

May 23, 2003

HEALTH CARE SYSTEM MEMORANDUM No. 111-03-05

SUBJ: SEVERE ACUTE RESPIRATORY SYNDROME (SARS) POLICY

- **SUMMARY:** This is a new Health Care System Memorandum.
- **PURPOSE:** To describe processes and procedures for early identification and isolation of persons who may have Severe Acute Respiratory Syndrome (SARS) to prevent transmission within the Health Care System.
- **POLICY:** This Health Care System will follow those recommendations described by the Centers for Disease Control and Prevention (CDC), World Health Organization (WHO), Veterans Health Administration (VHA), local, county, and state health authorities pertaining to the control of SARS.
- **PROCEDURES:** All procedures are outlined in detail in Attachment A.
- **RESPONSIBILITIES:**
 - a. **Health Care System Director** is responsible for ensuring that necessary resources are provided to establish a well-grounded, functioning plan, and shall require full compliance with all aspects of the Plan.
 - b. **Infection Control Program**, under the direction of the Health Care System Epidemiologist and Chief of Infectious Diseases is responsible for the development and implementation of policy regarding SARS and is authorized to institute appropriate surveillance, prevention, control measures, and exposure investigations. Infection Control staff will act as liaison with local, state and federal health authorities. Infection Control will provide education by maintaining updated links on the Infection Control website and will provide inservice training upon request.
 - c. **All Service Chiefs and Supervisors** are responsible for ensuring that all staff are familiar with the policies and procedures within this HCSM and that necessary resources for providing care to SARS patients are sufficiently allocated. Supervisors will make sure that staff caring for SARS patients have been adequately fit-tested for an N-95 respirator.

- d. **Environmental Health and Safety Section** of Quality Management is responsible for management and policy development (HCSM) for the Respiratory Protection Program. The Industrial Hygienist is responsible for periodic manual checks (smoke tube test or anometer) of the airflow for negative pressure rooms for Quality Assurance purposes.
- e. **Environmental Management Service** is responsible for environmental cleaning and management of standard and biohazardous waste.
- f. **Acquisition and Materiels Management Service** is responsible for supplying adequate levels of Personal Protective Equipment (PPE) within the clinical areas, and medical equipment decontamination.
- g. **Police and Security Service** is responsible for restricting access during transport of SARS patients within the facility and for assisting with enforcement of isolation, when requested.
- h. **Employee Health Service (EHS)** is responsible for symptom monitoring of any employees determined to have had exposure to a patient with SARS. EHS is responsible for performing respirator fit-testing of employees.
- i. **Engineering Service** is responsible for maintaining functional negative pressure rooms for isolation, including collection of electronic data documenting room air changes and negative pressure. Engineering will maintain engineering controls so that they comply with the OSHA, CDC and VACO requirements.
- j. **Microbiology Laboratory** is responsible for adhering to all CDC recommendations regarding specimen handling and shipping and for assuring a mechanism is in place for obtaining, shipping, and processing SARS order sets received from outlying clinics on the same day that they were obtained.
- k. **Employees** are responsible for carrying out the recommendations within this policy when caring for patients with SARS. They should be knowledgeable on procedures for donning and removing PPE safely to prevent contamination of themselves and the environment. Employees must also notify Infection Control after any exposures to suspected SARS patients, either in the health care setting or in the community.
- **REFERENCES:**
 - a. Centers for Disease Control and Prevention, Hospital Infection Control Practices Advisory Committee. Guideline for Isolation Precautions in Hospitals. Am J Infect Control 1996; 24(1): 24-52.
 - b. Santa Clara County Public Health Alert, April 1, 2003. Dr. Marty Fenstersheib, MD, MPH, Santa Clara County Health Officer.
 - c. Infection Control Guidance for Health Care Workers in Health Care Facilities and Other Institutional Settings. Health Canada, April 17, 2003.
 - d. MMWR May 16, 2003. Cluster of Severe Acute Respiratory Syndrome Cases Among Protected Health-Care Workers—Toronto, Canada, April 2003.

