

# **PART F. INFECTION CONTROL AND PREPAREDNESS IN HEALTHCARE FACILITIES**

## **NC Statewide Program for Infection Control and Epidemiology**

### **A. Introduction**

Influenza is a common cause of respiratory illness, requiring health-care visits and hospitalization. During the influenza season, outbreaks of healthcare associated influenza affect both patients and personnel in chronic care facilities and hospitals. The purpose of this chapter is to help healthcare facilities prepare for the presence of a novel or pandemic influenza virus in their facility.

### **B. Background**

#### **1. Incubation Period**

The incubation period for human influenza virus is short, usually 1 to 3 days (range 1 to 7 days). The incubation period of novel influenza viruses could be longer than for human influenza viruses. For example, the incubation period for the avian influenza A (H5N1) virus has been shown to be approximately 2 to 4 days, with ranges of up to 8 days.

#### **2. Route of Transmission**

Transmission of human influenza is predominately by large respiratory droplets (>5 microns nuclei) and to a lesser degree by the fine droplet nuclei that are expelled from the respiratory tract during coughing, sneezing and even talking. Transmission can also occur through direct contact with contaminated respiratory secretions or surfaces through fomites followed by the touching of one's nose or mouth. In previous reports of influenza A (H5N1) infections in humans, there has been no evidence to suggest airborne transmission of the disease in healthcare settings when only standard and contact precautions were used. Negative pressure isolation is not required for routine patient care and individuals with pandemic influenza.

#### **3. Diagnostic Criteria**

In the event of a pandemic, updates of clinical presentations, case definitions, and algorithms will be posted on the CDC influenza website (<http://www.cdc.gov/flu/>) and the WHO website (<http://www.who.int/en/>). Current surveillance criteria and epidemiological risk factors are summarized in Appendix B-1.

#### **4. Specimen Type and Collection**

The State Laboratory of Public Health (SLPH) has the capability to test for certain novel influenza viruses (H5 and H7). Instructions for specimen collection and transport can be found in Appendix H-1. Following standard precautions, all specimens should be regarded as potentially infectious and staff that collect or transport clinical specimens should adhere rigorously to protective measures in order to minimize exposure. The request form accompanying the specimen should be clearly labeled as "novel influenza virus" (e.g. influenza A H5 or H7 if one of these subtypes is suspected). The hospital laboratory as well as the SLPH should be notified by phone when the specimen is being transported.

#### **5. Cleaning and disinfection**

Environmental cleaning and disinfection for pandemic influenza follow the same general principles used daily in healthcare settings. The influenza virus is inactivated by the standard EPA approved disinfectants (e.g., 1:10 dilution of bleach in water) commonly used in hospitals.

## 6. Types of Infection Control Precautions

Infection control precautions are transmission-based, depending on the clinical presentation or syndrome and likely pathogens, until the infectious etiology has been determined.

**Standard Precautions** should be routinely practiced by all health-care personnel.

During the care of a patient with suspected or confirmed influenza:

- Wear gloves if hand contact with respiratory secretions or potentially contaminated surfaces is expected.
- Wear a gown if soiling of clothes with patient's respiratory secretions is expected.
- Change gloves and gowns after each patient encounter and perform hand hygiene.
- Decontaminate hands before and after touching the patient, after touching the patient's environment, or after touching the patient's respiratory secretions, whether or not gloves are worn.
- When hands are visibly soiled or contaminated with respiratory secretions, wash hands with either a non-antimicrobial or an antimicrobial soap and water.
- If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands in clinical situations. Alternatively, wash hands with an antimicrobial soap and water.

**Contact Precautions** should be understood by health-care personnel.

- Place patient into a private room if possible. If a private room is not available, place (cohort) patients with other patients either suspected or confirmed to have same diagnosis requiring contact precautions (e.g., resistant organism infection).
- Gloves and gown should be donned prior to entering room.
- Remove gloves and gown prior to leaving the patient's room and dispose of gloves and gown in a waste container.

