



INFECTION PREVENTION AND CONTROL PLAN 2022

Sept 2021

**LAC+USC MEDICAL CENTER
INFECTION PREVENTION AND CONTROL PLAN**

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PURPOSE:

The purpose of the Infection Prevention and Control Department (IPCD) is to prevent and control the acquiring of and the transmission of infections between patients, employees and visitors through education, surveillance and the analysis of epidemiological issues arising from the community demographics.

The IPCD meets Title 22 (California Administrative Code), California Occupational Safety and Health Administration (CA-OSHA), Joint Commission (JC), and the National Patient Safety Goals (NPSG).

Medicine, Nursing Services and all ancillary personnel have a joint responsibility and obligation to protect the health of the patients, visitors and the health care workers. Each employee is individually responsible to know and adhere to the Medical Center Infection Prevention Plan.

The Infection Prevention and Control Program Director is the Hospital Epidemiologist, who also provides leadership to the Infection Control Committee (ICC), an organized committee of the medical staff and their officers. The Hospital Epidemiologist has the authority to institute any surveillance, prevention or control measures to prevent potential danger or identified risks to patients, visitors and staff.

Under the direction of the Hospital Epidemiologist, the Infection Prevention and Control Department is responsible for the following:

- Administration and management of the LAC+USC Medical Center Infection Control Plan;
- Developing a system for identifying, evaluating, analyzing, reporting, investigating and controlling infections and communicable diseases;
- Developing and implementing policies governing control of infections and communicable diseases;
- Implementing policies governing control of infections and communicable diseases;
- Providing input in the employee health program with employee disease investigations;
- Acting as liaisons to the health department related to reportable diseases and community infection control issues;
- Serving as a resource to hospital staff and the community regarding communicable diseases;
- Reporting infection data as mandated by regulatory agencies;
- Participating and providing as a resource for medical staff and hospital committees, such as Infection Control, Emergency Management, Environment of Care; Construction; Medical Waste; and Sterilization and Disinfection practices.
- Evaluating and revising of Infection Prevention and Control Plan on an annual basis and as needed.

GOALS:

The annual goals of the Infection Prevention and Control Plan are based on the most recent Infection Control Risk Assessment (ICRA). Infection Control Department identifies the annual goals based on the risks with the largest impact on patient morbidity/mortality. The risk scores range from 0 to 9, with ≥ 7 being High risk and 6 being medium risk.

The goals are developed to:

- Prevent the transmission of infection to patients, visitors and staff;
- Provide a safe work environment;
- Improve patient care;
- Comply with regulatory requirements.

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The 2022 Risk Assessment of identified goals are:

- **DEVICE RELATED INFECTIONS:**
 - **GOAL:** Infection Control will participate in multidisciplinary subcommittees to develop strategies to reduce device related infections. By the end of the year 2022, surveillance for each of the following high-risk devices for infection will be reduced from the 2021 rates:
 - Central line related infections
 - Ventilator related infections
 - Catheter associated urinary tract infections
 - Surgical site infections
 - Abdominal hysterectomy
 - Colon surgery
- **SURVEILLANCE PATHOGENS:**
 - **GOAL:** Infection Control will participate in multidisciplinary subcommittees to reduce hospital acquired infections. By the end of the year 2022, the rates for the following infections will be reduced from the 2021 rates:
 - CDI organisms
- **ENVIRONMENTAL ISSUES:**
 - **GOAL:** Infection Control will participate in multidisciplinary subcommittees to develop strategies to increase hospital cleanliness and to reduce the burden of surface pathogens and the disease burden. By the end of the year 2022, the monitoring and rounding in assigned areas will show an improved cleanliness for all acute and outpatient areas.
 - Improved cleanliness of the hospital and clinics
 - Hand hygiene compliance
 - PPE compliance
 - Processing and sterilization of instruments

EPIDEMIOLOGY CONSULTATION ON INFECTION PREVENTION AND CONTROL ISSUES

The Infection Prevention and Control Department is a component of the Department of Epidemiology (EPI). Epidemiology is the branch of medical science concerned with the incidence and prevalence of disease in large populations. Infection Control provides the development/utilization of policies and procedures in the surveillance, investigation and compilation of statistical data of identified health care infections; consults with health care workers in the placing of isolation precautions; and authorizes the patient removal of isolation precautions. The purpose is to contain and minimize the risk of spreading infection/disease in patient care facilities (clinics and hospital settings).

The Department personnel is comprised of: 1 MD Hospital Epidemiologist (EPI Director); 1 ID Pharmacist (Antibiotic Stewardship); 10 Infection Preventionists (IPs); and 2 Clerical support.

The office is located in building “H”, “In-Patient Tower” (IPT), room C5E100. The office hours are Monday through Friday, from 0700 to 1630. On-call staff are available 24 hours by pager for consultation, to answer questions regarding infection control or to assist in resolving infection related issues. To contact the Hospital Epidemiologist or identify the Nurse Epidemiologist on call, contact the Department of Epidemiology at 323-409-6645 and an automated message recording system will inform you of the Epidemiologist on call and their pager number. The Medical Center Telephone Office (323-409-4906) can also provide on-call staff information.

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STANDARD PRECAUTIONS

STANDARD PRECAUTIONS were initiated to protect the health care worker from bloodborne pathogens, and to prevent the transmission of infectious agents between the health care worker, visitors and patients. STANDARD PRECAUTIONS are the first step in infection control and must be practiced by all healthcare workers at all times, and in all settings. Health care workers shall be trained and will use barrier devices provided for their safety to prevent contact with blood or other potentially infectious materials.

1. Hands and other skin surfaces must be thoroughly washed with soap and water (minimum 20 seconds) following exposure to blood and other body fluids.
2. Hand hygiene must be performed before entering and after exiting a patient room, and before and after each patient contact that involves touching the patient or their immediate environment.
3. After contact with a patient who is positive for *Clostridium difficile*, personnel must wash their hands with soap and water.
4. Personal Protective Equipment shall be readily available at the work site and shall include but not be limited to: gown, mask, gloves, goggles, and face shield
4. Fluid resistant gloves shall be worn when handling all blood and body fluids and while performing procedures where there is a potential for exposure. Hand hygiene must be done once the gloves are removed
5. Gloves must be removed, and hand hygiene performed following direct patient care and indirect care activities.
6. A fluid resistant barrier gown or disposable plastic apron shall be worn to protect clothing whenever there is a likelihood of clothing becoming soiled or wet with blood or body fluids.
7. Protective eye wear, surgical mask, or full-face shield shall be worn whenever there is a likelihood of splashing body fluids into the eyes, nose or mouth.
8. All specimens shall be transported to the laboratory in a closed, zip top plastic bag or plastic container.
9. Extreme caution shall be taken to prevent percutaneous injuries from needles and other sharp instruments. All sharps and used needles must be discarded in an approved sharps disposal container. **Activate sharps safety device after use. Do not recap, bend or break needles.** Securely seal sharps container when 3/4 full and place in appropriate area for pick up.
10. All body fluids to be discarded shall be flushed down a toilet or hopper.
11. All body fluid and blood spills shall be cleaned up with absorbent material then cleaned with a detergent solution followed by a disinfectant solution.
12. Soiled linen shall be placed in laundry bags, tied with a single knot, and left in an appropriate area for pick up. Do not overfill linen bags.
13. All contaminated disposable items shall be discarded in the appropriate covered trash container.
14. All parenteral and mucous membrane exposures must be reported immediately to the employee's immediate Supervisor and Health Care Service site.
LAC+U.S.C. Medical Center Employee Health Care Services Site (323-409-5236 / operator)
LAC+U.S.C. Emergency Room (323-409-6707 / operator)
15. **Healthcare workers are not to eat or drink in the patient care areas**

TRANSMISSION BASED PRECAUTIONS

Isolation transmission based precautions prevent the transmission of infection between infected patients, caregivers, other patients and visitors. Patients will be placed in precautions when they have or are suspected to have an infection or colonized with epidemiological significant pathogens that can be

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transmitted through the air, by droplet or direct contact.

The physician or his/her designee is responsible for notifying Epidemiology/Infection Prevention when a Communicable Disease is suspected or diagnosed that require barrier isolation precautions.

All health care providers who have contact with patients diagnosed with an infection or suspected of having a disease or infection, which requires institution of barrier precautions or isolation, shall comply with specific isolation precautions in addition to Standard Precautions.

