



**LAC+USC**  
Medical Center

# **INFECTION PREVENTION & CONTROL PLAN**

**Updated: Feb 2023**



# Welcome to LAC+USC Medical Center's Infection Prevention & Control Plan

## Welcome to Hospital Epidemiology and the LAC+USC Department of Infection Prevention & Control!

Hospitals and healthcare settings are full of potential infectious risks. The Covid-19 pandemic only highlights what has always been our primary mission: the provision and oversight of clear guidelines and practices to ensure a safe environment for LAC+USC Medical Center's staff and patients.

We hope you find this significantly revised plan helpful and useful. To the end, here is a list of helpful Infection Prevention & Control (IPC) reference tables in the document that you will likely refer to often.

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By following the procedures outlined in this Infection Prevention & Control Plan and our related policies, together we can achieve our goal of reducing risks of infections throughout the many areas of our medical center for our healthcare team members, patients, and visitors.

Led by expert Infectious Disease physicians and experienced nurse Infection Preventionists, the Department of Infection Prevention & Control is here to serve as your resource in addressing and overseeing all aspects of preventing infections, controlling the spread of identified infections, and adhering to regulatory requirements related to Infection Control.

We encourage you to reach out in any cases of uncertainty or where guidance is required related to preventing the spread of infections in your areas and units. We want to hear from you, and it is our goal to be available and build relationships with all staff within the medical center.



**LAC+USC Medical Center Infection Control Phone:** (323) 409-6645  
**SharePoint Site:** <https://lacounty.sharepoint.com/sites/dhs-lacusc-ipc>  
**Address:** 1100 N State Street, Clinic Tower A6E 107 • Los Angeles, CA 90033



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# SECTION I: IPC OVERVIEW and ORGANIZATION

## I-A: Infection Prevention & Control: Background, Purpose, Mission & Scope

**I-A.1 BACKGROUND:** Since its inception in the 1960s, the field of Infection Prevention and Control (herein referred to as “IPC”) has grown considerably. The field took shape in the 1970s following a landmark study on the efficacy of a nosocomial infection control project and grew in importance with the emergence of healthcare worker employee safety programs and the rise of multidrug-resistant organisms in the 1980s. In the 1990s and into the 2000s, focus on hospital-acquired infections grew, and the field played a larger role in regulatory, patient, and environmental safety, and quality improvement issues. In the present day, infection control data are available publicly. With the massive human and economic toll of modern pandemics like Ebola, Covid-19, antimicrobial resistance, and nosocomial infections, the importance of infection control has never been more prominent.

**I-A.2 IPC PURPOSE:** The purpose of the LAC+USC Department of Infection Prevention and Control is to prevent and control the acquisition and transmission of infections by and between patients, healthcare workers, and visitors throughout the medical center through implementation of best practices, education, surveillance, and the analysis of epidemiologic issues - both in the Medical Center and with respect to potentially transmissible diseases arising in the community.

**I-A.3 IPC MISSION & VISION:** LAC+USC Medical Center aims to maintain an ongoing Infection Control program designed to prevent, control, and investigate infections and communicable diseases among patients, healthcare workers, and visitors. The plan shall comply with current standard(s) of The Joint Commission on Hospital Accreditation {**IC.01.05.01**}. The LAC+USC IPC Plan and Department aim to contribute to a safe care environment and practices.

The procedures and activities of the LAC+USC IPC Department meet the standards and requirements outlined in the California Code of Regulations Title 22, California Occupational Safety and Health Administration (CA-OSHA), The Joint Commission (TJC), and the National Patient Safety Goals (NPSG). Where applicable, this Infection Prevention and Control Plan references relevant TJC, Centers for Medicare Services (CMS), and OSHA standards in { } brackets.

**I-A.4 IPC PLAN, SCOPE, & APPLICABILITY:** The Infection Prevention and Control Plan is applicable to **all** medical center personnel. Medical providers, nursing staff, and all ancillary personnel have a joint responsibility and obligation to protect the safety and health of patients, visitors, and their fellow healthcare workers. **All** personnel are individually responsible for knowing and adhering to the Medical Center Infection Control Plan {**IC.01.05.01, EP 6**}.

## I-B: Statement of Authority

The Infection Prevention and Control (IPC) Department is under the administrative authority of the LAC+USC Chief Medical Officer (CMO). The Hospital Epidemiologist will direct the Department on routine IPC matters, advising and obtaining direction from the CMO on policy issues {**IC.01.01.01**}. In emergencies, the Hospital Epidemiologist’s actions shall have the authority of the CMO’s office. Medical center administration recognize that any infection acquired during hospitalization, or any infection brought into the hospital, can potentially be hazardous to persons in the facility. Therefore, the IPC Committee, through its chairman (the Hospital Epidemiologist) or physician members the administrative authority to institute any appropriate preventive, surveillance, and/or control measures when any condition exists that could result in the spread of infection with the medical center or create a hazard for any person within its facilities.

The Assistant Nursing Director(s) and nurse Infection Preventionists assigned to the Epidemiology Department are under the direction and supervision of the Hospital Epidemiologist. Infection Preventionists have the authority to institute appropriate preventive or control measures when any infectious risk is thought to be present.

Examples of preventive and/or control measures include but are not limited to: instituting appropriate transmission-based precautions in accordance with this Plan and/or CDC guidelines, restricting visitors, temporarily closing a units or ward to further admissions in the case of a suspected or confirmed outbreak, restricting movement of patients from one area to another, and provision of education to staff, patients, and other persons at the hospital or its facilities. Other control measures may be implemented based on surveillance findings or Public Health recommendations {**IC.02.01.01, EP 2**}.

## I-C: Infection Prevention & Control Availability of Service and Contact Information

**I-C.1 INFECTION PREVENTION & CONTROL OFFICE HOURS & LOCATION:** The IPC Department is located in the **LAC+USC Clinic Tower 6<sup>th</sup> floor A6E** area. The IPC staff consists of a physician Hospital Epidemiologist, a physician Associate Hospital Epidemiologist, ten nurse Infection Preventionists (four Assistant Nursing Directors “ANDAs” and six Healthcare Facility Consultant RNs), one Administrative Assistant, and one additional clerical support staff member.

IPC Department office hours are 6:30 AM to 5:00 PM Monday to Friday.

During office hours, Epidemiology and IPC staff may be reached at the main office number 323-409-6645.

For afterhours coverage, see instructions below.

### I-C.2 INFECTION PREVENTION & CONTROL ON-CALL CONTACT INFORMATION MISSION

A nurse Infection Preventionist is on call 24/7, 7 days a week, and may be reached through the hospital’s pager operator at 323-409-4906 at night and on weekends and holidays. In case of less urgent after hours matters, messages may be left via voicemail on the main office number at 323-409-6645. Voicemail messages are answered within 1 business day.

For urgent Infection Control clinical matters outside of office hours, the on call physician Hospital Epidemiologist may be contacted (contact information always listed on AMION: amion.com -> login: lacusc -> scroll to Infectious Disease).

Additional roster and contact information for IPC Department personnel is summarized below **{IC.1.01.01, EP 1}**.

**TABLE 1: IPC CONTACT INFORMATION**

<b>IPC Main Office</b>	Office Phone: 323-409-6645 Office Fax: 323-441-4778 Email Listserv: LacuscInfectionControl@dhs.lacounty.gov	
Paul Holtom, MD	Hospital Epidemiologist	Email: pholtom@dhs.lacounty.gov Cell: 323-610-5197
Noah Wald-Dickler, MD, FACP	Associate Hospital Epidemiologist	Email: nwald-dickler@dhs.lacounty.gov Cell: 573-355-7139
James Agupitan, RN, CIC	Infection Preventionist	Email: jagupitan@dhs.lacounty.gov Pager: 323-410-3508
Jessica Castillo, RN	Infection Preventionist	Email: jcastillo777@dhs.lacounty.gov Pager: 323-410-3525
Ana Chavez, RN	Infection Preventionist (ANDA)	Email: anachavez@dhs.lacounty.gov Pager: 323-340-0569
Luisa Chong, RN, DNP, CIC	Infection Preventionist (ANDA)	Email: lchong@dhs.lacounty.gov Pager: 213-919-0720
Wasim Girgis, RN	Infection Preventionist	Email: wgirgis@dhs.lacounty.gov Pager: 323-410-3486
Esther Lau, RN	Infection Preventionist	Email: elau@dhs.lacounty.gov Pager: 323-410-3448
Patima Phongtratik, RN	Infection Preventionist	Email: PPhongtratik@dhs.lacounty.gov Pager: 323-410-3507
Ronald Vasquez, RN	Infection Preventionist (ANDA)	Email: rovasquez@dhs.lacounty.gov Pager: 323-372-7657
Rene Rothrock-Singleton	Infection Preventionist (ANDA)	Email: rrothrock@dhs.lacounty.gov Pager: 213-717-0120
Patricia Diaz	Senior Secretary II	Email: pdiaz@dhs.lacounty.gov Office: 323-409-6645
--- VACANT ---	Intermediate Typist Clerk	Office: 323-409-6645



## I-D.1: Hospital Epidemiologist & Associate Hospital Epidemiologist Job Description

**I-D.1.a POSITION SUMMARY:** The physician Hospital Epidemiologist, with assistance from the Associate Hospital Epidemiologist, serve as the Medical Directors of the IPC Department, have clinical authority over the IPC program {**IC01.01.01, EP 1**}, and chair/co-chair the Infection Control Committee. The chief responsibility of the Hospital Epidemiologist and Associate Hospital Epidemiologist is to provide expertise and leadership regarding strategies, practices, policies, procedures, and education aimed at preventing patient adverse events from hospital-acquired infections and antimicrobial resistance with the goal of improving patient care and hospital resource utilization.

**I-D.1.b POSITION QUALIFICATIONS:** physician (MD or DO) who satisfies all pertinent and recognized education, training, credentials, and professional society membership requirements for the position and function of Medical Director of Infection Prevention and Control including:

- Active member of the LAC+USC Attending Staff Association
- Documented fellowship training in Infectious Diseases from an ACGME-accredited institution {**CMS §482.42(a)**}
- ABIM board certification or board eligibility in Internal Medicine and the subspecialty of Infectious Disease
- Active ID supervising physician for the hospital Antimicrobial Stewardship Program {**MM.09.01.01, EPs 12,14,19**}
- Active member of the hospital Pharmacy & Therapeutics Antimicrobial Subcommittee
- Successful completion of specific training {**CMS §482.42(a)**} in Infection Control and Antimicrobial Stewardship
  - (e.g., *SHEA Primer on Healthcare Epidemiology & Antimicrobial Stewardship*)

**I-D.1.c RESPONSIBILITIES:** the physician Epidemiologists' general role is to provide expertise, leadership, and vision in Infection Prevention and Control policies and prevention measures, as well as antimicrobial utilization and resistance preventive measures for the medical center. Related specific duties include {**IC.01.01.01, EP 4**}, but are not limited to:

1. Oversee the development and implementation of hospital-wide infection surveillance, prevention, and control policies and procedures that adhere to nationally recognized guidelines and requirements.
2. Oversee the IPC Department's documentation of its infection surveillance, prevention, and control activities.
3. Oversee an annual review and update of the IPC Policy & Procedure Manual.
4. Guide the IPC staff and Infection Control Committee in the drafting and implementation of policies.
5. Lend Infectious Disease clinical expertise and leadership to identify, investigate, and resolve infectious outbreaks.
6. Communicate & interpret infection surveillance data to clinicians, administration, and Quality Improvement.
7. Train and educate staff, including medical staff & trainees, on practical applications of IPC guidelines and policies.
8. Actively participate in the administration and oversight of the hospital Antimicrobial Stewardship Program
9. Maintenance of an endemic viral surveillance database (including influenza, Covid-19, and mpox) and communication and interpretation of those surveillance results to the IPC and hospital staff and administration
10. Provide subject matter expertise and leadership with regard to special community and/or hospital disaster concerns (e.g., *bioterrorism preparedness, Pandemic Respiratory Viral Illness Preparedness*)
11. Maintain membership and advisory expertise to the Pharmacy & Therapeutics Committee and its Antimicrobial Subcommittee in collaboration with the Infection Control Committee for the following:
  - a. Monitor community and hospital infection trends with special regard to antimicrobial resistance monitoring
  - b. Provide expertise and leadership for antimicrobial resistance prevention strategies
  - c. In collaboration with the Microbiology and Pharmacy Departments, maintain regular surveillance reports on hospital antibiotic resistance (e.g., *hospital Antibigram*) {**IC.02.05.01, EPs 2,3**}
  - d. Designing, maintaining, and distributing current antimicrobial utilization guidelines relevant to clinicians
12. Regularly communicate with and act as liaison with the LA County Department of Public Health for communicable disease reporting and clinical management (e.g., *tuberculosis, measles, foodborne illness, etc.*)
13. Act as a liaison to Employee Health Services in policy and procedure development, vaccination compliance, pathogen exposure, and clinical consultant when infectious exposures arise among staff {**IC.02.03.01, EP 1**}.
14. Chair and/or co-chair the monthly LAC+USC Infection Control Committee as appointed by the Attending Staff Association
15. Serve on the Medical Executive Committee, reporting on preventive measures for hospital acquired infections
16. Serve on the DHS-wide Infection Prevention & Control Workgroup

## I-D.2: Nurse Infection Preventionist (IP) Job Description

**I-D.2.a POSITION SUMMARY:** Nurse Infection Preventionists (IPs) act as liaisons and resources for all issues related to Infection Prevention and Control throughout the medical center and are responsible for management of all IPC activities under the guidance of the Infection Control Committee and the physician Hospital Epidemiologist(s).

