SoHum Health

Southern Humboldt Community Healthcare District

GOVERNING BOARD MEETING

POLICY PACKET

December 28, 2023
Sprowel Creek Campus
286 Sprowel Creek Road
Garberville, CA 95542

SoHum Health

Southern Humboldt Community Healthcare District

Governing Board Meeting

Infection Prevention Policies

Sprowel Creek Campus
286 Sprowel Creek Road
Garberville, CA 95542

DEPARTMENT:	APPROVED:	Page **1** of **1**
Infection Prevention	**03/30/2023**	
SUBJECT:	**EFFECTIVE DATE:**	**SUPERCEDES:**
Aerosol Transmissible Disease Exposure Control Plan	**03/30/2023**	**11/29/2018**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("district" or "SHCHD") to utilize all feasible means to protect staff from occupational exposure to illness.

DEFINITIONS:

N/A

REFERENCES:

Cal-OSHA Title 8 CCR § 5199. Aerosol Transmissible Diseases, August 2009. Available at: https://www.dir.ca.gov/title8/5199.html Accessed March 20, 2023

REVIEWED BY:

Administrative Team

Medical Staff

Governing Board

DEPARTMENT:	APPROVED:	Page **1** of 1
Infection Prevention	**03/30/2023**	
SUBJECT:	**EFFECTIVE DATE:**	**SUPERCEDES:**
AUTHORITY STATEMENT	**03/30/2023**	**01/28/2021**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("District" or "SHCHD") to provide for those times when appropriate infection prevention measures must be taken to control an outbreak, or to assure employee and/or patient safety, so as not to require an emergency meeting of the Medical Staff.

PROCEDURE:

The Infection Preventionist has been given the authority by the Medical Staff, the Administration and the Board of Directors of the Southern Humboldt Community Healthcare District to initiate any appropriate surveillance, prevention, or control measures or studies necessary when or if there are reasons to believe that any patient or personnel may be in danger due to an infectious or contagious outbreak.

In the event of hospital infectious or contagious disease outbreak, or threat thereof, the Infection Preventionist, in conjunction with the Chief of Staff, will analyze the facts of the situation. Together they will make a recommendation to the Administrator. Authority has been vested in these three individuals to decide on the appropriate course of action, including if necessary, closing the hospital in whole or in part. The Chairperson of the Board will be notified of this action as soon as possible.

DEFINITIONS:

N/A

REFERENCES:

N/A

REVIEWED BY:

Administrative Team

Medical Staff

Governing Board

DEPARTMENT:	APPROVED:	Page **1** of **23**
Infection Prevention	**03/30/2023**	
SUBJECT:	**EFFECTIVE DATE:**	**SUPERCEDES:**
BLOODBORNE PATHOGEN EXPOSURE CONTROL PLAN	**03/30/2023**	**11/29/2018**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District to have a defined Bloodborne Pathogen Exposure Control Plan that meets regulatory requirements and is individualized for this district.

PURPOSE:

Congress created the Occupational Safety and Health Administration (OSHA) in 1970 to assure safe and healthful working conditions for all employees in the United States. OSHA's Bloodborne Pathogens Standard prescribes safeguards to protect workers against health hazards caused by bloodborne pathogens (BBP). The standard's requirements state what employers must do to protect workers who are occupationally exposed to blood or Other Potentially Infectious Materials (OPIM), as defined in the standard.

The purpose of this exposure plan is:

- To eliminate or minimize employee occupational exposure to blood and OPIM
- Identify employees who may be occupationally exposed to blood or OPIM in the performance of their regular job duties
- Provide information and training to employees exposed to blood and OPIM
- Provide appropriate treatment and counseling in the event of a bloodborne pathogen exposure incident
- Comply with OSHA Bloodborne Pathogen standard, 29 CFR 1910.1030 and California Title 8, CCR § 5193

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I. GENERAL PROGRAM MANAGEMENT

A. Responsible Persons

There are four major "Categories of Responsibility" which are central to the effective implementation of the Bloodborne Pathogen Exposure Control Plan. These are:

- The Exposure Control Officer
- Department Managers and Supervisors
- Education/Training Coordinator
- The Employees

The following sections define the roles played by each of these groups in carrying out the plan. Throughout this written plan, employees with specific responsibilities are identified. If an employee's assigned responsibilities change, the Infection Prevention/Employee Health Nurse is to be notified. Records will be updated accordingly.

Exposure Control Officer

The "Exposure Control Officer" will be responsible for overall management and support of the facility's Bloodborne Pathogens Compliance Program. Activities which are delegated to the Exposure Control Officer include, but are not limited to:

- Overall responsibility for implementing the Bloodborne Pathogen Exposure Control Plan for the entire facility.
- Working with administrators and other employees to develop and administer any additional bloodborne pathogens related policies and practices needed to support the effective implementation of the plan.
- Looking for ways to improve the Bloodborne Pathogen Exposure Control Plan, as well as to revise and update the plan when necessary.
- Collecting and maintaining a suitable reference library on the Bloodborne Pathogens Standard and bloodborne pathogens safety and health information.
- Knowing current legal requirements concerning bloodborne pathogens.
- Acting as facility liaison during OSHA inspections.
- Conducting periodic facility audits to maintain an up-to-date Bloodborne Pathogen Exposure Control Plan.
- Maintain a sharps injury log.

The Infection Prevention/Employee Health Nurse has been appointed as the facility's Exposure Control Officer. He/she will be assisted by the Medical Staff Committee, which provides the infection prevention functions at this facility.

Department Managers and Supervisors

Department Managers and Supervisors are responsible for exposure control in their respective areas. They work directly with the Exposure Control Officer and the employees to ensure proper exposure control procedures are followed.

Education/Training Coordinator

The Education/Training Coordinator will be responsible for providing information and training to all employees who have the potential for exposure to bloodborne pathogens. Activities falling under the direction of the coordinator include:

- Maintaining an up-to-date list of facility personnel requiring training (in conjunction with facility management.)
- Developing suitable education/training programs.
- Scheduling annual training sessions for employees.
- Maintaining appropriate training documentation such as "sign-in sheets," quizzes, etc.
- Periodically reviewing the training programs with the Exposure Control Officer, department managers and supervisors to include appropriate new information.

The Infection Prevention/Employee Health Nurse and Human Resources Manager have been selected to be the facility's Education/Training Coordinators.

Employees

As with all of the facility's activities, the employees have a vital role in the bloodborne pathogen's compliance program, for the ultimate execution of much of the Bloodborne Pathogen Exposure Control Plan rests in their hands. In this role they must:

- Know what tasks they perform that have occupational exposure.
- Attend the bloodborne pathogens training sessions upon hire, annually and as needed.
- Plan and conduct all operations in accordance with our work practice controls.
- Develop good personal hygiene habits.

B. Availability of the Bloodborne Pathogen Exposure Control Plan to Employees
The facility's Bloodborne Pathogen Exposure Control Plan is available to employees at all times. Employees are advised of this availability during their education/training sessions. Copies of the Bloodborne Pathogen Exposure Control Plan are kept in the Infection Prevention Policy and Procedure Manual at the hospital Nurses' Station and is available to all employees electronically on the User Share Drive in the Policy and Procedure folder (subfolder "Infection Prevention").

C. *Review and Update of the Plan*
It is important to keep the Bloodborne Pathogen Exposure Control Plan up to date. To ensure this, the plan will be reviewed and updated under the following circumstances:

- Annually.
- Whenever new or modified tasks and procedures are implemented which affect occupational exposure of our employees.
- Whenever employees' jobs are revised such that new instances of occupational exposure may occur.
- Whenever new functional positions are established within the facility, which may involve exposure to bloodborne pathogens**.**
- Whenever advised by OSHA or new regulations are passed.

II. EXPOSURE DETERMINATION
One of the keys to implementing a successful Bloodborne Pathogen Exposure Control Plan is to identify exposure situations employees may encounter. These situations include:

- Job classifications in which <u>all</u> employees have occupational exposure to bloodborne pathogens.
- Job classifications in which <u>some</u> employees have occupational exposure to bloodborne pathogens.
- Tasks and procedures in which occupational exposure to bloodborne pathogens occur. The Infection Prevention/Employee Health Nurse will work with department managers and supervisors to revise and update lists of tasks, procedures, and classifications as they change.

Job classifications in which <u>ALL</u> employees have exposure to bloodborne pathogens

Below are listed the job classifications in the facility where <u>all</u> employees handle human blood and other potentially infectious materials, which may result in possible exposure to bloodborne pathogens:

<u>Job Title</u>	**<u>Department/Location</u>**
Activities Director	SNF
Central Supply/Materials Management	Central Supply/Materials Management
Certified Nursing Assistants (CNA)	Clinic/Hospital/ER/SNF
Emergency Medical Technician (EMT)	Clinic/Hospital/ER/SNF
Environmental Services Worker (EVS)	District wide
Laboratory Technologist/Phlebotomist	Laboratory
Licensed Vocational Nurse (LVN)	Clinic/Hospital/ER/SNF
Medical Assistants (MA)	Clinic
Mid-Level Practitioner (MLP)	Clinic/Hospital/ER/SNF
Occupation Therapist (OT)	SNF
Patient Care Coordinator (PCC)	Clinic/Hospital/ER/SNF

Physician (MD)	Clinic/Hospital/ER/SNF
Registered Nurse (RN)	Clinic/Hospital/ER/SNF
Sterile Processing Tech	Sterile Processing
X-ray Technologist, Mammo Tech, CT tech	Radiology/CT/Hospital/ER/SNF

Job classifications in which ***SOME* employees have exposure to bloodborne pathogens.**

Below are listed the job classifications in this facility where some employees handle human blood and other potentially infectious materials, which may result in possible exposure to bloodborne pathogens:

Job Title	**Department/Location**
Dietary Workers	Kitchen
Maintenance	District wide

Work activities involving potential exposure to bloodborne pathogens

Below are listed the tasks and procedures in this facility in which human blood and other potentially infectious materials are handled, which may result in exposure to bloodborne pathogens:

Task/Procedure	**Job Title**	**Department/Location**
Assisting with Emergency trauma	Admitting, PCC, EMT, RN, MLP, X-ray	ER, Room (ER)
Bloody sputum collection	PCC, CNA, LVN, RN, MA	Acute, SNF, ER, Clinic
Changing soiled linens	X-ray, PCC, EMT, CNA, LVN, RN	Acute, SNF, ER, Clinic
Chest tube insertion	RN, MD	Acute, ER
Cleaning of patient rooms	EVS, RN, PCC, LVN	Acute, SNF, ER, Clinic,
Cleaning of patient food trays	Dietary	Kitchen/Dietary
Cleaning up of emesis/stool	PCC, EMT, CNA, LVN, RN, MD	Acute, SNF, ER, Clinic
Culture wounds, I & D procedures, Penrose drains	PCC, LVN, MD, RN, MLP	Acute, SNF, ER, Clinic
Decontamination- surgical instruments	Sterile Processing Tech	Sterile Processing
Disposal of sharps containers	EVS	ER, Acute, SNF, lab, Clinic
Dressing changes – wounds	RN, LVN, MLP, MD	Acute, SNF, ER, Clinic
Foley catheter insertions	RN, LVN, MD, MLP	Acute, SNF, ER
Glucometer checks	PCC, MLP, CNA, RN, LVN, MD	Acute, SNF, ER, Clinic
Handling of contaminated sharps	PCC, RN, LVN, MD, MLP, X-ray	Acute, SNF, ER, Clinic
Handling of deceased persons	RN, LVN, CNA, MD	Acute, SNF, ER
Hemocue testing	PCC, RN, LVN, MD, MLP	Clinic
Injections	RN, LVN, MLP, MD	Acute, SNF, ER, Clinic
IV contrast injection	X-ray tech, RN	X-ray, CT
IV starts & meds	RN, MLP, MD, X-ray	Acute, SNF, ER, Clinic
Laboratory phlebotomy	Lab tech, RN	Lab, Acute, SNF, ER, Clinic
Labor & delivery of newborn	MD, RN	ER
Mammograms	Mammography Tech	X-ray
Newborn care	MD, RN	ER
NG tube insertion	RN	Acute, SNF, ER
OB vaginal checks	RN, MD	ER, Clinic
Occult blood testing	PCC, MD, RN, CNA, Lab tech, MLP	Lab., Acute, SNF, ER, Clinic
Patient interactions, physical contact	Activities Director, O.T.	SNF
Processing of laboratory specimens	Lab Tech	Laboratory
Suctioning	RN, LVN, MD	Acute, SNF, ER, Clinic
Tissue specimen collection/handling	PCC, LVN, RN, MLP, MD	Clinic

Trauma (x-ray) patients	X-ray	X-ray, CT
Wounds - trauma in ER	RN, LVN, MLP, MD	ER

III. METHODS OF COMPLIANCE

There are a number of areas which must be addressed in order to effectively eliminate or minimize exposure to bloodborne pathogens in the facility. The first five areas are:

- The use of Standard Precautions.
- Establishing appropriate Engineering Controls.
- Implementing appropriate Work Practice Controls.
- Using necessary Personal Protective Equipment.
- Implementing appropriate
  - Equipment Cleaning
  - Environmental Cleaning
  - Laundry Procedures

Each of these areas is reviewed with employees during their bloodborne pathogens related training (see the "Information and Training" section of this plan for additional information). Rigorously following the requirements of OSHA's Bloodborne Pathogens Standard in these five areas, will eliminate or minimize the employee's occupational exposure to bloodborne pathogens.

A. Standard Precautions (formerly known as Universal Precautions)

Standard Precautions are used to prevent contact with all human blood and other body fluids. Standard Precautions are based upon the principle that all body fluids should always be assumed to be infectious for bloodborne pathogens, including Hepatitis B, Hepatitis C, and Human Immunodeficiency Virus (HIV). Refer to the Standard Precautions policy for details.

B. Engineering Controls

One of the key aspects to exposure control is the use of Engineering Controls to eliminate or minimize employee exposure to bloodborne pathogens. As a result, the facility employs equipment such as sharps disposal containers and self-sheathing needles as appropriate.

The following engineering controls are used throughout the facility:

- Hand washing facilities and alcohol-based hand sanitizer dispensers are readily accessible to all employees who have the potential for exposure.
- Protective sharps devices: retracting IV catheters and scalpels, needleless IV systems and protected syringes.
  - On at least an annual basis there is solicitation of non-managerial healthcare workers' input in evaluating and choosing devices.
- Containers for contaminated sharps have the following characteristics:
  - Puncture-resistant.
  - Color-coded or labeled with a biohazard warning label.
  - Leak-proof on the sides and bottoms.
- Specimen containers are:
  - Leak-proof.
  - Color-coded or labeled with a biohazard warning label or transported in a bag labeled with the Biohazard symbol.
  - Puncture-resistant, when necessary.
- Secondary containers are:
  - Leak-proof.
  - Color-coded or labeled with a biohazard warning label.
  - Puncture-resistant, if necessary.

C. Work Practice Controls

In addition to engineering controls, this facility uses a number of Work Practice Controls to help eliminate or minimize employee exposure to bloodborne pathogens.

The Infection Prevention/Employee Health Nurse is responsible for overseeing the implementation of these Work Practice Controls. He/she works in conjunction with department managers, supervisors and the facility's training coordinators to effect this implementation.

The facility has adopted the following Work Practice Controls as part of the Bloodborne Pathogens Compliance Program:

- Employees perform hand hygiene before putting gloves on and after removal of gloves or other personal protective equipment.
- Following contact with blood or any other potentially infectious materials (OPIM)*, employees perform hand hygiene as soon as possible.
    - *"Other potentially infectious material" (OPIM) I defined by OSHA as the following:
        - Semen
        - Vaginal secretions
        - Cerebrospinal fluid
        - Synovial fluid
        - Pleural fluid
        - Pericardial fluid
        - Peritoneal fluid
        - Amniotic fluid
        - Saliva during dental procedures
        - Any fluid visibly contaminated with blood
        - All body fluids in situations where it is difficult or impossible to differentiate between body fluids
        - Note that urine and feces, among other body fluids not listed above, are NOT OPIM, and therefore, items contaminated with these body fluids do not carry enough BBP to be considered regulated medical waste (unless visibly contaminated with blood).
- See "Exposure Incident and Post-Exposure Evaluation and Follow-up" below for work practice controls related to BBP exposure.
- Contaminated needles and other contaminated sharps are never bent or broken and they are not recapped or removed from the syringe unless:
    - It can be demonstrated that there is no feasible alternative.
    - The action is required by a specific medical procedure.
    - If needle removal is necessary, then do so with the use of a medical device.
    - If recapping is necessary, then do so using the one-handed scooping technique.
- Contaminated reusable sharps are placed in puncture-proof, lidded, labeled containers immediately or as soon as possible, for sterile processing.
- Eating, drinking, smoking, applying cosmetics or lip balm and handling contact lenses is prohibited in work areas where there is potential for exposure to bloodborne pathogens, including the nurses' stations.
- Food and drink is not kept in refrigerators, freezers, on countertops or other storage areas where blood or other potentially infectious materials may be present.
- Mouth pipetting/suctioning of blood or other potentially infectious materials is prohibited.
- All procedures involving blood or other potentially infectious materials are performed in a way which minimizes splashing, spraying or other actions generating droplets.
- Specimens of blood or other potentially infectious materials are placed in designated leak-proof containers and appropriately labeled for handling and storage.
- If outside contamination of a primary specimen container occurs, that container is placed within a second leak proof container that is appropriately labeled for handling and storage. (If the specimen can puncture the primary container, the secondary container must be puncture resistant as well.)
- All specimens of blood or other body fluids are transported to the Lab in a plastic bag

labeled with a Biohazard symbol.
    - The Lab can provide bags if a department runs out.
    - Biohazard specimen bags must be discarded into Red Bag waste, never into regular trash, even if empty.
    - State law requires that anything with a Biohazard label on it must be disposed of as regulated medical waste (Red Bag), regardless of whether or not it is visibly soiled.
- Equipment which becomes contaminated is examined prior to servicing or shipping and decontaminated as necessary (unless it can be demonstrated that decontamination is not feasible.)
    - An appropriate biohazard-warning label is attached to any contaminated equipment, identifying the contaminated portions.
    - Information regarding the remaining contamination is conveyed to all affected employees, the equipment manufacturer and the equipment service representative prior to handling, servicing or shipping.

When a new employee comes to the facility or an employee changes jobs within the facility, the following process takes place to ensure he/she is trained in the appropriate work practice controls:

- The employee's job classification and the tasks and procedures they will perform are checked against the Job Classifications and Task Lists.
- If the employee is transferring from one job to another within the facility, the job classifications and tasks/procedures pertaining to their previous position are also checked against these lists.
- Based on this "cross-checking" the new job classifications and/or tasks and procedures which will bring the employee into occupational exposure situations are identified.
- The employee is trained by the facility Training Coordinators or another instructor regarding any Work Practice Controls that the employee is not experienced with.

D. Personal Protective Equipment

Personal Protective Equipment (PPE) is the employees' last line of defense against bloodborne pathogen exposures. The facility provides (at no cost to the employee) the PPE necessary to protect against such exposures. This equipment includes, but is not limited to:

- Gloves
- Gowns
- Face shields/masks/respirators
- Safety glasses
- Goggles
- Mouthpieces
- Resuscitation bags
- Pocket masks
- Shoe covers

Department managers and supervisors are responsible for ensuring all departments and work areas have appropriate PPE available to employees.

During orientation and then annually, new employees are trained regarding the use of the appropriate PPE for their job classifications and tasks/procedures they perform. Additional training is provided, when necessary.

To determine whether additional training is needed, the employee's previous job classification and tasks are compared to those for any new job or function he/she undertakes. Any needed training is provided by the employee's department manager or supervisor working with the facility's Training Coordinators.

To ensure PPE is not contaminated and is in the appropriate condition to protect employees from potential exposure, the facility adheres to the following practices:

- All PPE is inspected periodically and replaced as needed to maintain its effectiveness.
- Reusable PPE is cleaned and decontaminated after use.
- Single-use personal protective equipment (or equipment that cannot, for whatever reason, be decontaminated) is disposed of immediately after use.

To make sure this equipment is used as effectively as possible, the employees adhere to the following practices when using personal protective equipment:

- Any garments penetrated by blood or other infectious materials are removed immediately, or as soon as possible.
- All personal protective equipment is removed prior to leaving a work area.
- Gloves are worn in the following circumstances:
  - Whenever employees anticipate hand contact with potentially infectious materials.
  - When performing vascular access procedures.
  - When handling or touching contaminated items or surfaces.
- Disposable gloves are replaced as soon as practical after contamination or if they are torn, punctured or otherwise lose their ability to function as an "exposure barrier."
- Utility gloves are decontaminated for reuse unless they are cracked, peeling, torn or exhibit other signs of deterioration, at which time they are disposed of.
- Masks and eye protection (such as goggles, face shields, etc.) are used whenever splashes or sprays may generate droplets of infectious materials.
- Protective clothing (such as a gown and apron) is worn whenever potential exposure to the body is anticipated.

E. Maintaining Cleanliness in the Facility

Maintaining the facility in a clean and sanitary condition is an important part of the Bloodborne Pathogens Compliance Program. EVS and nursing staff employ the following practices:

- All equipment and surfaces are cleaned and decontaminated between patients and after contact with blood or other potentially infectious materials:
  - After the completion of medical procedures.
  - Immediately (or as soon as feasible) when surfaces are overtly contaminated.
  - At the end of the work shift if the surface may have been contaminated during that shift.
- Protective coverings (such as plastic wrap, aluminum foil or absorbent paper) are removed and replaced:
  - As soon as it is feasible when overtly contaminated.
  - At the end of the work shift if they have been contaminated during that shift.
- All pails, bins, cans and other receptacles intended for use are routinely inspected, cleaned and decontaminated as soon as possible if visibly contaminated (e.g., emesis basins and commodes).
- Potentially contaminated broken glassware is picked up using mechanical means (such as dustpan and brush, tongs, forceps, etc.), never with hands - even if gloves are worn.
- Clean up of blood spills or OPIM
- Wear gloves (and other PPE, as may be appropriate)
- For small spills of blood (i.e., drops of blood) or OPIM on hard, non-porous environmental surfaces, the area is disinfected with a hospital-approved, tuberculocidal disinfectant (for example, Sani Cloth AF3 wipes).
- For large spills of blood or OPIM (e.g., >10 ml)
  - First clean the visible matter with disposable absorbent material and discard the contaminated materials as Red Bag waste.
  - Then disinfect the surface with a 1:10 solution of household bleach (1.5 cup household bleach to 1 gallon water) or hospital-approved, tuberculocidal disinfectant (for example, Sani Cloth AF3 wipes).
- If a sharps injury is possible:
  - Initially disinfect the spill with a 1:10 (5000 ppm) household bleach solution,
  - Then remove sharps very carefully (use forceps to pick up sharps and discard them into puncture proof sharps container)
  - Then clean surface as described above using absorbent material
  -

Finally, disinfect with a 1:100 (500 ppm) dilution of household bleach (0.25 cup household bleach to 1 gallon water) or a hospital approved, tuberculocidal disinfectant (for example, Sani Cloth AF3 wipes).

EVS is responsible for following the cleaning and decontamination schedule as outlined by Environmental Services policies and procedures.

F. Regulated Waste

Care is taken when handling regulated waste. Medical waste becomes regulated when it contains enough blood or other potentially infectious materials (OPIM) to potentially spread bloodborne pathogens. The Bloodborne Pathogens Standard uses the term, "regulated waste," to refer to the following categories of waste:

- Liquid or semi-liquid blood or OPIM, this includes:
  - Blood in blood tubes, blood or OPIM in suction canisters
- Contaminated items that would release blood or OPIM in a liquid or semi-liquid state if compressed, this includes:
  - Blood-soaked gauze
- Items that are caked with dried blood or OPIM and are capable of releasing these materials during handling, this includes:
  - Blood-soaked gauze that has dried and the blood could flake off
  - Bloody gloves or other items that have not absorbed the blood
- Contaminated sharps, including:
  - Needles, syringes with needles attached, and scalpels with blood in them
- Pathological and microbiological wastes containing blood or OPIM
- Any unfixed human tissue or organ from a human

EVS is responsible for the collection and handling of the facility's regulated waste.
The following procedures are used with all regulated waste:

- Discard into containers that are:
  - Closable;
  - Constructed to contain all contents and prevent leakage of fluids during handling, storage, transport or shipping;
  - Labeled or color-coded in accordance with the standard;
  - Closed prior to removal to prevent spillage or protrusion of contents during handling, storage, transport, or shipping.
  - If outside contamination of the regulated waste container occurs, it must be placed in a second container meeting the above standards.
- Containers for regulated waste are located throughout our facility, easily accessible to employees, and as close as possible to the sources of the waste.
- Waste containers are maintained upright, routinely replaced and not allowed to overfill.
- Whenever the employees move bags or containers of regulated waste from one area to another, open bags are closed securely prior to transport and placed inside an appropriate secondary container if leakage is possible from the first container.

G. Contaminated Laundry

Employees will handle contaminated linen using disposable gloves and hold it away from their clothing to prevent contamination. Place soiled linen in designated yellow bags utilizing standard precautions. These bags prevent soak-through and/or leakage of fluids to the exterior. Minimize the time spent handling laundry and avoid shaking out soiled linen to prevent dispersal of contaminants. Bag soiled linen as close as possible to the location where it was used. Whenever possible, bring a linen hamper to the point of collection (usually the patient's room) to avoid carrying bags of soiled linen through the corridors. Remove gloves and perform hand hygiene after handling soiled linen. Soiled laundry is picked up, cleaned and returned by a contracted laundry service.

IV. HEPATITIS B VACCINATION, POST-EXPOSURE EVALUATION AND FOLLOW-UP

Even with good adherence to exposure prevention practices, exposure incidents can occur. As a result, a Hepatitis B Vaccination Program and procedures for post-exposure evaluation and follow-up have been developed.

A. Vaccination Program

To protect employees as much as possible from the possibility of Hepatitis B infection, the facility has implemented a vaccination program. This program is available, at no cost, to all employees who have potential for occupational exposure to bloodborne pathogens.

The vaccination program consists of a series of three vaccinations over a six-month period followed by an antibody titer two months after completion of the series. As part of their bloodborne pathogens training, employees receive information regarding Hepatitis B vaccination, including its safety and effectiveness.

Vaccinations are performed under the supervision of a licensed physician or other healthcare professional. A list of employees taking part in the vaccination program is kept by the Employee Health Nurse. A list of employees who have declined to take part and have signed the "Vaccination Declination Form" is also kept. (See Policy Hepatitis B Immunization Program in the Infection Prevention Manual.) To ensure all employees are aware of the vaccination program, it is thoroughly discussed in the bloodborne pathogens training during orientation.

B. Exposure Incident and Post-Exposure Evaluation and Follow-up

An exposure incident involving bloodborne pathogens is defined as an eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials resulting from the performance of an employee's duties. Whenever an exposure occurs, wash the contaminated skin immediately with soap and water. Immediately flush contaminated eyes or mucous membranes with copious amounts of water. Medically evaluate exposed employees as soon as possible after the exposure incident in order that post-exposure prophylaxis, if recommended, can be initiated promptly.

The Infection Prevention/Employee Health Nurse will investigate every reported exposure incident in the facility. This investigation is initiated as soon as possible after the incident occurs and involves gathering the following information:

- When the incident occurred.
  - Date and time.
- Where the incident occurred.
  - Location within the facility.
- What potentially infectious materials were involved in the incident.
  - Type of material (blood, amniotic fluid, etc.)
- Source of the material.
- Under what circumstances the incident occurred.
  - Type of work being performed.
- How the incident was caused.
  - Accident.
  - Unusual circumstances (such as equipment malfunction, power outage, etc.).
- Personal protective equipment being used at the time of the incident.
- Actions taken as a result of the incident.
  - Employee decontamination.
  - Cleanup.
  - Notifications made
  - Post exposure prophylaxis if any

After this information is gathered it is evaluated, a written summary of the incident and its causes is prepared and recommendations are made for avoiding similar incidents in the future ("Incident Investigation Form", Appendix A). All documentation regarding the exposure incident, treatment, and counseling will be kept in the employee health record for 30 years.

In order to ensure that employees receive the best and most timely treatment if an exposure to bloodborne pathogens should occur, the facility has set up a comprehensive post-exposure evaluation and follow-up process. The "Post-Exposure Evaluation and Follow up Checklist" is used to verify that all the steps in the process have been taken correctly (Appendix B). The counseling checklist is filled out and signed by the employee (Appendix C). When indicated, the HIV Post Exposure Prophylaxis protocol (Appendix G) is followed. This is overseen by the Infection

Prevention/Employee Health Nurse. Post exposure evaluation is critically time sensitive and will be referred to the Clinic Medical Director or ED physician on duty if the Infection Prevention/Employee Health Nurse is not on site.

This process must remain confidential. Everything possible must be done to protect the privacy of the people involved.

If possible, the source individual's blood is tested (after their consent is obtained) to determine HBV, HCV or HIV infectivity. This information will be made available to the exposed employee, if it is obtained. At that time, the employee will be made aware of any applicable laws and regulations concerning disclosure of the identity and infectious status of a source individual. If legally required consent is not obtained, this fact should be documented in writing, unless there is other clear evidence consent could not be obtained.

With their consent, the blood of the exposed employee is tested for HBV, HCV and HIV status. Employees involved in an exposure incident have 90 days following baseline blood collection to decide if they wish to have their blood tested for baseline HIV status. The blood specimen must be preserved for this length of time if the employee does not initially give consent for testing. Available blood may be used for testing rather than redrawing a specimen if the blood samples were drawn from the source individual before the exposure incident. OSHA does not allow redrawing of blood specifically for HBV, HCV and HIV testing without the consent of the source individual.

Once these procedures have been completed, an appointment is arranged for the exposed employee with a qualified healthcare professional to discuss the employee's medical status. This includes an evaluation of any reported illnesses, as well as any recommended treatment.

C. Information Provided to the Healthcare Professional

The Healthcare Professional reviews the following to assist him/her in the care of the healthcare worker.

- A copy of the OSHA Bloodborne Pathogens Standard.
- A description of the exposure incident.
- The exposed employee's relevant medical records.
- Other pertinent information.
- Consider contacting the UCSF Clinician Consultation Center at (888) 448-4911
- Review the UCSF PEP Quick Guide for Occupational Exposures, (use link to web site for most current version in "References" below)

D. Healthcare Professional Written Opinion

After the consultation, the healthcare professional provides the facility with a written opinion evaluating the exposed employee's situation. A copy of this opinion is given to the exposed employee (Appendix D.)

In keeping with this process' emphasis on confidentiality, the written opinion will contain only the following information:

- Whether Hepatitis B Vaccination is indicated for the employee.
- Whether the employee has received the Hepatitis B Vaccination.
- Confirmation that the employee has been informed of the results of the evaluation.
- Confirmation that the employee has been told about any medical conditions resulting from the exposure incident which require further evaluation or treatment.

All other findings or diagnoses will remain confidential and will not be included in the written report.

E. Medical Record Keeping

The facility maintains comprehensive medical records on each employee. The Employee Health Nurse is responsible for setting up and maintaining these records, which include the following:

- Name of the employee.
- A copy of the employee's Hepatitis B Vaccination status.

- Dates of any vaccinations.
- Medical Records relative to the employee's ability to receive vaccination.
- Copies of the results of the examinations, medical testing and follow-up procedures which took place as a result of any exposure to bloodborne pathogens.
- A copy of the information provided to the consulting healthcare professional as a result of any exposure to bloodborne pathogens.

It is important to keep the information in these medical records confidential; it will not be disclosed or reported to anyone without the employee's consent (except as required by law).

A sharps injury log for recording percutaneous injuries from contaminated sharps will be kept. (See Appendix E.)

V. LABELS AND SIGNS

This facility has implemented a comprehensive biohazard warning-labeling program using Biohazard labels of the type shown on Appendix F, or when appropriate, using red color-coded containers. The Laboratory and Infection Prevention/Employee Health Nurse are responsible for setting up and maintaining this program in the facility.

The following items in the facility are labeled:

- Containers of regulated waste.
- Refrigerators/freezers containing blood or other potentially infectious waste.
- Sharps disposal containers.
- Other containers used to store, transport or ship blood and other potentially infectious materials.
- Laundry bags and containers.
- Contaminated equipment and instruments.

Labels affixed to contaminated equipment indicate which portions of the equipment are contaminated.

VI. INFORMATION AND TRAINING

Having well-informed and educated employees is extremely important when attempting to eliminate or minimize exposure to bloodborne pathogens. Because of this, all employees who have the potential for exposure to bloodborne pathogens participate in a comprehensive training program and are provided with as much information as possible on this issue.

Employees are retrained at least annually to keep their knowledge current. Additionally, all new employees, as well as employees changing jobs or job functions, will be given any additional training their new position requires at the time of their new job assignment.

Human Resources is responsible for seeing that all employees who have potential exposure to bloodborne pathogens receive this training. The Infection Prevention/Employee Health Nurse will assist the Human Resources Manager with this training.

A. Training Topics

The topics covered in the training program include, but are not limited to, the following:

- The OSHA Bloodborne Pathogens Standard (and where to obtain a copy or access electronically).
- The epidemiology and symptoms of bloodborne diseases.
- The modes of transmission of bloodborne pathogens.
- The facility's Bloodborne Pathogen Exposure Control Plan (and where employees can obtain a copy or access it electronically).
- Appropriate methods for recognizing tasks and other activities that may involve exposure to blood and other potentially infectious materials.
- A review of the use and limitations of methods that will prevent or reduce exposure, including:
  - Engineering Controls
  - Work Practice Controls

    - Personal Protective Equipment (PPE)
- Selection and use of personal protective equipment including:
    - Types available
    - Proper use
    - Location within the facility
    - Removal
    - Handling
    - Decontamination
    - Disposal
- Visual warnings of biohazards within the facility including labels, signs and "color-coded" containers.
- Information on the Hepatitis B Vaccine, including its:
    - Efficacy
    - Safety
    - Method of Administration
    - Benefits of Vaccination
    - The facility's free vaccination program.
- Actions to take and persons to contact in an emergency involving blood or other potentially infectious materials.
- The procedures to follow if an exposure incident occurs, including incident reporting.
- Information on the post-exposure evaluation and follow-up, including medical consultation the facility will provide.
- Include opportunities for interactive questions and answers at least annually, solicit employee feedback and suggestions for safe sharps products

B. Training Methods

The facility's training presentations make use of several training techniques including, but not limited to:

- Employee handouts
- Classroom presentation with slides, lecture and quiz
- DVD/video programs
- Internet training program
- Competency demonstrations (e.g., donning and doffing PPE)

C. Record Keeping

To facilitate the training of employees, as well as to document the training process, the facility maintains training records containing the following information:

- Dates of all training sessions.
- Contents/summary of the training.
- Names and qualifications of the instructors.
- Names and job titles of employees attending the training sessions.

These training records are available for examination and copying to our employees and their representatives, as well as OSHA and its representatives.

REFERENCES:

APIC Text (2018). Environmental Services Chapter. Available online by subscription.

"Bloodborne Pathogens Standard", California Code of Regulations, Title 8, Section 1593, www.dir.ca.gov/title8/5193.html. Accessed November 10, 2017.

"CDC Guidance for Evaluating Health-Care Personnel for Hepatitis B Virus Protection and for Administering Postexposure Management December 20, 2013", www.cdc.gov/mmwr/preview/mmwrhtml/rr6210a1.htm. Accessed November 10, 2017.

Centers for Disease Control and Prevention (2008). Guideline for Disinfection and Sterilization in Healthcare Facilities. Retrieved from https://www.cdc.gov/infectioncontrol/pdf/guidelines/disinfection-guidelines.pdf

"OSHA Bloodborne Pathogens Standard CFR 1910.1030", www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051. Accessed November 10, 2017.
"PEP Quick Guide for Occupational Exposures", University of San Francisco. Available online at: http://nccc.ucsf.edu/clinical-resources/pep-resources/pep-quick-guide/ Accessed November 10, 2017.

"Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Postexposure Prophylaxis", 2001, updated December 20, 2013. Available online at: www.cdc.gov/mmwr/PDF/RR/RR5011.pdf. Accessed November 10, 2017.

REVIEWED BY:

Administrative Team

Medical Staff

Governing Board

Appendix A

EXPOSURE INCIDENT INVESTIGATION FORM

Date of Incident: _____ Time of Incident: _____

Location: _____

Potentially Infectious Materials Involved:

Type: _____ Source: _____

_____ _____

Circumstances (work being performed, etc.): _____

_____

_____

How incident was caused (accident, equipment malfunction, etc.): _____

_____

_____

Personal protective equipment being used: _____

_____

Actions taken (decontamination, cleanup, reporting, etc.): _____

_____

_____

Recommendations for avoiding repetition: _____

_____

_____

Appendix B

POST-EXPOSURE EVALUATION AND FOLLOW-UP CHECKLIST

The following steps must be taken, and information transmitted, in the case of an employee's exposure to Bloodborne Pathogens:

Activity	**Completion Date**
☐ Employee furnished with documentation regarding exposure incident.	_____
☐ Source individual identified.	_____
(_____) Source Individual	
☐ Source individual's blood tested and results given to exposed employee.	_____
_____ Consent has not been able to be obtained.	
☐ Exposed employee's blood collected and tested.	_____
☐ Appointment arranged for employee with healthcare professional.	_____
(_____) Professional's name	

Documentation forwarded to healthcare professional.

_____ Bloodborne Pathogens Standard.
_____ Description of exposed employee's duties.
_____ Description of exposure incident, including routes of exposure.
_____ Result of source individual's blood testing.
_____ Employee's medical records.

Appendix C

EMPLOYEE BLOOD/BODY SUBSTANCE EXPOSURE

COUNSELING CHECKLIST

Employee Name: _____

Date of Exposure: _____

1. The risks of this exposure, based on the information currently available about the source patient, have been explained to me.
2. Recommendations regarding the Hepatitis B vaccine have been explained to me.
3. Testing of my blood for Hepatitis B, Hepatitis C, and Human Immunodeficiency Virus (HIV) has been offered to me and explained.
4. I am choosing the following options for testing my blood:

	Test	**Do NOT Test**	**Draw Sample, Store for 90 Days No Testing at This Time**
Hepatitis B			
Hepatitis C			
HIV			

5. A copy of the U.S. Public Health Service Occupational Exposure to HIV has been given to me.
6. I understand that I should report to Employee Health for evaluation of any acute illness causing a fever, rash, diarrhea or swollen glands within the next 3 months.
7. I understand that I may contact Employee Health to obtain the results of blood tests done on the source patient of my exposure. I also understand that this information is confidential and that the name and infectious status of this patient should not be disclosed to others.
8. Precautions I can take to avoid future similar exposures have been discussed with me.
9. The last time I had training in bloodborne pathogens was: _____.

_____ _____

Signature Date

Appendix D

SoHum Health

733 Cedar Street
Garberville, CA 95542
(707) 923-3921
shchd.org

MEMO

TO: _____

FROM: Employee Health

DATE

RE: Blood/Body Substance Exposure

The above-named employee has been evaluated by Employee Health for a blood/body substance exposure. The following information is being provided to you in accordance with OSHA Standard and Occupational Exposure to Bloodborne Pathogens.

_____ The employee has been vaccinated against Hepatitis B.

_____ Hepatitis B vaccine is indicated and the vaccine series has been initiated.

_____ Hepatitis B vaccine is indicated, but the vaccine has not been received.

The above named employee has been informed of the results of this evaluation and has been told about any medical conditions resulting from this exposure, which require further evaluation or treatment.

The following recommendations were made to the employee to avoid future similar exposures:

1. Use and/or activate needle safety device.
2. Avoid recapping needles, or if necessary to recap, use safety device or one handed scoop.
3. Dispose of device in appropriate puncture-resistant sharps container immediately after use.
4. Wear face protection when splashes can reasonably be anticipated.
5. Make sure needle disposal box is emptied when ¾ full.
6. Other: _____
7. Other: _____
8. No recommendation.