Nursing is responsible to educate the patient and their visitors on the isolation transmission based precautions, the personal protective equipment (PPE) needed and how to don and doff the PPE, and the importance of compliance with these precautions.

TYPES OF TRANSMISSION BASED PRECAUTIONS

	CONTACT	DROPLET	DROPLET/ CONTACT
Source of Transmission	Contact	Droplets	Contact and Droplet
Room Type	Private Room	Private Room	Private Room
Equipment for Healthcare Workers/ Visitors	Gloves, Gown	Surgical mask, Gloves	Surgical mask, gloves, gown, Goggles
Equipment for Patients when leaving room	Gown, gloves if age appropriate	Surgical mask	Surgical mask
Isolation Sign	Contact (Green)	Droplet (Orange)	Green/Orange
Examples of Diseases	Candida Auris MRSA (ORSA) draining (3) wound only ESBL (less than 90 days on culture) CRE VRE (vancomycin-resistant enterococcus) (3) MDR gram negative bacilli (3) RSV Skin: Diphtheria (cutaneous) Impetigo (7) Lice (6) Scabies ^{4,5} Staphylococcal Scalded Skin Syndrome Infectious Diarrhea Zoster (one dermatome)Diarrhea (GI): Campylobacter E. coli O15:H7 (2) Salmonella	Influenza (9) Diphtheria (pharyngeal) Hanta Virus Pneumonic Plague Rhinovirus Rubella Meningitis (suspected N. meningitis)(7) Mumps Pertussis/Whooping cough Parainfluenza Virus/Croup Group A Streptococcus (7) (Pharyngitis, pneumonia or scarlet fever) Marburg, Lassa Haemophilus Influenza	COVID 19/SARS 2 (9) face shield

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	Shigellosis <i>C. difficile</i> Hepatitis A Rotavirus Parainfluenza Human Metapneumovirus		
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TYPES OF PRECAUTIONS

	AIRBORNE	AIRBORNE/CONTACT
Source of Transmission	Airborne	Airborne and/or contact
Room Type	Private Room with Negative Pressure (keep door closed)	Private Room with Negative Pressure (keep door closed)
Equipment for Healthcare Workers/ Visitors	N-95 Respirator Mask or PAPR	N-95 Respirator Mask or PAPR Gown, Gloves
Equipment for Patients when leaving room	Surgical mask	Surgical mask, Isolation gown
Isolation Sign	Airborne (Pink)	Airborne (Pink) + Contact (Green)
Examples of Diseases	Tuberculosis or R/O Tuberculosis Measles/Rubeola (1)	Chickenpox Varicella Zoster (disseminated)(2) Metapneumovirus Avian Influenza (H7N9) Virus (8) Viral Hemorrhagic Fevers (Ebola, Marburg, Lassa) SARS, MERS, CORONA Virus, Pandemic Influenza

For questions on type and duration of precautions required for other selected infections and conditions, contact the Department of Epidemiology at 323-409-6645.

If a patient has two diseases, one of which requires Droplet Precautions and the other of which requires Airborne Precautions, the patients should be placed in Airborne/Contact Precautions.

Additional Special Requirements (note number by diseases):

1. No susceptible person to enter room.
2. Requires isolation if diapered or incontinent
3. Requires isolation until off antibiotics and culture negative. Refer to written guidelines from Epidemiology on ORSA, VRE, Multi-drug Resistant Organisms and C. Difficile
4. Scabies requires isolation until minimum 8 hours after initial treatment. Patient unit must be thoroughly cleaned and patient curtains changed
5. "Norwegian" or "Crusted Scabies" requires additional direction from Epidemiology.
6. Lice requires Contact Isolation until treatment completed until 24 hours of anti-microbial therapy completed
7. Requires eye protection and respirators for all patient-care activities.
8. Airborne precautions for aerosol generating procedures such as sputum induction, bronchoscopy, open suctioning, cardiopulmonary resuscitation, intubation, extubating, and autopsy procedures.

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9. Require eye protection and respirators for all patient-care activities.

PERSONAL PROTECTIVE EQUIPMENT

PPE is to be worn within the patient care room, procedure room or in other select locations, such as the lab or under emergency direction from DHS or Epidemiology. All PPE will be removed upon exiting the patient care room or procedure area and hand hygiene performed. PPE is not to be worn in open common areas.

Sequence for donning Personal Protective Equipment

1. Hand hygiene
2. Gown
3. N95 Particulate respirator
 - Perform seal check
4. Hair cover (if worn)
5. Goggles or face shield (if worn)
6. Gloves

Sequence for removal of Personal Protective Equipment (Needs Revision)

1. Gloves
2. Hand hygiene
3. Gown
4. Goggles
5. Mask
6. Cap (if worn)
7. Hand hygiene

PROCEDURES FOR TRANSMISSION BASED PRECAUTIONS

1. Orders:

Patients may be placed in protective precautions at the discretion of the Registered Nurse, Nurse Epidemiologist or Physician.

2. Observation and Care Factors

- a. Isolation precautions are to be reasonable to contain the spread of infection and should *never* compromise patient care.
- b. Educate all healthcare workers, visitors and patients to the special precautions. Allow patient and family opportunities for asking questions.
- c. All healthcare workers and visitors entering the room are expected to comply with posted signage.
- d. Provide patient safety, not solitary confinement.
- e. Limit the number of individuals entering the room/unit to a minimum.
- f. Arrange work so that personnel first care for clean then isolated patients.
- g. Take only equipment/supplies needed for immediate patient care into isolation room/unit.
- h. Patient activity outside isolation unit, i.e., walking, Physical/Occupational Therapy, etc., is permitted when appropriate precautions are maintained.

3. Setting Up

- a. Place isolation sign on door or in highly visible location to all persons entering the room / unit.
- b. Collect appropriate items/equipment that are needed for the specific isolation.
- c. Place inside the unit (as appropriate for type of isolation):
 1. Patient care equipment/supplies for immediate use

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2. Gloves
 3. Sharps container
 4. Linen hampers
- d. Place on cart outside the unit (as appropriate for type of isolation):
1. Isolation gowns (cuffed, long sleeved)
 2. Masks
 3. Gloves
 4. Protective eyewear / face shield

4. Care of Trash, Soiled Linen and Equipment:

No additional requirements are required. Follow Standard Precautions.

5. Transporting Patients:

The area receiving the patient is to be informed of the special isolation precautions required before patient arrives on ward/unit.

The patient is to wear surgical mask as appropriate for type of isolation.

Place isolation sign on front of the chart.

Transporter should request persons to exit elevator during patient transport

6. Transfers/Discharges

Notify Epidemiology before transfer to other acute areas, i.e., ICU, wards, outside hospitals or Nursing homes. There are no inter-ICU transfers without the approval of the Hospital Epidemiologist or his designee.

Most patients may be discharged home, Board and Care facilities and psychiatric facilities with no special precautions.

7. Clearance from Isolation:

Isolation precautions must be maintained until the patient has been cleared by Epidemiology or a note written by Attending Staff discontinuing isolation precautions.

If the patient is discharged and isolation precautions have not been discontinued by Epidemiology, Nursing is to leave the isolation sign in place on the door. Environmental Services will follow appropriate precautions while cleaning the room and then remove the sign.

8. Discontinuation of Isolation Unit:

When a patient with Oxacillin Resistant *Staph aureus* (ORSA), Vancomycin Resistant Enterococcus (VRE), *Clostridium difficile*, Multi-Drug Resistant gram-negative bacteria, Norwegian "crusted" scabies or other organisms or infections requiring isolation precautions is transferred or discharged, the unit requires decontamination.

Call Environmental Services to wash walls, floors and change curtains.

Decontamination of the unit should also be done whenever the unit environment is heavily soiled with the patient's blood or body fluids. Contact Epidemiology if there are any questions regarding room cleaning.

9. Documentation:

Record date and time when specific isolation precautions are initiated and discontinued and when education regarding isolation precautions is provided to patient or family.

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**REPORTING AND MANAGING HEALTH CARE WORKERS WITH A
COMMUNICABLE DISEASE OR EXPOSURE TO A COMMUNICABLE DISEASE**

It is the policy of these facilities to protect patients and health care workers from exposure to potential Communicable Diseases. It is also the responsibility of all health care workers to immediately advise their Supervisors if they have contracted and/or been exposed to a communicable disease. Notification is required to enable the facility to take protective measures on behalf of the patients and employees as well as maintaining control of communicable diseases within the hospitals and clinics.

