

Welcome to *California*



# Preventing Employee Infections



Basics of Infection Prevention  
2 Day Mini-Course  
Updated 2013

# Objectives

- Review essential activities of Employee Health (EH) programs.
- Describe communicable disease screening and immunization guidance.
- Describe prevention of bloodborne & airborne diseases.
- Review priorities in post exposure management



# Employee Health and Wellness

- Education of infection prevention would not be complete without recognizing the role of health care workers
- Health care workers may be both
  - Carriers of infections to patients
  - Recipients of infections from patients

The most crucial aspect is to keep both patients and health care workers safe and infection free



# Employee Health Activities

- Pre-employment
  - Communicable disease screening – immunity by titer or vaccine history
  - Physical
  - Drug screening
  - Latex allergy screening
  - TB screening
  - Respirator fit-testing
- Annual
  - TB testing
  - Vaccines
    - Annual influenza
    - Tdap
  - Respirator Fit testing
- Counseling
  - Infectious disease exposure risk
  - Work restrictions
  - Latex allergies
- Wellness Promotion
  - Ergonomic worksite evaluation
  - Smoking cessation
  - BP checks
  - Bloodborne pathogen injury prevention
- Infectious disease exposure investigations
- Post-exposure management



# HCW Immunization

## Immunization of Health-Care Personnel Recommendations of the Advisory Committee on Immunization Practices (ACIP)



Continuing Education Examination available at <http://www.cdc.gov/mmwr/cme/conted.html>.



U.S. Department of Health and Human Services  
Centers for Disease Control and Prevention

**TABLE 2. Immunizing agents and immunization schedules for health-care personnel (HCP)\***

Generic name	Primary schedule and booster(s)	Indications	Major precautions and contraindications	Special considerations
<b>Immunizing agents recommended for all HCP</b>				
Hepatitis B (HB) recombinant vaccine	2 doses 4 weeks apart; third dose 5 months after second; booster doses not necessary; all doses should be administered IM in the deltoid	Preexposure: HCP at risk for exposure to blood or body fluids; postexposure (see Table 4)	On the basis of limited data, no risk for adverse effects to developing fetuses is apparent. Pregnancy should not be considered a contraindication to vaccination of women. Previous anaphylactic reaction to common baker's yeast is a contraindication to vaccination.	The vaccine produces neither therapeutic nor adverse effects in HBV-infected persons. Prevacination serologic screening is not indicated for persons being vaccinated because of occupational risk but might be indicated for HCP in certain high-risk populations. HCP at high risk for occupational <sup>†</sup> contact with blood or body fluids should be tested 1–2 months after vaccination to determine serologic response.
Hepatitis B immune globulin (HBIG)	0.06 mL/kg IM as soon as possible after exposure, if indicated	Postexposure prophylaxis (see Table 4)	See package insert <sup>§</sup>	
Influenza vaccine (TIV and LAIV)	Annual vaccination with current seasonal vaccine. TIV is available in IM and ID formulations. LAIV is administered intranasally.	All HCP	History of severe (e.g., anaphylactic) hypersensitivity to eggs; prior severe allergic reaction to influenza vaccine	No evidence exists of risk to mother of fetus when the vaccine is administered to a pregnant woman with an underlying high-risk condition. Influenza vaccination is recommended for women who are or will be pregnant during influenza season because of increased risk for hospitalization and death. LAIV is recommended only for healthy, non-pregnant persons aged 2–49 years. Intradermal vaccine is indicated for persons aged 18–64 years. HCP who care for severely immunosuppressed persons who require a protective environment should receive TIV rather than LAIV.
Measles live-virus vaccine	2 doses SC; ≥28 days apart	Vaccination should be recommended for all HCP who lack presumptive evidence of immunity; <sup>¶</sup> vaccination should be considered for those born before 1957.	Pregnancy; immunocompromised persons,** including HIV-infected persons who have evidence of severe immunosuppression; anaphylaxis to gelatin or gelatin-containing products; anaphylaxis to neomycin; and recent administration of immune globulin.	HCP vaccinated during 1963–1967 with a killed measles vaccine alone, killed vaccine followed by live vaccine, or a vaccine of unknown type should be revaccinated with 2 doses of live measles virus vaccine.
Mumps live-virus vaccine	2 doses SC; ≥28 days apart	Vaccination should be recommended for all HCP who lack presumptive evidence of immunity. <sup>††</sup> Vaccination should be considered for those born before 1957.	Pregnancy; immunocompromised persons,** including HIV-infected persons who have evidence of severe immunosuppression; anaphylaxis to gelatin or gelatin-containing products; anaphylaxis to neomycin	HCP vaccinated before 1979 with either killed mumps vaccine or mumps vaccine of unknown type should consider revaccination with 2 doses of MMR vaccine.
Rubella live-virus vaccine	1 dose SC; (However, due to the 2-dose requirements for measles and mumps vaccines, the use of MMR vaccine will result in most HCP receiving 2 doses of rubella-containing vaccine.)	Vaccination should be recommended for all HCP who lack presumptive evidence of immunity. <sup>§§</sup>	Pregnancy; immunocompromised persons** including HIV-infected persons who have evidence of severe immunosuppression; anaphylaxis to gelatin or gelatin-containing products; anaphylaxis to neomycin	The risk for rubella vaccine-associated malformations in the offspring of women pregnant when vaccinated or who become pregnant within 1 month after vaccination is negligible. <sup>¶¶</sup> Such women should be counseled regarding the theoretical basis of concern for the fetus.

