



Joint Statement of the California Department of Public Health and the California Division of Occupational Safety and Health

Guidance for Infection Control for 2009 H1N1 Influenza in Health Care Settings

February 4, 2010

Revision History: This update reflects a revision to the CDPH case definition of suspect H1N1 for infection control purposes (issued February 4, 2010). The remainder of the recommendations in the Joint Statement of CDPH and Cal/OHSA Guidance for Infection Control for 2009 H1N1 Influenza in Health Care Settings of January 12, 2010 are unchanged.

Supersedes "PANDEMIC (H1N1) 2009 INFLUENZA: UPDATED RECOMMENDATIONS FOR HEALTH CARE SETTINGS (8/20/09)"

Introduction

This joint document serves to update the California Department of Public Health (CDPH) recommendations of August 20, 2009, for infection control for 2009 H1N1 influenza in health care settings based on the revised Centers for Disease Control and Prevention (CDC) "Interim Guidance on Infection Control Measures for 2009 H1N1 Influenza in Healthcare Settings, Including Protection of Healthcare Personnel," issued October 14, 2009 (http://www.cdc.gov/h1n1flu/guidelines_infection_control.htm). This document summarizes the significant changes in the CDC guidance and provides additional recommendations.

Updated CDPH recommendations for long-term care and outpatient settings are available at <http://www.cdph.ca.gov/HealthInfo/discond/Pages/H1N1CDPHGuidances.aspx>.

CDPH recommends that hospitals in California follow the provisions of this statement in conjunction with the updated CDC guidance. The California Department of Industrial Relations, Division of Occupational Safety and Health (Cal/OSHA) Aerosol Transmissible Disease Standard (<http://www.dir.ca.gov/title8/5199.html>) applies to 2009 H1N1 influenza; Cal/OSHA H1N1 guidance for employers and interim enforcement policy can be found at <http://www.dir.ca.gov/dosh/SwineFlu/SwineFlu.htm>.

On February 4, 2010, CDPH revised the case definitions of 2009 H1N1 influenza for infection control purposes (<http://www.cdph.ca.gov/HealthInfo/discond/Documents/H1N1-IC-CaseDefinitions.pdf>). Revised case definitions are summarized below.

Current Recommendations

CDPH and Cal/OSHA concur with the recommendations of the CDC guidance and urge California health care facilities and health care providers to develop and implement consistent policies and procedures.

The updated CDC guidance emphasizes a hierarchy of controls designed to minimize health care personnel (HCP) exposure to 2009 H1N1 influenza, including (order of preference) elimination of exposures, engineering controls, administrative controls, and, where exposure remains, personal protective equipment.

Specific CDC recommendations include:

- Continuation of the use of respirators at least as effective as fit-tested N95 respirators for close contact* with 2009 H1N1 influenza patients.†
- Use of standard precautions instead of contact precautions.
- Changing the recommended exclusion period for HCP with febrile respiratory illness to at least 24 hours after they no longer have a fever, without the use of fever-reducing medicines, unless they work with severely immunocompromised patients.‡
- For HCP who work with severely immunocompromised patients‡ and are returning to work after a febrile respiratory illness, consider temporary reassignment or exclusion from work for 7 days from symptom onset or until the resolution of symptoms, whichever is longer, unless absence of 2009 H1N1 viral RNA in respiratory secretions is documented by rRT-PCR.
- Using measures to conserve respirators when they are in short supply.

* Working within six feet of the patient or entering into a small enclosed airspace shared with the patient (e.g., average patient room).

† 2009 H1N1 patients include all patients who meet the definition of a suspected, probable or confirmed case of 2009 H1N1 influenza.

‡ Patients such as hematopoietic stem cell transplant recipients or burn unit patients during those periods in which the immunosuppressed person requires care in a protective environment (typically defined as a specialized patient-care area with a positive airflow relative to the corridor, high-efficiency particulate air filtration, and increased ventilation).

See the CDC guidance for complete recommendations.

Additional recommendations from CDPH and Cal/OSHA

Airborne Infection Isolation Rooms

- Consistent with CDC recommendations, for routine care, patients with suspect, probable or confirmed 2009 H1N1 influenza do not need to be placed in airborne infection isolation rooms. Airborne infection isolation rooms should be used for aerosol generating procedures if available. Airborne infection isolation

precautions for routine patient care should include the use of respirators by health care workers who are in direct contact with the patient, the use of masks or other source control measures when feasible by the patient, and the placement of the patient in a separate room with the door closed.