**Droplet Precautions** should be understood and practiced by health-care personnel.

In addition to Standard Precautions, observe Droplet Precautions during the care of a patient with suspected or confirmed novel influenza:

- Place patient into a private room as soon as possible. If a private room is not available, place (cohort) suspected influenza patients with other patients suspected of having influenza; cohort confirmed influenza patients with other patients confirmed to have influenza. Negative pressure rooms are not necessary.
- Masks should be donned when entering the room within 6-10 feet of the patient. Remove the mask when leaving the patient's room and dispose of the mask in a waste container.
- Eye protection (e.g., goggles) should be considered if the patient is producing infectious aerosols and close contact (within 3 feet) is possible
- Until placement in a private room, and if patient movement or transport is necessary, place a surgical mask on the patient.
- Patient should be maintained on Droplet Precautions for a minimum of 5 days, unless there is a full resolution of illness or another etiology is identified.

**Airborne Precautions** control measures should be understood by health-care personnel.

- Place patient in a private room that meets airborne isolation requirements (i.e., private room, negative pressure, air exhausted directly to the outside,  $\geq 6$  air exchanges per hour). Staff should perform a "tissue test" or other appropriate test to confirm negative pressure before placing the patient in the room, and then daily to ensure negative pressure is maintained.
- Personnel should wear an N95 respirator (prior fit test clearance and instructions on respirator use) when entering the room. If N95 respirators are not available, other NIOSH-certified N-, R-, or P-class respirators may be used. Any change in the type of respirator used would require additional fit testing of personnel. Powered air purifying respirators (PAPRs) should be used for high-risk procedures, and should be considered for workers who have not been fit tested for an N95 respirator. Training is required to ensure proper use and care of PAPRs. The [-----] (e.g., industrial hygienists) will be responsible for overseeing appropriate PAPR use.

- Until placement in a private room, and if patient movement or transport is necessary, place a surgical mask on the patient.

Additional precautions are advisable during a pandemic. Airborne Precautions may be necessary in the following special circumstances [see CDC October 2006 guideline at <http://www.pandemicflu.gov/plan/healthcare/maskguidancehc.html>]:

- Airborne Precautions (including eye protection) should be considered for performing all procedures that generate aerosols (e.g., sputum induction, aerosol medication therapy, bronchoscopy, intubation). If possible, Airborne Infection Isolation Rooms (AIIRs) should be used when performing high-risk aerosol-generating procedures.
  - i. Limit the use of aerosol-generating procedures on pandemic influenza patients to those that are deemed medically necessary.
  - ii. Use clinically appropriate sedation during intubation and bronchoscopy to minimize resistance and coughing during the procedure.
  - iii. Eye protection should consist of goggles that fit snugly around the eyes.
  - iv. A face shield may be worn over goggles to protect exposed areas of the face but should not be used as a primary form of eye protection for these procedures.
- Airborne Precautions should be considered for managing strains of influenza exhibiting increased transmissibility.
- Airborne Precautions should be considered during the initial stages of an outbreak of an emerging or novel strain of influenza, as early in a pandemic, it may not be clear that a patient with severe respiratory illness has pandemic influenza.
- Should Airborne Precautions be necessary, determine the number and location of Airborne Infection Isolation Rooms available. For example:
  - i. The AIIRs in the [-----] (e.g., PICU) are [-----].
  - ii. The AIIRs in the [-----] (e.g., MICU) are [-----].
  - iii. The AIIRs in the [-----] (e.g., general medicine unit) are [-----].

#### 7. Criteria for escalating Infection Control measures

During a pandemic, adherence to infection prevention and control policies and procedures is critical to minimize the transmission of pandemic influenza and other infectious diseases. Transmission risk in healthcare facilities (including hospitals, long-term care, and outpatient facilities) depends on the extent of pandemic influenza activity in the community and pandemic influenza activity in the facility. The pandemic influenza response for escalating infection control measures will be based on pandemic influenza activity and transmission risks. As the epidemiologic characteristics of the pandemic virus are more clearly defined, the state of North Carolina will, in conjunction with the CDC, provide updated infection control guidance.