**TABLE 2. (Continued) Immunizing agents and immunization schedules for health-care personnel (HCP)\***

Generic name	Primary schedule and booster(s)	Indications	Major precautions and contraindications	Special considerations
Tetanus and diphtheria (toxoids) and acellular pertussis (Tdap)	1 dose IM as soon as feasible if Tdap not already received and regardless of interval from last Td. After receipt of Tdap, receive Td for routine booster every 10 years.	All HCP, regardless of age.	History of serious allergic reaction (i.e., anaphylaxis) to any component of Tdap. Because of the importance of tetanus vaccination, persons with history of anaphylaxis to components in Tdap or Td should be referred to an allergist to determine whether they have a specific allergy to tetanus toxoid and can safely receive tetanus toxoid (TT) vaccine. Persons with history of encephalopathy (e.g., coma or prolonged seizures) not attributable to an identifiable cause within 7 days of administration of a vaccine with pertussis components should receive Td instead of Tdap.	Tetanus prophylaxis in wound management if not yet received Tdap***
Varicella vaccine (varicella zoster virus live-virus vaccine)	2 doses SC 4–8 weeks apart if aged ≥13 years.	All HCP who do not have evidence of immunity defined as: written documentation of vaccination with 2 doses of varicella vaccine; laboratory evidence of immunity <sup>†††</sup> or laboratory confirmation of disease; diagnosis or verification of a history of varicella disease by a health-care provider, <sup>§§§</sup> or diagnosis or verification of a history of herpes zoster by a health-care provider.	Pregnancy; immunocompromised persons; ** history of anaphylactic reaction after receipt of gelatin or neomycin. Varicella vaccination may be considered for HIV-infected adolescents and adults with CD4+ T-lymphocyte count ≥200 cells/uL. Avoid salicylate use for 6 weeks after vaccination.	Because 71%–93% of adults without a history of varicella are immune, serologic testing before vaccination is likely to be cost-effective.
Varicella-zoster immune globulin	125U/10 kg IM (minimum dose: 125U; maximum dose: 625U)	Persons without evidence of immunity who have contraindications for varicella vaccination and who are at risk for severe disease and complications <sup>¶¶¶</sup> known or likely to be susceptible who have direct, nontransient exposure to an infectious hospital staff worker or patient		Serologic testing may help in assessing whether to administer varicella–zoster immune globulin. If use of varicella–zoster immune globulin prevents varicella disease, patient should be vaccinated subsequently. The varicella–zoster immune globulin product currently used in the United States (VariZIG) (Cangene Corp. Winnipeg Canada) can be obtained 24 hours a day from the sole authorized U.S. distributor (FFF Enterprises, Temecula, California) at 1-800-843-7477 or <a href="http://www.fffenterprises.com">http://www.fffenterprises.com</a> .