**I-D.2.b POSITION QUALIFICATIONS:** Registered Nurse (RN) graduate of an accredited School of Nursing with:

- **EDUCATION:** bachelor's degree (required), master's degree preferred. Specific subject knowledge in Microbiology, Public Health, Infectious Diseases, and clinical care are required.
- **EXPERIENCE:** acute care nursing experience with supervisory experience preferred. Experience with computer applications in Infection Prevention and Control and Microsoft Office programs.
- **TRAINING:** stays current on IPC topics. Attends seminars and conferences on Infection Prevention & Control.
- **LICENSURE:** state license in Nursing.
- **CERTIFICATION:** Certification in Infection Control (CIC) is a goal for all active IPs. CIC designation in Table 1.

**I-D.2.c RESPONSIBILITIES:** IP's serve as facilitators, subject matter experts, and resources for hospital leadership and front-line staff members in matters related to evidence-based Infection Prevention and Control practices. IPs develop, facilitate, and coordinate the IPC program for LAC+USC Medical Center and ensure compliance with requirements of CMS, Joint Commission, LA County and California Departments of Public Health, and other applicable regulatory agencies. Specific Infection Preventionist responsibilities include, but are not limited to the following:

1. Plan, direct, and evaluate all aspects of the IPC program and manage its daily operations.
2. Establish and maintain an up-to-date IPC Plan and related IPC policies and procedures.
3. Conduct Infection Prevention & Control educational programs for all medical center personnel.
4. Daily surveillance of Microbiology laboratory data, including positive cultures from on assigned patient care units, that may indicate infection.
5. Conduct in-person rounds, at least weekly, on all assigned hospital areas and units
6. Assess isolation practices and maintain a daily, up-to-date record of all patients
7. Identify (and notify unit leadership and promote corrective action) of hospital-acquired infections.
8. Record information on hospital-acquired infections including location, site, dates of onset & procedures etc.
9. Initiation of epidemiologic investigation of significant clusters or incidences above established thresholds.
10. Compile, maintain, and report data related to surveillance of hospital-acquired infections
11. Serve as a liaison to and resource for all persons concerned with infection control-related issues.
12. Advise and education on all Infection Prevention & Control-related policies and procedures.
13. Consult and advise on the use of transmission-based precautions for communicable diseases.
14. Serve as a liaison with the LA County Department of Public Health and identify and report all cases of reportable communicable diseases to the appropriate Public Health division.
15. Implement and monitor appropriate use of personal protective equipment among staff.
16. Initiate control measures when communicable diseases arise among staff and patients including:
  - a. Generation of contact lists (using Employee Health Persinda-based exposure modules)
  - b. Collaborate with Employee Health Services to ensure exposed staff are aware of recommended prophylactic treatment (if any) and restrictions (if any) following exposure to a communicable disease.
  - c. Provide in-service education to front-line staff about the disease and necessary control measures.
17. Serve as a liaison to Employee Health Services in implementing infection control procedures related to infectious occupational health hazards of hospital staff
18. Serve as an active member of the Infection Control Committee and enactor of the committee's activities.
19. Serve as a consultant to Central Sterile and all departments performing disinfection and sterilization activities.
20. Advise and consult on all cleaning and disinfection agents used in cleaning of the hospital environment.
21. Serve as a liaison with the Nursing Department with specific function including, but not limited to,
  - a. Consult on all nursing functions pertaining to prevention, recognition, and management of infections
  - b. Provide staff with information to assess for infections, initiate control measures, and report infections to patients, primary physicians and the IPC Department
  - c. Monitor sterile products and equipment storage conditions on unit
22. Maintain membership on, and actively attend all meetings of, the Patient Safety Committee in order to ensure its adherence to best practices to reduce the risk of healthcare-associated infections

## **I-D.3: Assistant Nursing Director, Administration (ANDA) / IPC Department Nurse Director**

**I-D.3.a POSITION SUMMARY:** In addition to the above nurse IP roles and functions, the ANDA IPC Nurse Director is assigned the responsibility of supervising, scheduling, and coordinating the other nurse Infection Preventionists and office clerical staff. The IPC Nurse Director serves as a functional office manager, reporting to the Hospital Epidemiologist.

**I-D.3.b POSITION QUALIFICATIONS:** In addition to all above nurse IP qualifications listed in Section I-E.2, the IPC Nurse Director shall have prior direct experience in hospital-based Infection Prevention & Control as well as prior supervisory or managerial experience.

**I-D.3.c RESPONSIBILITIES:** In addition to the above nurse IP functions and duties (though in reduced relative volume in comparison to the other IPs to permit time for office administrative roles), the IPC Nurse Director is responsible for:

1. Annual assignments of IPs to cover all medical center clinical and non-clinical areas and units
2. Managerial tasks including but not limited to: IP and clerical staff vacation approval and scheduling, creating, and maintaining an up-to-date on-call schedule for afterhours medical center nurse IP coverage
3. Preparing required hospital administration reports including, but not limited to, quarterly Governing Body report
4. In conjunction with the physician Hospital Epidemiologist(s), leading and facilitating weekly IPC Staff Meeting
5. Interviewing and coordinating training of new Infection Prevention & Control nurse and clerical staff members

## **I-D.4: Administrative Support Staff**

**I-D.4.a POSITION SUMMARY:** an experienced clerical staff member will serve as a leader in an office administrative role (Senior Secretary or Administrative Assistant II or equivalent) for the IPC Department. Together with the additional clerical support staff member, the administrative staff member will provide the necessary office, human resources, supplies, and clerical support needed to maintain the many important IPC Office functions.

**I-D.4.b POSITION QUALIFICATIONS AND/OR TRAINING:** the office administrator will have three years' working experience in office work, analyzing and proposing solutions for organizational issues, systems, and procedures with at least one year in general office administrative staff work at a skilled level.

**I-D.4.c RESPONSIBILITIES:** the senior administrative office staff member will perform many functions including, but not limited to the following:

1. Maintain and update the IPC Department Policy and Procedure manual.
2. Provide clerical and administrative guidance and support for other office personnel.
3. Coordinate all clerical assignments and monitor completed work for accuracy and completeness.
4. Coordinate with Human Resources (HR) on all appropriate personnel transactions relating to office staffing. This includes coordinating and scheduling interviews for new staff and assisting with on-boarding procedures.
5. Interface with HR Payroll Department to resolve complex office payroll issues.
6. Manage office personnel files including gathering and maintaining records of staff required training certificates.
7. Coordinate all travel and training requests for the IPC Department including completion of required forms and preparing justification for LA County reimbursement of expenses.
8. Work closely with other Department and unit administrators to assist them in the submission of their units' policies and procedures for IPC review and approval.
9. Develop and distribute an annual calendar to ancillary departments to provide an update to the Infection Control Committee.
10. Prepare slides for, and facilitate scheduling and invitations to, the monthly Infection Control Committee Meeting.
11. Perform other special assignments, including assisting with meeting scheduling, at the request of the physician Hospital Epidemiologist.



## I-D.5: Clerical Support Staff

**I-D.5.a POSITION SUMMARY:** an experienced clerical staff member (Intermediate Typist Clerk or equivalent) will provide additional office clerical support for the IPC Department. Together with the senior administrative staff member, the additional office clerical support member will provide the necessary office, human resources, supplies, and clerical support needed to maintain the many important IPC Office functions.

**I-D.5.b POSITION QUALIFICATIONS AND/OR TRAINING:** the office administrator will ideally have two years' experience as a typist clerk or equivalent and three years of office work experience.

**I-D.5.c RESPONSIBILITIES:** additional clerical support staff member duties include, but are not limited to:

1. Screen telephone calls by providing requested information, taking messages, and relaying calls to office staff.
2. Type complex correspondence, forms, agendas, minutes, memos, and other documents in accurate form from rough drafts. This may include setting up forms and accurate typing skills.
3. Process and distribute all meeting agendas, minutes, and correspondence in a timely and efficient manner.
4. Keep records of a nature requiring specialized knowledge of timecards and payroll checks.
5. In coordination with hospital and unit administration, gather and compile patient unit statistics in an organized and useable format for the required surveillance activities of the IPC Department. This may include, for example, gathering unit-specific patient days, indwelling line and catheter days
6. Maintain (and order as necessary) staff uniform supplies including white coats.
7. Daily pick-up and delivery of mail from central mailboxes and other areas.
8. Gather, compile, and distribute to essential staff critical lab reports, including line lists of lab-identified Reportable Infectious Diseases and Multidrug-Resistant Organisms.
9. Procure any necessary supplies and maintain inventory control of office supplies.
10. Copy and prepare any necessary outgoing reports on an as-needed basis.
11. Maintain all office manuals and references in an up-to-date manner, reflecting any new changes.
12. Operate and request service as needed for all office equipment (e.g., computers, fax & copy machines etc.)
13. File and retrieve correspondence

## I-D.6: Management Expectations of All IPC Staff

**Staff Expectations:** the office and staff of Infection Prevention & Control are both an administrative- and patient-facing. We are also the liaisons between the medical center and numerous regulatory agencies. In these critical roles, it is critical that all staff members maintain the utmost in professional conduct and demeanor. The following are minimal expectations for all Infection Prevention & Control staff members.

- Arrive on time to work and adhere to assigned work schedules.
- Display pride in your work by being conscientious, cooperative, and particular about the quality of your work.
- Produce accurate and timely work - in an independent or collaborative - manner when required.
- Adhere to all LAC+USC Medical Center policies and procedures.
- Become a reliable and dependable resource for other office staff members.
- Take initiative in maintaining a high level of productivity by actively seeking other tasks when routine duties are completed.
- Be respectful towards those around you, and be considerate of your subordinates, peers, and supervisors.
- Interface and work collaboratively and effectively with other team members in our department and others.
- Respond to your supervisor's requests promptly and professionally.

# SECTION II: INFECTION PREVENTION & CONTROL ACTIVITIES

## II-A: Infection Surveillance

**II-A.1 BACKGROUND:** the term “surveillance” is defined as a method of measuring outcomes and related processes of care, analyzing the data, and providing information to healthcare team members to assist in improving those outcomes. Surveillance of hospital acquired infections (HAIs) is a requirement of CMS {§482.42} and Joint Commission {IC.01.05.01 EP 2} and is an essential activity of the medical center IPC program.

### II-A.2 HOSPITAL-ACQUIRED INFECTION SURVEILLANCE METHODS

Since the early 2000s in response to requirements for public information on HAIs, state and federal agencies have mandated reporting of infection-related data. In addition to satisfying these reporting requirements, infection surveillance efforts at LAC+USC are used for many additional purposes including: detecting and investigating disease clusters or outbreaks, assessing effectiveness of preventive control measures, measuring the effectiveness of interventions and performance improvement activities, and the identification of organisms and disease of epidemiologic importance.

In addition to required reporting of HAIs to the CDC’s National Healthcare Safety Network (NHSN), the IPC Department records and analyzes longitudinal HAI incidence data which is collated and reported at the monthly Infection Control Committee meeting. HAIs monitored and reported include: Central Line-Associated Bloodstream infections (CLABSIs), Catheter-Associated Urinary Tract Infections (CAUTIs) and hospital-onset infections due to MRSA, vancomycin-resistant enterococci (VRE), *C. difficile*, and carbapenem-resistant enteric organisms.

**Table 2** below summarizes infection-related surveillance and reporting methods utilized by the IPC Department.

### II-A.3 COMMUNITY, SEASONAL, AND PANDEMIC INFECTION SURVEILLANCE METHODS

While seasonal influenza monitoring has always been a key IPC activity, recent infectious outbreaks and pandemics – including monkeypox, Covid-19, and Respiratory Syncytial Virus (RSV) – have prompted formal surveillance and recording of clinical data related to the epidemiology of these infections which have the ability to affect both staff and patients throughout the medical center. Currently, the physician Hospital Epidemiologist(s) are responsible for maintaining a restricted access list of all lab-confirmed cases of Covid-19, influenza, and monkeypox. Via daily review of lab reports, data including current case positivity, inpatient and ED case counts, clinical symptoms, and dates of positive tests are recorded and maintained in a protected DHS OneDrive file and shared with relevant stakeholders including hospital administration, nursing & physician leadership, and Employee Health Services as relevant.