Respiratory Protection

- A comprehensive programmatic approach to HCP protection should substantially reduce the situations in which respirator use is needed, thereby reducing demand for respirators. This approach includes reviewing patient placement and work organization to reduce exposures to patients with influenza-like illness. However, even with the use of these measures, there may be respirator shortages. Health care facilities should attempt to maximize their supplies by contacting alternate suppliers and/or switching to alternate respirators. If these measures do not result in an adequate supply of respirators, health care facilities should contact their local health department or emergency management agency to request additional supplies (see below).
- Extended use and re-donning of respirators should be considered as potential means for optimizing respirator availability if respirator supply may not be adequate.
- Filtering facepiece respirators may be removed, stored, and re-donned by an employee if the employer has established procedures for this type of use, provided appropriate facilities for storage, and trained employees in how to remove, store, inspect, and re-don the respirator. For further information on extended use and redonning of respirators please refer to the Cal/OSHA Interim Guidance below.
- Facilities are encouraged to assess their current respirator supplies and their ability to obtain respirators in the immediate future. Interim guidance on distribution of state and federal stockpiles of N95 respirators for 2009 H1N1 influenza to address such shortages was issued by CDPH on October 22, 2009, and can be accessed at:
<http://www.cdph.ca.gov/HealthInfo/discond/Documents/H1N1-N95Distribution.pdf>. Facilities should document their efforts to obtain respirators per Cal/OSHA Interim Guidance using Appendix A, "Respirator Supply Documentation," at:
http://www.dir.ca.gov/dosh/SwineFlu/H1N1_Interim_Guidance-Respiratory_Supply_Documentation.pdf.
- More information regarding the use of respirators to protect employees from 2009 H1N1 influenza as per the Cal/OSHA Aerosol Transmissible Disease Standard, and methods for maximizing and conserving respirator supplies, is available at: http://www.dir.ca.gov/dosh/SwineFlu/Interim_enforcement_H1N1.pdf.

Transfer of Patients from Acute Care Hospitals to Other Health Care Settings

- The updated CDC guidance recommends continuing the isolation of 2009 H1N1 influenza patients for seven days after illness onset or until 24 hours after the resolution of fever and respiratory symptoms (whichever is longer), while a patient is in a healthcare facility. CDPH recommends that confirmed and probable 2009 H1N1 influenza patients in acute care hospitals be eligible for transfer to another setting (such as a skilled nursing facility) after they are free of fever (100° F [37.8° C] or greater) or signs of a fever for at least 24 hours, without the use of fever-reducing medications. The transfer of patients should not be based upon the availability of N95 respirators at the receiving facility.
- CDPH recommendations for 2009 H1N1 influenza in long-term care settings are available at <http://www.cdph.ca.gov/HealthInfo/discond/Pages/H1N1CDPHGuidances.aspx>. Additional recommendations for managing seasonal influenza can be found at <http://www.cdph.ca.gov/certlic/facilities/Documents/LNC-AFL-08-33Attachment.pdf>.
- Health care facilities, services and operations are within the scope of the Cal/OSHA Aerosol Transmissible Diseases Standard (Title 8, California Code of Regulations, Section 5199). These employers should review their policies and practices to ensure that they are consistent with this regulation (see link below).

Case Definitions for H1N1 infection control

- California health care facilities should follow the most recent CDPH case definitions of 2009 H1N1 influenza for infection control purposes which can be found at (<http://www.cdph.ca.gov/HealthInfo/discond/Documents/H1N1-IC-CaseDefinitions.pdf>). As of February 4, 2010, CDPH is using the following case definitions*:
 - A *suspect* case of 2009 H1N1 influenza is any patient whom a health care provider suspects, based on the patient's history and illness, of being infected with 2009 H1N1 influenza virus.
 - A *probable* case of 2009 H1N1 influenza is a person with a syndrome clinically compatible with influenza who has a PCR test that is positive for influenza A and unsubtypeable for A/H1 or A/H3.
 - A *confirmed* case of 2009 H1N1 influenza is a person with a syndrome clinically compatible with influenza who has laboratory confirmed 2009 H1N1 influenza by one or more of the following tests: real-time RT-PCR or viral culture.

* The case definitions may change in the future as the H1N1 pandemic continues to evolve. Health care providers should refer to the CDPH website (<http://www.cdph.ca.gov/HealthInfo/discond/Pages/H1N1CDPHGuidances.aspx>) for the most recent guidance on CDPH case definitions for H1N1 influenza for infection control purposes.

Resources

Additional information regarding the new CDC guidance and the Cal/OSHA Aerosol Transmissible Diseases Regulation:

Q&A Regarding Respiratory Protection For Preventing 2009 H1N1 Influenza Among Healthcare Personnel:

(http://www.cdc.gov/h1n1flu/guidelines_infection_control_qa.htm)

Questions and Answers about CDC's Interim Guidance on Infection Control Measures for 2009 H1N1 Influenza in Healthcare Settings, Including Protection of Healthcare Personnel:

(http://www.cdc.gov/H1N1flu/guidance/control_measures_qa.htm)

Cal/OSHA Interim Enforcement Policy on H1N1 and Section 5199 (Aerosol Transmissible Diseases):

(http://www.dir.ca.gov/dosh/SwineFlu/Interim_enforcement_H1N1.pdf)

Cal/OSHA Aerosol Transmissible Diseases Regulation (Title 8, California Code of Regulations, Section 5199): (<http://www.dir.ca.gov/Title8/5199.html>)

Thank you for your ongoing commitment to the 2009 H1N1 influenza response.