Epidemiology/Infection Control Responsibility

1. The Nurse Epidemiologist informs the Area Manager or Supervisor, who is responsible for completing a contact list.
2. Employee Health will conduct follow-up on HCWs upon receipt of the contact list reports.
3. Epidemiology will inform Public Health or conduct follow-up investigations when necessary to ensure treatment and/or resolution of the condition.

Supervisor Reporting Responsibilities

1. The unit/ area supervisor is responsible for:
 - a. Immediately reporting the incident to Epidemiology/Infection Control Officer (if the health care worker is diagnosed as having a disease listed above). The following information should be provided: HCW name, identification number, ward, disease and date of onset.
 - b. Completing the contact list
 - c. Forwarding completed contact list to Employee Health, which will assess exposure risk and potential disease process and provide necessary follow-up.
 - d. Completing the A Notice to Injured Employee Claiming Industrial Accident. (Form # H-194)
 - e. Completing the Employer's Report of Occupational Injury or Illness. (Form #5020)
 - f. Completing Supervisor's Investigation Report of Job Related Illness or Injury.
 - g. Assuring health care worker complies with procedures and required follow-up.

Health Care Worker Responsibility

1. The health care worker is responsible for:
 - Notifying the immediate supervisor of contact with a communicable disease or actual illness.
 - Obtaining treatment through Health Care Service site
 - Verifying with immediate supervisor that the a Notice to Injured Employee claiming Industrial Accident and the Employer's Report of Occupational Injury or Illness forms are completed

Health Care Service Site Responsibilities

1. On receipt of the Communicable Disease Confidential Report , Health Care Service site is responsible for contacting the area Supervisor / physician initiating the communicable disease report to advise him or her of the treatment or procedure required.
2. Health care workers' direct supervisor shall be notified if health care worker fails to report to Health Care Service site after adequate notification has been given to the health worker.

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Obtaining Employees Clearance to return to work after exposure to a Communicable Disease

1. Non-work related illness

Health Care Workers who develop any communicable disease must obtain medical release certificate from their Health Care Provider authorizing his/ her return to duty before returning to work. Notification must be taken to Human Resources Return to Work Unit.

2. Work Related Illness

Health Care Workers must have written medical clearance authorizing them to return to duty. Clearance documents must be presented to Human Resources/Personnel Return to Work Unit.

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WASTE MANAGEMENT

Waste Management in the LAC+USC Medical Center complies with the California Medical Waste Management Act, which defines waste stream by type of waste rather than by presence of a disease causing organism. It establishes methods for handling, tracking, treating and disposing of such waste. Biohazardous and sharps waste are considered to be medical waste.

At site of origin, solid waste shall be deposited in appropriate designated containers according to the system of designated separation. Liquid waste and patient excreta are discarded in toilet or hopper.

Environmental Services shall provide appropriate waste containers and shall remove trash from the locations. If the facility has trash chutes, only Environmental Services staff shall use trash chutes. Trash chutes shall not be used for the disposal of medical waste, biohazardous, sharps, excess pharmaceutical or hazardous waste. Final disposal is handled by Facilities Management or Environmental Services.

System for Designated Separation of Waste.

A. Regular Waste (Non biohazardous)

All waste **not** designated as Biohazardous, Sharps, Chemotherapy, Radiation or Pharmacy waste is deposited in this container. Container is white or neutral color, lined with clear plastic bag
A separate container may be available for glass containers and marked accordingly

B. Biohazardous Waste

Biohazardous waste includes the following:

Waste containing secretions, exudates, and excretions.

Exception: Normal Nursery diapers and waste from public and employee bathrooms are handled as non-biohazardous waste

Blood and blood products, Laboratory and pathological waste, Dialysis waste

Container is red* in color, covered and lined with a red plastic bag. Container and bag labeled **Biohazardous Waste** or with the international biohazard symbol and the word **Biohazard**.

Vacuum glass bottles that cannot be drained of fluids are placed in cardboard boxes with dividers, taped closed, labeled as Biohazardous waste and placed in designated area for Environmental Services pick-up. Pathology waste may also be discarded in a special white container that is affixed with a red biohazard label. The container is labeled Pathology Waste Incinerate Only.

C. Chemotherapy Waste

Trace Chemotherapy Waste

Trace chemotherapy drug related waste (contaminated through contact with but not pourable) is deposited in a special container and is considered Biohazardous.

Trash container for trace chemotherapy waste is yellow in color, covered and lined with a red

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leak proof plastic bag. Container and bag are labeled 'Chemotherapy Waste' with the biohazard symbol.

Sharps container for trace chemotherapy waste is yellow and white color, rigid, puncture resistant, and leak resistant when sealed and labeled Chemotherapy Waste with the biohazard symbol.

Bulk chemotherapy waste (pourable) is returned from the nursing units to the Pharmacy, where it is contained pending removal as 'hazardous waste'.

D. Sharps Waste

All needles, syringes and other devices, which have edges, points or corners capable of cutting or piercing, are deposited intact in this container. Activate sharp safety device before disposal/
DO NOT recap, bend or break needles.

Sharps container is red/white in color, rigid, puncture resistant, and leak resistant when sealed, and labeled Sharps Waste or Biohazard with the international Biohazard symbol.

When container is 3/4 full, the top is closed and sealed.

Sharps containers should be secured if located where unauthorized persons may have access.

E. Radioactive Waste

Radioactive waste, deposited in regular, sharps or biohazard containers, remains in the identified area until the waste is monitored by Radiation Safety Officer and is deemed free from any radioactivity.

The waste will then be removed and handled as per system for designated separation. If waste is determined to be radioactive for an extended period, Radiation Safety staff may move it to an interim location.

F. Pharmaceutical Waste

Partially used, damaged, contaminated, unwanted medications, expired (sent back to pharmacy with completed form), reconstituted or unused drugs that cannot be returned for credit.

Exception: Inhalers with contents under pressure or items on RCRA hazardous substances chart must be returned to the Pharmacy with a completed form for disposal.

Container is usually white in color, with a blue label stating pharmaceutical waste, incinerate only.

Table 1: LAC+USC Medical Center Disposal Guidelines

Table 2: RCRA Hazardous Substances

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**CLEANING AND DISINFECTION OF THE ENVIRONMENT
CONTROL OF PATHOGENS**

Use appropriate hand hygiene, personal protective equipment and isolation precautions, if applicable, during cleaning and disinfecting procedures and cleaning of biohazardous or potential biohazardous spills.

Use standard cleaning and disinfection protocols to control environmental contamination with Multiple Drug Resistant Gram Negative bacteria, Oxacillin Resistant Staph Aureus, Vancomycin Resistant and other potential pathogens. Read label regarding usage. Contact time is the time the surface must remain wet in order for the chemical to do its job.

Use Sodium Hypochlorite solution ½% for disinfection of the environmental surfaces in patient care areas housing patients with C. difficile or in areas where Epidemiology indicates there may be ongoing transmission of C. difficile or other. Read instructions and comply with contact time (Time the surface must remain wet).

Pay close attention to the cleaning and disinfection of high touch surfaces in patient care areas, i.e. bedrails, carts, charts, computer keyboards, bedside commodes, restrooms, door knobs or faucet handles. Read label regarding usage of cleaning solutions, and comply with the contact time. Contact time is the time the surface must remain wet in order for the chemical to do its job.

Thoroughly clean and disinfect environmental surfaces and common areas within the facility i.e. elevators, restrooms, lounges, waiting areas, countertops, furniture, telephones and medical equipment surfaces on a regular basis using approved EPA-registered disinfectants in accordance with the manufacturer's instructions. Comply with contact time (Time the surface must remain wet)

Advise families, visitors and patients regarding the importance of hand hygiene to minimize the spread of body substance contamination to surfaces.

Apply standard cleaning and disinfection procedures to control environmental contamination with respiratory and enteric viruses in Pediatric-care units and care areas for immunocompromised patients.

Clean surfaces that have become contaminated with body substances with approved disinfectant.

Use disposable barrier coverings as appropriate to minimize surface contamination.

Use standard procedures for containment, cleaning and decontamination of blood spills.

When an area is heavily soiled with blood or body fluids contact Environmental Services to clean the area. Environmental Services has a cleaning and decontamination procedure in their manual.