e. CDC SARS Infection Control Interim Guidelines:

<http://www.cdc.gov/ncidod/sars/>

- i. Respiratory Protection (May 6, 2003)
- ii. Interim Recommendations for Cleaning and Disinfection of the SARS Patient Environment (April 28, 2003).
- iii. Interim Domestic Guidance on Persons Who May Have Been Exposed to Patients with Suspected SARS (May 7, 2003).
- iv. Interim Guidance on Infection Control Precautions for Patients with Suspected SARS and Close Contacts in Households (April 29, 2003).
- v. Interim Domestic Guidance for Management of Exposures to SARS for Healthcare and Other Institutional Settings (May 7, 2003).
- vi. Updated Interim Domestic Guidelines for Triage and Disposition of Patients Who May Have Severe Acute Respiratory Syndrome (SARS) (April 25, 2003).
- vii. Safe Handling of Human Remains of SARS Patients: Interim Domestic Guidance (March 25, 2003, 1:30 PM EST).
- viii. Infection Control Precautions for Aerosol-Generating Procedures on Patients who have Suspected SARS (March 20, 2003).
- ix. Updated Interim Domestic Infection Control Guidance in the Health Care and Community Setting for Patients with Suspected SARS (May 1, 2003).
- x. Interim Laboratory Biosafety Guidelines for Handling and Processing Specimens Associated with SARS (April 16, 2003)

f. World Health Organization website for SARS:

<http://www.who.int/csr/sars/en/>

- i. Areas with recent local transmission of Severe Acute Respiratory Syndrome (SARS) (updated continually)
<http://www.who.int/csr/sars/areas/en/>
- ii. WHO guidelines/recommendations/descriptions
<http://www.who.int/csr/sars/guidelines/en/>

7. **RECISSION DATE:** May 23, 2006

8. **RESPONSIBLE OFFICIAL:**

Chief, Infectious Diseases

Health Care System Memorandum NO. 111-03-05
May 23, 2003

Elizabeth Joyce Freeman
Director

Attachments A&B

DISTRIBUTION: D

Attachment A

**VA PALO ALTO HEALTH CARE SYSTEM
Severe Acute Respiratory Syndrome (SARS) POLICY**

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CASE DEFINITIONS:

Case definitions are provided to set the clinical criteria for initiation of control measures. Control measures are the same for Suspect and Probable SARS cases. Therefore, for brevity, in the policy that follows, both categories are implied by the term, "SARS cases" or "patients with SARS".

1) Suspect SARS case

A patient with one or more clinical findings of respiratory illness (e.g., cough, shortness of breath, difficulty breathing, or hypoxia) *AND*

- Travel (including transit in an airport) within 10 days of onset of symptoms to an area with currently documented or suspected community transmission of SARS (see updated listing of SARS-affected areas on WHO website): <http://www.who.int/csr/sars/areas/en/>
OR
- Close contact within 10 days of onset of symptoms with a person known to be a SARS case. Close contact is defined as having cared for, having lived with, or having direct contact with respiratory secretions and/or body fluids.

2) Probable Case

A suspect case with one of the following:

- Radiographic evidence of pneumonia or respiratory distress syndrome.
- Autopsy findings consistent with respiratory distress syndrome without an identifiable cause.
- The Health Department must be notified of any suspect or probable SARS cases and will make the final determination regarding classification. See Public Health Reporting and Communication section.

ADMINISTRATIVE CONTROLS

Administrative Controls describe actions necessary for early identification, initiation of isolation procedures, and changes in care practices designed to prevent exposures within the facility. Engineering and Personal Protective Equipment needed for these procedures are described in subsequent sections.

1) Education

Education of health care workers is essential to safely manage SARS cases in clinical settings. Educational material should be developed to:

- Teach all frontline clinicians the SARS case definitions and how to locate updates
- Train all allied staff on how to conduct their duties safely.
- Patient teaching materials in simple language
- Visitor and family teaching materials in simple language
- Give instructions for SARS patients discharged to home.

