KERN HEALTH SYSTEMS

Policy and Procedure Review/ Revision

Policy 2.20-P Infection Control Program has been updated and is provided here for your review and approval.

Reviewer	Date	Comment/Signature
Doug Hayward	9/16/20	
Dr. Tasinga	9/15/2020	
Deb Murr	9/14/2020	
Jane Daughenbaugh	9/8/2020	

(CEO decision(s))

Board approval required: Yes ___ No ____ QI/UM Committee approval: Yes ___ No ___
Date approved by the KHS BOD: _____ Date of approved by QI: _____
PAC approval: Yes ___ No ___ Date of approval by PAC: _____
Approval for internal implementation: Yes ___ No ___
Provider distribution date: Immediately _____ Quarterly _____

Effective date: _____
DHCS submission: _____
DMHC submission: _____
Provider distribution: _____

KERN HEALTH SYSTEMS

KERN HEALTH SYSTEMS POLICY AND PROCEDURES					
SUBJECT: Infection Control Program				POLICY #: 2.20-P	
DEPARTMENT: Quality Improvement					
Effective Date: 08/2001	Review/Revised Date: 9/16/2020	DMHC		PAC	
		DHCS		QI/UM COMMITTEE	
		BOD		FINANCE COMMITTEE	

_____ Date _____
Douglas A. Hayward
Chief Executive Officer

_____ Date _____
Chief Medical Officer

_____ Date _____
Chief Health Services Officer

_____ Date _____
Director of Quality Improvement

POLICY:
All Kern Health Systems (KHS) contracted providers will actively participate in an effective infection control program for the surveillance, prevention, and control of infections and improving patient care through prompt reporting to the appropriate county agencies, education, and monitoring procedures. It is the policy of KHS' contracted facilities to maintain an infection control program that meets the minimum guidelines listed by California Code of Regulations Title 22 and Title 8: Cal/OSHA, 29 California Federal Register 1910.1030 OSHA Inst.

Providers must do the following:
A. Review patient infections that present the potential for prevention or intervention to reduce the risk of future occurrence
B. Design, implement, and monitor an exposure control plan and ensure that a copy is accessible to contracted provider employees

DEFINITIONS:

Blood and Other Potentially Infectious Materials (OPIM)	OPIM are all human body fluids, any unfixed tissue or organ (other than intact skin) from a human (living or dead), and HIV or HBV – containing blood, cells, tissues, organs, cultures, medium or solutions.
Bloodborne Pathogens	Pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to hepatitis B virus (HBV), hepatitis C virus (HVC) and human immunodeficiency virus (HIV).
Contamination	The presence or reasonably anticipated presence of blood or OPIM on any item or surface.
Decontamination	The use of appropriate physical or chemical means to remove, inactivate or destroy bloodborne pathogens so that a surface or item is no longer capable of transmitting infectious particles and is rendered safe for handling, use or disposal.
Infection	The spread of disease producing organisms/pathogens; the presence of pathogens in the body.
Universal Precautions	System of infectious disease control which assumes every direct contact with body fluids is infectious and requires every employee exposed to direct contact with body fluids be protected as though such body fluids were HBV or HIV infected.

PROCEDURES:

All contracted providers/facilities will have an appropriate Infection Control Program in place that deals with standard precautions, reportable communicable diseases, sterilization/disinfection of equipment, hazardous spills and the like.

Providers will review and identify active cases and persons exposed to disease through lab and x-ray reports suggesting an active infectious disease. When identified, the disease will be reported to Kern County Public Health Services Department (KCPHSD). Member will be notified and all people in contact with member will be notified to see a physician. An initial facility site review and subsequent reviews every three (3) years determine provider/facility compliance regarding an effective Infection Control Program.

1.0 EXPOSURE CONTROL PROGRAM

In order to eliminate the hazards of occupational exposure, KHS contracted providers must implement an exposure control plan for the work site with details on employee protection measures which describes: how the work site will use a combination of engineering and work practice controls, ensure the use of personal protective clothing and equipment, provide

training, medical surveillance, hepatitis B vaccinations, and sign and labels, among other provisions. Engineering controls are the primary means of eliminating or minimizing employee exposure and include the use of safer medical devices, such as needleless devices, shielded needle devices and plastic capillary tubes.