Appendix E

SOUTHERN HUMBOLDT COMMUNITY HEALTHCARE DISTRICT

SHARPS INJURY LOG

Please complete a separate log for each employee exposure incident involving a sharp.

Department:		
Date filled out:	By:	Extension:

Facility Injury ID#	Date of Injury Month/day/year	Time of Injury ☐ am ☐ pm	Sex (optional) ☐ male ☐ female	Age (optional)

Description of exposure incident:	**Job classification:**	**Department/Location:**
	☐ MD ☐ Nurse ☐ Medical Assistant ☐ Phlebotomist/lab tech ☐ EVS/laundry ☐ CNA/HHA ☐ Student, type _____ ☐ Other _____	☐ Patient Room ☐ ER ☐ Operating Room ☐ Procedure Rm ☐ CCU/ICU ☐ Clinical Laboratory ☐ Medical/outpatient clinic ☐ Service/utility area (disp rm/lndry) ☐ Other

Procedure:		**Did the exposure incident occur:**	
☐ Draw venous blood	☐ Heparin/saline flush	☐ During the use of sharp	☐ Disassembling
☐ Draw arterial blood	☐ Cutting	☐ Between steps of a multistep procedure	
☐ Injection, through skin	☐ Suturing	☐ After use and before disposal of sharp	
☐ Start IV/set up heparin lock		☐ While putting sharp into disposal container	
☐ Unknown/not applicable		☐ Sharp left, inappropriate place (table, bed, etc.)	
☐ Other: _____		☐ Other: _____	

Body part: (check all that apply)	**Identify sharp involved:** (if known)	Did the device being used have engineered sharps injury protection?
☐ Finger ☐ Hand ☐ Arm ☐ Face/head ☐ Torso ☐ Leg ☐ Other: _____	Type: _____ Brand: _____ Model: _____ e.g.: 18g needle/ABC Medical/"no stick" syringe	☐ yes ☐ no ☐ don't know Was the protective mechanism activated? ☐ yes-fully ☐ yes-partially ☐ no Did the exposure incident occur: ☐ before ☐ during ☐ after

Exposed employee: If sharp had no engineered sharps injury protection, do you have an opinion that such a mechanism could have prevented the injury? ☐ Yes ☐ No	Exposed employee: Do you have an opinion that any other engineering, administrative or work practice control could have prevented the injury? ☐ Yes ☐ No
Explain:	Explain:

Appendix F

Appendix G

PEP Quick Guide for Occupational Exposures (excerpt, web page last updated July 1, 2019)

Access complete PEP Quick Guide online at: http://nccc.ucsf.edu/clinical-resources/pep-resources/pep-quick-guide-for-occupational-exposures/

How to choose a PEP regimen?
Three-drug PEP regimens are now the recommended regimens for all exposures. There are some special circumstances in which a two-drug regimen can be considered/used, especially when recommended antiretroviral medications are unavailable or there is concern about potential toxicity or adherence difficulties. Consultation is recommended if a two-drug regimen is considered. In addition, the Guidelines state, "PEP is not justified for exposures that pose a negligible risk for transmission." Consultation with an expert can help determine if the exposure poses a "negligible risk" to explore whether alternative approaches, including a modified regimen, are appropriate.

PREFERRED 3-DRUG HIV PEP REGIMEN:

Truvada™ 1 tablet by mouth once daily
[co-formulated Tenofovir DF (Viread®; TDF) 300mg + emtricitabine (Emtriva™; FTC) 200mg]

PLUS

Raltegravir (Isentress®; RAL) 400mg by mouth twice daily

or

dolutegravir (Tivicay™) 50 mg PO once daily*

Duration: 28 days

Side effects and drug-drug interactions: See below
NOTE: Dolutegravir should not be given to women in their first trimester of pregnancy or women of childbearing potential.

ALTERNATIVE REGIMEN FOR PATIENTS WITH RENAL DYSFUNCTION (creatinine clearance ≤ 59 mL/min): Zidovudine plus lamivudine (co-formulated as Combivir®) PLUS raltegravir or dolutegravir. See dolutegravir caution, above.

ALTERNATIVE REGIMENS*
May combine one drug or drug pair from the left column with one pair of nucleoside/nucleotide reverse transcriptase inhibitors from the right column.

Raltegravir (Isentress®; RAL)	Tenofovir DF (Viread®; TDF) + emtricitabine (Emtriva™; FTC); available co-formulated as Truvada™
Dolutegravir (Tivicay®; DTG)	Tenofovir DF (Viread®; TDF) + lamivudine (Epivir®; 3TC)

Darunavir (Prezista®; DRV) + ritonavir (Norvir®; RTV)	Zidovudine (Retrovir™; ZDV; AZT) + lamivudine (Epivir®; 3TC); available co-formulated as Combivir®
Etravirine (Intelence®; ETR)	Zidovudine (Retrovir™; ZDV; AZT) + emtrictabine (Emtriva™; FTC)
Rilpivirine (Edurant™; RPV)	
Atazanavir (Reyataz®; ATV) + ritonavir (Norvir®; RTV)	
Lopinavir/ritonavir (Kaletra®; LPV/RTV)	

** The alternative regimens are listed in order of USPHS preference; however, other alternatives may be reasonable based upon patient and clinician preference.*

ARV drug dosing and toxicity monitoring *

HIV meds	Adult Dosing	Combination Form	Toxicity monitoring
Tenofovir DF	300 mg by mouth once daily	Truvada™	BUN, Creatinine, LFTs
Emtricitabine	200 mg by mouth once daily		Rash
Raltegravir	400 mg by mouth twice daily		Nausea, headache
Dolutegravir	50 mg by mouth once daily		Headache, insomnia

Zidovudine	300 mg by mouth twice daily	Combivir®	CBC, LFTs
Lamivudine	150 mg by mouth twice daily		Rash
Lopinavir/ritonavir (200/50 mg)	2 tabs by mouth twice daily	Kaletra®	GI toxicity, especially diarrhea. LFTs *Note: Lopinavir/ritonavir has many drug-drug interactions with common medications; use with caution (see below).

Note: For additional information on dosing, drug-drug interactions and toxicities, and toxicity monitoring, see our **downloadable antiretroviral drug tables at* http://nccc.ucsf.edu/wp-content/uploads/2017/08/CCC-ARV-Table-Nov-2019-long-final-19-1125.pdf

How long is PEP taken?

PEP is taken for 28 days. If source person testing is negative for HIV, PEP should be stopped.

How to monitor and manage side effects of PEP?

Side effects are generally self-limited, but can occasionally limit PEP adherence if they last throughout the 28-day PEP course. Gastrointestinal side effects (nausea, upset stomach, vomiting, diarrhea) are most common.

Headache, fatigue, and insomnia can also occur. Antiemetic and antidiarrheal medications can help support PEP medication adherence. If side effects are severe, consider changing to a different regimen. Toxicities are rare with the current preferred PEP regimens, are generally not life-threatening, and are reversible once PEP medications are stopped.

The most important concern with the preferred regimen, tenofovir DF/emtricitabine plus raltegravir, is potential renal toxicity from tenofovir DF. This regimen should be used with caution in those with impaired renal function or who are at high risk for impaired renal function.

Lab monitoring for drug toxicity: Check CBC, renal and hepatic function tests at baseline and two weeks after starting PEP.

What are common drug-drug interactions between PEP and the exposed person's medications?

• There are few significant drug interactions with medications used in first-line PEP regimens. Consultation with the PEPline or a PEP-experienced clinical pharmacist/clinician is advised for specific questions on drug-drug interactions. Aluminum- and magnesium-containing medications (e.g., most antacids, milk of magnesia) and Fe^{++} and Ca^{++}, which interact with raltegravir and dolutegravir, should be avoided during the period of PEP administration.

SoHum Health

DEPARTMENT:	APPROVED:	Page **1** of **1**
Infection Prevention	**03/30/2023**	
SUBJECT:	**EFFECTIVE DATE:**	**SUPERCEDES:**
BLOODBORNE PATHOGEN EXPOSURE CONTROL PLAN	**03/30/2023**	**11/29/2018**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District to have a defined Bloodborne Pathogen Exposure Control Plan that meets regulatory requirements and is individualized for this district.

DEFINITIONS:

Bloodborne pathogens are infectious microorganisms in human blood that can cause disease in humans. These pathogens include, but are not limited to, hepatitis B (HBV), hepatitis C (HCV) and human immunodeficiency virus (HIV).

REFERENCES:

APIC Text (2018). Environmental Services Chapter. Available online by subscription.

"Bloodborne Pathogens Standard", California Code of Regulations, Title 8, Section 1593, www.dir.ca.gov/title8/5193.html. Accessed November 10, 2017.

"CDC Guidance for Evaluating Health-Care Personnel for Hepatitis B Virus Protection and for Administering Postexposure Management December 20, 2013", www.cdc.gov/mmwr/preview/mmwrhtml/rr6210a1.htm. Accessed November 10, 2017.

Centers for Disease Control and Prevention (2008). Guideline for Disinfection and Sterilization in Healthcare Facilities. Retrieved from https://www.cdc.gov/infectioncontrol/pdf/guidelines/disinfection-guidelines.pdf

"OSHA Bloodborne Pathogens Standard CFR 1910.1030", www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051. Accessed November 10, 2017.
"PEP Quick Guide for Occupational Exposures", University of San Francisco. Available online at: http://nccc.ucsf.edu/clinical-resources/pep-resources/pep-quick-guide/ Accessed November 10, 2017.

"Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Postexposure Prophylaxis", 2001, updated December 20, 2013. Available online at: www.cdc.gov/mmwr/PDF/RR/RR5011.pdf. Accessed November 10, 2017.

REVIEWED BY:

Administrative Team

Medical Staff

Governing Board

DEPARTMENT:	APPROVED:	Page **1** of **1**
Infection Prevention	**03/30/2023**	
SUBJECT:	**EFFECTIVE DATE:**	**SUPERCEDES:**
Cleaning and Repair of Patient Equipment	**03/30/2023**	**01/27/2022**

POLICY:

POLICY:
It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "district") to clean and repair all patient care equipment, so as to prevent patient injury or the spread of infection.

DEFINITIONS:

N/A

REFERENCES:

Centers for Disease Control and Prevention, Guidelines for disinfection and sterilization in healthcare facilities 2019. Retrieved https://www.cdc.gov/infectioncontrol/pdf/guidelines/disinfection-guidelines-H.pdf

Guidelines for preventing health care associated pneumonia, 2003; MMWR 2004; 53 (RR03);1-36.

Manufacturer's suggested procedures: Invacare, Vanderlift, Braun, Clinitest, IVAC, Zoll, Welch-Allyn, 3M, Roche, AMI, Huntleigh, VidaCare, Schiller, Arizant, Reichert, Contec, Siemens, BD, OxyMat, 3M.

O'Malley, C. Device cleaning and infection control in aerosol therapy. Respiratory Care 2015; 60: 917-930.

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DEPARTMENT:	APPROVED:	Page **1** of **8**
Infection Prevention	**03/22/2023**	
SUBJECT:	**EFFECTIVE DATE:**	**SUPERCEDES:**
Construction Projects: Infection Control Risk Assessment	**03/22/2023**	**06/27/2019**

POLICY:
It is the policy of Southern Humboldt Community Healthcare District ("district" or "SHCHD") to proactively identify and mitigate infection risks that could occur during construction/renovation activities.

PURPOSE:
The purpose of this policy and procedure is to outline the process for performing an Infection Control Risk Assessment to ensure the minimization of infection risks related to construction and renovation projects.

BACKGROUND:
Infection risks and control strategies must be considered in planning for new construction and/or renovation projects in healthcare facilities. An Infection Control Risk Assessment (ICRA) is developed for all projects that may impact the health of patients, staff, or visitors. It is designed to maintain air quality and dust control in the facility during construction, demolition, and renovation projects. Microorganisms and fungal spores contained in aerosolized dust and debris are an infectious risk to hospitalized patients, particularly the elderly and immunocompromised. Construction activity carries the additional risk of waterborne pathogens in plumbing systems that have become stagnant from lack of use during construction or from the disruption of accumulated biofilms by the impact of construction work on existing plumbing.

The risk assessment is based on these factors of the project:

- Nature and scope of project (including expected dust generation and water interruptions)
- Location
- Duration
- Patient populations likely to be affected

PROCEDURE:
1. Initiate the Infection Control Risk Assessment (ICRA) process
    - It is the responsibility of the Engineering Department to notify the Infection Preventionist of any planned construction or renovation project in advance.
    - Notification will be e-mailed to the Infection Preventionist at least one week before the project begins whenever possible.
    - This notification will include a basic summary of the project, planned start date and completion date, exact location(s), and contractor (if any).

2. The Infection Preventionist will determine infection risk implications of the project and document recommendations on the ICRA with any necessary addenda (e.g., flushing of plumbing system after interruption of water supply).

3. If the project meets criteria for a Class III or Class IV project (refer to Infection Prevention Matrix Appendix A), an Infection Prevention Permit (Appendix B) will be required.
    - Class I and Class II projects do not require a permit.

4. The Infection Preventionist will complete a permit for any Class III or IV project, review with Engineering, and obtain the signature of Chief Operating Officer (COO) or Engineering Manager.

5. A copy of the Infection Prevention Permit is to be displayed at the entrance to the work area during entire construction period, including clean-up phase.

6. The ICRA and Permit originals are maintained by the Infection Preventionist.

7. The Infection Preventionist and Engineering Manager/COO will monitor the Construction area throughout the project (on a daily basis if possible) for adherence to the Permit requirements.

REFERENCES:

AMERICAN SOCIETY FOR HEALTHCARE ENGINEERING. INFECTION CONTROL RISK ASSESSMENT MATRIX OF PRECAUTIONS FOR CONSTRUCTION & RENOVATION. UPDATED 2009. ACCESSED JUNE 7, 2019.

Johnson, L, Construction and Renovation. In: Grota P, et al, eds. APIC Text Online. 2014. Available at http://text.apic.org/toc/infection-prevention-for-support-services-and-the-care-environment/construction-and-renovation#book_section_19714. Accessed June 7, 2019.

REVIEWED BY:

Infection Preventionist
Chief Nursing Officer

Appendix A (3 pages)
Infection Control Risk Assessment
Matrix of Precautions for Construction & Renovation

Step One:
Using the following table, *identify* the Type of Construction Project Activity (Type A-D)

TYPE A	**Inspection and Non-Invasive Activities**. Includes, but is not limited to: ▪ removal of ceiling tiles for visual inspection only, e.g., limited to 1 tile per 50 square feet ▪ painting (but not sanding) ▪ wallcovering, electrical trim work, minor plumbing, and activities which do not generate dust or require cutting of walls or access to ceilings other than for visual inspection.
TYPE B	**Small scale, short duration activities which create minimal dust** Includes, but is not limited to: ▪ installation of telephone and computer cabling ▪ access to chase spaces ▪ cutting of walls or ceiling where dust migration can be controlled.
TYPE C	**Work that generates a moderate to high level of dust or requires demolition or removal of any fixed building components or assemblies** Includes, but is not limited to: ▪ sanding of walls for painting or wall covering ▪ removal of floorcoverings, ceiling tiles and casework ▪ new wall construction ▪ minor duct work or electrical work above ceilings ▪ major cabling activities ▪ any activity which cannot be completed within a single workshift.
TYPE D	**Major demolition and construction projects** Includes, but is not limited to: ▪ activities which require consecutive work shifts ▪ requires heavy demolition or removal of a complete cabling system ▪ new construction.

Step 1: _____

Step Two:
Using the following table, ***identify*** **the Patient Risk Groups** that will be affected.
If more than one risk group will be affected, select the higher risk group:

Low Risk	Medium Risk	High Risk	Highest Risk
▪ Office areas	▪ Cardiology ▪ Echocardiography ▪ Endoscopy ▪ Nuclear Medicine ▪ Physical Therapy ▪ Radiology/MRI ▪ Respiratory Therapy	▪ CCU ▪ Emergency Room ▪ Labor & Delivery ▪ Laboratories (specimen) ▪ Medical Units ▪ Newborn Nursery ▪ Outpatient Surgery ▪ Pediatrics ▪ Pharmacy ▪ Post Anesthesia Care Unit ▪ Surgical Units	▪ Any area caring for immunocompromised patients ▪ Burn Unit ▪ Cardiac Cath Lab ▪ Central Sterile Supply ▪ Intensive Care Units ▪ Negative pressure isolation rooms ▪ Oncology ▪ Operating rooms including C-section rooms

Step 2_____

Step Three:
Determine the Infection Prevention risk level classification by matching the **Construction Project Type (A-D)** with the **Patient Risk Group (Low- Highest)** to find the **Class of Precautions (I-IV)** in the Matrix below. **Class I-IV or Color-Coded Precautions are delineated on the following page.**

IC Matrix - Class of Precautions: Construction Project by Patient Risk

	Construction Project Type			
Patient Risk Group	**TYPE A**	**TYPE B**	**TYPE C**	**TYPE D**
LOW Risk Group	**I**	**II**	**II**	**III/IV**
MEDIUM Risk Group	**I**	**II**	**III**	**IV**
HIGH Risk Group	**I**	**II**	**III/IV**	**IV**
HIGHEST Risk Group	**II**	**III/IV**	**III/IV**	**IV**

Note: Infection Control approval will be required when the Construction Activity and Risk Level indicate that **Class III** or **Class IV** control procedures are necessary.

Separate ICRA's and/or permits are required if different risk groups and/or different construction activities are planned for a project.

Step 3 _____

Description of Required Infection Control Precautions by Class

	During Construction Project	Upon Completion of Project
CLASS I	1. Execute work by methods to minimize raising dust from construction operations. 2. Immediately replace a ceiling tile displaced for visual inspection	1. Clean work area upon completion of task.
CLASS II	1. Provide active means to prevent airborne dust from dispersing into atmosphere. 2. Water mist work surfaces to control dust while cutting. 3. Seal unused doors with duct tape. 4. Block off and seal air vents. 5. Place dust mat at entrance and exit of work area 6. Remove or isolate HVAC system in areas where work is being performed.	1. Wipe work surfaces with cleaner/disinfectant. 2. Contain construction waste before transport in tightly covered containers. 3. Wet mop and/or vacuum with HEPA filtered vacuum before leaving work area. 4. Upon completion, restore HVAC system where work was performed.
CLASS III	1. Remove or Isolate HVAC system in area where work is being done to prevent contamination of duct system. 2. Complete all critical barriers i.e. sheetrock, plywood, plastic, to seal area from non work area or implement control cube method (cart with plastic covering and sealed connection to work site with HEPA vacuum for vacuuming prior to exit) before construction begins. 3. Maintain negative air pressure within work site utilizing HEPA equipped air filtration units. 4. Contain construction waste before transport in tightly covered containers. 5. Cover transport receptacles or carts. Tape covering unless solid lid.	1. Do not remove barriers from work area until completed project is inspected by the owner's Safety Department and Infection Prevention & Control Department and thoroughly cleaned by the owner's Environmental Services Department. 2. Remove barrier materials carefully to minimize spreading of dirt and debris associated with construction. 3. Vacuum work area with HEPA filtered vacuums. 4. Wet mop area with cleaner/disinfectant. 5. Upon completion, restore HVAC system where work was performed.

CLASS IV	1. Isolate HVAC system in area where work is being done to prevent contamination of duct system. 2. Complete all critical barriers i.e. sheetrock, plywood, plastic, to seal area from non work area or implement control cube method (cart with plastic covering and sealed connection to work site with HEPA vacuum for vacuuming prior to exit) before construction begins. 3. Maintain negative air pressure within work site utilizing HEPA equipped air filtration units. 4. Seal holes, pipes, conduits, and punctures. 5. Construct anteroom and require all personnel to pass through this room so they can be vacuumed using a HEPA vacuum cleaner before leaving work site or they can wear cloth or paper coveralls that are removed each time they leave work site. 6. All personnel entering work site are required to wear shoe covers. Shoe covers must be changed each time the worker exits the work area.	1. Do not remove barriers from work area until completed project is inspected by the owner's Safety Department and Infection Prevention & Control Department and thoroughly cleaned by the owner's Environmental Services Dept. 2. Remove barrier material carefully to minimize spreading of dirt and debris associated with construction. 3. Contain construction waste before transport in tightly covered containers. 4. Cover transport receptacles or carts. Tape covering unless solid lid. 5. Vacuum work area with HEPA filtered vacuums. 6. Wet mop area with cleaner/disinfectant. 7. Upon completion, restore HVAC system where work was performed.

Appendix B
Infection Control Construction Permit

					Permit No:
Location of Construction:					Project Start Date:
Project Coordinator:					Estimated Duration:
Contractor Performing Work					Permit Expiration Date:
Supervisor:					Telephone:
YES	NO	CONSTRUCTION ACTIVITY	YES	NO	INFECTION CONTROL RISK GROUP
		TYPE A: Inspection, non-invasive activity			GROUP 1: Low Risk
		TYPE B: Small scale, short duration, moderate to high levels			GROUP 2: Medium Risk
		TYPE C: Activity generates moderate to high levels of dust, requires greater 1 work shift for completion			GROUP 3: Medium/High Risk
		TYPE D: Major duration and construction activities Requiring consecutive work shifts			GROUP 4: Highest Risk

CLASS I	1. Execute work by methods to minimize raising dust from construction operations. 2. Immediately replace any ceiling tile displaced for visual inspection.	3. Minor Demolition for Remodeling
CLASS II	1. Provides active means to prevent air-borne dust from dispersing into atmosphere 2. Water mist work surfaces to control dust while cutting. 3. Seal unused doors with duct tape. 4. Block off and seal air vents. 5. Wipe surfaces with cleaner/disinfectant.	6. Contain construction waste before transport in tightly covered containers. 7. Wet mop and/or vacuum with HEPA filtered vacuum before leaving work area. 8. Place dust mat at entrance and exit of work area. 9. Isolate HVAC system in areas where work is being performed; restore when work completed.
CLASS III **Date** **Initial**	1. Obtain infection control permit before construction begins. 2. Isolate HVAC system in area where work is being done to prevent contamination of the duct system. 3. Complete all critical barriers or implement control cube method before construction begins. 4. Maintain negative air pressure within work site utilizing HEPA equipped air filtration units. 5. Do not remove barriers from work area until complete project is checked by Infection Prevention & Control and thoroughly cleaned by Environmental Services.	6. Vacuum work with HEPA filtered vacuums. 7. Wet mop with cleaner/disinfectant 8. Remove barrier materials carefully to minimize spreading of dirt and debris associated with construction. 9. Contain construction waste before transport in tightly covered containers. 10. Cover transport receptacles or carts. Tape covering. 11. Upon completion, restore HVAC system where work was performed.
CLASS IV **Date** **Initial**	1. Obtain infection control permit before construction begins. 2. Isolate HVAC system in area where work is being done to prevent contamination of duct system. 3. Complete all critical barriers or implement control cube method before construction begins. 4. Maintain negative air pressure within work site utilizing HEPA equipped air filtration units. 5. Seal holes, pipes, conduits, and punctures appropriately. 6. Construct anteroom and require all personnel to pass through this room so they can be vacuumed using a HEPA vacuum cleaner before leaving work site or they can wear cloth or paper coveralls that are removed each time they leave the work site. 7. All personnel entering work site are required to wear shoe covers.	8. Do not remove barriers from work area until completed project is checked by Infection Prevention & Control and thoroughly cleaned by Environmental. Services. 9. Vacuum work area with HEPA filtered vacuums. 10. Wet mop with disinfectant. 11. Remove barrier materials carefully to minimize spreading of dirt and debris associated with construction. 12. Contain construction waste before transport in tightly covered containers. 13. Cover transport receptacles or carts. Tape covering. 14. Upon completion, restore HVAC system where work was performed.

Additional Requirements:	
Date_____ Initials_____	_____Exceptions/Additions to this permit are noted by attached memoranda
Permit Request By:	Permit Authorized By:
Date:	Date:

DEPARTMENT:	APPROVED:	Page **1** of **1**
Infection Prevention	**03/30/2023**	
SUBJECT:	**EFFECTIVE DATE:**	**SUPERCEDES:**
CONTRACT LAUNDRY SERVICES	**03/30/2023**	**01/25/2018**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to assure that contract laundry services are in compliance with applicable laws and standards. The Infection Preventionist is responsible for assuring this compliance.

DEFINITIONS:

N/A

REFERENCES:

N/A

REVIEWED BY:

Administrative Team

Medical Staff

Governing Board

DEPARTMENT:	APPROVED:	Page **1** of **1**
Infection Prevention	**03/30/2023**	
SUBJECT:	**EFFECTIVE DATE:**	**SUPERCEDES:**
Definitions of Healthcare Associated Infections	**03/30/2023**	**01/25/2018**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to utilize the standard definitions from the Center for Disease Control and Prevention (CDC) for defining healthcare associated infections (HAI) so that data from the District can by compared to regional and national benchmarks.

DEFINITIONS:

N/A

REFERENCES:

N/A

REVIEWED BY:

Administrative Team

Medical Staff

Governing Board

DEPARTMENT:	APPROVED:	Page **1** of **2**
Infection Prevention	**03/30/2023**	
SUBJECT:	**EFFECTIVE DATE:**	**SUPERCEDES:**
Ebola Management	**03/30/2023**	**01/25/2018**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to anticipate and create procedures for caring for highly contagious patients.

DEFINITIONS:

Ebola Virus Disease (EVD) is a viral disease that is transmitted from animals to humans, and humans to humans. It is characterized by fever, anorexia, weakness, chills, headache, muscle aches, vomiting, diarrhea, abdominal pain, malaise. In later stages there can be seizures, watery bloody diarrhea, chest pain, confusion, conjunctival injection. Currently there is no cure for EVD, only symptomatic treatment. Prevention of transmission is the main focus in healthcare facilities.

Ebola is transmitted through direct contact with blood and body fluids, through mucus membranes or parenteral injury. Appropriate transmission-based precautions appropriate for EVD include CONTACT precautions and DROPLET precautions. Ebola is NOT airborne, therefore N-95 masks are not necessary. However current guidance suggests their use to prevent exposure in the event the patient is rapidly intubated, suctioned, or has another type of aerosol-generating procedure. If used, additional eye protection must be worn. Only symptomatic persons can transmit the disease.

CDC APPROACH TO MANAGEMENT:

The CDC has provided a framework for facility management of the suspect person presenting to the facility. This guidance calls for a three-tiered approach based on the ability of the facility to manage Ebola patients.

The three tiers are the <u>frontline</u> healthcare facilities, the Ebola <u>assessment</u> facilities, and the Ebola <u>treatment</u> facilities.

SHCHD is considered a <u>frontline</u> facility. The requirements for this include: (the 3 "I's")

- **IDENTIFY** and triage patients with a relevant history AND signs or symptoms compatible with EVD.
- **ISOLATE** immediately and provide personal protective equipment (PPE) for all who must provide initial care to this patient.
- **INFORM** the Infection Preventionist, the Administrator, the Director of Nursing, and the Public Health Department, asking to speak to the Medical Director.

REFERENCES:

California Department of Public Health. (2014). "Ebola Scenario and Template for Hospital Drill"

Center for Disease Control and Prevention. (2014). "Case Definition for Ebola Virus Disease"

Center for Disease Control and Prevention. (2014). "Interim Guidance for Environmental Infection Control in Hospitals for Ebola Virus"

Center for Disease Control and Prevention. (2014). "Infection Prevention and Control Recommendations for Hospital Patients with known or Suspected Ebola Hemorrhagic Virus in the U.S."

Center for Disease Control and Prevention. "Guidance for the Selection and Use of Personal Protective Equipment in the Healthcare Setting" [Video]

Center for Disease Control and Prevention. (2014). "Interim Guidance for Preparing Frontline Healthcare Facilities for Patients with Possible Ebola Virus Disease"

Center for Disease Control and Prevention. (2014). "Interim Guidance for US Hospital Preparedness for Patients with Possible or Confirmed Ebola Virus Disease: A Framework for a Tiered Approach"

Center for Disease Control and Prevention. (2015). Outbreak Preparedness.

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DEPARTMENT:	APPROVED:	Page **1** of **1**
Infection Prevention	**03/30/2023**	
SUBJECT:	**EFFECTIVE DATE:**	**SUPERCEDES:**
Glucometer Cleaning	**03/30/2023**	**11/30/2017**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to clean all patient care equipment as appropriate to prevent the spread of disease.

DEFINITIONS:

N/A

REFERENCES:

N/A

REVIEWED BY:

Administrative Team

Medical Staff

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DEPARTMENT:	APPROVED:	Page **1** of **1**
Infection Prevention	**03/30/2023**	
SUBJECT:	**EFFECTIVE DATE:**	**SUPERCEDES:**
Guidelines for Healthcare Workers with Infectious Diseases	**03/30/2023**	**01/25/2018**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to reasonably accommodate healthcare workers (HCW) who have been diagnosed as having an infectious disease. The facility has the responsibility to assist and support prevention of disease transmission. Therefore, while diagnosis with an infectious disease does not, in and of itself, justify termination, suspension, or reassignment of an employee, reasonable accommodation of the worker's infectious disease may nonetheless require modification of assignments or procedures, suspension, reassignment or termination. However, the only justifications for such actions shall be those related to the following:

1. Inability of the infected HCW to continue performing work responsibilities in an adequate and safe manner;

2. Inability to reasonably accommodate the HCW's infection without exposing other workers or patients to more than minimal risk of infections;

3. Inability to reasonably accommodate the HCW's infection without exposing him/her to additional opportunistic infections.

DEFINITIONS:

N/A

REFERENCES:

N/A

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DEPARTMENT:	APPROVED:	Page **1** of **1**
Infection Prevention	**03/30/2023**	
SUBJECT:	**EFFECTIVE DATE:**	**SUPERCEDES:**
Guidelines for Patient Placement	**03/30/2023**	**01/25/2018**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to carefully consider the potential for transmission of infection when making decisions regarding patient placement.

DEFINITIONS:

N/A

REFERENCES:

N/A

REVIEWED BY:

Administrative Team

Medical Staff

Governing Board

DEPARTMENT: Infection Prevention	APPROVED: 03/30/2023	Page **1** of **2**
SUBJECT: **Hand Hygiene**	EFFECTIVE DATE: 03/30/2023	SUPERCEDES: 11/30/2017

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to promote healthcare worker hand hygiene as an essential aspect of infection prevention and safe patient care.

GUIDELINES:

Hand hygiene is required:

1. Prior to preparation and administration of medications.
2. Prior to direct contact with patients/residents.
3. Upon entry and exit of patient/resident rooms.
4. After contact with a patient or resident's intact skin.
5. After contact with mucous membranes, blood or other body fluids, secretions, or excretions.
6. After contact with equipment and surfaces in the immediate vicinity of the patient/resident.
7. Prior to donning gloves and after removing gloves
8. Before moving from a contaminated body site or task to a clean body site or task
9. Before inserting indwelling urinary catheters or peripheral vascular catheters

Hand antisepsis with **alcohol-based hand sanitizer is preferred** over soap and water **except** in the situations listed below.

When to preferentially use soap and water to cleanse hands:

1. Before and after eating.
2. After using the restroom.
3. Before assisting patients/residents with food (cutting meat, buttering bread, etc.)
4. When hands are contaminated with proteinaceous material or visibly soiled with blood or other body fluids.
5. Following contact with a patient having suspected or confirmed Clostridium difficile or Noro Virus infection.

Hand Hygiene Education:

The Infection Preventionist is responsible for providing hand hygiene education to all staff upon hire, annually, and when special needs arise. Education includes the rationale for hand hygiene, appropriate indications, proper methods, and the location of products in the facility. Nursing staff are required to complete an annual demonstration of competency during Skills Days.

Artificial Nails:

Artificial nails harbor more organisms and are harder to clean than natural nails. Therefore, artificial nails for patient care staff are discouraged. However, because SHCHD has no high-risk areas (such as a Burn Unit or Neonatal Intensive Care Unit), artificial nails are not prohibited

It is recommended that natural nail tips be no longer than ¼ inch.

Hand Lotions*:*

An important aspect of the Hand Hygiene program is ensuring that a high-quality hand lotion is readily available to patient care staff. Frequent hand hygiene removes natural oils from the hands and can lead to dryness, chafing, and fissuring of the skin. These breaks in the skin barrier are painful and discourage appropriate hand hygiene. They can also be portals of entry for bacteria.

Daily or more frequent use of hand lotion is strongly encouraged to prevent skin breakdown. Dermatitis or other skin problems that do not resolve with the regular use of hand lotion should be reported to the Infection Preventionist.

Hand lotion containers with pump dispensers are stocked in the ED, the Hospital Nurses' Station, and the Clinic. To prevent contamination, avoid touching the opening of the pump when dispensing lotion.

The use of personal hand lotion products brought from home is discouraged and carrying lotion containers in one's pockets is not allowed. These practices can result in contaminated containers and subsequently, contaminated hands.

Accessibility of Hand Hygiene Products:

Accessibility of hand hygiene products is an important component of promoting hand hygiene. With this in mind, wall-mounted hand sanitizer dispensers have been installed throughout the facility. In particular, dispensers have been mounted at the entrance to every patient and resident room. There is also at least one dispenser inside each patient/resident room. Every patient care area has at least one handwashing sink with a soap dispenser. Environmental Services (EVS) staff monitors the dispensers and replaces them when empty.

Hand Hygiene Compliance Monitoring:

Staff adherence with recommended hand-hygiene practices is monitored as recommended by the CDC. When observations of compliance or non-compliance are made by Department Managers, immediate feedback to staff is required. Infection Control literature shows this to be an effective method for improving compliance.

The Infection Preventionist reports data on staff performance to Medical Staff and Nursing Staff at least quarterly. Improving and maintaining staff compliance with the Hand Hygiene policy is the responsibility of Department Managers.

DEFINITIONS:

N/A

REFERENCES:

N/A

REVIEWED BY:

Administrative Team

Medical Staff

Governing Board

DEPARTMENT: Infection Prevention	APPROVED: 03/30/2023	Page **1** of **1**
SUBJECT: **Urinary Catheters, Indwelling**	EFFECTIVE DATE: 03/30/2023	SUPERCEDES: 01/25/2018

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to utilize evidence-based practices to reduce the risk of catheter-associated urinary tract (CAUTI) infections.

DEFINITIONS:

CAUTI: occurs when germs (usually bacteria) enter the urinary tract through the urinary catheter and cause symptoms. CAUTIs have been associated with increased morbidity, mortality, healthcare costs, and hospital length of stay. They require treatment with antibiotics.

REFERENCES:

Association for Professionals in Infection Control (APIC), 2008. Guide to Elimination of Catheter-Associated Urinary Tract Infections (CAUTIs). APIC; Washington, DC. Retrieved from https://www.apic.org/Resource_/EliminationGuideForm/c0790db8-2aca-4179-a7ae-676c27592de2/File/APIC-CAUTI-Guide.pdf

Carr, H. (2014). Urinary Tract Infection. APIC on-line text available by subscription at www.apic.orgInstitute for Healthcare Improvement (IHI), 2011. How-To Guide: Prevention of Catheter-Associated Urinary Tract Infections. Cambridge, MA. Retrieved from http://www.ihi.org/resources/Pages/Tools/HowtoGuidePreventCatheterAssociatedUrinaryTractInfection.aspx

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DEPARTMENT:	APPROVED:	Page **1** of **1**
Infection Prevention	**03/30/2023**	
SUBJECT:	**EFFECTIVE DATE:**	**SUPERCEDES:**
Isolation Supplies	**03/30/2023**	**01/25/2018**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to make available all equipment and supplies necessary to care for an isolation patient in such a manner as to decrease the possibility of the spread of infection.

DEFINITIONS:

N/A

REFERENCES:

N/A

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DEPARTMENT:	APPROVED:	Page **1** of **1**
Infection Prevention	**03/30/2023**	
SUBJECT:	**EFFECTIVE DATE:**	**SUPERCEDES:**
Linen Handling	**03/30/2023**	**01/25/2018**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District (the "District") to store, handle, and transport linen in compliance with federal and state Occupational Safety and Health Administration (OSHA) regulations.

DEFINITIONS:

N/A

REFERENCES:

N/A

REVIEWED BY:

Administrative Team

Medical Staff

Governing Board

DEPARTMENT:	APPROVED:	Page **1** of **1**
Infection Prevention	**03/30/2023**	
SUBJECT:	**EFFECTIVE DATE:**	**SUPERCEDES:**
Mandatory Disease Reporting	**03/30/2023**	**01/25/2018**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District to report specified conditions and diseases to the local public health authority in accordance with local, state, and federal regulations.

DEFINITIONS:

N/A

REFERENCES:

Title 17, California Code of Regulations (CCR) §2500, §2593, §2641.5-2643.20, and §2800-

Locally reportable diagnoses and conditions http://www.humboldtgov.org/DocumentCenter/View/52310

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Administrative Team

Medical Staff

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DEPARTMENT:	APPROVED:	Page **1** of 1
Infection Prevention	**Date approved**	
SUBJECT:	**EFFECTIVE DATE:**	**SUPERCEDES:**
Multidrug-Resistant Organisms and C. difficile	**(Date policy is in effect)**	**03/28/2019**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to follow established evidence-based guidelines to prevent the development and transmission of multidrug resistant organisms (MDRO's) and Clostridioides ~~Clostridium~~ difficile (C. difficile)*.

PURPOSE:

The purpose of this policy and procedure is to:

1. ~~provide~~ Provide information about MDROs
2. D~~d~~escribe strategies for control of MDROs in the facility
3. ~~describe~~ Describe appropriate placement in the facility for patients with an MDRO
4. ~~describe~~ Describe the isolation precautions and infection prevention activities for patients with MDROs
5. ~~describe~~ Describe the role of the environment in the transmission of MDROs and appropriate methods to clean and disinfect the patient environment to prevent this transmission.
6. ~~delineate~~ Delineate patient and staff education required for the appropriate care of patients with MDROs.

DEFINITIONS:

1. ***Active Surveillance Cultures (ASC):*** Cultures collected for the purpose of identifying patients colonized or infected with MDRO's.
2. ***Cohort:*** ~~a~~ ***A*** patient colonized or infected with a specific infectious agent sharing a room (cohorted) with another patient infected/colonized with the same organism.
3. ***Colonization:*** ~~presence~~ Presence of microorganisms in or on a host with growth and multiplication, but without tissue invasion or damage, hence no signs or symptoms of illness.
4. ***High-risk patients***: ~~the~~ The following are patient risk factors for colonization or infection with MDRO's: Those with severe illness, those who have had previous exposure to antimicrobial agents, certain underlying disease conditions (chronic renal disease, IDDM, peripheral vascular disease, dermatitis), those who have had invasive procedures (dialysis, presence of invasive devices, urinary catheterization, ventilator, repeated contact with the healthcare system), advanced age.
5. ***Infection:*** The ~~the~~ entry and multiplication of an infectious agent into the tissues of the host causing signs and symptoms of illness.
6. ***Multidrug-resistant organism (MDRO***): ~~microorganisms~~Microorganisms, predominantly bacteria, which are resistant to one or more classes of antimicrobial agents. Most common in hospital settings are methicillin-resistant staphylococcus aureus (MRSA) and vancomycin resistant enterococcus (VRE). Others include extended spectrum beta lactamase (ESBL) producing organisms, and carbapenem resistant enterobacteriaceae (CRE).
7. ***C. difficile****:* ~~a~~*A* spore-forming bacteria that can infect the gut causing severe diarrhea and life-threatening complications. It is readily transmissible from patient to patient via the fecal-oral route. It may or may not be drug resistant, but infection control management is the same as multidrug resistant organisms.

STRATEGIES FOR CONTROL:

1. Education: employees must understand the concept of MDROs and their implications for care including the use of active surveillance cultures (ASC), full contact and modified contact precautions, appropriate patient placement, antibiotic stewardship, hand hygiene, and environmental hygiene.