2) Early Identification and Triage of Patients Who May Have SARS:

- SARS Health Alert signs are posted at all clinics and outpatient intake areas requesting patients with fever and one or more respiratory symptoms (cough, SOB, difficulty breathing, or hypoxia) notify clinic staff immediately. Such patients, once identified, will be immediately given a surgical face-mask to put on (if a mask cannot be tolerated, have the patient hold a towel or tissues over his/her nose and mouth). Clinic clerks must notify a nurse immediately any time a patient identifies him/herself as having symptoms listed on the Health Alert sign.
- Telephone Care Program staff will question patients who call with fever and respiratory symptoms regarding recent travel history. If the patient meets the SARS case definition. Telephone Care must notify the hospital or clinic that the patient will be going to so that they can meet and/or make arrangements to provide the patient with a mask before entering the hospital or clinic.

3) Outpatient Clinics and PAD Emergency Department (ED):

- All patients presenting with fever and one or more respiratory symptoms (cough, SOB, difficulty breathing, or hypoxia) should be given a surgical mask. If a mask cannot be tolerated, have the patient hold a towel over his/her nose and mouth.
- Escort patient to a private exam room (air-negative isolation room if in ED), as far from other patient care areas as possible. The room should have a red bag trash container, or a red bag may be placed in the room for biohazardous waste. Staff escorting patient should wear an N-95 respirator.
- Interview patient regarding recent travel to SARS-affected areas or exposure to known SARS case as soon as possible. Staff interviewing patients regarding travel history should wear an N-95 respirator.
- Clinic provider will don PPE appropriate for airborne, droplet, and contact isolation to perform physical examination of patient: N-95 respirator, face shield, gown, and gloves. For precise instructions on PPE wearing, removal, and disposal, see “Personal Protective Equipment and Hand Hygiene” section.

- If the person meets a case definition of SARS, consult Infectious Disease Fellow on call (pager 14217) and notify Infection Control (extension 65814). If patient is at PAD Clinic, notify ED and transfer there for further evaluation.
- A second staff member should be called to track patient movement and contact with staff and other patients within the clinic (See forms in Attachment B). SARS patient contact tracking form must be sent to Infection Control.
- If inpatient admission is required, arrange for admission to air-negative isolation room as quickly as possible. The decision to admit should be based on the patient's health care needs, not solely for the purpose of infection control unless they cannot be discharged directly to their home (i.e., travelers or homeless persons). Infection Control must be notified of the planned admission.
- Transfer from outlying clinics must be via ambulance. The patient should wear a surgical face mask (if a mask cannot be tolerated, have the patient hold a towel over his/her nose and mouth). If transporting through hallways or via elevator, these areas should be cleared of extraneous staff, patients, and visitors. Police may be called upon to assist with clearing the transport area. The accepting ward must be notified in advance of the arrival of a patient with suspected SARS.
- If patient is not ill enough to warrant admission, the laboratory tests contained within the SARS order set should be obtained prior to discharge to home (see Laboratory Testing section of this policy). NOTE: in order to minimize the amount of time the patient spends in the clinic while infectious, the laboratory specimens and chest x-ray should be carried out immediately, prioritizing this case above other clinic activities.
- Cubicles or rooms in outpatient areas where patients with suspected SARS are evaluated should be cleaned and disinfected before another patients is seen or cared for in that environment. Areas to be specifically targeted for cleaning include the examination table, semi-critical and non-critical surfaces.
- If patient is to be cared for at home, provide patient and/or family with CDC fact sheet "Interim Guidance on Infection Control Precautions for Patients with Suspected Severe Acute Respiratory Syndrome (SARS) and Close Contacts in Households" available at <http://www.cdc.gov/ncidod/sars/ic-closecontacts.htm>

4) Laboratory and Diagnostic Testing:

- Appropriate laboratory and diagnostic tests should be performed according to current recommendations (see VAPAHCS SARS Algorithm (Attachment C) at http://vapaweb/InfectionControl/SARS_Algorithm_Apr-8-03.pdf).

