wearing (PPE) consisting of:
  - peach scrubs
  - thumb looped gown
  - gloves
  - mask - may be necessary for some cases where the disease is airborne.
- All staff should change into peach scrubs in the anteroom before entering the isolation room. Before changing ensure that another member of staff is aware that this is where you have gone just in case of an accident or emergency.
- Shoe covers should be worn when entering isolation and removed as you exit. Gloves should be worn still while removing the shoe cover and special care should be taken whilst removing them so as not to contaminate the 'clean' shoes underneath.
- After each use, any worn scrubs should go in the wash bin. The kennel assistant assigned to isolation for that day will be charged with washing these. Peach scrubs should not be washed or stored with the blue/ green scrubs.
- Orange plastic jackets are available for use when it is cold/wet. These should be Clinell wiped after each use.

Organisation and planning

- Accumulate everything you will need to be able to treat/manage your patient prior to entering isolation. Calculate any drug doses and prepare accordingly as you will not have the paperwork with you to refer to.
- Staff should minimise the number of times they need to enter and exit isolation as much as possible. Having a 'clean' member of staff to help will be beneficial.
- Staff must not need to remove items from their pockets such as pens, thermometers as these should already be to hand.
- If occupied, each kennel in isolation should be identified with the patient's name on laminated card. All other paperwork will be stored on clipboards on the work surface in the anteroom.
- If the patient leaves isolation for a procedure the clipboard should remain outside of isolation and only the paperwork be taken.
- Paperwork should be completed following procedures but only after PPE has been removed and hands have been washed.

Caring for the patient in isolation

- Clinicians should be directed to admit patients through the isolation rear door.
- Some animals in isolation may have zoonotic infections – this should be drawn to the attention of all staff (Read Zoonotic disease protocol)
- Hands should be washed on entering and leaving the anteroom and before and after handling patients even if gloves have been worn. Pink vet beds should be used for all patients in isolation. Each dog should have a labelled red lead.
- Patients should be assigned a name labelled patient care box to keep ongoing bandage material, saline, etc in.
- If staff are required to kneel on the floor in isolation to treat a patient, an incontinence sheet should be used.
- Patients should be weighed daily using the scales just outside isolation. An incontinence sheet should be placed onto the scales for the patient to stand on. After use the scales and the floors should be cleaned using disinfectant. Ideally patient weight checks should coincide with daily walks to avoid having to clean the floors excessively.
- Under no circumstances should any isolation patient come into contact with another patient. Isolation patients should be walked out via the isolation rear door to the designated area outside. In some circumstances, staff may be advised not to walk out the patients due to the extreme risk of spreading infection.

Daily Cleaning

- The isolation ward has its own cleaning equipment.
- Patient kennels should be cleaned daily using G9 disinfectant and a new disposable cloth should be used for each kennel and thrown away after use.
- A red mop should be used to clean the floors twice daily (and as necessary) within isolation and this should be thrown away at the end of each day. It is the responsibility of the nurse to ensure that this is done. A kennel assistant will be assigned to isolation for their shift to assist with cleaning and patient care.
- All fomites such as light switches and door handles should be cleaned with a Clinell wipe regularly.
- Food bowls used within the unit should not be removed until they have first been soaked in a bucket of disinfectant (30 min contact time). This bucket should be positioned near to the door but still within the isolation unit. Where necessary any gross material or remaining food should be removed and disposed of into the infectious waste. Place a new set of gloves on to remove the bowls from the soak.

Daily Stocking

Please ensure that the anteroom is restocked appropriately, this task can be delegated to an assistant if necessary.

