UC Davis Health
Sacramento, CA
Department of Pathology and Laboratory Medicine

INFECTION CONTROL **Administrative Procedures 200.A**

PURPOSE:

To outline the role and scope of participation of the Department of Pathology in infection prevention and control activities, and to ensure compliance to the OSHA Standard on Bloodborne Pathogens and the UC Davis Health exposure control plan.

DEFINITIONS:

The role and scope of participation in infection prevention and control include those methods used in this department to reduce the risk of cross-transmission of infection. Lack of policy compliance identified as the cause of an employee or patient incident is to be reported to the Department of Pathology Management. A hospital incident report should be completed. These incidents are reported to the appropriate hospital committee(s) as per Hospital Safety Policies.

POLICY:

It is the policy of the Department of Pathology to:

A. Prevent cross-transmission of pathogens within the patient population and protect staff from contact with blood, blood products, body fluids and tissue. All patient specimens shall be treated as if contaminated. (Examples: drainage, feces, semen, urine, amniotic fluid, vaginal secretions, peritoneal fluids, tissue samples and cervical secretions.)

Comments:
UC Davis Health Department of Pathology staff shall include: Any person, including UC Davis Health Pathology faculty, students, trainees, volunteers, physicians, contract employees, and all other employees whose activities involve direct patient care or contact with blood or body fluids of patients at UC Davis Health.

1. All Department of Pathology staff shall be responsible for protecting their health through use of protective barriers (personal protective equipment or PPE) – gloves, mask, glasses/goggles/face shields, safety glasses, lab coats, gowns.
2. Department of Pathology supervisors shall monitor compliance on a daily basis and report discrepancies/changes to the respective Department of Pathology Manager.
3. Standard precautions: When coming in contact with blood, blood products, body fluids, and tissues, treat as if contaminated.

B. Provide measures for meeting employee safety in the workplace requirements, e.g. utilizing universal precautions, and supplying the appropriate protective barriers to prevent employee exposure to pathogens.

C. Ensure compliance with all OSHA/CAL/OSHA, Joint Commission, CAP standards, and other applicable codes and regulations pertaining to prevention and control of infection in the workplace.

PROCEDURE/RESPONSIBILITY:

I. **Laboratory Director, Managers, and Section Supervisors**

A. Section Supervisor:

1. Provides for the accessibility of gloves, gowns, masks, goggles/glasses/face shields, protective barriers, and hand soap to prevent employee exposure to pathogens.
   a. Routinely monitors accessibility of these supplies
   b. Keeps records of PPE supplies and provide documentation to external agencies (County, State, and Federal) with proof of supply availability.
2. Ensures employees obtain standard precautions instructions during new employee orientation. Staff training requirement is met through the Mandatory Annual Training (MAT) and Biosafety Training (MTS Module).
3. Documents employee attendance for orientation, training and annual educational update.
4. Coordinates employee immunization programs with Employee Health Services and maintains documentation of same.
5. Notifies Infection Control when a communicable disease exposure occurs in the workplace.
6 Evaluates employee performance including items related to infection control.
7. Assures filled infectious waste containers are disposed of in a timely manner in accordance with the hospital's hazardous materials and waste program.
8. Coordinates the following:
   a. Annual certification, as needed maintenance, and repair of safety cabinets and fume hoods. Note: STC site coordination done by QA
   b. Maintain safety cabinet records. Note: STC records are maintained by QA.
   c. Chemical hoods will be tested yearly.
   d. Biological hoods will be tested at least once a year.
   e. Issues with airflow readings or any unresolved alarms are to be reported to PO&M and/ or respective vendor for corrective maintenance.

B. The respective department manager will work closely with the Section Supervisors to ensure compliance and communication of any discrepancies, changes or incidences.

C. Laboratory Director will review all policies that address the safe working conditions

of department staff and the safe transport of any and all biological specimens. In addition, this review should verify that best practices are being followed relative to staff safety.