**Other immunobiologics that might be indicated in certain circumstances for HCP**

Quadrivalent meningococcal conjugate vaccine (tetraivalent (A,C,Y,W) for HCP ages 19–54 years, Quadrivalent meningococcal polysaccharide vaccine for HCP age >55 years	1 dose; booster dose in 5 years if person remains at increased risk	Clinical and research microbiologists who might routinely be exposed to isolates of <i>Neisseria meningitidis</i>	The safety of the vaccine in pregnant women has not been evaluated; it should not be administered during pregnancy unless the risk for infection is high.
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TABLE 2. (Continued) Immunizing agents and immunization schedules for health-care personnel (HCP)\*

Generic name	Primary schedule and booster(s)	Indications	Major precautions and contraindications	Special considerations
Typhoid vaccine IM, and oral	IM vaccine: 1 dose, booster every 2 years. Oral vaccine: 4 doses on alternate days. Manufacturer recommends revaccination with the entire 4-dose series every 5 years.	Workers in microbiology laboratories who frequently work with <i>Salmonella typhi</i> .	Severe local or systemic reaction to a previous dose. Ty21a (oral) vaccine should not be administered to immunocompromised persons** or to persons receiving antimicrobial agents.	Vaccination should not be considered an alternative to the use of proper procedures when handling specimens and cultures in the laboratory.
Inactivated poliovirus vaccine (IPV)	For unvaccinated adults, 2 doses should be administered at intervals of 4–8 weeks; a third dose should be administered 6–12 months after the second dose.	Vaccination is recommended for adults at increased risk for exposure to polioviruses including health-care personnel who have close contact with patients who might be excreting polioviruses. Adults who have previously received a complete course of poliovirus vaccine may receive one lifetime booster if they remain at increased risk for exposure.	Hypersensitivity or anaphylactic reactions to IPV or antibiotics contained in IPV. IPV contains trace amounts of streptomycin, polymyxin B, and neomycin.	



# Employee Exposure Investigations

- Warranted when staff are exposed to infectious diseases
  - May be patient-to-staff or visitor-to-staff
- Evaluate type of exposure and risk of transmission
- Make list who was exposed – staff, patients, visitors
- Evaluate need for post-exposure management
  - Prophylaxis
  - Vaccination
  - TB skin testing
- Determine if local public health or State should be notified



# Employee Exposure Investigations - continued

In addition to TB and BBP exposures, investigations may include

- Meningitis
- Lice
- Scabies
- Bed bugs
- Measles
- Varicella
- Pertussis



# Preventing Bloodborne Disease in HCW

- Standard Precautions mandatory
- HBV vaccination series offered to all staff with potential for blood exposure
- Hierarchy of prevention methods applied
  - Engineering controls – needleless devices
  - Work practice controls – no recapping
  - Appropriate cleaning, linen-handling, disposal of sharps
- Post-exposure prophylaxis (PEP) immediately available
- BBP training required annually and as needed
- Facilities must have BBP Exposure Control Plan



# OSHA Bloodborne Pathogen Requirements

- Bloodborne Pathogen Exposure Control Plan
  - Policies & Procedures must address Post Exposure management
  - BBP training required annually and as needed
  - Employees must be given opportunity to contribute to product evaluation for sharps safety



# Post Exposure Bloodborne Diseases

- Risk for transmission in healthcare settings
  - Hepatitis B Virus (HBV)
    - 1-6 % if e-antigen negative (HBeAg-)
    - 22-30% if e-antigen positive (HBeAg+)
  - Hepatitis C Virus (HCV)
    - 1.8%, range 0-7%
  - Human Immunodeficiency Virus (HIV)
    - 0.3% (1 in 300 exposures), range 0.2%-0.5%
- Less common or rare BBP
  - Syphilis
  - Malaria
  - Viral hemorrhagic diseases
  - Leptospirosis
  - Prion diseases