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2. Judicious use of antimicrobial agents: use of narrow spectrum agents when the infectious agent has been identified; treatment of infections, not contaminants or colonizations; avoiding excessive duration of therapy.
3. MDRO surveillance: of cultures, antibiotic selection, and infection rates.
4. Use of active surveillance cultures to identify colonized patients
5. Use of both Standard and Transmission-based precautions for all persons known to be infected with an MDRO.
6. Meticulous hand hygiene.
7. Consideration of decolonization when there is ongoing re-occurrence of infection in a cohort group.

NURSING PROCEDURES:

1. To be in compliance with California State law, the District will test the nares of all newly admitted patients for MRSA. Refer to the "Prevention of HAI" policy for guidance.
2. If a patient develops an MDRO during his/her stay and has a roommate, the roommate should be moved to a different room. The physician of the roommate will be informed; surveillance cultures will be obtained on that patient.
3. Screening Tests
    a. For MRSA: bilateral anterior nares cultures; urine and/or wound cultures if indicated.
    b. For VRE: rectal swabs and or wound cultures, if indicated.
    c. For CRE: collect a rectal or perirectal swab; urine, wound or other cultures if indicated.

DURATION OF ISOLATION PRECAUTIONS:

1. Isolation precautions are never to be discontinued without first consulting with the Infection Preventionist.
2. Optimal timelines for discontinuation of isolation precautions have not yet been established by the CDC or other authority.
3. At this facility, the following criteria are used to discontinue contact precautions
    a. For active MRSA infection, known or suspected:
        i. MRSA infection is ruled out by laboratory testing
        ii. After appropriate antimicrobial therapy has been completed and cultures from infected site are negative
    b. For VRE infection or colonization, known or suspected:
        i. After appropriate antimicrobial therapy has been completed (if actively infected) and three rectal swabs on three consecutive days are negative for VRE.
        rectal swabs on three consecutive days are negative for VRE.
        ii. VRE infection/colonization is ruled out by laboratory testing
    c. For C. diff, active infection, known or suspected:
        i. If C. diff toxins A or B are not found in the stool
        ii. If toxins are found, discontinue contact precautions no sooner than ~~48~~ 72 hours after diarrhea stops. Consider continuing contact precautions for the duration of the patient's stay.
4. Upon preparation for discharge, nursing staff will educate the patient and/or family regarding the MDRO and~~d~~
methods to prevent its spread in the home. An instructional sheet has been developed to assist in this education.

TRANSMISSION-BASED PRECAUTIONS FOR PATIENTS AND RESIDENTS COLONIZED OR INFECTED WITH MDRO:

1. At this facility, **contact precautions (full or modified)** are used for patients or residents
    ~~ii.~~ ~~known~~known or suspected to be **actively infected** with MDRO.
    ~~iii.~~ii. "Actively infected" means that the patient has clinical signs and symptoms of infection (e.g., fever, redness, heat, purulent exudate, etc.)
    ~~iv.~~iii. Transmission-based precautions can be discontinued using the criteria listed in "**DURATION OF ISOLATION PRECAUTIONS**" above.
2. Colonization with VRE, CRE, and other MDRO's of particular epidemiological importance requires contact precautions.
3. At this facility, contact precautions are **not** required for patients or residents **colonized** with MRSA or ESBL.

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4. All patients and residents, including those known to be colonized or infected with an MDRO should be encouraged to observe proper hand hygiene, especially before leaving their room (with assistance if necessary)
5. Special note regarding long term care residents colonized or infected with MDRO's
    a. The Centers for Disease Control and Prevention (CDC), the California Department of Public Health (CDPH), and the Association for Professions in Infection Control and Epidemiology (APIC) recognize that patient placement decisions in long term care facilities should be made on a case-by-case basis and should take into account the following:
        - Balancing infection risks with the need for more than one occupant in the room
        - The presence or absence of factors that increase the risk of transmission (as described in the "Guidelines for Patient Placement" policy).
        - The potential for isolation precautions to have adverse psychological impact on the infected or colonized resident.
        - ~~colonized resident~~
    b. It is appropriate to use the least restrictive approach possible that adequately protects the resident and others.
6. The Infection Preventionist will monitor the incidence of MDROs if there is determined to be an increase in the incidence of MDROs of evidence of transmission within the facility following implementation of this policy, additional staff education will be provided, and a more restrictive policy may be put into place.

~~a. If there is determined to be an increase in the incidence of MDROs or evidence of transmission within the facility following implementation of this policy, additional staff education will be provided, and a more restrictive policy may be put into place.~~

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USE OF FULL OR MODIFIED CONTACT PRECAUTIONS FOR PATIENTS ~~OR RESIDENTS~~ ACTIVELY INFECTED WITH MDRO:

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I. Full contact precautions are indicated for patients known or suspected to be actively infected that are NOT appropriate candidates for modified contact precautions.

~~I.~~ The following procedures will be followed~~Procedures:~~

1. Place the sign titled "Contact Precautions" at the room entrance and the isolation cart outside the room.
2. Gown and gloves are put on BEFORE entering the room and discarded BEFORE leaving the room.
3. Equipment must be dedicated to that patient and CANNOT come in and out of the room.
    a. Use disposable blood pressure cuff located in the Isolation Cart. Put the patient~~'s~~ name on it and leave it in the room. At the end of the ~~patient's~~ stay, or when he/she no longer is in isolation (or for a C. diff patient – no longer has diarrhea) the manometer should be removed and thoroughly decontaminated before being returned to the cart. The cuff should be discarded.
    b. A stethoscope from the Isolation Cart should be taken into the room and left there. It should be decontaminated at discharge or discontinuation of isolation and returned to the cart. Staff should not use their own stethoscope.
    c. "Temp Dots" should be used to take temperatures. They are located on the Isolation Cart. The IVAC or temporal thermometer should NOT be taken into the room.
4. Soiled linen is placed into regular YELLOW bags, as the commercial linen service treats all healthcare linen as contaminated.
5. Disposable dishes are NOT necessary. Discard everything on the tray that is disposable in the room and return the rest to Dietary. The dishwasher is sufficient to decontaminate dishes.
6. Patients should not leave the room unless medically necessary. Draining wounds should be covered.
7. Staff and visitors should wear gowns, which are discarded in the room before departure and NOT re-used.
8. Gloves are worn during all procedures, and discarded after every use, and when moving from a dirty to a clean site on the patient. Hand hygiene is performed before and after glove use.

II. Modified contact precautions (less restrictive than full contact precautions)

1. Modified contact precautions are used at this facility for patients ~~or residents~~ that are known or suspected to be actively infected with an MDRO but are determined by nursing staff and

Infection Prevention to have low risk for transmission. A patient ~~or resident~~ that can keep wounds (if present) covered and follow infection prevention precautions (e.g., good hand hygiene) is an acceptable candidate for less restrictive, modified contact precautions.

2. Patients with the following characteristics are generally NOT good candidates for modified contact precautions:
   a. are infected with C. difficile
   b. cannot or will not follow directions
   c. has uncontained wound drainage, fecal or urinary incontinence, or other uncontrolled secretions/excretions
   d. patient or resident is completely dependent on caregivers for ADL's requiring frequent close contact
   e. If infected with an unusual multidrug-resistant organism of epidemiological importance such as CRE or Vancomycin resistant MRSA. Full contact precautions are indicated for these patients.
3. If modified contact precautions are appropriate, place the sign titled "Modified Contact Precautions" at the room entrance. The sign has instructions for staff to follow.
4. How modified contact precautions differ from full contact precautions:
   a. Staff are not required to don gown and gloves before entering room. Gloves and gown are required only if there will be close contact with the patient or room environment such as repositioning the patient in bed, giving a bed bath, changing a wound dressing, or assisting with bedpan.
   b. Patient may ambulate and socialize without restrictions, but proper hand hygiene must be performed, and clean clothing or gown should be worn before leaving the room.
   c. Follow the guidance for full contact precautions in all other respects (dedicated equipment, daily and terminal cleaning, etc.)

SKILLED NURSING RESIDENTS AND ENHANCED STANDARD PRECAUTIONS

Enhanced Standard Precautions are used at this facility for Skilled Nursing Residents (SNF) residents who meet Enhanced Standard Precautions (ESP) criteria. ESP criteria is for residents known to be colonized or infected with a MDRO or at increased risk for MDRO acquisition (e.g, residents with wounds or indwelling medical devises. Staff will use hand hygiene and wear gloves and gowns for residents who are placed on ESP when providing for the following six group of care activities.

1. Morning and evening care,
2. Toileting and changing incontinence briefs,
3. Caring for devices and giving medical treatments, C
4. Cleaning and disinfecting the environment,
5. Wound care,
6. Mobility assistance and preparing to leave the room.

ENVIRONMENTAL SERVICES PROCEDURES:

1. Environmental services (EVS) personnel may enter rooms of patients with MDROs but must adhere to all isolation precautions posted.
2. Daily room cleaning: All equipment in rooms should be wiped down daily (bed rails, over bed tables, etc.). Cleaning supplies such as mop heads, cloths, etc., should not be taken from a CONTACT isolation room into another room. For that reason, the isolation room should be the last room cleaned each day. Used cleaning supplies must be sent for cleaning or discarded according to the policy for that piece of equipment. If further cleaning is needed in the department, the water and mop head must be changed before continuing.
3. Terminal cleaning (cleaning a room after patient discharge): All items used for terminal cleaning in a CONTACT precautions room should be sent for cleaning or discarded per policy after use in that room. Care must be taken to clean EVERY surface that could have been contaminated with the organism. This includes telephones, doorknobs, faucet handles, paper towel dispensers, light switches, etc. Cubicle curtains should be changed as part of terminal cleaning.

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4. Cleaning of Equipment: All re-usable patient care equipment must be cleaned and disinfected before it is used by another patient. Nursing staff should thoroughly clean the item with soap and water to remove all organic material; soaking may be necessary. After this, the item must be disinfected using an EPA approved germicide. The item should be wiped with the product and allowed to air dry as long as recommended by the manufacturer. This may require the item be wiped with an additional cloth.

PLACEMENT OF NEWLY ADMITTED PATIENTS WITH A KNOWN HISTORY OF MDRO'S:

1. When there is a history of multidrug-resistant organisms, avoid rooming the patient with anyone at high risk for infection unless current colonization can be ruled out by laboratory screening.
   a. Nursing staff will attempt to identify patients with a history of MDRO's by checking the Problem list module in the medical record, noting any history of MDRO's documented by a previous facility, and/or by interviewing the patient or family. If a history is identified by interview or from outside medical records, enter it in the Problem list.
2. In this facility, contact precautions are not required for newly admitted patients with a **history** of MDRO **unless**:
   a. Patient is suspected to have active infection with the MDRO at the time of admission. In this case, the patient should be placed on full or modified contact precautions until the MDRO is ruled out (usually by culture) and will remain in full or modified contact precautions if it is ruled in.

~~CLOSTRIDIUM~~ CLOSTRIDIOIDES DIFFICILE PATIENTS (REQUIRE FULL CONTACT PRECAUTIONS):

1. Tests for C. diff must be done on the liquid portion of the diarrhea only. It is a toxin test and not culture. The lab will reject formed stool specimens.
2. Alcohol is NOT effective against C. Diff spores, therefore thorough hand washing with soap and water and lots of friction is the preferred method of hand hygiene when caring for these patients.
3. If fecal contamination occurs, surfaces must be cleaned thoroughly with soap and water to remove debris. Decontamination with the current hospital approved product for C. diff spores must be used. Waste from the bedside commodes should be emptied carefully into the toilet to avoid splash or contamination of other surfaces. Municipal sanitation systems are sufficient to inactivate C. diff spores.
4. Isolation may be discontinued no earlier than three days after the patient's diarrhea stops. For patients incontinent of stool, dependent on staff for ADL's, and/or unable to follow hygiene instructions, it may be advisable to maintain full contact precautions for duration of stay.
5. It is not recommended to do post-therapy stool testing as toxins may be present for six weeks or longer in the absence of diarrhea.

EMPLOYEE EXPOSURE:

In the event of an outbreak of MRSA for which no cause can be identified, selective anterior nares cultures on employees may be done and decolonization procedures may be recommended.

DECOLONIZATION:

1. Consider decolonization when there is ongoing re-occurrence of infection in a cohort group.
2. Do not decolonize routinely (CDC recommendation)
3. A decision to attempt decolonization should be made with clear and achievable goals in mind
4. Recognize that successful decolonization is likely to be temporary.
5. Avoid the use of mupirocin or other antibiotic-based decolonizing agents to prevent drug resistance
6. Consult with the Infection Preventionist

REFERENCES:

1. Aureden, K. Et al. (2009). "Guide to Elimination of Methicillin-Resistant Staphylococcus aureus (MRSA) in the Long-Term Care Facility." Association for Professionals in Infection Control and Epidemiology (APIC). Centers for Disease Control. (2006~~)~~ ~~"~~) "Management of Multidrug-Resistant Organisms in Healthcare Settings." Healthcare Infection Control Practices Advisory Committee (HICPAC).
2. Centers for Disease Control. (2012). "2012 Toolkit – Guidance for Control of Carbapenem-Resistant

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3. Enterbacteriaceae." Available online at www.cdc.gov/hai/organisma/cre/cre-toolkit

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DEPARTMENT: Infection Prevention	APPROVED:	Page **1** of 1
SUBJECT: **On-Site Laundry Services**	EFFECTIVE DATE: **6/29/2023**	SUPERCEDES: **New**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to assure that laundry services provided on site are in compliance with applicable laws and standards. The Infection Preventionist is responsible for assuring this compliance.

Purpose:

To assure that laundry services provided on-site follow applicable laws and standards to reduce the risk of disease transmission to patients and staff.

DEFINITIONS:

On-Site Laundry Services: Laundry Services that are provided on-site in District facilities.

Contaminated Laundry: According to the Occupational Safety and Health Administration (OSHA), laundry that has been soiled with blood or other potentially infectious material (OPIM), or may contain sharps.

Soiled: A textile product that has been used or worn and soiled by perspiration, body oils, or one of the many other items to which it may have been exposed.

PROCEDURE:

1. Patient/Resident soiled or contaminated laundry, and other washable medical devices such as slings and gait belts, are laundered in-house by Environmental Services (EVS).
2. All items are bagged and tied closed at collection site, labeled with room and bed number if used with a specific patient, then transported to dirty utility room where they are placed in a linen barrel labeled patient belongings/slings and gait belts only.
3. Soiled or contaminated laundry will be handled with a minimum of agitation to prevent generating potentially contaminated lint aerosols in patient care areas.
4. EVS will pick up the blue linen bags and transport to laundry room on cart for further processing.
5. To protect from exposure to potentially infectious materials during collection, handling, and sorting of contaminated linens, EVS will follow standard precautions.
6. Personal protective equipment (PPE) including gown/apron, gloves, and face shield (if there is risk of splashing) will be worn and used when handling soiled or contaminated linens.
7. Hand hygiene will be performed before donning and doffing of PPE and when moving from dirty to clean areas.
8. Laundry will be handled as little as possible and with minimum agitation.
9. PPE used during handling of potentially infectious materials will be removed and discarded in a trash receptable and then hand hygiene performed before handling any clean linens.
10. Proper work practices will be used for containment, labeling, hazard communication, and ergonomics.

11. Each resident's personal laundry is to be washed and dried separately from other resident clothing, whenever possible.

12. At times, due to low volume, residents clothing items may be washed together but will be washed in hot water of at least 160 degrees F (71 degrees F) for a minimum of 25 minutes unless manufacturer recommendations state otherwise.

13. Normal laundry cycles are to be used in accordance with the washer and detergent manufacturer's recommendations.

14. Resident laundry and other washable medical devices will be laundered following Centers for Disease Control (CDC) and/or manufacturer recommendations.

    a. Use of hot water of at least 160 degrees F (71 degrees F) for a minimum of 25 minutes unless manufacturer recommendations state otherwise.

    b. Disinfectant is generally not needed when soiling is at low levels.

    c. Use of disinfectant will be on a case-by-case basis, depending on the origin of the soiled linen (e.g., linens from an area on contact precautions).

    d. Damp textiles will not be left in machines overnight.

15. Clean items are to be kept separate from dirty items.

16. Clean laundry will be transported to patient care areas on designated carts or within designated containers that is regularly, (e.g., at least once daily) cleaned with a neutral detergent and warm water solution.

17. Clean laundered washable medical devices will be placed in a clear plastic bag, tied closed with clean tag attached and hung in clean utility room.

18. All chemicals used in the laundry room will be properly labeled and meet the requirements of the Hazard Communication Standard from OSHA.

19. If any textiles become soiled during packaging and storage, they shall be reprocessed in accordance with previously stated processing guidelines.

REFERENCES:

Centers for Disease Control and Prevention (CDC) Guidelines for Environmental Infection Control in Healthcare Facilities (2003). Retrieved from https://www.cdc.gov/infectioncontrol/guidelines/environmental/index.html#g. Accessed May 1, 2023.

McLay, Carol, DrPH, BSN, RN, CIC, FAPIC, Healthcare Textile Services. In Chapel Hill, NC. APIC Text. (2005). Available at https://text.apic.org/toc/infection-prevention-for-support-services-and-the-care-environment/healthcare-textile-services. Accessed May 1, 2023.

Cal-OSHA Title 29 CCR § 51910.1200. Hazard Communication, Amended February 2013 Available at: https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1200. Accessed May 1, 2023.

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DEPARTMENT:	APPROVED:	Page **1** of **1**
Infection Prevention	**03/30/2023**	
SUBJECT:	**EFFECTIVE DATE:**	**SUPERCEDES:**
Outbreak Investigation and Management	**03/30/2023**	**01/25/2018**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide a system for the investigation and management of outbreaks of communicable disease *or* infectious conditions.

DEFINITIONS:

Communicable disease: an illness due to a specific infectious agent or its toxic products which arises through transmission of that agent or its products from an infected person, animal, or inanimate reservoir to a susceptible host, either directly or indirectly through an intermediate plant or animal host, vector, or the inanimate environment.

Outbreak: An increase over the expected occurrence of an event. In some cases, one incident (if it is a rare organism, for example) can be considered an outbreak.

REFERENCES:

N/A

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DEPARTMENT:	APPROVED:	Page **1** of **5**
Infection Prevention	**03/30/2023**	
SUBJECT:	**EFFECTIVE DATE:**	**SUPERCEDES:**
Pneumococcal Immunization of Adults	**03/30/2023**	**01/28/2018**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to assess the need for pneumococcal vaccination and to vaccinate adult patients and residents that meet screening criteria.

PURPOSE:

The purpose of this policy and procedure is to reduce morbidity and mortality from pneumococcal disease by providing District staff with current Advisory Committee on Immunization Practices (ACIP) recommendations for pneumococcal vaccine screening and administration for adults.

BACKGROUND:

Pneumonia caused by Streptococcus pneumoniae is a significant cause of morbidity and mortality worldwide. There are two vaccines targeted against S. pneumoniae: 23-valent pneumococcal polysaccharide vaccine (PPSV23) and 13-valent pneumococcal conjugate vaccine (PCV13). Until recently the recommendation for adult pneumonia vaccination was a single dose of PPSV23 for all adults 65 years and older. In late 2015, recommendations were expanded to include administration of both vaccines on separate dates, usually one year apart. In the presence of certain underlying medical conditions, the recommended interval is shorter.

PROCEDURE:

A. Assess adults for vaccination against Streptococcus pneumoniae (pneumococcus) infection according to the following criteria:

1. Routine pneumococcal vaccination

Assess adults age ≥65 years for need of pneumococcal vaccination. This includes all patients admitted to Acute, Swing, and SNF. Document this screening in the Admission Assessment.

Pneumococcal conjugate vaccine (PCV13) should be administered routinely to all previously unvaccinated adults age 65 years and older. Pneumococcal polysaccharide vaccine (PPSV23) is also recommended for all adults age 65 years or older. For complete details, see Table 3 on page 3.

2. Risk-based pneumococcal vaccination

Age 19 through 64 years with an underlying medical condition or other risk factor as described in Table 1 on page 2:

Table 1. Category of underlying medical condition or other risk factor	Recommended vaccines are marked "x" below		
	PCV13	PPSV23	PPSV23 booster*
Chronic heart disease,[1] chronic lung disease[2]		x	
Diabetes mellitus		x	
Chronic liver disease, cirrhosis		x	
Cigarette smoking		x	
Alcoholism		x	
Cochlear implant, cerebrospinal fluid leak	x	x	
Sickle cell disease, other hemoglobinopathy	x	x	x
Congenital or acquired asplenia	x	x	x
Congenital or acquired immunodeficiency,[3] HIV	x	x	x
Chronic renal failure, nephrotic syndrome	x	x	x
Leukemia, lymphoma	x	x	x
Generalized malignancy, Hodgkin disease	x	x	x
Iatrogenic immunosuppression[4]	x	x	x
Solid organ transplant, multiple myeloma	x	x	x

*a second dose 5 years after the first dose of PPSV23

1 Excluding hypertension

2 Including asthma

3 Including B- (humoral) or T-lymphocyte deficiency, complement deficiencies (particularly C1, C2, C3, and C4 deficiencies), and phagocytic disorders (excluding chronic granulomatous disease).

4 Diseases requiring treatment with immuno- suppressive drugs, including long-term systemic corticosteroids and radiation therapy

B. Screen for Contraindications and Precautions

Contraindications: Do not give pneumococcal vaccine (PCV13 or PPSV23) to a person who has experienced a serious systemic or anaphylactic reaction to a prior dose of the vaccine or to any of its components. For a list of vaccine components, refer to the manufacturer's package insert (www.immunize.org/packageinserts) or go to: www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf.

Precautions: Moderate or severe acute illness with or without fever.

C. Provide Vaccine Information Statements

Provide all patients with a copy of the most current federal Vaccine Information Statement (VIS). Provide non- English-speaking patients with a copy of the VIS in their native language if one is available and desired; these can be found at www.immunize.org/vis.

D. Prepare to Administer Vaccine

PCV13 must be given intramuscularly (IM). PPSV23 may be administered either IM or subcutaneously (SQ).

For vaccine that is to be administered IM, choose the needle gauge, needle length, and injection site according to the following chart:

Table 2. Gender and weight of patient	Needle gauge	Needle length	Injection site
Female or male less than 130	22–25	⅝"*–1"	Deltoid muscle of

lbs			arm
Female or male 130–152 lbs	22–25	1"	Deltoid muscle of arm
Female 153–200 lbs	22–25	1–1½"	Deltoid muscle of arm
Male 153–260 lbs	22–25	1–1½"	Deltoid muscle of arm
Female 200+ lbs	22–25	1½"	Deltoid muscle of arm
Male 260+ lbs	22–25	1½"	Deltoid muscle of arm

*A ⅝ inch needle may be used in patients weighing less than 130 lbs (<6 0 kg) for IM injection in the deltoid muscle only if the skin is stretched tight, the subcutaneous tissue is not bunched, and the injection is made at a 90° angle to the skin.

If you prefer SQ injection of PPSV23: choose a 23–25 gauge, ⅝ inch needle for injection into the fatty tissue overlying the triceps muscle.

E. Administer PCV13 or PPSV23, 0.5 mL, according to the following dosing information and schedule:

a. PCV13 must be administered by the IM route.
b. PPSV23 may be administered either IM or SQ.

Table 3*. Routine vaccination for all adults ages 65 years and older:*

Age of patient	**Vaccine(s) indicated** (see Table 1 on page 1)	**History of prior vaccination**	**Schedule for administration of PCV13 and PPSV23**
65 yrs or older	PPSV23 and 1-time dose of PCV13	None or unknown	Administer PCV13 followed in 1 year* by PPSV23.
		PPSV23 when younger than age 65 years; 0 or unknown PCV13	Administer PCV13 at least 1 year after previous PPSV23. Administer another PPSV23 at least 5 years after previous dose of PPSV23 and at least 1 year* after PCV13.
		PPSV23 when younger than age 65 years; PCV13	Administer another PPSV23 at least 5 years after previous dose of PPSV23 and at least 1 year* after previous dose of PCV13.
		PPSV23 when age 65 years or older; 0 or unknown PCV13	Administer PCV13 at least 1 year after PPSV23
		0 or unknown PPSV23; PCV13	Administer PPSV23 at least 1 year* after PCV13.

* For adults age 65 years and older with immunocompromising conditions, functional or anatomic asplenia, cerebrospinal fluid leaks, or cochlear implants, the interval between PCV13 and PPSV23 should be shortened to 8 weeks.

Table 4. *Risk-based vaccination for adults ages 19–64 years:*

Age of patient	**Vaccine(s) indicated** (see table on page 1)	**History of prior vaccination**	**Schedule for administration of PCV13 and PPSV23**
	For medical conditions in which only PPSV23 is indicated		
	1 dose PPSV23	None or unknown	Administer PPSV23.
	For medical conditions in which both PCV13 and PPSV23 (1 or 2 doses) are recommended		
		None or unknown	Administer PCV13 followed in 8 weeks by PPSV23.

19–64 years	1 dose PCV13 and 1 dose PPSV23 (i.e., cochlear implant; CSF leak)	0 or unknown PPSV23; 1 dose PCV13	Administer PPSV23 at least 8 weeks after PCV13.
		1 dose PPSV23; 0 or unknown PCV13	Administer PCV13 at least 1 year after PPSV23.
	1 dose PCV13 and 2 doses PPSV23 (e.g., immuno-compromised)	None or unknown	Administer PCV13 followed in 8 weeks by PPSV23 #1. Administer PPSV23 #2 at least 5 years after PPSV23 #1.
		1 dose PPSV23; 0 or unknown PCV13	Administer PCV13 at least 1 year after PPSV23 #1. Administer PPSV23 #2 at least 5 years after PPSV23 #1 and at least 8 weeks after PCV13.
		0 or unknown PPSV23; 1 dose PCV13	Administer PPSV23 #1 at least 8 weeks after PCV13. Administer PPSV23 #2 at least 5 years after PPSV23 #1.
		1 dose PPSV23; 1 dose PCV13	Administer PPSV23 #2 at least 5 years after PPSV23 #1 and at least 8 weeks after PCV13.
		2 doses PPSV23; 0 or unknown PCV13	Administer PCV13 at least 1 year after PPSV23 #2.

F. Documentation

Document each patient's vaccine administration information in the electronic medical record (EMAR). Documentation includes the date the vaccine was administered, the manufacturer, lot number, expiration date, vaccination site and route, and the name and title of the person administering the vaccine. By law, informed consent must be obtained prior to administering pneumococcal vaccine to a SNF resident, either from the resident (if competent) or his/her legal representative. Also document the vaccine administration information into the California Immunization Registry.

G. Be Prepared to Manage Medical Emergencies

1. About half of those vaccinated develop redness and pain at the injection site that resolves within 48 hours. Less than 1% develop fever, muscle aches, or severe local reactions.

2. Serious side effects have rarely been reported but, as with any drug, there is a possibility of allergic reaction. Have Epinephrine injection (1:1000) immediately available should an acute anaphylactic reaction occur.

3. For the Immunization Action Coalition (IAC) "Medical Management of Vaccine Reactions in Adults," go to www.immunize.org/catg.d/p3082.pdf.

4. To prevent syncope, vaccinate patients while they are seated or lying down.

H. Report All Adverse Events to VAERS

1. Report all adverse events following the administration of pneumococcal vaccine to the federal Vaccine Adverse Event Reporting System (VAERS) at www.vaers.hhs.gov. Forms are available on the website or by calling (800) 822-7967.

2. The nurse caring for the patient will enter a report in RL Solutions indicating a possible adverse reaction.

REFERENCES:

Kobayashi M, Bennett NM, Gierke R, Almendares O, Moore MR, Whitney CG, et al (2015). Intervals between PCV13 and PPSV23 vaccines: recommendations of the Advisory Committee on Immunization Practices

(ACIP). *MMWR*. 2015;64 (34):944-7. Retrieved from https://www.cdc.gov/mmwr/pdf/wk/mm6434.pdf#page=16

Standing orders for Administering Pneumococcal Vaccines (PCV13 and PPSV23) to Adults. Immunization Action Coalition, St. Paul, Minnesota (January 2017). Retrieved from http://www.immunize.org/catg.d/p3075.pdfReferences:

Kobayashi M, Bennett NM, Gierke R, Almendares O, Moore MR, Whitney CG, et al (2015). Intervals between PCV13 and PPSV23 vaccines: recommendations of the Advisory Committee on Immunization Practices (ACIP). *MMWR*. 2015;64 (34):944-7. Retrieved from https://www.cdc.gov/mmwr/pdf/wk/mm6434.pdf#page=16

Standing orders for Administering Pneumococcal Vaccines (PCV13 and PPSV23) to Adults. Immunization Action Coalition, St. Paul, Minnesota (January 2017). Retrieved from http://www.immunize.org/catg.d/p3075.pdf

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DEPARTMENT:	APPROVED:	Page **1** of **1**
Infection Prevention	**03/30/2023**	
SUBJECT:	**EFFECTIVE DATE:**	**SUPERCEDES:**
Pre-Hospital Emergency Personnel Exposures to Infectious Diseases	**03/30/2023**	**01/25/2018**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to adhere to both the federal and state requirements for notification of pre-hospital emergency personnel if it is determined that they have been exposed to certain infectious diseases.

DEFINITIONS:

Pre-hospital emergency medical care personnel: per California and federal law, these are mobile intensive care nurses (MICN), emergency medical technicians (EMT), paramedics, lifeguards, firefighters, peace officers, physicians, pre-hospital volunteers, and all others as delineated by law. Per federal law, these individuals are called "emergency response employees" (EREs).

REFERENCES:

California Health and Safety Code, Section 1797.188, amended 2017
California Code of Regulations, Title 17, Section 2500.
Ryan White Comprehensive AIDS Resource Emergency (CARE) Act
Code of Federal Regulations, 76, section 67742, November 2, 2011

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DEPARTMENT:	APPROVED:	Page **1** of **3**
Infection Prevention	**Date approved**	
SUBJECT:	**EFFECTIVE DATE:**	**SUPERCEDES:**
Prevention of C. difficile Transmission	**(Date policy is in effect)**	**07/26/2018**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "district") to use currently recommended, evidence-based practices to prevent the transmission of infections.

PURPOSE:

The purpose of this policy is to prevent the transmission of *C. difficile* within the facility.

Procedure:

Background:
Clostridioides difficile aka previously known as Clostridium difficile is a spore-forming, gram-positive anaerobic bacillus that produces two exotoxins: toxin A and toxin B. It is a common cause of antibiotic-associated diarrhea (AAD). Judicious and appropriate use of antibiotics is the best strategy for preventing *C. difficile* infections.

The risk for disease increases in patients with antibiotic exposure, proton pump inhibitors, gastrointestinal surgery/manipulation, long length of stay in healthcare settings, a serious underlying illness, immunocompromising conditions, and advanced age. Community onset cases usually occur within four weeks from discharge from a healthcare facility.

Diagnosis:

1. Clinical symptoms include watery diarrhea, fever, loss of appetite, nausea, abdominal pain/tenderness.
2. Specimen collection: When *C. difficile* is suspected, a stool specimen should be tested for C. diff Toxins A and B (do NOT order a stool culture).
    a. Collect 3-5 cc of liquid stool in a sterile container.
    b. The stool should be liquid enough to conform to the shape of the container. If stool is formed or semi-formed, it is not acceptable for testing.
    c. Label and place specimen in freezer until lab personnel can process it.

NOTE: *Clostridioides difficile* toxin is very unstable. The toxin degrades at room temperature and may be undetectable within 2 hours after collection of a stool specimen. False-negative results occur when specimens are not promptly tested or kept cold until testing can be done.

Transmission:
The major reservoir for *C. difficile* is infected humans and contaminated, inanimate objects. Transmission is by the fecal-oral route. The organism is ingested either as a vegetative form or as spores.

Since it is shed in feces, any surface, device, or material (e.g., bedside commodes, bedpans, and toilets; electronic rectal thermometers; bedside table/stands; bed rails; linens) that becomes contaminated with feces may serve as a reservoir for the *C. difficile* spores. *C. difficile* spores are transferred to patients mainly via the hands of healthcare personnel who have touched a contaminated surface or item.

Organisms in the vegetative state die rapidly within 24 hours. However, in their spore state, they are highly resistant to disinfection and can survive for many months on surfaces.

Treatment:

In about 20% of patients, Clostridioides difficile infection will resolve within 2-3 days of discontinuing the antibiotic to which the patient was previously exposed. The infection can usually be treated with an appropriate course (about 10 days) of antibiotics.

Patient placement and contact precautions:

1. Place suspected or confirmed patients in private rooms. If private rooms are not available, two patients with C. difficile can be placed in a room together (cohorted) as long as neither patient has another infectious organism present.
2. Use Full Contact Precautions (see Transmission-Based Precautions policy)
    a. Place isolation cart outside patient door
    b. Post the following:
        - "Full Contact Precautions" sign
        - "Wash with Soap and Water Before Leaving Room" sign
        - "Clean surfaces with [*name of currently approved disinfectant*]" sign
        - For privacy purposes, do not post any signage with the patient's diagnosis (C. difficile)
    c. Don gown and gloves prior to entering room; remove when leaving
    d. Dedicate equipment to patient whenever possible (thermometer, BP cuff, stethoscope, etc.)
        - Leave in the room
        - Disinfect with appropriate product before returning item to the isolation cart or the utility room
    e. Unused patient supplies must be discarded after contact precautions are discontinued

3. Nursing is to notify Environmental Services (EVS) whenever a patient or resident is placed on contact precautions for *C. difficile*.
    a. EVS personnel will adhere to Full Contact Precautions during room cleaning, including wearing full PPE and performing hand hygiene with soap and water prior to leaving room.
    b. A thorough terminal room cleaning must be performed after discontinuation of contact precautions or patient discharge
        - Privacy curtains must be laundered
        - The approved cleaning product will be used to clean environmental surfaces and allowed to remain wet for the manufacturer's recommended contact time.

4. After patient care or contact with the environment, remove gloves, and perform hand hygiene with soap and water
    a. Because alcohol does not kill *Clostridioides difficile* spores, use of soap and water is more efficacious than alcohol-based hand rubs.

5. Continue these precautions until diarrhea has been resolved for at least 48 hours or until discharge. Because *Clostridioides difficile* infected patients may continue to be colonized for prolonged periods following resolution of the acute infection, do not collect another stool specimen as a test of cure.

Cleaning of environment and medical equipment:

1. EVS personnel will do routine cleaning of patient rooms daily, with emphasis on high touch environmental surfaces. The approved cleaning product will be used and allowed to remain wet for the manufacturer's recommended contact time.
2. Nursing staff will be responsible for the cleaning and disinfection of reusable devices/medical equipment.

REFERENCES:

Dubberke, E. Carling, P., Carrico, R. et al. Strategies to Prevent *Clostridium difficile* Infections in Acute Care Hospitals: 2014 Update—Society for Healthcare Epidemiology of America; accessed at https://www.jstor.org/stable/10.1086/676023

Carrico, R., et al. Guide to Preventing Clostridium difficile Infections: APIC Implementation Guide; 2013. The Association for Professionals in Infection Control and Epidemiology. Accessed at https://apic.org/wp-content/uploads/2019/02/2013CDiffFinal.pdf

REVIEWED BY:

Administrative Team

Medical Staff

Governing Board

DEPARTMENT:	APPROVED:	Page **1** of 1
Infection Prevention	**Date approved**	
SUBJECT:	**EFFECTIVE DATE:**	**SUPERCEDES:**
Prevention of Healthcare Associated Infections	**(Date policy is in effect)**	**03/28/2019**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to comply with legislation requiring general acute care hospitals to implement certain processes aimed at reducing the incidence of healthcare associated infections.

Purpose:

The purpose of this policy and procedure is to delineate the policies and procedures at the district that are designed to reduce the incidence of healthcare associated infections (HCAIS).

DEFINITIONS:

Healthcare associated infections: Infections that patients get while receiving medical or surgical treatment, or from being in contact with healthcare services.

PROCEDURE:

A. MRSA Screening for new admissions

1. It is District policy that all patients who are admitted to the acute, swing, or skilled Nursing units will be tested for methicillin-resistant Staphylococcus aureus (MRSA), within 24 hours of admission. See "Specimen Collection for Microbial Testing" policy for screening instructions.

2. If the patient has an open wound, known or suspected to be infected with MRSA (or other multidrug resistant organism), the wound must also be cultured (using a blue top tube) and the patient placed in on CONTACT PRECAUTIONS until this culture result is returned. These precautions may be discontinued if the culture is not positive for MRSA or other multidrug resistant organism (MDRO). If the wound is positive, precautions must be continued during the patient's inpatient stay until the infection has resolved.

3. When a patient tests positive for MRSA, the attending physician will inform the patient or the patient's representative immediately, or as soon as practically possible. This shall be documented by Nursing staff in the medical record.

4. Prior to discharge, the hospital will provide both written and verbal instructions to patients that tested positive for MRSA regarding aftercare and precautions to prevent the spread of infection to others. The patient will be given a copy of the MRSA patient education material located in the Exit Care module. MRSA education must be documented on the Medication Reconciliation form.

B. Education procedure for known or suspected MRSA positive patients

1. All inpatients that receive MRSA testing will have this explained to them to the extent they are able to comprehend the information. Whenever possible, the family will be part of the discussion. This is especially necessary if the patient is being required to be on Contact Precautions until the cultures are returned. Isolation procedures are very anxiety-producing for both patients and families.

C. Environmental procedures to reduce health care associated infections

1. EVS: Regular disinfection of all restrooms, countertops, furniture, televisions, telephones, bedding, office equipment, and surfaces in patient rooms, nursing stations and storage units.

2. Nursing staff: Regular removal of accumulations of body fluid and intravenous substances and cleaning and disinfection of all movable medical equipment, including point-of-care testing devices such as glucometers, and transportable medical devices.

3. EVS: Regular cleaning and disinfection of all surfaces in common areas in the facility such as meeting rooms, waiting rooms, and lounges.

4. Environmental services staff are trained by the hospital and shall be observed for compliance with hospital sanitation measures. The training will begin at the start of employment, when new prevention measures have been adopted, and annually thereafter.

D. Infection Control Surveillance and Performance Improvement Program

1. The District shall provide for an individual with specialized education in infection surveillance, prevention, and control to manage an infection prevention program.

2. The District shall provide for a physician to be designated as the hospital epidemiologist. He/she must have participated in a continuing medical education program offered by CDC, SHEA, or any other recognized professional organization. Documentation of education is in the physician's credentialing file. The physician, the infection preventionist, and the Medical Staff will work together to meet the goals of the infection prevention program.

3. The program shall focus on methods to identify and reduce the risk of acquiring and transmitting infections among patients and their families, employees, and physicians. Education of staff, contract physicians, and other licensed independent contractors is conducted in methods to prevent transmission of HAIs, including MRSA and C. difficile.

4. Employee training includes topics of hand hygiene, facility specific isolation procedures, patient hygiene, and environmental sanitation procedures. This education is conducted annually.

5. The program includes responsibility for assuring adherence to evidence-based policies and procedures in the areas of inpatient and outpatient care, sterilization and disinfection, hazardous waste management, orientation and education, environmental services, policies and procedures, traffic control, product selection, integration of new services and/or personnel, applicable laws, Public Health Department, medication use, nutrition services, laundry and linen services, and engineering, particularly during renovation and/or construction.

E. Quarterly Reporting of HAI

1. As required by law, the Infection Preventionist will report all cases of catheter associated urinary tract infections (CAUTI), MRSA bloodstream infections (both community and healthcare associated), central line associated bloodstream infections, clostridium difficile infections (both community and healthcare associated) and Vancomycin-resistant enterococcal bloodstream infections (both community and healthcare associated), by the number of patient days quarterly. Reporting to the California Department of Public Health and the Centers for Medicare and Medicaid (CMS) will be done via the National Healthcare Safety Network (NHSN) web-based reporting system.

2. In addition, quarterly reports of hospital associated pneumonia, skin and soft tissue infection, influenza, and urinary tract infections will be reported internally at the Medical Staff meeting.