II. Faculty and Staff

1. Gloves

a. Wear gloves for all patient and specimen contact.
b. Personnel will use only non-latex powder-free gloves. Powder-free latex gloves may be used for very limited purposes after review and approval by the Laboratory Director.
c. Change gloves between patients and when gloves are soiled or torn.
d. Wash hands thoroughly after removing gloves.
e. Remove gloves before touching uncontaminated telephones, charts, computers, monitors, doorknobs, refrigerator handles, and pens/pencils and before leaving the work area.
f. Carry spare non-sterile vinyl exam gloves in uniform/lab coat pocket for use with unexpected contact with blood and body fluids.

2. Gowns

a. The phlebotomist will wear a clean lab coat during patient contact. This garment will be for patient contact only and will be separate from any other protective garment worn during specimen processing in the laboratory.
b. Lab coats or gowns will be worn by employees performing specimen processing and by other employees as designated by individual laboratory sections.
c. All coats/gowns must be completely fastened.

3. Masks, Goggles/Glasses, and Protective Barriers

a. Protect mucous membranes (eyes, nose, mouth) by wearing masks, glasses/goggles/face shields when performing procedures where splashing of face is likely to occur.
b. Disposable goggles/glasses/face shields may be reused if not splashed with blood. If reusable glasses/goggles or face shields become contaminated with blood, the user shall disinfect item with hospital approved disinfectant.

C. All Faculty and Staff

1. All persons must wash their hands after completing laboratory activities and must remove protective clothing (including gloves) before leaving the laboratory.

2. Smoking and vaping is prohibited in the laboratory areas.
3. Application of cosmetics, lip balm, cologne, hand lotion, or manipulation of contact lenses in work areas is prohibited.
4. All hair must be pulled back off of the neck and shoulders when working within the technical sections.
5. No open food or drink, including chewing gum, will be placed or consumed in any area of the laboratory except where designated. No food or beverage will be stored in specimen processing areas or within refrigerators containing specimens or reagents. Specific refrigerators are designated for Food Storage Only.
6. Biological safety cabinets (Class I or II) should be used whenever procedures are conducted that have a high potential for aerosol production.
7. There will be no mouth pipetting. Mechanical pipetting devices must be used for manipulating all liquids.
8. All laboratory accidents will be documented on an appropriate accident report form.
9. Laboratory work surfaces must be decontaminated and disinfected after any spill and at the completion of each shift.
10. Latex Allergy:
    a. The laboratory makes every effort to protect personnel from the allergic reactions due to job-related exposure to natural rubber latex in gloves and other products.
    b. The possibility of latex allergy and the role of powder (cornstarch and/or talc) in the dispersion of latex proteins will be included in the annual Laboratory Safety Training.
    c. Personnel are expected to report any allergic reaction while working. Personnel suffering from an allergic reaction or suspected allergic response will be immediately sent to Employee Health for evaluation.

11. Needlesticks: Report needlesticks or blood splashes on the Needlestick/Blood Splash Form (See UC Davis Health Administrative Policy 2167, "Blood/Body Fluid Exposure (Needlesticks)").
12. Sharp Instruments: Place all sharp instruments, disposable glassware, and needles in puncture-proof containers.
13. Blood/Body Fluids Spill: Clean spills with approved hospital disinfectant or fresh 10% bleach.
14. Laboratory Specimen: Place laboratory specimen(s) in a plastic zip-lock biohazard bag. Separate bags must be used for each individual patient's specimen(s). If applicable, place accompanying paper requisition in the external pocket of the zip-lock bag.
15. Waste Disposal:
    a. Contaminated materials - any disposables used in the performance of a blood draw or urine collection that come in contact with a patient or a specimen are considered contaminated. These items may include but are not limited to:

gloves, Kimwipes, gauze, paper towels, and tourniquets. Place these items in red biohazard bags for disposal if they are grossly bloody. Phlebotomy disposables not dripping wet with blood may be discarded in regular trash/waste. Paper contaminated with blood and/or body fluids should be placed in plastic sheet protectors before photocopying; grossly bloody paper may be discarded in red biohazard bags. Discarding non-bloody phlebotomy supplies may increase hazard waste generation and result in a lab becoming designated as a "large quantity waste generator" when it is not warranted.

b. Contaminated materials that are reusable must be decontaminated before use.