If a minor area is soiled with blood or body fluids do the following:

- Put on personal protective equipment

- Use absorbent material to pick-up the fluid.

- Discard soiled linen used in linen hamper

- Discard soiled disposable material in bio-hazardous trash container

- Use a disinfectant to clean spill area

- Dispose of cloth used to clean in biohazardous container

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Remove personal protective equipment and discard in proper container
Wash hands.

DECONTAMINATION AND STERILIZATION

PURPOSE

To provide guidelines for the decontamination and sterilization of instruments, supplies, equipment and implant devices. Such guidelines are consistent in intent and application, enabling the same level of services in all areas, which do sterilization. It is the intent of these institutions to standardize our procedures so that sterilization and decontamination are effected with the same standard practice throughout the Network.

Facilities must designate an administrative authority to assure adherence with the policies and procedures contained herein. Each facility must maintain an accurate inventory of all sterilizers by location including central sterilization locations.

DEFINITIONS

Sterilization

A process designed to remove or destroy all viable forms of microbial life, including bacterial spores, to an acceptable sterility assurance level.

High level Disinfection

A process achieved by immersion in Metricide Plus OPA (ortho-phthalaldehyde Disinfection solution) for a minimum of 12 minutes or a EPA registered glutaraldehyde solution for A minimum of 45 minutes on pre-cleaned objects that come into contact with mucous membranes or non-intact skin

Disinfection

Approved disinfecting towelettes will clean and disinfect when used as directed. Use one towelette to completely preclean surfaces of all gross debris. Use a second towelette to thoroughly wet the surface. Repeated use of the product may be required to ensure the surface remains visibly wet for the contact time listed on the product label

Decontamination:

A process of rendering items contaminated with organisms that may be capable of producing disease or infection, safe for handling by personnel. Read label and follow manufacturer's instructions

Central Sterilization Location (CSL):

A sterile reprocessing unit receives soiled/contaminated instrumentation, supplies and equipment from multiple locations. These items are cleaned and sterilized for distribution and reuse.

POLICY

Sterilization and decontamination areas are administered by a facility appointed representative who is under the direction of Nursing Director of Surgical Services with Epidemiology providing guidance and monitoring compliance with these procedures. Epidemiology will identify the locations that may use high-level disinfection and monitor for appropriateness of use.

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INFECTION PREVENTION AND CONTROL PLAN

The hospital implements infection prevention and control activities when doing the following:
Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies.

High level disinfection may be used if sterilization is not possible as in the case of flexible GI scopes.

Procedures to implement the policy that include but are not limited to the following, meet the guidelines of regulatory sterilization practice.

Event-related shelf life for all sterilized items processed in the hospital and date-related shelf life for commercially processed items.

Load Control System and Documentation

Loading and Unloading of Sterilizers

Sterilization of Implants

Bowie-Dick Test on Pre-vacuum Sterilizers

Maintenance and Cleaning of Sterilizers

Biological/Chemical Monitoring of Sterilizers

Sterile Packaging and Wrapping Technique

Decontamination of Instruments, Supplies and Equipment

Recall of Supplies

Metricide OPA Plus (ortho – phthaldehyde) High Level Disinfection

Resert XL HLD (Hydrogen Peroxide 2.0%) High Level Disinfection

Documentation to ensure sterilizers are operated properly and safely is maintained in accordance with regulatory requirements and infection control protocols for the safe operation, testing and maintenance of sterilizer.

The Sterile Reprocessing Manual is revised as needed by Nurse managing Sterile Reprocessing areas and Epidemiology. The manual, once revisions are completed, is maintained in each area, where there are operating sterilizers.

Materials Management and Central Reprocessing will assist in the Emergency collection and disposition of supplies when special warnings have been issued by the manufacturer, governmental agency or when warranted by the hospital's quality control/ assurance process.

REPROCESSING OF SINGLE USE ITEMS

LAC+USC Medical Center do not reprocess single use devices on site.

EXPIRATION DATING OF STERILE ITEMS

Before using sterile items, note the expiration date and integrity of packaging. Facility sterilized items are stamped with a label that gives the date sterilized and the expiration date. Commercially prepared items are to be considered sterile until the labeled expiration date. If no expiration date is present, they are to be considered sterile as long as the integrity of the packaging is not compromised.

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INFECTION PREVENTION AND CONTROL PLAN**

CRUSTED SCABIES CONTROL PLAN

PURPOSE

Crusted scabies (Norwegian Scabies) is a highly communicable infestation and must be reported to Epidemiology/Infection Control and the Acute Communicable Disease Unit in accordance with Los Angeles County Department of Public Health regulations.

POLICY

A comprehensive control program has been developed in conjunction with the Los Angeles County Acute Communicable Disease Unit (ACD) to prevent the nosocomial spread of scabies.

GUIDELINES

The program consists of, but is not limited to, the following:

PATIENT MANAGEMENT

- Isolation of the patient
- Notification of Epidemiology/Infection Control
- Education of all staff on disease and its control
- Obtaining skin scrapings to confirm disease
- Removal of hyperkeratotic crusts
- Treatment with scabidical agent
- Weekly examination and skin scrapings until no new lesions occur
- Isolation until negative skin scrapings have been obtained from a minimum of three anatomical sites and until Dermatologist or Infectious Disease physician has determined the patient to be scabies-free.

MANAGEMENT OF INDIVIDUAL CONTACTS

- Notify potentially exposed staff of the need for evaluation and prophylactic treatment.
- Treatment of all symptomatic staff and prophylactic treatment of their household members (staff may not return to work until the treatment is complete).
- Provide clear patient-use instructions for scabicide. Prophylactic treatment of all asymptomatic staff that were exposed to the patient's environment before control measures
- Treatment of all asymptomatic patients on the affected unit/ area, including those transferred or discharged.
- Environmental cleaning of affected units or areas simultaneously with treatment.

MANAGEMENT OF SCABIES OUTBREAK

Definition: Increase in the incidence if new cases above the baseline within a defined period of time, defined geographical location or within the hospital

- Two or more confirmed (positive skin scraping) cases of scabies identified in patients, healthcare workers, volunteers and/or visitors during a two (2) week period of time, or
- One confirmed (positive skin scraping) case and at least two (2) clinically suspect cases identified in patients, healthcare workers, volunteer and/or visitors during a two (2) week period of time, or
- At least two (2) clinically suspect cases identified in patients, healthcare workers, volunteers and/or visitors during a two (2) week period of time.

Nosocomial transmission is highly probable if scabies is confirmed in two or more healthcare workers who have worked in the same area of the facility within the previous six weeks and who do not have an apparent source of exposure outside the facility

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1. Action
Immediate removal from work any healthcare worker with signs and symptoms of scabies and refer HCW to Employee Health.
2. Evaluate patients on affected units and place patients with suspected scabies in Contact Isolation until treatment completed.
3. Report nosocomial scabies outbreaks and single cases of **crusted scabies** to Public Health.
4. Meet with staff to identify risk factors contributing to the outbreak and implement control measures.
5. If five or more healthcare workers working in the same area are diagnosed with scabies, it is likely that the source case was a patient with crusted scabies infection.
6. Treat symptomatic patients and healthcare workers. Provide prophylactic scabicide to all contacts of symptomatic cases.
7. Provide training to all staff on the signs and symptoms of scabies. People can be infected and contagious for up to six weeks before any symptoms start.
8. Perform environmental cleaning of the infected units. Ideally these steps should be accomplished within the same 24 hour period to prevent re-infestation of treated or prophylaxed individuals

RESPONSIBILITY

Epidemiology/Infection Control working with the Health Care Service site and the Public Health Department will initiate the control and treatment measures. Epidemiology/Infection Control will notify all Departments /areas that are affected.

REFERENCES:

Los Angeles County of Los Angeles – DHS Public Health Programs and Services Acute Communicable Disease Control. Draft Guidelines for the Prevention and Control of Scabies in Los Angeles County Health Care Facilities, August 1997.

Los Angeles County of Los Angeles – DHS Public Health Programs and Services Acute Communicable Disease Control. Communicable Disease Manual January 2003.

Guidelines for the Prevention and Control of Scabies in Los Angeles County Health Care Facilities – County of Los Angeles Department of Public Health Acute Communicable Disease Control. July 2006

Los Angeles County of Los Angeles – DHS Public Health Programs and Services A Manual of Departmental Rules, Regulations and Control Procedures (Communicable Disease Control) Revised 7/2012.