REFERENCES:

Association of Professionals in Infection Control (APIC). Elimination Guide: MRSA Transmission in Hospital Settings, California Supplement (2009). Retrieved from https://apic.org/Resource_/EliminationGuideForm/16c7a44f-55fe-4c7b-819a-b9c5907eca72/File/APIC-MRSA-California.pdf

Centers for Disease Control and Prevention (CDC) Guidelines for Disinfection and Sterilization in Healthcare Facilities (2008). Retrieved from https://www.cdc.gov/infectioncontrol/pdf/guidelines/disinfection-guidelines.pdf

Centers for Disease Control and Prevention (CDC), 2007. Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. Retrieved from https://www.cdc.gov/infectioncontrol/pdf/guidelines/isolation-guidelines.pdf

Centers for Disease Control and Prevention (CDC), (2006). Management of Multidrug-Resistant Organisms in Healthcare Settings. Retrieved from https://www.cdc.gov/mrsa/pdf/mdroguideline2006.pdf

State of California, Senate Bill 739, Chapter 526, (2006). Retrieved from http://www.dhcs.ca.gov/provgovpart/initiatives/nqi/Documents/SB739.pdf
State of California, Senate Bill 1058, Chapter 296, (2008). Retrieved from http://med.stanford.edu/shs/update/archives/DEC2008/1_sb1058.pdf

State of California, Senate Bill 158, Chapter 294, (2008). Retrieved from http://www.leginfo.ca.gov/pub/07-08/bill/sen/sb_0151-0200/sb_158_bill_20080925_chaptered.pdf

REVIEWED BY:

Administrative Team

Medical Staff

Governing Board

DEPARTMENT:	APPROVED:	Page **1** of **1**
Infection Prevention	**03/30/2023**	
SUBJECT:	**EFFECTIVE DATE:**	**SUPERCEDES:**
Purewick Female External Catheter	**03/30/2023**	**01/27/2022**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD" or "District") to implement practices that reduce the risk of healthcare-associated infections (HAI's) as much as possible.

DEFINITIONS:

N/A

REFERENCES:

N/A

REVIEWED BY:

Administrative Team

Medical Staff

Governing Board

DEPARTMENT:	APPROVED:	Page **1** of **2**
Infection Prevention	**03/30/2023**	
SUBJECT:	**EFFECTIVE DATE:**	**SUPERCEDES:**
Rabies Prophylaxis	**03/30/2023**	**01/25/2018**

POLICY:

POLICY:
It is the policy of Southern Humboldt Community Healthcare District to provide rabies prophylaxis, as appropriate, based on current guidelines from the Advisory Committee on Immunization Practices (ACIP).

BACKGROUND INFORMATION:
As a rural county, residents have frequent contact experiences with wild animals. All mammals can become infected with rabies, but in Humboldt the disease is seen most commonly in the skunk, the bat, and the fox. The rabies virus is transmitted through the infected animal's saliva or brain/nervous system tissue. One can only contract rabies by coming in contact with these specific bodily excretions and tissues. Exposure occurs when the virus is introduced via a bite wound, open cuts in skin, or onto mucous membranes such as the mouth or eyes. Incubation generally varies from one week to one year, but typically is one to three months, dependent upon factors such as the location of virus entry and viral load. Because the frequency and type of local rabies activity varies, consultation with a public health official given current conditions.

It's important to remember that rabies is a medical urgency but not an emergency. There are two important instances, when, after consideration of the exposure, delay might be recommended by Public Health:

a) If the biting animal can be located and its brain tested, post exposure prophylaxis (Post-EP) could potentially be delayed a few days for the results.
   - For testing guidance contact **Environmental Health at 707-445-6215**.
   - After hours and weekends, call the **Health Officer via the Sheriff at 707-445-7251**

b) A rabid cat, dog, or ferret will die within 10 days of symptom onset. If the rabies risk came from the bite of a cat, dog or ferret, and that animal can be observed to survive a 10-day quarantine, rabies exposure can be ruled out.

DEFINITIONS:

Rabies is a preventable viral disease most often transmitted through the bite of a rabid animal. The rabies virus infects the central nervous system of mammals, ultimately causing disease in the brain and death. The vast majority of rabies cases reported to the Centers for Disease Control and Prevention (CDC) each year occur in wild animals like bats, raccoons, skunks, and foxes, although any mammal can get rabies.

References:

Center for Disease Control (CDC) (2020.) What is Rabies. Retrieved from: https://www.cdc.gov/rabies/about.html

Center for Disease Control (CDC) (2014.) Rabies Vaccine. Retrieved at: https://www.cdc.gov/rabies/medical_care/vaccine.html.

Humboldt County Public Health Guidance 2017 (attachment A) and Algorithm (attachment B)

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Administrative Team

Medical Staff

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DEPARTMENT: ***Safety and Emergency Preparedness***	**APPROVED:** ***03/30/2023***	Page **1** of **4**
SUBJECT: ***Infectious Disease Respiratory Outbreak***	**EFFECTIVE DATE:** ***03/30/2023***	**SUPERCEDES:** ***New***
POLICY: ***Emergency Preparedness Plan: Respiratory Pandemics including Seasonal/Regional Surges***		

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to establish and maintain an emergency preparedness/disaster plan for infectious disease disasters including pandemics and/or seasonal/regional surges in coronavirus disease (COVID-19)/influenza or other potentially infectious respiratory diseases.

DEFINITIONS:

Coronavirus Disease: Infectious disease caused by the SARS-Cov-2 virus.

Outbreak: sudden rise in the number of cases of a disease. An outbreak may occur in a community or geographical area or may affect several countries.

Pandemic: A global outbreak of disease in humans that affects at least two continents and/or exceeds expected rates of morbidity and mortality.

PROCEDURE:

1. In the event of a pandemic or widespread COVID-19/influenza activity in the community, or other potentially infectious respiratory activity, the Chief Nursing Officer or Infection Preventionist will be in contact with the Humboldt County Public Health Department.

2. The District will implement their infection prevention and control recommendations.

3. All health care personnel (HCP) and visitors will follow current California Department of Public Health (CDPH) and Center for Disease Control (CDC) masking guidelines.

4. Notify visitors of current guidelines via posted notices.

5. Evaluate healthcare personnel for symptoms or respiratory infection; perform rapid covid or influenza to confirm the causative agent and remove from duties as appropriate. If excluded from duties, they should not return to work until they have been cleared by Infection Prevention and have met criteria to return to work.

6. Visitors under the age of 16 will not be permitted in the hospital unless they are the parent of a hospitalized patient or if significant compelling circumstances exist. Such circumstances will be determined by the patient's physician, the nursing unit manager, and Infection Prevention.

7. All potential visitors will need to complete a screening interview conducted by designated staff stationed at the hospital entrances and/or the acute/SNF Nursing station. All visitors must wear a hospital visitor badge while visiting.

8. Visiting hours will be strictly enforced and may be modified or terminated at any time.

9. Visits will be controlled to allow for appropriate screening for acute respiratory illness before entering the hospital and appropriate instruction on use of personal protective equipment (PPE) and other precautions (e.g., masks, hand hygiene, limiting surfaces touched) while in the patient's room. Visitors will be instructed to limit their movement within the facility.

10. For patients in isolation for SARS-CoV-2 or influenza infection, visitors will be limited to persons who are necessary for the patient's emotional well-being and care.

11. All other hospitalized patients will be allowed only one visitor at a time at the discretion of the department manager.

12. Patients coming to the Emergency Department (ED) with a cough and/or fever will be asked to put on a mask and triaged outside or in COVID surge tent prior to entry to the hospital, if available. If positive for either, patient will be cared for in tent, whenever possible, until disposition of patient.

    - If patient is critically ill and requires care in the ED, patient will be placed in ED bed 1. Any patient in ED bed 2 will be moved to ED bed 3 or 4 when possible. The door will be closed between the rooms. Appropriate signage will be hung outside the ED and the entrance to the room indicating full PPE required for entry and for all staff caring for the patient. Transfer process will begin as soon as possible for higher level of care.

A. Control of SARS-CoV-2/or Influenza Viral Outbreaks

When an outbreak occurs in the healthcare facility, the following measures may be taken to limit transmission:

1. Perform rapid SARS-CoV-2 or influenza viral testing of patients and personnel with recent onset of symptoms suggestive of infection with COVID-19 or influenza. In addition, for influenza, obtain viral cultures from a subset of patients to determine the infecting virus type and subtype and to confirm the results of rapid tests since most rapid tests are less sensitive than cultures. Coordinate collection and pick up of specimens for viral culture with the Humboldt County Public Health lab.
    - Test for other respiratory viruses when there is a cluster of respiratory infections in the facility and influenza and SARS-CoV-2 tests are negative.

2. Implement droplet and airborne isolation precautions for all patients/residents with suspected or confirmed COVID-19 or influenza.

3. Separate suspected or confirmed positive patients/residents from asymptomatic patients. The patient/resident will be placed in designated isolation area (room 101, 102, or COVID tent), doors will remain shut and appropriate signage illustrating PPE required and measures needed for HCP to take when entering and exiting the patient room. For those requiring a higher level of care, transfer process will be started.

    - For any patient/resident undergoing aerosol generating procedures (APG's) CalOSHA Aerosol Transmissible Disease standards will be followed which requires use of a N95 or higher level of respiratory protection.
    - Eye protection and N95 respirators or PAPRs are required when caring for COVID 19 patients.

4. Restrict staff movement from areas of the facility having outbreaks.

5. Administer the SARS-CoV-2 vaccine or boosters and/or the current season's influenza vaccine as appropriate to unvaccinated patients/residents and healthcare personnel. Follow current vaccination recommendations for the use of vaccines.

6. Administer COVID-19 therapeutics or influenza antiviral prophylaxis and treatment to patients/residents and healthcare personnel according to current recommendations.

7. Consider SARS-CoV-2 therapeutics or influenza antiviral prophylaxis for all healthcare personnel, regardless of their vaccination status.

8. In the presence of co-infection, antiviral agents active against influenza and against SARS-CoV-2 may be administered concomitantly.

9. Curtail or eliminate elective medical admissions during outbreaks, especially those characterized by high attack rates and severe illness, in the community or acute-care facility.

10. Consult with Humboldt County Public Health for additional guidance.

B. Emergency Staffing Contingency Plans:

1. If additional staff are needed to care for a surge of SARS-CoV-2 positive patients/residents, emergency staffing contingency plans will be followed.

2. The District will partner with the local Medical Health Operational Area Coordinator (MHOAC) through the County Emergency Operations Center (EOC); as a first line for staffing contingency plans.

3. The District maintains a contract with one staffing agency that has the ability to offer 'rapid response" or "crisis" staff placements with Medical Solutions. Medical Solutions Contact number cell phone (858) 946-3909.

4. Additional resources include local California Health Corps and state/federal asset "teams", Disaster Healthcare Volunteers; California Medical Assistant Teams (CalMats). The facility would work through the local MHOAC and the EOC for such placements; Humboldt County DHHS Public Health, 529 I Street, Eureka, CA. 95501; Emergency Preparedness Program Coordinator can be contacted at (707) 353-5408.

    - Additional way to reach the local Emergency Medical Services Authority (EMSA) is through Humboldt County Emergency Medical Services; Main Phone Number: (916) **322-4336** https://emsa.ca.gov/disaster-healthcare-volunteers/

REFERENCES:

APIC Text of Infection Control and Epidemiology. (2020). Washington, D.C.: Association for Professionals in Infection Control and Epidemiology.

CDPH AFL 23-12 Covid-19 Recommendations for PPE, Resident Placement/Movement, and Staffing in SNFs.

CDPH AFL 22.07.1 Guidance for Limiting the Transmission of COVID-19 in SNF's.

CDPH AFL 22-31 Movement of Patients/Residents in the Healthcare Continuum During Seasonal Surges and the Coronavirus Disease 2019 (COVID-19) Pandemic

REVIEWED BY:

Infection Prevention

Safety Committee

Medical Staff

Governing Board

DEPARTMENT:	APPROVED:	Page **1** of **1**
Infection Prevention	**03/30/2023**	
SUBJECT:	**EFFECTIVE DATE:**	**SUPERCEDES:**
Safe Injection Practices	**03/30/2023**	**01/25/2018**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to ensure that all members of the healthcare team comply with current recommendations from the Centers for Disease Control and Prevention (CDC) and the Association of Professionals in Infection Control (APIC) regarding safe injection practices.

DEFINITIONS:

N/A

REFERENCES:

Centers for Disease Control and Prevention (2007). 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. Retrieved from https://www.cdc.gov/infectioncontrol/pdf/guidelines/isolation-guidelines.pdf.

Centers for Disease Control and Prevention. One and Only Campaign. Retrieved from http://oneandonlycampaign.org/safe_injection_practices. Accessed December 14, 2017.

The Association for Professionals in Infection Control and Epidemiology (APIC), 2016. APIC Position Paper: Safe Injection, Infusion, and Medication Vial Practices in Health Care (2016). Retrieved from https://www.apic.org/Resource_/TinyMceFileManager/Position_Statements/2016APICSIPPositionPaper.pdf.

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Administrative Team

Medical Staff

Governing Board

DEPARTMENT:	APPROVED:	Page **1** of **3**
Infection Prevention	**Date approved**	
SUBJECT:	**EFFECTIVE DATE:**	**SUPERCEDES:**
Standard Precautions	**(Date policy is in effect)**	**01/25/2018**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to follow the guidelines for standard and transmission-based precautions as set forth by the Occupational Safety and Health Administration (OSHA) and the Healthcare Infection Control Practices Advisory Committee (HICPAC).

PURPOSE:

The purpose of this policy and procedure is to prevent the transmission of infectious agents in the healthcare facility.

BACKGROUND:

Standard Precautions are the foundation for preventing the transmission of microorganisms in healthcare settings. These guidelines were introduced in 1991 with the issuance of the Occupational Safety and Health Administration (OSHA) Blood Borne Pathogen Standard. They address the potential for transmission of infection through unprotected contact with patients' blood and body fluids or from contact with their mucous membranes or non-intact skin. Transmission of infection requires a source of infection, a mode of transmission, and a vulnerable host. Application of Standard Precautions is intended to break the cycle and prevent the transmission of microorganisms between healthcare personnel (HCP), patients, and the environment.

The effectiveness of Standard Precautions depends on the adherence of HCP to all of its key components: hand hygiene, appropriate use of personal protective equipment, disinfection of surfaces and equipment, safe injection practices, Respiratory Hygiene/Cough Etiquette, and appropriate patient placement.

PROCEDURE:

A. Standard Precautions are utilized for the care of all patients, in all healthcare settings, at all times, even in the absence of a suspected or confirmed infectious process.
   a. The basic concept of Standard Precautions is to treat all patients' blood or body fluids as if they are infectious material.

B. The application of Standard Precautions is determined by the nature of the patient interaction and the extent of anticipated exposure to blood, body fluid, or pathogen exposure, during the care of all patients.

C. All key components of Standard Precautions must be followed to break the cycle of microorganism transmission:

1. **Hand Hygiene**
   a. Hand hygiene is the single most important measure to reduce the risk of transmitting microorganisms
   b. Refer to the Hand Hygiene Policy and Procedure

2. **Appropriate use of Personal Protective Equipment (PPE)**
   a. PPE is designed to protect the wearer's skin, eyes, mucous membranes, airways, and clothing from coming into contact with infectious agents. The selection of PPE is made based on the tasks being performed and anticipated level of exposure the employee expects to encounter.

   b. Fluid-resistant gowns worn when HCP anticipate performing patient care activities or procedures in which exposed skin or clothing are likely to be exposed to any patient blood, body fluids, secretions, or excretions.
   c. Gloves: worn when HCP anticipate touching the mucous membranes or non-intact skin of a patient or any patient blood, body fluids, secretions, or excretions.
      i. Gloves should also be worn when handling or touching equipment or environmental surfaces that have been contaminated.
      ii. Hand hygiene should always be practiced immediately when gloves are removed.

3. Barrier masks or barrier masks with shields: worn when HCP anticipate sprays of blood or body fluids, particularly respiratory secretions. HCP, patients, or visitors in healthcare settings also wear barrier masks to limit the spread of potentially infectious respiratory secretions.

4. Surgical masks: worn by HCP to protect the patient from infectious agents in the HCP's nose or mouth during sterile procedures such as insertion of catheters or injections into spinal or epidural spaces during lumbar puncture procedures.

5. Goggles/face shields: worn by HCP to protect the eyes and face of the wearer from sprays of respiratory secretions, blood, or body fluids. They should be worn when the HCP anticipate participating in a procedure that has the potential to generate splashes or sprays of blood, body fluids, secretions, or excretions. Personal eyeglasses or contact lenses do not provide adequate protection and are not considered acceptable eye protection. The use of face shields allows HCP to wear their own personal eyeglasses and increase protection to other areas of the face, including the eyes.

6. **Disinfecting Surfaces and Equipment** between patient uses
   a. All patient care items used for multiple patient contacts must be disinfected between uses
   b. Clean and disinfect surfaces that are likely to be contaminated with pathogens, including those that are in close proximity to the patient.
   c. Refer to the Cleaning and Repair of Patient Equipment Policy and Procedure.

7. **Safe Injection Practices**
   a. HCP should always use a sterile, single-use disposable syringe and needle for each injection given.
   b. Care needs to be taken to ensure that all injection equipment and medication vials remain free from contamination.
   c. Refer to Safe Injection practices Policy and Procedure.

8. **Respiratory Hygiene/Cough Etiquette**
   a. Measures that are put into place to contain respiratory secretions in patients and accompanying individuals who have signs and symptoms of a respiratory infection.
   b. Refer to the Respiratory Hygiene/Cough Etiquette Policy and Procedure.

9. **Patient Placement**
   a. The potential for transmission of infectious agents must be included in patient placement decisions.
   b. Refer to the Guidelines for Patient Placement Policy and Procedure

Related policies:
- Hand Hygiene
- Cleaning and Repair of Patient Equipment
- Safe Injection Practices
- Respiratory Hygiene/Cough Etiquette
- Guidelines for Patient Placement
- Bloodborne Pathogen Exposure Control Plan

REFERENCES:

Boyce JM, Pittet D; Healthcare Infection Control Practices Advisory Committee; HICPAC/SHEA/APIC/IDSA. Hand Hygiene Task Force. Guideline for hand hygiene in health-care settings: Recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force. MMWR Recomm Rep 2002;51(RR-16):1-45.

Centers for Disease Control and Prevention (CDC). Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008. CDC Website. 2008. Retrieved from: http://www.cdc.gov/hicpac/pdf/guidelines/Disinfection_Nov_2008.pdf.

Dolan SA, Felizardo G, Barnes S, et al. APIC position paper: Safe injection, infusion, and medication vial practices in healthcare. *Am J Infect Control* 010;38:167-172.

Occupational Safety & Health Administration (OSHA). Bloodborne Pathogen Standard. OSHA Website. 2013. Retrieved from: https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051#1910.1030(d)(1).

Siegel J, Rhinehart E, Jackson M and the Healthcare Infection Control Practices Advisory Committee (HICPAC). 2007 Guideline for Isolation Precautions: preventing transmission of infectious agents in healthcare settings. Centers for Disease Control and Prevention Website. 2007. Retrieved from: http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf.

REVIEWED BY:

Administrative Team

Medical Staff

Governing Board

SoHum Health

DEPARTMENT: Infection Prevention	APPROVED: Date approved	Page **1** of **3**
SUBJECT: **Tetanus, Diphtheria, Pertussis (Tdap) Immunization in the Emergency Department**	**EFFECTIVE DATE:** **08/15/2022**	**SUPERCEDES:** **01/28/2021**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to offer vaccines in accordance with the guidelines of the Centers for Disease Control and Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP).

BACKGROUND:

Tetanus infection is a disease of the nervous system caused by the bacteria clostridium tetani. C. tetani spores live in the soil and enter the body through open wounds. Tetanus vaccine confers disease immunity that lasts for approximately 10 years.

Diphtheria is an acute infectious respiratory infection caused by Corynebacterium diphtheriae. It causes a thick coating to develop at the back of the throat that may obstruct breathing.

Pertussis is a droplet borne respiratory infection caused by the bacterium Bordetella pertussis. The illness is characterized by paroxysms of cough followed by a high pitched "whoop" and sometimes vomiting. It can affect persons of all ages, but infants too young to be fully immunized are at highest risk of serious illness and death. Pertussis incidence has been on the increase in adults due to waning immunity from childhood vaccination.

The vaccines: In 2005, a new vaccine offering protection against Diphtheria, Pertussis, and Tetanus was introduced containing tetanus, reduced diphtheria toxoid, and acellular pertussis vaccine (Tdap). The same year, the ACIP and CDC recommended routine vaccination for teens and adults, especially if they have contact with infants under 12 months old. In 2011, the CDC expanded its recommendations to include pregnant women in their third trimester to prevent pertussis transmission to their infants. Infants are very susceptible to pertussis and more likely than older children or adults to die if they become infected. Hispanic infants and those less than 37 weeks gestation may be at particularly high risk for death.

Two Tdap vaccines are available in the United States. Boostrix (GlaxoSmithKline Biologicals, Rixensart, Belgium) is licensed for use in persons aged 10 through 64 years, and Adacel (Sanofi Pasteur, Toronto, Canada) is licensed for use in persons aged 11 through 64 years.

PROCEDURE:

A. Obtain a patient history, determining if there are any contraindications, including:
1. Previous vaccination with Tdap (unless pregnant (see "Recommendations" above).
2. Serious or life-threatening allergic reactions following these vaccines.
3. Guillain-Barré syndrome (patient should consult with their personal medical provider)
4. History of coma or long repeated seizures within 7 days after previous vaccination with DTP, DTaP, or Tdap.

B. If patient is a candidate for Tdap vaccination:
1. Provide patient with the most recent *Vaccine Information Sheet* (VIS sheet) –

"What You Need to Know: Tetanus, Diphtheria Pertussis (Tdap)" from the CDC.
2. Obtain signed consent.
3. Administer Tdap 0.5 ml, IM x1 in deltoid
4. Complete the "Vaccine Administration Record"
5. Document the vaccine lot number, manufacturer, injection site, VIS date
    a) Have the patient and witness sign the form
    b) Person who administered vaccine signs form and documents date and time of administration
6. Complete a vaccination record for parent or guardian, if appropriate.
7. Document the vaccine in the patient's electronic medical record and in the California Immunization Registry (CAIR).

C. Review common and potentially serious side effects with patient or guardian, including:
1. Pain, redness or swelling at the injection site.
2. Mild fever of 100.4.
3. Headache, tiredness, mild flu like symptoms.
4. Encourage the patient to notify their provider for a high fever, unusual behavior or severe pain at the injection site.

D. Be prepared for the possibility of a vaccine reaction during the visit:
1. Severe reactions are rare, estimated at fewer than 1 in a million doses. However, have Epinephrine injection (1:1000) immediately available should an acute anaphylactic reaction occur.
2. For the Immunization Action Coalition (IAC) "Medical Management of Vaccine Reactions in Adults," go to www.immunize.org/catg.d/p3082.pdf.
3. To prevent syncope, vaccinate patients while they are seated or lying down and consider observing them for 15 minutes after receipt of the vaccine.

Follow up:

A. Patients who experience any adverse reactions to vaccines should report those to their provider.

B. If a patient comes to the facility with suspected adverse reaction to an immunization, a report will be completed with the "Vaccine Adverse Event Reporting System" (VAERS). Forms are available on the website (www.vaers.hhs.gov) or by calling (800) 822-7967.

C. The nurse caring for the patient will enter a report in RL Solutions indicating a possible adverse reaction.

Dosage Considerations:

1. Tdap is only for children 7 years and older, adolescents, and adults.
2. **Adolescents** should receive a single dose of Tdap, preferably at age 11 or 12 years.
3. **Pregnant people** should get a dose of Tdap during every pregnancy between 27 and 36 weeks, to help protect the newborn from pertussis. Infants are most at risk for severe, life-threatening complications from pertussis.
4. **Adults** who have never received Tdap should get a dose of Tdap.
5. Also, **adults should receive a booster dose of either Tdap or Td** (a different vaccine that protects against tetanus and diphtheria but not pertussis) **every 10 years**, or after 5 years in the case of a severe or dirty wound or burn.

Contraindications:

Tdap booster vaccine is *contraindicated*:
1. In those with history of serious allergic reaction (anaphylaxis) to any component of the vaccine. See manufacturer's insert for list of vaccine components.
2. In those with history of coma or prolonged seizures within 7 days of receiving a vaccine with the pertussis component. In this situation, give Td instead of Tdap.

Seek Medical consultation if history of:

1. Seizures or other nervous system problem such as encephalopathy
2. Severe pain or swelling after any vaccine containing diphtheria, tetanus, or pertussis
3. Guillain Barré Syndrome (GBS)

Simultaneous vaccination of Tdap with MMR and Influenza vaccine is safe.

Currently, Tdap is licensed only for a single dose across all age groups.

DEFINITIONS:

N/A

REFERENCES:

Centers for Disease Control and Prevention. (2021, August 6). *Vaccine information statement*. Centers for Disease Control and Prevention. Retrieved August 19, 2022, from https://www.cdc.gov/vaccines/hcp/vis/vis-statements/tdap.html.

Centers for Disease Control and Prevention. (2020, January 22). *Diphtheria, tetanus, and pertussis vaccine recommendations*. Centers for Disease Control and Prevention. Retrieved August 19, 2022, from https://www.cdc.gov/vaccines/vpd/dtap-tdap-td/hcp/recommendations.html.

Vaccine information statements. Tdap - Tetanus, Diphtheria, Pertussis - Vaccine Information Statement. (n.d.). Retrieved August 19, 2022, from https://www.immunize.org/vis/vis_tdap.asp.

REVIEWED BY:

Administrative Team

Medical Staff

Governing Board

DEPARTMENT: Infection Prevention	APPROVED: 03/30/2023	Page **1** of **1**
SUBJECT: **Transmission-Based (Isolation) Precautions**	EFFECTIVE DATE: 03/30/2023	SUPERCEDES: 01/25/2018

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to institute Transmission-Based Precautions in addition to Standard Precautions for patients with documented or suspected infection or colonization with highly transmissible or epidemiologically important pathogens for which additional precautions are needed to prevent transmission.

DEFINITIONS:

N/A

REFERENCES:

Barrends, C. (2014). Isolation precautions (transmission-based precautions). APIC Text of Infection Control and Epidemiology. Available on-line by subscription at www.apic.org.

California Code of Regulations, Title 8, Section 1593, Bloodborne Pathogens Standard. Retrieved from: https://www.dir.ca.gov/title8/5193.html

Cal-OSHA Title 8 CCR § 5199. Aerosol transmissible diseases, August 2009. Retrieved from: http://www.dir.ca.gov/oshsb/atdapprvdtxt.pdf

Carrico, R. (2013). Guide to preventing clostridium difficile infections. APIC Implementation Guide. Retrieved from https://apic.org/Resource_/EliminationGuideForm/59397fc6-3f90-43d1-9325-e8be75d86888/File/2013CDiffFinal.pdf

Siegel J, Rhinehart E, Jackson M, et al., and the Healthcare Infection Control Practices Advisory Committee (HICPAC). 2007 Guideline for isolation precautions: preventing transmission of infectious agents in health care settings. Retrieved from https://www.cdc.gov/infectioncontrol/pdf/guidelines/isolation-guidelines.pdf

Siegel J, Rhinehart E, Jackson M, et al., and the Healthcare Infection Control Practices Advisory Committee (HICPAC). Management of multidrug-resistant organisms in healthcare settings, 2006. Retrieved from: https://www.cdc.gov/mrsa/pdf/mdroguideline2006.pdf

Wiksten, T. (2014). Standard precautions. APIC Text of Infection Control and Epidemiology. Available on-line by subscription at www.apic.org.

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REVIEWED BY:

Administrative Team

Medical Staff

Governing Board

DEPARTMENT:	APPROVED:	Page **1** of **4**
Infection Prevention	**Date approved**	
SUBJECT:	**EFFECTIVE DATE:**	**SUPERCEDES:**
Use of Powered Air Purifying Respirator	**(Date policy is in effect)**	**06/26/2021**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("District" or "SHCHD") to provide respiratory protection for those healthcare workers for whom an N-95 particulate respirator is not effective or unable to be used.

DEFINITIONS:

Powered Air Purifying Respirator: Device that uses a blower to pass contaminated air through a HEPA filter, which removes the contaminant and supplies purified air to a facepiece.

PROCEDURE:

BACKGROUND:

The OSHA Airborne Transmissible Disease Standard (ATD) requires facilities to provide adequate protection for its healthcare workers who are caring for patients with respiratory/airborne conditions. In most cases, this standard can be met with the use of an N-95 particulate respirator. These respirators require fit-testing to each wearer to assure they fit properly, thus preventing airborne organisms from getting to the wearer's respiratory tract. They are only effective if they fit properly.

Annual fit testing is required to assure a continued good fit. Changes in facial shape or facial hair can alter the proper fit of the respirator and could prevent adequate protection. In addition, certain medical conditions could make it difficult for an employee to wear an N-95 respirator safely. For these reasons, it may be necessary for a different type of respiratory protection to be available. The PAPR is reserved for employees for whom N-95's are determined not to be adequate protection.

EQUIPMENT:

The district has three NIOSH approved, battery-powered Versaflo TR-6710N PAPRs manufactured by 3M Corporation. Each comes with a charging station, a hood, a flow tester, filters, beltpack, and a breathing tube with breathing tube covers. Each PAPR is stored in its own carrying case on the bottom shelf of the wire shelving unit outside the Emergency Room. The charger is stored in the same location and attached to a surge-protector. The battery packs are plugged into the charger continuously. Assuring the batteries are charged is the responsibility of the Engineering Manager.

TRAINING:

1. All healthcare workers who have the potential to be exposed to airborne pathogens are fit tested to N-95 particulate respirators annually. In the event that a HCW is unable to be fitted properly, he/she will be informed that for adequate protection, he/she must use a PAPR.

2. All HCWs who require PAPRs must be trained annually and prove competency before being able to use the PAPR. Training is the responsibility of the Infection Preventionist and consists of a video, practice session,
quiz, and competency testing.

SAFETY:

1. As with fit-testing N-95's, OSHA requires a medical evaluation for the user.

2. The PAPR should not be used if the battery registers less than 80%. The length of time the battery can be used at one time cannot be determined as it depends on filter load, amount of contaminants in the room, the power setting used, the battery condition, and the environment. The user MUST do frequent battery checks during prolonged use to gauge battery life. If the battery gets low, it must be returned to the charger and exchanged for another.

3. These PAPRs are for use in oxygen environments only when biological material may be present. They should not be used when entering rooms filled with gases, fire, or other strong contaminants, such as cleaning products as they do not provide protection against these contaminants.

4. Users should never turn off the PAPR, remove the hood, or reach a hand into the faceshield area while still inside the contaminated room as this could allow contaminants to enter breathing area.

5. If the blower stops or alarms sound, the user must leave the area immediately and remove the hood.
   The motor should be turned off and the system taken to Engineering for analysis. Users should not attempt a repair. All repairs and maintenance is done by the Engineering Department.

6. The amount of air flowing from the blower must be checked before each use to assure there is adequate flow for the user. The PAPR should not be used if the airflow indicator does not indicate enough flow. The PAPR should be sent to Engineering to replace the filters.

SUPPLIES:

Versaflo TR-600 PAPR
PAPR hood
Blower and battery pack

Airflow indicator
Breathing tube, covers, twist ties

Disposable gloves
Disinfecting wipes
Disposable gown

Clean towel or blue pad (for cleaning after use)

PROCEDURE: INSTRUCTIONS FOR THE HEALTHCARE WORKER FOR DONNING THE PAPR

1. When the need for a PAPR arises, the user obtains the entire carrying case and a battery from the charger. The lights on the battery charger indicate that the battery is fully charged. The battery is removed from the charger by pushing in on the blue button on the battery (just above the charger lights.) There are four indicator lights on the bottom of the battery which should light up green after the button is pushed. If not, it should be returned to the charger and another battery selected. The battery should be checked for cracks or damage; it should not be used if these exist and should be sent to Engineering for review.

2. The PAPR case, battery, and all supplies should be taken to an area where there is room to lay it all out on a flat surface. After doing hand hygiene and putting on gloves, the user disinfects the surface with a disinfecting wipe and lays out all the supplies.

3. The hood should be disinfected both inside and outside with a disinfecting wipe and allowed to dry.
   The battery, the motor, the belt and the hose should all be wiped down with a disinfecting wipe.

4. The battery is attached to the bottom of the PAPR by inserting the hinge end (end closest to the pins) into the PAPR and pushing the other end down into place until it snaps securely.

5. The breathing tube is covered with a tube cover and the ends are secured with a pipe cleaner. The user removes gloves and does hand hygiene.

6. The power button is located on the top far left of the motor; it should be turned on at this time. It will begin to run through a self-test start up sequence; each of the lights will flash and every

light has a designated meaning. The battery charge lights are located on the battery-shaped indicator. The filter status indicator is the set of lights directly to the right. If all are green, it means it has a new filter with full capacity. If only the bottom light is illuminated red, it means the filter is depleted and needs replacing. This is the responsibility of Engineering.

7. The airflow button is the button directly to the right of the power button. There are three levels of airflow which can be changed by pressing and holding the airflow button; the change will be indicated by a beep and an additional indicator lighting up to the right.

8. The PAPR's airflow **must** be checked to be sure it is high enough to ensure the wearer's safety
   a. The Airflow Indicator should be attached it to the outflow port on the motor. The Airflow indicator MUST be positioned vertically to the floor during this testing. It can take up to one minute for the air flow to stabilize.
   b. An indicator card determines the level of airflow required. Both the temperature of the room and the building elevation are required to determine how much flow is required. It is appropriate to use a standard temperature of 68 degrees Fahrenheit and a physical elevation of 1000 feet for Garberville (actual elevation is 545 feet). With these numbers, the chart indicates that the airflow (where the bottom of the orange ball rests) needs to be at level "E."
   c. The airflow indicator should be wiped with a disinfecting wipe and stored in one of the side pockets of the PAPR case.

9. The breathing tube is attached to the motor by inserting the end with the two pins into the outflow port and twisting one-quarter turn to the right until it snaps into place.

10. The user now dons the belt by closing the latch in the front and tightening the belt to fit snugly in the small of the back.

11. The user puts the hood over his/her head by grabbing the elastic under the chin and pulling it up and over the head. The ears should NOT be inside the facial area. The hood's apron should be spread out over the shoulders.

12. The breathing hose must be attached to the hood immediately by pushing it into the opening until it snaps. The airflow is adjusted by pushing and holding the airflow button, if necessary.

13. If a gown is needed, it should be put on at this time. The user must be careful not to tear the neckpiece of the gown or ties when pulling it over the head. The back ties must be tied under the motor, so as not to obstruct the air intake which is above the battery.

PROCEDURE: INSTRUCTIONS FOR THE HEALTHCARE WORKER FOR DOFFING THE PAPR

1. As with doffing any PPE, the gown and gloves must be removed carefully so as not to contaminate oneself. These must be discarded inside the patient room. Hand hygiene follows BEFORE exiting the room.

2. After donning new gloves, the user removes the hood and the motor and places them on the table and turns off the motor.

3. The breathing tube must be removed from the motor gently, with the outflow port of the PAPR UPSIDE DOWN to prevent debris from entering the machine and by turning the tube one-quarter turn to the left. The breathing tube is disconnected from the hood by carefully squeezing the levers on the side of the tube and gently pulling it out of the hood. Care must be taken not to tear the hood.

4. Using disinfecting wipes, the hood is disinfected inside and outside and set aside on the clean towel/pad.

5. The cover on the breathing tube is discarded and the breathing tube is disinfected and set aside on the clean towel/pad. If necessary, the tube can be washed in soap and water, but must be FULLY DRY before being returned to the case or attached to a machine again.

6. The motor and belt should be disinfected on all sides and set aside on the clean towel/pad.

7. The battery is separated from the motor and wiped down with a disinfecting wipe. The four pins on the bottom of the battery should not be cleaned. These are coated with a special material.

8. When all items are fully dry they can be returned to the case. The case should be returned to the storage area and put battery back into charger properly.

NOTE: PER THIS PROCEDURE, THE PAPR IS CLEANED BEFORE AND AFTER USE.

REFERENCES:

Cal-OSHA Title 8 CCR § 5199. Aerosol Transmissible Diseases, August 2009. Available at: https://www.dir.ca.gov/title8/5199.html Accessed March 20, 2023

3M Versaflo Powered Air Purifying Respirator (PAPR) Assembly. Retrieved from: pdfViewer.aspx.pdf (3m.com)

REVIEWED BY:

Administrative Team

Medical Staff

Governing Board

SoHum Health

Southern Humboldt Community Healthcare District

Governing Board Meeting

Compliance Policies

Sprowel Creek Campus
286 Sprowel Creek Road
Garberville, CA 95542

SoHum
Health
Southern Humboldt
Community Healthcare District
733 CEDAR STREET
GARBERVILLE, CA 95542
(707) 923-3921

DEPARTMENT: Compliance	NO:	Page 1 of 2
SUBJECT: **Complaints and Grievances Policy**	EFFECTIVE DATE: **01/01/2024**	SUPERSEDES: **New**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD," "SoHum Health," or "District") to respond to complaints and grievances according to applicable regulations and in a patient-centered, standardized way. SoHum Health strives to provide excellent quality of care and services. Every effort is made to resolve complaints at the time a complaint is received. Grievances are acknowledged, investigated, and an appropriate response provided to the patient/patient representative in a timely manner. Timely is defined as within seven (7) days to acknowledge the grievance and within thirty (30) days for the completion of the investigation and a final response back to patient. Billing issues are not usually considered grievances for the purposes of this policy.

All patients/patient representatives have the right to file a complaint, grievance, concern, or suggestion, without consequence. Complaints or grievances involving situations which place a patient in immediate danger are resolved immediately in collaboration with the appropriate service director or manager, administrator, and or medical staff leader. SoHum Health encourages staff members to invite feedback from patients and families and work immediately to resolve the patient/patient representative complaints, at the time the complaint is voiced. Complaints, grievances, or suggestions may include but are not limited to quality-of-care issues, patient safety concerns, staff competency, physician or staff behavior, abuse, neglect, patient harm, or any noncompliance with regulatory requirements.

DEFINITIONS:

A. Complaint:
   - A verbal expression of dissatisfaction regarding care or services provided, which can be resolved while the patient is still receiving care at the facility.

B. Grievance is identified as any of the following:
   - Any complaint which cannot be resolved promptly by the staff present.
   - Any complaint received in writing, including email.
   - Any complaint involving abuse, neglect, or issues of compliance regarding Medicare Conditions of Participation.
   - Any complaint where the patient or patient representative has requested a written response.

REFERENCES:

National Archives and Records Administration. (2022, October 6). PART 482 - CONDITIONS OF PARTICIPATION FOR HOSPITALS. Code of federal regulations: A point in time eCFR system. Retrieved October 10, 2022, from https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482

Legal Information Institute, Cornell Law School (2022, April 25). Cal. code regs. Tit. 22, § 70707 - patients' rights. Legal Information Institute. Retrieved October 10, 2022, from https://www.law.cornell.edu/regulations/california/22-CCR-70707#:~:text=(a)%20Hospitals%20and%20medical%20staffs,may%20be%20read%20by%20patients.

REVIEWED BY:

Chief Quality and Compliance Officer

Medical Staff
Governing Board

SoHum
Health
Southern Humboldt
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733 CEDAR STREET
GARBERVILLE, CA 95542
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DEPARTMENT: Compliance	NO:	Page 1 of 1
SUBJECT: **District Compliance Policy**	EFFECTIVE DATE:	REVISED:

POLICY:
It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to act in a legal manner, consistent with all applicable governmental standards and requirements. The District Compliance Plan ("plan") is designed to enhance and further demonstrate SHCHD's commitment to achieve the highest level of awareness of governmental and legal requirements.