2009 H1N1 Influenza

Guidance on Case Definitions to be Used for Infection Control in California Health Care Settings

February 4, 2010

Revision History: Supersedes case definitions in August 20, 2009 guidance: California Department of Public Health Pandemic (H1N1) 2009 Influenza Infection Control Recommendations for Hospitalized Patients

Background

As of the week of January 11, 2010, only 5% of a sample of hospitalized patients tested for 2009 H1N1 influenza were PCR positive, as compared to other periods in the pandemic when the rate of positive tests has been 30% or greater. The low percentage of positive tests calls into question the usefulness of the current California Department of Public Health (CDPH) definition of a suspect 2009 H1N1 influenza case (i.e., any patient <60 years of age with febrile respiratory illness and a new onset cough) for infection control purposes at this time.

Therefore, CDPH is revising the 2009 H1N1 influenza infection control suspect case definition. This revision reflects the current decreased prevalence of 2009 H1N1 influenza relative to other respiratory pathogens that produce a clinical illness similar to that of both 2009 H1N1 and seasonal influenza.

For the purposes of infection control guidance only, CDPH considers a period of “low incidence” to be any period in which the rate of positive 2009 H1N1 influenza PCR tests in hospitalized patients is less than 10% for three consecutive weeks. CDPH will be monitoring the rate of positive samples and will make further updates to the recommendations if the situation changes.

Updated 2009 H1N1 Case Definitions for Infection Control Purposes

- A **suspect case** of 2009 H1N1 influenza is any patient whom a health care provider suspects, based on the patient’s history and illness, of being infected with 2009 H1N1 influenza virus.
- A **probable case** of 2009 H1N1 influenza is a person with a syndrome clinically compatible with influenza who has a PCR test that is positive for influenza A and unsubtypeable for A/H1 or A/H3.
- A **confirmed case** of 2009 H1N1 influenza is a person with a syndrome clinically compatible with influenza who has laboratory confirmed 2009 H1N1 influenza by one or more of the following tests: real-time RT-PCR or viral culture.

Rationale

During periods in which there is a low incidence of 2009 H1N1 influenza it is reasonable to rely on the clinical judgment of professional staff in determining whether a patient is likely to have 2009 H1N1 infection, based on the patient's clinical presentation, history, age, the local incidence of 2009 H1N1 influenza, recent ill contacts, 2009 H1N1 influenza vaccination status, and other factors.

Respiratory protection

- CDPH continues to recommend the use of respiratory protection at least as protective as a fit-tested N95 respirator for health care workers providing care to suspect, probable or confirmed 2009 H1N1 influenza patients.
- Health care workers should have the option of wearing a respirator when in contact with patients with acute respiratory symptoms even if a clinician has not determined that the patient is suspected of being infected with 2009 H1N1 influenza.
- Health care workers with unprotected exposures to confirmed 2009 H1N1 influenza patients should be provided the opportunity for a medical evaluation. Most, but not all, health care workers who have received 2009 H1N1 influenza vaccine will be immune. Decisions about the need for antiviral post-exposure prophylaxis should be made on a case-by-case basis.

Clinical presentation of influenza

The clinical presentation of 2009 H1N1 influenza infection is largely indistinguishable from that of seasonal influenza. The diagnosis of influenza based on clinical presentation is difficult and varies with the age of the patient. High fever is common in children with seasonal influenza but decreases in frequency with age, while adults are more likely than children to have headache and myalgia.¹

A recent study among patients with acute respiratory illness found that the absence of leukocytosis (white blood cell count above the normal range) was positively associated with 2009 H1N1 and seasonal influenza. The absence of leukocytosis added the greatest discriminatory power when combined with the CDC/WHO influenza-like illness definition (presence of temperature >38.0°C and cough or sore throat).²

However, even during peak influenza activity, the accuracy of the clinical diagnosis of influenza may be limited because of the presence of other respiratory pathogens that can cause symptoms similar to those of influenza viruses.³

Patient history and severity of illness should be considered in the decision for initial precautions. The decision to isolate may be made by the physician or nursing staff. Isolation should be discontinued by the physician when it is no longer necessary.

References

Silvennoinen H, et al. Clinical presentation of influenza in unselected children treated as outpatients. *Pediatr Infect Dis J.* 2009;28: 372–375.

Ong AK, et al. Improving the Clinical Diagnosis of Influenza-a Comparative Analysis of New Influenza A (H1N1) Cases. *PLoS ONE.* 2009;4(12): e8453.

Uyeki TM. Influenza diagnosis and treatment in children: a review of studies on clinically useful tests and antiviral treatment for influenza. *Pediatr Infect Dis J.* 2003; 22:164-171.

Thank you for your ongoing commitment to the 2009 H1N1 influenza response.



