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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

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Revision History: 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.

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 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 H1N1viral RNA in respiratory secretions is documented by rRT-PCR.
- Using measures to conserve respirators when they are in short supply.

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* 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 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 H1N1patients 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).

Suspected cases of 2009 H1N1 Influenza (definition):

CDPH continues to recommend that, for infection control purposes, health care facilities consider a **suspected case** of 2009 H1N1 influenza infection as:

- Any patient less than 60 years of age with a fever (>37.8°C or 100°F) and new onset of cough, or
- Any patient whom a health care provider believes, based on the patient's history and illness, to have a high likelihood of being infected with 2009 H1N1 influenza virus.

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.