## II-B: Outbreak Investigation

**II-B.1 BACKGROUND:** the investigation of infectious disease outbreaks and clusters of cases of infectious diseases is a critical component of the IPC Department’s activities and responsibilities {IC.01.05.01 EP 5}.

**II-B.2 OUTBREAK PROCEDURES:** outbreaks or suspected outbreaks are investigated by the Hospital Epidemiologist and nurse Infection Preventionists with the full and timely cooperation of staff members.

For a detailed description of IPC outbreak investigation and mitigation procedures, please refer to the Infection Control Policy entitled: “*Outbreak Investigation & Management*”, available on our SharePoint page by clicking [here](#).

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

<b>Table 2: Hospital Acquired Infection Surveillance Methods</b>			
<b>Hospital Acquired Infection</b>	<b>Method(s) of Surveillance</b>	<b>Reporting Methods</b> (all reported to NHSN unless specified)	<b>Relevant Additional References / Policies</b>
<b>Central Line Associated Bloodstream Infections (CLABSI)</b>	<ul style="list-style-type: none"> <li>• Central lines identified by:</li> <li>• CLABSI cases are identified by:</li> </ul>	<ul style="list-style-type: none"> <li>• Current rate, SIR, and year trend reported at monthly Infection Control Committee meeting</li> <li>• Each confirmed CLABSI is reviewed by IPC staff with the Unit Director &amp; Patient Safety Officer</li> </ul>	LAC+USC Infection Control Policy "CLABSI Prevention"
<b>Catheter Associated Urinary Tract Infections (CAUTI)</b>	<ul style="list-style-type: none"> <li>• Urinary catheters identified by:</li> <li>• CAUTI cases identified by:</li> </ul>	<ul style="list-style-type: none"> <li>• Current rate, SIR, and year trend reported at monthly Infection Control Committee meeting</li> <li>• Each confirmed CLABSI is reviewed by IPC staff with the Unit Director &amp; Patient Safety Officer</li> </ul>	LAC+USC Infection Control Policy "CAUTI Prevention"
<b>Surgical Site Infections (SSI)</b>	<ul style="list-style-type: none"> <li>• SSIs identified by active review of                             <ul style="list-style-type: none"> <li>○ IP Worklist,</li> <li>○ (Orchid Report for Possible SSI</li> <li>○ ICD-10 Code Report for SSIs:</li> </ul> </li> <li>• Specific SSIs are currently reported depending variable CDPH requirements</li> </ul>	<ul style="list-style-type: none"> <li>• Current SSI rate, SIR, and year trend reported at monthly Infection Control Committee meeting</li> <li>• LEAP Frog scores incorporate NHSN-abstracted SSI's for: Colectomy, Hysterectomy, &amp; C-section</li> <li>• All identified SSI cases reported to surgical/procedural unit surgeon leadership</li> </ul>	LAC+USC Infection Control Policy "Surgical Site Infection Prevention"
<b>Methicillin-Resistant <i>Staph aureus</i> (Hospital-onset MRSA bacteremia)</b>	<ul style="list-style-type: none"> <li>• Identified by Lab Report of blood cultures w/ MRSA</li> <li>• IPC staff review all Lab identified cases to ensure hospital onset and MRSA (not MSSA)</li> <li>• Select high-risk patient groups* undergo routine MRSA nares screening upon hospital admission</li> </ul>	<ul style="list-style-type: none"> <li>• Current rate, SIR, and year trend reported at monthly Infection Control Committee meeting</li> <li>• Each confirmed case is reviewed by IPC staff with the Patient Safety Officer</li> </ul>	*LAC+USC Infection Control Policy "MRSA Active Surveillance"
<i>C. difficile</i> Colitis	<ul style="list-style-type: none"> <li>• Cases identified by review of (+) stool <i>C. diff</i> PCR</li> </ul>	<ul style="list-style-type: none"> <li>• Current rate, SIR, and year trend reported at monthly Infection Control Committee meeting</li> <li>• Each confirmed case is reviewed by IPC staff with the Patient Safety Officer &amp; primary service</li> </ul>	
<b>Multidrug-Resistant Organisms (MDROs)</b>	<ul style="list-style-type: none"> <li>• Cases identified by review of lab reports and auto-implemented contact isolation orders</li> <li>• MDRO Surveillance for: VRE, MRSA, CRE &amp; ESBL</li> </ul>	<ul style="list-style-type: none"> <li>• Current rate, SIR, and year trend reported at monthly Infection Control Committee meeting</li> <li>• Annually updated antibiogram posted on intranet</li> </ul>	LAC+USC Infection Control Policy "Management of Patients Infected with MDROs"
<b>Ventilator-Associated Pneumonia (VAP)</b>	<ul style="list-style-type: none"> <li>• Surveillance via review of intubated patients with positive sputum cultures</li> </ul>	<ul style="list-style-type: none"> <li>• <b>NOT</b> currently reported to NHSN</li> </ul>	

## II-C: Communicable Disease Exposure Investigations

Notification will be provided to all employees who were exposed to a transmissible infectious disease without the use of proper personal protective equipment. IPs review all hospitalized patients for any confirmed or suspected transmissible disease. They are also notified of ATDs, such as pulmonary tuberculosis, diagnosed in outpatient clinics and areas.

When new diagnoses of a transmissible infectious disease are made, IPC staff investigate the circumstances of the case, including whether appropriate transmission-based precautions were implemented prior to and at the time of diagnosis.

In instances where Infection Control's investigation reveals a potential ATD exposure incident due to tuberculosis or Covid-19, a formal Exposure (aka "Infection Prevention Record") will be generated in the DHS-wide, electronic, Employee Health Database called "Persinda" (aka Infection Control Module). Each Exposure Case in the Infection Control Module will have a unique, identifying Case Index Number assigned for tracking. Prior exposure cases are also maintained in the Persinda Employee Health database for future review for a minimum of three years {CA – Title 22 §.70723.c}.

During exposure investigations, Infection Preventionists will record several data elements for each Exposure Case to be able to track and identify potential affected personnel. Given numerous potential affected employees in an area, the final step of each electronic Exposure Case log is the identification of area supervisors and managers who are sent notification of the exposure via automated email notification. Area supervisors will assess which employees may have been present and/or exposed during the specified exposure timeframe and log those employees into the case's Persinda log. This then triggers automated email and text notifications to all potentially exposed, logged employees from the exposure, instructing them to present to Employee Health for a formal intake and evaluation, either in person or by phone at (323) 409-5236.

For a detailed description of procedures related to exposures to Airborne Transmissible Diseases (ATDs), please refer to the Infection Control Policy "*Airborne Transmissible Disease Exposure Control Plan*", available on our SharePoint [here](#).

For a detailed description of procedures related to specifically to staff exposures to Bloodborne Pathogens, please refer to the Infection Control Policy "*Bloodborne Pathogen Exposure Plan*", available on our SharePoint [here](#).

## II-D: Antimicrobial Stewardship

**II-D.1 BACKGROUND:** in accordance with California Health & Safety Code (HSC) {HSC.1288.85} and TJC national standards {MM.09.01.01}, LAC+USC maintains an active and highly effective Antimicrobial Stewardship Program (ASP). With common goals of the prevention of multidrug-resistant infections and reduction of resultant patient harm, the ASP works collaboratively with the Department of Infection Control and Prevention. The hospital's ASP is responsible for developing a hospital-wide program, based on evidence-based practices, with the goal of monitoring and improving the use of antibiotics and communicating and collaborating with medical staff, nursing and pharmacy leadership, and ICP personnel on issues related to antibiotic use and overuse.

**II-D.2 ANTIMICROBIAL STEWARDSHIP TEAM:** membership consists of a multidisciplinary core {MM.09.01.01, EP 13} which includes Infectious Disease physicians and fellows, board-certified Infectious Disease pharmacists and pharmacy residents, microbiologists, and Infection Control personnel. The Antimicrobial Subcommittee, chaired by the physician Hospital Epidemiologist {MM.09.01.01, EP 11} on which the team members sit, reports directly to the hospital's Pharmacy and Therapeutics Committee.

**II-D.3 ANTIMICROBIAL STEWARDSHIP ACTIVITIES:** for a detailed description of LAC+USC's ASP activities, surveillance methods, and interventions, please refer to the Pharmacy Department Policy entitled "Antimicrobial Stewardship Program" for which Infectious Disease physician and Infection Control consultation was elicited in drafting.

**II-D.4 ANTIMICROBIAL STEWARDSHIP RESOURCES:** for additional resources, including evidence-based empiric antibiotic guidelines and Expected Practices, antibiotic formulary restrictions, an updated hospital Antibiogram and more, please visit the Pharmacy Services page: intranet homepage → Clinical Systems → Pharmacy Services → Infectious Disease.

## II-E: Oversight of Disinfection and Sterilization

**II-E.1 BACKGROUND:** in order to reduce the risk of infections associated with medical equipment, devices, and supplies, {IC.02.02.01}, the IPC Department oversees all disinfection (low-level and high-level) and sterilization processes for the medical center.

**II-E.2 IMPLEMENTATION:** although individual units are responsible for developing, implementing, logging, maintaining, regularly maintaining, and testing the effectiveness of their disinfection and/or sterilization procedures and processes, the IPC Department provides consultation and general oversight of and approve implementation of all new High-Level Disinfection products and processes. Notably, a number of medical center units defer the performance of High-Level disinfection (HLD) and instrument reprocessing to Central Sterile Services. But whether disinfection of reusable instruments occurs in Central Sterile or in the local units, those units are responsible for documenting, implementing, and updating their procedures in consultation with the IPC Department.

**II-E.3 FURTHER HLD DETAILS:** for further details on high-level disinfection, please refer to the Infection Control Policy “High-Level Disinfection for Semi-Critical Instruments” [here](#) and Nursing Policy #1207 “High Level Disinfection Procedure” available online in the Nursing Policy Manuals section of the LAC+USC Policy & Procedure Portal: intranet homepage → Reference Materials → Policy & Procedure Portal → Nursing Policy Manuals.

## II-F: Evaluation of New Personal Protective Equipment (PPE) & Cleaning Supplies

**II-F.1 BACKGROUND:** to reduce the risk of infections in the healthcare setting and provide the safest environment to patients and staff, the IPC Department oversees, reviews, and approves all new personal protective equipment and cleaning supplies to be used and distributed throughout the medical center {IC.02.02.01 EP 2}.

**II-F.2 PROCEDURE:** by review of current literature and product market, and in conjunction with DHS Supply Chain Operations, IPC personnel review all new products proposed for use and distribution within the medical center. New products are reviewed with respect to their effectiveness and approval status, including approval by the National Institute of Occupational Safety and Health (NIOSH), and with consideration of their relative cost and availability and user-friendliness.

## II-G: New Employee Orientation to Infection Prevention & Control (“NEO”)

**II-G.1 BACKGROUND:** hundreds of new employees begin employment within the medical center every year, and typically with biweekly start dates on the 1<sup>st</sup> and 16<sup>th</sup> of each month. All staff are responsible for understanding and following medical center-wide policies and procedures, including those related to Infection Prevention & Control. IPC staff provide formal orientation to all new employees on medical center Infection Prevention & Control issues {HR.01.04.01}.

**II-G.2 PROCEDURE:** a trained nurse Infection Preventionist from the IPC Department will provide an orientation session to all new staff during their mandatory onboarding training which covers basic medical center principles and procedures related to Infection Prevention & Control. Critical topics covered during orientation include basics of hand hygiene, {NPSG.07.01.01}, basics of PPE, primary disinfectant products, Tuberculosis and Bloodborne Pathogen Control plans, exposure management, Aerosol-Transmitted Diseases, transmission-based precautions, and where to find the hospital’s Infection Control Plan on the hospital intranet. For new physicians-in-training, the Hospital Epidemiologist will provide the orientation to all newly hired physician trainees during their required on-boarding and orientation.

## II-H: Environment of Care Rounds & Consultation

**II-H.1 BACKGROUND:** IPC staff are part of a multidisciplinary group which includes Facilities Management, Administration, Regulatory Affairs, Environmental Services, Patient Safety, and the Safety Office, the IPC Department is a critical participant in the medical center’s Environment of Care (EOC) rounds, with the goal of minimizing infectious risks within the environment of care {EC. 01.01.01}.