2009 H1N1 Influenza Infection Control Guidance For Hospitalized Patients February 4, 2010

Revision History: Supersedes “Pandemic (H1N1) 2009 Influenza Infection Control Recommendations For Hospitalized Patients. (8/20/09)”

Originating programs: Healthcare Associated Infections Program, Center for Health Care Quality, and Division of Communicable Disease Control, Center for Infectious Diseases

Current Recommendations

Hospitals should refer to the following documents for the most recent recommendations on infection control in hospitalized patients:

- CDPH and Cal/OSHA joint statement “Guidance for Infection Control for 2009 H1N1 Influenza in Health Care Settings” issued on February 4, 2010 (<http://www.cdph.ca.gov/HealthInfo/discond/Documents/H1N1-ICGuidanceHealthCareSettings.pdf>)
- CDPH “Guidance on Case Definitions to be Used for Infection Control in California Health Care Settings” issued on February 4, 2010. (<http://www.cdph.ca.gov/HealthInfo/discond/Documents/H1N1-IC-CaseDefinitions.pdf>)
- The Centers for Disease Control and Prevention “Interim Guidance on Infection Control Measures for 2009 H1N1 Influenza in Healthcare Settings, Including Protection of Healthcare Personnel,” issued on October 14, 2009 (http://www.cdc.gov/h1n1flu/guidelines_infection_control.htm)
- The Cal/OSHA Aerosol Transmissible Disease Standard, which is available at (<http://www.dir.ca.gov/title8/5199.html>). The Cal/OHSA Interim Enforcement, Policy and Appendix A: Respiratory Supply Documentation can be found at <http://www.dir.ca.gov/dosh/SwineFlu/SwineFlu.htm>.

Resources

CDPH 2009 H1N1 Influenza Homepage:
<http://www.cdph.ca.gov/HealthInfo/discond/Pages/H1N1Home.aspx>

Thank you for your ongoing commitment to the 2009 H1N1 Influenza response.



Infection Control Guidance for 2009 H1N1 Influenza in Outpatient Settings February 4, 2010

Revision History: Supersedes "California Department of Public Health (CDPH) recommendations for 2009 H1N1 influenza in outpatient settings."

Originating Programs: Healthcare Associated Infections Program, Center for Health Care Quality, and Division of Communicable Disease Control, Center for Infectious Diseases.

Introduction

This document provides updated guidance on revised case definitions for H1N1 and guidance regarding implementation of the Centers for Disease Control and Prevention (CDC) revised infection control recommendations of October 14, 2009 in the outpatient setting: http://www.cdc.gov/h1n1flu/guidelines_infection_control.htm.

Highlights

- **Revised CDC recommendations**
- **CDPH/ Cal/OHSA Joint statement of February 4, 2010**
- **CDPH Revised Case Definitions of 2009 H1N1 Influenza for Infection Control Purposes (February 4, 2010)**
- **Summary of CDPH Infection Control Recommendations for 2009 H1N1 Influenza in Outpatient Settings**
 - Case Definitions
 - Patient Triage
 - Infection Control Precautions
 - Health Care Personnel
 - Patient/ Family Instructions
 - Additional Resources

Current Recommendations

CDC Infection Control Recommendations (revised October 14, 2009)

The revised CDC recommendations (http://www.cdc.gov/h1n1flu/guidelines_infection_control.htm) emphasize a hierarchy of controls designed to minimize health care worker exposure and decrease transmission in the health care setting. Revised isolation precautions include:

- Continued use of respiratory protection that is at least as protective as a fit-tested N95 disposable respirator for health care personnel who are in close contact with patients suspected to have 2009 H1N1 influenza;
- Use of standard precautions instead of contact precautions; and
- A shortened exclusion period for health care workers (HCWs) with influenza-like illness (ILI). HCWs with ILI should not return to work until 24 hours after fever is resolved (without the use of fever-reducing medicine).

CDPH and Cal/OSHA Joint Statement (February 4, 2010)

On August 5, 2009, the California Occupational Safety and Health Administration (Cal/OSHA) Aerosol Transmissible Diseases (ATD) Standard went into effect (<http://www.dir.ca.gov/Title8/5199.html>). Patients who meet the CDPH definitions of a suspected, probable or confirmed case of 2009 H1N1 influenza must be managed in accordance with the ATD Standard specific to the setting.

CDPH has issued a joint statement with Cal/OSHA (<http://www.cdph.ca.gov/HealthInfo/discond/Documents/H1N1-ICGuidanceHealthCareSettings.pdf>) that concurs with the revised CDC guidance of October 14, 2009.

Summary of CDPH Infection Control Recommendations for 2009 H1N1 Influenza in Outpatient Settings

This guidance is restricted to infection control issues. Other guidance, including how to identify and care for 2009 H1N1 influenza patients is located on the CDC website at: [http://www.cdc.gov/\(H1N1\)flu/guidance/](http://www.cdc.gov/(H1N1)flu/guidance/).

- **Case Definitions:** California outpatient facilities should follow the most recent CDPH case definitions of 2009 H1N1 influenza for infection control purposes which can be found at (<http://www.cdph.ca.gov/HealthInfo/discond/Documents/H1N1-IC-CaseDefinitions.pdf>). As of February 4, 2010, CDPH is using the following case definitions*:
 - A *suspect* case of 2009 H1N1 influenza is any patient whom a health care provider suspects, based on the patient's history and illness, of being infected with 2009 H1N1 influenza virus.
 - A *probable* case of 2009 H1N1 influenza is a person with a syndrome clinically compatible with influenza who has a PCR test that is positive for influenza A and unsubtypeable for A/H1 or A/H3.
 - A *confirmed* case of 2009 H1N1 influenza is a person with a syndrome clinically compatible with influenza who has laboratory confirmed 2009 H1N1 influenza by one or more of the following tests: real-time RT-PCR or viral culture.