# Body Fluid Exposure Risk

- Higher risk body fluids
    - Blood
    - Amniotic Fluid
    - Peritoneal Fluid
    - Cerebrospinal fluid
    - Pleural Fluid
    - Pericardial Fluid
    - Vaginal Fluid/Semen
    - Any body fluid with visible blood (saliva after dental)
  - Low/No risk\*
    - Sweat
    - Tears
    - Feces
    - Saliva
    - Urine
- \* Unless visibly contaminated with blood

# Exposure Risk by Injury Type

- Infection risk dependent on type of exposure
- Ordered highest to lowest risk
  - Deep puncture from a used hollow bore needle
  - Laceration or wound with a “dirty” scalpel or instrument
  - Puncture through a bloody glove
  - Blood/body fluid on non-intact skin
  - Non-intact skin or mucous membrane contact with dried blood
  - Splash to mucous membranes

# Bloodborne Disease Post-Exposure Management

- Clean with soap and water
- Flush mucous membranes with water
- Flush eyes with eye irrigant or clean water
- No evidence of benefit from
  - application of antiseptics or disinfectants
  - squeezing (“milking”) puncture sites
- Avoid bleach and other agents caustic to skin



# BBP Post-exposure Management: Assess Infection Risk

- Type of exposure
  - percutaneous
  - mucous membrane
  - non-intact skin
  - bites resulting in blood exposure
  - Depth, quantity, or duration of exposure
- Body fluid
  - Blood
  - Other bloody fluid
  - Tissue
- Assess viral load of source
  - HBsAg
  - HCV antibody
  - HIV antibody
- If source unknown, assess epidemiologic and clinical evidence to determine post-exposure treatment

# BBP Post-exposure Management: Testing

- Immediate testing

Source (if available)	Employee
Rapid HIV	Rapid HIV
HBsAG	HBsAG
HBcAB	HBcAB
HBsAB	HBsAB
Hepatitis C Antibody	Hepatitis C Antibody
	Hepatic Function Panel

- Employee follow-up

At 6 weeks, 12 weeks and 6 months

Test for HCV antibody, HIV, liver function

CDC MMWR 9/30/05 54 (RR09) 1-7



# Post-exposure Prophylaxis for Hepatitis B: Source HBsAg **Positive**

Vaccination and antibody status of <b>Exposed</b>	Treatment for <b>Employee</b> when <b>Source HBsAg+</b>
Unvaccinated	HBIG x1 & initiate Hepatitis B vaccine series
Previously Vaccinated  Known Responder  Known non-responder  Antibody Response unknown	No treatment  HBIG x1 & initiate re-vaccination –or– HBIG x 2  Test exposed person for anti-HBs <ol style="list-style-type: none"> <li>1. If adequate, no treatment</li> <li>2. If inadequate HBIG x1 &amp; vaccine booster</li> </ol>

# Post-exposure Prophylaxis for Hepatitis B: Source HBsAg **Negative or Unknown**

Vaccination and antibody status of <b>Exposed Employee</b>	Treatment for <b>Employee</b> when <b>Source HBsAg- or status unknown</b>
Unvaccinated	Initiate Hepatitis B vaccine series
Previously Vaccinated  Known Responder  Known non-responder  Antibody Response unknown	No treatment  If known high risk source, treat as if source were HBsAg positive  Test exposed person for anti-HBs <ol style="list-style-type: none"> <li>1. If adequate, no treatment</li> <li>2. If inadequate, vaccine booster &amp; recheck titer in 1-2 months</li> </ol>

# Post-exposure Prophylaxis for Hepatitis C

- Prompt wound care or flushing of mucous membranes
- Prophylaxis not recommended
  - Immunoglobulin not effective
  - No data support use of antivirals (e.g., interferon) for preventing infection; may be effective only with established infection
  - Antivirals not FDA approved for this setting
- Consider expert consultation



# Post-exposure Prophylaxis for HIV

- If indicated, send to MD for assessment for PEP management as soon as possible after exposure
  - Regard as an urgent medical concern; hours rather than days
  - Ensure CBC, liver panel, pregnancy test done prior to initiation of meds
  - Provide counseling about potential side effects of medications
- Interval after which PEP is no longer effective is unknown
  - Initiating days or weeks after exposure might be considered for higher risk exposure