- The appropriate tests have been incorporated into a VISTA order set (“SARS order set”), available in CPRS. By using this order set, providers can order all recommended tests with one order. The SARS order set consists of the following tests:
 - a. CXR,
 - b. Pulse oximetry,
 - c. CBC and differential,
 - d. Blood cultures,
 - e. Sputum Gram’s stain and culture,
 - f. Testing for Influenza A and B, and Respiratory Syncytial Virus,
 - g. Legionella urinary antigen test and sputum culture.
- Specimens are to be handled as outlined below under Laboratory Specimen Handling.

5) Inpatient Isolation And Management Of Patients Suspected Of Having SARS

For detailed description of proper use of Personal Protective Equipment (PPE) and Hand Hygiene procedures, see “Personal Protective Equipment and Hand Hygiene” section of this policy.

- Prior to accepting the patient, a nurse on the admitting unit must notify Engineering to enable the audible alarm for the negative pressure monitoring devices for the air-negative isolation room. Signs must be posted outside the door indicating that airborne, contact, and droplet precautions are in place.
- Precautions signs must remain for the entire length of stay and for one hour after discharge of the patient with suspected or SARS.
- Admission to the room will be limited to essential primary care-providers and EMS staff. Windows and doors into the room must be kept closed at all times except when entering or exiting. The door is to remain closed at all times and for at least 1 hour after patient is discharged.
- A sitter should be assigned to remain outside the isolation room. Sitter responsibilities include limiting entry to essential staff, documenting the names of all staff (and visitors, if applicable) entering room, enforcing the donning of PPE, and tutoring on the appropriate removal and disposal of PPE.
- Employees shall be required to wear PPE appropriate for airborne, droplet and contact isolation. Employees will don an N-95 respirator, cover gown or suit, and gloves while in

the anteroom of the air-negative isolation room. A face shield should also be worn for close contact, or when performing aerosol-producing procedures (eyeglasses are not adequate).

- Upon leaving the room, remove all PPE within the antechamber, before exiting to the hall. Disposable PPE must be discarded into biohazardous waste bags, and cover gowns must be placed in laundry hampers located in the ante-room. For precise instructions on PPE removal and disposal, see “Personal Protective Equipment and Hand Hygiene” section.
- Hands must be washed and/or decontaminated immediately upon removal of PPE and before exiting to the hallway.
- Ideally patients should be confined to their rooms and patient movement outside of the room should be avoided as much as possible. All procedures, including X-ray and bronchoscopy, should be performed in-room if possible. Patients should be out of their rooms for essential procedures only and should wear a surgical mask at all times when outside the room.

6) Aerosol generating procedures:

- Aerosolized medication treatments (i.e., nebulizer), sputum induction, ventilator management, BiPAP, intubation, bronchoscopy, airway suctioning are all examples of procedures likely to produce droplet nuclei. For patients with suspected SARS, these procedures should be minimized and performed only with extreme caution.
- Aerosol-producing procedures may only be performed in an air-negative room.
- Efforts to minimize patient resistance (i.e., adequate sedation) should be taken.
- The minimum number of personnel should be present during the procedure.
- One staff member should be assigned the task of limiting entry to essential staff, documenting the names of all staff entering the room, enforcing the donning of PPE, tutoring on the appropriate removal and disposal of PPE. A list of personnel present in room during the procedure should be included in the procedure note and communicated to Infection Control.

7) Operating Room Procedures

- When clinically feasible, consideration should be made to perform operative procedures in the SARS patient’s room instead of the operating room.
- If transfer to the operating room is necessary, the operating room should be notified as far in advance as possible. If possible, perform the case as the last case of the day.