**II-H.2 PROCEDURE:** weekly, formal, multidisciplinary EOC walk rounds are conducted according to a schedule prepared by hospital Administration which is designed intentionally to regularly cover all units within the medical center. A



nurse Infection Preventionist is assigned to attend EOC rounds on a rotating basis, such that at least one IP is present during each EOC rounds. Particular attention is given, but not limited to, the following Infection Prevention & Control aspects of EOC during rounds: clean utility areas' absence of clutter and dirty objects; expired supplies; corrugated/cardboard boxes; appropriate item storage not on floors or underneath sinks, and on wire racks with solid bottom shelves; approved unit-specific cleaning supplies; soiled linens; and appropriate PPE use, signage, and availability within the unit.

## II-I: Unit-Based IPC In-Service, Education & Policy Reviews

**II-I.1 BACKGROUND:** although all medical center staff must complete formal IPC orientation during their required orientation and annually as a part of Employee Reorientation, a number of circumstances may arise in which IPC staff conduct unit-specific education on one or more aspects of Infection Prevention & Control practices.

**II-I.2 IN-SERVICE PROCEDURE:** individual unit-based Infection Prevention & Control education or “in-services” may be conducted and/or requested in a particular medical center unit in any of several circumstances, including:

- Required annual in-service education on practices specific to their clinical areas
- observed breaches in IPC practices, occurrence, or pattern of a hospital-acquired infections in a certain unit,
- outbreak or cluster of cases of an infectious disease in a certain unit,
- changes in IPC practices or procedures which may affect a particular unit,
- identified need for Just-In-Time Infection Control-related training
- upon staff request by calling 323-409-6645.

All instances of a unit-based in-service IPC educational session will be documented with records of such trainings maintained by the IPC Department.

**II-I.3 ANCILLARY SERVICES POLICY & PROCEDURE REVIEW:** individual departments and units within the hospital each have unique infection-related issues to contend with. IPC will review and approve all unit-based policies & procedures to ensure their compliance with all aspects of the control and prevention of infections. IPC will distribute a calendar to all unit Directors/Managers on an annual basis, indicating which month their policies and procedures are due for review. All policy and procedure reviews will be documented in the Infection Control Committee minutes with such records maintained by the IPC Office. All Infection Control Committee activities/minutes are routinely reported to the Medical Executive Committee.

## II-J: Infection Prevention & Control Program Evaluation

**II-J.1 BACKGROUND:** in order to assess the effectiveness of our Infection Prevention & Control program, the IPC Department regularly evaluates the aspects of this Plan as well as all related policies at least annually and whenever infectious risks significantly change {**IC. 03.01.01 EP 01**}. For additional details, please refer to our IPC Policy entitled “*Infection Control Performance Improvement Plan*”.

**II-J.2 INFECTION PREVENTION & CONTROL RISK ASSESSMENT:** annually, or sooner as indicated whenever community or hospital-based infectious risks increase, the IPC Department generates a formal, prioritized Infection Control Risk Assessment for the medical center. Evaluation of the infectious risks most relevant to the medical center are assessed annually and included in the formal Risk Assessment.

Please refer to Appendix B of this Plan for a summary of the 2023 Infection Control Risk Assessment.

**II-J.3 INFECTION PREVENTION & CONTROL GOALS** annually, or sooner when indicated, the IPC Department develops targeted goals based on its Risk Assessment and in collaborating with hospital Quality Improvement and Patient Safety. The annual goals are reviewed each year to determine the effectiveness of targeted interventions and to determine new areas for focus and improvement.

Please refer to Appendix C of this Plan for the 2023 Infection Prevention & Control goals and an assessment of our performance on our targeted 2022 goals.

# SECTION III: TRANSMISSION-BASED PRECAUTIONS

## DEFINITIONS:

There are two tiers of recommended precautions to prevent the spread of infections in healthcare settings: **Standard Precautions** and **Transmission-Based Precautions**. Standard precautions are used for \*ALL\* patient care and make use of common sense practices and personal protective equipment use that protect healthcare workers from infection and prevent the spread of infection from patient to patient. Transmission-based precautions are used *in addition* to Standard Precautions for patients with certain known or suspected infections to further reduce transmission risk.

## III-A: Standard Precautions

**Standard Precautions** were originally developed to protect the healthcare workers from bloodborne pathogens and to prevent the transmission of infectious agents between healthcare workers, visitors, and patients. **Standard Precautions** are the first step in preventing and controlling the spread of infection throughout the medical center and must be practiced by all healthcare workers at all times, and in all settings {IC.02.01.01 EP2}. Healthcare workers shall be trained and will use barrier devices provided for their safety to prevent contact with blood or other potentially infectious materials.

Standard Precautions to be observed at all times and for all patient care include the following elements in Table 3:

**Table 3: Elements of Standard Precautions**

### 1). Hand Hygiene {NPSG.07.01.01 EP 1}

1. Staff should use an alcohol-based hand rub or wash with water (minimum 20 seconds)
  - Before entering & exiting any patient room, and before & after each patient contact in multi-occupant rooms
  - Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive device
  - Before moving from work on a soiled body site to a clean body site on the same patient
  - After touching a patient or the patient's immediate environment
  - After contact with blood, body fluids, or contaminated surfaces
  - Immediately after glove removal
2. Staff must wash their hands **specifically with soap & water, \*\*NOT\*\* Alcohol-based hand rub**
  - When hands are visibly dirty or contaminated with proteinaceous or bodily fluid material
  - After contact with patients with *Clostridioides difficile*. Alcohols have poor activity against *C. difficile* spores
  - After ten consecutive applications of alcohol-based hand rub (to prevent emollient build up)
  - After eating or preparing food
  - After using the restroom

## Table 3 (continued): Standard Precautions

### 2). Use of Personal Protective Equipment (PPE) Whenever Exposure to Infectious Material is Expected

- PPE will be readily available on clinical units and include: gowns, masks, gloves, goggles, face shields
- Fluid-resistant gloves should be worn when handling all blood and body fluids and while performing procedures where there is a potential risk for exposures. Hand hygiene must be performed once the gloves are removed.
- Fluid-resistant barrier gowns or disposable plastic aprons should be worn to protect staff and their clothing whenever there is a risk of splashes or clothing becoming soiled or wet with blood or body fluids.
- Protective eye wear, surgical mask and/or full-face shield should be worn whenever there is risk of splashing body fluids into the eyes, nose, or mouth.

### 3). Respiratory Hygiene/Cough Etiquette

- Cover your mouth and nose with a tissue when coughing or sneezing
  - Use the nearest waste bin to dispose of the tissue after use
  - Perform hand hygiene after contact with respiratory secretions and contaminated objects
  - In times of respiratory pandemic (e.g., Covid-19): adhere to all PPE and mask mandates\*
  - Surgical masks will be readily available at all major medical center and outpatient entrances for staff & visitors
- \*Refer to current "PPE Expected Practice During the Covid-19 Pandemic" on the DHS SharePoint link [here](#).*

### 4). Methods to Reduce Bloodborne Pathogen Exposures

- If present, activate sharps safety devices (e.g., needle re-sheathing device) after use of sharp devices & needles.
  - Do not recap, bend, or break needles.
  - All sharps and used needles must be discarded in approved sharps disposal containers.
  - Securely seal sharps containers with 3/4 full and place in appropriate area for pick up.
  - All body fluids to be discarded should be flushed down a toilet or hopper.
  - All body fluid and blood spills should be cleaned up with absorbent material, then cleaned with a detergent solution, followed by a disinfectant solution.
  - Soiled linens should be placed in laundry bags, tied with a single knot, and left in an appropriate area for pick-up. Do not overfill linen bags.
  - All contaminated disposable items should be discarded in appropriate, **covered** trash containers.
  - All percutaneous and mucous membrane exposures should be reported immediately\*
  - In accordance with OSHA standards, Healthcare workers are not to eat or drink, apply cosmetics or lip balm, or handle contact lenses in patient care and work areas where there is a reasonable likelihood of occupational exposure. {**OSHA Part 1910.1030(d)(2)(x)**}
  - Food and drink shall not be kept in storage areas or on countertops or benchtops where blood or other potentially infectious materials area present {**OSHA Part 1910.1030(d)(2)(xi)**}
- \*For more information refer to the "Bloodborne Pathogen Exposure Plan", available on our SharePoint site [here](#).*

### 5). Staff Grooming

- Fingernails must be clean with tips less than 1/4 inch-long.
- Artificial nails are not permitted for staff who have direct contact with patients, handle instruments or patient care equipment, supplies, food, specimens, or medications.
  - "Artificial fingernails" are defined as any material applied to fingernails for the purpose of strengthening or lengthening nails (e.g., tips, acrylic, porcelain, silk, jewelry, overlays, wraps, fillers, etc.)
- Hand jewelry with large stones should not be worn as they may tear gloves.
- Hand jewelry with crevices should not be worn as germs are hard to remove from crevices.

## III-B: Transmission-Based Precautions

**III-B.1 BACKGROUND:** **Transmission-based precautions** are used in addition to universal standard precautions when the route(s) of transmission of an infection are not completely interrupted using Standard Precautions alone. There are three categories of Transmission-Based precautions: Contact Precautions, Droplet Precautions, and Airborne Precautions. Each are summarized below. For some disease that have multiple routes of transmission (e.g., disseminated varicella), more than one Transmission-based category may be used {**IC.021.01.01 EP 3**}.

When Transmission-based precautions (no longer referred to as “isolation”) are indicated, efforts must be made to counteract possible adverse effects on patients including anxiety and mood disturbances, perceptions of stigma, reduced contact with clinical staff, and increases in preventable adverse events in order to improve acceptance by patients and staff. Nursing is responsible for educating patients and visitors on applicable Transmission-Based Precautions, and the provision of and instructions on use of PPE, and the importance of compliance with these precautions.

**Table 4: Procedures for Transmission-Based Precautions**

**1). Orders:**

- a. Patients may be placed in precautions at the discretion of nursing, IPC, or physician.
- b. Electronic isolation precaution orders’ start & stop date/time are recorded in the Orchid order history

**2). Observation & Patient Care Factors**

- a. Precautions are used to decrease infection transmission, but should **NEVER** compromise patient care
- b. Staff, visitors, and patients should be educated about precautions and given a chance to ask questions.
- c. All staff and visitors entering the room are expected to comply with posted signage.
- d. Limit the number of individuals entering the room. IPC is available for consultation to assist.
- e. Take only those supplies needed for immediate care in an isolation room.

**3). Setting Up Isolation Rooms**

- a. Place appropriate isolation sign on door or in highly visible location to all persons entering the room.
- b. Equipment to be gathered and kept **INSIDE** the room (as appropriate for isolation type):
  - o Supplies for immediate use, gloves, sharps container, linen hampers
- c. Equipment to be stored in a cart **OUTSIDE** the room
  - o Isolation gowns, masks/respirators, gloves, protective eyewear / face shields

**4). Transporting Patients**

- a. Notify the receiving unit of required isolation precautions prior to patient arrival on the unit.
- b. For airborne and droplet isolation: patients should be masked during transport.
- c. Place an isolation sign on the front of the patient’s paper chart.
- d. See “Contact Precautions” below regarding additional considerations during patient transport

**5). Transfers / Discharges**

- a. Inter-ICU transfers for patients in precautions must be approved by the IPC Department.
- b. Receiving outside facilities **MUST** be notified when transferring patients still in isolation precautions
- c. Most patients may be discharged home, to Board & Care and similar facilities with no additional precautions. How those facilities manage and implement their Infection Control practices is beyond local IPC scope.