**PEP**line

## National Clinicians' Post-Exposure Prophylaxis Hotline (PEPline)

- Free consultation for clinicians treating occupational exposures to HIV and other bloodborne pathogens
- 24 hours a day
- 7 days a week
- 1-888-HIV-4911
- [www.ucsf.edu/hivcntr/](http://www.ucsf.edu/hivcntr/)

**Joint program of UCSF/SFGH  
Supported by HRSA and CDC**



# HIV PEP for **Percutaneous Injuries**

Exposure Type	Source			
	HIV Positive Class 1	HIV Positive Class 2	HIV Status or Source Unknown	HIV Negative
<b>Less severe</b>	Recommended basic PEP	Recommended expanded PEP	Generally No PEP Assess risks for HIV	No PEP
<b>More Severe</b>	Recommended expanded PEP	Recommended expanded PEP	Generally No PEP Assess risks for HIV	No PEP

Class 1: Asymptomatic or known low viral load

Class 2: Symptomatic, AIDS, or known high viral load

If PEP administered and source is later determined to be HIV-negative, PEP should be discontinued

# HIV PEP for **Mucous Membrane Exposures**

Exposure Type	Source			
	HIV Positive Class 1	HIV Positive Class 2	HIV Status or Source Unknown	HIV Negative
<b>Less severe (few drops)</b>	Consider basic PEP	Recommended basic PEP	Generally No PEP Assess risks for HIV	No PEP
<b>More Severe (Major splash, large volume)</b>	Recommended basic PEP	Recommended expanded PEP	Generally No PEP Assess risks for HIV	No PEP

Class 1: Asymptomatic or known low viral load

Class 2: Symptomatic, AIDS, or known high viral load

If PEP administered and source is later determined to be HIV-negative, PEP should be discontinued



# Determining When HIV PEP Prophylaxis Not Necessary

- Situations where HIV PEP is rarely, if ever, warranted include
  - Intact skin contact with blood and potentially infectious body fluids
  - Exposure to unknown source in populations where HIV prevalence is low
  - Low-risk exposure to unknown source

# Monitor for HIV PEP Toxicity

- Test at baseline and 2 weeks after starting PEP
  - complete blood count
  - renal and hepatic profiles
- Follow-up testing if taking protease inhibitor
  - monitor for hypoglycemia
  - monitor for crystalluria, hematuria, hemolytic anemia, and hepatitis if on indinavir
- Modify regimen if toxicity noted
- Expert consultation encouraged



# Prevention of Airborne Transmissible Diseases in Health Care Workers

Risk reduction strategies include

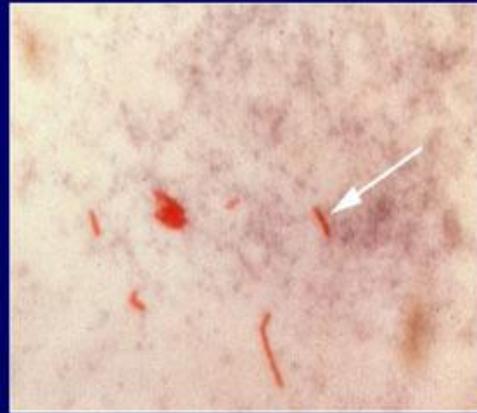
- Follow Standard precautions
  - Routinely wear mask if patient coughing or has uncontained respiratory secretions
- Cough etiquette by patients, visitors, health care workers
- Apply mask on ill/coughing person for source control
- TB screening upon hire and annually
- Annual influenza vaccination
- Comply with Aerosol Transmissible Disease (ATD) Standard



# Pulmonary Tuberculosis (TB)

- Caused by bacteria *Mycobacterium tuberculosis*
- **A**cid **F**ast **B**acilli can be seen on a stained slide