- The operating room to be used should be cleared of any unnecessary or overstocked equipment in advance. Remove OmniCell and unused furniture from the room. Suture cart and Service Cart should be kept outside the room for the outside circulator to deliver to the inside circulator.
- The SARS patient should be transferred directly to the operating room in the shortest time possible. The patient should wear a surgical facemask. The transporters should wear an N-95 respirator.
- The number of operating room staff present in the room should be minimized. There should be no exchange of staff for the duration of the cases unless it is absolutely necessary. An outside circulator will be assigned to allow the inside circulator to remain inside the room.
- In the operating room, personnel should wear an N-95 respirator, clean surgical scrubs and full-body cover gown or suit, gloves, hair cover, shoe covers, and a face shield (prescription glasses alone are not sufficient).
- Door to the sterile core will not be used and should be closed during the entire case. Door to the outer core should remain closed as much as possible. Traffic in and out of the room should be kept to an absolute minimum. The outside will be deliver additional needed supply and instrument to the circulator in the room. Signs must be posted outside the door indicating that Airborne, Contact, and Droplet Precautions are in place.
- During the operation, keep all equipment and carts as far as possible from the operating table. For needed items (e.g. drugs from the anesthesiology cart), request a colleague not touching the patient to obtain it to minimize cart contamination.
- Equipment Decontamination: All OR equipment coming in contact with a SARS patient or contained within their room should be wiped down thoroughly with LPH solution before using on another patient. Equipment that is normally sterilized or high-level disinfected after use should be processed as usual. Personnel performing equipment decontamination should wear an N-95 respirator, cover gown or suit, gloves, and a face shield.
- At the end of the case, before leaving the room, hands must be washed and/or decontaminated with an alcohol-based hand rub immediately upon removal of PPE including shoe covers. Follow detailed description of removal of PPE in PPE and Hand Hygiene section of this policy. Personnel involved in transporting the patient to an isolation room in the PACU or back to the wards should wear a new N-95 respirator.
- Recover patient in air-negative PACU isolation room.

8) Equipment decontamination:

- Wherever possible, disposable or dedicated patient equipment should be used.

- All equipment coming in contact with a SARS patient or contained within their room should be wiped down thoroughly with quaternary ammonium solution before using on another patient. Exercise extreme caution with respiratory equipment, such as ventilators, biPAP machines, and nebulizers, as these are likely to be the most contaminated with respiratory secretions.
- Equipment that is normally sterilized or high-level disinfected after use should be processed as usual.

9) Environmental Cleaning:

- Contamination of fomites with the SARS agent may play an important role in transmission. The following procedures for maintaining a clean environment must be followed:
- A bucket containing quaternary ammonium solution (“Blue Skies” or “Wet Task”) with cloth wipes should be kept in the suspect SARS patient’s room at all times. Any spills or splatters of secretions or excretions should be wiped up immediately using one of the disinfectant-soaked wipes.
- EMS employees cleaning a room occupied by a SARS patient should wear an N-95 respirator, cover gown or suit, gloves, and a face shield suitable for airborne, contact and droplet precautions. PPE will be removed and discarded or placed in a laundry hamper before moving on to another patient’s room. Hand washing after PPE removal is mandatory. See PPE and Hand Hygiene section for detailed instructions on wearing, removal, and disposal of PPE.
- EMS will thoroughly clean all surfaces daily as per policy. Additional cleaning for SARS patient’s rooms will include extra attention to surfaces likely to be touched by hands of patient and health care workers: bed rails, sink area, toilet, wall railings, door handles, phone etc. These surfaces should be wiped down at least twice a day.
- Upon discharge of a patient with SARS, postpone terminal cleaning by one hour, to allow the ventilation system to reduce the concentration of any potential airborne particles. Terminal cleaning should be performed as per policy, with the addition of changing and laundering of the curtain dividers.

10) Trash Disposal

Until the transmission of the SARS agent is better understood, all trash contaminated with secretions or excretions of SARS patients should be disposed of in red bags, as biohazardous trash.

11) Visitors:

Visitors to SARS patients should be discouraged, however, decisions to allow visitors may be made on compassionate grounds. In this case, any visitors must be educated and must comply with isolation requirements outlined above under "Isolation and Management of Patients Suspected of Having SARS." All visitors are required to wear an N-95 respirator (general instructions on donning mask will be provided, but fit-testing will not be required for visitors).