**LAC+USC MEDICAL CENTER
INFECTION PREVENTION AND CONTROL PLAN**

MEASLES (RUBEOLA) AND RUBELLA (GERMAN MEASLES) CONTROL PLAN

PURPOSE

To protect health care worker (HCW) from acquiring and transmitting Rubeola and Rubella to patients and staff.

POLICY

All Health Care Workers will demonstrate immunity to Rubella and Rubeola. Those without demonstrated immunity must provide documentation of 2 series of immunization.

DEFINITIONS

Rubeola Immunity: A person shall be considered immune to Rubeola if he/she has a positive Rubeola antibody titer. Persons of any age and job class, who work in a health care facility, shall be evaluated for Rubeola immunity when they are hired or at the time of their health care assessment or job assignment unless they provide documentation of immunity.

Rubella Immunity: A person shall be considered immune to Rubella if he/she has a positive rubella antibody titer. Persons, of any age and job class, who work in a health care facility, shall be evaluated for Rubella immunity when they are hired or at the time of health care assessment or job assignment unless they provide documentation of immunity.

Health Care Worker (HCW): Any person who is on facility grounds and who is employed by the facility (compensated or uncompensated). This term is inclusive of students, affiliating personnel and contract workers.

Rubella Exposure: Face-to-face or room contact with a case from 7 days before to 7 days after the rash onset) in patients, visitors and HCW who are not known to be immune to Rubella/Rubeola

Measles (Rubeola) Exposure: Face-to-face or room contact with a case from 4 days before to 4 days after the rash onset in patients, visitors and HCW who are not known to be immune to Rubella/Rubeola

METHODS OF COMPLIANCE

1. Human Resources, the Contract Monitor, or the appropriate area supervisor shall refer all Health Care Workers to the HCSS.
2. Documentation of Measles and Rubella Immunity status(s) will be recorded in the HCW health record. HCW may bring documentation of 2 doses of MMR.
3. Where no documentation is presented blood will be drawn to assess immunity status.
4. HCW with MMR (2 doses) documentation without demonstrated immunity will be given a booster; and must demonstrate they are not pregnant. HCW will be retested and notified by the HCSS if no immunity is demonstrated.
5. HCW without demonstrated immunity who can provide documentation of 2 Rubella Measles series will be not be given another Rubella/Measles Vaccination series (2 injections) and retested. Those with still little or no measurable antibody present HCW should be considered immune.

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6. HCW will be instructed on the possible adverse reactions to these vaccines and contra-indications to vaccinations (See below).

Measles and Rubella vaccine(s) is contraindicated for persons with the following conditions:

- a. Immunodeficiency and/ or immunosuppression.
 - b. Severe febrile illness. (Determination of severity of febrile illness requires nursing and, if necessary, medical judgment.) Vaccine administration should not be postponed for minor illnesses such as mild upper respiratory infections.
 - c. Pregnant females.
 - d. Anaphylactic allergy to eggs or neomycin. (If rubella vaccine alone is being given, a history of anaphylactic reactions to egg ingestion need not be considered).
 - e. Recipient of Immune Serum Globulin or blood transfusion within the last (3) months.
7. HCW with contra-indications will not be vaccinated by the HCSS without express written approval from their private physician who will be encouraged to perform these vaccinations.
 8. All HCWs must be immune to Rubella and Rubeola in order to work in this facility.
 9. Whenever possible women of childbearing age, who are sexually active, will be vaccinated during their menses. The last menstrual period shall be recorded in the medical record and they will be instructed not to become pregnant during the succeeding three months. Such instructions must also be documented in the medical record.
 10. Measles and Rubella shall be administered, meeting all requirements of Departmental of Health Services Policy for Informed Consent and the County of Los Angeles DHS Acute Communicable Disease Control.

HCW IMMUNIZATION PROTOCOL

Immunoprophylaxis for Measles (Rubeola) in Exposed HCW and patients

1. Measles vaccine given within 3 days after first exposure is sometimes successful in preventing infection.
2. Immune Serum Globulin is more effective than vaccine in preventing or modifying illness if given within 6 days after first exposure, and is protective for two to three months. It is recommended for the following exposed persons:

Pregnant women with no immunity
Immunocompromised persons
3. Despite immunoprophylaxis, exposed persons may develop Measles within the two-week incubation period

Immune Serum Globulin

Immunocompetent:

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Dosage: 0.11 ml/lb. (0.25 ml/kg) body weight, IM, to a maximum dose of 15 cc in divided doses
- Maximum dose 5 ml per site.

Immunocompromised:

Dosage: 0.22 ml/lb. (0.5 ml/kg) body weight, IM, to a maximum dose of 15 cc in divided doses
- Maximum dose 5 ml per site.

Measles Adult Vaccinations

Dosage: 0.5 ml S.C. as a single dose

Post Immunization Titer check at 30 days. If immunity is not demonstrated a second dose is administered, in aforementioned dosage.

Rubella Vaccination

Dosage: 0.5 ml S.C. as a single dose

Post Immunization Titer Check at 30 days. If immunity is not demonstrated a second dose is administered, in aforementioned dosage.

Rubella-Measles Vaccine (MR)

Dosage: 0.5 ml S.C. as a single dose

Post Immunization Titer Check at 30 days. If immunity is not demonstrated a second dose is administered, in aforementioned dosage.

Measles-Rubella-Mumps Vaccine (MMR)

Dosage: 0.5 ml S.C. as a single dose

Post Immunization Titer Check at 30 days. If immunity is not demonstrated a second dose is administered, in aforementioned dosage.

Reporting of Adverse Drug Reactions:

All adverse reactions to these vaccines will be reported to the HCSS supplying pharmacy so that appropriate notification and reporting to public health authorities and pharmaceutical suppliers may occur in accordance with the Centers for Disease Control Vaccine Adverse Reporting System.

MANAGEMENT OF RUBELLA AND MEASLES OUTBREAK

1. Juveniles
 - a) Patients with or suspected to have Rubella/Measles will be placed in Negative Pressure Isolation room and placed in Droplet Precautions for 7 days (Rubella)/ 4 days (Measles) (Measles) after the rash appears. Immunocompromised patients shall remain in Droplet. Isolation for the duration of their illness. Staff members with documented immunity to Rubella/Measles will provide care to these patients

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b) Non immune juveniles exposed shall be isolated as in 1a for 23 days (Rubella)/15 days. (Measles) after exposure, if practical. Immunization may be offered for future potential exposures, in the event the current exposure did not induce immunity.

c) Defer the admission of pregnant women not known to be immune to Rubella/Measles. Prompt discharge of such women already in the institution if possible. but rather to women in the first 5 months of pregnancy.

d) Recently discharged patients who have been exposed to Rubella/Measles and who are of unknown immune status are advised to avoid contact with pregnant women in the first 5 months of pregnancy for the next three weeks. Immunization may be offered for future potential exposures, in the event the current exposure did not induce immunity.

2. Health Care Workers

HCW ill with known or suspected Rubella/Measles shall stay home from work for 7 days after rash onset. Their Private provider will provide medical release certificate to clear HCW who will go to Human Resources Return to Work Unit before returning to work. Immunocompromised HCW will continue off duty for the duration of their illness. Their Private provider will provide medical release certificate to clear HCW who will go to Human Resources Return to Work Unit before returning to work.

Reporting of Cases to Public Health

All cases of Measles (Rubeola) and Rubella shall be reported to Public Health as is outlined in the Infection Control Plan.

REFERENCES:

US DHS Publications No 80-5225, 1970, revised 1980 (Rubella)

USPHS Advisory Committee on Immunization Practices: Rubella prevention. MMWR 1990; 39/No. RR15: 1-17

DHS Policy No. 103, Public Health Policy and Procedures (Rubeola)

California DHS Immunization Unit Management of Rubella Outbreaks in Hospitals and other Institutions (Including Jails and Prisons) March 1991

DHS Policy No. 314, Informed Consent

Advisory Committee on Infections within Hospitals of the American Hospital Association: Recommendations for the Control of Rubella within Hospitals. Infection Control 2:410-411,424, 1981.

Measles (Rubeola) Prevention and Control- Recommendations for Health Care Providers and Facilities, California Morbidity, #13 #14, April 7, 1995. Recommendations for Use and Storage of Immunobiologicals and Other prophylactic Agents.