16. Phlebotomists:

Adhere to all protective equipment requirements when entering a room of a patient in isolation. Follow instructions on posted signs.

17. Disposal/Capping/Recapping Used Needles and Syringes

a. Use needle-less devices whenever possible.

b. Recapping used needles (even one-handed) should be avoided if at all possible.

c. All used needles, syringes, and sharps are to be discarded as described herein:

1) DO NOT cap, break, clip, or bend contaminated needles or syringes after use.

2) Place all needles, syringes, and sharp objects directly into sharps containers.

3) Do not force items into the sharps container and avoid overfilling sharps container. Close freestanding containers securely when full. Once the lid is on the freestanding container, the container should be placed in the designated areas for disposal of sharps containers.

d. Following these procedures will:

1) Prevent injuries to personnel.

2) Prevent access to these items by unauthorized persons.

e. Sharps container shall be located in each area where needles and syringes are used. The sharps containers will be properly disposed of by Environmental Services.

f. Needles may be capped or recapped ONLY under the following limited circumstances and only using a mechanical device or one-handed method:

1) A needle container is not available.

2) If used before any contamination from a human/animal source.

REFERENCES:

- Centers for Disease Control (CDC) Guidelines for Infection Prevention and Control Guidelines. https://www.cdc.gov/infectioncontrol/guidelines/index.html

- UC Davis Health Administrative Policies 2000-2041: Infection Control
- UC Davis Health Administrative Policies 2150-2177: Employee Health Services
- CAP (College of American Pathologists) 2020 Laboratory General Checklist.

PROCEDURE HISTORY

Date	Written/ Revised By	Review/Revision	Approved Date	Approved By
9/91	D. Lowe	New	9/91	R.D. Cardiff
12/91	J. Carlson	Revised	12/91	R.D. Cardiff
5/93	D. Lowe	Revised	5/93	R.D. Cardiff
7/94	D. O'Sullivan	Revised	7/94	R.D. Cardiff
4/96	D. O'Sullivan	Annual Review	4/96	R.D. Cardiff
10/96	D. O'Sullivan	Annual Review	10/96	R. Green
4/97	S. Hatcher	Revised	4/97	E.C. Larkin
8/97	D. O'Sullivan	Revised	8/97	E.C. Larkin
11/98	D. O'Sullivan	Revised	11/98	E.C. Larkin
7/99	D. O'Sullivan	Annual Review	7/99	E.C. Larkin
6/00	D. O'Sullivan	Annual Review	6/00	R. Green
11/00	D. O'Sullivan	Revision	11/00	R. Green
7/01	D. O'Sullivan	Annual Review	7/01	R. Green
3/02	D. O'Sullivan	Annual Review	3/02	R. Green
2/03	D. O'Sullivan	Annual Review	2/03	R. Green
9/03	D. O'Sullivan	Revision	10/03	R. Green
10/04	D. O'Sullivan	Revision	10/04	R. Green
10/05	D. O'Sullivan	Annual Review	10/05	R. Green
10/06	D. O'Sullivan	Annual Review	10/06	R. Green
11/07	D. Wright	Revision	11/07	R. Green
9/08	D. O'Sullivan	Annual Review	9/08	L. Howell
10/08	D. Wright	Revised	10/08	L. Howell

Date	Written / Revised By	Review/Revision	Approved Date	Approved By
09/09	D. Wright	Revised	09/09	L. Howell
08/10	D. O'Sullivan	Revised	08/10	L. Howell
10/12	R. B Duplantier T. Cox	Revised: one patient's specimen(s) per each transport bag;	10/12	L. Howell
10/14	T. Cox	Revised: non-bloody phlebotomy supplies in regular trash	10/14	L. Howell
10/16	S. Okimura	Biennial Review	10/16	L. Howell
11/19	E. Karanja/ N. Kaur/ G. Opp	Revised: Updated Header, CAO role, references and links. Incorporate retired P&P 205	11/19	L.Howell
09/21	E. Karanja	Revised supervisor responsibilities, added vaping, chewing gum, and hair tie requirements	09/21	L. Howell via OnBase