It is the responsibility of each District representative to comply with the Compliance Policy, Procedure, and Plan. The Policy, Procedure, and Plan establish a framework for compliance with health care laws by SHCHD. They are not intended to set forth all the substantive programs and practices of SHCHD designed to achieve compliance. SHCHD maintains various compliance practices and those practices continue to be part of its overall legal compliance effort.

REVIEWED BY:
Chief Quality and Compliance Officer
Chief Nursing Officer
Chief Executive Officer
Medical Staff
Governing Board

SoHum
Health
Southern Humboldt
Community Healthcare District
733 CEDAR STREET
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(707) 923-3921

DEPARTMENT: Compliance	NO:	Page 1 of 1
SUBJECT: **District Compliance Policy**	EFFECTIVE DATE:	REVISED:

POLICY:
It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to act in a legal manner, consistent with all applicable governmental standards and requirements. The District Compliance Plan ("plan") is designed to enhance and further demonstrate SHCHD's commitment to achieve the highest level of awareness of governmental and legal requirements.

It is the responsibility of each District representative to comply with the Compliance Policy, Procedure, and Plan. The Policy, Procedure, and Plan establish a framework for compliance with health care laws by SHCHD. They are not intended to set forth all the substantive programs and practices of SHCHD designed to achieve compliance. SHCHD maintains various compliance practices and those practices continue to be part of its overall legal compliance effort.

REVIEWED BY:
Chief Compliance Officer
Chief Nursing Officer
Chief Executive Officer
Medical Staff
Governing Board

SoHum Health

Southern Humboldt Community Healthcare District

GOVERNING BOARD MEETING

NURSING POLICIES

Sprowel Creek Campus
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DEPARTMENT: Nursing	APPROVED:	Page 1 of 1
SUBJECT: **Abuse and Neglect Investigation**	EFFECTIVE DATE: 06/27/23~~06/27/23~~	SUPERCEDES: 04/05/18

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Policy:
It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to ensure all employees comply with the provisions of laws regarding reporting of suspected child, elder and/or dependent adult, and domestic abuse.

Purpose:
The purpose of this policy and procedure is to delineate the process for abuse and neglect investigational procedures. To Provide guidance on identifying and addressing circumstances in which a patient is suspected of having been subject to physical or emotional abuse and/or neglect, exploitation, abandonment, domestic violence, sexual abuse, or other factors creating high risk of such harm.

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Procedure:
The Southern Humboldt Community Healthcare District addresses abuse and neglect by first screening all employees and performing a background check before the hiring process. The next step is prevention, which is started at the employee's first day of hire during orientation. This education is also followed-up yearly during our annual in-service. The next step involves investigating alleged reports of abuse and/or neglect.

Investigation:
If an employee is accused of abuse and/or neglect the manager of the department must be notified as soon as possible. The manager then must notify the Human Resources manager, who is responsible for assisting with administration leave, if needed; the Chief Nursing Officer (CNO), who is responsible for assisting with the investigation, ensuring resident safety and comfort, notifying the appropriate agency, among other tasks; and the Chief Executive Officer (CEO), who is responsible for overseeing the investigation and legalities involved. The investigating manager must fill out a Quality Risk Report if one has not been started after the notification and the investigation report template.

The investigation report template includes the following:
- Date/Time of Original Incident:
- Resident/Patient/Employee Interview Investigation:
- Regulatory Reporting Requirements Date and Time Reported:
- Patient's Family:
- CDPH:
- Administrator:
- Employee Counseling/Suspension, etc.:
- Overall outcome:
- Follow up:

The completed investigation report is reviewed by the CNO and reported monthly at the Patient Safety Meeting.

If an employee is being investigated for allegations of abuse and/or neglect the resident has the right to another caregiver. The resident must remain comfortable and safe during the investigation. To ensure resident comfort and safety during the investigation the CNO or designee will have a supervised discussion/assessment with the resident to verify that the measures are being fulfilled. The manager of the department will arrange for either employee administrative leave or department transfer to ensure the resident feels safe and comfortable during the investigation.

References:
State operations manual: 483.12 Freedom from abuse and neglect, and exploitation (REV. 173 issued: 11-22-17, effective: 11-28-17, implementation: 11-28-17)

Reviewed By:

Chief Nursing Officer	Director of Nursing
ED/Acute Care Manager	Skilled Nursing Manager

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DEPARTMENT: Nursing	APPROVED:	Page 1 of 1
SUBJECT: **Admission of the Patient**	EFFECTIVE DATE: 05/30/2019 ~~06/27/2023~~	SUPERCEDES: 04/26/2018 05/30/2019

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Policy:
It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to admit patients according to a specified checklist e.g., Acute Admission Checklist, Swing Checklist or SNF checklist.

Purpose:
The purpose of this policy and procedure is to ensure that the medical staff will follow the appropriate steps regarding all patient admissions~~,~~ and to provide safe and expedient patient care.

Procedure:

1. Receive report from the department/facility that the patient is coming from. Document the nurse's name in the chart of the nurse that gave the report along with the date and time.
2. Notify Admitting Registration with an admission slip of the patient's admission date and ~~time~~time.
3. Prepare the assigned room and bed with needed supplies and equipment, i.e., turn down ~~blankets~~blankets. and sheet, lay out a hospital gown, make sure the scales for obtaining a weight are available, IV Pump is in the room, water pitcher, toothbrush, patient gown, and socks, etc.
4. Receive the Patient from admitting, or department transferring them, and assist with transport to the hospital room, ensure consents are signed.
5. Place the ID ~~wrist band~~wristband, allergy, and any risk alert band necessary on the patient.
6. Obtain Vital Signs and weight.
7. Obtain any stat lab work order, EKG, x-rays etc.
8. Ensure that the Physician completes the needed orders for the patient, i.e., diet, activity, vital sign frequency, I&O's, monitor, fluids, and medications.
9. Notify both pharmacy and dietary of admission.
10. Once the patient has been made comfortable and their stability is confirmed, the primary nurse can begin the admission charting.
11. All charting must be done through Electronic Health Records using ~~Heathland Centriq~~EPIC. Begin with the Acute Admission Assessment, the Acute/OBS Shift Assessment, and Wound Assessment, if needed, located in the Assessment tab. Make sure to go over the patient's medical history including Allergies, Medication Reconciliation, Home Medications, Problem, Surgical, Immunization, Family History, and Pregnancy History (if applicable), all located in their respective tabs. Write chart notes as needed through the Chart Notes tab and record intake and output (~~I&O's~~I&Os) and Vital Signs through their respective tabs. Assign and review care plans that are applicable to the patient through the Plan of Care Tab.

Reviewed By:
Emergency Department
Acute Nurse Manager
Chief Nursing Officer

SoHum Health
Southern Humboldt Community Healthcare District
733 Cedar Street
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(707) 923-3921

DEPARTMENT: Nursing	APPROVED:	Page 1 of 9
SUBJECT: **The California End of Life Option Act**	EFFECTIVE DATE: 05/30/2019 ~~06/23/2023~~	SUPERCEDES: 03/28/2019 ~~05/30/2019~~

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Policy:
It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to participate in the ~~End of Life~~End-of-Life Option Act.

Purpose:
The California End of Life Option Act allows an adult patient with capacity, who has been diagnosed with a terminal disease with a life expectancy of six months or less, and who meets other requirements, to request a prescription for a drug for the purpose of ending his or her life (aid-in-dying drug) through self-administration of the drug.

The purpose of this policy is to describe the requirements and procedures for compliance with The California End of Life Option Act and to provide guidelines for responding to patient requests for information about aid-in-dying drugs in accordance with federal and state laws and regulations.

The requirements outlined in this policy do not preclude or replace other existing policies, including but not limited to Withdrawing or Foregoing ~~Life Sustaining~~Life-Sustaining Treatment, Pain Management, Advance Directives /POLST, Resuscitation Status (DNR), or End-of-Life Care, referenced herein.

DEFINITIONS (for purposes of this policy)

Surrogate:
A surrogate decision maker can be an agent appointed in an advanced health care directive or a durable power of attorney for health care, or a ~~court appointed~~court-appointed conservator of the person. When patients without such an agent or conservator lose the capacity to make health care decisions, a family member, domestic partner, or persons with whom the patient is closely associated may be considered to act as surrogates for health care decisions.

Capacity to Make Health Care Decisions:
A patient who, in the opinion of the patient's attending physician, consulting physician or psychiatrist, pursuant to Probate Code section 4609, and has the ability to understand the nature and consequences of a health care decision, the ability to understand its significant benefits, risks, and alternatives and the ability to make and communicate an "informed decision" (defined herein) to health care providers.

Aid-in-dying Drug:
A drug determined and prescribed by a physician for a qualified patient, which the qualified patient may choose to self-administer to bring about his or her death due to a terminal disease.

Terminal Disease:
An incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, result in death within six months.

Attending Physician:
The physician who has primary responsibility for the health care of the patient and treatment of the patient's terminal disease. An attending physician does not include a resident, fellow, physician assistant or nurse practitioner. The attending physician may not be related to the patient by blood, marriage, registered domestic partnership, or adoption, or be entitled to a portion of the patient's estate upon death. The attending physician may not serve as a witness to the patient's written request for aid-in-dying drug.

Consulting Physician:
A physician who is independent from the attending physician and who is qualified by specialty or experience to make a professional diagnosis regarding a patient's terminal illness. The consulting physician may not be related to the patient

by blood, marriage, registered domestic partnership, or adoption, or be entitled to a portion of the patient's estate upon death. A consulting physician does not include a resident, fellow, physician assistant or nurse practitioner.

Mental Health Specialist:
Only a licensed psychiatrist or licensed psychologist may act as a mental health specialist. The mental health specialist may not be related to the patient by blood, marriage, registered domestic partnership, or adoption, or be entitled to a portion of the patient's estate upon death. It does not include a resident, fellow, physician assistant or nurse practitioner.

Informed decision:
A decision by a patient with a terminal disease to request and obtain a prescription for a drug that the patient may self-administer to end the patient's life that is based on an understanding and ~~acknowledgement~~ acknowledgment of the relevant facts, and that is made after being fully informed by the attending physician of all the following:

- The patient's medical diagnosis and prognosis
- The potential risks associated with taking the drug to be prescribed
- The probable result of taking the drug to be prescribed
- The possibility that the individual may choose not to obtain the drug or may obtain the drug but may decide not to ingest it
- The feasible alternatives or additional treatment opportunities, including, but not limited to, comfort care, hospice care, palliative care, and pain control.

Self-Administer:
A qualified patient's affirmative, conscious, and physical act of administering and ingesting the aid-in-dying drug to bring about his or her death in the method prescribed by the physician.

PROCEDURE:
The ~~End of Life~~End-of-Life Option Act (herein after the "Act") allows adult (18 years or older) terminally ill patients, with the capacity to make health care decisions, seeking to end their life, to request lethal doses of drugs from an attending physician. These terminally ill patients must be California residents (as defined herein) who will, within reasonable medical judgment, die within 6 months. Patients requesting lethal doses of a drug must satisfy all requirements of the Act in order to obtain the prescription for that drug. Such a request must be initiated by the patient and cannot be made through the utilization of an Advance Health Care Directive, POLST or other document. It cannot be requested by the patient's surrogate.

Southern Humboldt Community Healthcare District allows its physicians and other ~~health care~~healthcare providers who qualify under the Act to participate in activities authorized by the ~~End of Life~~End-of-Life Option Act, if they so choose.

Southern Humboldt Community Healthcare District physicians and other health care providers may, as applicable and as defined in the Act and herein:

- Perform the duties of an attending physician
- Perform the duties of a consulting physician
- Perform the duties of a mental health specialist
- Prescribe drugs under this Act
- Fill a prescription under this Act
- Be present when the qualified patient self-administers the aid-in-dying drug provided that the physician does not participate or assist the patient in self-administering the life-ending drugs.
- Assist in patient or provider support related to the Act.

Southern Humboldt Community Healthcare District neither encourages nor discourages participation in the Act; participation is entirely voluntary. Only those providers who are willing and desire to participate should do so. Those persons who do choose to participate are reminded that the overall goal is to support the patient's end-of-life wishes, and that participation may not necessarily result in aid-in-dying drugs being prescribed if the patient's needs can be met in other ways (~~e.g.~~e.g., pain management, hospice or palliative care).

Participation in activities authorized under the Act is completely voluntary. A Southern Humboldt Community Healthcare District physician, staff or employee that elects, for reasons of conscience, morality, or ethics, not to engage in activities authorized by the Act is not required to take any action in support of a patient's request for a prescription for an aid-in-dying drug, including but not limited to, referral to another provider who participates in such activities. Southern Humboldt Community Healthcare District physicians or employees who experience moral or

spiritual distress related to patient requests to access the Act may utilize supportive services such as our employee assistance program.

Southern Humboldt Community Healthcare District does not permit the ingestion or self-administration of an aid-in-dying drug in its hospitals, clinics or elsewhere on its premises. However, inquiry and discussion of such a request is permitted during a patient's hospitalization. An attending physician may prescribe the aid-in-dying drug after discharge so long as all the requirements of the Act are fulfilled (see section V for requirements).

Southern Humboldt Community Healthcare District does not accept new patients solely for the purpose of accessing the Act. Eligible individuals must be current Southern Humboldt Community Healthcare District patients receiving care for a terminal disease.

When a patient makes an inquiry about, or requests access to activities under the Act, the patient will initially be referred to a clinic nurse-only appointment. Nurses who are well versed in the requirements of the Act will assist with patient understanding of the Act, inform them about the process and provide educational material related to the patient's end of life options. This activity will augment, but not substitute, the obligations of the attending and consulting physicians' roles described herein. If the patient's physician chooses not to participate in the Act, which is his or her right under the law, a social worker will assist in the identification of a Southern Humboldt Community Healthcare District physician who does participate.

The Act requires the involvement of two physicians; an attending physician and a consulting physician as defined in the Act and herein in Section V; and requires that at least one of these physicians be privileged pursuant to criteria set forth by the Southern Humboldt Community Healthcare District Medical Staff for participation in the Act.

Any request for the Act must go before medical staff for review and approval to ensure all requirements of the Act are indeed met. Southern Humboldt Community Healthcare District will provide oversight and may review records to the extent necessary to ensure all the safeguards of the law have been followed and the correct documentation completed and submitted to the California Department of Public Health. Southern Humboldt Community Healthcare District will also review all cases of use of the Act for quality improvement purposes. Attending physicians are required to report all patient requests for aid-in-dying drugs to Southern Humboldt Community Healthcare District Risk Management.

In consideration of the vulnerabilities of particular patient populations, including but not limited to patients who lack social support or patients with disabilities, Southern Humboldt Community Healthcare District requires a thorough assessment for consent and capacity determination beyond what is required by the Act. These safeguards will serve the objective of protecting individuals who might seek aid-in-dying drugs but are not capable of making an autonomous and informed choice.

(Note: A mental health assessment is required by law only if the attending or consulting physician determines that the patient has indications of a mental disorder. However, a hospital may, if it so chooses, adopt a requirement that attending physicians obtain a mental health assessment prior to prescribing an aid-in-dying drug.)

PROCEDURES

Requirements of the California End of Live Option Act

Patients qualified to request aid-in-dying drugs: Existing BH adult patients who have capacity to make health care decisions and who have a terminal disease may make a request to receive a prescription for an aid-in-dying drug if all the following conditions are met:

- The patient's attending physician has diagnosed the patient with a terminal disease
- The patient has voluntarily requested an aid-in-dying drug on three separate occasions as described herein
- The patient has the physical and mental capacity to self-administer the aid-in-dying drugs

The patient is a California resident and is able to establish residency through at least one of the following:

- Possession of a California Driver license or ID card issued by the State of California
- Registration to vote in California
- Evidence that the patient owns, rents or leases property in California
- The filing of a California tax return for the most recent tax year

Notwithstanding fulfillment of the above requirements, eligible individuals must be current Southern Humboldt Community Healthcare District patients receiving care for a terminal disease. Individuals who present to Southern Humboldt Community Healthcare District for the sole purpose of requesting an aid-in-dying drug are not eligible to request aid-in-dying drugs from physicians, staff or employees.

A patient must not be considered a "qualified individual" under the Act solely because of age or disability. If there is concern regarding the voluntariness of the patient's request by any member of the health care team, or if there is disagreement between health care team members regarding whether the patient's needs can be met in ways other than by a prescription for an aid-in-dying drug, these concerns must be shared with the Ethics Committee, which will pursue the concerns with the utmost seriousness to avoid inappropriate utilization or application of the Act. Aid-in-dying drugs will not be prescribed at any time in the presence of concerns on the part of Southern Humboldt Community Healthcare District regarding the voluntary nature of the request.

Method of request for aid-in-dying drug and documentation requirements: Requests for aid-in-dying drugs must come directly and solely from the patient who will self-administer the drugs. Such requests cannot be made by a patient's surrogate or by the patient's health care provider.

To make a request for a prescription for an aid-in-dying drug, the patient must directly submit to his or her attending physician:

- Two oral requests (made in person) that are made a minimum of 15 days apart. Patients who are unable to speak because of their medical condition shall communicate their request in a manner consistent with their inability to speak, such as through sign language. The attending physician must document these requests in the medical record (the Act does not specify any particular language);
  AND
  One written request using the form required by the State of California "Request for an Aid-in-Dying Drug to End My Life in a Humane and Dignified Manner" (CHA Form 5-5). This form must be scanned into the patient's medical record. Form 5-5 sets forth the following conditions:
  The written request form (Form 5-5) must be signed and dated, in the presence of two witnesses, by the patient seeking the aid-in-dying drug.

The witnesses must also sign the form and by so doing attest that to the best of their knowledge and belief the patient is all the following:

- An individual who is personally known to them or has provided proof of identity.
- An individual who voluntarily signed the request in their presence.
- An individual whom they believe to be of sound mind and not under duress, fraud or undue influence.

The patient's attending physician, consulting physician and mental health specialist cannot serve as witnesses. Additionally, only one witness may be related to the requesting patient by blood, marriage, registered domestic partnership or adoption or be entitled to a portion of the requesting patient's estate upon death or own, operate or be employed by a health care facility where the patient is receiving medical care or resides.

The request may not be made through a nurse practitioner, physician assistant, resident or fellow. Nurse practitioners, physician assistants, residents and fellows must notify their attending physician about any patient request for aid-in-dying medication. They are not authorized under BH policy to participate as statutory providers under the Act.

Within 48 hours prior to self-administration of the aid-in-dying drug, the patient must complete the State of California issued form "Final Attestation for an Aid-in-Dying Drug to End my Life in a Humane and Dignified Manner" (CHA Form 5-6). If the attending physician receives this document, he or she is required to put it in the patient's medical record.

Responsibility of the attending physician: The responsibilities of an attending physician are non-delegable. Before prescribing the aid-in-dying drug, the attending physician must do all of the following: Make the initial determination about whether the patient is qualified under the Act as described in above, including determination that:

- The patient has the capacity to make health care decisions
- The patient has a terminal disease, medically confirmed by a consulting physician
- The patient has made a voluntary request for an aid-in-dying drug, including completion of witness attestations that the patient is of sound mind and not under fraud, duress or undue influence
- The patient has met the residency requirements of the Act
- Confirm that the patient is making an informed decision as defined herein
- Refer the patient to a consulting physician. (NOTE: Southern Humboldt Community Healthcare District requires that at least one of the involved physicians be privileged to participate in the Act through the Southern Humboldt Community Healthcare District's Medical Staff.)
- If the attending or consulting physician determines that the patient has indications of a mental disorder, the patient must be referred for a mental health assessment. This assessment must be documented in the patient's medical record.
- Confirm that the patient's request does not arise from coercion or undue influence. The physician must do this

by discussing with the patient, outside the presence of any other person except for an interpreter as described below) whether or not the patient is feeling coerced or unduly influenced by another person. Family members or friends of the patient cannot act as interpreters.

Counsel the patient about the importance of:

- Having another person present when he or she ingests the aid-in-dying drug
- Not ingesting the aid-in-dying drug in a public place. "Public place" means any street, alley, park, public building, or any place of business or assembly open to or frequented by the public, and any other place that is open to the public view, or to which the public has access
- Notifying the next of kin of his or her request for an aid-in-dying drug. A patient who declines or is unable to notify next of kin must not have his or her request denied for that reason
- Participating in a hospice program
- Maintaining the aid-in-dying drug in a safe and secure location until the patient takes it

Inform the patient that he or she may withdraw or rescind the request for an aid-in-dying drug at any time and in any manner. The patient has the right to change his or her mind without regard to his or her mental state. Therefore, if a patient makes a request for an aid-in-dying drug while having capacity to make health care decisions, then loses his or her capacity, the patient can still decide not to take the aid-in-dying drug.
Offer the patient an opportunity to withdraw or rescind the request for an aid-in-dying drug before prescribing the drug.

- Verify, for a second time, immediately before writing the prescription for an aid-in-dying drug, that the patient is making an informed decision
- Confirm that all requirements are met and all appropriate steps are carried out in accordance with the law (as outlined in this policy) before writing a prescription for an aid-in-dying drug
- Fulfill all the documentation requirements (see Section 6 below)
- Inform BH Risk Management that such a request has been made
- Complete the Attending Physician Checklist & Compliance form (CHA Form 5-7) and place it as well as the completed Consulting Physician Compliance form (CHA Form 5-8) in the patient's medical record. Arrange for the forms submittal to CDPH by the Santa Rosa District Office
- Give the requesting patient the Final Attestation form (CHA Form 5-6) to the patient and instruct the patient about completing it
- Complete the Attending Physician Follow-up form (CHA Form 5-9) and submit it to CDPH through the Santa Rosa District Office

Responsibility of consulting physician:

A physician who chooses to act as a consulting physician must not be involved in the patient's health care and must do all the following:

- Examine the patient and his or her relevant medical records
- Confirm in writing the attending physician's diagnosis and prognosis
- Determine that the individual has the capacity to make medical decisions, is acting voluntarily and has made an informed decision.
- If the attending or consulting physician determines that the patient has indications of a mental disorder, the patient must be referred for a mental health assessment. This assessment must be documented in the patient's medical record.
- Fulfill the documentation requirements (see below).
- Complete the State of California form "End of Life Option Act Consulting Physician Compliance form (CHA Form 5-8).

Responsibility of mental health specialist:

In the interest of protecting mentally ill patients, or patients lacking capacity, from receiving prescriptions for aid-in-dying drugs and to ensure a vigilant and systematic examination for depression or other mental health conditions that could be interfering with informed decision making, all patients who request an aid-in-dying drug shall be screened through a mental health assessment.

A psychiatrist or psychologist who chooses to act as a mental health specialist must conduct one or more consultations with the patient and do all of the following:

- Examine the qualified patient and his or her relevant medical records
- Determine that the patient has the mental capacity to make medical decisions, act voluntarily, and make an informed decision
- Determine that the patient is not suffering from impaired judgment due to a mental disorder. Patients with depression are not automatically excluded and it must be determined that a mental illness is interfering with decision making capacity.
- Document in the patient's medical record a report of the outcome and determinations made during the mental health specialist's assessment
- Fulfill the documentation requirements (see below)

Documentation requirements:

All of the following must be documented in the patient's medical record:

- All oral requests for aid-in-dying drugs
- All written requests for aid-in-dying drugs
- The attending physician's diagnosis and prognosis, and the determination that the qualified patient has the capacity to make healthcare decisions, is acting voluntarily, and has made an informed decision, or that the attending physician has determined that the individual is not a qualified patient
- The consulting physician's diagnosis and prognosis and verification that the qualified patient has the capacity to make health care decisions, is acting voluntarily and has made an informed decision, or that the consulting physician has determined that the individual is not a qualified patient
- A report of the outcome and determination made during a mental health specialist's assessment
- The attending physician's offer to the qualified patient to withdraw or rescind his or her request at the time of second oral request
- A note by the attending physician indicating that all requirements of the Act have been met and indicating the steps taken to carry out the request, including a notation of the aid-in-dying drug prescribed
- Death Certificate: The Act does not provide direction as to what cause of death should be referenced on the patient's death certificate. The Act provides that actions taken under the Act shall not, for any purpose, constitute suicide, assisted suicide, homicide or elder abuse. It is BH policy that the physician reference the California End of Life Option Act as the manner of death and the patient's underlying medical condition that qualified the patient for the aid-in-dying drug should be reported as the underlying cause of death. The ingestion of the aid-in-dying drug should be recorded as an antecedent cause.

Use of an Interpreter Requirements:

Option 1: The written request form signed by the patient (CHA Form 5-5) must be written in the same language as any conversations, consultations or interpreted conversations or consultations between a patient and his or her attending or consulting physician.

Option 2: CHA Form 5-5 may be prepared in English even when the conversations or consultations were conducted in a language other than English if the interpreter completes the interpreter attestation on the form.

The interpreter must not be related to the patient by blood, marriage, registered domestic partnership, or adoption or be entitled to a portion of the patient's estate upon death. The interpreter must meet the standards promulgated by the California Healthcare Interpreting Association or the National Council on Interpreting in Health Care or other standards deemed acceptable by CDPH. BH will also provide its interpreters training from the California Healthcare Foundation. 2011. Web: www.chcf.org/publications/2011/11/interpreting-palliative-care-curriculum or the equivalent. Whenever practicable, BH will provide interpreters who have received this training.

Prescribing or delivering the aid-in-dying drug:

After the attending physician has fulfilled his or her responsibilities under the Act, the attending physician may deliver the aid-in-dying drug in any of the following ways:

- Dispensing the aid-in-dying drug directly, including ancillary medication intended to minimize the patient's discomfort, if the attending physician meets all of the following criteria:
- Is authorized to dispense medicine under California law (the Act does not specify which drugs can be used as an aid-in-dying drug);
- Has a current USDEA certificate; and Complies with any applicable administrative rule or regulation.

Aid-in-dying drugs cannot be dispensed by a physician in the inpatient setting.

With the patient's written consent, contacting a pharmacist, informing the pharmacist of the prescription, and delivering the written prescription personally, by mail, or electronically to the pharmacist. It is not permissible to give

the patient a written prescription to take to a pharmacy. The pharmacist may dispense the drug to the patient, the attending physician, or a person expressly designated by the patient. This designation may be delivered to the pharmacist in writing or verbally.

Delivery of the dispensed drug to the patient, the attending physician, or a person expressly designated by the patient may be made by personal delivery, or with a signature required on delivery, by UPS, US Postal Service, Federal Express or by messenger service.

Physicians should counsel patients that leftover aid-in-dying drugs should be properly disposed by returning to a facility authorized to dispose or as provided by the Board of Pharmacy.

CDPH reporting requirements:

Within 30 calendar days of writing a prescription for an aid-in-dying drug, the attending physician (through Southern Humboldt Community Healthcare District's Administrative Office) must submit the documents listed below to CDPH either by mail or by fax, (916) 440-5209. If mailed, the completed forms should be sent in envelopes marked "confidential" to:

CDPH Public Health Policy and Research Branch Attention: End of Life Option Act
MS 5205
P.O. Box 997377
Sacramento, CA 95899-7377

To protect confidentiality, CDPH has not established an email address for forms submission.

The following documentation is to be sent to the CDPH:

- A copy of the qualifying patient's written request: Request for an Aid-in-Dying Drug to End My Life in a Humane and Dignified Manner (CHA Form 5-5)
- The End of Life Option Act Attending Physician Checklist & Compliance form (CHA Form 5-7)
- The End of Life Option Act Consulting Physician Compliance form (CHA Form 5-8)
- Within 30 calendar days following the qualified patient's death from ingesting the aid-in-dying drug, or any other cause, the attending physician (through the Southern Humboldt Community Healthcare District's Administrative Office) must submit to CDPH the End of Life Option Act Attending Physician Follow-Up form (CHA Form 5-9).

APPENDIX
A. Guidelines for Physicians

REVIEWED BY:
Chief Nursing Officer
Chief Executive Officer
ED/Acute Nurse Manager

REFERENCES:
California Health and Safety Code section 443 et seq. (End of Life Option Act)
California Probate Code section 4609

Appendix A: Guidelines for Physicians about the End of Life Option Act

1. Guidelines for a physician responding to a patient's request for an aid-in-dying drug:

- The highest quality health care is an outgrowth of a partnership between the patient, the family and the health professional or professional team. Within the context of this continuing relationship, physicians must seek to ascertain the underlying causes of suffering at the end of life, and then aggressively implement measures to correct them. Appropriate education in palliative care and medical management; advanced communication skills to discover the patient's wishes and value choices; connection to services, support and

resources; and appropriate sharing of decision making with the patient and the patient's family can go a long way toward alleviating suffering and improving care at the end of life. Physicians should continue to provide assistance in dealing with dying patients' symptoms, needs and fears.

- When a patient asks about the End of Life Option Act, the attending physician's initial response should be to explore the meaning behind the question, regardless of his/her personal views or willingness to participate. Loss of control, abandonment, financial hardship, burden to others, and personal or moral beliefs may be areas of concern to many patients.
- The attending physician should seek to understand what constitutes unacceptable suffering in the patient's view. Pain, other physical symptoms, psychological distress, and existential crisis are potential causes of suffering.
- The attending physician has an obligation to explore treatment for symptoms for which there are treatment options available. This includes hospice, psychological support, and other palliative care.
- The physician should recommend that a patient complete an advance directive and POLST.
- The attending physician should reflect on his/her own beliefs and motivations and the policies of the health care system, and consider the impact of those motivations on decision making with patients near the end of life.

2. Guidelines for a physician speaking to family members, caregivers or supporters about a patient's request for an aid-in-dying drug:

- When a patient has authorized the attending physician to share protected health information with his or her family, caregiver or supporters, the following are suggested as guidelines for participating physicians and other health care professionals work with families:
- It is important for health care professionals to recognize the critical role that family and friends play in the life and care of a patient. Families can provide knowledge of a patient's values and personality. Families are profoundly affected by the care of the patient at the end of life.
- It is also important to recognize the different responses family members and supporters may have to a patient's request for an aid-in-dying drug under the Act. Some may be supportive, others may become supportive, and still others may be consistently opposed.
- Physicians who agree to participate in the Act are required to recommend to the patient that the next of kin be notified of the request for a lethal dose of medication. However, a refusal to do so does not in itself make a patient ineligible for the Act. Some patients have difficult relationships or religious or moral differences with family members; their decisions regarding disclosure generally should be respected based on confidentiality. However, there may be circumstances which create concerns regarding an adverse impact on family, and that would indicate the need for further dialogue.
- Physicians are required to counsel patients about the importance of having another person present when the aid-in-dying drug is taken. However, the Act does not require another person to be present.
- Patients and family members have a great need for information about the Act and its requirements, what to expect during the ingestion of a lethal dose of medication, and what to expect afterwards.

  Also, the attending physician should confirm that the members of the health care team are willing to participate. It behooves the attending physician and other appropriate professionals or volunteers to supply the needed information in as much detail as possible, and to plan strategies for care. This planning should include:

- The specific requirements and process of the Act, including a timeline
- Alternatives to the Act, including comfort care, palliative care, hospice care, and pain control
- Discussion of disclosure to family members; discussion of who will be present at the time the patient takes the lethal dose of medication
- Suggesting that Advance Directives and Physician Orders for Life-Sustaining Treatment (POLST) are appropriately completed and available where the patient is receiving care
- An idea of what to expect during the ingestion of the aid-in-dying drug, and contingency plans if things do not proceed as expected, especially if the death takes longer than expected. Death may not be immediate and may take hours
- Discussion of the availability of the attending physician, either in person or by phone, to deal with questions and complications, or for support
- Information on funeral arrangements, including a plan to have the attending physician notify the hospice and funeral home that the death was expected and that he/she will sign the death certificate
- Health care professionals should understand the special needs of families involved with the Act for discussion of their experiences and the concern about secrecy. Secrecy may prolong the grieving process

3. Guidelines for physicians when an aid-in-dying patient presents to the Emergency Department (ED) following ingestion of aid-in-dying drug:

- Even with careful planning, it is possible that deaths that take longer than expected might lead to occasional ambulance calls and transport to emergency departments and thus, ED physicians may care for patients who are brought to the ED

EDs should have policies for addressing the care of these patients consistent with following the known wishes of the patient as evidenced by an Advance Directive and POLST.

SoHum
Health
Southern Humboldt
Community Healthcare District
733 Cedar Street
Garberville, CA 95542
(707) 923-3921

DEPARTMENT: Human Resources	APPROVED:	Page 1 of 4
SUBJECT: **Care Planning for, Inpatients, Swing, and SNF**	EFFECTIVE DATE: 05/30/2019 ~~06/27/2023~~	SUPERCEDES: 10/26/2017

POLICY:
It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide all inpatients, swing patients and SNF residents with an accurate and up-to-date plan of care.

Inpatient
All inpatients will have at least **two computerized** care plans developed by the interdisciplinary team within 24 hours of admission. Inpatient care plans are found in the Electronic Medical Record under the care plans tab within Heathland, the hospital's current EMR system. *Nursing will review inpatient care plans each shift and will update and resolve care plans accordingly.*

Swing
All Swing patients will have paper care plans that are hand-written and stored in the patient's paper chart at the nursing station. These care plans are reviewed weekly by nursing and are updated or resolved accordingly by the interdisciplinary team. Every three months the MDS coordinator determines if the ~~care plan~~care plan is current and either discontinues it or updates it accordingly.

When paper care plans are removed from the patient chart at the nursing station, they are sent to Medical Records to be scanned under documents in the patient's electronic medical record in Heathland. Previously hand-written care plans can be found here.

Skilled Nursing Facility (SNF)
All SNF residents will have paper care plans that are hand-written and stored in the resident's paper chart at the nursing station. These care plans are reviewed weekly by nursing and are updated or resolved accordingly by the interdisciplinary team monthly. Every three months the MDS coordinator determines if the ~~care plan~~care plan is current and either discontinues it or updates it accordingly.

When paper care plans are removed from the resident chart at the nursing station, they are sent to Medical Records to be scanned under documents in the patient's electronic medical record in Heathland. Previously hand-written care plans can be found here.

PURPOSE:
The purpose of this policy and procedure is to delineate the process for care planning and documentation. The purpose of care planning is to develop a coordinated and comprehensive plan in order to meet the individual's needs. Care planning includes participation from all involved health care disciplines and is initiated on admission with continual reassessment until patient/resident discharge or death. The primary process utilized is the patient/resident assessment with the results of this process being used to develop care plans specific to each resident.

PROCEDURE:

Definition

The care plan is a current, written, and personalized plan for each individual indicating the care he/she needs, how it can best be accomplished, and the goals the interdisciplinary team collectively hopes to help the person achieve.

Upon admission, the nurse gathers data and inputs it into the Electronic Medical Record (EMR) system for inpatients or writes paper care plans for Swing/SNF patients and residents. The nurse will complete weekly summaries which will then be used to gather data for the Minimum Data Set (MDS). The MDS coordinator will enter the data into the jRAVEN system. The MDS system ~~auto populates~~auto-populates appropriate plans of care for each individual resident. The plans of care are found in paper form which are initiated and updated as needed by the MDS coordinator and the

nursing staff and are reviewed by the Skilled Nursing Facility (SNF) Manager/Director of Nursing (DON) monthly for one quarter after admission than quarterly thereafter until resident discharge or death.

Any change in condition requires notification to the provider, Skilled Nursing Facility (SNF) Manager/Director of Nursing (DON), and a full care plan review and/or update.

The process of evaluation and re-assessment of the care plan will occur on a continuing basis as needed until discharged. However, each individual resident care plan will be reviewed and re-evaluated at least every month.

Guidelines

- The care plan is a permanent part of the health record.
- The care plan shall be kept in the health record and shall be readily available to all personnel providing patient care.
- The language shall be simple to ensure all levels of the interdisciplinary team can understand the plan of care.

Care Plan Development

It is the responsibility of nursing services to develop and maintain all patient and resident care plans. However, all members of the interdisciplinary team shall participate in developing the plan of care, including their observations of the resident and recommendations.

Steps of Development:

- Gathering information
- Writing the plan
- Using the plan
- Evaluating the plan

Gathering Information

In order to develop a meaningful care plan, information shall be gathered as it relates to the following needs or problems: (On admission utilize the information gathered from the Nursing Assessment.)

- Motor ability
- Elimination
- Sleep and rest
- Food and fluids
- Sensory
- Emotional
- Mental
- Personal, cultural and social
- Spiritual
- Physical factors
- Discharge plans

Sources of information

- Health records
- Patient/Resident
- Family
- Physician
- Other health care personnel when applicable (physical therapist, social worker, occupational therapist, dietitian, activity director)
- Screening guide

Developing the plan of care

Upon initiating the care plan, all pertinent identifying information regarding the patient/resident will be completed first. Information regarding the following components of the resident care plan will then be determined and recorded:

- The problems, needs, and goals
- The interdisciplinary services plan of care
- The discharge plan

PROBLEMS, NEEDS, GOALS

Identify the problems or needs of the patient/resident. After the information has been gathered the data must be analyzed in order to determine what resident problems and needs exist. The following guidelines should be employed when identifying, selecting, and recording problems.

- The date the care plan was populated or initiated should reflect the date that the problem was identified.
- A person's problem is a difficulty or concern experienced by only them. Be sure to determine the patient/resident's needs not your own.
- The resident's problems include currently existing difficulties as well as potential problems. (i.e., potential skin breakdown in a high-risk resident)
- Problem statements should be written so as to reflect physical, psychological, or social difficulties.
- Problem statements should be followed with a "due to" and or "related to" phrase relating the perception of the cause of the problem from a nursing standpoint.

Determine the goals or expected outcomes. When determining expected outcomes or goals, the following should be kept in mind:

Short-term goals

A short-term goal is a quick resulting effort which can realistically be reached within the patient's abilities. Each problem should have a short-term goal. It should be simple, specific, measurable, and patient-oriented. It should indicate progress toward problem resolution.

Long-term goals

A long-term goal is the end result of short-term goals which leads to the highest obtainable level of independence for the patient/resident. The long-term goal is stated in relation to the expected course of the resident's condition and is determined collectively by the health care team.

Sample explanation: Self-care may be a long-term goal, but for a person who has had a radical mastectomy, this long-term goal is attained step-by-step through the achievement of short-term objectives such as self-feeding, combing hair, applying make-up, self-direction in doing prescribed exercises, and acceptance of the operation and its implication.

Changes: If any goal changes (long or short term), nursing will resolve it and initiate a new goal and current date.

Select the actions/approaches

When selecting appropriate actions or approaches toward resolving problems, the following must be remembered:

- Actions must clearly state and be specific as to the "how."
- Some actions or approaches may be more appropriate to defer or may be medically prescribed to defer until a later time (i.e., defer a bladder training program until the problem of anxiety is resolved).
- In some cases, there are no immediate solutions, but the problem remains under consideration until actions or approaches can be determined. Although specific actions are performed according to the individual responsible discipline, the health care team's collective actions provide the most effective solution toward resolution of the resident's problem.

Document resolution of the problem

As a problem becomes resolved, the appropriate date will be indicated in the care plan.

Interdisciplinary Services

- All interdisciplinary services shall provide information regarding problems, goals, plan of care, treatment, etc. as appropriate. This information should then be recorded in the care plan. The interdisciplinary services will review and update the care plan as needed.
- The Activity Plan shall be outlined, reviewed, and updated on the resident care plan on a quarterly basis and as needed.

Using the Plan

In order to develop and maintain a complete resident care plan and promote continuity of care, input and involvement from nursing personnel from working shifts is necessary. Additionally, more information may be gathered, or resident needs may change as a result of physiological, pathological, and psychological processes. As the plan is used and desired results are not achieved or as changes occur, the team action may need to be modified to meet the needs of the resident.