**6). Clearance from Isolation**

- a. Precautions must be maintained until cleared by the IPC staff or a note is written by the Attending physician.
  - o *Criteria for discontinuing precautions are different for each disease! Contact IPC for assistance.*
- b. If patients are discharged prior to removal of precautions, the isolation sign should stay in place on the door.  
\* ***This alerts Environmental Services to follow appropriate precautions while cleaning the room!*** \*

**7). Room Cleaning and Decontamination**

- a. When patients with infections requiring transmission-based precautions are transferred or discharged, their rooms require decontamination (aka “terminal cleaning”) before new patients can be admitted to the room
- b. Call Environmental Services at x98257 to wash walls, floors, and high-touch surfaces & change curtains
  - o *Nursing will clean all patient-care equipment*
- c. So long as appropriate respiratory protection is worn by EVS, there is no need to wait for any specified period of time before cleaning the room of a transferred/discharged patient with an aerosol-transmitted disease, including but not limited to Covid-19

**Table 5: Summary of Transmission-Based Precautions**

	<b>CONTACT PRECAUTIONS</b>	<b>DROPLET PRECAUTIONS</b>	<b>AIRBORNE PRECAUTIONS</b>
<b>Source of Transmission</b>	Direct or indirect contact with infected patients or the patient’s environment	Close respiratory or mucous membrane contact with respiratory secretions. Such pathogens or diseases aren’t infectious over long distances.	Respiratory or mucous membrane contact with fine aerosolized respiratory particles that remain infectious over long distances.
<b>Room Type</b>	Private Room	Private Room	Private Airborne Infection Isolation Room with Negative Pressure & Anteroom <b>(Keep door closed)</b>
<b>PPE for Staff</b>	Gown, Gloves	Surgical or Procedural mask	Fitted N-95 Respirator Mask or CAPR® (Controlled Air Purifying Respirator)
<b>PPE for Patients Upon Room Exit</b>	Wheelchair: place gown on patient Bed/gurney: clean sheet over patient	Surgical or procedural mask	Surgical or procedural mask
<b>Standardized Precaution Sign (Don’t substitute)</b>			
<b>Example Diseases &amp; Organisms</b>	<ul style="list-style-type: none"> <li>• Carbapenem-resistant enterics (CRE)<sup>1</sup></li> <li>• ESBL-producing organisms<sup>1</sup></li> <li>• <i>C. difficile</i> (special <b>BROWN</b> Isolation Sign)</li> <li>• Invasive Group A streptococcal infections</li> <li>• Lice (pediculosis)<sup>2</sup></li> <li>• MRSA (draining wounds only)<sup>1</sup></li> <li>• Multidrug-resistant organism (MDRO)<sup>1</sup></li> <li>• Respiratory syncytial virus (RSV)</li> <li>• Scabies<sup>3</sup></li> <li>• Vancomycin-resistant enterococci (VRE)<sup>1</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Covid-19 without any AGPs<sup>4</sup></li> <li>• <i>Haemophilus influenzae</i> type B</li> <li>• Influenza virus</li> <li>• Invasive meningococcal disease</li> <li>• Mumps (infectious parotitis)</li> <li>• <i>Mycoplasma pneumoniae</i></li> <li>• Parvovirus B19</li> <li>• Pertussis</li> <li>• Rhinovirus</li> </ul>	<ul style="list-style-type: none"> <li>• Disseminated varicella (Herpes zoster)<sup>5</sup></li> <li>• Covid-19 requiring AGPs<sup>4</sup></li> <li>• Measles (rubeola)</li> <li>• Pulmonary tuberculosis</li> </ul>

Notes:

1. Refer to IPC Policy “*Management of Patients Infected with Multidrug-Resistant Organisms*” for further details. Available on our SharePoint site [here](#).
2. Patients with lice require contact precautions for 24 hours after initiation of appropriate therapy.
3. Patients with scabies require contact precautions until 24 hours after effective therapy. For suspected Norwegian “crusted” scabies, contact the IPC office.
4. For more details on Covid-19 PPE and precautions, refer to the “*PPE Expected Practice During the Covid-19 Pandemic*” on DHS’ SharePoint [here](#).
5. For single dermatome “shingles”: contact precautions alone are required, until all lesions are crusted. For confirmed or suspected disseminated varicella (e.g., pulmonary involvement or rash lesions outside the primary or adjacent dermatomes), contact + airborne precautions should be used for the duration of illness.



### III-C: Contact Precautions

**III-C.1 BACKGROUND:** Contact Precautions are intended to prevent transmission of infectious agents that are spread by direct or indirect contact with the patient's environment. Contact precautions also apply where the presence of excessive wound drainage, fecal incontinence, or other bodily discharges increase potential for environmental contamination and risk of transmission. Elements of patient care for patients requiring Contact Precautions are summarized in Table 6:

Table 6: Contact Precautions	
<b>1). Ensure Patient Placement in Single Patient Rooms</b>	
<ul style="list-style-type: none"> <li>➤ Single patient rooms should be used for patients requiring Contact Precautions.</li> <li>➤ If no single patient rooms are available, consultation with the IPC Department is required to assess risks associated with other placement options (e.g., cohorting, keeping patients with existing roommates etc.)</li> </ul>	
<b>2). Use Appropriate Personal Protective Equipment</b>	
<ul style="list-style-type: none"> <li>➤ Wear <b>GOWN &amp; GLOVES</b> for any interactions that may involve contact with the patient or their environment.</li> <li>➤ Don PPE upon room entry, and <b>DISCARD PPE PRIOR TO EXITING</b> the patient's room.</li> </ul>	
<b>d3). Limit Transport and Movement of Patients to Medical-Necessary Purposes</b>	
<ul style="list-style-type: none"> <li>➤ Patients in Contact Precautions should have exams and procedures performed in the room where possible.</li> <li>➤ When transport or movement of patients in Contact Precautions is necessary:                             <ul style="list-style-type: none"> <li>○ If transported by wheelchair, the patient will wear a disposable gown</li> <li>○ If transported by bed or gurney, a clean sheet will be placed over the patient</li> <li>○ Before and after transport, perform hand hygiene, then wipe the handles of transport wheelchairs and beds with a hospital-approved disinfectant wipe</li> <li>○ Staff should <b>NOT</b> wear gowns and gloves while transporting the patient <i>unless direct patient contact is anticipated</i> (e.g., bagging between ventilator attachments)</li> </ul> </li> </ul>	
<b>4). Use Disposable or Dedicated Patient Care Equipment</b>	
<ul style="list-style-type: none"> <li>➤ This includes common equipment such as disposable stethoscopes &amp; blood pressure cuffs</li> <li>➤ If multiple patient use of equipment is unavoidable, clean &amp; disinfect such equipment before use on other patients</li> </ul>	
<b>5). Cleaning and Disinfection of Rooms Vacated by Patients on Contact Precautions</b>	
<ul style="list-style-type: none"> <li>➤ When patients on Contact Precautions are transferred or discharged, the patient room requires decontamination.</li> <li>➤ Call Environmental Services 323-409-8257 to wash walls, floors, and change curtains</li> <li>➤ Nursing is responsible for cleaning medical equipment and other non-disposable patient care items</li> </ul>	

**III-C.2 SPECIAL CONTACT PRECAUTION SITUATIONS:** Unique Contact Precautions situations include:

Pathogen	Comments
<b>MRSA</b>	Contact Precautions only for actively draining wounds whose drainage cannot be contained by wound dressing. Refer to our <i>MRSA Active Surveillance</i> and <i>MDRO</i>
<b>Multidrug-Resistant Organisms (MRDO)</b>	Duration of Contact Precautions varies by pathogen -- e.g., VRE, ESBL, CRE, carbapenem-resistant <i>A. baumannii</i> (CRAB) etc. Refer to " <i>Management of Patients Infected with MDROs</i> " <a href="#">here</a> .
<b>Lice</b>	Contact precautions required until 24 hours after initiation of effective therapy.
<b>Scabies</b>	Contact precautions required until 24 hours after initiation of effective scabicide therapy. As "crusted" scabies lesions can be difficult to treat, please contact the IPC Office if this form is suspected.
<b><i>Clostridioides difficile</i> "C. diff"</b>	Special <b>BROWN</b> Isolation signs must be used. Contact precautions must remain for the duration of admission, even if symptoms resolve. Use soap & water (not alcohol-based hand rub) for hand hygiene.

## III-D: Droplet Precautions

**Droplet Precautions** are used for patients with known or suspected infection with pathogens transmitted by respiratory droplets (i.e., large particle droplets >5 µm in size) that are generated by a patient who is coughing, sneezing, or talking. Because these pathogens do not remain infectious over long distances in healthcare facilities, special air handling and ventilation are not required to prevent droplet transmission. Table 7 summarizes elements of Droplet Precautions.

Table 7: Elements of Droplet Precautions
<b>1). Source Control</b>
<ul style="list-style-type: none"><li>➤ Patients should be masked (surgical or procedural mask) until transferred to an individual inpatient room</li><li>➤ In <i>ambulatory settings</i> like clinics: patients should be placed in an exam room as soon as possible and instructed to follow Respiratory Hygiene/Cough Etiquette as outlined in Table 3</li><li>➤ Patients should wear masks during transport and while outside their rooms while in the medical center</li></ul>
<b>2). Ensure appropriate placement in single rooms if available and possible</b>
<ul style="list-style-type: none"><li>➤ Single patient rooms should be used if available, with preference (but not required) that doors remain closed</li><li>➤ If no single patient rooms are available or feasible, patient care should <b>NOT</b> be delayed for patients with diseases requiring Droplet Precautions.<ul style="list-style-type: none"><li>○ <i>Example:</i> patients with asymptomatic Covid-19 or mild influenza <b>NOT</b> requiring an aerosol-generating procedure <b>can</b> receive hemodialysis in open bay areas like ED Observation so long as they are masked and staff interacting with patients wear appropriate PPE including gowns, gloves, and masks.</li></ul></li></ul>
<b>3). Use appropriate respiratory PPE</b>
<ul style="list-style-type: none"><li>➤ Don a <b>surgical or procedural mask</b> prior to room entry or patient space</li><li>➤ Although surgical or procedural masks are the minimum requirement for care of patients requiring Droplet Precautions, healthcare workers may opt (and will be provided with) to use higher-level respiratory protection such as hospital-issued N-95 respirators or CAPRs for which the staff member has been trained to use</li></ul>

## III-E: Airborne Precautions

**III-E.1 BACKGROUND: Airborne Precautions** prevent transmission of infectious agents that remain suspended in aerosols in the air and travel great distances due to their small size (less than 5 µm). Consequently, concern for transmission of these pathogens in the medical center relates to airflow patterns within the facility. These diseases include measles, smallpox, chickenpox, pulmonary tuberculosis, avian influenza. SARS-CoV-2 infection also requires airborne isolation when aerosol-generating procedures are used.

Key elements of Airborne Precautions are summarized in Table 8. For comprehensive details, staff may refer to the medical center's Aerosol Transmissible Disease (ATD) Control Plan on our SharePoint site [here](#) in addition to the medical center's Respiratory Protection Program available here.

Table 8: Elements of Airborne Precautions
<b>1). Patient Placement</b>
<ul style="list-style-type: none"><li>➤ In inpatient settings, place patients in an Airborne Infection Isolation Room (AIIR) with negative pressure</li><li>➤ Doors must be kept shut</li><li>➤ Room negative air pressure will be continually monitored via use of visual indicators ("ball in the wall")</li><li>➤ When no AIIR is available, mask and place patients in a private room with staff to wear N-95 respirators</li></ul>
<b>2). Respiratory personal protective equipment</b>
<ul style="list-style-type: none"><li>➤ Staff caring for patients with ATDs must wear a hospital-issued N-95 respirator or CAPR</li><li>➤ Don respirator prior to room entry</li><li>➤ When no AIIR is available, mask and place patients in a private room with staff to wear N-95 respirators</li><li>➤ <b>Approved</b> visitors must wear hospital-issued surgical masks at all times while visiting.</li></ul>

# SECTION IV: ENVIRONMENTAL CONTROLS OF INFECTION

## BACKGROUND

Although the physical environment serves as a reservoir for many microorganisms, it is rarely implicated in direct disease transmission. Inadvertent exposures to environmental opportunistic pathogens, such as *Aspergillus* and *Legionella*, within air and water sources respectively, in healthcare settings may result in infections with significant morbidity. Lack of adherence to established standards and guidance (e.g., water quality and monitoring, proper ventilation in operating rooms and Airborne Infection Isolation rooms, and proper use of disinfectants) can result in adverse patient outcomes.

In addition to measures described in previous sections, the use of several environmental controls throughout the medical center helps to reduce the risk of environmentally-mediated infections among staff and patients.

**IV-A. WATER MANAGEMENT PROGRAM:** in 2019, and in partnership with the Nalco Water© company, LAC+USC implemented – and continues to maintain – an ongoing, comprehensive Water Management Program {EC.02.05.02} which includes detailed descriptions of all medical center potable, cooling, and other at-risk water systems as well as a regular water sampling process that addresses *Legionella* and other waterborne pathogens. In addition, the Water Management Program outlines remediation procedures to decontaminate water lines in cases where water sampling results indicate levels of microbial growth out of defined parameters. Paper or electronic copies of the Water Management Program are maintained with Facilities Management and in the IPC Office. The Water Management Program is overseen, maintained, and implemented by the Facilities Manager and Engineering Department Program Manager, in collaboration and consultation with representatives from the Safety Office, Infection Prevention & Control, Plumbing, Groundskeeping, and Risk Management.

All results of environmental water sampling are communicated by Facilities Management to the IPC Office, at a minimum monthly and sooner as needed if results in a sampled area exceed established microbial colony count cutoffs, so that appropriate restrictions and workflows may be implemented in affected clinical units. Additionally, IPC is notified daily via electronic Incident Report Alerts from Facilities Management, of any significant water or steam intrusions throughout the medical center. The IPC staff meeting minutes include logs of our responses to significant water intrusions throughout the medical center.