* The case definitions may change in the future as the 2009 H1N1 pandemic continues to evolve. Health care providers should refer to the CDPH website (<http://www.cdph.ca.gov/HealthInfo/discond/Pages/H1N1CDPHGuidances.aspx>)

for the most recent guidance on CDPH case definitions for 2009 H1N1 influenza for infection control purposes.

- **Patient Triage**

There are three opportunities to perform triage in a timely manner to prevent unnecessary exposure of other patients and staff to 2009 H1N1 influenza. Health care workers at the point of first contact should be trained to screen patients for 2009 H1N1 influenza.

- Signs in appropriate languages for the community should be posted at entrances. An example of a sign follows:

TO ALL PATIENTS
To STOP the spread of flu,
Do you have a
<ul style="list-style-type: none">• Fever?• New cough?• Runny nose?• Sore throat?
If Yes, PLEASE
<ul style="list-style-type: none">• Put on a mask over your nose and mouth. (Masks are xxx (indicate location))• Cough or sneeze into a tissue or your sleeve• Throw away tissues into the nearest trash can• Wash hands after touching your nose, mouth, or eyes<ul style="list-style-type: none">○ If no sink is near, use hand gel
THANK YOU for stopping the spread of flu.

For additional examples of signage in multiple languages, see <http://www.health.state.mn.us/divs/idepc/diseases/flu/languages.htm>.

- If possible, triage patients when they call for an appointment. If the patient has symptoms of acute respiratory illness, ask the patient to put on a mask before or immediately upon entering the clinic or office.
- When the patient enters the clinic or office, they should be assessed immediately for symptoms of acute respiratory illness. Signage, masks, and other supplies should be prominently displayed at or near the entrance (ideally, at least 6 feet away from the reception desk) so that symptomatic patients can put on a mask before checking in. If the patient is unable to tolerate being masked, the patient should not remain in the waiting room but should be taken to an examination room as soon as possible and the door should remain closed. Partitions (e.g., transparent panels/windows/desk enclosures) should be installed in triage areas as physical barriers to shield staff from respiratory droplets. Clinic personnel performing triage on

suspected 2009 H1N1 patients should wear a fit-tested respirator at least as effective as N95 respirators. (See discussion of respiratory protection below. Note: the Cal/OSHA ATD standard provides an exception to the required use of respiratory protection for outpatient facilities meeting the definition of “referring employers” if the patient is masked. See <http://www.dir.ca.gov/Title8/5199.html> for Cal/OSHA requirements)

- Provide the patient with illustrations on how to wear a surgical mask over their nose and mouth. The mask should remain on at all times to the extent possible while in the clinic or office waiting area, examination room (while waiting for evaluation) and during transportation to the emergency department (if necessary).
 - Coordinate with and follow instructions from your local health department on respiratory specimen collection.
 - If the patient must be transported to a hospital by ambulance, the hospital emergency room and the ambulance transport service should be notified of the possible 2009 H1N1 influenza diagnosis and instructed to take the appropriate infection control precautions.
- **Infection Control Precautions**

The following precautions are recommended for health care personnel who are in close contact with patients with suspected, probable or confirmed 2009 H1N1 influenza. For the purposes of this document, close contact is defined as working within 6 feet of the patient or entering into a small, enclosed airspace shared with the patient (e.g., average patient room):

- Standard Precautions - For all patient care, use nonsterile gloves for any contact with potentially infectious material, followed by hand hygiene immediately after glove removal; use gowns along with eye protection for any activity that might generate splashes of respiratory secretions or other infectious material. Contact precautions with the routine use of gown and gloves when entering a patient room are no longer recommended.
- Hand Hygiene: Health care personnel should perform hand hygiene frequently, including before and after all patient contact, contact with respiratory secretions, and before putting on and upon removal of PPE. Soap and water or alcohol-based hand sanitizers should be used. (If hands are visibly dirty, soap and water should be used to clean the hands prior to using hand sanitizers).
- Respiratory Protection: CDC and CDPH continue to recommend the use of respiratory protection that is at least as protective as a fit-tested, disposable N95 respirator for health care personnel who are in close contact with patients with suspected, probable or confirmed 2009 H1N1 influenza. This recommendation applies uniquely to the special circumstances of the current 2009 H1N1 pandemic during the fall and winter of 2009-2010 and both CDC and CDPH will continue to evaluate new information as it becomes available. The Cal/OSHA ATD standard also requires the use of respirators for 2009

H1N1 at this time. Information regarding the application of the ATD standard to 2009 H1N1, and methods for maximizing and conserving respirator supplies, is available from Cal/OSHA at: <http://www.dir.ca.gov/dosh/SwineFlu/SwineFlu.htm> and in resources listed at the end of this guidance.

