



SHELTER INFECTION CONTROL

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Shelter Cleaning Procedures

Some contagious illnesses are highly contagious, all areas, items, and surfaces that may have been contaminated (within a 10- to 25-foot radius of the vomit incident) must be cleaned and disinfected in order to kill the illness. Norovirus can remain on surfaces that have been cleaned and can still cause infection. A bleach solution is recommended to clean/disinfect surfaces that were or may have been contaminated. Handle items carefully to avoid spreading the virus.

For cleaning and disinfection, the following items are needed: disposable gloves and masks. Steps for cleaning and disinfection are:

Prepare a bleach solution

1. Use $\frac{3}{4}$ cup concentrated bleach (or 1 cup of regular strength bleach) to one gallon of water.
2. Be sure to prepare fresh bleach solutions daily, because bleach can lose effectiveness if left out and exposed to air.
3. Bleach should never be mixed with other cleaners/disinfectants as it can create poisonous gases.

Cleaning of material such as vomit, diarrhea, urine

1. Remove vomit or diarrhea right away! Items that are difficult to clean should be discarded.
2. Soak up vomit and diarrhea using disposable absorbent materials, such as cloth, baking soda, paper towels. Do not vacuum vomit as vacuuming can spread the virus.
3. Use soap and hot water to wash and rinse the area or object.
4. Wipe dry with paper towels.
5. Dispose of all biohazard waste in a red biohazard bag, immediately tie the bag and dispose of the bag in trash receptacle.

Disinfection

1. After an area or object has been cleaned, it must be disinfected.
2. Wipe surfaces with freshly made bleach solution making sure that the remaining surface is left quite damp.
3. Leave bleach solution on the surface for at least 5 minutes covering the entire surface.
4. Let surface air dry.
5. Rinse thoroughly with clean water.
6. Remove all personal protective equipment (gloves, masks, etc.) after use and discard in a plastic bag.
7. Wash hands with soap and water.

Additional Recommendations for:

- Disinfect common use surfaces with disinfectant after screening of individual.
- Vacuum the floor and furniture slow and thoroughly, particularly where the infested person sat or lay.
- Do not use fumigant sprays or fogs.

Cleaning Supplies Storage

Do not leave any cleaning product unattended or with guests, without staff supervision.

All cleaning products need to be stored in the designated storage areas:

- Building A – chemical storage closet behind donations,
- Building B - towel room, 2nd floor supply room, dining room cot storage, medical isolation storage (Room 19)

Sanitization Schedule (See Attached)

Cleaning and disinfection high-touch surfaces (door handles, handrails, light switches, toilets, faucets, tables, chairs, walls, and shared items) will be performed four (4) times a day and as needed.

Cleaning schedule is 3:00A, 9:00A, 3:00P, and 9:00P

Sanitization Locations (See Attached)

Asylum Seeking Shelter Infection Control

Temporary shelters are not expected to administer health care services in the traditional sense. Often, the temporary interval may be prolonged beyond expectation at initiation of the shelter. However, screening and infection prevention and control strategies are critical to identify potentially infectious or acutely ill individuals and prevent the spread of disease within a shelter.

Preventing and controlling outbreaks in a shelter setting can be challenging. The risk for person-to-person transmission may be higher due to community dining, shared bathroom facilities and sleeping quarters. The California Department of Public Health (CDPH) has issued the following guidelines to prevent and control infectious disease outbreaks in a community shelter setting.

Influenza & Upper Respiratory Illness¹

Definition for Influenza-like Illness

Influenza like Illness (ILI) is defined as fever (temperature of 100°F* [37.8°C] or greater) and a cough and/or a sore throat in the absence of a KNOWN cause other than influenza. Older people and those with impaired immune systems may not present with fever, therefore, clinical judgement is needed in assessing ILI in the elderly and immunocompromised.

Transmission of Influenza-like Illness

The transmission of many respiratory infections is thought to occur largely through inhalation of respiratory aerosols, most often at distances of less than six feet. Transmission is common among close contacts and likely to account for the majority of transmission.

Infection may also occur when respiratory droplets expelled by an infectious person land directly upon the eyes of another person. Self-inoculation of the eyes or nose is also possible when hands are contaminated after touching contaminated objects or surfaces.

Influenza Symptoms:

- Fever* or feeling feverish/chills
- Cough
- Sore throat
- Runny or stuffy nose
- Muscle or body aches
- Headaches
- Fatigue (tiredness)
- Some people may have vomiting and diarrhea; this is more common in children than adults

*Not everyone with influenza will have a fever.

Screening

Shelter guests

- New shelter guests should be screened for ILI at entry.
- All shelter guests should be instructed verbally and with signage in appropriate language to report any new onset of ILI symptoms (fever $\geq 100^{\circ}\text{F}^*$, cough and/or sore throat). Guests reporting ILI should be assessed by provider on site.
- Ambulatory guests with ILI should be provided with a surgical or procedure mask, if available, and instructed to wear a mask at all times when less than six feet of other people. Individuals/families may be isolated if indicated. Individuals presenting with tuberculosis symptoms should be immediately given a surgical mask and referred to an onsite provider for further evaluation. If masks are not available, ill guests should be instructed to stay at least six feet, when possible, but no less than three feet away from other people. Ill guests should also be instructed to:
 - Avoid shelter areas where other people are congregating.
 - Use respiratory hygiene/cough etiquette (if masks are not available, cover coughs and sneezes with a tissue or cough/sneeze into elbow or sleeve).
 - Perform frequent hand hygiene.
- Maintain recommended infection control precautions until ill guests have been afebrile for 24 hours without the use of antipyretics, whether or not antiviral medication has been prescribed.
 - Guests should be instructed to continue respiratory hygiene/cough etiquette and hand hygiene.

*Older people and those with impaired immune systems may not present with fever, therefore, clinical judgement is needed in assessing ILI in the elderly and immunocompromised.

Key Infection Control Principles for Reducing Influenza Transmission in Shelters

There are four main principles for limiting the spread of respiratory infections in shelters:

1. Source controls: This involves limiting dispersion of infectious aerosols from an infectious person.

- Respiratory hygiene/cough etiquette -All people in the shelter should practice respiratory hygiene/cough etiquette at all times (covering coughs and sneezes, if ill, when in close contact with others). Coughs and sneezes may be contained with tissues, or by coughing/sneezing into the elbow or sleeve. Used tissues should be disposed of in a waste container. Infection control information for children is available at: <http://professionals.site.apic.org/>
- Use of masks -If sufficient supplies exist, surgical/procedure masks are recommended for ill guests when they are in close contact with others (i.e., less than 6 feet away). If masks are not available, ambulatory ill guests should practice “spatial (or social) distancing,” i.e., attempt to maintain a distance of > 6 feet, but no less than 3 feet, from other people.
- Hand hygiene –All people in the shelter should practice frequent hand hygiene with soap and water or an alcohol-based hand rub. Alcohol-based hand rub is effective against influenza viruses, and most other respiratory viruses.
- Treatment of cases -Treatment with antivirals is recommended to reduce the period of infectiousness. See [CDPH Influenza Antiviral Guidance for Shelter Residents, December 2018](#). Antiviral agents should be started within the first 48 hours of symptom onset for maximum benefit.

2. Environmental controls: These include methods to reduce the concentration of infectious respiratory aerosols in the air and the presence of any contaminated surfaces and items.