At a minimum, the exposure control plan must include the following:

A. A description of how it was determined that an exposure occurred. This must be based on the definition of occupational exposure **without regard to personal protective clothing and equipment**.
B. The procedures for evaluation of the circumstances surrounding an exposure incident.
C. The method for implementing sections of the OSHA standards that cover the methods of compliance, hepatitis B vaccination and post-exposure follow-up, communication of hazards to employees, and record keeping. The schedule of how and when the provisions of the standard will be implemented may be as simple as a calendar with brief notations describing the methods of implementation, and an annotated copy of the standard.
D. The plan must be reviewed and updated at least annually or whenever new tasks and procedures affect occupational exposure. It must be made accessible to employees in accordance with *Title 29 Code of Federal Regulations*, Part 1910.20 (e).

Information and training must be provided at no cost to the employee during working hours at the time of initial assignment and a least once a year thereafter. Additional training is needed when existing tasks are modified or new tasks are added that result in an employee's occupational exposure to bloodborne pathogens.

2.0 PREVENTIVE MEASURES

2.1 Infection Control Program

Providers will review and identify active cases and persons exposed to disease (i.e. Sexually Transmitted Disease [STD], Tuberculosis [TB] etc.) through lab and x-ray reports suggesting an active infectious disease. When identified, the disease will be reported to Kern County Public Health Services Department (KCPHSD). The member will be notified and all people in contact with member will be notified to see a physician

KHS will perform an initial facility site review and subsequent review every three (3) years to determine provider/facility compliance regarding an effective Infection Control Program. Public Health Memorandum of Understandings (MOUs) and provider policy and procedures for treatment and reporting are processes for potential prevention and/or intervention to reduce risk of future occurrence.

2.2 Health Screening

Contracted provider personnel are required to pass an initial health screening to detect communicable disease states, such as TB, in order to maximize patient and staff safety.

2.3 Hepatitis B Vaccination

Contracted providers must make the hepatitis B vaccine and vaccination series available to all employees who have occupational exposure as well as provide a post-

exposure evaluation and follow up to all employees who experience an exposure incident. The vaccine and vaccinations, as well as all medical evaluations and follow up, must be made available at no cost to the employee, provided at a reasonable time and place, and performed by or under the supervision of a licensed physician or another licensed health care professional whose scope of practice allows him or her to independently perform such activity. Vaccinations also must be administered according to current recommendations of the U.S. Public Health Service. Employees who decline the vaccination must sign a declination form. (See Attachment A). The employee may request and obtain the vaccination at a later date and at no cost, if he/she continues to be exposed.

2.4 Standard Universal Precautions

All materials, instruments, environmental surfaces, etc., that could possibly be contaminated with blood or body fluids should be considered infectious. The proper use of infection control techniques and clean/sterile supplies and equipment should be employed to prevent cross contamination of infection.

Universal precautions are intended to prevent health care workers from parenteral, mucous fluids of all patients must be considered potentially infectious for blood borne pathogens. Universal precautions apply to the following:

A. Blood or other body fluids containing visible blood
B. Semen and vaginal secretions
C. Unfixed tissues or organs
D. Cerebrospinal fluid (CSF)
E. Synovial fluid
F. Pleural fluid
G. Peritoneal fluid
H. Pericardial fluid
I. Amniotic fluid
J. Saliva in dental procedures
K. All body fluids in situations where it is difficult or impossible to differentiate between body fluids.

General infection control practices including the use of gloves for digital examination of mucous membranes and endotracheal suctioning, and handwashing after exposure to saliva should further minimize any minute risk.

3.0 METHODS OF CONTROL

3.1 Needlestick Safety

Contaminated sharps are discarded immediately. Sharp containers are located close to the immediate area where sharps are used and are inaccessible to unauthorized persons. Sharps are not bent, removed from a syringe, or recapped except by using a one-handed technique. Needleless systems, needle devices, and non-needle sharps are used unless exemptions have been approved by Cal/OSHA (8CCR, Section 5193). Security of portable containers in patient care areas is maintained at all times. Any device capable of cutting or piercing (e.g. syringes, hypodermic needles, needleless devices, blades, broken glass, slides, vials) are placed in a closable, puncture-resistant,

labeled, leak-proof container. If these requirements are met, containers made of various materials (e.g. cardboard, plastic) are acceptable. Containers are not filled above the manufacturer's designated fill line, or more than ¾ full. Supply of containers on hand is adequate to ensure routine change-out when filled.

3.2 Sharps Injury Documentation

Site has a method in place to document sharps injuries. Date, time, description of exposure incident, share type/brand, follow up care is documented within 14 days of injury accident.