- **Patient Care Equipment and Environmental Infection Control:** Routine cleaning and disinfection strategies used during influenza seasons can be applied to the environmental management of 2009 H1N1 influenza. Management of laundry, utensils and medical waste should also be performed in accordance with procedures followed for seasonal influenza. More information can be found at: http://www.cdc.gov/ncidod/dhqp/gl_enviroinfection.html.
 - Reusable examination equipment such as stethoscopes and blood pressure cuffs should be disinfected with a properly diluted, EPA-approved, germicidal solution after use on a patient with influenza-like illness. All disinfectants must be used in accordance with the conditions in the EPA approval.
 - Environmental surfaces should be disinfected with a properly diluted EPA-approved disinfectant after the patient leaves the examination room and before admitting another patient to that room. Cleaning may focus on surfaces likely to have been touched by the patient. Patient rooms should not be reoccupied before the required contact time for the disinfectant has passed.
 - It is not possible for CDPH to recommend an optimal time to leave rooms unoccupied between patients at this time because there is insufficient information regarding potential transmission by infectious aerosols that may remain in room air after the patient has left.
 - Disposable examination gowns, sheets, and respirators may be disposed of as regular waste.
 - No special precautions are required for the handling of laundry, unless it is contaminated with blood or other potentially infectious materials.
 - Within the clinic, frequently touched surfaces and items (doorknobs, elevator buttons, restrooms, chairs, etc.) should be cleaned and disinfected according to a regular schedule that can be maintained throughout the influenza season.
- **Health Care Personnel**

Health care personnel who develop a fever and respiratory symptoms should be:

 - Strongly encouraged not to report to work, or if at work, to promptly notify their supervisor and infection control personnel/occupational health to be relieved of their duties.

- Requested not to return to work for at least 24 hours after they no longer have a fever, without the use of fever-reducing medicines.
- If off work, instructed not to report to work at a second job for at least 24 hours until they no longer have a fever without the use of fever-reducing medicines.

A longer exclusion period applies to personnel who provide care to severely immunocompromised patients.

More information on monitoring and management of ill health care personnel is available at

http://www.cdc.gov/h1n1flu/guidelines_infection_control.htm.

- **Patient/Family Instructions**

For information regarding the care of a sick person at home consult the CDPH (<http://www.cdph.ca.gov/HealthInfo/discond/Documents/CDPH-H1N1HomeCare.pdf>) or CDC (http://www.cdc.gov/h1n1flu/guidance_homecare.htm) recommendations for homecare of persons with influenza and other respiratory infections.

Additional Resources

Additional information regarding the new CDC guidance and the Cal/OSHA Aerosol Transmissible Diseases Regulation:

Q&A Regarding Respiratory Protection For Preventing 2009 H1N1 Influenza Among Healthcare Personnel:

http://www.cdc.gov/h1n1flu/guidelines_infection_control_qa.htm.

Questions and Answers about CDC's Interim Guidance on Infection Control Measures for 2009 H1N1 Influenza in Healthcare Settings, Including Protection of Healthcare Personnel:

http://www.cdc.gov/H1N1flu/guidance/control_measures_qa.htm.

Cal/OSHA Interim Enforcement Policy on H1N1 and Section 5199 (Aerosol Transmissible Diseases):

http://www.dir.ca.gov/dosh/SwineFlu/Interim_enforcement_H1N1.pdf.

Cal/OSHA Aerosol Transmissible Diseases Regulation (Title 8, California Code of Regulations, Section 5199): <http://www.dir.ca.gov/Title8/5199.html>.

Guidance from Cal/OSHA on the use of respirators is available at:

<http://www.dir.ca.gov/dosh/SwineFlu/SwineFlu.htm>.

A Model Respiratory Protection Program for long-term care facilities is posted on the California Association of Health Facilities (CAHF) Web site. Options for medical evaluation are discussed.

http://www.cahfdownload.com/cahf/dpp/CAHF_ModelRespiratoryProtectionProgram.pdf

Fit-testing procedures can be found in the Cal/OSHA Respiratory Protection Standard, Appendix A: <http://www.dir.ca.gov/Title8/5144a.html>.



Infection Control Guidance for 2009 H1N1 Influenza in Long-Term Care Facilities February 4, 2010

Revision History: Supersedes "California Department of Public Health (CDPH) recommendations for 2009 H1N1 influenza in long-term care facilities (8/20/09)."

Originating programs: Healthcare Associated Infections Program, Center for Health Care Quality, and Division of Communicable Disease Control, Center for Infectious Diseases.

Introduction

This document provides updated guidance on revised case definitions for H1N1 and guidance regarding implementation of the Centers for Disease Control and Prevention (CDC) revised infection control recommendations of October 14, 2009: http://www.cdc.gov/h1n1flu/guidelines_infection_control.htm.

Highlights

- **Revised CDC Recommendations**
- **CDPH / Cal/OSHA Joint Statement of February 4, 2010**
- **CDPH Revised Case Definitions of 2009 H1N1 Influenza for Infection Control Purposes (February 4, 2010)**
- **Summary of CDPH Infection Control Recommendations for 2009 H1N1 Influenza in Long-Term Care Facilities**
 - Case Definitions
 - Infection Control
 - Health Care Personnel
 - Visitor Recommendations

CDC Infection Control Recommendations (revised October 14, 2009):

The revised CDC recommendations (http://www.cdc.gov/h1n1flu/guidelines_infection_control.htm) emphasize a hierarchy of controls designed to minimize health care worker exposure and decrease transmission in health care settings. The recommendations include:

- continuation of the recommendation to use respiratory protection that is at least as protective as a fit-tested N95 disposable respirator for health care personnel who are in close contact with patients with suspect, probable or confirmed 2009 H1N1 influenza;

- a change from contact precautions to standard precautions; and
- a shortened exclusion period for health care workers with influenza-like illness.