- It is anticipated that immunization (for the pandemic influenza strain) will not be available in the early stages of a pandemic and perhaps not even available in later stages, necessitating an emphasis on infection prevention, control practices, and personal protective equipment (PPE)
- Strict adherence to hand hygiene recommendations is the cornerstone of infection prevention and, in conjunction with adherence to isolation precautions, may be the only preventative measures available during a pandemic.

The primary strategies for preventing pandemic influenza are the same as those for seasonal influenza: vaccination, early detection and treatment with antiviral medications, and the use of infection control measures to prevent transmission during patient care. However, when a pandemic begins, a vaccine may not yet be widely available, and the supply of antiviral drugs may be limited. The ability to limit transmission in healthcare settings will, therefore, rely heavily on the appropriate and thorough application of infection control measures.

## C. Interpandemic Phases 1 and 2

### 1. Encourage Vaccination of All Healthcare Workers

It is recommended that all health care workers be vaccinated with the current WHO recommended influenza vaccine. This is an important infection control measure to prevent the spread of influenza from healthcare workers to their patients. Ensure adequate supply of vaccine.

2. Respiratory Hygiene/Cough Etiquette

Respiratory Hygiene/Cough Etiquette Programs should be ongoing at the first point of contact with a potentially infected person to prevent transmission of all respiratory tract infections in health-care settings, including influenza.

Respiratory/Cough Etiquette Program includes:

- posting visual alerts and instructional materials to:
  - teach appropriate hand hygiene and Standard Precautions
  - instruct patients and visitors with symptoms of a respiratory infection to inform health-care personnel and report to a specified screening and/or evaluation site;
- providing tissues to patients and visitors to cover their mouth and nose when coughing and sneezing;
- providing hand hygiene materials in waiting room areas (e.g., alcohol-based agents);
- ensuring supplies for hand washing are available at sinks;
- providing surgical masks to persons who are coughing;
- designating a separate waiting area (at least 3 feet away) in waiting rooms where patients and visitors with respiratory symptoms may be segregated;
- encouraging coughing persons to sit at least 3 feet away from others; and
- having health-care personnel observe Droplet Precautions in addition to Standard Precautions

3. Education

Health-care personnel who would be involved in caring for a patient with a novel strain of influenza should receive training in the above Respiratory Hygiene/Cough Etiquette program, emphasizing modes of transmission, appropriate infection control precautions and exposure control.

4. Antivirals for Influenza

Some antiviral drugs are clinically effective and may be used for both treatment and prevention of uncomplicated influenza A infection. See Part D: Antivirals for further discussion. CDC often issues guidance during the influenza season regarding use of antivirals. For healthcare workers needing to receive antiviral prophylaxis to prevent influenza infection:

- Pre-exposure antiviral prophylaxis should be taken for at least 6 weeks.
- Post-exposure prophylaxis should be taken for at least 7 days and should begin as soon as possible after exposure.

5. Develop system-wide business continuity of operations plan to address potential personnel and bed shortages, as well as other issues that may arise during a pandemic.

## D. Pandemic Alert Phase 3

1. In a pandemic alert phase 3 in which a novel strain of influenza A has been detected in humans, with no or minimal human to human transmission of the virus, consider screening all patients hospitalized with pneumonia for the following characteristics that might indicate a higher index of suspicion for novel virus infection:

- In the 10 days before illness onset, travel to or close contact with other ill persons who recently traveled to a previously affected novel influenza A area.

2. Assess availability of vaccines, antiviral agents, supplies, and equipment both consumable (e.g., PPE) and durable (e.g., ventilators).

- Adequate supplies of vaccines, antiviral agents, supplies, and equipment will be determined and maintained within the facility.