- Ventilation -Adequate ventilation to ensure good airflow and prevent concentration of respiratory aerosols.
- Sanitation -Cleaning and disinfection of contaminated surfaces and items. The disinfection agent used to clean shelters should be an EPA-registered chemical disinfectant, if available. Manufacturer's recommendations for dilution and contact time should be used.
 - If an EPA-registered disinfectant (see <https://www.epa.gov/pesticide-registration/selected-epa-registered-disinfectants>) is not available, refer to the APIC document at <http://professionals.site.apic.org/> for alternative disinfectants (e.g., household bleach solution) that can be used temporarily.
- Waste management -Follow routine procedures for biomedical waste generated at shelters. Masks are only necessary if close contact with an ill guest is anticipated during waste collection.

3. Administrative controls: These include establishing an appropriate infection-control infrastructure and implement appropriate infection-control measures.

- Staffing –Implement staffing plan that promotes an adequate guest-to-staff ratio and mitigates illness and burnout. Provide appropriate vaccination coverage to staff.
- Cohorting and isolation -Separate the ill from other guests to reduce the risk of transmission of infection from ill guests to others and limit contact between infected and uninfected people (including nonessential staff).
- Active surveillance during outbreaks –Institute surveillance for ILI in staff and clients.
- Spatial separation between guests -Beds should be placed at least 6 feet apart or head-to toe with beds 3 feet apart if space is limited. Mobile screens can be used to encourage compliance with separation areas.
- Supplies and equipment – Use disposable supplies or routinely clean/disinfect shared medical equipment such as blood-pressure cuffs, stethoscopes, oxygen masks, and tubing per manufactures guidelines.
- Provide PPE for staff as appropriate.
- Infection control precautions -Use of appropriate infection control precautions should be instituted.
 - Standard Precautions -Routine infection control precautions that apply to all contacts in all health care and shelter settings. They involve respiratory hygiene/cough etiquette (cover coughs and sneezes); hand hygiene; and use of appropriate PPE by staff when handling blood, body substances, excretions, and secretions, including eye protection if splashes onto eye mucosa are anticipated.
 - Droplet Precautions (used in addition to Standard Precautions) – Requires the use of surgical or procedure masks for routine care of potentially infectious persons with ILI. Surgical masks can be used for the administration of nebulized medications and the collection of nasopharyngeal specimens.
 - Respiratory hygiene/cough etiquette and good hand hygiene are recommended at all times.

4. Personal protective equipment (PPE): The strategies listed above reduce, but do not eliminate, the possibility of exposure to infection. To further reduce these risks to healthcare workers and other people interacting with ill guests in the shelter, PPE should be used together with the strategies when there may be an increased risk of pathogen transmission. PPE use should be according to risk of exposure. Careful risk assessment is needed on an ongoing basis to assess the need for and appropriateness of PPE. The effectiveness of PPE is dependent on adequate supplies, staff training, appropriate use, and proper hand hygiene. Hand hygiene should be performed after removal of all PPE.

- **Masks and Respirators** -Masks, if properly worn, are likely to be the most effective of all PPE to protect against a disease that is spread by the respiratory route. Priority for use of masks is as follows: (a) protection of caregivers and healthcare staff, i.e., those in close contact with guests; (b) controlling transmission at the source by providing a mask to ill guests. Surgical masks or procedure masks (usually with ear loops) are recommended for routine care provided by staff and caregivers, when they are in close contact with ill guests (i.e., less than 6 feet away).
 - Particulate respirators (e.g., NIOSH-certified N95 respirators) are recommended for aerosol-generating situations/procedures associated with an increased risk of respiratory disease transmission (in addition to eye protection, plus gloves and gowns as appropriate).
 - Aerosol generating procedures include emergency airway procedures, intubation, and open suctioning of airway secretions.
 - Particulate respirators should be used according to the manufacturer's instructions, be fit tested, and the user should perform a seal check before each use, for which training is required.
 - When particulate respirators are not used properly, their effectiveness may be no greater than surgical or procedure masks.
 - All medical masks (particulate respirator, surgical, procedure) should fit the user's face tightly covering the mouth and nose.
 - After removing or changing masks, hand hygiene should be performed.
 - PPE is single use when supplies are sufficient and should be disposed of appropriately after use within the Respiratory Isolation Area before exiting.
 - Care must be taken not to touch the face or mask with the hands in order to avoid contamination from particles that may be on the outside of the mask.
- **Eye Protection** - Eye protection should also be used during aerosol-generating procedures. Eye protection with goggles or a visor should also be used in conjunction with masks when in direct close contact with a patient (less than six feet), and sprays of secretions onto the eye mucosa are anticipated or possible.
- **Gloves** – Gloves should be worn if contact with blood, body fluids, respiratory secretions, excretions, mucous membranes, or non-intact skin is anticipated, including during aerosol-generating procedures associated with a possible risk of pathogen transmission. Gloves do not provide full protection against hand contamination. Change gloves between tasks and procedures on the same patient and after contact with potentially infectious material. Gloves should be removed after use, before touching non-contaminated items and surfaces, and before going to another patient.
- **Gowns** – Gowns should be worn to protect skin and prevent soiling of clothing during activities that are likely to generate splashes or sprays of blood, body fluids, secretions, or excretions. Select a gown that is appropriate for the activity and amount of fluid likely to be encountered. If the gown in use is not fluid-resistant and splashing or spraying of potentially infectious material

is anticipated, a waterproof apron should be worn over the gown. Remove a soiled gown as soon as possible and place it in a waste or laundry receptacle (as appropriate).

Norovirus & GI Issues²

People crowded together in evacuation centers/shelters may be vulnerable to infectious disease outbreaks, which can be caused by bacteria, parasites, and more commonly viruses, such as norovirus. Preventing and controlling outbreaks of norovirus-like illnesses can be challenging in evacuation centers/shelters. The risk for person-to-person transmission may be higher due to community dining and shared bathroom facilities and sleeping quarters. The California Department of Public Health (CDPH) is providing the following general recommendations to assist local health department staff in investigating and controlling outbreaks of norovirus-like illness in evacuation centers/shelters.

Norovirus Symptoms:

- Vomiting
- Nausea
- Diarrhea
- Stomach Cramps
- Low Grade Fever
- Headache
- Body Aches

Norovirus Screening

If persons in the evacuation center/shelter are sick with vomiting and diarrhea, evacuation center/shelter staff should:

- Encourage handwashing and personal hygiene. Proper handwashing includes covering all parts of the hands, including fingernails, with soap; rubbing lathered hands together vigorously for at least 20 seconds; thoroughly rinsing hands with water; and drying hands with a paper towel. Of note, hand sanitizers are not an acceptable substitute for handwashing because they are usually not effective against norovirus.
- Place handwashing signs in restrooms and at other locations throughout the evacuation center/shelter.
- Provide guests and volunteers/staff with a fact sheet about gastrointestinal disease.
- Maintain a line list of all persons with gastrointestinal illness and the date of their illness onset. Ask sick persons about the type and frequency of symptoms (including whether they have fever or bloody diarrhea) to determine if medical care is necessary.
- Ill staff should be sent home for a minimum of 48 hours after diarrhea and vomiting has stopped.
- Separate sick persons from other guests until 48 hours after diarrhea and vomiting has stopped. If possible, isolate ill guests in a separate room or section of the evacuation center (preferably with its own bathroom facilities) away from well persons.
- Designate some toilets “FOR USE BY ILL PERSONS ONLY”. These toilets should be easily accessible to ill persons.
- The isolation room or section should have easily cleanable floors (e.g., not carpet) and fixtures.

- Serve food to ill persons away from persons who are not sick.
- Provide guests with plastic bags (e.g., small bathroom trash can liners) to contain vomit and to dispose of diapers.
- A specialized cleaning crew with appropriate cleaning, disinfection, and personal protective equipment (see below) should be ready to respond quickly to clean up vomit and stool in any area.
- Consider limiting transfer or movement of ill persons and staff/volunteers between shelters to limit the spread of infection.