The mere development of the plan for each person does not ensure that it will be followed; this is accomplished through assignment of team members on the basis of their competence and the needs of the patients. In addition, it is necessary to make periodic observations and evaluations of each patient and determine that:

- The right person is caring for the resident
- The plan is being carried out
- The goals are being met

Evaluating the Plan

When evaluating and re-assessing the plan of care for the resident, the following shall be considered:

- Are the patient/resident's problems still current? Are there new problems?
- Are the short-term goals realistic?
- Are the actions/approaches appropriate and effective?
- Are the health care disciplines involved in the plan of care as needed?
- Does the long-term goal remain appropriate?

Discharge Plan

Part of the resident care planning process includes an assessment of the resident in terms of planning for his/her discharge to a lower level of care whenever possible.

REFERENCES:
DPSNFIVC.18

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DEPARTMENT: Nursing	APPROVED:	Page 1 of 1
SUBJECT: **Critical Lab Values**	EFFECTIVE DATE: 05/30/2019 ~~06/27/2023~~	SUPERCEDES: 04/05/2018

Policy:
It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to Report critical lab values in a timely and correct manner.

Purpose:
The purpose of this policy and procedure is to provide a protocol notification for critical patient test results.

Procedure:

A Critical test result will be reported to the physician that ordered the test. If the physician is unavailable, then:

Critical test results will be reported to the Emergency Department or Acute Nurse by the lab personnel unless it is after business hours, then Quest will report the test result.

A. The licensed caregiver receiving the call from the lab should:
   - Chart the date, time, and the personnel ~~who~~ whom they talked to
   - Verify that the read-back was performed.
   - The person receiving the results is responsible for immediately contacting the physician or licensed caregiver.
   - Chart the date, time, and name of the MD informed. ~~, and~~ Chart~~if~~ any new orders received~~orders given~~ or actions taken.

B. All of this information shall be charted through the Chart Note tab in Heathland Centriq, a template is available for thorough charting.

C. If a critical result is called ~~afterhours~~after-hours, an on-call provider must be informed as soon as possible.

References:
California Department of Public HEALTH (CDPH) General Acuter Care Hospital Relicensing Survey
State Operations Manual 483.50(a)(2) page 553 (Rev. 173 Issued: 11-22-17, Effective: 11-28-17, implementation: 11-28-17

Reviewed By:
California Department of Public HEALTH (CDPH) General Acuter Care Hospital Relicensing Survey
State Operations Manual 483.50(a)(2) page 553 (Rev. 173 Issued: 11-22-17, Effective: 11-28-17, implementation: 11-28-17

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DEPARTMENT: Nursing	APPROVED:	Page 1 of 2
SUBJECT: **Discharge Instructions for Acute In-Patients and Swing Patients**	EFFECTIVE DATE: 05/30/2019 ~~06/27/2023~~	SUPERCEDES: 10/26/2017

POLICY:
It is the policy of Southern Humboldt Community Healthcare District ("SHCHD" or "District") to assess and reassess a patient's need for services following discharge using a coordinated interdisciplinary approach during the patient's hospital stay as well as to provide each patient with a functional set of discharge instructions and education relevant to their diagnosis and patient stay.

PURPOSE:
The purpose of this policy is to ensure Acute, and Swing Patients are discharged according to their needs and to outline the process for discharging a patient to home with or without follow-up care.

PROCEDURE:
Verbal communications concerning discharge, or the discharge planning process shall be conducted in layman's terms using the patient's preferred language. Written discharge instructions shall also be provided, using materials that have been translated into the patient's preferred language whenever possible.

1. Assist in contacting the patient's family/caregiver(s) to inform them of the discharge date and confirm transportation arrangements.
2. The nurse caring for the patient must complete the discharge instructions.
3. Provide patient and family/caregiver(s) with a written discharge instruction sheet

~~Written~~ The written discharge instruction sheet given to the patient/caregiver will detail:

1. Any scheduled follow-up appointments or specialty referrals
2. Medications and prescribed treatments to continue at home
3. Medications discontinued upon discharge
3. Provider contact information
4. Diet and activity level
5. RN and patient signature for returned patient medications and personal belongings
6. Information about any community resources identified during the discharge process
7. Any wound care, CVC/PICC care, urinary catheter care, proper brace care, or any other care specific to devices or procedures to be continued at home after ~~discharge~~discharge.
8. Availability of assistance from community resources, including referrals to other health care agencies, as appropriate.

Ask the patient and family/caregiver(s) to verbalize their understanding of the discharge instructions *and* to give a return demonstration of any care procedures.

The following information **must be documented** in the patient's discharge note or on appropriate approved forms in the medical record:

1. Description of all discharge-related patient/family/caregiver education and teaching related to care of specific to patient diagnosis, Central Venous Catheter lines/ports, indwelling urinary catheters, wound care, or proper medication administration.

2. Discharge vital signs.

3. Availability of transportation.

4. Assessment of availability and readiness of family or ~~other caregiver~~other caregivers (s) to assist with the care of the patient at home ***and*** description of proper return demonstration of any care procedures.

5. Availability of medical equipment, supplies, and medication as indicated.

6. Follow-up plan.

May use Admission/Discharge Resource Binder to assist with this process. Kept at Nursing Station.

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DEPARTMENT: Nursing	APPROVED:	Page 1 of 1
SUBJECT: **Enteral Tube Feeding**	EFFECTIVE DATE: 05/30/2019 ~~06/27/2023~~	SUPERCEDES: 04/26/2018

Policy:
It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide only bolus tube feeding to patients if there is a Physician's order. SHCHD does not provide continuous tube feeding for any patient.

Purpose:
The purpose of this policy and procedure is to outline the policy surrounding enteral tube feeding at SHCHD.

Procedure:
Enteral tube feeds will be administered to patients who are in need but are only to be administered through bolus feeding with a Physician's order for bolus feeding, specifying the type of tube feeding, the amount of tube feed per bolus administration and the amount of free water boluses to be given for hydration of the patient.

For all enteral tube feed boluses administered the enteral tube shall be flushed with 30ml of tap water before and after the bolus is administered.

1. The nurse shall follow the written order of a provider regarding the enteral tube feeding bolus using the six rights of administration, per the Medication Administration policy.
2. The equipment needed for the administration is a non-sterile 60ml catheter tip syringe and 2 non-sterile graduated cylinders. One graduated cylinder shall be labeled "water" while the other shall be labeled "tube feed" and they both shall be labeled with the date and time they were first used. The nurse shall measure the needed amounts into the correctly labeled cylinders.
3. The nurse shall begin with testing the residual of the tube ONLY if the tube is placed in the stomach. If the residual is greater than 500ml then the tube feed shall be held, and the contents shall be returned to the stomach via the tube and rechecked in 2 hours. If there is less than 500ml the nurse shall continue with the tube feed as ordered.
4. The nurse shall flush the tube with 30ml of tap water by placing the 60ml syringe into the graduated cylinder with water and drawing up the 30ml and then uncapping the tube that is attached to the patient's abdomen and attaching the tip of the syringe to the tube and slowly pushing the water out of the syringe and into the tube.
5. The nurse shall administer the tube feed in the amount per the provider's order in the same fashion.
6. The nurse shall again flush the tube with tap water in the same fashion.
7. In the event that a patient has tube feeding from home that is not in cans/bottles but prepared in a bag that is to be spiked with tubing and administered through a tube that may be confused with IV tubing, that tube shall be labeled with a purple sticker with "tube feed- NOT IV" written on the label.
8. The supplies used for tube feeding boluses shall be discarded every 24 hours and new supplies used for the next tube feeding bolus.

References:
Enteral Feeding Tubes; Complication and Nursing Care; Agre P, Brown P, Stone K. Tube feeding troubleshooting guide. The Oley Foundation. March 2016.
American Geriatrics Society Ethics Committee and Clinical Practice and Models of Care Committee. American Geriatrics Society feeding tubes in advanced dementia position statement. *J Am Geriatr Soc.* 2014;62(8):1590-3.

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DEPARTMENT: Nursing	APPROVED:	Page 1 of 1
SUBJECT: **Epidural Lines/Catheters**	EFFECTIVE DATE: **05/30/19** ~~**06/29/23**~~	SUPERCEDES: **06/05/15**

Policy:
It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to not insert epidural catheters or accept a patient with an epidural catheter in place by direct admission or transfer.

Purpose:
The purpose of this policy and procedure is to outline the policy of SHCHD regarding epidural catheters.

Procedure:
1. SHCHD will not accept a transfer or admit a patient with an epidural catheter.
2. In the event that SHCHD were to have to care for a patient with an epidural catheter in place, the pump and tubing being used for the epidural continuous infusion shall be labeled with a yellow sticker marked "epidural."
3. If an Emergency Department patient with an epidural catheter requires admission, the patient shall be transferred as soon as possible to the nearest and most appropriate facility for care.

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DEPARTMENT: Nursing/ALL Departments	APPROVED:	Page 1 of 3
SUBJECT: **Fall Prevention/ Risk Assessment**	EFFECTIVE DATE: 05/30/2019	SUPERCEDES: 01/25/2018

POLICY:
It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to assess the fall risk for each inpatient, swing bed patient, and Skilled Nursing Facility resident upon admission.

PURPOSE:
The purpose of this policy and procedure is to ensure the safety of every inpatient, swing bed patient, and resident and that each inpatient, swing bed patient, and resident is assessed for their risk of a fall at the time of admission. Additionally, each resident in the Skilled Nursing Facility will be re-assessed quarterly with each review of the Minimum Data Set (MDS) and an update to the specific care plan for Fall Risk if applicable.

Recent studies have identified the following characteristics of the fall-prone patient:

1. Age 65 or older.
2. Poor general health.
3. Normal or abnormal mental status such as dementia.
4. A history of falls.
5. Decreased mobility.
6. Urinary frequency or diarrhea; and
7. Sensory deficit, particularly impaired vision.

Falls often occur:

1. In the early morning or evening.
2. After patients have received sedatives, tranquilizers, diuretics or antihypertensive.
3. Attempts to meet physical needs are often present.
4. Patients described themselves as independent but were preoccupied by life crises.
5. Patients believe falls were inevitable; and
6. Patients did not seek help prior to attempting activities that led to falling.

The following procedures will be implemented in order to assess patients for risk of falls.

All patients will be assessed upon admission and throughout the hospital stay for characteristics of the fall-prone patients:

1. Age.
2. State of health.
3. Mental status.
4. Mobility.
5. Elimination patterns.
6. Sensory deficits.
7. History of fall; and
8. Medications.

PROCEDURE:
All patients are assessed at the time of admission using the Morse Fall Scale. If the Morse Fall Scale is calculated as moderate or high a Fall Risk Assessment will be completed. Following the initial patient assessment, patients and residents will be re-assessed in the event any change in condition as noted in 2-8 of the above list occurs. Any patient or resident experiencing a change in condition as noted from the above list will be re-assessed for Fall Risk and the individualized Falls Care Plan updated as appropriate. In the event of a fall, a new Fall Risk Assessment and

Fall Risk Record will be completed and documentation of such in the EMR is completed, along with any updates and/or new interventions implemented and reflected on the individualized Care Plan.

Morse Fall Scale

If the Morse Fall Scale is calculated as moderate or high; initiate fall precautions and complete the Fall Risk Assessment. The computer automatically assigns risk ~~level~~ levels according to categories checked for each individual patient and resident. The scale assesses the following:

1. Ambulatory status; use of safety devices
2. Integrity of gait; steady or unsteady
3. Previous history of falls
4. Medications; IV therapy/access
5. Secondary diagnoses, dementia, cognitive impairment
6. Mental status; orientation to person, place, and time

A. In order to reduce the risk of patient falls certain precautions will be taken for all patients regardless of their level of risk. Paying particular attention to the four "Ps"; Pain, Potty, Positioning, Possessions.

1. Assess the patient for pain level, the need for elimination, position of comfort and make sure that possessions are within reach.
2. Call bell within reach, bed in a low position, and lock the bed wheels.
3. Place bedside tables and over-bed tables close to the client.
4. Encourage the client to rise from the bed or chair slowly to prevent dizziness resulting from postural hypotension.
5. Remove clutter from bedside tables, hallways, and bathrooms.
6. Instruct all clients as to the location of emergency call bells in the bathrooms.
7. See that wheelchairs remain locked when transporting a client from the bed to a wheelchair or back to bed.
8. The use of side rails may be necessary to protect elderly clients from falling out of bed.
9. Place a pull tab alarm on high-risk patients when up in chairs and/or wheelchairs; use chair pad and bed pad alarm as indicated for high ~~fall risk~~fall-risk patients/residents who have a diagnosis of dementia and/or the Minimum Data Set (MDS) reflective of ~~a~~ cognitive impairment. The integrity of the alarms is to be checked during hourly rounding.
10. Use lift devices for those patients who have been identified as not being able to transfer safely otherwise.

B. If the Morse Fall Scale is calculated as moderate or high the following interventions and safety precautions are put in place and entered ~~on~~ into the Falls Care Plan:

1. Patient care plan is based on the nursing diagnosis of potential for injury, Falls.
2. Door frame outside the patient's room will be marked with a Fall Risk sign to alert ~~health care~~healthcare workers that the patient is at risk for falls.
3. Patient's chart shall be identified with labels stating High Risk and/or Fall Precautions, and a fall precaution bracelet will be placed on their bed rail and their wheelchair for the Skilled Nursing Facility patients, and a Fall Risk bracelet placed on any inpatient or swing bed patient identified as a Fall Risk.
4. The patient/resident that has been assessed as a high risk for falls will be assessed every 1 hour and as necessary for the level of comfort, elimination needs, and other comfort measures.
5. Patients are informed to call a nurse for any ambulation assistance; hourly rounding occurs on all Skilled Nursing residents and other patients deemed to be a high risk for falls.
6. Those patients or residents who have been diagnosed with dementia or identified through the MDS assessment with a cognitive impairment will not be left unassisted or unsupervised during transfers or activities of daily living (ADLS)

C In the event of a fall the following will be completed:

1. Call the provider/ stay with the patient.
2. Place patient back in bed, if not contraindicated
3. Assess for injury and complete a set of vital signs
4. Assess for mechanism of fall
5. Call the patient's family or advocate

6. Document circumstances
7. Complete a Fall Assessment and the Fall Risk Record
8. Notify the nursing manager
9. Complete an ~~on-line~~online RL solutions report

REFERENCES:

1. Title 22 DIVS CH1 ART3-70213(a) Nursing Services Policies and Procedures
2. California Advocates For Nursing Home Reform (CANHR); http://www.canhr.org/factsheets/nh_fs/html/fs_CareStandards.html
3. Falls-Risk Assessment and Prevention in Long Term Care; https://www.medicalmutual.com/risk/practice-tips/tip/falls-risk-assessment-and-prevention-in-long-term-care/62

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DEPARTMENT: Nursing	APPROVED:	Page 1 of 2
SUBJECT: **Hourly Rounding**	EFFECTIVE DATE: 05/30/2019 ~~07/03/2023~~	SUPERCEDES: 04/26/2018

Policy:
It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to do hourly rounds on all in-patients, ~~swing bed~~swing-bed patients, and skilled nursing facility residents.

Purpose:
The purpose of this policy and procedure is to decrease falls, decrease the need for patients/residents to press the call light for help, decrease hospital-acquired pressure ulcers, and~~effect a decrease in falls, decrease the need for patients/residents to press the call light for help, decrease hospital-acquired pressure ulcers as well as~~ increase patient and employee safety and satisfaction. This policy will help bring nurses back to the bedside and improve safety, clinical outcomes, and ~~building~~ build trust with our patients.

Procedure:
Rounds must be done on all patients and residents on an hourly basis. Rounds consist of an LVN, CNA, or RN walking into each room to visually check on each patient/resident. Rounds shall be tailored to the needs of the patient/resident using the FIVE P's of rounding, pain, positioning, potty, periphery i.e. call light, phone, TV remote, and water and pump.
For example, on each hourly round:

1. Patients who need assistance to the restroom shall be offered assisted toileting.
2. The patient's pain control shall be assessed if pain has been an issue~~If pain has been an issue, the patient's pain control shall be assessed~~.
3. The patient shall be assessed for comfort and positioning in bed if they appear uncomfortable or are unable to change position independently.
4. Patients with a peripheral intravenous catheter in place, shall have the IV site assessed, along with any continuous fluids/ IV antibiotics that may be running.
5. Monitor leads shall be checked for proper placement, on those with cardiac monitoring ordered.
6. The patient's wristbands shall be checked for placement and correctness.
7. The room shall be checked for safety hazards
8. It shall be checked that the patient has the call light within reach and other essentials such as the phone, tissue, and water.
9. If the patient/resident needs a bed alarm or any other type of alarm, it shall be checked to ensure~~has the need for a bed alarm or any other type of alarm, it shall be checked to make sure~~ it is activated.

Assessing the 5 P's:

The nurse will ask:

Pain: How is your pain?

Position: Are you comfortable? (Turn and Position patient)

Potty: Do you have bathroom needs?

Periphery: Do you need me to move the phone, call light, trash can, water cup or over bed table? (Move the phone, fill the water cup). Ensure all equipment is plugged in. Eliminate unnecessary clutter.

Pump: Check the IV pump.

Nursing shall document in the Electronic Medical Record under chart notes that hourly rounds were done and what they did for the patients. There should be one note in the system with multiple time stamps or multiple entries per shift documenting the 5 P's.

REFERENCES:

Readiness Rounds. "The 5 Ps of Rounding: The Foundation of Patient Satisfaction." MedSurg Nursing, May-June 2018, 17.3.42.

Olrich, Todd, Melanie, Kalman, Nigolian, Cindy "Hourly Rounding: A Replication Study" MedSurg Nursing, January-February 2012, Vol. 21/No. 1

Stempniak, Marty "Preventing Falls" Hospital and Health Networks Magazine, June. 2015

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DEPARTMENT: Nursing	APPROVED:	Page 1 of 2
SUBJECT: **Insertion and Maintenance Of Peripheral Intravenous Catheters**	EFFECTIVE DATE: 05/30/2019 ~~07/03/2023~~	SUPERCEDES: 04/26/2018

POLICY:
It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to establish and maintain peripheral intravenous access on patients as needed for the intermittent or continuous administration of medications and fluids.

PURPOSE:
~~The purpose of this policy and procedure is to~~ This policy and procedure describe the process of obtaining and maintaining peripheral intravenous access on a patient on whom it is deemed necessary.

PROCEDURE:
Once a physician or practitioner has deemed it necessary for a patient to have a Peripheral Intravenous catheter (IV) inserted, a qualified person will gather the supplies necessary to insert the IV.

Qualified personnel consists of a Medical Doctor (MD), Registered Nurse (RN), Nurse Practitioner (NP), or an IV-certified Licensed Vocational Nurse (LVN).

Supplies:

- Tourniquet
- 2% ~~chlora~~chlorаprep swabs
- gloves
- Angiocath (size determined based on the situation)
- 3-10ml syringe prefilled with 0.9% normal saline
- Extension set with removable ULTRASITE injection site and a luer-loc connector
- Transparent Dressing
- Tape

1. After examining the patients' upper peripheral extremities (lower peripheral extremities, if multiple failed attempts on the upper extremities) and deciding the site ~~that~~ where the venipuncture will take place, the extension set will be primed with the 0.9% NS by connecting the syringe to the luer-loc connector on the end of the Ultrasite valve.

2. The tourniquet will be placed above the site and the site will be cleaned with chloraprep and allowed to air dry.

3. Perform hand hygiene and don gloves. The Angiocath will be inserted, and the catheter threaded into the vein with positive blood flow signifying correct placement. The safety button will be pressed so that the needle retracts and the safety mechanism is activated.

4. The extension set will be connected to the Angiocath and then flushed for patency. Checking for swelling, pain, and redness. Pull back slightly on the Angiocath and watch for blood return to indicate good placement.

5. The Angiocath and the tubing will be secured with tape and a transparent dressing. The dressing will be labeled with the date, time, and initials of the person who inserted the IV. Replace the tubing every 72 hours and label it with the date to be changed.

6. The IV site will be checked for patency by flushing with at least 3ml 0.9% NS and watching for swelling, pain, redness, and blood return with the flush~~,~~ before each IV medication is administered or once a shift if the patient is not currently receiving any IV medications. IV assessment will be charted in the Electronic Health Record (EHR) at least once per shift. This shall be charted through the IV Site icon.

7. If a patient has multiple IV/central line sites and multiple medications/fluids that are being administered to the different lines, the qualified personnel that are responsible for monitoring the lines will label all lines with a

date and time sticker and all medication bags with an orange medication label that clearly states the medication or fluid that is being administered through that ~~particular~~ IV line and then chart in the EHR chart notes that the lines were labeled to prevent medication and/or fluid errors.

8. Clean the injection port with an alcohol pad before accessing the system to flush or administer medication. Scrub vigorously for several seconds.

9. Inspect the catheter insertion site daily for signs of phlebitis and infection (warmth, erythema, tenderness, swelling, or discharge). Remove the catheter if signs of phlebitis, infection, or extravasation are present.

10. For inpatients, the IV can be in place for up to 96 hours as long as it remains patent and without signs of phlebitis or infection. After the four days have passed the IV must be discontinued and restarted in another location unless the Provider order instructs otherwise.

11. All inpatients must have a patent IV while admitted to the hospital to allow for emergency medication administration unless otherwise ordered by the provider.

REFERENCES:

Grady, N.P. (2015). Guidelines for the Prevention of Intravascular Catheter-Related Infections. Center for Disease Control and Prevention.

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DEPARTMENT: Nursing	APPROVED:	Page 1 of 1
SUBJECT: **IV Administration of Potassium Chloride**	EFFECTIVE DATE: 05/30/2019 ~~07/03/2023~~	SUPERCEDES: 04/26/2018

Policy:
It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to treat all patients with hypokalemia effectively and safely.

Purpose:
The purpose of this policy and procedure is to ensure that intravenous Potassium Chloride will be safely prepared and administered.

INTRAVENOUS POTASSIUM CHLORIDE CAN BE FATAL IF GIVEN INAPPROPRIATELY.

Procedure:
IV ACCESS:
Peripheral vein, large
20-gauge intravenous catheter or larger

DILUENTS:
- NS or D5W
- MEDICATION / DILUTIONS / INFUSION RATES
- 10 mEq / 100 ml / 1 hr
- 20 mEq / 250 ml / 2 hr
- 40 mEq / 500 ml / 4 hr
- Maximum Concentration of Potassium Chloride is 1 mEq / 10 ml
- Maximum Infusion Rate is 10 mEq / hr
- Typically hang 1000 ml NS bag with medication in order to decrease pain and irritation.

ADMINISTRATION PROCEDURES:
Intravenous Potassium Chloride is delivered via a dedicated line; no other solutions or connections to the line unless approved by the pharmacist.
Potassium Chloride is **never** delivered as a bolus.

ALL IV INFUSIONS OF POTASSIUM MUST BE DELIVERED BY AN INFUSION PUMP.
Intravenous Potassium Chloride solutions should be prepared immediately prior to administration and the bag should be adequately mixed by inverting the bag at least 10 times. The infusion must be properly labeled with the Medication, dose, and patient sticker. Potassium Chloride must be documented in full; abbreviations are not acceptable. Disconnect the infusion line as soon as the infusion is completed.

MONITORING
Cardiac Monitor, continuously.
Assess the infusion site frequently for pain and phlebitis.
Immediately stop infusion if there are any signs and symptoms of infiltration and report to the ordering provider.

References:
UpToDate.com 2014, Potassium Chloride: Drug Information Lexicomp
NSW Health PD205 342 Safe Handling of IV Potassium Chloride in Health Care Facilities
Royal Hospital for Women; Clinical Policy and Procedures 2009

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DEPARTMENT: Nursing	APPROVED:	Page 1 of 1
SUBJECT: **Lippincott and Up-to-Date References**	EFFECTIVE DATE: 05/30/2019 ~~07/03/2023~~	SUPERCEDES: 02/05/2014

Policy:
It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to use the Lippincott Manual of Nursing Practice or Up to Date as a general guide to basic procedures (guidelines), medication reference and nursing process (nursing process overview) as indicated.

Key Points:

1. Any reference to diagnostic testing, including laboratory and other invasive and noninvasive diagnostic and imaging procedures, medications, etc., which require a physician's order will only be initiated upon a physician's order for a specific patient.

2. Relevant clinical content and guidelines are offered in a logical and readily accessible format online or in the reference manual.

3. Use of the nursing process provides a nursing frame of reference and continuity.

4. Included is the essential knowledge and understanding for monitoring the changing status of patients so that complications can be prevented, or their effects minimized

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DEPARTMENT: Nursing	APPROVED:	Page 1 of 2
SUBJECT: **Medication Administration**	EFFECTIVE DATE: 05/30/2019 ~~07/03/2023~~	SUPERCEDES: 04/26/2018

POLICY:
It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to administer medications according to the acceptable standards of practice.

PURPOSE:
The purpose of this policy and procedure is to describe the basic elements of safe, efficient, medication administration.

PROCEDURE:

- **RIGHT PATIENT, RIGHT DOSE, RIGHT DRUG, RIGHT ROUTE AND RIGHT TIME**

1. The complete act of administration entails removing an individual dose from a previously dispensed, properly labeled container, verifying the dose with the prescriber's orders, giving the individual dose to the proper patient and promptly recording the time and dose given.

2. No medication or treatment shall be given except on the order of a person lawfully authorized to give such an order. However, certain parenteral medications require specific diluents for preparation. In this case, the medication will be mixed following the manufacturer's suggested procedures. No specific order is required.

3. Only medications listed in the Hospital Formulary and approved by the Medical Staff may be administered. Homemade preparations may not be administered unless brought into the facility by the patient/resident, and an order is obtained from the physician. All non-formulary medications are to be given to Material Management to be entered into Healthland. The nurse should not enter the medication themselves.

4. Only licensed personnel, i.e., RNs or LVNs, are assigned responsibility for preparing, administering, and recording ~~of~~ medications and treatments, with the following exceptions:

    a. Students in the healing arts professions may administer medications and treatments only when the administration of such is incidental to their course of study as approved by the professional board or organization legally authorized to give such approval.

    b. Unlicensed persons may, under the direct supervision of licensed nursing or licensed medical personnel, during training or after completion of training and demonstrated evidence of competence, administer the following:

        - Medicinal shampoos and baths.
        - Laxative suppositories and laxative enemas.
        - Non-legend topical ointments, creams, lotions, and solutions when applied to intact skin surfaces. Unlicensed persons shall **NOT** administer any medication associated with the treatment of eyes, ears, nose, mouth, or genitourinary tract.

5. Medication will always be prepared, administered, and properly recorded by the same person, i.e., no one will give a medication prepared by another person.

6. Preparation of doses for more than one scheduled administration time shall not be permitted.

7. Medications shall be administered as soon as possible after doses are prepared, but no more than two (2) hours after preparation and shall be given at the time ordered or within one (1) hour on either side of the time designated. For oral medications, the nurse administering the medication remains with the patient until the medicine is swallowed. Medications will **NOT** be left at the bedside for the patient to take ~~at a later time~~later~~,~~ unless there is a ~~physician~~ physician's order.

8. Patients shall be identified prior to the administration of all medications.

9. Medications supplied for one patient shall **NOT** be administered to another patient.

10. If the medication is liquid suspension or emulsion, the bottle shall be well shaken before measurement of a dose.

11. The recording of the medication or treatment shall be done AFTER administration by the person who administered it with the date and time. Medications are to be signed off in the Electronic Medical Record (EMR) once the medication has been administered.

12. When charting the administration of any PRN medication, the nurse will document full details including the patient's symptoms, method, route and time of administration, the effect of medication, and signature.

13. Medication errors and untoward drug reactions are immediately reported to the attending physician, charted in detail on the nurse's notes, and described in the electronic event reporting system.

14. The attending physician will be promptly notified of the facility's inability to obtain or administer on a prompt and timely basis, drugs, equipment, supplies, or services as prescribed under conditions ~~which~~ that present a risk to the health, safety, or security of the patient.

15. A medication review form will be submitted monthly. (See attached form)

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Clinic Nurse Manager
MD Clinic Physician
Medical Director
Chief Nursing Officer

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DEPARTMENT: Nursing	APPROVED:	Page 1 of 2
SUBJECT: **Patient and Staff Safety Plan**	EFFECTIVE DATE: 05/30/2019 ~~07/03/2023~~	SUPERCEDES: 04/26/2018

Policy:
It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide a safe environment for patients, visitors, and staff.

Purpose:
The purpose of this policy and procedure is to provide general safety guidelines for the staff to follow.

Safety is a very important part of the acute care unit as it concerns patients and employees. All nursing staff must be trained in their duties to assure safety in the acute care unit for the patients, the general public, and employees. Be aware and know the risks involved in your job. Explain safety rules to patients and staff and set the example of safety awareness and practices for co-workers, patients, and visitors.

Procedure:

Work Areas or Stations
- All drawers and doors closed when not in use.
- Electrical equipment is turned off when not in use.
- All needles, glass, and razor blades are placed in an appropriate biohazard container for disposal.
- Uniforms shall not restrict free movement or be designed ~~as~~ to allow entanglement in equipment.
- All aisles and hallways are clear. Store all equipment in the proper area.
- All outside doors are to be kept closed and locked after 9 PM, outside doors are never to be left propped open under any circumstances.

Patient Safety
- All patients are instructed in the use of the call light at the time of admission.
- All patients are provided with identification bracelets at the time of admission:
  - A white bracelet with name, physician, date of admission, and hospital number
  - A red bracelet for allergy identification
  - A yellow bracelet if identified as a fall risk after ~~assessment~~assessment.
- All acute care beds are equipped with side rails* and shall be used when:
  - Patients are under sedation
  - Unconscious patients
  - Any patients when admitted are under the influence of alcohol or narcotics
  - Patients in a confused state of mind
  - When the patient is sleeping if the patient may be considered at high risk for falls

*Nurse's notes should indicate when side rails are in place. The bed is also to be in the lowest position.

- All patient bathing and toilet areas are equipped with grab bars.
- Automatic regulation of the temperature of the hot water supply is maintained in order that the temperature does not exceed 110° Fahrenheit.
- Use of portable electric heaters is prohibited.

Oxygen Safety
- Patients and visitors shall be instructed about oxygen hazards.
- No oil, alcohol, or any substance that may ignite readily will be used on the patient while oxygen is in use.
- Oxygen and other gas cylinders shall be transported on carriers.
- All cylinders shall be secured.
- Read the cylinder label carefully before administering oxygen to a patient.
- Any faulty regulators, valves, or oxygen leaks should be reported to the Maintenance department immediately.

Any equipment that malfunctions is to be taken out of service immediately and reported to Engineering and a work order is placed through email to group work orders.

Safety Rules ~~specific~~ Specific to the Acute Care Unit

- When restraints are required, a physician's order will be obtained prior to the use of the restraints. Use the pre-printed order set and restraint assessment flow sheet in EHR
- **NO SMOKING** in the building.
- The identification band is to be checked using two patient identifiers before the administration of medication, IV fluid, blood, or blood product and before any procedure invasive or otherwise.
- All electrical equipment brought into the acute care unit must have had an electrical safety check by engineering within an appropriate period of time, prior to use in the unit.
- No portable electric heaters or electric blankets may be used by any patient or resident.
- No electric shavers will be used on patients if the patient is on oxygen in the acute care unit.
- Visitors must check in at the nurse's station before entering the room.
- In an emergency or code blue scenario RN's may follow ACLS and PALS protocols until a physician arrives.
- When breaking ampules use a piece of gauze between your fingers and the ampules to keep from cutting yourself; always use a filter needle when removing medication from a glass ampule.
- Always use standard precautions for all patients and use personal protective equipment (PPE) in accordance with the situation, the patient's diagnosis, and hospital policy.
- If transmission-based precautions are in place for any patient or resident all visitors and staff must wear the appropriate personal protective equipment (PPE). ~~Nursing~~ The nursing staff is to teach and role model for the family/visitors.
- Clean medical devices and equipment between every patient and when visibly soiled per facility policy.
- Use an aseptic technique for the insertion and manipulation of invasive patient lines (e.g., Foley catheters, central lines, and peripheral IV catheters).

Any adverse event reportable or non-reportable (a patient safety event) will be documented by submitting the appropriate report ~~into~~ to RL Solutions and will be reviewed by the Patient Safety Committee for quality assurance performance improvement measures.

A patient safety event is defined as the following, but not limited to:

- ~~Healthcare associated~~Healthcare-associated infections (HAI)
- Fall with or without injury
- Medication error

REVIEWED BY:
CEO/Administrator
Chief Nursing Officer/Director of Patient Care Services
Emergency Department/Acute Nurse Manager
Emergency Department/Hospital Medical Director
Infection Preventionist
Safety Committee/Environmental/Engineering Manager
Skilled Nursing Facility Director

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DEPARTMENT: Nursing	APPROVED:	Page 1 of 1
SUBJECT: **Patient or Resident Fall**	EFFECTIVE DATE: 05/30/2019 ~~07/03/2023~~	SUPERCEDES: 04/26/2018

Policy:
All patients will have an appropriate assessment and definitive care as needed following any fall, accident, or unusual occurrence.

Purpose:
To provide patients/residents with consistent and appropriate care following a fall.

Procedure:
1. Staff who are with the patient/resident during the fall, should stay with the patient, call out for help or turn the call light on.
2. Patient/resident should not be moved until he/she has been assessed for fractures and/or other injuries.
3. Determine if the patient/resident lost consciousness. Determine the current level of consciousness.
4. Have the patient explain if he/she can, where he/she was going or what happened.
   Ask the patient questions which cannot be answered with a "yes" or "no."
   (i.e., "Where were you going when you fell?" NOT "Were you going to the bathroom when you fell?")
5. Inspect for any cuts, bruises, or bone deformities.
6. Provide emotional support to the patient and/or family as appropriate.
7. Assist back to bed as condition indicates or take to the ED if necessary, after clinic hours.
8. Obtain a "Fall Sheet" and begin taking vital signs according to form. All patients/residents will have one hour of vital signs taken.
9. If the fall was unwitnessed, the patient must be treated as though he/she has a head injury. Enter vital signs and the neuro assessment in the EHR. Checks are to be done every 15 minutes x 4, then q 2 hours x 24 hours.
10. Notify the physician of a fall based on assessment and nursing judgment.
11. Physician may discontinue vital signs if appropriate. This must be done by a written order into the Computerized Physician Order Entry system (CPOE).
12. Notify the patient's family as soon as possible, if appropriate. If it is at night and the patient appears uninjured, you may wait until morning.
13. Document carefully in the nurses' progress notes.
14. Submit a report ~~into~~ to RL Solutions and notify the appropriate nurse manager and or chief nursing officer as appropriate.

Document the following:
1. Complete assessment of the resident including the description of any wound or injury
2. Neuro assessment if applicable
3. Complete vital signs: initial and ongoing
4. Time MD was notified
5. Time family notified
6. Update the fall risk assessment
7. Update the resident's plan of care

Reviewed By:
Chief Nursing Officer/Director of Patient Care Services
Skilled Nursing Facility Nurse Director

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DEPARTMENT: Nursing	APPROVED:	Page 1 of 2
SUBJECT: **Physician Orders for Life-Sustaining Treatment (POLST)**	EFFECTIVE DATE: 05/30/2019 ~~07/03/2023~~	SUPERCEDES: 04/25/2019

POLICY:
It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to have the admitting physician fill out a Physician Orders for Life-Sustaining Treatment (POLST) form for all patients on observation and all patients admitted to an acute, swing or SNF bed.

PURPOSE:
The purpose of this policy and procedure is to outline the rules surrounding the Physician Orders for Life-Sustaining Treatment (POLST) form in order to outline the interventions that the patient would like to have done, in the event that ~~life-sustaining~~life-sustaining interventions are needed. This form does not replace the Advanced Directive but compliments it and serves as basic instructions if there is no Advanced Directive on file.

DEFINITION:
The Physician ~~Orders~~ Order for Life-Sustaining Treatment (POLST) is a physician order form that complements an advance directive by converting an individual's wishes regarding life-sustaining treatment and resuscitation into physician orders. It is designed to be a statewide mechanism for an individual to communicate his or her wishes about a range of life-sustaining and resuscitative measures. It is designed to be a portable, authoritative, and immediately actionable physician order consistent with the individual's wishes and medical condition, which shall be honored across treatment settings.

The POLST form:

- Is a standardized form that is brightly colored (PINK) and clearly identifiable
- Can be revised or revoked by an individual with ~~decision-making~~decision-making capacity at any time
- Is legally sufficient and recognized as a physician order
- Is recognized and honored across treatment settings
- Provides statutory immunity from criminal prosecution, civil liability, discipline for unprofessional conduct, administrative sanction, or any other sanction to a healthcare provider who relies in good faith on the request and honors a POLST

PROCEDURE:

The physician is responsible for discussing the efficacy or appropriateness of the treatment options with the patient, or if the patient lacks ~~decision-making~~decision-making capacity the ~~patients'~~ patient's legally recognized ~~health care~~healthcare ~~decision maker~~decision-maker. Once the POLST form is completed, it must be signed by the patient, or if the patient lacks ~~decision-making~~decision-making capacity the resident's legally recognized ~~health care~~healthcare decision maker~~,~~ and~~AND~~ the attending physician.

1. The POLST form will be completed on all patients within 24 hours of admission to acute care, observation, or Swing bed.

2. At the time that it is decided that a patient will be admitted to the hospital for observation, acute stay, or swing bed the admitting physician will meet with the patient and fill out the Physician Orders for Life-Sustaining Treatment (POLST) form per the patient's wishes or if the patient lacks ~~decision-making~~decision-making capacity the resident's legally recognized health care decision maker. In the event that~~,~~ the patient is discharged or transferred for any reason, the original POLST form will go with the patient and a copy will be put in the patient's medical records.

3. After the POLST form is completed, the nurse will document the existence of the POLST form on the admission assessment and review the form for completeness (e.g., signed by patient or legally recognized

healthcare decision maker, and by a physician).

4. Once reviewed, the original POLST should be placed in the patient's chart with all areas on the form filled out completely and a patient sticker attached to the form along with the advanced directive if needed.

5. If the patient is transferred to another facility, the original pink POLST, and copies of the patient's advance directive should always accompany the patient. A copy of the POLST must be obtained and submitted to Medical Records.

6. At any time, the patient with ~~decision making~~decision-making capacity can revoke the POLST form or change his/her mind about his/her treatment preferences by executing a verbal or written advance directive or, after consultation with the patient's physician, a new POLST will be created. The new POLST form must be signed by the physician and the patient and the revoked POLST must be voided.

7. All discussions about revising or revoking the POLST should be documented in the resident's medical record. This documentation should include the time and date of the discussion, the parties involved, the essence of the conversation, and plans for follow-up action if needed.

8. To void POLST, draw a line through the entire Section A through D and write "VOID" in large letters. The original POLST marked "VOID" should be signed and dated.

CONFLICT RESOLUTION:
If there are any ethical concerns or conflicts about the POLST orders, appropriate resources e.g., risk management, care conferences, legal, or other administrative or medical staff resources- may be utilized to resolve the conflict.

REFERENCES:

Emergency Medical Services Authority #111: Do Not Resuscitate (DNR) and POLST, 5th Revision. January 2018.

National Task Force Recognizes California for "Mature" POLST Program. Coalition for Compassionate Care of California. May 2017.

The official POLST form for California is approved by the Emergency Medical Services Authority. You can download a copy of the form for printing by going to the Coalition of Compassionate Care of California website at: www.CoalitionCCC.org.

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Medical Director
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DEPARTMENT: Nursing	APPROVED:	Page 1 of 2
SUBJECT: **Pressure Ulcer Prevention**	EFFECTIVE DATE: 05/30/2019 ~~07/03/2023~~	SUPERCEDES: 10/26/2017

Policy:
It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to follow accepted ~~Evidence Based~~Evidence-Based Practice put forth by the National Pressure Ulcer Advisory Panel to ensure that patients admitted for care and treatment to the Facility do not develop pressure ulcers.