- Bandage material
- T-connectors
- Elastoplast
- Clippers
- Alcohol swabs
- Bucket of disinfectant for bowl cleaning
- Gloves of various sizes
- Infectious waste bin
- Pre-made flushes
- Needles
- Syringes
- Bungs
- Swabs
- Blue towel
- Incontinence sheets
- Thermometer
- Thermometer covers
- Scissors
- KY Lubrication
- Sharps bin

Cleaning isolation once the patient has been discharged

- When shutting down the isolation unit, PPE should always be worn
- All bedding should be placed into a washing bag. All newspaper should be disposed of into infectious waste.
- The kennel should be cleaned of any gross matter and then G9 disinfectant should be used to clean in a systematic manner, ensuring all surfaces are covered. Use the cloth to clean around the base edges. The contact time required is 30 minutes.
- Any surfaces potentially exposed to the patient should be cleaned with G9 disinfectant solution and left to air dry. This includes the floor and opposite facing kennels
- Infusion pumps should be disinfected, along with fomites such as light switches and door handles.
- Open but unused bandage material should be discarded.
- Patient care boxes should be disinfected.
- The changing curtain should be washed and new one hung.
- One regular kennel and one walk in kennel should be prepared and ready for use. This ensures they are ready if a clinician needs to admit a patient straight from the consulting room to the isolation ward.
- Wash hands thoroughly after cleaning.

1.10.2020 Danielle Banks/Sophie Lawrence
Updated 26.3.2020 Danielle Banks

DAVIES
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Hand Hygiene

Hand hygiene is widely acknowledged to be the single most important activity for reducing the spread of infection.

Five times for hand hygiene:

1. Before animal contact
2. Before a clean/sterile procedure
3. Following potential body fluid exposure
4. Following animal contact
5. Following contact with the animal's environment

Hands should be washed routinely using liquid soap and warm water. While alcohol hand gel in some situations is a practical alternative to soap and water, alcohol is not a cleaning agent and therefore should not be used as a substitute for soap.

Hand preparation increases the effectiveness of de-contamination:

- Keep nails short, clean and varnish free.
- Cuts and abrasions should be covered with a waterproof dressing.
- Keep hands well moisturized to keep skin from drying out which can hinder hand washing.

Hand drying is important as improper drying can re-contaminate hands that have been washed. Wet surfaces transfer organisms more effectively than dry ones and inadequately dried hands are prone to skin damage. Disposable paper hand towels are the best method as friction reduces the number of organisms.

Danielle Banks 15.06.19

How to Handwash?

WASH HANDS WHEN VISIBLY SOILED! OTHERWISE, USE HANDRUB

Duration of the entire procedure: 40-60 seconds

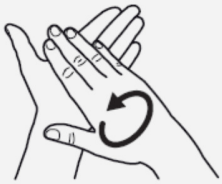
0

Wet hands with water;

1

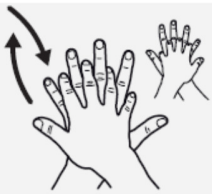
Apply enough soap to cover all hand surfaces;

2



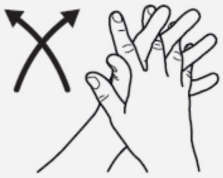
Rub hands palm to palm;

3



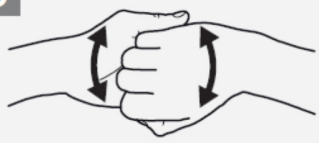
Right palm over left dorsum with interlaced fingers and vice versa;

4



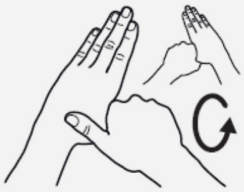
Palm to palm with fingers interlaced;

5



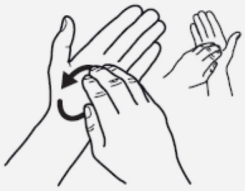
Backs of fingers to opposing palms with fingers interlocked;

6



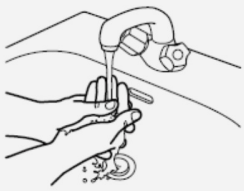
Rotational rubbing of left thumb clasped in right palm and vice versa;

7



Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;

8

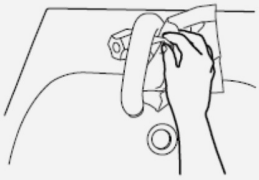


Rinse hands with water;

9

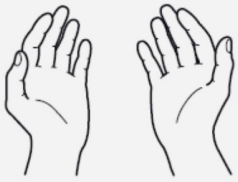
Dry hands thoroughly with a single use towel;

10



Use towel to turn off faucet;

11



Your hands are now safe.