Norovirus Environmental Control

Since norovirus is highly contagious, all areas, items, and surfaces that may have been contaminated (within a 10- to 25-foot radius of the vomit incident) must be cleaned and disinfected in order to kill norovirus. Norovirus can remain on surfaces that have been cleaned and can still cause infection. Be sure to disinfect all surfaces after cleaning. Although there may be health concerns with using bleach because it can be an irritant, a bleach solution is recommended for outbreaks of norovirus-like illness. Wear disposable gloves and masks. Handle items carefully to avoid spreading the virus. Cleaning and disinfection of bathrooms and high-touch surfaces (door handles, hand rails, light switches, toilets, faucets, tables, chairs, walls, and shared items) should be performed multiple times a day and as needed.

For cleaning and disinfection, the following items are needed: disposable gloves, masks, gowns, eye protection, shoe covers, and household bleach. Steps for cleaning and disinfection are:

Prepare a bleach solution

1. Use $\frac{3}{4}$ cup concentrated bleach (or 1 cup of regular strength bleach) to one gallon of water.
2. Be sure to prepare fresh bleach solutions daily, because bleach can lose effectiveness if left out and exposed to air.
3. Bleach should never be mixed with other cleaners/disinfectants as it can create poisonous gases.

Cleaning

1. Remove vomit or diarrhea right away! Items that are difficult to clean should be discarded.
2. Soak up vomit and diarrhea using disposable absorbent materials, such as cloth, baking soda, paper towels, or kitty litter. Do not vacuum as vacuuming can spread the virus.
3. Use soap and hot water to wash and rinse the area or object.
4. Wipe dry with paper towels.
5. Dispose of all waste in a plastic trash or biohazard bag and immediately close and dispose of the bag.

Disinfection

1. After an area or object has been cleaned, it must be disinfected.
2. Wipe surfaces with freshly made bleach solution making sure that the remaining surface is left quite damp.
3. Leave bleach solution on the surface for at least 5 minutes covering the entire surface.

4. Let surface air dry.
5. Rinse thoroughly with clean water if an object may come in contact with food or the mouths of people.
6. Remove all personal protective equipment (gloves, masks, etc.) after use and discard in a plastic bag.
7. Wash hands with soap and water.

Additional Recommendations for:

- Cloth and Plush Items
 - Clothing/linens/textiles and plush items, including bedding and mattress covers, should be machine-washed and dried at a temperature greater than 170° F. If there are no on-site laundry facilities, double wrap soiled items in plastic bags, and take them to an off-site facility to be washed and dried. Plush items that cannot be laundered should be disposed of in a sealed bag.

Scabies³

Scabies is an infestation of the skin caused by a parasitic mite. The female mite burrows under the top layer of the skin to lay eggs and can remain there for one to two months. The eggs hatch and become adult mites within 10 to 15 days and can continue the infestation until proper treatment is applied.

Scabies is most commonly transmitted by having prolonged direct or frequent skin-to-skin contact with a person already infested with the mites, usually among sexual partners and household members. Scabies may also be transmitted through contact with an infested person's clothing, bedding, or towels (fomites). The risk for person-to-person transmission of scabies in an evacuation center/shelter is increased due to shared spaces and close sleeping quarters.

Scabies Symptoms

- Intense itching, especially at night and over most of the body.
- Presence of mite burrow(s), often forming a zigzag or "S" pattern on the skin.
- Presence of rash or skin lesions such as red, raised bumps, blisters, brown nodules or pimple like irritations.
- Common sites of infection:
 - Between the fingers and toes, pubic and groin area, armpits, bends of elbows and knees, wrists, navel, breasts, lower portion of buttocks, penis and scrotum, and waist and abdomen.

Scabies Treatment

- Refer suspected individual to see on site provider.
- Follow shelter protocol for treatment and procedure of scabies diagnosis. Use prescribed medication as directed.
- Dispose of clothes worn by the individual.
 - For items that can't be washed, dry-clean them or place them in a sealed plastic bag for two weeks to kill any remaining mites.
- Disinfect common use medical supplies (blood-pressure cuffs, stethoscopes, oxygen masks, and tubing) and surfaces with disinfectant after screening of individual.

Lice ⁴

Head lice are small insects that live in people's hair and feed on their blood. Lice glue their eggs, or "nits," to hair so that the nits do not get brushed off. Lice die quickly (within two days) without feeding so they cannot live very long away from their host. Nits take six to nine days to hatch, and seven or more days for the lice to become egg-laying adults.

Individuals can give head lice to other persons when they share combs, hats, clothing, barrettes, helmets, scarves, headphones, or other personal items. Lice do not jump from person to person. Head lice can be a common problem in evacuation shelter/center if not properly diagnosed and treated.

Lice Symptoms

- Pruritus
- A tickling feeling or a sensation of something moving in the hair
- Irritability and sleeplessness
- Sores on the head or area of concern caused by scratching

Lice Treatment

- Refer suspected individual to see on site provider.
- Follow shelter protocol for treatment and procedure of lice diagnosis. Use prescribed medication as directed.
- Dispose of clothes worn by the individual.
 - Place combs, brushes, hair bands, and barrettes in hot water (>130°F) for 5-10 minutes, or soak them in rubbing alcohol or a disinfectant (like Lysol®*) for one hour.
 - Seal items that cannot be washed in plastic bags for 2 weeks to kill lice by preventing them from getting a blood meal.
- Vacuum the floor and furniture, particularly where the infested person sat or lay.
 - Do not use fumigant sprays or fogs; they are not necessary to control head lice and can be toxic if inhaled or absorbed through the skin.

Transportation of Guests with Communicable Disease ⁵⁻⁶

When transporting shelter guests diagnosed with a communicable disease, precautions must be taken in order to mitigate the spread of illness. Shelter management should take the following into account prior to assigning staff to transport guests who may have a communicable disease.

- **Immunity status:** Transport of guests suspected or know to have vaccine-preventable communicable diseases (chickenpox, measles, hepatitis A) is most safely done by those with known immunity (adequately vaccinated or known to be immune) to transport them.
- **Immunocompromised status:** Individuals with immune compromise - such as pregnant women, people with diabetes, HIV, cancer, or on immune-suppressive medications – should refrain from transporting potentially infectious guests.

Additionally, the following precautions should be taken when transporting guests with any known/possible infectious disease.

- Minimize movement and transport of the guest to only what is required for treatment and isolation.
- Restrict immunocompromised shelter staff and those with no known immunity status from transporting or working closely with the guest.

- Promote staff immunizations in addition to practicing Standard Precautions.
- Open infections, including wounds, drainage and rash should be appropriately covered.
- Use seats/seat covers that can easily be cleaned per guidelines [refer to cleaning protocols in other parts of the document] or disposed of.

For the transportation of shelter guests with known/suspected airborne or droplet infections (e.g. varicella, tuberculosis, influenza), the following precautions should be followed.

- Place a mask on the guest & instruct them in cough etiquette.
- Roll down the windows and seat the infectious guest next to an open window.
- Do not use car's air conditioning system or recirculated air.
- Travel time should be minimized (ideally less than 30 minutes).
- Healthcare personnel transporting patients who are on Airborne Precautions do not need to wear a mask or respirator during transport if the patient is wearing a mask and infectious skin lesions are covered. Avoid using the air conditioner or recirculating air settings during transport.

References

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Diarrhea Procedure

Background:

Diarrhea is defined as 3 or more loose or watery stools that occur more frequently than usual.