Purpose:
The purpose of this policy and procedure is to set forth practice guidelines for the bedside nurse to adhere to as ascribed ~~from~~ by the Agency for Healthcare Research and Quality (AHRQ) and adhering to recommendations from the National Pressure Ulcer Advisory Panel (NPUAP) for prevention of pressure ulcers, treatment of pressure ulcers and treatment of pressure ulcers in "special populations", which refers to that population of patient most at risk for pressure ulcer.

Procedure:

A. Conduct A Thorough Risk Assessment on Admission That Is Inclusive of A Skin Assessment

1. Per policy all patients admitted to the facility will have a skin assessment completed in the first 8 hours of admission and then daily thereafter.
2. Skin inspection should include assessment for localized heat, edema, pain or induration (hardness), especially in individuals with darkly pigmented skin.
3. If a pressure ulcer is present on admission and/or a pressure ulcer develops while in the facility, the following is documented and reported; area of body pressure ulcer present, measurement and staging of ulcer inclusive of depth and any tunneling present, color, and odor.
4. Consent to photograph will be obtained from the patient or patient advocate if the patient is unable to give consent and a photograph of the area will be taken and placed in the EMR.
5. If appropriate additional photographs will be taken to demonstrate improvement and/or worsening of the affected area.

B. Assessment of Nutritional Status

1. Screen and assess the nutritional status of every individual at risk of pressure ulcers in each ~~health care~~healthcare setting.
2. Diabetic patients are especially vulnerable and should be closely monitored for pressure areas
3. Use a valid, reliable, and practical tool for nutritional screening that is quick and easy to use, and acceptable to both the individual and health care worker.
4. Provide nutritional support to each individual with nutritional risk and pressure ulcer risk, following the nutritional cycle. This should include:

    - Nutritional Assessment
        - Estimation of nutritional requirements
        - Comparison of nutrient intake with estimated requirements
        - Provide appropriate nutrition intervention, based on the appropriate feeding route
        - Monitoring and evaluation of nutritional outcome, with a reassessment of status at frequent intervals while an individual is at risk

C. Repositioning for the Prevention of Pressure Ulcers

1. The use of repositioning should be considered in all at-risk individuals
2. Repositioning should be undertaken to reduce the duration and magnitude of pressure over vulnerable areas of the body
    a. High pressures over bony prominences, for a short period of time, and low pressures over ~~bony~~ bony prominences, for a long period of time, are equally damaging. In order to lessen the individual's risk of pressure ulcer development, it is important to reduce the time and the amount of pressure she/he is exposed to.

3. Repositioning frequency will be determined by the individual's tolerance, his/her level of activity and mobility, his/her general medical condition, the overall treatment objectives, and assessments of the individual's skin condition.
4. Assess the individual's skin condition and general comfort. If the individual is not responding as expected to the repositioning regime, reconsider the frequency and method of repositioning.
5. An individual should be repositioned with greater frequency on a ~~nonpressure redistributing~~non-pressure-redistributing mattress
6. ~~Bed bound~~Bed-bound residents and patients are to be turned every two hours with the ~~assist~~ assistance of two healthcare workers to avoid injury to the resident or patient as well as injury to healthcare workers.
7. Residents and patients are to be checked for incontinent episodes at each turn with appropriate undergarment change as well as appropriate linen change.

    a. ~~Skin care~~Skincare and or dressing changes at each turn as appropriate and per provider order, with appropriate documentation entered into the EMR
    b. Reposition the individual in such a way that pressure is relieved or redistributed, avoid subjecting the skin to pressure and shear forces**.**
    c. Use transfer aids to reduce friction and shear. Lift — do not drag —the individual while repositioning. (Use two healthcare workers)
    d. Avoid positioning the individual on bony prominences with existing ~~non-blanchable~~non-blanch-able erythema.
    e. Repositioning should be undertaken using the 30-degree tilted ~~side-lying~~side-lying position (alternately, right side, back, left side) or the prone position if ~~the~~ the individual can tolerate this and her/his medical condition allows. Avoid postures that increase pressure, such as the 90-degree side-lying position, or the semi-recumbent position.

8. Limit the time an individual spends seated in a chair without pressure relief.
    a. When an individual is seated in a chair, the weight of the body causes the greatest exposure to pressure to occur over the ischial ~~tuberosity's~~tuberosity. As the loaded area in such cases is relatively small, the pressure will be high; therefore, without pressure relief, a pressure ulcer will occur very quickly.

D. Documentation

1. Documentation to include the following elements:
    a. Skin Assessment to be completed and documented within 8 hours of admission
    b. Daily skin assessment to be documented in the EMR
    c. Presence of pressure ulcer on admission
    d. Area of the body that pressure ulcer is present, measurement and staging of ulcer inclusive of depth and any tunneling present, color, and odor
    e. Documentation of developing pressure ulcer; with a report to the manager, request for pressure ulcer treatment from PCP
    f. Documentation of type of ~~skin care~~skincare, medication use, and type of dressing
    g. Care plan to be opened that speaks to the pressure ulcer ASAP but within at least 24 hours of discovery

2. Record repositioning regimes, specifying frequency (at least every two hours for ~~bed bound~~bed-bound residents and patients and every two hours at night for all residents and patients who cannot reposition themselves safely or adequately) and the position adopted, and include an evaluation of the outcome of the repositioning regime.

REFERENCES:

1. Agency for Healthcare Research and Quality (AHRQ); Preventing Pressure Ulcers in Hospitals; September 2014; https://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/index.html
2. National Pressure Ulcer Advisory Panel (NPUAP); Prevention of pressure ulcers, treatment of pressure ulcers and treatment of pressure ulcers in "special populations"; http://www.epuap.org/wp-;content/uploads/2016/10/final_quick_prevention.pdf

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DEPARTMENT: Nursing	APPROVED:	Page 1 of 2
SUBJECT: **Transport/Transfer of Acute Care Patients**	EFFECTIVE DATE: 05/30/2019 ~~07/03/2023~~	SUPERCEDES: 04/05/2018

POLICY:
It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to affect the appropriate transfer of all patients who require a higher level of care in compliance with EMTALA standards.

PURPOSE:
The purpose of this policy and procedure is to delineate the steps required to transfer patients from the acute/swing beds to other facilities.

PROCEDURE:
If a patient presents to SHCHD with an Emergency Medical Condition that cannot be definitively treated at SHCHD then the patient is stabilized to the extent possible within the capabilities of SHCHD and then transferred to an appropriate facility for definitive care.

It is acceptable to transfer an unstable patient if the benefits outweigh the risks and is documented by the practitioner accordingly.

I. The following are requirements for all patient transfers:

1. Patient transfer must be based solely on medical necessity or patient request.
2. Patients requesting transfers must sign the "patient request for transfer" part of the Transfer Summary.
3. Patients or their legal representatives must be provided with ~~an~~ informed consent for transfer ~~which~~ which includes an explanation of the risks and benefits of transfer (Transfer Summary).
4. Patients must be stabilized to the extent possible prior to transfer.
5. Patients must be accompanied by all pertinent medical records including laboratory studies, radiology reports, and discs.
6. Patients must be accompanied by appropriately qualified medical personnel for the medical condition i.e., BLS or ACLS transport. If necessary, an RN must accompany the patient to their destination.
7. Patients must be transferred with transport equipment appropriate for ~~the~~ their medical condition.
8. The receiving facility must confirm available space and adequate personnel to appropriately care for the patient.
9. The receiving physician or service must accept the patient for transfer.
10. An adequate medical report of the patient's condition at ~~that~~ the time of transfer must be given to the receiving facility and documented on the medical record.

A patient Transfer Summary Form will accompany the patient to receiving facility and a copy will ~~be~~ be scanned in as a part of the permanent medical record at SHCHD with a patient label on the form.

II. **Required medical record documentation for all transfers**: If emergency services are needed prior to the transfer, the patient will be transferred to the Emergency Department (ED) and after emergency care has been provided, patients who require transfer to a higher level of care will be transferred per the ED transfer policy and procedure. If the patient is transferred to another facility directly from acute care, the medical records shall contain copies of the following.

A. Acute Record
   1. Medical Summary
   2. Face Sheet
   3. Patient Name
   4. Address
   5. Sex
   6. Race
   7. Age
   8. Insurance Status

C. Transfer Summary Form

1. Name of referring physician and hospital
2. Name of the physician at the receiving hospital consenting to accept the patient.
3. Date and time of acceptance.
4. Date and time of transfer.
5. Summary of the risks and benefits of transfer signed by the transferring physician.
6. Transfer Summary signed by the patient and reason for transfer stated.
7. Patient vital signs, IV rate & Glasgow Coma Scale at bottom of Transfer Summary record.
8. Patient request for transfer signed if the transfer is at the patient's request.
9. All other information in the spaces provided.

D. All diagnostic test results.

E. An extra face sheet, copy of Transfer Summary, and an Ambulance Transfer prescription filled out by MD stating the reason for transfer by the ambulance crew. **CANNOT say "**higher level of care needed." Must state actual reason such as Need for Cardiologist or Neurologist.

III. Necessary documentation by the physician in the acute patient chart must include:

A. Acceptance by the receiving facility, including the accepting party's name and position in the receiving facility, and the date and time of acceptance.

B. The suspected diagnosis, the patient's stabilized condition, written record of the medical information transmitted via telephone to the receiving hospital, and mode of transport.

C. The original Transfer Summary shall be sent to the receiving hospital with copies of the medical record and appropriate diagnostic test results. A copy of the Transfer Summary and Ambulance Transfer prescription will be kept in the medical record.

D. The nurse will document the report given to (~~Nurses~~ Nurse's name) at (hospital) on which floor. The nurse will also document the time the patient left in the chart notes.

IV. Patients will be transferred by ambulance, except in the following cases:

A. Transfers permissible by private car:

1. The physician has determined that the patient is medically "fit" and stable to be transported without medical assistance.
2. If it is inadvisable for a patient to be transferred without medical assistance (ambulance) but the patient insists upon arranging his or her own transportation (drives himself/herself, public transportation, or driven by family or friends) the attending physician will discuss the request with the patient; outline the risks and potential consequences of transfer without medical assistance and benefits of transfer by ambulance and document the discussion in patient's medical record.

**If the patient still insists on transfer by private car, the attending physician will notify the receiving hospital's physician and thoroughly document the refusal to transport by ambulance. Patients have the right to refuse medical treatment and can leave Against Medical Advice (AMA). An "Informed Consent to Refuse" form must be filled out and signed by the patient. If the patient refuses to sign the form, it will still be filled out and signed by the appropriate medical staff.

REFERENCES:
California Hospital Association's "Consent Law Manual," "EMTALA" and "A Guide to Patient to Anti-Dumping Laws" 2017

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DEPARTMENT: Nursing	APPROVED:	Page 1 of 3
SUBJECT: Physical or Chemical Restraint	EFFECTIVE DATE: 05/27/2021 ~~07/03/2023~~	SUPERSEDES: 3/11/2013

Policy:
It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to implement emergency intervention procedures for behavior control means those techniques used in the management of patients who exhibit severe aggressive or explosive behavior which ~~poses~~ pose an immediate threat of bodily harm to the patient or others.

Purpose:
To keep patients safe who may be displaying behaviors that may cause harm to ~~self~~ themselves or others in the healthcare setting.

Note: Restraints physical or otherwise will not be used on any In-patient, Swing Bed patient or Skilled Nursing Resident.

Definitions:
1. "Restraint" means control of the client's behavior or activities through the use of physical or pharmaceutical means other than postural support.
2. "Behavioral restraint" means "mechanical restraint" or "physical restraint" and is used as an intervention when a person presents an immediate danger to self or to others. It does not include restraints used for medical purposes, including, but not limited to, securing an intravenous needle or immobilizing a person for a surgical procedure.
3. "Containment" means a brief physical restraint of a person for the purpose of effectively gaining quick control of a person who is aggressive or agitated or who is a danger to self or others.
4. "Mechanical Restraint" means the use of a mechanical device, material, or equipment attached or adjacent to the person's body that he or she cannot easily remove and that restricts the freedom of movement of all or part of a person's body, or restricts normal access to the person's body, and that is used as a behavioral restraint.
5. "Physical restraint" means the use of a manual hold to restrict freedom of movement of all or part of a person's body, or to restrict freedom of movement of all or part of a person's body, or to restrict normal access to the person's body, and that is used as a behavioral restraint. "Physical restraint" is staff-to-person physical contact in which the person unwillingly participates. "Physical restraint" does not include briefly holding a person without undue force in order to calm or comfort~~,~~ or physical contact intended to gently assist a person in performing tasks or to guide or assist a person from one area to another.
6. "Serious injury" means significant impairment of the physical condition as determined by qualified medical personnel, and includes but is not limited to, burns, lacerations, bone fractures, substantial hematoma, or injuries to internal organs.
7. "Chemical restraint" means the use of psychotherapeutic or ~~behavior modifying~~behavior-modifying drugs used to prevent a client from exhibiting an identified maladaptive behavior.

Procedure: SHCHD ED may not use
1. A physical restraint or containment technique that obstructs a person's respiratory airway or impairs the person's breathing or places pressure on a person's back or places his or her body weight against the person's torso or back.
2. May not use a pillow, blanket, or other item covering the person's face as a part of a physical or mechanical restraint or containment process.
3. May not use physical or mechanical restraint or containment on a person who has known medical or physical condition, and where there is reason to believe that the use would endanger the person's life or seriously exacerbate the person's medical condition.
4. May not use prone mechanical restraint on a person at risk for positional asphyxiation as a result of one of the following risk factors that are known to the provider:
    a) Obesity
    b) Pregnancy
    c) Agitated delirium or excited delirium syndromes

d) Cocaine, methamphetamine, or ETOH intoxication
e) Exposure to pepper spray
f) Preexisting heart disease, including, but not limited to, an enlarged heart or other cardiovascular disorders.
g) Respiratory conditions, including emphysema, bronchitis, or asthma

5. Staff m~~M~~ay not place a person in a facedown position with the person's hands held or restrained behind the person's back.
6. Medication shall not be used as punishment, as a substitute for a program, or for the convenience of staff.
7. No restraints with locking mechanisms shall be used.
8. ~~Patient's~~ Patients shall not be placed in a room that is locked or where the door is held closed by any means.

Restraints may be used for

1. The protection of the patient during treatment and diagnostic procedures, such as intravenous therapy, tube feeding, and catheterization.
2. To protect the aggressive, assaultive, acutely disturbed, or severely confused patient from injuring himself or others in the Emergency Department.

In consideration of applying restraints, SHCHD staff will

1. Make sure that physical restraints are designed and used in such a way as not to cause physical injury to the client and to ~~insure~~ ensure the least possible discomfort to the ~~clients~~client.
2. Whenever possible, the staff member monitoring the person shall not be involved in restraining the person.
3. Shall afford to persons who ~~are restrained~~have restrained the least restrictive alternative and the maximum freedom of movement, while ensuring the physical safety of the person and others and shall use the least number of restraint points.
4. Will ensure that restraints of any form are not imposed as a means of coercion, discipline, convenience, or retaliation by staff. This right includes~~,~~ but is not limited to, the right to be free from the use of a drug used in order to control behavior or to restrict the person's freedom of movement~~,~~ if that drug is not a standard treatment for the person's medical or psychiatric condition.
5. Careful consideration shall be given to the methods by which the restraints may be speedily removed in the event of fire or other emergency.
6. Patients placed in restraints shall be observed by qualified treatment personnel at least every 15 minutes. This observation shall be noted and initialed in the patient's health record following each observation.
7. Opportunity for motion and exercise shall be provided for a period of not less than ten minutes ~~during each~~ every two hours in which restraint is applied. The exercise periods shall be documented in the patient's record.
8. Restraints of any kind will not continue for any period longer than that necessary to control the behavior for which such restraint is employed.
9. Ensure that patients shall be restrained only in an area that is under the supervision of staff and shall be afforded protection from other patients who may be in the area.
10. When drugs are used to restrain or control behavior or to treat a disordered thought process, the following shall apply:
    a) The specific behavior or manifestation of a disordered thought process to be treated with the drug is identified in the patient's medical record.

    b) The plan of care for each patient specifies data to be collected for use in evaluating the effectiveness of the drugs and the occurrence of adverse reactions.

In consideration of Use of Physical and/or Chemical restraints for Pediatric Patients

1. Restraints for children either physical or chemical must be used as a last resort and such use must be to the benefit of the pediatric patient.
2. It is recommended by the American Academy of Pediatrics that when restraint is needed the use of anxiolysis and mild sedation be used to avoid the use of physical restraint.
3. The decision to use physical restraint should be made by the physician; but may be initiated by the Registered Nurse in extenuating circumstances.
4. Even with proper restraint, mental or cardiopulmonary status may deteriorate unexpectedly; pediatric patients are to be continuously monitored with time-limited orders.
5. Frequent safety checks, vital sign monitoring, evaluation of limb neurovascular status and assistance with nutritional and bathroom needs are required.
6. Observation of the pediatric patient in restraints must be ongoing by nursing staff and at least every 15 minute checks with appropriate documentation of safety checks.

Retrieval of Physician's orders for restraints

1. Orders for restraints are used as temporary emergency measures to protect the patient from injury to self or others and only upon a written or telephone order of a physician.
2. Telephone orders shall be recorded immediately in the patient's medical record and shall be signed by the prescriber within 48 hours.
3. There are no PRN (as needed) orders for physical restraints.
4. The patient's record shall include an entry noting the time of application and removal of restraints, justification for and authorization of all periods of restraints and signature of the person applying the restraints.
5. Orders for physical restraints shall be in force for not longer than 12 hours.

REFERENCES:

1. California Code of Regulations; 22 CA ADC 77103. Behavioral Restraint and Seclusion; 2/14/20 Register 2020, No. 7

2. Pediatrics; Official Journal of the American Academy of Pediatrics; Pediatric and Adolescent Mental Health Emergencies in the Medical Services System: the Committee on Pediatric Emergency Medicine; Pediatrics May 2011, 127 (5) e1356-e1366; DOI: https://doi.org/10.1542/peds.2011-0522; retrieved March 2021

REVIEWED BY:
Chief Nursing Officer
ED/Acute Care Nurse Manager
Medical Director

SoHum Health

Southern Humboldt Community Healthcare District

Governing Board Meeting

Employee Health

Sprowel Creek Campus
286 Sprowel Creek Road
Garberville, CA 95542

DEPARTMENT: Employee Health	APPROVED:	Page **1** of **8**
SUBJECT: **Blood, Body, or Substance Exposure and Management**	**EFFECTIVE DATE:** TBD	**SUPERCEDES:** **03/28/2019**

POLICY:
It is the policy of Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide a safe work environment. Minimizing blood and body fluid exposures is important in this regard and can be done through use of (a) sharp safety equipment, (b) adherence to safe handling and disposal practices, (c) the provision and use of personal protective equipment, and (d) staff immunization.

PURPOSE:
The purpose of this policy and procedure is to detail the recommended evaluation, initiation of prophylactic therapy, and necessary follow up care needed in the situation of workplace blood and body fluid exposure.

DEFINITION:
- **Body fluids considered infectious:** substances that have been implicated in the transmission of HIV and viral hepatitis, i.e., blood, cerebrospinal, synovial, pleural, peritoneal, pericardial, amniotic fluids. Breast milk, semen and vaginal secretions are known as infectious agents but have not been implicated in occupational settings as a mechanism of transmission unless they are contaminated with VISIBLE blood.
- **Body fluids considered non-infectious if no visible blood present:** sputum, nasal secretions, saliva, sweat, tears, urine, feces, emesis (gastric fluids).
- **Blood borne Pathogens:** for the purpose of this policy blood borne pathogens refer to human immunodeficiency virus **(**HIV), hepatitis B virus (HBV), and hepatitis C virus (HCV).
- **Healthcare Personnel (HCP):** HCP refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances (e.g., blood, tissue, and specific body fluids); contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. These HCP may include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the health care facility, and persons (e.g., clerical, dietary, environmental services, laundry, security, maintenance, engineering and facilities management, administrative, billing, and volunteer personnel) not directly involved in patient care but potentially exposed to infectious agents that can be transmitted among from HCP and patients.

CONSULTATION:
- It is recommended that all practitioners caring for health care workers who have had a possible exposure call the Clinician Consultation Center **PEPline (1-888-448-4911)**, which offers advice on occupational needle sticks, splashes, and other potential exposures to HIV, and hepatitis B and C. In addition, PEP Quick Guide is available to guide urgent PEP decision-making online at http://nccc.ucsf.edu when phone consultation is unavailable.

PROCEDURE:

IMMEDIATE TREATMENT

Percutaneous (needle sticks/sharp objects) Injury (where there is the slightest suggestion that the integrity of skin has been broken by a potentially contaminated item)
1. Wash wound thoroughly with sudsy soap and running water. If water is not available, use alcohol. Betadine soap, not Betadine solution, is acceptable for this step. (This first step with soap directly reduces the virus's ability to infect).
2. Remove any foreign materials embedded in the wound.
3. If not allergic, disinfect wound with Betadine solution.

Non-intact Skin Exposure
1. Wash skin thoroughly as in #1 above.

2. If not allergic, disinfect with Betadine solution.
3. There is no evidence that squeezing the wound or applying topical antiseptics further reduces the risk of viral transmission.

Mucous Membrane Exposure

1. Irrigate copiously with tap water, sterile saline or sterile water.

Intact Skin Exposure

2. Exposure of intact skin to potentially contaminated material carries no significant risk and is not considered an exposure. Thoroughly clean and wash exposed intact skin.

POST-EXPOSURE

Transmission of blood borne pathogens:

1. For transmission of blood borne pathogens (HIV, HBV and HCV) to occur, an exposure must include both of the following:
    a. **Infectious body fluid**: Blood, semen, vaginal fluid, amniotic fluid, breast milk, cerebrospinal fluid, pericardial fluid, peritoneal fluid, pleural fluid and synovial fluid.
        i. **Note:** saliva, vomitus, urine, feces, sweat, tears and respiratory secretions do not transmit HIV (unless visibly bloody).
    b. **A portal of entry** (percutaneous, mucous membrane, cutaneous with non-intact skin).
2. If both of these factors are not present, there is no risk of transmission and further evaluation is not required.

Education:

- Exposed person (EP) shall be counseled about the risks involved by the appropriate healthcare provider.

Potential exposure to HIV:

- Whenever a worker has been exposed to potentially blood borne pathogens, PEP is indicated. For these exposures, prompt initiation of PEP followed by telephone or in-person consultation with a clinician experienced in HIV PEP is recommended. See above *Consultation*.

Testing:

- All exposed individuals will be given the opportunity to have their blood tested for HBV, HCV, and HIV.
- If EP refuses, they will be given the option of having a sample of their blood drawn and frozen for 90 days if they should decide they would like HBV or HIV testing within that time period.
- Determination of source person's (SP) infection status should be assessed as soon as possible after exposure through blood tests offered by SHCHD.
- All blood tests from the SP and EP require consent for testing.
- **Baseline testing should be performed at the time the exposure is reported or within 3 days of the exposure.**
    - **Source Person (SP):**
        - **HBV:** HBsAg
        - **HCV:** HCV antibody
        - **HIV:** HIV antibody
        - NOTE: If the source of an exposure is an infant less than 15 months old, determine the risk status of the mother. If blood testing is indicated, use mother's blood.
    - **Unknown SP:** Evaluate the likelihood of exposure to a source at high risk for HBV, HCV, or HIV infection.
    - **Exposed Person (EP):**
        - **HBV**: Anti-HBs titer if vaccine status is unknown.
        - **HCV:** Anti-HCV antibody and ALT
        - **HIV:** HIV antibody

Post-Exposure prophylaxis (PEP)

- Give PEP as soon as possible, preferably within 24 hours.
- Offer pregnancy testing to all women of childbearing age not known to be pregnant; PEP can be given to pregnant women.
- Seek expert consultation if viral resistance suspected.
- Advise exposed persons to seek medical evaluation for any acute illness occurring during follow-up.

See Attached: Recommended Laboratory HIV Testing Algorithm for Serum or Plasma Specimens

HBV

Post-Exposure prophylaxis (PEP)

Recommendations:

- Vaccination and antibody response status of exposed person:
  - Unvaccinated
    - Source HBsAg positive
      - HBIG x 1 and initiate the hepatitis B vaccine series
    - Source HBsAg negative
      - Initiate hepatitis B vaccine series
    - Source Unknown or not available for testing
      - Initiate hepatitis B vaccine series
  - Previously Vaccinated:
    - Known responder
      - Source HBsAg positive, HBsAg negative, or Unknown or not available for testing
        - No Treatment
    - Known non-responder
      - Source HBsAg positive
        - HBIG x 1 and initiate reactivation or HBIG x 2
      - Source HBsAg negative
        - No treatment
      - Source Unknown or not available for testing
        - If known high risk source, treat as if source were HBsAg positive
    - Antibody response unknown
      - Source HBsAg positive
        - Test exposed person for anti-HBs
          - If adequate, no treatment necessary
          - If inadequate, HBIG x 1 and vaccine booster
      - Source HBsAg negative
        - No treatment
      - Source Unknown or not available for testing
        - Test exposed person for anti-HBs
          - If adequate, no treatment necessary
          - If inadequate, HBIG x 1 and vaccine booster

Terms:
Hepatitis B immune globulin (HBIG); dose is 0.06mL/kg intramuscularly
Hepatitis B surface antigen (HBsAg)
Responder: person with adequate levels of serum antibody to HBsAg (i.e., anti-HBs ≥10mIU/mL)
Non-responder: person with inadequate response to vaccination (i.e., serum anti-HBS <10mIU/mL)
Antibody to HBsAg (anti-HBs)

Follow-Up Testing

- Test for anti-HBs 1 – 2 months after last dose of vaccine series or vaccine booster
- Follow-up not needed if exposed person immune to hepatitis B or received HIBG PEP.

HCV

Post-Exposure prophylaxis (PEP)
Recommendations:

- No prophylaxis treatment indicated.

Follow-Up Testing
If initial:

- Anti-HCV test negative:
  - Test HCV RNA ≥ 3 weeks after exposure
    - Positive: Refer to specialist for further evaluation and treatment.
    - Negative: No further testing required.
- Anti-HCV test positive:
  - Perform Reflex HCV RNA test
    - Positive: refer to specialist for preexisting chronic infection.
    - Negative:
      - Perform follow-up testing as stated above under Anti-HCV test negative.

Post-Exposure prophylaxis (PEP)

Recommendations:

- PEP is generally recommended when an exposure to an HIV positive person has occurred. Additional source person information (e.g., the SP's current or most recent viral load, HIV treatment, history of resistance to HIV medications) can be helpful. Additionally, for an HIV positive SP who has been durably suppressed on HIV medications, transmission risk to the exposed person is significantly lowered.
- PEP is generally not warranted in cases of an unknown source person. However, consider PEP in settings where exposure to HIV-infected persons is likely.
- If it is uncertain whether the exposure constitutes a significant risk and consultation is not available within a few hours, PEP can be started and then consultation may be obtained at a later time, although timely and comprehensive assessment is key.
- If the source person's HIV test is negative at the time of the exposure, they are generally considered uninfected and HIV PEP is not recommended.
    - The "window period" for HIV Ab seroconversion (the period between initial HIV acquisition/infection and development of detectable HIV antibodies) can cause patient and provider anxiety. The Guidelines state, "To date, no transmission to health care workers from an exposure source during the window period has been detected in the United States."
    - Therefore, investigation of whether a source person might be in the "window period" is unnecessary for determining whether HIV PEP is indicated **unless** acute HIV is clinically suspected, or recent (within the previous 1-2 months) high-risk exposure has occurred. If acute HIV is highly suspected, PEP should be started while an HIV RNA PCR ("viral load") is sent from the source person.

Route of exposure	Risk of exposure when source person is HIV positive	Factors increasing risk
Percutaneous	~ 1/435 episodes (0.23%)	hollow bore needles, visibly bloody devices, deep injury, and device used in an artery/vein
Mucous membrane	~ 1/1000 episodes (0.09%)	large volume
Cutaneous	< 1/1000 episodes (0.09%)	must involve non-intact skin integrity

Note: These estimates are from exposures to blood; risk for transmission from infectious fluids other than HIV-infected blood is probably considerably lower than for blood exposures.

Initiation of HIV PEP

- PEP if indicated should be started without waiting for the results of the HIV test.
- If the result from testing the source patient is not immediately available or a complete evaluation of the exposure is unable to be made within 2 hours of the exposure, PEP should be initiated while source testing and further evaluation are underway.
- A negative HIV test only demonstrates that the exposed worker was not previously infected with HIV before the exposure occurred; the baseline HIV test *cannot* determine whether the exposed worker was infected as a result of the exposure.
- **First Dose** should be given as soon as possible. Optimal time to start PEP is within hours of exposure, rather than days. The PEPline considers 72 hours post-exposure as the outer limit of opportunity to initiate PEP; however, a delay of that scale is believed to compromise PEP efficacy.
- Decisions regarding initiation of PEP beyond 36 hours post exposure should be made on a case-by-case basis with the understanding of diminished efficacy when timing of initiation is prolonged.
- When the source patient is confirmed to be HIV-negative, clinicians should discontinue the PEP regimen before completion.
- If the exposed worker's baseline test shows evidence of HIV infection acquired before the exposure and initiation of PEP, decisions regarding continuation of Antiretroviral Therapy (ART) should be based on current treatment guidelines. However, the PEP regimen should not be discontinued until the positive result is repeated with a confirmatory assay.
- If the exposed worker's week 4 post-exposure HIV test results are indeterminate or the exposed worker has symptoms suggestive of acute HIV infection, clinicians should continue ART beyond 28 days until a definitive diagnosis is established.

HIV PEP

- **Preferred HIV 3-Drug Occupational PEP Regimen (medication carried by SHCHD):**

    - Truvada [Tenofovir DF 300mg & emtricitabine 200mg] by mouth once daily PLUS
    - Raltegravir 400mg by mouth twice daily
    - Duration 28 days, unless source person is determined to be HIV negative then medication regimen can be stopped before 28 days.
- Alternative regimens available; however, other medications are not available at the District.

Monitoring HIV PEP

HIV Meds	Adult Dosing	Combination Form	Toxicity Monitoring
Tenofovir DF	300 mg by mouth daily	Truvada	BUN, Creatinine, LFTs
Emtricitabine	200mg by mouth daily		Rash
Raltegravir	400 mg by mouth twice daily		Nausea, headache

HIV Exposures in Pregnant Women

- Starting PEP in pregnant exposed persons should be based on considerations similar to those of non-pregnant exposed persons.
- When deciding to start PEP, treating physician should discuss with the pregnant EP should discuss with the potential risks of exposing her fetus to antiretroviral (ARV) medications.
- All pregnant women starting ARVs should be entered in the Antiretroviral Pregnancy Registry, a database designed to collect information on the outcomes of ARV-exposed pregnancies regardless of HIV status: http://www.apregistry.com.
- Acute HIV in pregnancy incurs a high risk of vertical transmission.
- The use of most PEP medications can be justified when the benefits outweigh the risk of infant (and maternal) exposure to ARVs.
- Based on limited data, use of ARVs in pregnancy, including in the first trimester, does not appear to increase the risk of birth defects compared to the general population.
- Toxicities from currently recommended PEP medications are not thought to be increased in pregnancy.

HIV PEP options in pregnancy

- If PEP is to be started in a pregnant exposed person, reasonable options include:
    - Truvada [Tenofovir DF 300mg & emtricitabine 200mg] by mouth once daily PLUS Raltegravir 400mg by mouth twice daily
    - Duration 28 days, unless source person is determined to be HIV negative then medication regimen can be stopped before 28 days.
        - Pros Include: well-tolerated, TDF/FTC and RAL are both preferred agents in treating HIV+ pregnant women per current DHHS Perinatal Guidelines, very low potential for drug-drug interactions.
        - Cons Include: need for twice daily dosing with RAL.
- Other PEP options may be considered in the event of intolerance, source persons with resistant virus, medication access challenges, or EP preference. In these instances, providers should seek expert consultation.

HIV exposures in Lactating Exposed Persons

- Breastfeeding is not a contraindication for PEP.
- When deciding to start PEP, lactating exposed persons should discuss with the treating clinician the potential risks and benefits of infant exposure to antiretroviral (ARV) medications through breastmilk. The decision to take PEP and/or continue breastfeeding is complex and individualized, and expert consultation is recommended.
- Acute HIV in a breastfeeding mother greatly increases the risk of HIV transmission to her infant.
- There are somewhat limited data on PEP medications in breastmilk:
    - Tenofovir DF and emtricitabine (TDF and FTC, components of Truvada™) and protease inhibitors can be detected in breastmilk only in very limited amounts.
    - Raltegravir (RAL, Isentress®)—unknown extent of breastmilk penetration
    - For women who choose to take PEP, pumping and discarding is an option to allow continuation of lactation while preventing infant ARV and (possible) HIV exposure.
    - For women who choose not to take PEP, pumping and storing breastmilk while waiting for the source person's HIV testing results is an option. This allows continuation of lactation while not exposing infants to PEP medications or potentially to HIV.

Treatment Procedure:

- The duration of treatment is four weeks (28 days). Prescriptions should be written for one week at a time in case the medication is able to be discontinued due to negative source patient HIV results.
- The exposed person should be seen in the emergency room and have a complete medical history, review of systems, and baseline physical examination. Laboratory studies: baseline HIV antibody, Complete Blood Count (CBC) and differential, platelet count, BUN, serum creatinine, total bilirubin, ALT, AST, amylase, and electrolytes.
    - Pregnancy Test: Even though PEP has been proven to be safe for pregnant and lactating women, all women of childbearing age must have a blood pregnancy test before starting treatment. Exposed persons with positive pregnancy tests should be referred to a specialist (i.e., Infectious Disease) consultant to manage their PEP.
- Informed Consent: The HCP must review the information regarding PEP and sign the Informed Consent before starting PEP. Individuals under 18 must have parental consent.

Follow-up

- If unknown HIV status or high-risk exposure returns negative, treatment can be discontinued.
- For follow-up on positive HIV exposures, it is advised that the treating practitioner consult with an Infectious Disease specialist.
- Employee should be evaluated by a practitioner at 2-, 4-, and 6-weeks post exposure. The main purpose of these visits is to elicit any signs or symptoms related to either drug toxicity or acute HIV infection.
- A focused physical examination should be performed at the 6-week visit. The EP should be encouraged to report any symptoms to their physician between their regularly scheduled visits.
- **Follow-up laboratory studies:**
    - Obtained at weeks two and six following initiation of treatment CBC with differential, platelet count, BUN, serum creatinine, total bilirubin, ALT, AST, amylase, and electrolytes. Additional blood tests may be ordered as needed based on any abnormalities that develop during treatment.
    -
- **Follow-up HIV testing**
    - If SP is HIV negative, no follow-up testing is clinically indicated for the EP.
    - If SP is HIV positive, re-test EP for HIV at 6 weeks and at 3-4 months.
    - Note: Follow-up testing (as opposed to *baseline* testing) can be with either a 3rd or 4th generation HIV test. Both reliably identify if HIV infection has occurred, although the 4th generation HIV Ag/Ab test is preferred for diagnosing *acute* HIV. A 4th generation test would not necessarily provide important advantages in post-exposure *follow-up* beyond the first month (or so) after an exposure. Follow-up HIV testing is not needed out to 6 months, as final testing at 3-4 months is sufficient to identify whether transmission has occurred. These PEPline recommendations are slightly different from the USPHS occupational PEP Guidelines, and consistent with the more recent USPHS non-occupational PEP Guidelines.
    - Extended HIV testing to 12 months is indicated only for EP who actually acquire HCV infection after exposure to an HCV-HIV co-infected source person.
    - If SP cannot be tested for HIV or SP is unknown, testing should be as above.
    - Symptoms of acute HIV should prompt immediate evaluation.
- Infectious Disease Specialist Consultation is HIGHLY recommended for the following circumstances:
    - The source patient is known to be HIV positive, or test results are positive in a previously unknown status.
    - Prior diagnosis of HIV in the EP.
    - Pregnant or lactating EP.
    - If the EP is currently being treated with any potentially myelosuppressive, hepatoxic, or nephrotoxic drugs.
    - Liver dysfunction as evidenced by bilirubin, ALT and/or AST greater than 5 times upper limit of normal.
    - Evidence of compromised bone marrow function as indicated by hemoglobin <9.5gm/dl, granulocytes <1,000, or platelets <50,000.
    - Any other significant underlying medical illness which may jeopardize the safety of the EP while taking PEP.

REPORTING

1. Report the exposure immediately to the supervisor in charge, Chief Nursing Officer (CNO), Clinic Nurse Manager (CNM), or the Employee Health Nurse (EHN), who will assess exposure and refer exposed person to Emergency Department (ED) or Clinic for further treatment.
2. If exposed during non-business hours and the above individuals are not available, the EP will be seen and evaluated in the ED by the physician on duty. In addition, the CNO, CNM, or the EHN will be contacted by phone to report exposure.
3. The EP will:
    a. Complete the "Notice for Injured Workers" form and return to Human Resources.
    b. Complete the incident report through the facility electronic incident reporting system and include the following:
        i. Date and time of the exposure;
        ii. Details of the procedure being performed and the use of protective equipment at the time of the exposure;
        iii. The type, severity, and amount of fluid to which the worker was exposed;
        iv. Details about the SP;
        v. Whether consent was obtained for HIV testing of the SP;
        vi. Any medical documentation that provides details about post-exposure management; and
        vii. Any other pertinent information.

See Employee Injuries Policy and Procedure in Human Resources Section.

DOCUMENTATION

Recording Information Following Occupational Exposure

- When an occupational exposure occurs, the following information should be recorded in the EP confidential medical record:
    - date and time of the exposure
    - details of the procedure being performed and the use of protective equipment at the time of the exposure
    - the type, severity, and amount of fluid to which the worker was exposed
    - details about the SP
    - whether consent was obtained for HIV testing of the SP
    - medical documentation that provides details about post-exposure management
- If the EP declines PEP, this decision should be documented in the worker's medical record.

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REVIEWED BY:

Administrative Team

Medical Staff

REVIEWED BY:

Administrative Team

Medical Staff

Governing Board

DEPARTMENT: Employee Health	APPROVED:	Page **1** of 1
SUBJECT: **Employee Health Procedures**	**EFFECTIVE DATE:** **TBD**	**SUPERCEDES:** **03/28/2019**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide a safe work environment that helps prevent the occurrence of occupational illness or injury.

DEFINITIONS:

N/A

PROCEDURE:

SHCHD does not have a formal Employee Health Department. In the event that the Employee Health Nurse requires medical assistance regarding an employee health issue the Clinic Medical Director, or the Chief of Medical Staff, or the emergency room physician is available as a resource.

1. New Employees:
    a. Human Resources can provide new employees with the *New Employee Health Handout* prior to their Pre-Employment physical.
    b. Pre-Employment Health Examination
        i. Each post-offer applicant will receive a pre-employment health examinations by an Advance Practitioner(s) or Medical Doctor(s) at SHCHD to determine that the person is sufficiently free of disease to perform assigned duties and does not have any health condition that would create a hazard for them self, fellow employees, or patients or visitors. The health examination will include a medical history and physical evaluation. The Clinic Medical Director OR Hospital Medical Director will co-sign all employment health examinations within 30 days of examination.
        ii. Candidates who pass this examination may be hired.
    c. Newly hired persons will have tuberculosis (TB) screening completed, if documentation is not available for previous testing within the last year (90 days for Skilled Nursing employees*). See Employee Immunization and Tuberculosis (TB) Screening Policy and Procedure*
    d. Immunization screening and completion of immunization program participation forms will be done by the Employee Health Nurse or designee. All employees will be screened for positive titers, documented past history of infection, or evidence of immunization for the following: Measles, Mumps, and Rubella (MMR), Varicella (chicken pox), Hepatitis B, Tetanus, Diphtheria, Pertussis (Tdap), and COVID-19.
    See Employee Immunization and Tuberculosis (TB) Screening Policy and Procedure
    e. All appropriate staff will be fit-tested for the N-95 particulate respirator masks.
    See Respiratory Protection Program Policy and Procedure

2. Employee Annual Screening:
    a. Tuberculosis screening will be done on all employees, volunteers and licensed independent practitioners.
    b. Influenza vaccine will be offered to all employees.
    c. N-95 respiratory device fit testing to appropriate staff.