Los Angeles County Department Health Services Public Health Programs Acute Communicable Disease Program (Revised 2010)

LAC+U.S.C. Medical Center Policy for Rubella Testing and Immunizations 2010

**LAC+USC MEDICAL CENTER
INFECTION PREVENTION AND CONTROL PLAN**

VARICELLA (CHICKENPOX) CONTROL PLAN

PURPOSE

All Health Care Workers will demonstrate immunity to Varicella to protect health care workers from acquiring and transmitting Varicella to patients and staff.

POLICY

Definitions:

Varicella Immunity: A person shall be considered immune to Varicella if he/she has a positive Varicella antibody titer. Persons without documented immunity who present with documentation of being given 2 vaccine series do not need to be evaluated for Varicella immunity when they are hired or at the time of their health care assessment or job assignment.

Health Care Worker (HCW): Any person who is on facility grounds and who is employed by the facility (compensated or uncompensated). This term is inclusive of students, affiliating personnel and contract workers. HCW assigned to facility must demonstrate immunity to Varicella.

Varicella (Chicken pox) Exposure: Face-to-face or room contact with a case from 2 days before onset of rash to 7 days after the rash onset or until all lesions are dry) in patients, visitors and HCW who are not known to be immune to Varicella.

METHODS OF COMPLIANCE

1. All HCW shall be referred to the HCSS by Human Resources, the Contract Monitor, or the appropriate area supervisor to the HCSS.
2. Documentation of Varicella Immunity status will be recorded in the HCW health record.
3. Where no documentation is presented blood will be drawn to assess immunity status.
4. HCW without demonstrated immunity will be notified by the HCSS
5. HCW without demonstrated immunity will be offered Varicella Vaccination
6. HCW will be instructed on the possible adverse reactions to these vaccines and contra-indications to vaccinations (See below :)

Varicella vaccine is contraindicated for persons with the following conditions:

- a. Immunodeficiency and/or immunosuppression.
- b. Severe febrile illness. (Determination of severity of febrile illness requires nursing and, if necessary, medical judgment.) Vaccine administration should not be postponed for minor illnesses such as mild upper respiratory infections.
- c. Pregnant females.

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- d. Anaphylactic allergy to eggs or Neomycin.
- 7. HCW with contra-indications will not be vaccinated by the HCSS without express written approval from their private physician who will be encouraged to perform these vaccinations.
- 8. All HCW without contra-indications will be asked to consent for immunization. Vaccination will not proceed without properly executed consent.
- 9. HCWs shall be assigned to an alternate job site if immunity cannot be induced by immunization, there is medical contraindication or the HCW refuses.
- 10. Whenever possible women of childbearing age, who are sexually active, will be vaccinated during their menses. The last menstrual period shall be recorded in the medical record and they will be instructed not to become pregnant during the succeeding three months. Such instructions must also be documented in the medical record.
- 11. Varicella vaccine shall be administered, meeting all requirements of Departmental of Health Services Policy for Informed Consent and the County of Los Angeles DHS Acute Communicable Disease Control.

HCW IMMUNIZATION PROTOCOL

Immunoprophylaxis for Varicella (Chickenpox) in Exposed HCW and patients

- 1. Varicella vaccine given within 3 days after first exposure is sometimes successful in preventing infection.
- 2. Varicella Zoster Immune Serum Globulin is more effective than vaccine in preventing or modifying illness if given within 96 hours of exposure, and is protective approximately two to three months. It is recommended for the following exposed persons:

Nonimmune pregnant women
Immunocompromised persons
- 3. Despite immuno-prophylaxis exposed persons may develop Varicella within the two-week incubation period

Varicella Zoster Immune Serum Globulin (VZIG)

Immuno-competent:

Dosage: HCW over 40 grams - 625 units of Varicella Zoster Immune Globulin (5 vials)

Immuno-compromised:

Dosage: HCW over 40 grams - 625 units of Varicella Zoster Immune Globulin (5 vials)

Varicella Adult Vaccination

Dosage: Two (2) 0.5 ml doses subcutaneous administer 4 - 8 weeks apart

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Post Immunization Titer Check 30 days after immunization.

HCW who are not immune after timed Varicella vaccination will be counseled by their HCSS to receive Varicella Zoster Immune Globulin when exposed to individual with active Varicella, as outlined in the nonimmune employee exposure

Reporting Of Adverse Drug Reactions:

All adverse reactions to these vaccines will be reported to the HCSS supplying pharmacy so that appropriate notification and reporting to public health authorities and pharmaceutical suppliers may occur in accordance with the Centers for Disease Control Vaccine Adverse Reporting System.

Healthy persons in whom Varicella-like rash develops following vaccination have a minimal risk for transmission of vaccine virus to their close contacts. Vaccinees in which vaccine-related rash develops must notify the HCSS and not report to work.

Herpes Zoster (shingles) can occur after Varicella virus vaccination as it can after natural varicella disease. Up to the present, the incidence of Herpes Zoster in otherwise healthy adults is expected to be less than in unvaccinated adults. The long-term effect of Varicella virus vaccine on the incidence of Herpes Zoster is unknown at present.

MANAGEMENT OF VARICELLA OUTBREAK

1. Patients

- c. Patients with Varicella or suspected to have Varicella will be placed in Airborne / Contact Precautions in isolation rooms or in rooms with similarly affected individuals for a minimum of 7 days after the rash appears or until all lesions are dry. All immunocompromised patients shall remain in Airborne Precautions for the duration of their illness. Staff members with documented immunity to Varicella will provide care to these patients.
- d. Nonimmune exposed patients exposed shall be isolated as in 1a above for the period of 10 days after exposure until day 21 after exposure. Immunization may be offered for future potential exposures, in the event the current exposure did not induce immunity.
- e. Defer the admission of pregnant women not known to be immune to varicella; prompt discharge of such women already in the institution if possible. This does not apply to pregnant women at term being admitted for delivery, but rather to women in the first 5 months of pregnancy.
- f. Recently discharged patients who have been exposed to Varicella and who are of unknown Immune status are advised to avoid contact with pregnant women in the first 5 months of pregnancy for the next three weeks. Immunization may be offered for future potential exposures, in the event the current exposure did not induce immunity.

2. Visitors

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- a. Pregnant women shall be prohibited from entering the room where patients with known Varicella are housed.
 - b. Other persons will be advised not to enter these isolation areas if they have unknown or uncertain immunity to Varicella.
3. Health Care Workers
- a. HCW ill with known or suspected Varicella shall stay home from work for 7 days after rash onset or until all lesions are dry. Their private provider will provide medical release certificate to clear HCW who will go to Human Resources Return to Work Unit before returning to work.
 - b. HCW exposed without documented immunity to Varicella should stay home from day 10 to day 21 following exposure.
 - c. Nonimmune pregnant exposed HCW in the first 5 months of pregnancy shall stay home from work until one week after the rash on the last case fades.
 - d. Nonimmune exposed HCW in household contact with pregnant women should be promptly immunized.

GUIDELINES

1. Documentation of Varicella immunization or titer will be recorded in the employee's health record.
2. Health care workers (HCW) who cannot provide documentation of Varicella titer or immunization must be re-immunized.
3. Appropriate precautions shall be taken to avoid immunization of pregnant females and to counsel female employees about avoidance of pregnancy for three (3) months following immunization.
4. If the HCW develops a rash following Varivax administration he/she must contact the HCSS who remove the worker from work until rash has disappeared.
5. Varicella Zoster Immune Globulin (VZIG) may be offered to pregnant or immunocompromised documented negative health care workers who are inadvertently exposed to individuals who are infectious with Varicella. The VZIG is available from the pharmacy with a special request form (Blue letter gram).
6. Documented titer negative individuals who have been exposed to an individual with Varicella will be removed from work on day 10 following exposure by Health Care Service site and remain off work until day 21 after exposure or if they develop disease until all lesions are dry.

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7. Health care workers who develop Varicella must notify their supervisor and Health Care Service site as soon as possible if they are diagnosed with varicella. If they suspect varicella they must contact Health Care Service site and be assessed to verify the diagnosis.

8. Health care workers with Varicella cannot return to work until they have been cleared by the Health Care Service site. HCSS will provide the HCW with documentation to be given to the area supervisor prior to returning to work.