If someone has diarrheal illness, especially bloody diarrhea, shigellosis should be considered, and the individual should not be living in a congregate setting with shared restrooms. People who are sick from *Shigella* infection usually start experiencing symptoms 1 to 2 days after contact with the bacteria. Symptoms of shigellosis include diarrhea (sometimes bloody), fever, stomach pain, and tenesmus – defined as feeling need to pass stool (poop) even when the bowels are empty. Stools tend to be of small volume, and severe dehydration is uncommon. Symptoms usually last 5 to 7 days, but some people may experience symptoms anywhere from a few days to 4 or more weeks. People who are in poor health or who have immune systems weakened from diseases such as HIV/AIDS, or chemotherapy for cancer, are more likely to get sick for a longer period of time if they have shigellosis. They should seek medical attention if they think they have shigellosis to determine the best course of treatment. Young children with shigellosis may present with seizures before bloody diarrhea.

Procedure:

*Individuals with diarrhea, especially bloody diarrhea, should not be living in congregate setting with shared restrooms.
No public health travel restrictions placed on guest, but medical judgement should always be used to determine if the patient is too ill to travel safely.

Conduct health screening assessment to identify the following:

- Fever or chill
- Nausea, vomiting, or diarrhea
- Blood in stool in the last week

Emphasize hand hygiene, especially:

- Before preparing food or eating
- After the bathroom or changing diapers

Diarrhea present in guest?

If stool testing is positive, Epidemiology Program will contact JFS Case Management to obtain:

- Travel destination
- Travel method
- Point of contact
- Address
- Phone number

Moderate to severe symptoms, or bloody diarrhea present?

For guests with diarrhea, be sure to assess for these signs/symptoms:

- Fever
- Bloody diarrhea
- Severe stomach cramping or tenderness
- Dehydration
- Feels or appears very ill
- Tenesmus

Offsite isolation for any of above.
 Physician to make level of care decision.

Mild symptoms present, without bloody diarrhea?

Refer to Emergency Department via ambulance (9-1-1) or non-emergent transport depending on severity.

Volunteer or staff:
 Arrange for transport to off-site isolation (hotel).

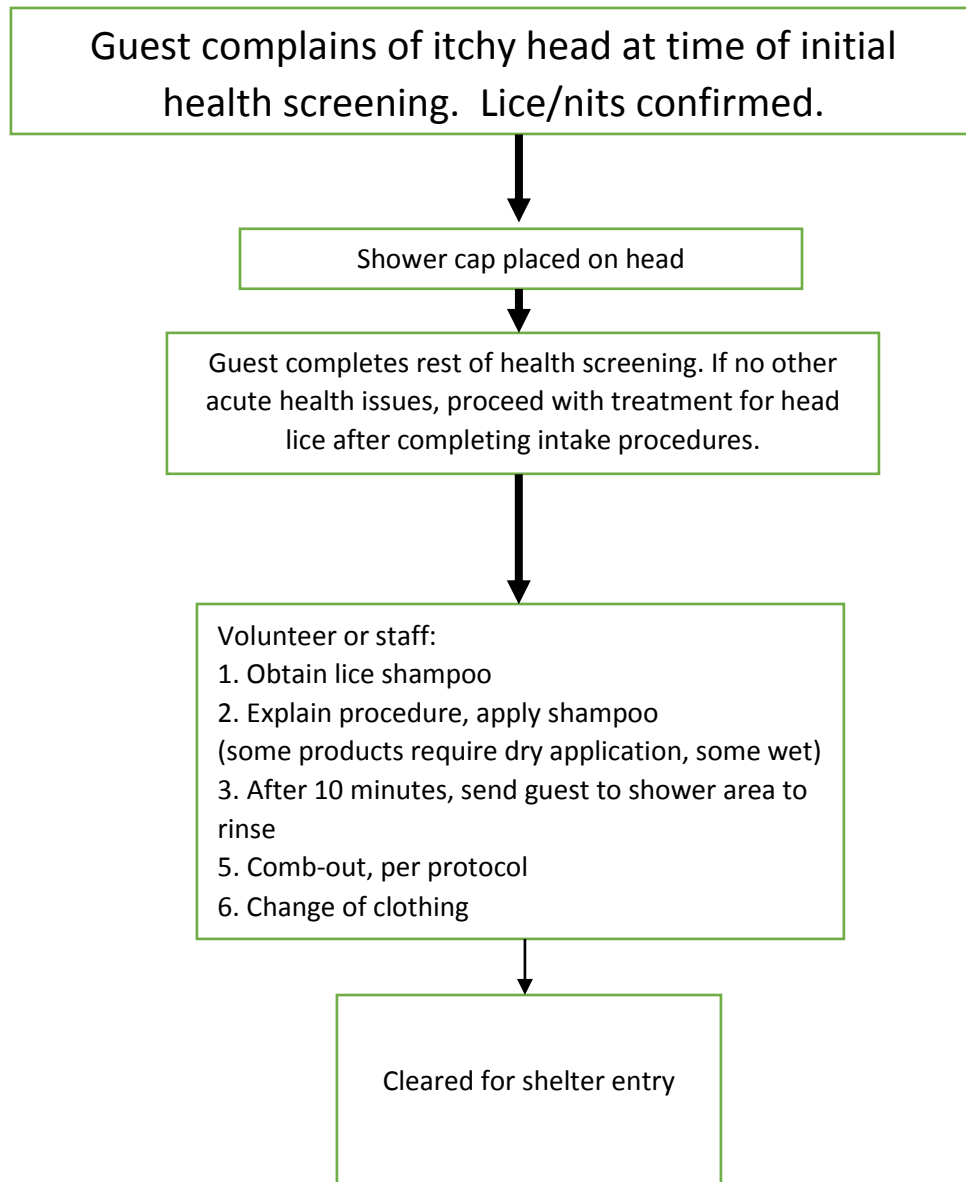
May enter shelter if able to manage diarrheal episodes, or if child in diapers.
 Hand hygiene

Head Lice policy and procedures

Background:

1. All incoming guests are asked if they have an itchy scalp. If yes, they get a visual exam of the head. This procedure has 29% sensitivity. More accurate is combing wet hair with nit comb and looking for lice (91% sensitive). However, this is impractical for a rapid health assessment setting. Only the finding of live lice confirms the diagnosis, but because of the low sensitivity of visual exam, consider treating those with only nits as well.
2. Those with diagnosis or probably diagnosis get pyrethroid/permethrin shampoo—volunteer or other staff must get the shampoo from the cupboard, apply on guest, wait 10 min, direct guest to the shower area, and complete the procedure below before guest is cleared for shelter entry.

Procedure:



Note:

For pregnant guests --	Permethrin (NIX, CVS Lice Treatment)	Category B
For most guests -----	Pyrethrum/Piperonyl Butoxide (RID, Sunmark Lice Shampoo)	Category C

Influenza-like Illness Policy and Procedures

Background:

Children aged <5years of age, but especially those <2years of age, are at increased risk for hospitalization or severe or complicated influenza infection. Pregnant women and those with certain underlying health conditions are also at high risk. Diagnosis of influenza in the congregate setting is important so that measures can be undertaken to prevent spread to the unexposed and complications to the already exposed. Results of influenza virus testing might change outbreak control strategies in this setting. Clinical diagnosis may be supplemented by laboratory diagnosis, antiviral treatment, isolation, or other infection control measures. **See back page for CDC guidelines re: influenza testing & treatment.**

Guest has flu-like symptoms
A 100.4°F or higher oral temperature or feeling feverish/chills

AND one or more*:

- Cough
- Sore throat
- Headaches and/or body aches
- Difficulty breathing or shortness of breath
- Fatigue

*Some guests, including young children and guests with H1N1, may have more atypical symptoms such as GI complaints (nausea, vomiting, diarrhea, poor appetite)

Isolation/Quarantine

Individuals with ILI are considered infectious 1 day prior to symptom onset to 7 days after the onset of symptoms AND after they become afebrile x24 hours. Guests should not return to the shelter during that time. No public health travel restriction.