3. Physicians, Licensed Independent Practitioners, and contracted persons:
    a. Health requirements for these individuals may include:
        i. Annual TB screening; this may be done at the district or at another facility

ii. Annual Influenza Program participation; this may be done at the district or at another facility
iii. Annual N-95 particulate respirator masks fit-testing participation if patient-care services are provided.

b. It is recommended that these individuals provide evidence of immunity to Hepatitis B as well as evidence of Tdap, MMR, and Varicella immunization; however, it is not the responsibility of the district to provide the evidence or the immunizations, if titres are negative.

4. Employees Injured on Job:
   a. Complete both the "Notice of Injured Worker Form" and the "Worker's Compensation Claim Form (DWC 1)" as soon as possible after the incident. Both forms are forwarded to the Human Resources Manager who will manage any Worker Compensation Claims and make appropriate OSHA reporting. Employees who require treatment for their injury are referred to either the clinic or the Emergency Room where they are registered as a patient and appropriate care given.
   See Employee Injuries Policy and Procedure

5. Infectious/Contagious Outbreaks and/or Exposures:
   a. The Employee Health Nurse, or designee, is responsible for managing outbreaks and employee exposures with the assistance of the Infection Preventionist and will arrange for employees to get the appropriate tests and any follow up as needed, including determining work restrictions, if necessary.
   See Outbreak Management Policy and Procedure

6. Employees will register at the Admitting Department for all employee health procedures that cannot be completed within the facility (i.e., radiologic imaging and laboratory specimens).
   a. A face sheet and consent will be generated and will go to the appropriate department.
   b. The Employee Health Nurse or designee will enter the appropriate order into the EMR/CPOE/Future Orders, using the Chief of Staff as ordering physician, as a Protocol order.
   c. If a procedure is done after hours by the Employee Health Nurse, the employee will sign and outpatient consent. This consent and a copy of the documentation will be forwarded to Admitting, so the employee can be registered during normal business hours.
   d. Employees will be registered using: Service: Outpatient (12), Primary Insurance: 2/2062 (SHCHD), Secondary Insurance: none, Guarantor: the employee's name, Admitting Diagnosis: Employee Health, Admitting physician: (Current Chief of Staff).

7. Employee Health Department:
   a. Will keep an active, confidential Employee Health File for each employee in either an electronic file on the server or paper file locked in file cabinet.
   b. Separated employee(s) from the District, will be archived in either an electronic file on the server or paper file locked in designated file cabinet for 10 years following separation from SHCHD.
   c. Records containing information regarding an employee's exposure to Blood borne pathogens will be kept by the district for a total of 30 years after the employee separation.
   d. Access is to Employee Health files are limited to the Employee, the Employee Health Nurse or designee, the Chief Nursing Officer, Chief of Staff, and the Chief Executive Officer.
   e. Employees may have copies of any/all of their file by completing a Release of Information form and forwarding it to the Employee Health Nurse. Whenever possible, records will be made available to the employee within one week.
8. Employee Health Miscellaneous
   a. SHCHD is a latex-free glove facility per recommendations of The National Institute for Occupational Safety & Health (NIOSH).

9. The Employee Health Program, which includes the Employee Health Nurse, is responsible for:
   a. Pre-employment and new hire health screening and testing
   b. Employee and Contracted Persons Immunizations
   c. TB Screening Program
   d. N-95 Particulate Respirator Fit Testing

e. Monitoring employee exposures to blood and body fluids, as well as adherence to Standard Precautions and post-exposure protocols. Providing counseling, referrals, and assistance following post-exposure.
f. Maintaining employee database of communicable diseases and immunizations
g. Determining communicability of transmissibility of employees with infections processes in conjunction with other department(s) (i.e., Infection Prevention)
h. Employee exposure management
i. Employee Health Records maintenance
j. Employee education and training in areas of employee health information and safety
k. Providing employee health statistical data to assist with plans for risk reduction programs
l. Active member of Safety Committee
m. Resource to other departments in matters related to employee health
n. Interfaces with the Medical Staff

ATTACHMENTS:

- New Employee Health Handout
- New Employee History and Physical Form

REFERENCES:

Association for Professionals in Infection Control and Epidemiology, Inc. (APIC)
- Online, www.apic.org

California Code of Regulations
- Title 8, Section 5193, Blood borne Pathogens.
- Title 22:
  - Section 72535, Employees' Health Examination and Health Records.
  - Section 70713, Use of Outside Resources.
  - Section 70723, Employee Health Examination and Health Records.

California Department of Public Health (CDPH) - California Tuberculosis Controllers Association (CTCA) Joint Guidelines (2013). Guidelines for Prevention and Control of Tuberculosis in California Long Term Health Care Facilities

California Hospital Association. Record and Data Retention Schedule Manual (most recent version available).

Centers for Disease Control and Prevention (CDC). (2011). "Immunizations of Health Care Personnel—Recommendations of the Advisory Committee on Immunization Practices." MMWR 60(RR-07); 1-45.

Centers for Disease Control and Prevention (CDC)
- Recommendations and Guidelines
- Immunization Schedules
- Vaccine Information Statements (VIS)
- Tuberculosis (TB)

REVIEWED BY:

Administrative Team

Medical Staff

Governing Board

DEPARTMENT: Employee Health	APPROVED:	Page **1** of **3**
SUBJECT: **EMPLOYEE HEALTH PROCEDURES**	**EFFECTIVE DATE:** ~~9/6/2023~~TBD	**SUPERCEDES:** **03/28/2019**

PROCEDURE:
SHCHD does not have a formal Employee Health Department. In the event that the Employee Health Nurse requires medical assistance regarding an employee health issue the Clinic Medical Director, or the Chief of Medical Staff, or the emergency room physician is available as a resource.

1. New Employees:
    a. Human Resources can provide new employees with the *New Employee Health Handout* prior to their Pre-Employment physical.
    b. Pre-Employment Health Examination
        i. Each post-offer applicant will receive a pre-employment health examinations by an Advance Practitioner(s) or Medical Doctor(s) at SHCHD to determine that the person is sufficiently free of disease to perform assigned duties and does not have any health condition that would create a hazard for them self, fellow employees, or patients or visitors. The health examination will include a medical history and physical evaluation. The Clinic Medical Director OR Hospital Medical Director will co-sign all employment health examinations within 30 days of examination.
        ii. Candidates who pass this examination may be hired.
    c. Newly hired persons will have tuberculosis (TB) screening completed, if documentation is not available for previous testing within the last year (90 days for Skilled Nursing employees*). See Employee Immunization and Tuberculosis (TB) Screening Policy and Procedure*
    d. Immunization screening and completion of immunization program participation forms will be done by the Employee Health Nurse or designee. All employees will be screened for positive titres, documented past history of infection, or evidence of immunization for the following: Measles, Mumps, and Rubella (MMR), Varicella (chicken pox), Hepatitis B, Tetanus, Diphtheria, Pertussis (Tdap), and COVID-19.
    See Employee Immunization and Tuberculosis (TB) Screening Policy and Procedure
    e. All appropriate staff will be fit-tested for the N-95 particulate respirator masks.
    See Respiratory Protection Program Policy and Procedure

2. Employee Annual Screening:
    a. Tuberculosis screening will be done on all employees, volunteers and licensed independent practitioners.
    b. Influenza vaccine will be offered to all employees.
    c. N-95 respiratory device fit testing to appropriate staff.

3. Physicians, Licensed Independent Practitioners, and contracted persons:
    a. Health requirements for these individuals may include:
        i. Annual TB screening; this may be done at the district or at another facility
        ii. Annual Influenza Program participation; this may be done at the district or at another facility
        iii. Annual N-95 particulate respirator masks fit-testing participation if patient-care services are provided.
    b. It is recommended that these individuals provide evidence of immunity to Hepatitis B as well as evidence of Tdap, MMR, and Varicella immunization; however, it is not the responsibility of the district to provide the evidence or the immunizations, if titres are negative.

4. Employees Injured on Job:

a. Complete both the "Notice of Injured Worker Form" and the "Worker's Compensation Claim Form (DWC 1)" as soon as possible after the incident. Both of these forms are forwarded to the Human Resources Manager who will manage any Worker Compensation Claims and make appropriate OSHA reporting. Employees who require treatment for their injury are referred to either the clinic or the Emergency Room where they are registered as a patient and appropriate care given.
See Employee Injuries Policy and Procedure

5. Infectious/Contagious Outbreaks and/or Exposures:
   a. The Employee Health Nurse, or designee, is responsible for managing outbreaks and employee exposures with the assistance of the Infection Preventionist, and will arrange for employees to get the appropriate tests and any follow up as needed, including determining work restrictions, if necessary.
   See Outbreak Management Policy and Procedure

6. Employees will register at the Admitting Department for all employee health procedures that cannot be completed within the facility (i.e., radiologic imaging and laboratory specimens).
   ~~6.~~a. An Outpatient Consent will be signed by employee prior to the procedure.
   ~~a. A face sheet and consent will be generated and will go to the appropriate department.~~
   b. The Employee Health Nurse or designee will enter the appropriate order into the EMR as a future order ~~/CPOE/Future Orders,~~ using the Chief of Staff as ordering physician, as a Protocol order.
   c. If a procedure is done after hours by the Employee Health Nurse, the employee will sign an~~d~~ outpatient consent. This consent and a copy of the documentation will be forwarded to Admitting, so the employee can be registered during normal business hours.
   d. Employees will be registered using: ~~Service: Outpatient (12), Primary Insurance: 2/2062 (SHCHD), Secondary Insurance: none, Guarantor: the employee's name, Admitting Diagnosis: Employee Health, Admitting physician: (Current Chief of Staff).~~ One click -> Lab or Radiology -> Appointment details will be Employee Health + type of procedure being performed.
   ~~d.~~e. Employees will be registered under the Employee Health Guarantor and marked as self-pay.

7. Employee Health Department:
   a. Will keep an active, confidential Employee Health File for each employee in either an electronic file on the server or paper file locked in file cabinet.
   b. Separated employee(s) from the District, will be archived in either an electronic file on the server or paper file locked in designated file cabinet for 10 years following separation from SHCHD.
   c. Records containing information regarding an employee's exposure to Blood borne pathogens will be kept by the district for a total of 30 years after the employee separation.
   d. Access is to Employee Health files are limited to the Employee, the Employee Health Nurse or designee, the Chief Nursing Officer, Chief of Staff, and the Chief Executive Officer.
   e. Employees may have copies of any/all of their file by completing a Release of Information form and forwarding it to the Employee Health Nurse. Whenever possible, records will be made available to the employee within one week.
   ~~e.~~
8. Employee Health Miscellaneous
   a. SHCHD is a latex-free glove facility per recommendations of The National Institute for Occupational Safety & Health (NIOSH).

9. The Employee Health Program, which includes the Employee Health Nurse, is responsible for:
   a. Pre-employment and new hire health screening and testing
   b. Employee and Contracted Persons Immunizations
   c. TB Screening Program
   d. N-95 Particulate Respirator Fit Testing
   e. Monitoring employee exposures to blood and body fluids, as well as adherence to Standard Precautions and post-exposure protocols. Providing counseling, referrals, and assistance following post-exposure.
   f. Maintaining employee database of communicable diseases and immunizations

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g. Determining communicability of transmissibility of employees with infections processes in conjunction with other department(s) (i.e., Infection Prevention)
h. Employee exposure management
i. Employee Health Records maintenance
j. Employee education and training in areas of employee health information and safety
k. Providing employee health statistical data to assist with plans for risk reduction programs
l. Active member of Safety Committee
m. Resource to other departments in matters related to employee health
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ATTACHMENTS:

- New Employee Health Handout
- New Employee History and Physical Form

REFERENCES:

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- Online, www.apic.org

California Code of Regulations
- Title 8, Section 5193, Blood borne Pathogens.
- Title 22:
  - Section 72535, Employees' Health Examination and Health Records.
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Centers for Disease Control and Prevention (CDC)
- Recommendations and Guidelines
- Immunization Schedules
- Vaccine Information Statements (VIS)
- Tuberculosis (TB)

REVIEWED BY:

Administrative Team

Medical Staff

Governing Board

Employee Health Procedures

733 Cedar Street
Garberville, CA 95542
(707) 923-3921
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Southern Humboldt Community Healthcare District

NEW EMPLOYEE HEALTH HANDOUT

Employee Name: _____Department/Title: _____

1. **New Employment Physical**
   a. Required for employment.
   b. Location:
      i. **SOUTHERN HUMBOLDT COMMUITY CLINIC**
      509 Elm Street, Garberville, CA 95542, phone: (707) 923-3925.
   c. You are **REQUIRED** to arrive 30 minutes prior to your appointment time.

   d. **APPOINTMENT DATE/TIME:** _____

2. **TB Screening**
   a. **Bring all TB related paperwork** (all TB skin tests within the last 12 months, proof of past positive TB testing, and chest x-ray within the last 3 months, or QuantiFERON blood test).
   b. An IGRA TB blood test is required for all employees unless specific documentation is available. This will be determined by the employee health nurse.

3. **Immunization Records**
   a. **Bring proof of immunization or blood titers** (blood draw done to see if you are immune or not) if available for the following:
      i. 2 **MMR vaccines** (Measles, Mumps, Rubella)
      ii. 3 **Hepatitis B vaccines** (EHN will let you know if this is required)
      iii. 2 **Varicella vaccines** (unless you have had Chicken Pox in the past)
      iv. **TDAP** (for tetanus, diphtheria and whooping cough)
      v. **Flu vaccine** (during flu season)
      vi. **COVID-19 Vaccine**

4. **Disability**
   a. If you have a disability, please be ready to specify what your limitations are. If you have permanent Workers Comp restrictions from previous employment, bring documentation of these restrictions.

5. **Questions**
   a. Contact
      i. Human Resources: (707) 923-3925 EXT 1230
      ii. Employee Health Nurse: (707) 923-3921 EXT 1292

PLEASE BE AWARE THAT UNTIL YOUR HEALTH RECORD HAS BEEN COMPLETED AND YOU HAVE PASSED YOUR MEDICAL EVALUATION, YOU WILL NOT BE ABLE TO ATTEND NEW EMPLOYEE ORIENTATION.

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Southern Humboldt Community Healthcare District

New Employee History and Physical Form

Employee Name:		**Date of Birth:**		**Age:**	
Phone Number(s):	( )		( )		
Address:					
Job Title & Department:					

Current Medical Provider

Name of Doctor:	**Phone Number: ( )**
Address:	

Review of Symptoms

Do you have any of the following?	**YES**	**NO**	**Do you have any of the following?**	**YES**	**NO**
Weight loss/ Weight gain (circle)			Palpitations or skipped beats		
Fevers			Chest pain or tightness		
Headaches			Indigestion/heartburn		
Dizziness/ Vertigo			Abdominal pain		
Difficulty hearing			Diarrhea/Constipation		
Seasonal allergies			Irregular periods		
Sinus problems			Frequent urinary tract infections		
Tiredness or falling asleep during the day			Kidney stones		
Unable to tolerate heat or cold			Back pain		
Wheezing			Joint pain or swelling		
Cough			A history of broken bones		
Skin problems (rash, eczema, psoriasis)			Swelling of the legs		
Difficulty with vision/ Wear lenses or glasses					
Shortness of breath with or without exertion					

Have you ever had: ☐ a car accident ☐ loss of consciousness ☐ heart attack ☐ loss of vision ☐ panic attacks ☐ seizure ☐ psychiatric disorder ☐ heart injury ☐ stroke ☐ paralysis ☐ back injury ☐ abnormal heart rhythm

Current Medical Conditions ☐ **NONE**

Please List	Date of onset (mo/yr)	Please List	Date of onset (mo/yr)

Past Medical Conditions ☐ **NONE**

Please List	Date of onset (mo/yr)	Please List	Date of onset (mo/yr)

Surgeries/Hospitalizations □ **NONE**

Please List	Date of onset (mo/yr)	Please List	Date of onset (mo/yr)

Family History □ **NONE**

Please List	Circle affected relative	Please List	Circle affected relative
	Father/ Mother/ Sister/ Brother/ Child/Grandmother/ Grandfather		Father/ Mother/ Sister/ Brother/ Child/Grandmother/ Grandfather
	Father/ Mother/ Sister/ Brother/ Child/Grandmother/ Grandfather		Father/ Mother/ Sister/ Brother/ Child/Grandmother/ Grandfather
	Father/ Mother/ Sister/ Brother/ Child/Grandmother/ Grandfather		Father/ Mother/ Sister/ Brother/ Child/Grandmother/ Grandfather

Medications List □ **NONE**

1		4		7	
2		5		8	
3		6		9	

Allergies to medications or other substances? □ **NONE**

Medication/Substance	Reaction	Medication/Substance	Reaction

Social History

Do you smoke cigarettes? □ YES, # per day _____ □ NO □ FORMER	Do you use illegal drugs? □ YES □ NO
How many alcoholic drinks do you consume per DAY?	WEEK?
How many minutes of exercise do you get per DAY?	WEEK?
How many hours of television do you watch per DAY?	
How many times do you eat fast food per WEEK?	

Do you have any condition (physical, medical, or psychological) that would require special accommodation in order for you to perform your job? □ YES □ NO (if yes, please explain below)

I, the undersigned, certify the above answers are true and complete to the best of my knowledge, and give the Examining Practitioner permission to submit a report to Southern Humboldt Community Healthcare District. I understand that any false statements of relevant facts could be cause for discharge.

Employee Name: _____ **Date of Birth:** _____

Employee Signature: _____ **Date:** _____

Practitioner Reviewed Signature: _____ **Date:** _____

New Employee History and Physical Form

Physical Examination

Employee Name:		**Date of Birth:**		**Age:**	
Job Title & Department:					

Height	**Weight**	**BMI**	**Blood Pressure**	**Pulse**	**O2Sat**	**Temp**	**Respirations**

Vision:	**Uncorrected/ Corrected** (circle)	**OD**	**OS**	**OU**	**Color Blind** □ Yes □ No

Hearing	**Hears without difficulty** □ Yes **Some Hearing difficulty** □ Yes (explain)
HEENT:	
Neck:	
Chest/Lungs:	
Heart:	
Abdomen:	
Musculoskeletal:	
Neurological:	
Skin:	
Other:	
Assessment:	

□ It is medically acceptable for this person to be placed in, or returned to, the above position. They are able to perform the essential functions of the position.

□ It is medically acceptable for this person to be placed in, or returned to, the above position with the following restrictions. Accommodations are required in order for this candidate to be able to perform the essential functions of the position: _____

□ Correctable Health Problems(s)

1. It is medically acceptable for this person to be place in, or returned to, the above position on a temporary basis, but condition(s) must be diagnosed and/or treated by _____ (date).
2. It is medically recommended that placement in the above position be deferred until health problem(s) are diagnosed and/or treated or reviewed again.

   Comments (if indicated): _____

□ It is medically recommended that this person NOT be placed in the above position due to the following limitations/inability to perform the essential functions of the position: _____

Practitioner Name: _____

Practitioner Signature: _____ **Date:** _____

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Southern Humboldt Community Healthcare District

TB Screening Questionnaire and Consent for TB screening blood test

Employee Name: _____ Department: _____

1. In the last year, have you had any of the following symptoms?

YES	NO	
☐	☐	Persistent cough lasting three (3) weeks or more
☐	☐	Coughing up blood
☐	☐	Hoarseness lasting three (3) weeks or more
☐	☐	Chest pains
☐	☐	Unexplained, excessive fatigue
☐	☐	Unexplained, persistent fever lasting three (3) weeks or more
☐	☐	Unexplained, excessive sweating at night, or chills
☐	☐	Loss of appetite
☐	☐	Unexplained weight loss

2. In the last year:

YES	NO	Don't Know	
☐	☐	☐	Have you been told by a health care provider that your immune system is not working right, or that you cannot fight infection?
☐	☐	☐	Have you worked in a location where patients with active TB receive care or services?
☐	☐	☐	Have you lived with or had close contact with someone who has TB disease?
☐	☐	☐	Have you had an abnormal chest x-ray?
☐	☐	☐	Have you worked, volunteered, or lived in any institution such as another medical facility, jail, group home or homeless shelter?
☐	☐	☐	Have you traveled or lived outside of the United States for longer than one (1) month? Where and when? _____

Employee Signature: _____ Date: _____

I consent to the following Tuberculosis screening test. I have had an opportunity to ask questions which were answered to my satisfaction. I understand the benefits and risks of the **Quantiferon-TB Gold Plus** blood test. I consent to the procedure that is being performed under the instructions of SHCHD policy and chief medical director.

Employee Signature: _____ Date: _____

Facility Representative: _____ Date: _____

Test date: _____ Result_____Follow up needed? Yes No

Comments_____

_____

Revised 3/5/2021

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Southern Humboldt Community Healthcare District

Respiratory Medical Evaluation Form

This questionnaire is used in determining whether or not you have a medical condition that may affect your ability to safely wear a respirator. We anticipate being able to approve most people for respirator use based on this questionnaire alone. In some cases we may ask for more information or additional medical testing/evaluation. Fit testing is also required and is done separately. All medical information is considered confidential.

All information must be completed for respirator approval:

Employee Name: _____ Age: _____ Job Title: _____ Dept.: _____

1. When using respirator work is: ❑ Light ❑ Moderate ❑ Heavy
2. Shifts per week respirator is worn: ❑ less than one ❑ 1-4 ❑ Almost every shift
3. Length of time respiratory is worn during a shift: ❑ Less than 1 hour ❑ 1-5 hours ❑ 5-12 hours

	Has a doctor ever told you that you have any of the following:					
		YES	**NO**		**YES**	**NO**
Medical History	**Angina**			**Lung Disease**		
	Heart Attack			**Emphysema**		
	Heart Disease			**Asthma**		
	High Blood Pressure			**Epilepsy or Seizures**		
	Diabetes treated with insulin			**Smoking history:** ❑ Current ❑ Former ❑ Never		
Explain "YES" answers below:						
List any medications you are taking below? ❑ None						

		YES	**NO**
Review of Symptoms	**Are you short of breath at rest?**		
	Do you get short of breath when walking?		
	Do you get short of breath at work?		
	Do you get chest pain with certain activities?		
	Do you have medical problems that might interfere with respirator use?		
	Have you ever had problems wearing a respirator?		
Explain "YES" answers below:			

EMPLOYEE SIGNATURE: _____ Date: _____

Employee Health Dept. Use Only	**_____ Approved _____ Approved w/ Restrictions _____ Denied More Information Needed (specify):**
	Restrictions/Remarks:

Reviewed by Practitioner's Name: _____

PRACTITIONER SIGNATURE: _____ Date: _____

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Southern Humboldt Community Healthcare District

Employee Immunization Program
Varicella Virus Vaccine
Participation Form

Employee Name: _____ **Department:** _____

☐ I have written documentation of 2 doses of varicella vaccine, **OR** I have written documentation of laboratory evidence of immunity or laboratory confirmation of disease, **OR** I have written documentation of diagnosis of history of varicella disease by health-care provider, or diagnosis of history of herpes zoster by health-care provider.

☐ I have no documentation and would like a varicella titer done.

- ☐ If varicella titer is negative, I would like the varicella immunizations.
- ☐ If varicella titer is negative, I decline the vaccine at this time. I understand that due to my risk of occupational exposure to the varicella virus I may be at risk of acquiring this disease. I have been given the opportunity to have a varicella titer done, and if negative, the varicella immunizations. I understand that by declining this vaccine, I continue to be at risk of acquiring this serious disease. If in the future I continue to have exposure to this infectious disease and want to be vaccinated, I can receive the vaccine at this time. *Written declination is required by California law (AB 354), Cal/OSHA Aerosol Transmissible Disease Standard (July 2010).*

  Reason for declination:

  _____

Employee Signature: _____ **Date:** _____

Facility Representative: _____ **Date:** _____

☐ Documentation of varicella vaccine, immunity, or medical record obtained. **Date:** _____

Date of Titer and Result: _____ **Date of Vaccination:** _____

☐ Varicella titer ordered. **Date:** _____ **Result:** _____

NOTE(S): _____

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Southern Humboldt Community Healthcare District
Employee Immunization Program
Measles, Mumps, Rubella (MMR) Virus Vaccine
Participation Form

Employee Name: _____ **Department:** _____

☐ I have written documentation of 2 doses of MMR vaccine, **OR** I have written documentation of laboratory evidence of immunity or laboratory confirmation of diseases, **OR** I have written documentation of diagnosis of history of MMR disease by health-care provider, **OR** I was born before 1957.

☐ I have no documentation and would like a MMR titer done.

- ☐ If MMR titer is negative, I would like the MMR immunizations.
- ☐ I MMR titer is negative I decline the vaccine at this time. I understand that due to my risk of occupational exposure to the MMR virus I may be at risk of acquiring this disease. I have been given the opportunity to have a MMR titer done, and if negative, the MMR immunizations. I understand that by declining this vaccine, I continue to be at risk of acquiring one of these serious diseases. If in the future I continue to have exposure to these infectious diseases and want to be vaccinated, I can receive the vaccine at this time.
  Written declination is required by California law (AB 354), Cal/OSHA Aerosol Transmissible Disease Standard (July 2010).
  Reason for declination: _____

Employee Signature: _____ **Date:** _____

Facility Representative: _____ **Date:** _____

☐ Documentation of MMR vaccine, immunity, or medical record obtained. **Date:** _____

Date of Titer and Result: _____ **Date of Vaccination:** _____

☐ MMR titer ordered. **Date:** _____ **Result:** _____

NOTE(S): _____

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Southern Humboldt Community Healthcare District

Employee Immunization Program
Hepatitis B Virus Vaccine
Participation Form

Employee Name: _____ **Department:** _____

☐ I have written documentation of 3 doses of Hepatitis B vaccine, **OR** I have written documentation of laboratory evidence of immunity.

☐ I have no documentation and would like a Hepatitis B titer done.

☐ If the Hepatitis B titer is negative, I would like the Hepatitis B immunizations.

☐ If Hepatitis B titer is negative, I decline the vaccine at this time. I understand that due to my risk of occupational exposure to the Hepatitis B virus I may be at risk of acquiring this disease. I have been given the opportunity to have a Hepatitis B titer done, and if negative, the Hepatitis B immunizations. I understand that by declining this vaccine, I continue to be at risk of acquiring this serious disease. If in the future I continue to have exposure to this infectious disease and want to be vaccinated, I can receive the vaccine at this time.
Reason for declination: _____

Employee Signature: _____ **Date:** _____

Facility Representative: _____ **Date:** _____

☐ Documentation of vaccine, immunity, or medical record obtained. **Date:** _____

Date of Titer and Result: _____ **Date of Vaccination:** _____

☐ Hepatitis B titer ordered. **Date:** _____ **Result:** _____

NOTE(S): _____

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Southern Humboldt Community Healthcare District

Employee Immunization Program
Tetanus toxoid, reduced Diphtheria toxoid, and acellular Pertussis (Tdap) Vaccine Participation Form

Employee Name: _____ **Department:** _____

☐ I have written documentation of Tdap vaccine.

☐ I have no documentation and would like a Tdap vaccine. ***I request that the vaccine be given to me.*** I have read the "Td/Tdap Vaccine Information Statement," dated 08/06/2021 I have had an opportunity to ask questions which were answered to my satisfaction. I understand the benefits and risks of Tdap vaccine.

☐ I decline Tdap vaccine at this time. I understand that due to my risk of occupational exposure to the pertussis virus I may be at risk of acquiring this disease. I have been given the opportunity to have a Tdap vaccine. I understand that by declining this vaccine, I continue to be at risk of acquiring one of these serious diseases. If in the future I continue to have exposure to these infectious diseases and want to be vaccinated, I can receive the vaccine at this time.
Written declination is required by California law (AB 354), Cal/OSHA Aerosol Transmissible Disease Standard (July 2010).

Reason for declination: _____

Employee Signature: _____ **Date:** _____

Facility Representative: _____ **Date:** _____

☐ Documentation of vaccine. **Date:** _____

☐ Tdap Vaccine Administered- **Date:** _____ **Site & Route:** _____

Manufacturer: _____ **Lot Number:** _____

Name and title of administer: _____

NOTE(S): _____

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Influenza Vaccine Participation Form

Southern Humboldt Community Healthcare District

INFLUENZA VACCINE CONSENT

I have read the "Influenza Vaccine Information Statement" form dated 08/06/2021. I have had an opportunity to ask questions which were answered to my satisfaction. I understand the benefits and risks of influenza vaccine. I declare that I do NOT have an allergy to eggs, have never had a severe reaction to the influenza vaccine, and have never had Guillain-Barre Syndrome.
I request the vaccine be given to me.

Year: _____
Lot#:
Exp:
NDC:

Print Name_____ Department: _____

Signature/Date: _____

Date Given: _____Administered by: _____ Injection Site: _____

INFLUENZA VACCINE DECLINATION

My employer or affiliated health facility, SHCHD, has recommended that I receive influenza vaccination to protect the patients I serve.
I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease that kills thousands of people in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare workers to protect this facility's patients from influenza, its complications, and death.
- If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding the virus can spread influenza to patients in this facility.
- If I become infected with influenza, even if my symptoms are mild or non-existent, I can spread it to others, and they can become seriously ill.
- I understand that the strains of virus that cause influenza infection change almost every year and, even if they don't change, my immunity declines over time. This is why vaccination against influenza is recommended each year.
- I understand that I cannot get influenza from the influenza vaccine.

Knowing these facts, I choose to DECLINE vaccination at this time. I may change my mind and receive vaccination later if vaccine is available. I have read and fully understand the information on this declination form.
I decline vaccination for the following reason(s). Please check all that apply.

☐ I was vaccinated elsewhere this season (date/location: _____)

☐ My philosophical or religious beliefs prohibit vaccination.

☐ I have an allergy or medical contraindication to receiving the vaccine.

☐ Other reason – please tell us. _____

Signature: _____ **Date:** _____

Printed Name: _____

SoHum Health

733 Cedar Street
Garberville, CA 95542
(707) 923-3921
shchd.org

Southern Humboldt Community Healthcare District

CERTIFICATION OF COVID-19 VACCINE STATUS

(When responding to this inquiry, provide no more information than is requested on this form).

Employee Name: _____ **Date of Birth:** _____
Department: _____

I have written documentation of (1) or (2) doses of the (*list vaccine name*) _____

COVID-19 vaccine: Dose #1_____ Dose #2_____ **Booster:** _____

☐ I request an *exemption* from the COVID-19 vaccine mandate based on my religious beliefs.

☐ I am excused from receiving any COVID-19 vaccine due to Qualifying Medical Reasons.
Written statement from your provider must be provided stating individual qualifies for exemption including probable duration of inability to receive the vaccine.

I understand that I am required to provide accurate information in response to the questions above and that failure to do so may result in disciplinary action. In addition, I will be considered *unvaccinated,* and will therefore be required to follow all public health orders required of unvaccinated individuals.

As of today, I am requesting an exemption for the COVID-19 vaccination, and I acknowledge the following facts:

- COVID-19 vaccination is recommended for me and all healthcare workers to protect our patients from COVID-19 disease, its complications, and death.
- Some people with COVID-19 have no symptoms allowing the spread of the illness to others.
- I understand that I cannot get COVID-19 from the COVID-19 vaccine.
- Due to the infectiousness of COVID-19, my declining to be vaccinated could have life threatening consequences to my health, to those with whom I have contact, including my patients and other patients in this healthcare setting, including my coworkers, my family, and my community.
- I understand that workplace safety protocols and practices may differ based on my vaccination status.
- I understand that I may be required to complete an educational module as part of the exemption process.
- I understand that while we take all steps to ensure a safe workplace for caregivers and patients, we cannot guarantee that I will not be exposed to or infected with COVID-19.
- I understand that I may rescind my declination at any time and become vaccinated.

By signing this form, I certify that (i) I am the individual completing the form; (ii) all information entered on this form is true and accurate to the best of my knowledge; and (iii) I agree with all terms and conditions as listed above.

Employee Signature: _____ **Date:** _____

DEPARTMENT: Employee Health	APPROVED:	Page **1** of **2**
SUBJECT: **Respiratory Protection Program**	**EFFECTIVE DATE:** TBD	**SUPERCEDES:** **08/26/2021**

POLICY:
It is the policy of Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide respiratory protection devices to all staff whenever there is a possibility of exposure to an Aerosol Transmissible Disease (ATD).

RESPIRATORY PROTECTION DEVICES (RPD):

1. The primary respiratory device selected for use in this facility is a particulate filter respirator (PFR N-95) which is approved by the National Institute for Occupational Safety and Health (NIOSH).

2. Medical Evaluation for Fit Testing:
    a. Staff who will wear RPDs will be evaluated for any condition that may preclude its use.
    b. Personnel will be screened upon employment and on an annual basis.
    c. General screening for pertinent medical conditions will be conducted prior to fit-testing. Each employee will complete a general medical screening questionnaire.
    d. A medical provider will approve each employee for use of a respirator.
    e. Further medical evaluation will be done on any employee who may have difficulty wearing the RPD while performing his/her duties or when adverse health effects result.

3. Employee Fit Testing:
    a. Qualitative fit testing is performed using a saccharin or bitter technique on all designated employees.
    b. Will be done at the time of hire and annually, using the same make and model of RFD that the employee will use in the workplace.
    c. Whenever a new make or model is introduced, fit-testing to the new RPD must be done.
    d. If the specific type of RPD cannot be fitted properly to an individual, either another brand will be obtained, or, the employee will be asked to stay away from individuals who could carry ATDs.
    e. Employees are encouraged to inform their manager if an RPD no longer appears to fit him/her properly.
    f. Employees with facial hair or other conditions that interfere with obtaining an adequate fit will not be permitted to wear a respirator. This will preclude his/her working with certain patients known or suspected of having an ATD, unless he/she is trained to use a PAPR (powered air purifying respirator). *See policy "Use of Powered Air Purifying Respirators."*

4. Unless Administration deems otherwise in certain circumstances, re-donning of masks in not permitted at the district.

HIGH RISK INDIVIDUALS/PROCEDURES:

1. Staff who are considered at high risk for being exposed to Aerosol Transmissible Diseases include:
    a. Registered nurses, licensed vocational nurses, certified nursing assistants, activities workers, radiology staff, laboratory staff, admitting staff, housekeeping staff, rural health clinic staff, and engineering staff.

2. Procedures performed in this facility which can be considered high-risk include:
    a. Endotracheal intubation, gastric intubation, respiratory treatments, sputum inductions, and respiratory tract suctioning.

3. Use of Negative Isolation Rooms:
    a. The hospital does NOT have a negative isolation room. Patients requiring isolation must be transferred to a facility with these rooms. However, not all ATDs require negative isolation rooms, therefore not all of these patients will be transferred. For this reason, all employees who may interact with inpatients need to be familiar with these respirators.

REVIEWED BY:

Administrative Team

Medical Staff

Governing Board

SoHum Health

DEPARTMENT:	APPROVED:	Page **1** of **1**
Employee Health		
SUBJECT:	**EFFECTIVE DATE:**	**SUPERCEDES:**
Respiratory Protection Program	TBD	**08/26/2021**

PROCEDURE:

1. Only personnel who have received specific education on ATDs, have been fit-tested for a Respiratory Protective Device (RPD), and have undergone training regarding the use and wearing of RPD may assist with procedures being performed on a patient with a known or suspected ATD.
2. Before use of the RPD, the employee should perform a fit check, which has been demonstrated in the training session.
3. Management of Possible ATD Patients:
    a. All suspected or confirmed ATD whose condition requires an isolation room will be transferred promptly to a facility with a negative pressure room.
    b. Outpatients:
        i. Place suspected ATD patient in separate waiting area, away from other patients. Place patient in room equipped with the recommended ventilation, if available.
        ii. Place a surgical mask (N-95 respirator may be used) on the patient and instruct patient to keep mask on.
        iii. Provide the patient with tissues with instructions to cover mouth or nose when coughing or sneezing.
        iv. Should schedule suspected ATD patients at a time to avoid contact with immunocompromised patients.
        v. Tuberculosis precautions must be followed for patients known to have active TB, but who have not completed treatment until they are known to be non-infectious.
    c. Emergency Medical Services:
        i. The patient should wear a surgical mask (N-95 respirator may be used) when being transported if an ATD is suspected or confirmed.
        ii. The healthcare worker should wear RPD.
        iii. Emergency-response personnel are responsible for their own respiratory protection program.
    d. DP/SNF:
        i. All new residents require TB symptom screening and Interferon-Gamma Release Assays (IGRAs
        ii. All new residents with a previous positive-tuberculin skin test (TST) reaction require testing through Interferon-gamma release assays (IGRA) and/or chest x-ray (CXR) AND TB symptom screening.
        iii. Residents shall be evaluated annually for through appropriate testing (i.e., TST, CXR and/or IGRA) and TB symptom screening.
        iv. TST conversions will receive further diagnostic testing by the provider and require notifying the facility's Infection Preventionist.
        v. After suspected exposure to TB, negative TST residents will require a repeated TST 10 weeks after exposure.
        vi. Residents with suspected and confirmed cases of TB will require prompt transfer and treatment at the receiving facility.

REVIEWED BY:

Administrative Team

Medical Staff

Governing Board

SoHum Health

Southern Humboldt Community Healthcare District

Governing Board Meeting

Safety and Emergency Preparedness

Sprowel Creek Campus
286 Sprowel Creek Road
Garberville, CA 95542

DEPARTMENT:	APPROVED:	Page **1** of **2**
Safety and Emergency Preparedness	**Date approved**	
SUBJECT:	**EFFECTIVE DATE:**	**SUPERCEDES:**
Emergency Preparedness		03/30/2023

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide a guide to ensure adequate planning for both natural and man-made disasters and to describe the coordinated efforts made in collaboration with federal, state, tribal, regional and local emergency preparedness agencies.

PURPOSE:

The purpose of this policy is to clearly outline the Four Core elements of Emergency Preparedness and describe specifically how those elements will be applied to Southern Humboldt Community Healthcare District during a natural or man-made emergency or disaster. Four Core elements are: Risk Assessment and Emergency Planning, Communication Plan, Policies and Procedures, Training and testing.

REVIEWED BY:

Administrative Team

Medical Staff

Governing Board

DEPARTMENT:	APPROVED:	Page **1** of **1**
Safety and Emergency Preparedness	**03/30/2023**	
SUBJECT:	**EFFECTIVE DATE:**	**SUPERCEDES:**
Infectious Disease Respiratory Outbreak	**03/30/2023**	**New**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to establish and maintain an emergency preparedness/disaster plan for infectious disease disasters including pandemics and/or seasonal/regional surges in coronavirus disease (COVID-19)/influenza or other potentially infectious respiratory diseases.

DEFINITIONS:

Coronavirus Disease: Infectious disease caused by the SARS-Cov-2 virus.

Infectious Disease Disaster: A disaster that results from an infectious disease. This includes bioterrorism attacks, outbreaks of emerging infectious diseases, and pandemics.

Outbreak: sudden rise in the number of cases of a disease. An outbreak may occur in a community or geographical area or may affect several countries.

Pandemic: A global outbreak of disease in humans that affects at least two continents and/or exceeds expected rates of morbidity and mortality.

REFERENCES:

APIC Text of Infection Control and Epidemiology. (2020). Washington, D.C.: Association for Professionals in Infection Control and Epidemiology.

CDPH AFL 23-12 Covid-19 Recommendations for PPE, Resident Placement/Movement, and Staffing in SNFs.

CDPH AFL 22.07.1 Guidance for Limiting the Transmission of COVID-19 in SNF's.

CDPH AFL 22-31 Movement of Patients/Residents in the Healthcare Continuum During Seasonal Surges and the Coronavirus Disease 2019 (COVID-19) Pandemic

REVIEWED BY:

Administrative Team

Medical Staff

Governing Board