For additional information on various infection-related aspects of the medical center's water supplies, please refer to:

- LAC+USC Water Management Program (paper & electronic copies available in the IPC Office)
- IPC Policy “*Environmental Microbiologic Sampling*”, available on our SharePoint [here](#)
- IPC Policy “*Bacteriologic and Endotoxin Monitoring of Hemodialyzers*”, available on our SharePoint [here](#)

**IV-B. INFECTION PREVENTION AND CONSTRUCTION:** the IPC Department consults in the development of all new facilities renovations and construction, including a formal Infection Control Risk Assessment (ICRA) for all projects which involves the generation of any potential airborne or other particulate debris or disruptions to water systems. Please refer to DHS Policy No. 918.01 “Design/Construction and Maintenance Risk Assessment” [here](#) for ICRA process details.

**IV-C. AIR QUALITY AND SAMPLING:** environmental air within buildings can be affected by many factors including indoor traffic, temperature, relative humidity, airflow dynamics, relative particle concentrations, and the performance of air handling components. Certain regulatory requirements require air sampling for potential pathogens in specific medical center areas (e.g., pharmacy sterile compounding areas). And at times, air sampling may be indicated to evaluate for potential hazards in certain remediation circumstances such as substantial water leaks. In such cases, air sampling will only be performed by certified personnel of contracted environmental sampling vendors. Any air samples will be collected, prepared, and delivered for processing to the appropriate contracted laboratory. Results of any air sampling or testing are communicated by the contracting lab to the Safety Office and the IPC Department. Any necessary changes to clinical operations or services required as a result of environmental microbiologic sampling results (e.g., temporary closure of a particular area) will be communicated by Infection Control & Prevention to area supervisors/managers.

In addition to the above, critical air parameters including temperature and humidity in procedural areas including operating rooms, angiography and endoscopy suites, and Labor & Delivery suites are communicated electronically to the IPC Office on a daily basis. Records of these reports maintained in the IPC Department shared drive.

For additional details on environmental controls related to potential airborne pathogens, please refer to:

- o IPC Policy “*Environmental Microbiologic Sampling*”, available on our SharePoint [here](#)
- o IPC Policy “*Aerosol-Transmissible Disease Control Plan*” available on our SharePoint [here](#)
- o Medical Center “*Respiratory Protection Plan*” available on our SharePoint [here](#)

## IV-D: ENVIRONMENTAL CLEANING & DISINFECTION

**IV-D.1 BACKGROUND:** Medical Center environmental cleaning is essential for maintain a safe patient environment. Failure to properly clean and disinfect equipment and environmental surfaces may lead to transmission of pathogens via contamination. Environmental decontamination plays an important role in decreasing bioburden, which helps reduce the risk of healthcare-associated infections. Environmental surfaces including **noncritical** items as designated by the Spaulding Classification System as well as high-touch surfaces in the clinical environment like countertops, bedrails, and tray tables. For further details on semi-critical (e.g., endoscopes) high-level disinfection and critical (e.g., surgical instrument) sterilization processes, please refer to IPC Policy “*High-Level Disinfection for Semi-Critical Instruments*” [here](#). Note, LAC+USC does not reprocess single-use devices on site {IC02.02.01 EP 05}


**IV-D.2 ENVIRONMENTAL CLEANING PRODUCTS (LOW-LEVEL DISINFECTION):** The Infection Prevention & Control Department consults in the development of effective cleaning and disinfection procedures for the Environmental Services department. Comprehensive cleaning procedures for specific are maintained and updated by the Environmental Services Department (EVS) and approved by the IPC Department. Please refer to the comprehensive *Department of Environmental Service’s Policy and Procedure Manual* for detailed information on EVS cleaning processes. The IPC Department evaluates all new proposed cleaning and disinfectant products and discusses with Central Supply Chain operations prior to new product distribution for use throughout the medical center.

Staff should be familiar with cleaning product specifications used in noncritical areas within their units. An important example is the use of different disinfectant wipes. In all cases, staff should only use hospital-approved cleaning products in clinical areas and **always** refer to Manufacturer’s Instructions for Use of **any** disinfectant product.


Currently, LAC+USC distributes several disposable germicidal wipes for use within the medical center. Commonly referred to by the color of their containers’ tops, these disinfectant products have different kill times required to kill the specified pathogens. Make sure to use Orange Top wipes in areas housing patients with *C. difficile*.

**Table 9: Primary Disinfectant Products**


**Orange Top Wipes**

	<b>Product Name</b>	Sani-Cloth <b>BLEACH</b> ® Disposable Wipes
	<b>Active Ingredient</b>	Bleach (sodium hypochlorite)
	<b>Dwell / Wet / Time</b>	<b>FOUR</b> minutes
	<b>Active Against <i>C. diff</i> Spores?</b>	<b>YES</b>


**Grey Top Wipes**

	<b>Product Name</b>	Sani-Cloth AF3® Disposable Wipes
	<b>Active Ingredient</b>	Quaternary ammonium compounds
	<b>Dwell / Wet / Time</b>	<b>THREE</b> minutes
	<b>Active Against <i>C. diff</i> Spores?</b>	<b>NO</b>


**Red Top Wipes**

	<b>Product Name</b>	Sani-Cloth Plus® Disposable Wipes
	<b>Active Ingredient</b>	Quaternary ammonium compounds
	<b>Dwell / Wet / Time</b>	<b>THREE</b> minutes
	<b>Active Against <i>C. diff</i> Spores?</b>	<b>NO</b>


**CaviWipes**

	<b>Product Name</b>	CaviWipes® Disposable Wipes
	<b>Active Ingredient</b>	Quaternary ammonium compounds
	<b>Dwell / Wet / Time</b>	<b>THREE</b> minutes
	<b>Active Against <i>C. diff</i> Spores?</b>	<b>NO</b>

**Purple Top Wipes**

	<b>Product Name</b>	<b>SUPER</b> Sani-Cloth® Disposable Wipes
	<b>Active Ingredient</b>	Quaternary ammonium compounds
	<b>Dwell / Wet / Kill Time in minutes</b>	<b>TWO</b> minutes
	<b>Active Against <i>C. diff</i> Spores?</b>	<b>NO</b>

**Blue Top Wipes**

	<b>Product Name</b>	OPTIM 1® Disposable Wipes
	<b>Active Ingredient</b>	Hydrogen peroxide 0.5%
	<b>Dwell / Wet / Kill Time in minutes</b>	<b>ONE</b> minute
	<b>Active Against <i>C. diff</i> Spores?</b>	<b>NO</b>

**IV-D.3 LAUNDRY & LINENS:** Healthcare textiles are fabric or cloth products (including gowns, sheets, and bedding) that touch patients and staff, directly or indirectly, on a daily basis. As specified in CA Title 22 – Article 8 §.70825.a, the medical center will maintain an adequate supply of clean linen for at least three complete bed changes for the hospital’s licensed bed capacity. Contaminated textiles are known to be sources of pathogenic microorganisms. Fortunately,



hygienically clean laundry carries negligible risk to healthcare workers and patients, provided that clean textiles, fabric, and clothing are not inadvertently contaminated before use.

Key Infection Prevention & Control aspects related to healthcare textiles include the following.

- a. **Handling Contaminated Textiles:** soiled linens must be assumed to be contaminated; personnel who handle soiled linen must follow standard precautions at all times. Staff handling soiled or otherwise contaminated linens should always perform hand hygiene, use protective barriers (e.g., disposable gowns and gloves), and removal foreign objects from the contaminated linen product stream.
- b. **Soiled Linen Processing:** used and soiled linens should be placed in storage containers with bags that: are functionally capable of containing wet or soiled textiles; prevent contamination of the environment during collection, transport, and storage; do not tear when fully loaded; and can be closed securely to prevent textiles from falling out. Filled soiled linen bags should be tied with a gooseneck knot and stored in appropriate areas of soiled utility rooms for collection.
- c. **Clean Linen Storage:** clean linens should never be stored with soiled or contaminated items or supplies. Clean linens removed from packaging should be stored in closed containers or covered shelving units.
- d. **Healthcare Worker Attire & Hygiene:** the role of healthcare workers' attire in transmission of bacteria and development of healthcare-associated infections is not clear. In alignment with the Association of peri-Operative Registered Nurses recommendations, all perioperative personnel should wear freshly laundered surgical attire (scrubs) that is laundered at a healthcare-accredited laundry facility. Perioperative staff should refer to the OR Policy entitled "*Operating Room Attire*" for details.
- e. **Infection Prevention Surveillance of Contracted Laundry Facilities:** like most US hospitals, LAC+USC Medical Center currently outsources its laundering services to an outside contractor. Currently, all DHS hospitals (including LAC+USC), contract laundry services with Crothall Healthcare<sup>®</sup>. While the LA County DHS Department of Contracts and Grants is responsible for overall monitoring and compliance with the laundering services provided by contract, at least annually members of one of the four DHS hospitals' IPC Departments conducts an on-site survey of the contracted laundry facility with aspects of the survey including, but not limited to: on-site personnel hand hygiene, separation of soiled and clean processing areas, soiled linen processing, cleaning of transport vehicles, water temperatures and wash cycle times, and clean linen handling. Results of these assessments are recorded by and maintained with the IPC Department and shared with DHS Grants & Contracts. Clean linen from the contracted commercial laundry vendor will be delivered to the medical center completely wrapped and delivered to the designated clean receiving area {CA Title 22 – Article 8 §.70825.c}.

**IV-E STERILE ITEM EXPIRATION DATING:** Before using sterile items and medications, note the expiration date and integrity of the packaging. Facility-sterilized items are stamped with a label giving the date sterilized and the expiration date {NPSG.03.04.01}. Commercially prepared items to be considered sterile until the label expiration date. In no expiration date is present, these items are considered to be sterile as long as the packaging's integrity is not compromised.

**IV-F FLOWERS AND PLANTS IN PATIENT CARE AREAS:** Flowers and potted plants can potentially serve as reservoirs of a number of microbial pathogens, including molds, fungi, and some bacteria. Generally speaking, the risk of infection associated with flowers and potted plants is greatest for deeply immunocompromised persons, particularly allogeneic hematopoietic stem cell transplant (HSCT) recipients. Therefore, fresh flowers, dried flowers, and potted plants are **PROHIBITED** in patients care areas for immunocompromised patients. Such areas include, but are not limited to: IPT 7B, 3B, 3C, and outpatient chemotherapy infusion areas. Any area with decorative *artificial* plants and flowers is responsible for cleaning them regularly.

#### **IV-G SERVICE ANIMAL POLICY**

The LAC+USC Medical Center complies with all aspects of the Americans with Disabilities Act (ADA) of 1990 in order to ensure qualifying service animals can accompany patients in permitted areas throughout the medical center. Service animals are working animals, not pets or emotional support animals. A service animal is defined as any dog (and in some cases, miniature horses) trained to perform tasks or services for the benefit of an individual with a disability. Such tasks may include: guiding individuals who are blind or have low vision, alerting persons who are deaf or hard of hearing, alerting and protecting persons who are having a seizure, pulling wheelchairs, opening doors, picking up dropped items,

retrieving medicine and other items. Service animals do not include wild animals, cats, nonhuman primates, reptiles, rabbits, pigs, goats, ferrets, rodents, or amphibians.

Service animals are prohibited at all times from the following areas due to higher risk of infection and potential harms:

<ul style="list-style-type: none"><li>• Monitored Emergency Room beds</li><li>• ICUs</li><li>• Operating rooms</li><li>• Anesthesia recovery areas</li><li>• Cath Lab</li><li>• Labor and Delivery areas</li></ul>	<ul style="list-style-type: none"><li>• Contact, airborne, or droplet precautions</li><li>• Areas with equipment critical for life support</li><li>• Food preparation areas used for cleaning or storage of human food, utensils, and dishes</li><li>• Employee toilet/shower/dressing areas</li><li>• Medication preparation areas</li></ul>	<ul style="list-style-type: none"><li>• Sterile/clean supply room</li><li>• Linen storage areas</li><li>• Areas where soiled/contaminated materials are stored</li><li>• Areas where patients are immunocompromised</li></ul>
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For further details on LAC+USC's policy, including workflows and procedures, please refer to LAC+USC Medical Center Policy No. 240 entitled "*Animals in Hospital/Healthcare Setting*". It is available [here](#) on the LAC+USC Policy & Procedure portal under Medical Center Policies --> Section 200: Patient Rights and Organization Ethics.

#### **IV-H CLEAN AND SOILED UTILITY ROOMS**

The LAC+USC Medical Center complies with all hospital and clinic building codes and regulations, including the need for dedicated clean and soiled utility rooms within each unit. Adherent to TJC standards, these rooms must adhere to certain specifications related to air pressure relationships, temperature, and humidity. Some important practical aspects related to clean and soiled utility rooms include the following:

- Clean utility rooms should be maintained under **positive pressure** with respect to surrounding hallways
- Soiled utility rooms should be maintained under **negative pressure** with respect to surrounding hallways
- Doorways should never be propped open (i.e., tape over door latches or insertion of test tubes into door catches)





## IV-I: Unit-Based: WASTE MANAGEMENT

**IV-I.1 BACKGROUND:** in accordance with several regulatory requirements, including several TJC Infection Control Standards {[IC02.01.01 EP 06](#)} and the California Waste Management Act (CWMA), the medical center implements practices to minimize the risk of infection when storing and disposing of potentially infectious waste material and reduce the risk of contamination of food and clean/sterile supplies.