CDPH/Cal/OSHA Joint Statement (February 4, 2010)

CDPH has issued a joint statement with the California Occupational Safety and Health Administration (Cal/OSHA) (<http://www.cdph.ca.gov/HealthInfo/discond/Documents/H1N1-ICGuidanceHealthCareSettings.pdf>) supporting the CDC guidance. Additionally, the joint statement includes a revision to the earlier CDPH recommendation regarding the transfer of confirmed 2009 H1N1 influenza patients to long-term care facilities. CDPH now recommends that 2009 H1N1 influenza patients being treated in an acute care hospital may be transferred to a long-term care facility (such as a skilled nursing facility) if medically appropriate, after they are free of fever (100° F [37.8° C] or greater) or signs of a fever for at least 24 hours without the use of fever-reducing medications.

Additional guidance for employers and employees, including the application of the Cal/OSHA Aerosol Transmissible Disease Standard to long-term care facilities, is available from Cal/OSHA at <http://www.dir.ca.gov/dosh/SwineFlu/SwineFlu.htm>. The standard can be found at: <http://www.dir.ca.gov/Title8/5199.html>.

Current CDPH Recommendations

- **Case Definitions:** California long-term care facilities should follow the most recent CDPH case definitions of 2009 H1N1 influenza for infection control purposes which can be found at (<http://www.cdph.ca.gov/HealthInfo/discond/Documents/H1N1-IC-CaseDefinitions.pdf>). As of February 4, 2010, CDPH is using the following case definitions*:
 - A *suspect* case of 2009 H1N1 influenza is any patient whom a health care provider suspects, based on the patient's history and illness, of being infected with 2009 H1N1 influenza virus.
 - A *probable case* of 2009 H1N1 influenza is a person with a syndrome clinically compatible with influenza who has a PCR test that is positive for influenza A and unsubtypeable for A/H1 or A/H3.
 - A *confirmed case* of 2009 H1N1 influenza is a person with a syndrome clinically compatible with influenza who has laboratory confirmed 2009 H1N1 influenza by one or more of the following tests: real-time RT-PCR or viral culture.

* The case definitions may change in the future as the 2009 H1N1 pandemic continues to evolve. Health care providers should refer to the CDPH website (<http://www.cdph.ca.gov/HealthInfo/discond/Pages/H1N1CDPHGuidances.aspx>)

for the most recent guidance on CDPH case definitions for 2009 H1N1 influenza for infection control purposes.

- **Infection Control**

Additional recommendations for managing seasonal influenza can be found at <http://www.cdph.ca.gov/certlic/facilities/Documents/LNC-AFL-08-33Attachment.pdf>.

- Admission and Transfer

The admission to long-term care facilities of patients with recent onset of fever and cough who are 60 years of age or older should be based upon the ability of the facility to provide appropriate care and not upon previous recommendations for isolation for suspected or confirmed cases of 2009 H1N1 influenza. Unless the patient meets the case definition of suspected, probable or confirmed 2009 H1N1 influenza, long-term care facilities should follow precautions for seasonal influenza and other respiratory illness for residents with a recent onset of fever and cough:

<http://www.cdph.ca.gov/certlic/facilities/Documents/LNC-AFL-08-33Attachment.pdf>.

Patients from an acute care hospital who are probable or confirmed cases of 2009 H1N1 influenza may be transferred to a long-term care facility (such as a skilled nursing facility) after they are free of fever (100° F [37.8° C] or greater) or signs of a fever for at least 24 hours without the use of fever-reducing medications, without waiting for the 7th day following onset of illness. Patients from an acute care hospital who have a negative test for influenza A by PCR testing or have an alternative diagnosis established may be transferred as usual.

Base the transfer of residents with known or suspect influenza to other facilities on their clinical condition and not on their need for isolation alone.

Maintain close communication between long-term care facilities and acute-care facilities to ensure that transfers are not admitted with unrecognized febrile respiratory illness.

In the event of an outbreak of acute febrile respiratory illness in residents over 60 years old, follow the Recommendations for the Prevention and Control of Influenza in California Long-Term Care Facilities, 2008-2009 unless 2009 H1N1 influenza is suspected:

<http://www.cdph.ca.gov/certlic/facilities/Documents/LNC-AFL-08-33Attachment.pdf>.

- Residents with suspect, probable or confirmed H1N1 Influenza

CDPH and CDC guidelines for 2009 H1N1 influenza in health care settings (<http://www.cdph.ca.gov/HealthInfo/discond/Pages/H1N1HealthPros.aspx> and http://www.cdc.gov/H1N1flu/guidelines_infection_control.htm) should be followed for any resident or patient suspected by a health care provider of being infected with 2009 H1N1 influenza:

- Health care workers should use a fit-tested N95 respirator when caring for 2009 H1N1 influenza patients. If N95 respirators are not available, use a surgical mask while proceeding to acquire N95 respirators as quickly as

possible. Respirator use should be part of a comprehensive respiratory protection program, in accordance with Cal/OSHA regulations.