3.3 Hand Washing Technique

Hand washing is one of the oldest, simplest, and most consistent methods to prevent the spread of infections by decreasing contamination of the hands. Hands should be washed in all of the following circumstances:

A. Upon arrival to the office (to remove microorganisms brought in from off the premises)
B. Before, between, and after all physical contacts with patients
C. Before and after performing any personal bodily function
D. After handling used dressings, sputum containers, secretions, drainage from a patient, and other contaminated items
E. On leaving the exam room of a patient on isolation precautions and after handling items from such a room
F. When hands are obviously soiled
G. On completion of duty before going home (to avoid transmission of microorganisms to the home)

The following steps should be followed to wash hands:

A. Remove all jewelry
B. Turn on the water and adjust temperature
C. Wet hands and forearms with water
D. Lather with anti-microbial soap
E. Cleanse fingernails
F. Rinse thoroughly
G. Dry hands and forearms well
H. Turn off water using a clean paper towel
I. Leave sink area neat and clean

Hand washing facilities are available in the exam room and/or utility room and include an adequate supply of running water, soap, and single use towels or hot air drying machines. Sinks with standard faucet, foot-operated pedals, 4-6 inch wing-type handles, automatic shut-off systems, or other types of water flow control mechanism are acceptable. Staff is able to demonstrate infection control "barrier" methods used on site to prevent contamination of faucet handle, door handles and other surfaces until hand washing can be performed. On occasions when running water is not readily available, an antiseptic hand cleanser, alcohol-based hand rub, or antiseptic towelette is acceptable until running water is available (29CFR 1919.1030).

Hand washing prevents infection transmission by removing dirt, organic material, and

microorganisms from hands. Hand washing with plain (non-antimicrobial) soap in any form (e.g., bar, leaflet, liquid, powder, granular) is acceptable for general patient care. Antimicrobial agents or alcohol-based antiseptic hand rubs are used for hand washing when indicated to remove debris and destroy transient microorganisms (e.g., before performing invasive procedures, after contact with potentially infectious materials). Plain and antiseptic hand wash products are properly maintained and/or dispensed to prevent contamination.

3.4 Isolation Procedures

Each clinic or office must outline a plan of action to care for a potentially infectious patient by promptly isolating the patient from the reception area and other patients. This can accomplished, upon identification of a potentially infectious patient, through the use of an alternative entrance or through assignment of the last appointment slot to this patient and request that the patient wait outside until the reception area is clear of other patients. All offices must have a rash sign posted outside their office entrance.

4.0 PERSONAL PROTECTIVE EQUIPMENT (PPE)

PPE is available for staff use on site, and includes water repellant gloves, clothing barrier (e.g., gown, sheets), face/eye protection (e.g. goggles, face shield), and respiratory infection protection (e.g. mask). Availability of other necessary PPE is specific to the practice and type of procedures performed on a site. PPE is specialized clothing and/or equipment for protection against bloodborne pathogen hazards, and does not include general work clothes (e.g. uniforms, cloth lab coats) that permit liquid to soak through. General work clothes are appropriate only if blood/OPIM does not penetrate through employee's work clothes, undergarments, skin, eyes, mouth, or other mucous membranes under NORMAL conditions of use.

Contaminated laundry (soiled with blood/OPIM or having contained contaminated sharps) is laundered at a commercial laundromat, by a contracted laundry service, or a washer and dryer on site. Manufacturer's guidelines are followed to decontaminate and launder reusable protective clothing. Laundry requirements are "not applicable" if only disposable PPE is used on site.

Gloves are required when it can be reasonably anticipated that the employee may have hand contact with blood, OPIM, mucous membranes, and non-intact skin; when performing phlebotomy or IV venipuncture therapy; and when handling or touching contaminated items or surfaces. To prevent transmission, gloves should also be worn during direct contact with any patient with a skin rash or lesion. Hands are to be washed immediately after removal of gloves or other PPE.

5.0 HOUSE KEEPING

The provider must develop and implement a cleaning schedule that includes appropriate methods of decontamination and tasks or procedures to be performed. This written schedule must be based on the type of surfaces to be cleaned, the type of contamination present, the tasks or procedures to be performed, and the location within the facility.

5.1.1 Routine Decontamination

Work site is maintained in a clean and sanitary condition. Contaminated work are decontaminated with an appropriate disinfectant (29 CFR 1910.1030) immediately when surfaces become overtly contaminated, there is a spill or blood or OPIM, procedures are completed, and at the end of the work shift if the surface may have become contaminated since the last cleaning. Written "housekeeping" schedules have been established and are followed for regular routine daily cleaning. Staff is able to identify frequency for routine cleaning of surfaces and equipment, the disinfectant used, and responsible persons.