AFB smear



AFB (shown in red) are tubercle bacilli

# Tuberculosis - continued

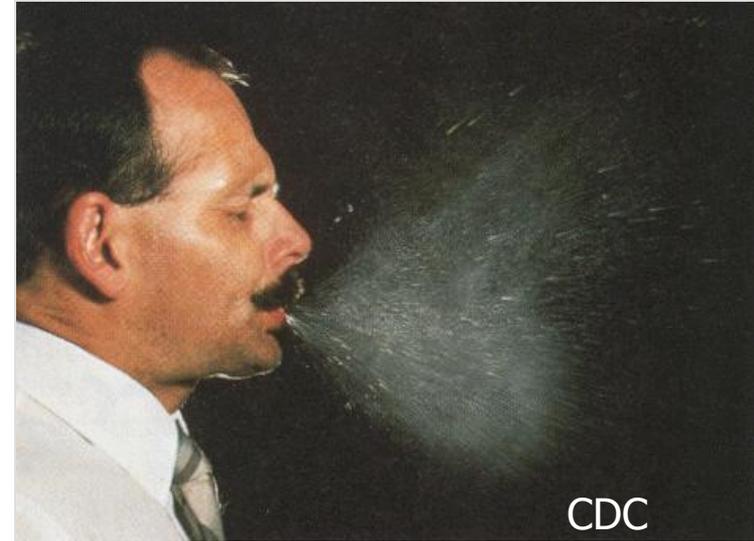
- Serious chronic illness; can be fatal if untreated
- Transmitted by airborne route
  - Patient contact not required for exposure
  - Droplets can stay afloat for hours and travel on air currents
- Not extremely infectious
  - Likelihood of transmission affected by
    - infectiousness of patient
    - environmental conditions
    - duration of exposure
  - Most persons exposed do not become infected



# Transmission of TB

## Increased risk of transmission

- From infection person with
  - Forceful cough
  - Acid-fast bacilli (AFB) in sputum
  - Laryngeal disease
  - Cavitation on chest xray
- Undergoing cough-inducing procedures
- In small closed spaces with poor ventilation
- Failing to cover nose/mouth when coughing



# Risk of TB Infection and Disease

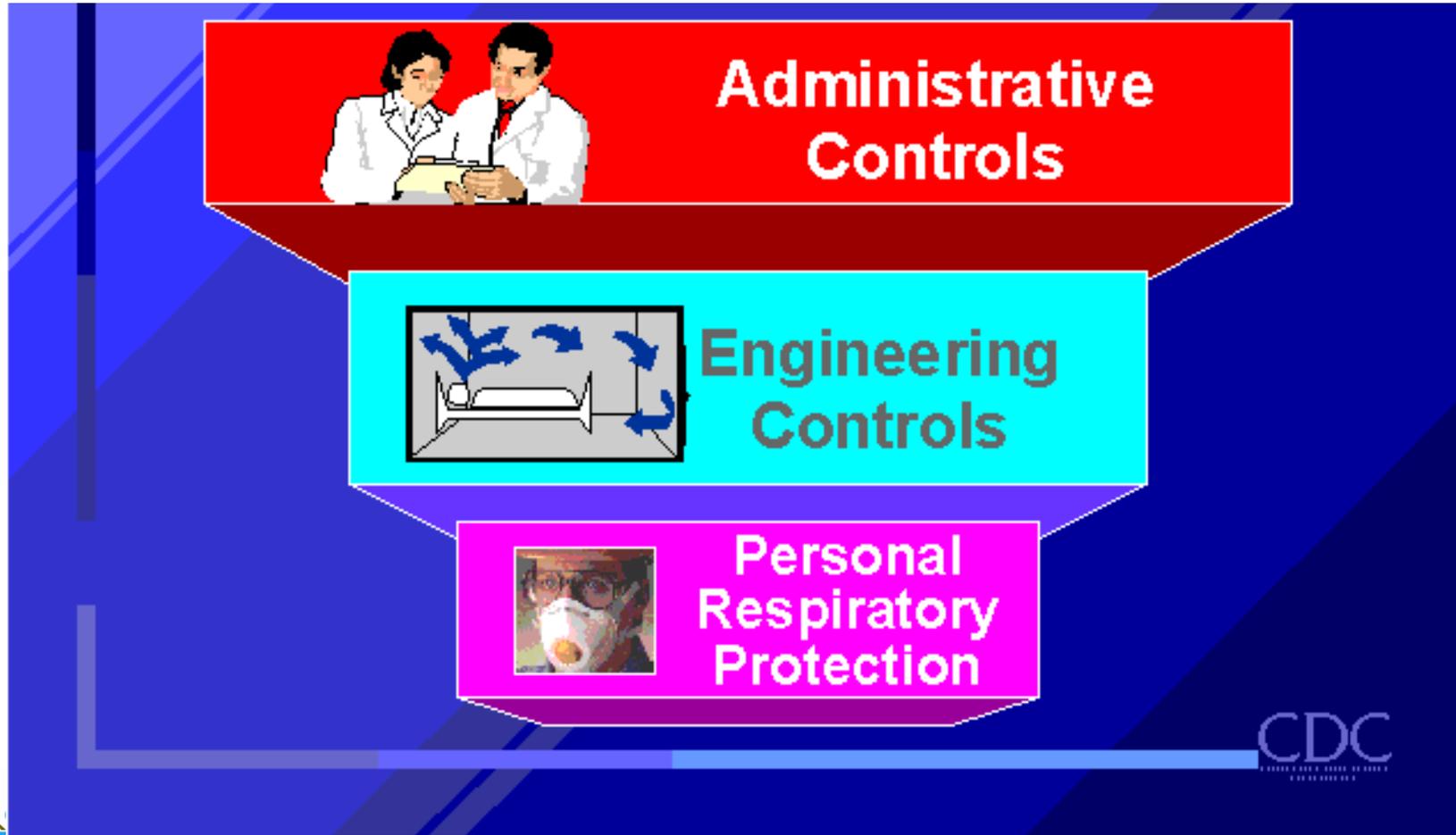
## Highest Risk for Infection

- Medically under-served, low income
- High-risk minority populations
- Persons who inject drugs
- Close contacts to suspect/known cases
- Foreign-born from high prevalence areas
- Healthcare workers serving high risk patients

## Highest Risk for Progression to Disease

- HIV infected, or otherwise immune compromised
- Recently infected with TB
- Certain chronic medical conditions
- IV drug abusers
- History of inadequately treated TB
- Stressors, such as recent immigration

# Hierarchy of TB Prevention Strategies



# Annual TB Testing

- Identifies health care workers newly infected with TB
  - Enables prompt treatment to minimize risk of respiratory disease



- Serves as an ongoing evaluation for effectiveness of TB prevention strategies
  - May identify improvement needs in control measures

# TB Risk Assessment

- Determine HCW to be included in annual TB screening program
  - Annual skin testing
  - Review symptoms with previously positive employees
  - Annual chest xray not required
- Determine HCW to be included in Respiratory Protection Program, require fit testing
- Identify areas with increased risk for TB transmission
- Assess if adequate number of Airborne Infection Isolation Rooms
- Conduct periodic reviews of TB prevention strategies



# Airborne Transmissible Disease (ATD) Standard

- Applies to all health care settings
  - Includes
    - Hospitals
    - Skilled nursing facilities
    - Hospices
    - Private medical offices
    - Paramedic and emergency services
    - And many others

Exceptions: dental offices and outpatient settings where ATDs are not diagnosed or treated



# ATD Requirements

- Written ATD Plan
  - Policies & Procedures addressing ATD
    - Education & training for prevention
    - TB Screening
    - Post exposure management
  - Provide seasonal influenza vaccination to all employees with potential for occupational exposure
  - Engineering controls for management of patients with ATDs
  - Fit testing for respiratory protection
  - Maintenance of employee health records



# ATD Requirements- Engineering Controls

- Airborne Infection Isolation Room (AIIR)
  - 12 air exchanges per hour (ACH)
- AND
- Daily verification of negative pressure (via smoke stick or flutter test) while room is occupied
- PAPR for high hazard procedures
  - Includes sputum induction, bronchoscopy, intubation, open system suctioning, aerosolized nebulizer treatment



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**Subchapter 7. General Industry Safety Orders**  
**Group 16. Control of Hazardous Substances**  
**Article 109. Hazardous Substances and Processes**

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**§5199. Appendix A.**

**ATD Standard Appendix A:  
Specifies diseases that require  
airborne or droplet precautions**

**Appendix A – Aerosol Transmissible Diseases/Pathogens (Mandatory)**

This appendix contains a list of diseases and pathogens which are to be considered aerosol transmissible pathogens or diseases for the purpose of Section 5199. Employers are required to provide the protections required by Section 5199 according to whether the disease or pathogen requires airborne infection isolation or droplet precautions as indicated by the two lists below.