At its site of origin, solid waste should be deposited in appropriate containers according to the designation summarized in the table below. Liquid waste and patient excreta (feces) should be discarded in patient toilets or hoppers. Environmental Services will provide appropriate waste containers and remove trash from patient locations as outlined in the “*Environmental Services Policies and Procedure Manual*”. Only Environmental Services staff will access trash chutes and elevators designated for the transport of soiled materials. Such restricted areas will be labeled with appropriate biohazard signs {[CWMA § 118.118310.a](#)} and may be secured by use of locks on doors or employee-specific card access.

**IV-I.2 WASTE CONTAINERS:** staff should be aware of, and adhere to, appropriate use of various waste containers. The following table summarizes the appropriate use of different containers for waste disposal.

**TABLE 10: WASTE DISPOSAL BINS**

WASTE	CONTAINER	CONTENTS
<b>SHARPS WASTE</b>		<ul style="list-style-type: none"> <li>Any device that is sharp at the time of disposal</li> <li>Includes: needles, scalpels, razor blades, broken glass, trocars, empty ampules, glass slides &amp; pipettes, empty syringes, <b>empty</b> medication vials, guide wires, scissors, <b>empty</b> syringes</li> <li>Replace container when <math>\frac{3}{4}</math> full</li> </ul>
<b>PHARMACEUTICAL WASTE (non-RCRA)</b>		<ul style="list-style-type: none"> <li>Acceptable non-RCRA, non-hazardous pharmaceutical waste includes: partial IVs, unused pills, partial vials, sponges soaked in liquid medications</li> <li>Sharps, needles, syringes, and vials <b>WITH</b> remaining medications</li> <li>Note: <a href="#">RCRA</a> pharmaceuticals should <b>NOT</b> be disposed of in blue pharmaceutical waste bins. Use “black bucket” bins as below.</li> </ul>
<b>HAZARDOUS (RCRA) PHARMACEUTICAL WASTE “BLACK BUCKET”</b>		<ul style="list-style-type: none"> <li>Certain hazardous pharmaceuticals and medications including, but not limited to: warfarin, nicotine (gum, patches, lozenges), dandruff shampoo or lotion, cough syrup/elixir containing &gt;24% alcohol, iodine, hydrochloric acid, acetic acid, phenol, multi-dose vaccines</li> <li>Chemotherapy IV bags &amp; tubing that have moving liquid in them when tilted or moved</li> <li>See the EPA’s listed of registered RCRA-pharmaceutical agents <a href="#">here</a></li> </ul>
<b>CHEMOTHERAPY WASTE</b>		<ul style="list-style-type: none"> <li>Disposal of supplies used to administer chemotherapy</li> <li>Chemotherapy sharps and glass bottles that are <b>empty</b></li> <li>Chemotherapy IV bags and tubing that have <b>NO MOVING LIQUID</b> when moved or tilted</li> </ul>

**TABLE 10 continued: WASTE DISPOSAL BINS**

<p><b>BIOHAZARDOUS WASTE</b></p>		<ul style="list-style-type: none"> <li>• Used for <b>INFECTIOUS WASTE</b> including blood and blood products, blood-soaked items, bags and IV tubing containing blood products</li> <li>• Infectious body fluids</li> <li>• Microbiology specimens containing bacteria, viruses, and other microbes</li> <li>• Hemovac and wound vac drains</li> <li>• Chest drainage units</li> <li>• Replace containers at ¾ full</li> </ul>
<p><b>REGULAR TRASH</b></p>		<ul style="list-style-type: none"> <li>• Gloves, gowns, masks etc. that do <b>NOT</b> have blood or blood by-products</li> <li>• Chux disposable underpads and paper towels</li> <li>• Empty IV tubing</li> <li>• Non-regulated medical waste</li> <li>• <b>NOTE:</b> trash bins for food must have a closed lid at all times. This prevents attracting flies which can lead to maggot infestations, including of patients!</li> </ul>
<p><b>PLACENTA WASTE CONTAINER</b></p>		<ul style="list-style-type: none"> <li>• For placenta transport only!</li> </ul>
<p><b>UNIVERSAL WASTE CONTAINER</b></p>		<ul style="list-style-type: none"> <li>• For batteries not contaminated by blood or blood by-products</li> <li>• *For Operating Room use only!</li> <li>• Use disinfectant wipes to clean batteries before disposal</li> <li>• Tape both poles of all batteries prior to disposal</li> </ul>
<p><b>RADIOACTIVE WASTE CONTAINER</b></p>		<ul style="list-style-type: none"> <li>• Radioactive waste must be labeled properly</li> <li>• The Radiation Safety Office must be called to remove this waste to its designated area, where it must be monitored by qualified staff, until its safe and appropriate disposal</li> </ul>

## Appendix A – Infection Prevention & Control Policy Listing

<b>Policy Title</b>	<b>Policy No. (Updated Feb 2023)</b>
<b>2023 Infection Prevention &amp; Control Plan</b>	<b>IPC-01</b>
<b>Infection Control Evaluation &amp; Improvement</b>	<b>IPC-02</b>
<b>Outbreak Investigation &amp; Management</b>	<b>IPC-03</b>
<b>Antibiotic Susceptibility &amp; Antimicrobial Stewardship</b>	<b>IPC-04</b>
<b>Influenza Vaccination of Workforce Members</b>	<b>IPC-05</b>
<b>Specimen Transport</b>	<b>IPC-06</b>
<b>Environmental Microbiologic Sampling</b>	<b>IPC-07</b>
<b>MRSA Active Surveillance</b>	<b>IPC-08</b>
<b>High-Level Disinfection for Semi-Critical Instruments</b>	<b>IPC-09</b>
<b>Bacteriologic &amp; Endotoxin Monitoring of Hemodialyzers</b>	<b>IPC-10</b>
<b>Surgical Site Infection (SSI) Prevention</b>	<b>IPC-11</b>
<b>Central Line-Associated Bloodstream Infection Prevention</b>	<b>IPC-12</b>
<b>Catheter-Associated Urinary Tract Infection Prevention</b>	<b>IPC-13</b>
<b>Bloodborne Pathogen Exposure Control Plan</b>	<b>IPC-14</b>
<b>Management of Patients with Multidrug-Resistant Organisms (MDROs)</b>	<b>IPC-15</b>
<b>Sterile Field Failure</b>	<b>IPC-16</b>
<b>Tuberculosis Exposure Control Plan</b>	<b>IPC-17</b>
<b>Ebola &amp; Other Viral Hemorrhagic Fevers Control Plan</b>	<b>IPC-18</b>
<b>Cleaning of Pediatric Playroom &amp; Toys</b>	<b>IPC-19</b>
<b>Meningococcal Meningitis Exposure Control Plan</b>	<b>IPC-20</b>
<b>Prion Disease &amp; Transmissible Spongiform Encephalopathy</b>	<b>IPC-21</b>
<b>Respiratory Protection Program</b>	<b>IPC-22</b>
<b>Hand Hygiene Policy</b>	<b>IPC-23</b>
<b>Pandemic Respiratory Illness Plan</b>	<b>IPC-24</b>
<b>Influx &amp; Surge of Contagious Diseases Requiring Hospitalization</b>	<b>IPC-25</b>
<b>Airborne Transmissible Disease (ATD) Exposure Control Plan</b>	<b>IPC-26</b>
<b>Bed Bug Guidelines</b>	<b>IPC-27</b>



**APPENDIX B: 2023 INFECTION PREVENTION & CONTROL RISK ASSESSMENT**

POTENTIAL PROBLEM	PROBABILITY: <i>How likely is this to occur?</i>			RISK / IMPACT: <i>How severe is it if it occurs?</i>			FACILITY EVENT PREPAREDNESS			RELATIVE RISK
	High	Moderate	Low	High	Moderate	Low	Low	Moderate	High	SCORE
SCORE	3	2	1	3	2	1	3	2	1	
<b>Device-related infection</b>										
Central Line Related BSI		x		x					x	6
Ventilatory Related PNA		x			x			x		6
Catheter Associated UTIs		x			x				x	5
Endoscope-related Infection			x		x				x	4
Surgical Site Infections		x			x			x		6
<b>Surveillance Pathogens</b>										
MRSA Bacteremia			x		x				x	4
VRE Bacteremia			x	x					x	5
ESBL-producing organisms	x				x				x	6
Carbapenem-resistant organisms			x	x				x		6
<i>M. tuberculosis</i>	x			x					x	7
<i>C. difficile</i> colitis		x			x			x		6
<b>Surgical Site Infections</b>										
Abdominal Hysterectomy		x			x				x	5
Colon Surgery		x			x				x	5
<b>Environmental Sources of Infections</b>										
Foodborne illnesses			x			x			x	3
Vermin/Vector-borne Illness		x			x				x	5
Airborne Environmental Source		x			x				x	5
Surface / Immediate Environment		x			x				x	5
Contaminated Instrument/Equipment		x			x				x	5
Water Sources (e.g., <i>Legionella</i> )		x			x				x	5
Contaminated Medications / Products			x		x				x	4
<b>Infectious Occupational Health Hazards</b>										
Bloodborne Pathogen Exposures		x		x					x	6
Tuberculosis Exposure	x				x				x	6
Vaccine preventable diseases			x		x				x	4
Non-Vaccine preventable illnesses			x		x				x	4
Hand Hygiene Compliance		x			x			x		6
Influenza Vaccine Non Compliance	x					x			x	5
COVID-19 Vaccine Non Compliance			x			x		x		4
<b>Building / Facility Sources of Infection</b>										
Construction & Renovation		x			x			x		6
Utility disruption (water, electric)	x				x			x		7
OR Temp/Humidity out of range	x					x		x		6
<b>Special Situations</b>										
Bioterrorism			x	x				x		6
Internal clusters & outbreaks		x			x				x	5
Emerging pathogens (Ebola)			x		x				x	4
<i>Candida auris</i>			x			x			x	3
Epidemic/Pandemic (COVID-19)		x				x			x	4
Monkeypox			x		x				x	4
<b>LEGEND</b>				≥ 7			Very High Risk			
				6			High Risk			
				5			Medium Risk			
				4			Low Risk			
				3			Minimal Risk			