- Additional storage location for vaccines, antiviral agents, supplies, and equipment will be determined.
  - A 3 month surplus of consumable supplies (e.g., surgical masks, N-95 respirators) is recommended.
3. Guideline for prioritization of laboratory services will be reviewed and/or developed.
4. Vaccination
- Vaccination of healthcare personnel with seasonal influenza vaccine should continue; vaccinating with seasonal human influenza vaccine reduces the risk of co-infection of healthcare personnel with a novel or avian influenza virus and a human influenza virus.
  - Healthcare personnel with direct patient contact and ancillary support staff are one of the highest priority groups to receive pandemic influenza vaccine once it is available. A complete list of recommended priority groups for pandemic influenza vaccine is in the US DHHS Pandemic Influenza Plan, released in November 2005. Estimating the number of personnel in certain priority groups should begin. Local health departments can be a resource in making these estimations.
5. Identify source for back-up supplies of antivirals and plan for treatment and prophylaxis (both pre- and post-exposure) for selected healthcare personnel. Recent guidelines on the prioritization of antivirals during a pandemic are outlined in the US DHHS Pandemic Influenza Plan, released in November 2005. These recommendations should be utilized to determine how much antiviral medication would be needed for groups of healthcare personnel.
6. All healthcare workers are expected to provide care for patients with known or suspected novel influenza A virus, as well as comply with all infection control and public health recommendations.
7. If a healthcare worker provides care at more than one facility, the healthcare worker will be instructed to notify [-----] (e.g., supervisor) if one of the facilities is providing care to novel virus patients.

## **E. Pandemic Alert Phases 4 and 5**

1. In the presence of pandemic alert phases 4 or 5, in which a novel influenza virus has resulted in small or large clusters of limited human to human spread, signs (in appropriate languages) will be placed outside the Emergency Department (ED) / outpatient facilities requesting that persons with certain epidemiologic criteria coupled with an influenza-like illness identify themselves to the [-----] (e.g., police, triage nurse).
- A mask should be placed on the patient prior to them entering the ED.
  - Persons accompanying the patient for evaluation should be screened for symptoms of the novel virus ideally prior to entering the facility.
  - Posted visual alerts will recommend “respiratory hygiene” precautions.
2. Intake and triage staff will be trained on how to assess risks for the pandemic strain of influenza and use any applicable tools (thermometers, signs/symptoms of pandemic influenza) to screen patients. The pre-identified pandemic influenza coordinator or designee will develop a strategy to assign responsibility.
3. Initiate active screening of symptomatic patients for either a personal or contact history of travel to geographic area with novel virus activity.
4. Adherence to infection prevention and control policies and procedures is critical to minimize the transmission of novel influenza virus and other infectious diseases. Transmission risk in healthcare facilities (including hospitals, long-term care, and outpatient facilities) depends on the extent of novel virus

activity in the community and novel virus activity in the facility. Decisions regarding the need for escalating infection control measures will be based on novel virus activity and transmission risks.

5. During a potential pandemic of any size, existing staffing shortages may be amplified by illness among staff members, fear and concern about the novel virus, and isolation and quarantine of exposed staff or ill/exposed family members. Staffing shortages are likely to escalate as a pandemic progresses. The strain involved in patient care and prolonged use of personal respiratory protection may intensify staffing challenges. Determination of how staffing needs will be met as the number of patients increases and/or staff become ill or are quarantined should occur.

- The staffing needs for a patient with novel or pandemic influenza A virus may be greater (e.g., twice the normal staffing ratio) than that normally provided for other non-ICU and ICU patients.
- Example: The minimum number of staff and ancillary staff necessary to care for a single patient or group of patients on any given day is [-----] (i.e., 2 nurses and 1 assistant for 8 patients).
- Example: The minimum staffing requirements for providing care for two patients with novel influenza A will be [-----].
- Use of alternative staffing resources (e.g., retired healthcare workers, volunteers, contract workers, students, residents) may be needed but will require training and support during the outbreak response.
  - Contract agencies are [-----] and may be reached at [-----].
- If quarantine is used as an exposure management tool, some healthcare workers may be placed on 'home/work restrictions' to ensure sufficient staffing levels. Healthcare workers on home/work restrictions should travel only between home and the healthcare facility for the duration of the restriction.
- During a pandemic of any size, all infection control professionals will be needed to formally monitor and reinforce compliance with PPE measures and policies.