REFERENCES:

California DHS Interim Guidelines for Handling and Use of Varicella Vaccine, June 15, 1995
Recommendations for the Use of Live Attenuated Varicella Vaccine, Committee on Infectious Diseases, A. A. P., Pediatrics 95:5, May 1995

DHS Policy No 314, Informed Consent.

LAC+U.S.C. Medical Center Policy for Varicella Testing and Immunizations 2010

Recommendations for Use and Storage of Immunobiologicals and Other Prophylactic Agents.

Los Angeles County Department Health Services Public Health Programs Acute Communicable Disease Program (Revised 1/03)

Los Angeles County Department Health Services Public Health Programs Acute Communicable Disease Program (Revised 2010)

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MUMPS (INFECTIOUS PAROTITIS) CONTROL PLAN

PURPOSE

All Health Care Workers will demonstrate immunity to Mumps to protect health care workers from acquiring and transmitting Mumps to patients and staff.

POLICY

Mumps Immunity:

1. All healthcare workers should have documentation of having received two (2) doses of MMR vaccine or other acceptable evidence of immunity to measles, mumps and rubella in the health care worker/s health record.

2. Because birth before 1957 is only presumptive evidence of immunity, health care facilities should consider recommending one (1) dose of MMR vaccine for workers borne before 1957 who do not have evidence for mumps when they are hired or at the time of their health care assessment or job assignment.

Health Care Worker (HCW): Any person who is on facility grounds and who is employed by the facility (compensated or uncompensated). This term is inclusive of students, affiliating personnel and contract workers.

Mumps (Parotitis) Exposure: Face-to-face or room contact with a case from 7 days before to 9 days after the onset of parotitis. Maximum infectiousness occurs between 2 days before and 4 days after onset of illness

Health Care Service Site (HCSS)

Employee Health

Reporting Of Adverse Drug Reactions:

All adverse reactions to these vaccines will be reported to the HCSS supplying pharmacy so that appropriate notification and reporting to public health authorities and pharmaceutical suppliers may occur in accordance with the Centers for Disease Control Vaccine Adverse Reporting System.

MANAGEMENT OF MUMPS OUTBREAK

1. Patients
 - a. Patients with Mumps or suspected to have Mumps will be placed in Airborne/Contact precautions in isolation rooms or in rooms with similarly affected individuals for a
 - 1) Minimum of 9 days from onset of parotitis.
 - 2) Individuals should be counseled to not go to school or the workplace until 9 days after onset of parotitis if susceptible contacts are present.
 - 3) All immunocompromised patients shall remain in Airborne Precautions for the duration of their illness. Staff members with documented immunity to Mumps will provide care to these patients.

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2. Visitors
 - a. Pregnant women shall be prohibited from entering the room where patients with known Mumps are housed.
 - b. Other persons will be advised not to enter these isolation areas if they have unknown or uncertain immunity to Mumps.

3. Health Care Workers
 - a. Health care workers who develop Mumps must notify their supervisor and Health Care Service site as soon as possible if they are diagnosed with mumps. If they suspect mumps they must contact Health Care Service site and be assessed to verify the diagnosis.
 - b. Documented titer negative individuals who have been exposed to an individual with Mumps will be removed from work on day 12 following exposure by Health Care Service site and remain off work until day 25 exposure or 15 days after parotitis onset if they develop the infection.
 - c. Health care workers with Mumps cannot return to work until they are no longer infectious. Their private provider will provide medical release certificate to clear HCW who will go to Human Resources Return to Work Unit before returning to work.
 - d. Vaccine is contraindicated in immunosuppressed. For theoretical reasons pregnant women or women planning a pregnancy in next month should not receive the Mumps vaccine although no evidence exists that the mumps vaccine causes fetal damage.

GUIDELINES

1. All healthcare workers should have documentation of having received two (2) doses of MMR vaccine or other acceptable evidence of immunity to measles, mumps and rubella. In the health care worker/s health record.
2. Because birth before 1957 is only presumptive evidence of immunity, health care facilities should consider recommending one (1) dose of MMR vaccine for workers borne before 1957 who do not have evidence for mumps.
3. Vaccine is contraindicated in immune suppressed. For theoretical reasons pregnant women or women planning a pregnancy in next month should not receive the Mumps vaccine although no evidence exists that the mumps vaccine causes fetal damage.
5. Immunize contacts, Immunization after exposure may not always prevent infection. IG is not effective and is not recommended.
6. Documented titer negative individuals who have been exposed to an individual with Mumps will be removed from work on day 12 following exposure by Health Care Service

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site and remain off work until day 25 exposure or 15 days after parotitis onset if they develop the infection.

REFERENCES:

Advisory Committee on Immunization Practices:

<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm55e601a1.htm>

Centers for Disease for Disease Control and Prevention

<http://www.cdc.gov/nip/diseases/mumps/>

<http://www.cdc.gov/nip/diseases/mumps/ACHAguidance-ltr.pdf>

American College Health Association:

<http://www.acha.org/ACHAMumpsSignedFinal.pdf>

<http://www.acha.org/mumps> 06.cfm

DHS Policy No 314, Informed Consent.

Recommendations for Use and Storage of Immunobiologicals and Other Prophylactic Agents.

Los Angeles County Department Health Services Public Health Programs Acute Communicable Disease Program (Revised 1/07)

Control of Communicable Disease Manual 18th edition American Public Health Association (Revised 2004)

Los Angeles County Department Health Services Public Health Programs Acute Communicable Disease Program (Revised 2010)

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FLOWERS AND PLANTS IN PATIENT-CARE AREAS

Flowers and potted plants need not be restricted from areas for immunocompetent patients

Staff directly involved with patient care should not do care and maintenance of flowers and potted plants.

If plant or flower care by patient-care staff is unavoidable, instruct the staff to wear gloves when handling plants and flowers and perform hand hygiene after glove removal.

Do not allow fresh or dried flowers or potted plants inpatient care areas for immunocompromised patients.

Any area having artificial plants and flowers to beautify environment is responsible for cleaning these plants.

ANIMAL ASSISTED ACTIVITIES AND SERVICE ANIMAL POLICY

ANIMAL ASSISTED ACTIVITIES

Persons trained in providing activities or therapies safely must control animals that visit this facility and know the animal's health status and behavior traits. To mitigate allergic responses, the animal must be bathed < 24 hours before and groomed to remove loose hair prior to coming into the facility.

Children 5 years of age and older may actively participate in animal program with the approval of their parent, physician or nurse. Following animal contact patients and personnel use hand hygiene.

Place a sheet over the bedside to protect surface of bed, if the animal visits the child at the bedside. Use routine cleaning protocols to clean surfaces after therapy sessions.

If an incident of biting or scratching occurs during the animal assisted therapy or activity. Promptly clean and treat scratches, bites or other breaks in the skin.

Remove the animal permanently from these programs and report the incident promptly to appropriate authorities. (Infection control, animal program coordinator or local animal control personnel) Submit an incident report for internal documentation and review.

SERVICE ANIMAL POLICY

Avoid providing facility access to nonhuman primates and reptiles as service animals.

Allow service animal's access to the facility in accordance with the Americans with Disabilities Act of 1990, unless the presence of the animal creates a direct threat to other persons or a fundamental alteration in the nature of the services. Service animals are not authorized to enter into an OR, Intensive Care Units, Labor and Delivery suite or unit, or any invasive procedure areas as referenced in the Americans with Disabilities Act and the LAC+USC Medical Center Policy 240, Animals in Hospital/Healthcare Setting.

When a decision must be made regarding a service animal's access to any particular area of the health-care facility, evaluate the service animal, patient, and health-care situation on a case by case basis to

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determine whether significant risk of harm exists and whether reasonable modifications in policies and procedures will mitigate this risk.

If a patient **must** be separated from his or her service animal while in the health-care facility, ascertain from the person what arrangements have been made for supervision or care of the animal during this period of separation. Make appropriate arrangements to address the patient's need in the absence of the service animal.

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**LAC+USC MEDICAL CENTER PULMONARY PHYSIOLOGY LABORATORY SLEEP LABORATORY POLICY 4.1:
PATIENT SAFETY/INFECTION CONTROL POLICY**

PURPOSE:

The Pulmonary Physiology Laboratory monitors patient safety as required by the Joint Commission (TJC), National Patient Safety Goal (NPSG).