CDC reference: <https://www.cdc.gov/flu/about/disease/>

Procedure:

Put mask on guest.

1. Treatment

Consider treatment with oseltamivir for ill guest and chemoprophylactic doses to family members traveling with ill guest. Watch ill guest and family members take initial doses. See treatment and prophylaxis guidelines on p.2

Provider evaluation

May utilize point-of-care test. Testing most helpful when diagnosis is uncertain, not with classic symptoms (negative test does not r/o influenza).
If diagnosed with influenza by symptomatology or testing, proceed to step 1

2. Disposition

Determine if safe to go to hotel isolation versus needing Emergency Department evaluation

3. Provider: complete referral/disposition forms for ill guest and each family member. Notify Shelter Manager of guest disposition. Family to await isolation area awaiting transport to hotel or healthcare facility.

4. Reporting

For positive onsite test, **complete CMR** and submit with referral form to lead nurse; **include patient name, DOB, disease reported.**

Fax to CoSD Epi at end of shift: (858) 715- 6458

OR

Email to: Epi-
CDReporting.HHSA@sdcounty.ca.gov

CDC Guide for considering influenza testing when influenza viruses are circulating in the community

During high influenza activity, diagnosis should be made based on clinical influenza-like-illness (ILI) criteria due to the limited sensitivity of available point-of-care tests. During lower ILI activity, point-of-care testing can be used as a diagnostic aid. See [algorithm\(1\)](#) for more information.

Treatment protocol:

Guests 14 days and older diagnosed with influenza may be treated with Tamiflu as determined by a medical provider. This includes those who are pregnant or have renal disease (see dosing adjustment guidelines for renal disease on UpToDate).

Infants, age:	Dose
14 days to 11 months	3mg/kg/dose oral suspension BID x5 days
Children age 1-18 years, weight:	
<= 33lbs (<=15kg)	One 30mg tab PO BID x5 days
33.0 – 50.7 lbs (>15 to 23kg)	One 45mg tab PO BID x5 days
50.8 – 88.0 lbs (>23 to 40kg)	One 60mg tab PO BID x5 days
>88 lbs (>40kg)	One 75mg tab PO BID x5 days
Adults	One 75mg tab PO BID x5 days

Prophylaxis protocol:

Any guests older than 3 months may receive oseltamivir prophylaxis as determined by medical provider. This includes pregnant women who are at particularly high risk of death and complications from flu

Infants, age:	Dose
14 days to 11 months	3mg/kg/dose oral suspension Daily x7 days
Children age 1-18 years, weight:	
<= 33lbs (<=15kg)	One 30mg tab PO Daily x7 days
33.0 – 50.7 lbs (>15 to 23kg)	One 45mg tab PO Daily x7 days
50.8 – 88.0 lbs (>23 to 40kg)	60mg PO Daily x7 days
>88 lbs (>40kg)	75mg PO Daily x7 days
Adults	75mg PO Daily x7 days

References:

1. <https://www.cdc.gov/flu/professionals/diagnosis/algorithm-results-circulating.htm>
2. <https://www.cdc.gov/flu/professionals/antivirals/index.htm>
3. <https://www.cdc.gov/flu/highrisk/children-antiviral.htm>
4. <https://www.cdc.gov/flu/professionals/diagnosis/consider-influenza-testing.htm>

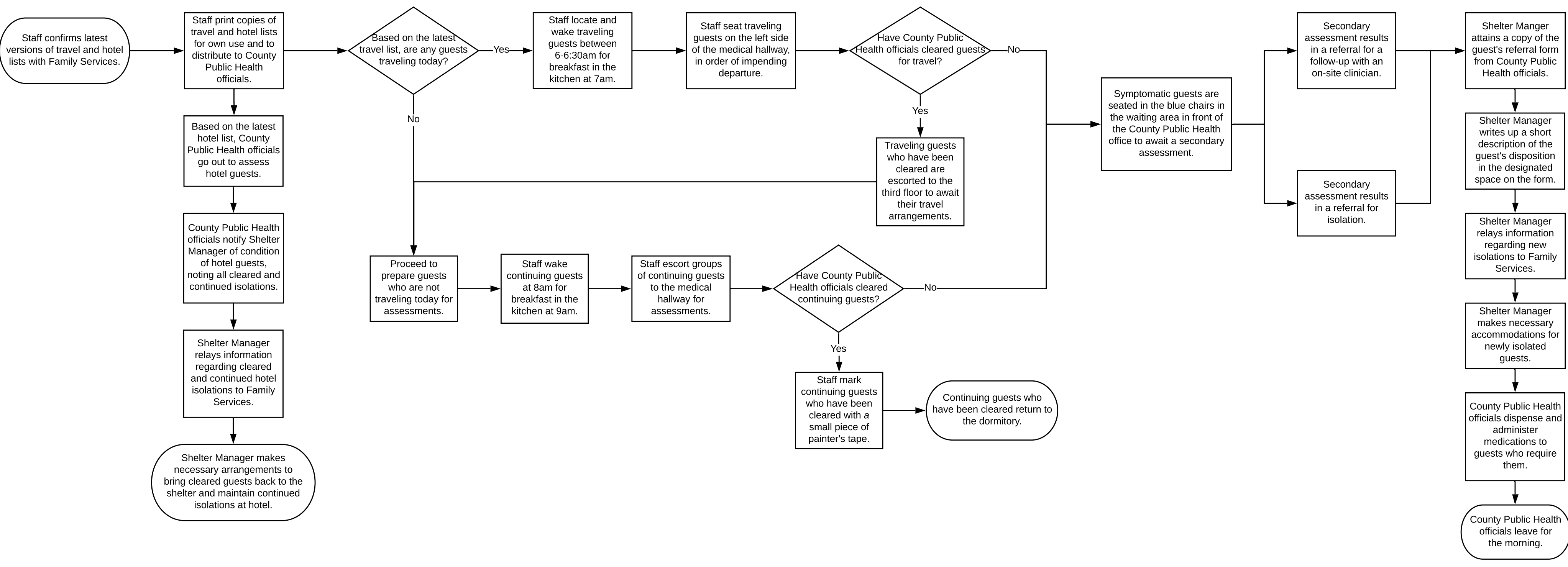
Influenza Outbreak

Procedure:

1. Shelter Manager will confirm the Final Departure (FD) List and Off-Site Guest List with Case Managers.
 - a. Travel List - details which guests have confirmed travel arrangements/off-site appointments.
 - b. Off-Site Guest List - details which guests are currently staying in the hotel
 - i. Hotel guests have been referred to medical isolation in hotel by County Public Health officials.
2. Shelter Manager prints physical copies of the Final Departure (FD) List and Off-Site Guest List.
 - a. Shelter Manager provides County Public Health officials with copies upon their arrival.
 - b. If there were guests in the hotel the night prior, County Public Health officials send their staff to the hotel to assess these guests.
 - c. County Public Health officials assess hotel guests to determine if guests need to remain medically isolated or are cleared to return to shelter/travel.
 - i. Medically isolated guests must be asymptomatic for at least 24 consecutive hours before being cleared by County Public Health officials to return to the shelter/travel.
 - ii. County Public Health officials notify the Shelter Manager of which guests have been cleared.
 - d. The Shelter Manager communicates the names of cleared guests and continued hotel isolations to Case Managers.
 - e. The Shelter Manager makes the necessary arrangements to bring cleared guests back to the shelter and maintain continued isolations at the hotel.
 - i. Medically Cleared Guests - checking guests out of the hotel and designating volunteers or staff to pick up cleared guests.
 - ii. Continued Isolation Guests - extending the reservation for existing hotel rooms. Depending upon the occupancy of the hotels in use, guests may need to relocate.
 1. If a hotel is at occupancy, the Shelter Manager will reserve rooms at another hotel and make the appropriate arrangements to relocate guests.
3. Based on the Final Departure (FD) List, Operations Staff will determine if any guests are traveling on this day. Operations staff must prioritize preparing traveling guests for the morning medical assessments so that they are not late for their travel arrangements.
 - a. Guests will have been woken, showered, eaten breakfast, and medically assessed before non-traveling guests for an early breakfast in the kitchen at 7am.
 - b. Operations staff seat traveling guests in the medical hallway. Guests are seated in the order of departure time from shelter.
 - c. County Public Health officials determine if guests are cleared to travel on this day. Guests are most likely cleared by County Public Health officials if they are asymptomatic.