6. During a pandemic, a shortage of hospital beds may occur.

- Develop policies and procedures for shifting patients between nursing units to free up bed space in critical-care units or to cohort suspected or confirmed influenza patients.
- Consult with hospital licensing agencies on plans and processes to expand bed capacity during a pandemic. These discussions should take into account the need to provide staff, medical equipment, and supplies to care for the number of hospitalized patients.
- A lack of hospital beds may lead to a strategy of utilizing non-licensed inpatient beds for patient management (e.g., PACU, observation beds) following approval from appropriate personnel and authorities.
- Identify appropriate state agencies [-----] at [-----] to discuss how bed availability, including available ICU beds and ventilators, will be tracked during a pandemic. (See Part E for further discussion of surge capacity issues).
- A pandemic may easily overwhelm hospital capacity. In this event, hospitals and communities will need to provide care in alternate care facilities (ACFs), such as school or university gymnasiums. (See Part E for more details).
  - Assist the local community and health authorities in developing policies and procedures for these ACFs. Ensure the following issues are addressed:
    - Bed capacity and spatial separation of patients
    - Facilities and supplies for hand hygiene
    - Lavatory and shower capacity for large numbers of patients

- Food services (refrigeration, food handling, and preparation)
  - Medical services
  - Staffing for patient care and support services
  - PPE supplies
  - Cleaning/disinfection supplies
  - Environmental services (linen, laundry, waste)
  - Safety and Security
7. Institute 24 hour telephone triage system with appropriate translation services.

## **F. Pandemic Phase 6 (without cases occurring in North Carolina)**

1. In the presence of increased and sustained human to human spread of a novel virus in the general population, but before there are cases identified in North Carolina, screening of patients entering the facility will escalate from passive (e.g., signs at the entrance) to active (e.g., direct questioning, respiratory symptoms, temperature monitoring).
2. Patients with suspected pandemic influenza virus requiring medical evaluation should be seen in the following designated area [-----] (i.e., the Infectious Disease Clinic). If possible, the designated area should be notified prior to the patient's arrival.
  - The patient will be requested to wear a surgical mask.
  - Persons accompanying the patient for evaluation should be screened for symptoms of the novel virus ideally prior to entering the facility.
3. Clinicians and intake and triage staff will be regularly updated (i.e., every 12 hours) on the status of the pandemic locally, nationally, and internationally (i.e., via email, memoranda, or meetings).
4. If a patient is confirmed as having the pandemic influenza virus, monitor for nosocomial transmission of the pandemic strain of influenza within the healthcare facility.
5. Hospital access controls:
  - When pandemic influenza is present in the United States, preventing unrecognized pandemic influenza patients from entering the facility will be essential. Restricting access to the facility will assist in the implementation of effective surveillance and screening. Consider limiting hospital visitors and involve police services to enforce access limitations in the event when there are a few cases of pandemic influenza in the facility but NO nosocomial transmission.
  - Consider limiting hospital admissions, transfers, and discharges (in accordance with local/state recommendations and regulations) in the event that nosocomial transmission of a pandemic strain of influenza occurs. For example
    - i. consider limiting hospital admissions to those patients with the pandemic strain of influenza only
    - ii. consider early discharge of newborn infants to home in order to minimize exposure
  - Establish criteria and protocols for closing the facility to new admissions and transfers in the event that nosocomial transmission of a pandemic strain of influenza occurs (i.e., healthcare workers ill).
6. Communication and Reporting
  - A pandemic influenza will generate a need for rapid analysis of the status of patients and transmission in the healthcare facility and reporting of this information to employees and public health officials, as well as to the public, the media, and political leaders.