5.2 Spill Procedure

All spills are immediately contained and cleaned up by appropriate staff. Staff is able to identify procedures for prompt decontamination of blood/body fluid spills, the disinfectant used, and the responsible persons.

5.3 Disinfectant Products

Products used for decontamination have a current EPA-approved status. Effectiveness in killing HIV/HBV/TB is stated on the manufacturer's product label.

5.4 10% Bleach Solution

10% Bleach Solution is changed/reconstituted ***every*** 24 hours (due to the instability of bleach after being mixed with water). Surface is cleaned prior to disinfecting (due to presence of organic matter such as dirt, blood, or excrement which inactivates active ingredient, sodium hypochlorite). Surface is air dried or allowed appropriate time (states on label) before drying. Manufacturer's directions, ***specific*** to every bleach product, are followed carefully.

5.5 Sterilization Methods

5.5.1 Cleaning prior to sterilization

Prior to undergoing the sterilization process, soiled instruments/equipment are thoroughly cleaned, rinsed, dried, and inspected for the presence of dried blood or other debris. Personnel are able to demonstrate or verbally explain procedure(s) used for cleaning prior to sterilization and to locate written directions on site.

5.5.2 Cold/Chemical Sterilization

Product manufacturer's directions are strictly followed for instrument pre-soaking treatment, solution preparation, solution exposure procedures, safety precautions (e.g. room temperature, area ventilation), and post-sterilization processes. Sterilization exposure times and solution expiration date/time is communicated to staff. Written procedures for cold sterilization are available on site to staff.

Cold sterilization solutions are effective against HIV and Hepatitis B viruses. Instruments are thoroughly cleaned with an appropriate detergent solution and thoroughly rinsed with water prior to immersing in the selected cold sterilizing solution. Instruments are cold sterilized according to the product's manufacturer's guidelines regarding the length of soaking time, mixture ratio of the product to water, etc. Cold sterilization solution potency is checked according to the manufacturer's recommendations to ensure proper sterilization.

5.5.3 Autoclave/Steam Sterilization

Autoclave manufacturer's directions are strictly followed for instruments pre-cleaning, machine loading, operation safety precautions, minimum time-temperature criteria, and post sterilization processes. Written operating procedures for autoclave are available on site to staff. If instruments/equipment are transported off-site for sterilization, equipment-handling and transport procedures are available on site to staff.

5.5.4 Autoclave Maintenance

Autoclave is maintained and serviced according to manufacturer's guidelines including routine cleaning and calibration. If the manufacturer's guidelines are not present on site, the autoclave is serviced annually by a qualified technician. A dated sticker on the autoclave or a service receipt is acceptable documentation of appropriate maintenance. An Autoclave Log is maintained, documenting every cycle that is processed, listing the date, time of operation, temperature attained, steam pressure, length of cycle, and processor's initials.

5.5.5 Spore Testing

Autoclave spore testing is performed ***at least monthly,*** unless otherwise stated in manufacturer's guidelines. Written procedures for performing routine spore testing and for handling positive spore tests results are available on site to staff. If spore tests are positive, the autoclave is removed from service immediately until inspection is completed and a negative retest occurs. Procedures include report problem, ***repair*** autoclave, ***retrieve*** all instruments sterilized since last negative spore test, ***retest*** autoclave and ***re-sterilize*** retrieved instruments (***R***eport/***R***epair/***R***etrieve/***R***etest/ ***R***e-sterilize). Testing results are returned from the contracted lab within a ***two-week*** period.

5.5.6 Documentation

Documentation of the following activities is maintained on site:

A. Autoclave maintenance: mechanical problems, inspection dates, results/outcome of routine servicing, calibration, repairs, etc.
B. Sterilization loads: date, time and duration of run cycle, temperature, steam pressure, operator of each run
C. Biological spore testing: date, results, type of spore test used, person performing/documenting test results

5.5.7 Sterile Packages

Storage areas for sterilized packages are clean, dry and separated from non-sterile items by a functional barrier (e.g., shelf, cabinet door, drawer). Sterilized package *outside* labels *must* include *the processing date, the processor's initials,* and general contents (e.g., suture set). Each item in a sterile package need not be listed on the label if a master list of package contents is available elsewhere on site. Maintenance of sterility is event related, not time related. Sterilized items are considered sterile until damaged and should be removed from sterile package storage area. Site has a process for routine evaluation of sterilized packages.