Influenza Outbreak

- i. Operations staff escort traveling guests who have been cleared by County Public Health officials to the third floor to await their departure.
4. As space becomes available in the medical hallway, Operations staff will proceed to prepare non-traveling guests for medical assessments. This may begin at the same time traveling guests are being assessed; if so, staff may need to clearly divide the space between traveling and non-traveling to ensure traveling guests are prioritized.
 - a. Operations staff wake non-traveling guests at 8am for breakfast in the kitchen at 9am.
 - b. Operations staff escort groups of non-traveling guests to the medical hallway for assessments.
 - c. County Public Health officials determine if non-traveling guests need medical isolation. Guests are cleared by County Public Health officials if they are asymptomatic.
 - i. Operations staff mark cleared non-traveling guests with a green wrist band.
 - ii. Non-traveling guests who have been cleared may return to the dormitory.
5. County Public Health officials do not clear guests who appear symptomatic. Symptomatic guests are seated in the blue chairs in the waiting area in front of the County Public Health office to await a secondary assessment.
 - a. The secondary assessment may result in a referral for a follow-up with an on-site clinician. The guest is escorted to the on-site clinic (FQHC) for their follow-up.
 - b. The secondary assessment may result in a referral for isolation. Guests may be isolated due to scabies or flu.
6. The Shelter Manager is notified of the referral and attains a copy of the Referral/Disposition Form from County Public Health officials.
7. The Shelter Manager writes up a short description of the guest's disposition in the designated space on the Referral/Disposition Form; including the guest's on-site isolation room number or a guest's hotel name and room number, as well as any relevant notes about the guest's condition that are not already mentioned on the Referral/Disposition Form.
8. The Shelter Manager communicates information regarding newly isolated guests to Case Managers.
9. The Shelter Manager makes the necessary accommodations for newly isolated guests.
 - a. This may include designating volunteers or staff to drive newly isolated guests to a hotel.
 - b. Continued Isolation Guests - extending the reservation for existing hotel rooms. Depending upon the occupancy of the hotels in use, guests may need to relocate.
 - i. If a hotel is at occupancy, the Shelter Manager will reserve rooms at another hotel and make the appropriate arrangements to relocate guests.
10. County Public Health officials will dispense and administer medications to guests who require them.
11. County Public Health officials leave for the morning.



Measles Procedure

Background:

Measles symptoms usually begin 8-12 days (up to 21 days) after exposure with a prodrome of fever as high as 105°F (40.5°C), malaise, cough, coryza, and conjunctivitis. Three to five days following onset of the prodrome, a maculopapular rash develops. Koplik spots (clustered white spots on the buccal mucosa at the first and second molars) may precede the rash and persist after rash onset. The rash usually begins around the ears and hairline and then spreads down to cover the face, trunk, arms, and legs.

The sequence of symptom presentation, vaccination and travel histories, and medication use are critical in distinguishing measles from other causes of maculopapular rash and fever. It is unlikely to be measles if there is no rash on the face, if there is no fever at rash onset, or if rash appears less than two days or greater than 7 days after symptom onset.

The virus is transmitted by direct contact with infectious droplets or airborne spread when an infected person breathes, coughs, or sneezes. Measles virus can remain infectious in air for up to two hours after an infected person leaves an area.

Procedure:

Measles is highly infectious and is transmitted by airborne spread of respiratory droplets. Typically, measles patients are contagious from four days before to four days after rash onset.

Severely ill or requiring transfer to higher level of care:

Family to wait in open-air

Notify EMS and Emergency Department of anticipated transport and arrival of a suspected measles case

Transport should be by EMS or volunteer staff with **known immunity** (history of measles or of 2-doses of measles vaccine), with car windows down and A/C off.

Guest has a fever and maculopapular rash

Immediately put mask on guest; and place in a separate room

Physician evaluation

Immediately report suspected measles cases to Epi Program (619) 692-8499 Mon-Fri 8-5 or (858)565-5255 after hours and weekends to coordinate testing.
Provide the following: Full name, DOB, Date of Onset, Disposition/location (hotel name). Identify individuals potentially exposed, in order to assist public health in identifying others who may need to be isolated pending check of immunity status.

* Infected people should be isolated for four days after they develop a rash. Guests should not return to the shelter during that time and **should not travel** until cleared by Public Health.

CDC reference:

<https://www.cdc.gov/measles/hcp/>

Mildly or moderately ill:
Volunteer or staff: family to wait in open-air (in rooftop parking area) awaiting disposition to off-site isolation (hotel).

Please inform guest that a Public Health Nurse will contact them in the morning to collect a specimen.

Mumps Procedure

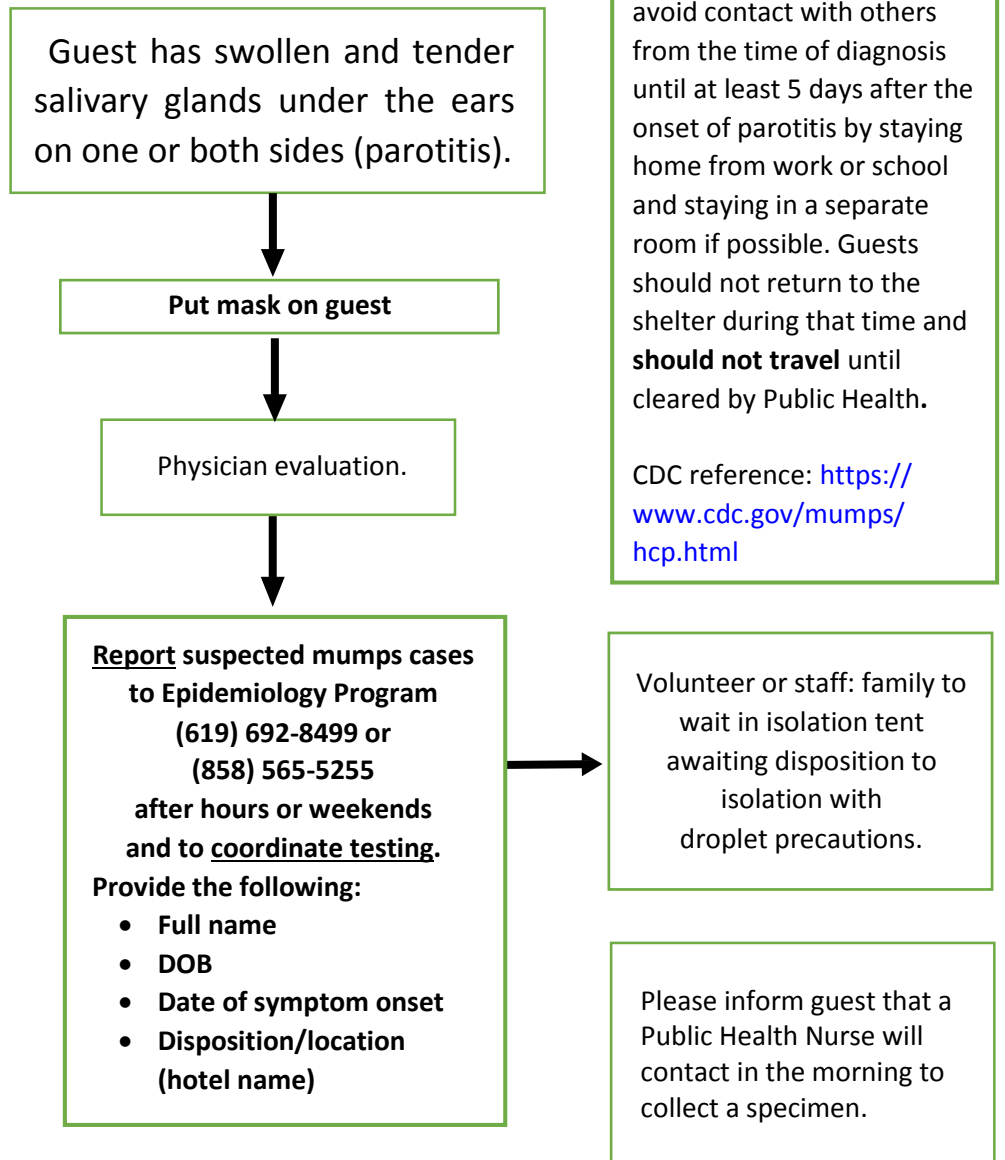
Background:

The average incubation period for mumps is 16 to 18 days, with a range of 12 to 25 days.

Mumps usually involves pain, tenderness, and swelling in one or both parotid salivary glands (cheek and jaw area). Swelling is first visible in front of the lower part of the ear. It then extends downward and forward as fluid builds up in the skin and soft tissue of the face and neck. Swelling usually peaks in 1 to 3 days and then subsides during the next week. The swollen tissue pushes the angle of the ear up and out. As swelling worsens, the angle of the jawbone below the ear is no longer visible. Often, the jawbone cannot be felt because of swelling of the parotid. One parotid may swell before the other, and in 25% of patients, only one side swells. Other salivary glands (submandibular and sublingual) under the floor of the mouth also may swell but do so less frequently (10%).

Nonspecific prodromal symptoms may precede parotitis by several days, including low-grade fever which may last three to four days, myalgia, anorexia, malaise, and headache. Fever may persist for 3 to 4 days. Parotitis lasts at least 2 days, but may persist longer than 10 days. Mumps infection may also present only with nonspecific or primarily respiratory symptoms, or may be asymptomatic.

Procedure:



Pregnancy Assessment Procedure

Pregnancy testing is offered to women who are unaware of pregnancy status and menstrual period is delayed by at least 2 weeks or irregular.

Positive test result or known pregnancy.
Calculate estimated due date and document on the screening form by asking start date of last normal menstrual period.
Measure blood pressure and record on screening form

Refer to physician

Elevated BP (>135/85)?
Any positive symptoms?

- Vaginal bleeding
- Leaking vaginal fluid
- Contractions
- Pelvic pain

Refer to Labor & Delivery or Emergency Department for urgent assessment

No to both

Yes to either

At ≤ 36 weeks

- Asymptomatic
- Normal BP

NO SPECIFIC TRAVEL RESTRICTIONS UNLESS DICTATED BY AIRLINE.

At > 36 weeks

- Asymptomatic
- Normal BP

JFS and guest will review options and risks for travel.

Pregnant women traveling for more than 4 hours should be educated on deep venous thrombosis:

- Signs and symptoms
- Risk reduction strategies.

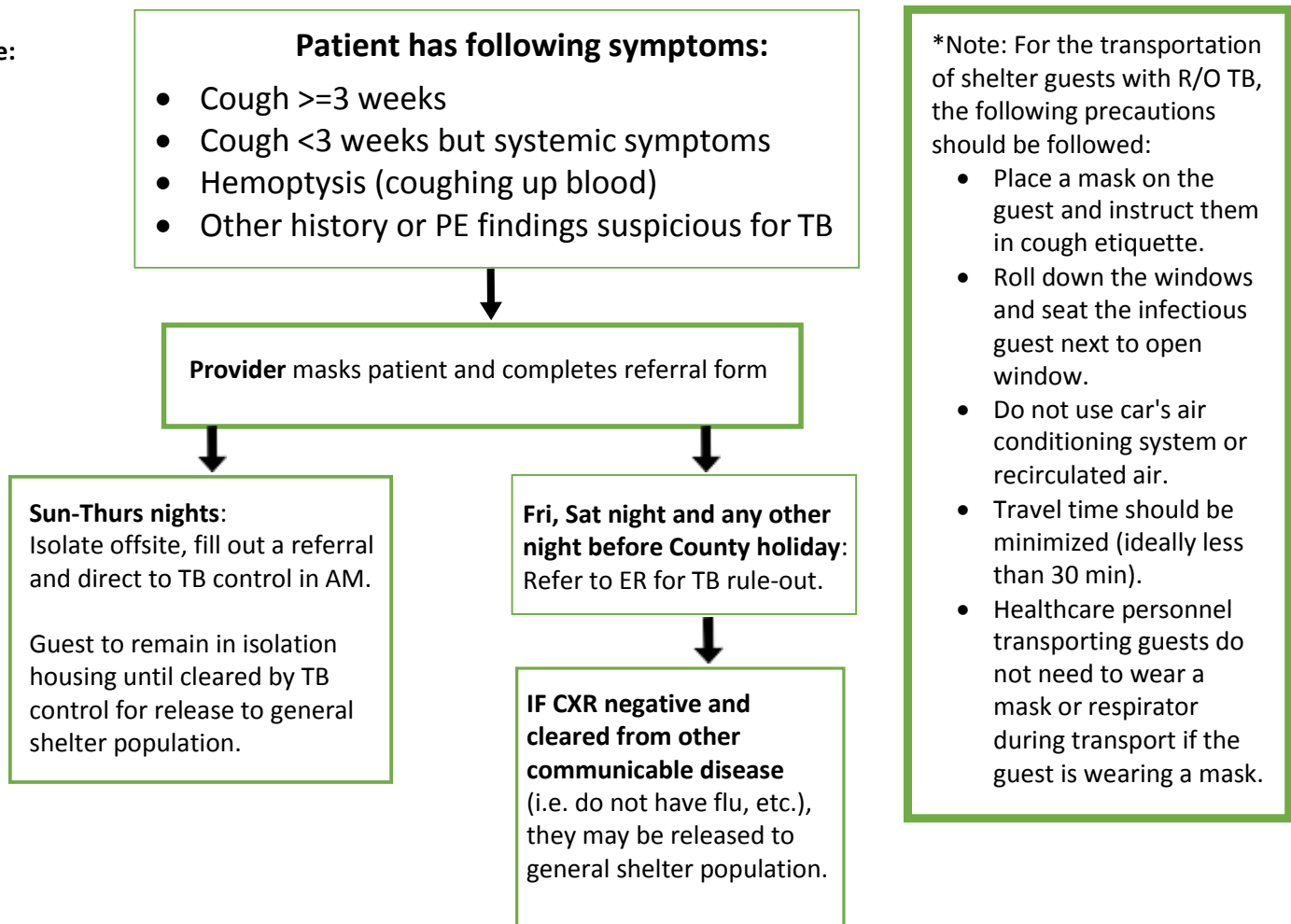
CDC advice: move legs frequently and get up and walk around every 2 hours.