- On an as needed basis (e.g., two times per day) the health care staff will have a conference call with the state and local health departments to report and receive information on pandemic influenza activity in the healthcare facility and the community. This call may also discuss discharge planning of pandemic influenza patients with health department officials to ensure appropriate follow-up and case management in the community.
- The Hospital Emergency Incident Command System (HEICS) will be activated when there are one or more cases of pandemic influenza in the community.
- Healthcare facility numbers:
  - Infection Control: [-----]
  - Infectious Disease Consult: [-----]
  - House Nursing Supervisor: [-----]
  - ED Attending: [-----]
  - Hospital Police: [-----]
  - Local Health Department: [-----]
  - State General Communicable Disease Branch: [-----]
  - Medical Examiner: [-----]

## **G. Pandemic Phase 6 (with cases occurring in North Carolina)**

1. Activate the Hospital Emergency Incident Command System (HEICS) under facility's existing disaster management plan.

2. In the presence of increased and sustained human to human spread of a novel virus in the general population, when cases are identified in the United States, institute a strategy to monitor the health of staff and patients who are potentially exposed to the pandemic strain of influenza. Exposure consists of providing care in the same room of a patient with pandemic influenza or being in the same room of a person with suspected pandemic influenza without proper PPE (personal protective equipment).

- Exposure Reporting Processes: Establish an exposure reporting process that includes various methods for identifying exposed personnel such as self-reporting by employees, observation of non-compliance with PPE, and logs of personnel entering pandemic influenza patient rooms.
  - Employees will self-report to [-----] (i.e., supervisor).
  - Observance of non-compliance will be reported to [-----] (i.e., supervisor).
  - Logs will be maintained of all persons entering pandemic influenza patient rooms.
  - These logs will be provided to [-----] (i.e., supervisor).

3. Management of asymptomatic healthcare personnel exposed to pandemic influenza

- Personnel who may have been exposed to pandemic influenza should be vigilant for fever or respiratory symptoms following exposure for 1-5 days. Persons who develop fever or respiratory symptoms should limit interactions outside the home and should not go to work, school, child care, church, or other public areas. Persons should notify their occupational health service provider.
- Exposed unprotected healthcare personnel who are asymptomatic must be evaluated prior to work each day by occupational health or designee. Ensure coverage is inclusive of students, contract, and hospital employees.
  - Students: Student Health [phone number and location]
  - Hospital employees: Occupational Health Services [phone number and location]
  - University employees: University Occupational Health [phone number and location]
  - Contract employees: Emergency Department or designee [phone number and location]
- Such examinations will be performed for 5 days following the last unprotected exposure.
- Exposed unprotected healthcare personnel should monitor their own temperature twice per day and report any elevated temperature (i.e.,  $\geq 38^{\circ}\text{C}$ ) to their occupational health provider or designee.

4. Management of symptomatic healthcare personnel exposed to pandemic influenza:

- Exposed healthcare personnel who develop fever and/or respiratory symptoms should not report to work. Persons should immediately report by phone the development of fever and/or respiratory symptoms as follows.
  - Occupational health at [-----], or designee [-----] at [-----]. The healthcare worker should report to the [-----] (i.e., Infectious Disease Clinic) for clinical evaluation as medically necessary.

5. Health care workers should have access to mental health professionals to help them cope with the emotional strain of managing a pandemic (e.g., Employee Assistance Program, Critical Incident Stress Management, and Psychiatry).

6. In the presence of a formal pandemic declaration with cases documented in North Carolina, screening should be coordinated with access controls, a triage station outside the facility to screen patients before they enter the facility, priority triage of persons with respiratory symptoms, and/or telephone screening of patients with appointments.