Packs must list the processing date and the processor's initials on the outside wrapper.

Packs are covered and stored in clean, dust-free areas, away from moisture and heavy traffic areas.

5.5.8 Instrument Cleaning

Instruments must be cleaned initially utilizing an appropriate detergent preparation. After thorough cleaning, the instruments are rinsed, dried, lubricated (if indicated), and wrapped appropriately. Cloth or "paper cloth" disposable wrappers and/or cellophane/paper "peel-strip" pouches are used for wrapping instrument trays and/or single instruments.

5.5.9 Critical Instrument

A critical instrument, one that has penetrated soft tissue or bone or has come in contact with mucous membranes, must be sterilized in a heat sterilizer or heat pressure sterilizer.

5.5.10 Shelf Life

Each facility stipulates the "shelf-life" for all processed packs and instruments. Some facilities utilize "event related sterility" which means that the article is sterile until opened or the pack is damaged. Others may choose to specify the exact time in months that a stored article is considered sterile. It is a general rule that cellophane/paper pouches that are not heat sealed are considered sterile for six (6) months from the processing.

6.0 LABELING

Fluorescent orange or orange-red warning labels must be attached to containers of regulated waste, to refrigerators and freezers containing blood or OPIM, and to other containers used to store, transport, or ship blood or OPIM. These labels are not required when all the following conditions apply:

A. Red bags or red containers are used
B. Containers of blood, blood components, or blood products are labeled as to their contents and have been released for transfusion or other clinical use
C. Individual containers of blood or OPIM are placed in a labeled container during storage, transport, shipment or disposal

7.0 BIOHAZARDOUS WASTE DISPOSAL

See *KHS Policy and Procedure #2.21 - Management of Biohazardous Waste*.

8.0 MANDATED COMMUNICABLE DISEASE REPORTING

Providers must comply with all areas of *KHS Policy and Procedure #3.29 – Condition/ Disease Reporting*.

9.0 EDUCATION, INTERVENTION, AND PREVENTION PROGRAM

Contracted providers should implement an education, intervention, and prevention program appropriate to the patient population served and the associated risk of potential future infectious disease processes. Training occurs prior to initial exposure to potential infections. Review and re-training sessions must occur at least annually.

Personnel must know where to locate information/resources on site and how to use the

information. Evidence of training may include informal in-services, new staff orientation, external training courses, educational curriculum and participation lists, etc. Evidence of training must be verifiable.

Training documentation must contain the employee's name, job title, training date(s), type of training, contents of training session, and names/qualifications of trainers. Records must be kept for three (3) years.

10.0 OSHA STANDARDS

Provider offices should offer provisions for employees who have an exposure incident as described by the OSHA Standard for Bloodborne Pathogens. Exposure incidents include needlesticks and any specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials. Reporting an exposure incident enables the employer to evaluate the circumstances surrounding the exposure incident to prevent reoccurrence. All exposure incidents must be documented, reported, and investigated with a medical evaluation and appropriate follow-up.

ATTACHMENTS:

- Attachment A – *Hepatitis B Vaccination Declination Form*

REFERENCE:

California Code of Regulations Title 22
Title 8: Cal/OSHA, 29 California Federal Register 1910.1030 OSHA Inst.
DHCS PL 14-004
DHS Comment Letter 09/19/01 (Procedure (3)). DHS Contract §6.5.12.3

Revision 2020-08: Policy reviewed by Director of Quality Improvement. Validated and updated regulatory references. **2016-01: Policy reviewed by QI Supervisor. Signatory list updated. Policy revised per current site review standards and Policy Letter (PL) 14-004. Revision 2013-08:** Policy reviewed by Director of Quality Improvement, Health Education and Disease Management. No revision need, titles updated. [1] **Revision 2010-05:** Minor revisions provided by the Director of Quality Improvement, Health Education and Disease Management. **Revision 2005-09:** Routine review. **Revision 2004-08:** Routine review. Revised per DHS Contract 03-76165. There is no longer any mention of an Infection Control Program in the new contract. **Revision 2003-06**: Per DHS comment letter 3/4/2003. **Revision 2002-11:** To incorporate suggestions made by DHS auditors (Medical Review YE 08/31/00).

KERN HEALTH SYSTEMS

Attachment A

HEPATITIS B VACCINATION DECLINATION FORM

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time.

I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease.

If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Employee Signature: _____

(Printed) Name: _____

Date Signed: _____

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