POLICY:

Technical staff must notify a physician when non-emergency medical assistance is required for a patient within our laboratory setting. An “on-call” sleep physician is assigned to be available to technicians after hours, on weekends, and on holidays. Staff will document that calls to “on-call” physicians were answered in a timely manner. Staff will also document any instances of patient “hand-off”, when, during either overnight or daytime polysomnographic testing, a patient is transferred to another unit, service, or facility under physician’s orders

In case of Medical EMERGENCY, follow “CODE ASSIST” or “CODE BLUE” per standard protocol.

PROCEDURE:

Non-emergency medical assistance:

1. At least one day prior to the date of the study, designated staff reviews the eConsult (referring document). Bring any discrepancies to the attention of the supervisor for a correction.
2. At the time of the study, assess the patient, and note any physical or psychological problems. *If there are any* problems that need physician intervention before patient hook-up, during testing, or after testing while the patient is still in the laboratory area, contact (page) the Pulmonary Resident or Medical Director, following the steps in this procedure. Also inform the supervisor of the problem. **ALL communications/attempts will be documented in Sleep Lab Log Book and in ORCHID.**

Contacting the Resident

- a. To find out the name of the Fellow, go to the LAC+USC Home Page. Go to the ‘Clinical Systems’ section (on the left column), find the word ‘AMION”, and click. At the Login screen, type in **lacusc** (all in small letters) as the password, then click on the ‘Login’ button.
- b. A new screen will appear. Look at the left column; it lists the names of departments. Scroll down to ‘**IM-Pulmonary/CC Residents**’. Click binocular symbol in the middle column. Look at the row labeled “**LAC-NIGHT**”. The name listed in that row is the physician on call that evening.
- c. Page the Fellow. If you do not get a return call after 5 minutes’ time, page him a second time.
If you still do not get a response after another 5 minutes’ time, contact Attending.

Contacting Attending

- a. The same step as above to log-in.
- b. Look for ‘**IM-Pulmonary/CC Attendings**’. Click binocular symbol next to it.
- c. Look for **Director, Sleep Services ON CALL** (8am – 8pm):
Juarez, Ricardo:
Page number: 213-287-1797 (or call his cell at 626-827-7825, per his permission)

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NOTE: In a normal circumstance, Director, Sleep Service is assigned to be ON CALL 24/7, from 8 am to 8 am. His contact number is on the board for your quick reference.

Note: if the patient situation is an **emergency**, do **not wait** for return calls, or make numerous attempts to contact the Resident. Instead, follow the **“Code Assist”** OR **“CODE BLUE”**, **as appropriate**, per outline in the protocol for LAC+USC Medical Center.

3. When a physician is reached, clearly explain the problem. Listen carefully to any orders he/she gives. If there is any doubt to his/her orders, ask other sleep technician to speak with the doctor to clarify the order. Under no circumstance should any action affecting patient care, or O₂ therapy, be implemented unless the doctor’s order to do so is absolutely clear. Implement his/her orders as appropriate.
 - a. As soon as is practicable, **document situation details in ORCHID**, under “documentation”. Use as much explanatory text as is necessary.
 - b. Additionally, briefly document the situation in the area Sleep Laboratory log book.

Universal precautions

Standard procedures to reduce the spread of infection help assure the safety of the staff and patients.

All sleep staff will follow Universal Precautions and Blood borne Pathogen Standards for contact with all patients.

- **All technicians are properly trained on dealing with infection control during their orientation period and also retrained once a year.**
- **Technicians are responsible for washing their hands before and after contact with patient.**
- **All sleep lab employees will routinely use barrier precautions to prevent skin and mucus membrane exposure to all blood and body fluids. Barrier precautions may include the use of gloves, gowns, masks, goggles aprons, etc., depending on the type of exposure.**
- **All Personal Protective Equipment (PPE) are located in the technician supply room.**
- **Patients or technicians with any type of communicable illness or open wounds need to be rescheduled to a later date.**

Screening protocols:

The primary objectives of this section are to:

1. Enhance early recognition of a patient who may have a communicable disease of urgent health concern upon arrival at the Sleep Laboratory
2. Prompt the rapid institution of infection control measures to minimize potential transmission to staff, patients and their family.

A. Initial Patient Encounter (During a Reminder Call):

perform “communicable disease triage screening” for respiratory or rash communicable diseases on ALL patients who present or self-identify with a fever.

Screening on the phone will include asking all sleep patients about fever and the presence of respiratory symptoms (cough or shortness of breath) and rash symptoms, as well as epidemiologic risk factors, such as recent travel. Staff will note the time at which the patient was screened on the ORCHID.

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The following questions will be asked of all patients at the initial screening on the phone during a reminder call which is 2-3 days before sleep study appointment date.

- ❖ *Have you had **fever** (elevated temperatures)?*
- ❖ *Have you had **cough or a rash**?*
- ❖ *Have you had **shortness of breath** or difficulty breathing?*
- ❖ *Have you had a **headache**?*
- ❖ *Have you had **nausea or vomiting**?*
- ❖ *Have you had **an opened wound**?*
- ❖ *Have you had **lice**?*
- ❖ *Have you had **any kind of skin diseases**?*

* If there are one or more of these sign(s)/symptoms(s), consult with the Medical Director or the supervisor, before confirmation for an appointment is made.

NOTE: Additional information for staff

Some common contagious skin diseases

- *Scabies:*
 - Itching, often severe and usually worse at night
 - Thin, irregular burrow tracks made up of tiny blisters or bumps on skin
- *Ringworm:*
 - A scaly ring-shaped area, typically on the buttocks, trunk, arms and legs
 - Itching
 - A clear or scaly area inside the ring, perhaps with a scattering of red bumps
 - Slightly raised, expanding rings
 - A round, flat patch of itchy skin
 - Overlapping rings
- *Impetigo:*
 - reddish sores on the skin, often clustered around the nose and lips. These sores quickly grow into blisters, ooze and burst, and then form a yellowish crust.
- *Methicillin-resistant Staphylococcus aureus (MRSA):*
 - swollen, painful red bumps that might resemble pimples or spider bites.
 - warm to the touch
 - full of pus or other drainage
 - fever
- *Molluscum contagiosum (MC):*
 - are raised, round and flesh colored
 - are small — typically under about 1/4 inch in diameter
 - characteristically have a small indentation (umbilication) or dot at the top near the center
 - can become red and inflamed
 - itchy
 - can be easily removed by scratching or rubbing, which can spread the virus to adjacent skin
 - usually appear on the face, neck, armpits, arms and tops of the hands in children

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- may be seen on the genitals, lower abdomen and inner upper thighs

A. On Appointment Day (upon arrival):

The following questions (same questions that are used during reminder call) will be again asked in case that sign(s) and symptom(s) occur/develop after a reminder call was made.

- ❖ *Have you had **fever** (elevated temperatures)?*
- ❖ *Have you had **cough or a rash**?*
- ❖ *Have you had **shortness of breath** or difficulty breathing?*
- ❖ *Have you had a **headache**?*
- ❖ *Have you had **nausea or vomiting**?*
- ❖ *Have you had **an opened wound**?*
- ❖ *Have you had **lice**?*
- ❖ *Have you had **any kind of skin diseases**?*

* If there are one or more of these sign(s)/symptoms(s), consult with the Medical Director or the supervisor, **immediately**, before proceeds for sleep study.

Electrical Safety

All patient-related equipment is inspected for mechanical and electrical integrity.

- Each piece of equipment will be kept in good working and will be visually inspected before and after each use.
- Manufacturer's recommendations will be followed for periodic monitoring of recording equipment
- Electrical-safety testing will be performed yearly by Clinical Engineer Department
- Compliance with this policy will be documented
- Equipment including but not limited to: reusable sensors (gold cup electrodes, snoring microphones, etc.), junction boxes, CPAP machines, computers will be visually inspected before and after each shift.
- Any defective or broken equipment will be replaced as soon as the problem develops. Reserve equipment will be readily available.
- Annual safety inspections are made in equipment used in the Sleep Laboratory by the Clinical Engineering Department. Repairs to equipment are made by the Clinical Engineering Department and the companies (**SomnoStar™ z4 Sleep System** by Vyair Medical and **OmniLab Advanced multi-mode titration system** by Philips Respironics) as required by agreement.
- Annual equipment checks are kept in a log in at Clinical Engineering Department.