- In the presence of pandemic influenza activity in North Carolina and cases at this facility, all persons entering the facility will be screened. A “Pandemic Evaluation Center” will be used to separate pandemic influenza patients from other patients seeking care at [-----] (i.e., UNC Health Care System). When there is a presence of pandemic influenza activity in North Carolina, the [-----] (i.e., ID Clinic) will be used as the “Pandemic Evaluation Center”. To prevent exposure of staff, patients and visitors, the [-----] (i.e., outside entrance/emergency exit) will be used.
- When the number of potential pandemic influenza cases exceeds [-----] (i.e., 100) persons per day, the [-----] (i.e., Ambulatory Care Center) will be used as the “Pandemic Evaluation Center”. Before the facility is used, determine needed ventilation, water supply, traffic routes, and modes of transport for patients who must be taken from the evaluation center to the healthcare facility.
- Clinicians will contact the following department(s) [-----] (i.e., hospital epidemiology/infection control) and individual(s).
- The local health department number is [-----].
- If the local health department cannot be reached, contact the NC General Communicable Disease Control Branch at 919-733-3419 (24/7 via pager).

7. Strict adherence to Droplet Precautions is to be practiced by all health-care personnel.

In addition to Standard Precautions, observe Droplet Precautions during the care of a patient with suspected or confirmed strain of pandemic influenza:

- Place patient into a private room.
- Wear a surgical mask upon entering the patient’s room or when working within 3 feet of the patient.
- Remove the mask when leaving the patient’s room and dispose of the mask in a waste container.
- If patient movement or transport is necessary, patient must wear a surgical mask.

8. Cohorting of Patients

- A lack of Airborne Infection Isolation Rooms (AIIRs), private rooms, or a need to concentrate infection control efforts and resources may lead to the following:
  - i. Cohorting patients in individual rooms on the same floor, rather than placing them on separate units or in AIIRs throughout the hospital.
  - ii. Converting private rooms/AIIRs to double rooms to accommodate more patients with pandemic influenza or those requiring Airborne Isolation. This strategy should only be implemented following approval from the Incident Commander, Federal and State authorities, and to the extent that staff could manage the number of patients on the unit.
  - iii. In the event that cohorting is necessary, cohort suspected influenza patients with other patients suspected of having the pandemic strain of influenza; cohort confirmed influenza patients with other patients confirmed to have pandemic influenza.
  - iv. Maintain 3 feet of separation between patients.

9. Movement and transport of patients with influenza should be limited as much as possible. If a patient must be transported, adhere to the following guidelines:

- Place surgical mask on patient.
- Always notify recipient area prior to patient transport.
- Follow alternate route designated for transport of influenza patients (separate from main traffic route).
- Dedicated pathways will be determined by the pandemic influenza coordinator or designee.
- The following elevators will be utilized: [-----].
- The following corridors will be utilized: [-----].
- Consider limiting hospital admissions, transfers, and discharges (in accordance with local/state recommendations and regulations) in the event that nosocomial transmission of pandemic influenza occurs.

10. Visitors should be limited to reduce the likelihood of pandemic influenza transmission among visitors, patients, and health care workers.

- Guardians of minor children and no more than 2 significant others (e.g., spouse, sibling) may visit provided that they do not have fever or respiratory symptoms. An exception to the visitation rule can be made by the Director of Infection Control/ Hospital Epidemiology in consultation with state or local public health authorities.
- Visitors will receive infection control training via [-----] (e.g., brochures, video) and comply with infection control measures.
- Symptomatic persons exposed to pandemic influenza patients will be excluded from visitation.

11. In-hospital post-mortem care:

- Health care workers must follow standard precautions when caring for a patient with pandemic influenza who is deceased.

## **H. Second or Subsequent Waves**

1. Maintain active screening and surveillance measures per Section E above and as directed by local/state health officials.

2. Maintain strict adherence to Droplet Precautions per above.

## **I. Postpandemic Period**

1. Return to interpandemic routine operations.