12) Discharge Planning

Discharge to home should be encouraged when medically feasible. Give family/household members the CDC handout: <http://www.cdc.gov/ncidod/sars/pdf/ic-closecontacts-sars.pdf> Coordination with the County Health Dept. will be necessary for all discharges of SARS patients. Contact Infection Control to facilitate

13) Special Circumstances:

In the event of an influx of greater than 6 suspect SARS cases at any one time, HEICS will be activated and if deemed necessary by the Director and/or Incident Command Officer, the GM&S Nursing MB-1 Activation Plan will go into effect. In this case, Building MB-1 will be activated as an emergency isolation ward (see GM&S Nursing protocol for further details). All Infection Control Procedures will remain the same.

14) Laboratory Specimen Handling

- It is estimated that several thousand diagnostic specimens from patients with SARS have been processed in routine clinical laboratories throughout the world and to date there have been no reported clusters of SARS illness among laboratory workers. Nonetheless, reasonable precautions should be taken when dealing with laboratory specimens of suspected SARS patients to prevent unguarded aerosolization. Specimens sent to the lab must be labeled accordingly and the laboratory alerted to ensure proper handling. All ordering should be done through the SARS order set on CPRS.
- The following activities may be performed in Biosafety level 2 (BSL-2) laboratories with appropriate BSL-2 work practices in place:
 - a. Routine diagnostic testing of blood and serum samples.
 - b. Routine examination of bacterial or mycotic cultures.
 - c. Final packaging of specimens for transport to diagnostic laboratories for additional testing. Specimens should already be in sealed, decontaminated primary container. All regulations for transporting of human specimens within national borders must be followed.
 - d. Any procedure that may generate aerosols must be done in a class 1 or class 2 biological safety cabinet with staff wearing cuffed cover gowns and gloves.

- e. Work surfaces should be decontaminated after specimens are processed per usual protocol.

15) Pathology/Autopsy Specimen Handling

Standard Autopsy PPE must be worn, with the addition of respiratory protection in the form of an N-95 respirator. Refer to the CDC's Safe Handling of Human Remains of SARS Patients: Interim Domestic Guidance for more detailed information:

<http://www.cdc.gov/ncidod/sars/pdf/sarsautopsy.pdf>

ENGINEERING CONTROLS

Engineering controls for Air Negative Isolation rooms are described in HCSM 138-01-20. This memorandum establishes policies and procedures for engineering controls, engineering work practices and reporting requirements for Airborne Precautions rooms.

PERSONAL PROTECTIVE EQUIPMENT and HAND HYGIENE

1) Interviewing and Transporting of possible SARS cases:

Personnel should wear an N-95 respirator in this situation where physical contact with the patient can be expected to be minimal.

2) Physical Examination and other Patient Care Procedures:

- Staff entering the room to perform a physical examination or provide other types of patient care requiring extensive physical contact must wear PPE appropriate for respiratory, droplet and contact precautions. This PPE includes:
 - a. N-95 respirator,
 - b. cover gown or suit,
 - c. gloves,
 - d. a face shield,
 - e. shoe covers in the OR setting.
- All staff performing their duties within a room used for a patient with SARS should use the same PPE. Personnel performing equipment decontamination should also wear this same equipment.
- Any personal protective equipment (PPE) contaminated with secretions or excretions from the patient must be removed and disposed of in red bag trash container in the room

where the suspected SARS case was examined. PPE used in the course of examining or treating a suspected SARS case should not be worn or disposed of outside the room.

- PPE should be removed and disposed of in the ante-room in the following fashion:
 - Remove cover gown grasping the shoulder and peeling downward so that gown is turned inside-out. Roll up gown and immediately dispose of in laundry hamper.
 - Remove gloves by slowly peeling them down over hand, turning inside out as you go. Immediately place inside-out gloves into foot-operated red bag trash container.
 - WASH HANDS.
 - With clean hands, remove face shield and N-95 respirator. Immediately dispose of in foot-operated red bag trash container.
 - WASH HANDS AGAIN, thoroughly. An alcohol-based hand rub may also be used.