World Health Organization

Patient Safety

A World Alliance for Safer Health Care

SAVE LIVES
Clean **Your** Hands

WHO acknowledges the Hôpitaux Universitaires de Genève (HUG), in particular the members of the Infection Control Programme, for their active participation in developing this material.

May 2009

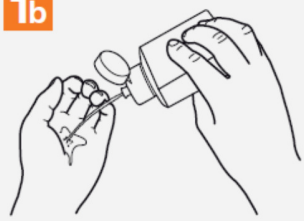
How to Handrub?

RUB HANDS FOR HAND HYGIENE! WASH HANDS WHEN VISIBLY SOILED

Duration of the entire procedure: 20-30 seconds

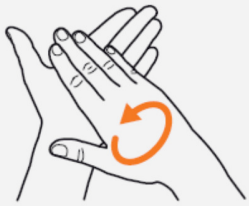
1a

1b



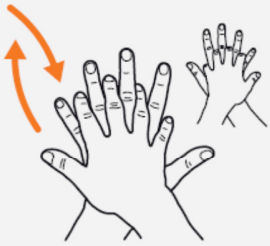
Apply a palmful of the product in a cupped hand, covering all surfaces;

2



Rub hands palm to palm;

3



Right palm over left dorsum with interlaced fingers and vice versa;

4

Palm to palm with fingers interlaced;

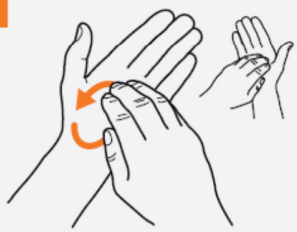
5

Backs of fingers to opposing palms with fingers interlocked;

6

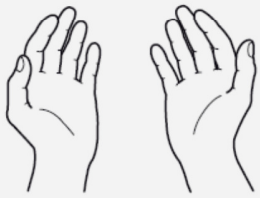
Rotational rubbing of left thumb clasped in right palm and vice versa;

7



Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;

8



Once dry, your hands are safe.

World Health Organization

Patient Safety
A World Alliance for Safer Health Care

SAVE LIVES
Clean Your Hands

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May 2009

Management of Tier 4 and Tier 4 Plus patients undergoing diagnostic and surgical procedures.

Planning

- Check with the head nurse/supervisor running the department that day which is the most appropriate room is which the procedure should be performed.
- Where possible, the procedure should be carried out after all other procedures.
- All anticipated equipment should be prepared before the patient is collected.
- Equipment should be kept to one side so that it is only contaminated when it is used.
- Keep the number of people involved to a minimum

Personal Protective Equipment (PPE)

- All staff involved in the procedure must adhere to the dress code as stipulated for the individual patient.
- Should a member of staff be called for advice, but minimal handling of the patient is required a blue thumb loop gown and gloves should be worn.
    - If an isolated case needs to be prepared for theatre staff involved with the case should wear a blue thumb loop gown and gloves over blue scrubs and not a white coat when outside theatre. People should change their blue scrubs after dealing with an infected case.
    - Once the patient is prepared and moved to theatre the gowns should be disposed of into clinical waste. Remember to take a new thumb loop gown in to theatre prior to the procedure for use afterwards.