## APPENDIX C: Summary of 2023 Infection Prevention & Control Goals

Goal	Strategies	Comments																																			
<p><b>Goal #1</b></p> <p><b>Maintain the CLABSI SIR at ≤ 1.0 in all inpatient and ICU units.</b></p>	<ul style="list-style-type: none"> <li>a. Conduct annual survey to monitor compliance with the CLABSI bundle metrics.</li> <li>b. Targeted CLABSI education for the nurses in line management and for Residents at Boot Camp in line insertion practices.</li> <li>c. Cont. swabbing of all IV Infusion hubs exclusively with EtOH caps.</li> <li>d. Chlorhexidine bathing daily for <b>ALL</b> patients with central lines</li> <li>e. Continue training staff on use of red caps (Clear Guard) for hemodialysis ports.</li> <li>f. Monthly presentation and case review of all reportable HAI cases conducted at the committee. Use of “huddle board” on each unit.</li> <li>g. Nursing leadership to conduct mini root-cause analyses at the unit level.</li> <li>h. Re-train unit CLABSI Champions on Central Line dressings by the PICC team</li> <li>i. Comply with line management documentation and observations monitored via the steering committee, with unit rounding findings reported to the CLABSI Committee</li> <li>j. Continue emphasis on extension of peripheral IV’s and their dressings to 7 days.</li> <li>k. Continue identifying “Line Necessity” during Daily Dose huddles.</li> <li>l. Continued promotion of midline catheter (rather than PICC lines)</li> <li>m. Continue use of Tegaderm chlorhexidine gluconate (CHG) IV dressing securements</li> </ul>	<p>Target CLABI SIR is &lt;1.0.</p> <table border="1" data-bbox="1312 334 1997 565"> <thead> <tr> <th>Year</th> <th>CLABSI Count</th> <th>Line Days</th> <th>SIR</th> <th>Rate Per 1000 Line Days</th> </tr> </thead> <tbody> <tr> <td>2017</td> <td>44</td> <td>22092</td> <td>1.743</td> <td>1.99</td> </tr> <tr> <td>2018</td> <td>44</td> <td>24337</td> <td>1.485</td> <td>1.81</td> </tr> <tr> <td>2019</td> <td>34</td> <td>25035</td> <td>0.882</td> <td>1.36</td> </tr> <tr> <td>2020</td> <td>24</td> <td>26064</td> <td>0.794</td> <td>0.92</td> </tr> <tr> <td>2021</td> <td>14</td> <td>23215</td> <td>0.486</td> <td>0.60</td> </tr> <tr> <td>2022</td> <td>12</td> <td>17158</td> <td></td> <td>0.70</td> </tr> </tbody> </table> <p><b>2022 Performance:</b> Significant progress, particularly in ICUs, in adhering to new CHG dressings and other components of our CLABSI bundle.</p>	Year	CLABSI Count	Line Days	SIR	Rate Per 1000 Line Days	2017	44	22092	1.743	1.99	2018	44	24337	1.485	1.81	2019	34	25035	0.882	1.36	2020	24	26064	0.794	0.92	2021	14	23215	0.486	0.60	2022	12	17158		0.70
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<p><b>Goal #2</b></p> <p><b>Maintain the CAUTI SIR at ≤ 1.0 in all units.</b></p>	<ul style="list-style-type: none"> <li>a. Continue active surveillance for CAUTIs, and Infection Preventionists will continue to report to units/wards all patients meeting CAUTI criteria for NHSN reporting</li> <li>b. QI to continue to monitor documented compliance with the CAUTI bundle components in all inpatient areas with review at each CAUTI Committee meeting.</li> <li>c. Continue to educate regarding importance of peri wipes and new products to improve perineal care and indwelling catheter care.</li> <li>d. Nursing to continue to use of nurse driven protocol for removal of indwelling urinary catheters and continue use of bladder scanning in wards and ICUs</li> <li>e. Continue encouraging the use of external female catheters such as PureWick™ on the wards and ICUs whenever possible.</li> <li>f. Continue reporting indwelling urinary catheter necessity during Daily Dose, Administrative Rounds &amp; unit-based team huddles on Med/Surg wards.</li> </ul>	<p>Target CAUTI SIR &lt;1.0.</p> <table border="1" data-bbox="1312 1070 1997 1300"> <thead> <tr> <th>Year</th> <th>CAUTI Count</th> <th>Cath Days</th> <th>SIR</th> <th>Rate Per 1000 Line Day</th> </tr> </thead> <tbody> <tr> <td>2017</td> <td>52</td> <td>20592</td> <td>1.498</td> <td>.25</td> </tr> <tr> <td>2018</td> <td>40</td> <td>16054</td> <td>1.463</td> <td>.25</td> </tr> <tr> <td>2019</td> <td>34</td> <td>16066</td> <td>1.237</td> <td>.21</td> </tr> <tr> <td>2020</td> <td>40</td> <td>17882</td> <td>1.314</td> <td>2.2</td> </tr> <tr> <td>2021</td> <td>14</td> <td>23215</td> <td>0.486</td> <td></td> </tr> <tr> <td>2022</td> <td>19</td> <td>16491</td> <td></td> <td>1.15</td> </tr> </tbody> </table>	Year	CAUTI Count	Cath Days	SIR	Rate Per 1000 Line Day	2017	52	20592	1.498	.25	2018	40	16054	1.463	.25	2019	34	16066	1.237	.21	2020	40	17882	1.314	2.2	2021	14	23215	0.486		2022	19	16491		1.15
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### Goal #3

**Maintain an SIR of  $\leq 1.0$  for index Surgical Site Infections (SSIs) for all 29 reportable procedures, including an emphasis on the three procedures for whose SSIs contribute to LeapFrog Hospital Safety Grades.**

- Continue weekly meetings with IT (Orchid Infection Control Team) and Health Information Management (HIM) to obtain timely denominator data for surgical procedures.
- Provide direct feedback to operating surgeons and surgical Division Chiefs on surgical site infection data, including rates of SSIs for index surgical procedures.
- Provide prompt and direct reports to Surgical Chiefs regarding missing Operative Report notes which prevent NHSN reporting of SSIs
- Continue monitoring pre-operative chlorhexidine gluconate (CHG) cleansing for both inpatient and outpatient surgeries. This is a collaborative QI effort with the Anesthesia perioperative staff.
- Continue collaboration with HIM on correctly coding surgical procedures, as our IPs cannot enter necessary case information until surgeries are properly coded.

#### 2022 Performance and Comments:

An intensive internal, and a CDPH external, validation it became apparent that a number of coding and

YEAR	No. NHSN All-Adult Surgical Procedures <sup>†</sup>	All Surgical Site Infection Count*	SIR	SIR 95% CI (SIR p value)
2018	2414	4	<b>0.137</b>	0.060 - 0.271 p = 0
2019	3158	7	<b>0.165</b>	0.084 - 0.295 p = 0
2020	2226	2	<b>0.057</b>	0.014 - 0.155 p = 0
2021	3035	3	<b>0.05</b>	0.013 - 0.137 p = 0
2022*	2300	9*	<b>0.188*</b>	0.092 - 0.345 p = 0
<b>CESAREAN SECTIONS (LeapFrog Contributor only)</b>				<b>SIR 95% CI (SIR p value)</b>
YEAR	No. CSEC Procedures	CSEC SSIs	SIR	
2018	93	0	<b>0</b>	0 - 2.290 p = 0.27
2019	290	1	<b>0.265</b>	0.013 - 1.309 p = 0.13
2020	307	1	<b>0.212</b>	0.011 - 1.043 p = 0.31
2021	226	0	<b>0</b>	0 - 0.865 p = 0.31
2022	160	0	<b>0</b>	0 - 1.169 p = 0.08
<b>Complex 30-Day SSIs for Colorectal Surgeries (NHSN CMS)</b>				<b>SIR 95% CI (SIR p value)</b>
YEAR	No. COLO Procedures	COLO SSIs	SIR	
2018	232	1	<b>0.068</b>	0 - 1.169 p = 0.006
2019	321	1	<b>0.047</b>	
2020	239	0	<b>0</b>	
2021	253	0	<b>0</b>	
2022	172	2	<b>0.172</b>	
<b>Complex 30-Day SSIs for Hysterectomies (NHSN CMS)</b>				<b>SIR 95% CI (SIR p value)</b>
YEAR	No. HYST Procedures	HYST SSIs	SIR	
2018	201	0	<b>0</b>	
2019	294	3	<b>1.329</b>	
2020	271	0	<b>0</b>	
2021	276	1	<b>0.458</b>	
2022	172	0	<b>0</b>	

<sup>†</sup>Includes all 13 surgical procedures NHSN-designated for 30-day SSI surveillance (AAA, AMP, APPY, AVSD, BILI, CEA, CHOL, COLO, CSEC, GAST, HTP, HYST, KTP) and all 13 surgical procedures NHSN-designated for 90-day surveillance (BRST, CARD, CBGB, CBGC, CRAN, FUSN, FX, HER, HPRO, KPRO, PACE, PACE, PVBY, VSHN).

<p><b>Goal #4</b></p> <p><b>Increase Hand Hygiene compliance to 85% by June 2023 and maintain that throughout 2023.</b></p>	<p>a. The Hand Hygiene goal remains a collaborative initiative with Patient Safety and QI.</p> <p>b. Trained observers continue to monitor and record hand hygiene compliance.</p> <p>c. Educational material continues to be distributed by screensavers, public posters, and posted grades on compliance at the entrances to wards/units.</p> <p>d. Compliance is supported and reviewed by the administrative executive leadership</p> <p>e. Hand Hygiene Compliance is reported at monthly Infection Control Committee meetings</p>	<table border="1"> <thead> <tr> <th>YEAR</th> <th>Number of HH Observations</th> <th>% Compliance</th> </tr> </thead> <tbody> <tr><td>2018</td><td></td><td></td></tr> <tr><td>2019</td><td></td><td></td></tr> <tr><td>2020</td><td></td><td></td></tr> <tr><td>2021</td><td></td><td></td></tr> <tr><td>2022</td><td></td><td></td></tr> </tbody> </table> <p>Insert 2022 monthly graph</p> <p>HERE</p>	YEAR	Number of HH Observations	% Compliance	2018			2019			2020			2021			2022					
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<p><b>Goal #5</b></p> <p><b>Increase PPE compliance in proper use of Personal Protective Equipment in all areas to &gt; 90% by June 2023 &amp; increase compliance to &gt;95% by December 2023.</b></p>	<p>a. Continue reporting overall PPE compliance at monthly Infection Control Committee meetings and sharing these data with management teams.</p> <p>b. Continue monitoring compliance via direct observation during rounds and in collaboration with alternate, trained auditors.</p> <p>c. Just-in-Time coaching and education by Infection Preventionists with staff during weekly in-person unit rounds.</p> <p>d. Review of Patient Safety Score Cards including PPE use and MDRO Education for patients and their families</p> <p>e. Continue annual PPE education by nursing supervisors in their units and Infection Preventionists in non-clinical departments</p>	<table border="1"> <thead> <tr> <th>YEAR</th> <th>Number of PPE Observations</th> <th>% Compliance</th> </tr> </thead> <tbody> <tr><td>2018</td><td></td><td></td></tr> <tr><td>2019</td><td></td><td></td></tr> <tr><td>2020</td><td></td><td></td></tr> <tr><td>2021</td><td></td><td></td></tr> <tr><td>2022</td><td></td><td></td></tr> </tbody> </table> <p>Insert 2022 monthly graph</p> <p>HERE</p>	YEAR	Number of PPE Observations	% Compliance	2018			2019			2020			2021			2022					
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<p><b>Goal #6</b></p> <p><b>Decrease and maintain the hospital-onset <i>C. difficile</i> colitis SIR below the</b></p>	<p>a. High priority focus for hospital administration DHS-wide</p> <p>b. Focus on reduction of inappropriate <i>C. difficile</i> PCR testing including:</p> <p>i. Lab cancellation of all specimens collected &gt;24 hours after initial order</p> <p>ii. Requirement for attending co-signature for all <i>C. difficile</i> PCR orders</p> <p>iii. Attestation that all <i>C. difficile</i> PCR orders correspond to compatible clinical signs and symptoms</p> <p>iv. Automatic hard block on all <i>C. difficile</i> PCR orders in patients with EMR-documented laxative administration in the prior 48 hours</p>	<table border="1"> <thead> <tr> <th>Year</th> <th>HO-<i>C. diff</i> Cases</th> <th>SIR</th> </tr> </thead> <tbody> <tr><td>2017</td><td></td><td></td></tr> <tr><td>2018</td><td></td><td></td></tr> <tr><td>2019</td><td></td><td></td></tr> <tr><td>2020</td><td></td><td></td></tr> <tr><td>2021</td><td></td><td></td></tr> <tr><td>2022</td><td></td><td></td></tr> </tbody> </table>	Year	HO- <i>C. diff</i> Cases	SIR	2017			2018			2019			2020			2021			2022		
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<p><b>national 2023 QIP qualifying cutout</b></p>	<ul style="list-style-type: none"> <li>c. In addition to the above EMR-based methods, all <i>C. difficile</i> PCR specimens must be accompanied by an attending-signed paper order form.</li> <li>d. Monthly physician review of all confirmed positive <i>C. difficile</i> tests with communication to ordering providers on appropriateness of testing</li> <li>e. Develop and implement a formal IPC <i>C. difficile</i> prevention policy, similar to our other HAI policies</li> <li>f. With addition of fidaxomicin to the DHS formulary, ID Consult review and approval of confirmed <i>C. difficile</i> cases for consideration of fidaxomicin which has been shown in some studies to reduce recurrence rates compared to standard oral vancomycin regimens</li> </ul>																													
<p><b>Goal #7</b> <b>Maintain hospital-onset MRSA bloodstream infections below SIR of 1.0.</b></p>	<ul style="list-style-type: none"> <li>a. Work with Orchid IT and Cerner to address discrepancies between lab-reported (LabID) NHSN HO-MRSA entries and manual reviews</li> <li>b. Address IT issues where MSSA was identified incorrectly as MRSA</li> <li>c. Physician (Patient Safety Officer and Hospital Epidemiologist) review of all NHSN-reported cases for opportunities to avoid</li> </ul>	<table border="1"> <thead> <tr> <th>Year</th> <th>MRSA Cases</th> <th>SIR</th> <th>Rate Per 1000 Line Day</th> </tr> </thead> <tbody> <tr> <td>2017</td> <td></td> <td></td> <td></td> </tr> <tr> <td>2018</td> <td></td> <td></td> <td></td> </tr> <tr> <td>2019</td> <td></td> <td></td> <td></td> </tr> <tr> <td>2020</td> <td></td> <td></td> <td></td> </tr> <tr> <td>2021</td> <td></td> <td></td> <td></td> </tr> <tr> <td>2022</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Year	MRSA Cases	SIR	Rate Per 1000 Line Day	2017				2018				2019				2020				2021				2022			
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