**Diseases/Pathogens Requiring Airborne Infection Isolation**

Aerosolizable spore-containing powder or other substance that is capable of causing serious human disease, e.g. *Anthrax/Bacillus anthracis*  
Avian influenza/Avian influenza A viruses (strains capable of causing serious disease in humans)  
Varicella disease (chickenpox, shingles)/Varicella zoster and Herpes zoster viruses, disseminated disease in any patient. Localized disease in immunocompromised patient until disseminated infection ruled out  
Measles (rubeola)/Measles virus  
Monkeypox/Monkeypox virus  
Novel or unknown pathogens  
Severe acute respiratory syndrome (SARS)  
Smallpox (variola)/Variola virus  
Tuberculosis (TB)/*Mycobacterium tuberculosis* -- Extrapulmonary, draining lesion; Pulmonary or laryngeal disease, confirmed; Pulmonary or laryngeal disease, suspected  
Any other disease for which public health guidelines recommend airborne infection isolation

**Diseases/Pathogens Requiring Droplet Precautions**

Diphtheria pharyngeal  
Epiglottitis, due to *Haemophilus influenzae* type b  
*Haemophilus influenzae* Serotype b (Hib) disease/*Haemophilus influenzae* serotype b -- Infants and children  
Influenza, human (typical seasonal variations)/influenza viruses  
Meningitis  
*Haemophilus influenzae*, type b known or suspected  
*Neisseria meningitidis* (meningococcal) known or suspected  
Meningococcal disease sepsis, pneumonia (see also meningitis)  
Mumps (infectious parotitis)/Mumps virus  
Mycoplasmal pneumonia  
Parvovirus B19 infection (erythema infectiosum)  
Pertussis (whooping cough)

# ATD Standard in Outpatient Settings

- Outpatient clinics do not provide same level of care as inpatient settings
  - Shorter duration of exposure
- Apply ATD Standard to extent feasible
  - Place person in separate room or area
  - Provide separate ventilation or filtration
  - Source control is primary; mask patient
  - In absence of source control, employee must wear N95 respirator or above when entering room or area



# ATD Standard in Facilities Other than Hospitals

Many health care facilities are not equipped to care for persons ill with an ATD

- If a resident develops respiratory illness
  - Transfer within 5 hours
  - Do not transfer if detrimental to resident's condition
- In absence of AIIR, place ill patient in single room with door closed
  - May cohort with other ill patients
  - Employees wear an N95 respirator to enter



## References and Resources

- California Code Regulations, Title 8, Section 5193 (BBP ECP)
- CAL-OSHA ATD Standard <http://www.dir.ca.gov/title8/5199.html>
- CDC Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Setting  
[http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5417a1.htm?s\\_cid=rr5417a1\\_e](http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5417a1.htm?s_cid=rr5417a1_e)
- *Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV and HIV and Recommendations for Postexposure Prophylaxis*, CDC, MMWR, June 29, 2001 / Vol 50 / No. RR-11
- Cal/OSHA Guidance for the 2010-2011 Influenza Season regarding the Application of the Aerosol Transmissible Diseases Standard (Issue Date: 11/5/2010)
- PEPLine at <http://www.ucsf.edu/hivcntr/Hotlines/PEPLine>; telephone 888-448-4911
- Joint Guidelines for Prevention and Control of Tuberculosis in CA Long Term Health Facilities. California Department of Public Health [www.cdph.ca.gov/](http://www.cdph.ca.gov/)



# Questions?

For more information, please contact any  
HAI Liaison Team member

Thank you