Moving the Patient

- Assign a 'clean runner' to help move the patient. This person will not handle the patient but will open doors etc. so that there is no contamination outside of the areas the animal is being treated.
- Transport the patient on a trolley or in a carrier where possible. If the patient is likely to be shedding an airborne pathogen, check that the route is clear of other patients before moving.
- If an isolated patient is being walked to and from a procedure, ensure that the pathway is clear of other patients and consider whether the floor needs to be disinfected afterwards.
- When transferring a case into theatre, someone needs to remain gowned and gloved until the patient has been transferred to the operating table. The supervisor will be appropriately gowned but will need help transferring the patient. If staff that have prepped the patient are grossly contaminated, then use common sense to change gowns/gloves before moving the patient to theatre. Once the patient is safely secured on the table, and monitoring attached, the PPE may be removed.
-

The procedure

- If possible the 'clean runner' will not handle the patient but will be responsible for handling clean equipment, such as the anaesthetic monitor, x-ray control panels, computer etc., fetching materials/drugs and completing paperwork etc. Paperwork, computers, door handles etc. must not be handled by contaminated hands.

- If a clean runner is not available, ensure that gloves and gowns are removed, hands washed and then gloves and gown replaced at appropriate times, e.g. when leaving the room or filling out paperwork.
- Try to work within a small area to minimise the areas of contamination. Tidy up as you go along and discard contaminated items in the infectious waste bin.
- Outside of theatre a trolley should be used for all the equipment, with clean items kept in a box (if possible) and passed by the clean runner. Used items should be placed on the bottom of the trolley.
- Ensure clippers used are clearly labelled and left on the trolley used to prep the patient, this is to avoid anyone using them on another case before they have been decontaminated.
- If unusual equipment/areas of the room have been contaminated, make sure that this is highlighted so that the person cleaning the room knows to include them.
- Leave a sign to mark the area you are leaving as infected and out of use and inform the relevant supervisor so that they can organise for the area to be cleaned as soon as possible. Close the door to the room as you leave where possible.

<u>Cleaning</u>

- Following the procedure the room should be cleaned as quickly as possible. If there is delay or the patient will be going back to the room for further procedures such as post op xrays the door should be clearly labelled as being 'out of use'.
- The person cleaning the room should wear the same PPE as was worn for the patient.
- The person cleaning the room should ascertain the level of cleaning the room requires by asking either a head nurse/supervisor or nurse/clinician involved with the case.
- Points to consider when deciding on the level of cleaning:
    - What procedure was performed? Was there any flushing/aerosols of fluids which would have likely contaminated the room further? What precautions were taken to keep contamination to a minimum? Where was the main area of work/contamination? Is the infection zoonotic/air bourne? Does the room have ventilation? If the room does have ventilation, how many room air changes are achieved per hour?
    - Was there a 'clean' runner? Room contamination should be reduced if there was a clean runner.
    - Were all unused instruments and kits kept in the dedicated 'clean' box?
    - Was all 'dirty' kit kept on the trolley?
- Once the level and area of cleaning required is established, gather all equipment/products for cleaning and commence cleaning.
- The instrument trolley should stay in the dirty theatre until sterile supplies are ready to take the kit for processing. All infected kit is washed in the washer/disinfector, and all other kit should be in sterile supplies to avoid cross contamination.
- The area should be removed of any gross matter first and then cleaned with G9 disinfectant in a systematic direction ensuring each surface is covered. Use a disposable cloth. Contact time is 30 minutes.
- The floor should be mopped with G9 disinfectant using a double mopping system and then the mop head disposed of.
- Ensure any active ventilation is working and and the door remains closed. If active ventilation is not present, and an airbourne pathogen is of concern, ventilate the room via the window with the door closed for as long as possible.
- Check with a head nurse/supervisor if you are unsure on how to correctly clean/decontaminate any kit/equipment.
- Open but unused bandage material should be discarded.

- Any unused instruments should have been kept in the ‘clean’ box. If this has not occurred then the outer package should be stripped from the instrument without contaminating the inner packaging and then it should be returned to theatre for repacking and re-sterilising.
- Any used instruments should be washed of gross contamination placed in the diagnostic instrument transport box with lid on and returned to theatre. The box should be labelled with a ‘contaminated kit’ sticker. Advise sterile services if the case was zoonotic.

Danielle Banks October 2019
Updated 26.03.2020 Danielle Banks