Hands must be washed immediately upon removal of PPE. Frequent hand washing and/or hand decontamination with an alcohol-based hand rub should be performed, particularly before contact with a patient, after contact with a patient, after contact with body fluids, secretions, and excretions, contact with any objects considered likely to be contaminated, and after removing gloves.

RESPIRATORY PROTECTION PROGRAM

An N-95 respirator is recommended for use in caring for patients with suspected SARS. Staff wearing respirators must be fit-tested to assure proper fit and sizing of the respirator. The full description of issuance, care, maintenance, and training for the use of N-95 respirators is in HCSM QM-98-07, "Respiratory Protection Program."

PUBLIC HEALTH REPORTING AND COMMUNICATION

- SARS cases must be reported immediately to Santa Clara County Health Department (408-885-4214 during business hours) by the diagnosing physician. For evenings or weekends, notify the Santa Clara County Public Health Officer on call by calling the County Communications hotline at 408-299-2501.
- Notify Infection Control at extension 65814.
- All contact with local and State Public Health authorities should be charted in the electronic patient record (VISTA).

- The collection and transport of specimens to be examined by any outside laboratory including local, State Public Health, and CDC authorities, should be charted in the electronic patient record (VISTA).
- The County Communicable Disease Officer is responsible for enforcing isolation and/or quarantine. If a patient with SARS attempts to leave AMA, the County Communicable Disease Officer should be contacted to enforce the appropriate quarantine law..

POST EXPOSURE FOLLOW UP

- Infection Control and local health authorities will investigate and perform contact tracing for all suspected cases of SARS. Employees who have cared for SARS cases while wearing all recommended PPE will be regularly contacted by Employee Health over the 10 day period after exposure to inquire about any fever or respiratory symptoms.
- Employees identified as having had unprotected exposure (face-to-face contact without appropriate PPE) will be monitored as follows:
 - Employee Health will perform active surveillance for fever and respiratory symptoms (e.g., daily screening). Employees who develop such symptoms should not report for duty, but should stay home and report symptoms to Employee Health immediately.
 - Employees who develop fever or respiratory symptoms during the 10 days following unprotected exposure to a SARS patient will be excluded from duty until 10 days after the resolution of fever and respiratory symptoms. During this time, the employee should avoid contact with persons both in the facility and in the community.
 - Quarantine (voluntary restriction of movements of persons who are exposed but not ill) will not be implemented unless deemed necessary by local health authorities.
 - Management of employees who have had unprotected exposure to a SARS patient during a high-risk aerosol-producing procedure (such as intubation, aerosolized medication treatment, etc.) will be on a case-by-case basis and may include exclusion from duty.

RESEARCH

- All proposed SARS research projects must be approved by the Biosafety Committee, Institutional Review Board, VA R&D Committee, Director and Infection Control. Infection Control should be notified of the start date of any project.
- The following activities require BSL-3 facilities and BSL-3 work practices:
 - Viral cell culture of the etiologic agent.
 - Manipulations involving growth or concentration of the etiologic agent.

- Processing of materials for subsequent molecular analysis.
- Molecular manipulations resulting in infectious particles.
- The following activities require Animal BSL-3 facilities and Animal BSL-3 work practices:
 - Inoculation of animals for potential recovery of the agent from SARS samples.
 - Any protocol involving animal inoculation for confirmation and/or characterization of putative SARS agents.

SARS Patient Contact Tracking Form

Date/Time of SARS Dx: ___/___/___ AM / PM

Patient (name): _____ Last 4 SS#: _____

Public Health Contact (Name, County): _____

Date/time of exposure: ___/___/___ AM / PM to ___/___/___ AM / PM

Location(s) of potential exposure: _____

Name and phone number person performing tracking: _____

Department or Unit: _____

Name and phone number of Unit supervisor: _____

Please identify all potentially exposure HCW (Please print):

Date/ Time	Name of Staff Exposed	Activities performed, noting PPE used

(Continued, see additional pages, _____total)