- Follow standard precautions (contact precautions are no longer recommended).
- Patients with suspect, probable or confirmed 2009 H1N1 influenza should be placed in isolation according to CDPH recommendations and Cal/OSHA requirements, regardless of age, until they are free of fever for at least 24 hours without the use of fever-reducing medications or 7 days following the onset of illness, whichever is longer. If PCR tests for 2009 H1N1 influenza virus are performed and are negative, long-term care facilities should follow infection control recommendations for seasonal influenza.

Although the current CDC guidance recommends a single patient room when feasible for 2009 H1N1 influenza patients, it is recognized that vacant single rooms are of limited availability in a long-term care facility. The risk of transmission to a roommate of a 2009 H1N1 influenza patient depends upon the degree to which they have been in close contact with the infected resident at the time of onset of their illness. If the roommate is already infected, moving the roommate may further spread the disease. Therefore, decisions to move 2009 H1N1 influenza patients or their roommates should consider the risk of infection to the roommate as well as other consequences of the move.

- **Health Care Personnel**

- Strongly encourage employees who develop a fever, cough, sore throat or other respiratory symptoms not to report to work, or if at work, to cease patient care activities and immediately notify their supervisors and infection control personnel. They should not report to work at a second job. They should stay home from work until at least 24 hours after they no longer have a fever or signs of a fever without the use of fever reducing medicines.
- Continue to make arrangements to have a supply of N95 respirators or other equivalent respiratory protection and identify sources of antiviral medication for use in the event of exposure to or an outbreak of 2009 H1N1 influenza. Standard precautions are routine, and facilities should ensure that supplies of masks and respirators and other equipment, such as eye protection (face shields or goggles) and gowns, are available for staff use.

Cal/OSHA requires a respirator program for the use of N95 respirators that includes medical evaluation, fit-testing and training. However, these requirements should not prevent a facility from providing N95 respirators to employees as an interim emergency measure. Medical evaluation, training and fit-testing can then be done as soon as is reasonably possible.

A Model Respiratory Protection Program for facility use is posted on the California Association of Health Facilities (CAHF) website. Options for medical evaluation are discussed. Fit-testing procedures are detailed in Appendix A.
http://www.cahfdownload.com/cahf/dpp/CAHF_ModelRespiratoryProtectionProgram.pdf.

Guidance from Cal/OSHA on the emergency use of respirators is available at <http://www.dir.ca.gov/dosh/SwineFlu/SwineFlu.htm>.

Information on respirators, including general instructions for use is available at <http://www.cdc.gov/niosh/topics/H1N1flu/>.

- **Visitor Recommendations**

- General Visitor Policies**

- There are currently no CDC or CDPH recommendations to actively screen health care facility visitors for symptoms of 2009 H1N1 influenza infection. Many facilities are currently excluding visitors under age 16 due to the increased risk of 2009 H1N1 influenza infection in this age group. Suggestions might include posting signs discouraging ill persons from visitation (see below), developing an exposure questionnaire that includes information about fever and symptoms administered as the visitor enters the facility, or actively screening the visitor for fever and symptoms as they enter the facility. To prevent transmission of 2009 H1N1 influenza in all health care settings, CDC recommendations for Respiratory Hygiene/Cough Etiquette should be communicated to all persons entering a health care facility: www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm.

- The recommendations include:

- Post visual alerts instructing all persons to report symptoms of acute febrile respiratory illness at the first point of contact.
 - Offer masks to symptomatic persons.
 - Ensure that tissues and waste disposal containers are readily available.
 - Instruct persons to perform hand hygiene.
 - Ensure that supplies for hand hygiene are available: soap and clean paper towels where sinks are located or dispensers of alcohol-based hand sanitizers.

- Visitor Triage (Screening) and Suggested Signage**

- Family members and friends should be discouraged from visiting if they currently have symptoms of an acute febrile respiratory infection. If visitation is necessary for a resident's well-being or care the following information should be communicated.

VISITORS

IF YOU HAVE A FEVER AND SORE THROAT OR NEW COUGH AND YOU MUST ENTER THIS HEALTHCARE FACILITY, PLEASE FOLLOW THESE INSTRUCTIONS:

- Place a mask, located (location of mask instructions) over your nose and mouth before entering and wear the mask at all times while in this facility,
- Cough or sneeze into a tissue or your sleeve,
- Dispose of tissues in the nearest waste receptacle after use, and
- Clean your hands when entering this facility, after contact with your respiratory secretions and after contact with any patient/resident.
- Limit your time in the facility and go only to the location where your presence is needed.

THANK YOU FOR PROTECTING PATIENTS/RESIDENTS AND STAFF

Visitors to Patients in Isolation Precautions

Long-term care facilities should develop and implement procedures for visitors of patients/residents who have been placed in isolation precautions. Consider limiting visitors of patients in isolation to persons who are necessary for the patient's emotional well-being and care. Personal protective equipment for visitors may be at the discretion of the facility and should take into account prior exposure to the patient and the ability of the visitor to comply with isolation requirements. Procedures should at minimum require visitors to sanitize their hands with an alcohol-based product prior to entering an isolation room.

Thank you for your ongoing commitment to the 2009 H1N1 influenza response.