Chest X-ray Procedure to Rule Out Tuberculosis (*Mycobacterium tuberculosis*)

Background:

Common TB symptoms include a chronic cough lasting longer 3 weeks or longer, chest pain, coughing up blood, fever, chills, night sweats, fatigue, anorexia, and weight loss. A Chest X-ray is the main method to detect pulmonary (and potentially infectious) TB. Reactivation TB represents 90% of adult cases among HIV-uninfected individuals and results from reactivation of a previous focus of mycobacterial containment at the time of primary infection. The apical posterior segments of the upper lobes or the superior segment of the lower lobe of the lung are frequently involved. The most common chest radiograph finding in a child with TB disease is a primary complex, which consists of opacification with hilar lymphadenopathy, in the absence of notable parenchymal involvement. Children under 5 years of age should receive a PA and lateral.

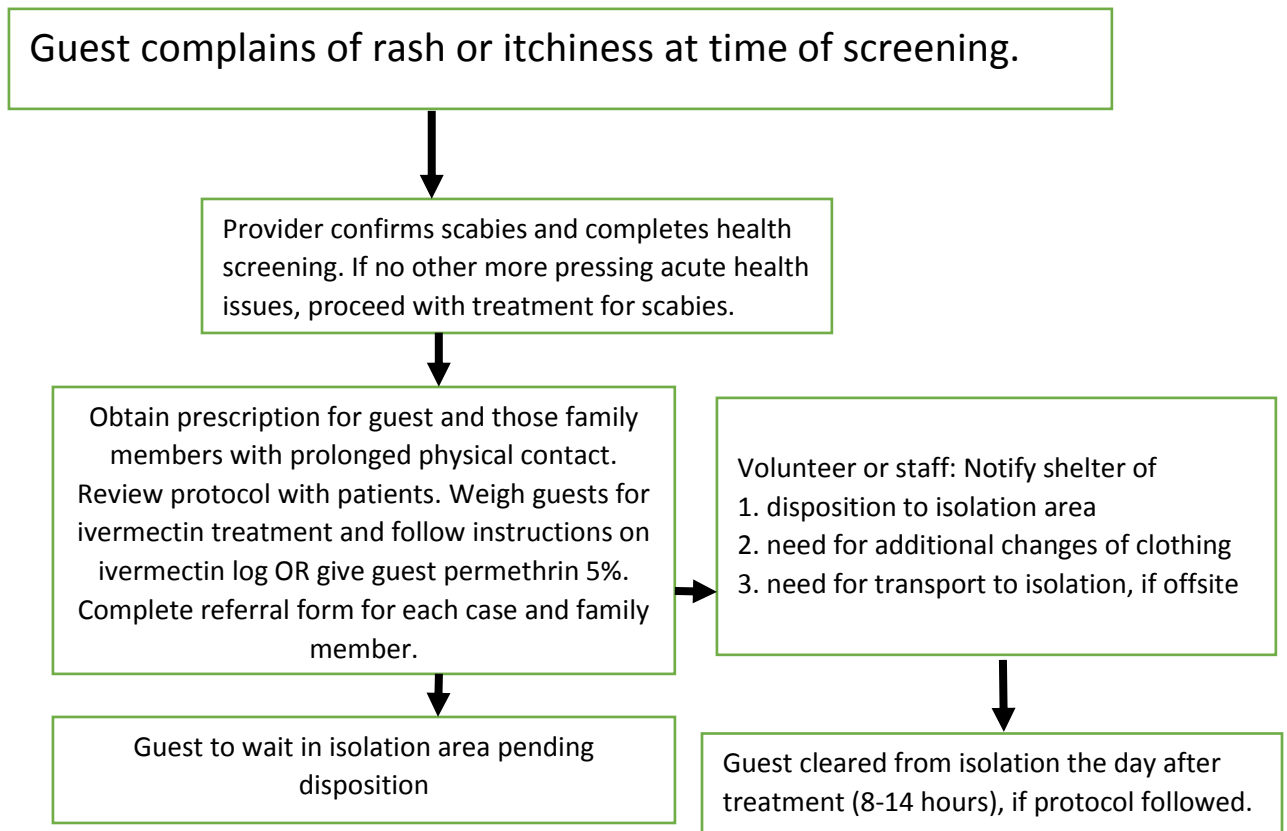
Procedure:



Scabies policy and procedures

1. All incoming guests are asked if they have an itchy head or itchy skin or rash.
2. A presumptive diagnosis can be made on the basis of consistent history and physical exam-- intense pruritus and multiple small, erythematous papules that are often excoriated. Burrows, which appear as 2 to 15 mm, thin, serpiginous lines, may be visible. The fingers, wrists, elbows, axillae, areolae, periumbilical skin, waist, male genitalia, knees, buttocks, and feet are common sites of involvement.
3. Transmission of scabies usually occurs through direct and prolonged skin-to-skin contact, as may occur among family members or sexual partners. Casual skin contact is unlikely to result in transmission. Transmission through fomites (eg, clothing, bedclothes, or other objects) used by a person with classic scabies is uncommon. Consider these factors when deciding whether to treat family members. Infants with scabies, being held by their parents, are more likely to transmit than adolescent children.
4. There are two different treatments for scabies, permethrin cream **5%** (30gm tube usually sufficient for adult) or oral ivermectin 3mg tablets, dosing by weight (see dosing below). In a meta-analysis, they were similarly effective.
5. Permethrin: Guest should be instructed to massage cream into skin from neck to soles of the feet, including under fingernails and toenails (trimming nails is helpful, if possible). In young children, scalp involvement is common, so permethrin should also be applied to the scalp and face (sparing the eyes and mouth) in this population. Permethrin should be removed by washing (shower or bath) after 8 to 14 hours. They should put on clean clothes and discard or bag the other clothes.
6. Ivermectin: cannot be given to pregnant/lactating women, children ≤ 15 kg, or people with certain neuro disorders. Dose is 200 mcg/kg as a single dose. 15kg=3mg, 30kg=6mg, 45kg=9mg, 60kg=12mg, 75+kg=15mg.
7. This policy is for classic scabies. Crusted scabies is poorly defined, erythematous patches, scaly, malodorous, often on scalp, hands, or feet but can cover entire integument and pruritus may be minimal. Guests with crusted scabies should be referred for evaluation. Crusted scabies is highly contagious.

Procedure:



Varicella policy and procedures

Background:

1. The average incubation period for varicella infection is 14 to 16 days, range 10 to 21 days. The period of infectivity is generally considered to last from 48 hours prior to the onset of rash until skin lesions have fully crusted. The clinical manifestations of varicella in healthy children typically include a prodrome of fever, malaise, or pharyngitis, loss of appetite, followed by the development of a generalized vesicular rash, usually within 24 hours. The rash, which is usually pruritic, appears in successive crops over several days. The lesions begin as macules that rapidly become papules followed by characteristic vesicles; these lesions can then develop a pustular component followed by the formation of crusted papules. The guest with varicella typically has lesions in different stages of development on the face, trunk and extremities. New vesicle formation generally stops within four days, and most lesions have fully crusted by day six in normal hosts. Crusts tend to fall off within about one to two weeks.
2. Chickenpox is highly contagious, with secondary household attack rates of >90 percent in susceptible individuals. Families with a varicella case need airborne precautions, so will need isolation offsite (hotel).
3. Pregnant women can have maternal and fetal complications from varicella.

Procedure:

