i. New Policies and Procedures

SoHum Health

Subject: Transmission-Based (Isolation) Precautions	Manual: Infection Prevention

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") 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.

PURPOSE:

The purpose of this policy and procedure is to prevent the transmission of epidemiologically important or highly transmissible microorganisms.

PROCEDURE:

- **When to initiate Transmission-based Precautions:**
    - Upon admission with clinical symptoms (diarrhea, rashes) or condition (influenza, meningitis) warrants precautions, pending confirmation of diagnosis.
    - Upon receipt of lab findings (e.g., multidrug resistant organism or highly transmissible organism of epidemiological importance such as measles)
    - The decision to place a patient on transmission-based precautions can be made by nursing staff or medical staff.
    - Be sure to inform Infection Prevention and document the indication of isolation in the medical record.

- **Contact precautions.** Contact precautions are used for diseases transmitted by contact with the patient or the patient's environment. Full or modified contact precautions are indicated for diseases caused by organism such as Clostridium difficile and multidrug-resistant organisms that have been demonstrated to cause heavy environmental contamination, including vancomycin-resistant enterococci (VRE) and methicillin-resistant Staphylococcus aureus (MRSA).
    - Refer to the multi-drug resistant Organism and C. difficile policy for details on the use of contact precautions (full or modified) for patients known or suspected to be colonized or infected with MDRO's.
    - Contact precautions are also indicated for infestations of skin parasites (see Treatment of Skin Parasites policy.
    - **Requirements for full contact precautions:**
        - Patient Placement: A single room is preferred; however, patients with the same disease or organism may share a room. In cases where there is a shortage of patient rooms, prioritize patient cohorts by conditions that may foster transmission (i.e., uncontained drainage, stool incontinence), giving them priority for single patient room placement. See the Multidrug-resistant Organism and C. difficile policy for guidance.
        - Personal protective equipment (PPE): Wear a gown and gloves on room entry. Change the gown and gloves between patients even if both patients share a room and/or one or both are on Contact precautions. Always use hand hygiene between glove changes.
        - Patient transport: Limit patient transport outside the room to medically necessary purposes. Inform the receiving department of the transmission-based precaution status of the patient. Cover or contain potentially infectious body fluids before transport. The transported should discard contaminated PPE before transport. Don clean PPC to handle the patient at the destination.

        - Environmental measures: Clean daily with a focus on high-touch, patient bathrooms, and areas close to the patient. Environmental service workers should don gown and gloves before room entry to clean and disinfect the patient room. Meticulous environmental cleaning and use of products with a C. difficile inactivation label claim combine with adherence to hand hygiene and good laundry practices are recommended to decrease transmission of C. difficile.
        - Discontinuation of contact precautions: Contact Precautions are discontinued only after consultation with the Infection Preventionist. Generally, this is when signs and symptoms of the infections have resolved or according to pathogen-specific recommendations. For MDROs national recommendations are inconclusive. The current guideline is that any colonized or infected patient with drug resistant Acinetobacter baumanii or carbapenem-resistant gram-negative organisms remain on Contact Precautions for the entire length or stay in healthcare facilities.

    - **Requirements for modified contact precautions:**
        - Refer to the Multidrug-resistant Organisms and C. difficile policy for guidance on how modified contact precautions differ from full contact precautions and when to consider implementing them. The decision should be made in consultation with the Infection Preventionist.

- **Droplet Precautions.** Droplet Precautions prevent transmission of diseases caused by large respiratory droplets that are generated by coughing, sneezing, or talking. Diseases transmitted by the droplet route include, but are not limited to, influenza, pertussis, and bacterial meningitis due to Neisseria meningitidis.
    - Patient placement: Single rooms are preferred; however, patients with the same disease may share a room.
        - Priority should be given to patients with excessive sputum production when single-patient rooms are in short supply. Patients must be spatially separated by at least 6 feet. Draw privacy curtains between patients. Avoid placing immunocompromised patients with patients who are on Droplet Precautions especially if those patients may have adverse outcomes from infections.
    - Personal protective equipment: Wear a surgical mask on room entry. Handle items contaminated with respiratory secretions (e.g., tissues, handkerchiefs) with gloves. Change PPE between patients and perform hand hygiene.
    - Patient transport: Limit patient transport outside the room to medically necessary purposes. I the patient must leave the room, instruct the patient to wear a surgical mask and follow respiratory hygiene and couth etiquette. Once the patient is masked, the patient transporter does not need to wear a surgical mask (except when following COVID-19 mask mandates). Notify the receiving department of the isolation precautions status.
    - ER and Clinic: Patients who present with clinical respiratory syndromes should be instructed in the practice of respiratory hygiene and cough etiquette and given surgical masks to wear until an examination room can be provided. Place patients requiring Droplet precautions in an examination room as soon as possible. HCP should don surgical masks on room entry and replace with clean surgical mask upon room exit.
    - Skilled Nursing Facility (SNF): Make decisions on patient placement on a case-by-case basis after considering all options in consultation with Infection Prevention. Ambulatory patients on Droplet Precautions should be instructed to wear a surgical mask in common areas. All patients should be instructed in the proper use of respiratory hygiene and cough etiquette.
    - Environmental measures: Daily cleaning with hospital-approved disinfectant of high-touch and horizontal surfaces. Environmental services personnel should on a surgical mask before room entry.
    - Discontinuation of Droplet Precautions: Discontinue Droplet precautions after signs and symptoms have resolved or according to pathogen-specific guidelines.

- **Airborne Precautions:** Airborne Precautions are used to prevent transmission of infectious organisms that remain suspended in the air and travel great distance due to their small size (less than 5 microns). These diseases include measles, smallpox, chickenpox, pulmonary tuberculosis,

avian influenza, and acute respiratory syndrome (SARS)-associated coronavirus including SARS-Cov-2.

- **Trash receptacles:** are NOT to be placed outside the entrance to the room in the corridor. EXCEPTION: when on airborne precautions, N-95 respirators are removed after leaving the room and discarded in a closable receptacle outside the room. Trash can be placed into regular trash bags.

- **Linens and Dishware:** All linen can be bagged in regular yellow bags. Disposable dishes are not necessary.

- **Education of patient and visitors (including family):** Education will be provided to the patient and visitors about isolation practices, including hand hygiene and not bringing contaminated items out of the patient room. Visitors are expected to perform hand hygiene when entering and leaving the room. For full contact isolation, visitors will need to wear gloves and gown. For modified contact precautions, visitor will need to wear gown and gloves if close contact with the patient or immediate patient environment is anticipated. Visitors entering droplet precaution room will wear a surgical mask on entering the room. Visitation to patients on airborne isolation awaiting transfer will be discouraged. If visitation is necessary, staff will assist the visitor in donning an N-95 respirator and will keep visit as short as possible.

- **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.
  - Morning and evening care,
  - Toileting and changing incontinence briefs,
  - Caring for devices and giving medical treatments, C
  - Cleaning and disinfecting the environment,
  - Wound care,
  - Mobility assistance and preparing to leave the room.

DEFINITIONS:
None

Subject: Compression	Manual: Mammography

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to assure adequate compression can be achieved and to prevent excessive force in manual and power modes.

PURPOSE:

Adequate compression increases contrast, improves image sharpness and decreases radiation exposure.

FREQUENCY:

Semi-annually or if reduced compression is suspected.

EQUIPMENT:

~~Analog~~ Bb~~b~~athroom scale or Compression scale ~~and~~ ~~several~~
Tt~~t~~owels
18 x 24 cm flat compression paddle~~.~~

PROCEDURE:

- Perform test in manual and power modes.
- Place towels above and below scale if needed and orient dial away from compression device to
- facilitate reading.
- Using power mode, lower the compression device until it stops automatically.
- Read and record pounds of pressure.
- Release compression and repeat procedure in manual mode.
- If criteria is exceeded in the power mode or minimum compression cannot be achieved
  - manually, contact Hologic Inc. for service.

CRITERIA:

~~Power Mode = Greater than 25 pounds~~
~~Manual Mode = Minimum 25 pounds~~
~~Maximum compression force in power mode = 45 pounds~~
A compression force of at least 25 pounds must be provided.
The maximum compression force for the initial power drive must be between 25 pounds and 45 pounds.

DEFINITIONS:

None

SoHum Health

Subject: Consumer Complaints	Manual: Mammography

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to provide a patient or patient's representative with a mechanism for filing and obtaining resolution for serious complaints.

PURPOSE:

To establish a process for collecting and resolving serious consumer complaints.

PROCEDURE:

- Patients who express **verbal** dissatisfaction will be directed to the Lead Technologist on shift/or Department Manager or Jerold Phelps Community Hospital administrator, whichever is appropriate.
- Patients wishing to **document** serious complaints in writing will be provided with the name and address of the hospital administrator and/or the hospital's accreditation bodies.
- Complaints received by administration will be handled as follows:
  - Administration will contact the technologist and/or radiologist as appropriate.
  - Copies of written complaints or brief notations regarding verbal complaints will be provided to the department.
  - The patient will be contacted by appropriate personnel in an attempt to resolve the issue.
  - If resolution cannot be achieved at the facility level, the patient will be provided with the address of the accreditation bodies.
- Patients with serious complaints they feel cannot be resolved at the facility level, or who wish to contact the accreditation bodies directly, will be provided with all necessary information.
- Printed instructions for patients who believe they have suffered a "serious adverse event" will be posted in the Mammography Room. ~~(See attachment.)~~
- A "serious adverse event" is defined as an event that may significantly compromise clinical outcomes or an event for which a facility fails to take timely corrective action including:
  - Poor image quality.
  - Failure to send report in a timely manner or lay summary within 30 days.
  - Use of unqualified personnel.
  - Missed cancers.
- All complaints will be addressed and resolved as soon as possible.
- All unresolved serious complaints will be reported to the *American College of Radiology* and/or the *State of California, Department of Public Health* within 30 days.
- All complaints, relevant documentation, and outcomes will be maintained for at least three (3) years in the outcome section of the Mammography Quality Assurance/Quality Control Manual.

DEFINITIONS:
None

SoHum Health

Subject: Responsibilities of Quality Assurance Personnel	Manual: Mammography

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to provide a list of responsibilities of all Quality Assurance personnel.

PURPOSE:

Quality Assurance is performed to maintain consistent high quality mammographic images.

PROCEDURE:

LEAD INTERPRETING PHYSICIAN:

- Retain general responsibility for ensuring QA requirements are met.
- Review and update the *Mammography Policy and Procedure* manual annually.
- Review QA procedures, QC documentation, clinical image quality and operating procedures quarterly.
- Review Mammography Physicist's QC test results annually or more frequently as required.
- ~~Semi-a~~Annually review, evaluate, and sign Medical Audits and~~Biopsy~~ Outcomes Analysis for each interpreting Radiologist.

MAMMOGRAPHY QUALITY CONTROL TECHNOLOGIST:

- Perform QC testing to include:
  - Detector Flat Field Calibration
  - Artifact Evaluation
  - Phantom Image
  - SNR and CNR Measurements
  - Viewing Conditions
  - Repeat Analysis
  - Compression
  - Geometry
  - Alignment
- Contact service personnel as necessary.
- Compile test results and provide them to inspectors, medical physicist and Lead Interpreting Physician at appropriate intervals.
- Compile mammography outcome data for each radiologist and provide results to the lead interpreting physician ~~semi-~~annually.

MAMMOGRAPHY PHYSICIST:

- Evaluate QC test results annually or more frequently as required.
- Establish protocol for corrective actions and provide follow-up procedures for necessary corrections.
- Annually assess test conditions, technique factors and measured or calculated results and provide a pass/fail indication for each of the following tests:
  - Mammographic Unit Assembly evaluation
  - Alignment of x-ray field, light field, image receptor and compression paddle
  - Focal spot size and condition
  - kVp accuracy/reproducibility
  - Beam quality assessment (HVL).
  - Automatic Exposure Control (AEC) system performance
  - Breast entrance exposure, mean glandular dose and AEC reproducibility

- Image quality evaluation
- Artifact assessment
- System resolution

- Breast entrance air kerma
- Radiation output rate

- Annually document and provide guidance regarding any deficiencies in the following:
  - Performance of tests or tasks evaluated
  - Documentation of corresponding QC records
  - Interpretation of test results

- Annually survey and provide a written report to include dates of survey and report, physicist's signature, and results.

- Assure that calibration of air kerma measuring instruments occurs every two (2) years or following repairs. (Accuracy **must = ± 6%**).

SHARED RESPONSIBILITIES OF LEAD INTERPRETING PHYSICIAN, QC TECHNOLOGIST AND MEDICAL PHYSICIST:

Ensure that Quality Assurance records are maintained on:

- Employee qualifications to meet assigned QA tasks.
- Mammography techniques and procedures.
- Quality control, including:

  - Monitoring data
  - Problems detected by analysis of the data.
  - Corrective actions
  - Effectiveness of corrective actions

- Safety and protection.
- Ensure that Quality Control records include results of each test until the completion of the next annual inspection (where the facility is in compliance).

~~**PROCEDURE:**~~

~~N/A~~

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Ancillary On-Call Services	**Radiology**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to provide emergency on-call ancillary services after normal business hours.

PROCEDURE:

- **Prior** to calling the ancillary staff member on call, orders must be entered in the electronic medical records.~~Healthland (EMR)~~ and the patient ~~or specimen~~ must be ready for ordered exam(s).
    - In the event of expected intubation, stroke or other major~~extraordinary~~ trauma, radiology tech may be called in prior to patient's arrival.
- Verify that the tech you are calling is in fact the tech on-call. Please refer to the on-call schedule.
- Unless otherwise instructed, (tech is at a different number, etc.) call the department call phone provided by the hospital. If there is no response, call the on-call tech's personal phone. If there is no answer, repeat call in 5 minutes. If all methods fail, call the Department Manager. Techs have a 30-minute callback window.

DEFINITIONS:
None

SoHum Health

Subject: Confidentiality/Patient Privacy	Manual: Radiology

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to maintain all patient-related information gathered by the Radiology Department securely and to share in accordance with federal and state HIPAA laws.

PROCEDURE:

- All patient-identifiable information will be secured during lunch and after hours.
- All images used for educational purposes will have the identification removed prior to use.
- Radiology reports or other information will be released only to appropriate personnel.
- Radiology images, reports and other patient data may be released to an outside physician or healthcare facility to provide a continuum of care. If images are requested by the patient on any day other than the date of examination, a "Release of Information" form must be filled out prior to burning a disc ,printing access page and/or sending reports.

PRIVACY:

- Patients will be provided with as much privacy as available.
  - Doors to the X-ray room, ~~and or~~ Ultrasound room and CT suite will be kept closed when in use.
  - Patients will be provided with a gown or covered with a sheet or blanket.
  - Visitors and non-essential personnel will remain in the hallway unless approved by paient and technologist.
- When possible, patients will be interviewed for additional information away from public areas.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Fluoroscopy	**Radiology**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to no longer provide fluoroscopy services due to not having a radiologist on site. A Technologist Fluoroscopy Certificate is required if the technologist exposes a patient to fluoroscopy or is asked to position the patient or equipment or make technique selection during exposure of the patient. This may only be done under the supervision of a Radiologist or Physician certified as a Fluoroscopy Operator and Supervisor.

PURPOSE:

The purpose of this policy and procedure is to ensure fluoroscopy services will no longer be performed at this facility due to not having a Radiologist on site. All patients needing fluoroscopy procedures will be referred to a facility with the appropriate staffing and equipment.

PROCEDURE:
N/A

DEFINITIONS:
None

Subject:	Manual:
Infection Prevention in CT	**Radiology**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") that the CT scanner will be cleaned after each use and disinfected as needed.

DEFINITIONS:

CT: Computed Tomography

PROCEDURE:

- Keep all equipment clean. Remove all body fluids and IV contrast spills using an approved cleaning solution. Do not spray any solution directly onto machine, use wipes or cleaning cloth. Approved cleaning solutions/wipes;
    - Warm water and soap mixture or mild antiseptic
    - Common household bleach, diluted 10:1
    - ~~Sani-Cloth HB for Mylar window~~
    - Sani-Cloth AF3 for table and accessory items

- Use hospital approved disinfectant wipes or solution for areas that come into direct contact with body fluids (i.e. blood). Wiped areas must remain moist for 10 minutes (reapply if surface dries sooner).
    - Common household bleach, diluted 10:1
    - Sani-Ccloth ~~HB~~AF3

- The technologist shall perform appropriate hand washing technique prior to and after each exam and wear gloves while cleaning and when appropriate for patient care (see facility handwashing policy for more details).

~~**DEFINITIONS:**~~
~~None~~

SoHum Health

Subject: Infection Prevention	Manual: Mammography

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") that all patient contact surfaces are to be cleaned prior to each mammography patient. A pre-packaged disposable Mammography Pad shall be used with each patient and disposed of after individual patient use.

PROCEDURE:

- All patient contact surfaces are to be cleaned with a lint free cloth or pad and diluted dishwashing liquid to remove residual make-up, deodorant, body powders or other artifacts. Solution should not be sprayed.

- If more than soap and water is required to clean, use one of the below followed by diluted dishwashing liquid solution.
    - 10% chlorine bleach and water solution
    - 70% isopropyl alcohol (not diluted)
    - 3% maximum concentration of hydrogen peroxide solution

- Patient contact surfaces include:
    - Compression paddle
    - Face shield
    - Underside and chest wall edge of compression paddle
    - Hand grips

- Surfaces in contact with blood, discharge from the nipple or open wounds shall be cleaned after each mammography view and disinfected with a bleach solution followed by diluted dishwashing liquid upon completion of the exam.

- The technologist shall perform appropriate hand washing technique prior to each mammography patient and wear gloves when appropriate (i.e., patients with open wounds, skin conditions, etc.).

- Patients with wounds, discharge, or potentially contagious skin conditions will be logged on the *Mammography Infection Prevention Log* and will be reviewed quarterly by the Infection Preventionist.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Negative or Benign Mammogram Reports	**Mammography**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to ensure that all patients shall receive a written notification of the results of their mammogram and breast density in a timely manner.

PROCEDURE:

- Patients shall be instructed to self-address an envelope at the time of their mammography appointment.
- The envelope shall be used to mail the patient their negative BI-RADS (category 1, 2 or 3) results letter. All patients will be informed about breast density. The patient's personal density findings shall be included in the report.~~If the mammogram reveals dense breast tissue, a dense breast letter shall be mailed to the patient instead of the general negative/benign letter~~. All reports shall be mailed within 30 days of the date of examination.
- Negative/benign (category 1 or 2) mammography interval is generally one year. Interval for follow-up for "Probably Benign" BI-RADS category 3 is generally 6 months but shall be determined by the Radiologist's recommendation.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Critical Findings	**Radiology**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to utilize the capabilities of the Online Radiology service to provide immediate feedback in the event of critical findings.

PURPOSE:

The purpose of this policy and procedure is to delineate those radiological abnormalities to which the medical providers will be alerted immediately either by the Radiologist or the Technologist.

PROCEDURE:

The following is a list of critical findings (defined as those findings the ordering provider will be notified of immediately):

- Stroke, acute hemorrhage or active bleeding, any acute intracranial hematoma, new intracranial herniation
- Unstable spinal fractures, new spinal fractures
- Pneumothorax or hemothorax, new pulmonary embolism, new aortic dissection or rupture
- Free air
- Any aneurysm
- Bowel obstruction
- Volvulus
- New tumor
- Deep vein thrombosis (DVT)
- Ectopic pregnancy
- Testicular torsion
- Any other condition the radiologist believes to be immediately life or limb threatening or may significantly affect the patient's outcome or disposition.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Mandatory Reporting	**Radiology**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") that the facility will comply with all mandatory California State and federal laws of reporting.

PROCEDURE:

Except for an event that results from patient movement or interference, a facility shall report to the department an event in which the administration of radiation results in any of the following:

- Repeating of a CT examination, unless otherwise ordered by a physician or a radiologist, if one of the following dose values is exceeded:
    - 0.05 Sv (5 rem) effective dose
    - 0.5 Sv (50 rem) to an organ or tissue
    - 0.5 Sv (50 rem) shallow dose to the skin

- A CT X-ray examination for any individual for whom a physician did not provide approval for the examination if one of the following dose values is exceeded:
- 0.05 Sv (5 rem) effective dose
    - 0.5 Sv (50 rem) to an organ or tissue
    - 0.5 Sv (50 rem) shallow dose to the skin

- A CT X-ray for an examination that does not include the area of the body that was intended to be imaged by the ordering physician or radiologist if one of the following dose values is exceeded:
    - 0.05 Sv (5 rem) effective dose
    - 0.5 Sv (50 rem) to an organ or tissue
    - 0.5 Sv (50 rem) shallow dose to the skin

- CT exposure that results in unanticipated permanent functional damage to an organ or a physiological system, hair loss, or erythema, as determined by a qualified physician.

- A CT dose to an embryo or fetus that is greater than 50 mSv (5 rem) dose, that is a result of radiation to a known pregnant individual unless the dose to the embryo or fetus was specifically approved, in advance, by a qualified physician.

The facility shall, no later than five business days after the discovery of a therapeutic event described in paragraphs 3 to 5, inclusive, of subdivision (a) and no later than 10 business days after discovery of an event described in paragraphs 1 to 4, inclusive, of subdivision (a), provide notification of the event to the department and the referring physician of the person subject to the event and shall, no later than 15 business days after discovery of an event described in subdivision (a), provide written notification to the person who is subject to the event.

DEFINITIONS:
None

SoHum Health

Subject: Quality Assurance in CT	Manual: Radiology

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") that quality assessment/quality control is performed within the standards and guidelines provided by the ACR and the CT equipment manufacturer and that regular quality control (QC) testing shall be performed by qualified quality assurance (QA) personnel at appropriate intervals. Designated equipment, in accordance with written protocol, will be used for all testing.

PROCEDURE:

The QA procedures and data shall include the following:

- Daily QC tests
  - Water CT number and standard deviation
  - Artifact evaluation
- Monthly QC tests
  - Visual checklist
  - Grey level performance of acquisition monitors
- The QC forms and equipment evaluation shall be performed as needed and equipment shall be evaluated by medical physicist every 12-14 months.
- All protocols will be established with the supervising radiologist and developed with consideration to patient's age, size and medical conditions while following the principles of ALARA for radiation protection.
  - For quality improvement purposes, a physician peer-review system that includes evaluation of accuracy of interpretation as well as appropriateness of the examination shall be performed.
  - Complications and adverse events or activities will be monitored, reported and reviewed in order to identify opportunities to improve patient care.

QUALITY ASSESSMENT EQUIPMENT

- A CT water-filled, cylindrical phantom provided by equipment manufacturer (GE)
- Small level to ensure accuracy
- Appropriate form with acceptable action limits.~~(see form for action limits)~~

DEFINITIONS:

None

Subject:	Manual:
Scope of Practice in CT	**Radiology**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to provide a procedure to delineate the hours of operation, age range of patients and procedure if CT is down or no tech is available.

PROCEDURE:

- The CT department will be open for scheduled outpatient exams from 8:30 a.m. to 5:00 p.m. Monday through Sunday. Emergency exams always take precedence and are available 24 hours a day, 7 days a week. After normal business hours, the CT tech will be available on-call for the Emergency Department (ED).
- The CT department will accept patients of all ages with a valid physician's order and authorization (as needed). No patients requiring sedation during the CT exam will be performed at this facility.
- In the event that the CT scanner is down or no CT tech is available, the ED shall be notified immediately to ensure proper patient care.
- Also, in the event that the CT scanner is down or no CT tech is available, all scheduled exams will be rescheduled.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Lead Interpreting Physician	**Mammography**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") that the Lead Interpreting Physician (Radiologist) shall be responsible for, but not limited to, the following:

1. Be licensed to practice medicine.

2. Possession of a current and valid Radiology Supervisor and Operator certificate issued by the State of California, Department of Public Health.

3. Certification by the American Board of Radiology or the American Osteopathic Board of Radiology.

4. Have 60 hours documented Category I Continued Medical Education (CME) in mammography (40 hours if initially qualified before April 28, 1999), at least 15 of which must have been acquired in the three years immediately prior to the physician meeting his/her initial requirements.

5. Have initial interpretation experience of 240 mammograms in preceding six (6) months.

6. Continue to interpret at least 960 mammographic examinations over a 24-month period.

7. Earn at least 15 Category I CME in a 36-month period, at least six of which must be related to each mammographic modality used.

8. Review and sign Annual Review of Mammography Policy & Procedure Manual.

9. Review and sign the Quality Control (QC) log and review all images taken quarterly.

10. Control of quality, radiation safety and technical aspects of examinations including:

    a. Establish, review and update of procedure manual annually.

    b. Develop protocol for standard mammographic views and techniques.

    c. Assure that mammography technologists hold current California Radiologic Technologist (CRT) certificates in diagnostic radiography and advanced certification in mammography as demonstrated by:
       - American Registry of Radiologic Technologists (ARRT) certification of Advanced Qualification in Mammography and/or
       - California certificate in Mammographic Radiology Technology.

    d. Establish and monitor a Quality Assurance/Quality Control (QA/QC) program to be carried out by the medical physicist and Mammography Radiologic Technologist as required by the State of California and the American College of Radiology (ACR).

    e. Assure mean glandular dosage for one contact craniocaudal (CC) view of a 4.5 level compression on a breast that is 50% adipose and 50% glandular tissue and does not exceed 100 millirads per radiograph without grid and 200 millirads with grid.

PROCEDURE:
N/A

DEFINITIONS:
None

Subject:	Manual:
ED/Inpatient Transport for CT Services	**Radiology**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to ensure the safety and comfort of our patients.

PURPOSE:

The purpose of this policy and procedure is to clarify methods to ensure the safety and comfort of (Emergency Department) ED and inpatients while being transported for CT services, including protection from inclement weather and traffic movement in between the CT structure and the ED entrance.

PROCEDURE:

Patients will be escorted by a varying number of staff members based upon the method of transport.

- Patients who can walk without assistance will be accompanied by a single employee to, and if necessary, from the CT building.
- Patients requiring the use of a wheelchair will be accompanied by a single employee to, and if necessary, from the CT building.
- Patients requiring gurney transport will be accompanied by a minimum of two employees to and from the CT building.

During periods of inclement weather, patients will be provided with coverage from the weather appropriate for the circumstance through the use of umbrellas, additional blankets, and/or water-resistant coverings.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Power Outage in CT	**Radiology**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to provide a procedure in case of a power outage to the CT scanner.

PROCEDURE:

- The CT scanner is not on back-up power and is not connected to the generator.
- The ED shall be notified immediately to ensure proper patient care.
- All scheduled exams will be rescheduled.
- If there is an exam in progress, the patient will immediately be removed from the scanner using the emergency release on the table.
- If the patient has been injected with IV contrast but the scan was not completed, the patient will receive an "After Your CT Scan" handout and contrast administration notes will be placed in the medical records including contrast type, volume, and site of injection as well as gauge used. The patient will be rescheduled for the following week and may require a creatinine clearance lab test prior to IV contrast administration. If no contrast was injected, patient will be removed from scanner and rescheduled for next available appointment.

DEFINITIONS:
None

SoHum Health

Subject: Community Volunteering	Manual: Outreach

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to support staff engagement in community events and local charity. As such, staff members can be eligible to receive their regular hourly pay for up to 16 hours per calendar year to volunteer at approved charitable events.

Guidelines for eligible volunteer work:

- Service must be for an approved 501(c)(3) organization or reputable service group.
- Must be conducted within the boundaries of the Healthcare District.
- Cannot be religious or political in nature.

PROCEDURE:

- Staff who are interested in volunteering must provide the following information to their supervisor at least two weeks prior to event – event date, time, affiliated organization, and nature of volunteer work.
- The supervisor will determine if the event meets the guidelines for eligible volunteer work, referring to the approved list of organizations ~~(located in S:\Policy & Procedure\Outreach\Current)~~. The approved list of organizations can be found in the Outreach Manual located in the SoHum Health document management system. (MCN). If the requested organization is not on the approved list, please inquire with the Outreach Manager to determine if it should be added.
- The supervisor will determine whether the employee's shifts are able to be covered without using overtime. Overtime cannot be used to make up for work that is missed while volunteering, or to cover for an employee who is volunteering.
- If the requirements are met (within the District, on approved list of organizations, not political or religious, and doesn't require overtime to cover) the supervisor may approve the volunteer time.
- On the employee's time sheet, they will use the designated payroll code to enter the number of hours spent volunteering, not to exceed 16 hours per calendar year.
- The employee must wear a SoHum Health t-shirt and name badge while volunteering.
- Staff members are not allowed to accept incentives for volunteering when they are being paid. This includes gift cards, stipends, and other gifts.
- Pictures from the volunteer work should be sent to the Outreach Manager, for promotional use.

DEFINITIONS:
None

SoHum Health

Subject: Scope of Service	Manual: Materials Management

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD," "District," "SoHum Health") to be involved in or directly responsible for all supply chain activities within the institution.

~~It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to be directly or indirectly responsible for some of the major supply chain activities within the institution.~~

PROCEDURE:

- The Materials Management ~~– Supply Process Distribution~~ Department is directly responsible for the following activities:
    - Receiving of supplies and equipment
    - Shipping of supplies and equipment
    - Supply storage and inventory control
    - Distribution of supplies ~~(~~including ~~the~~ Periodic Automatic Replenishment [PAR] levels ~~program)~~ and equipment
    - Monitoring of supply and service usage
    - Supply contract renewal and review through GPO and Primary wholesalers

- The Materials Management ~~– Supply Process Distribution~~ Department is involved in ~~indirectly responsible for~~ the following activities:
    - Product assessment, evaluation, and standardization
    - Cost savings activities reviews
    - Review and procurement related to Code, Disaster, isolation cart inventory, replenishment, and distribution.
    - Materials also assists ~~works with~~ the Pharmacy department with ~~to~~ replenishment and distribute their ~~these~~ supplies.

DEFINITIONS:
None

SoHum Health

Subject: Backorders	Manual: Materials Management

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to monitor backorders from suppliers and work to fill them as soon as possible.

PROCEDURE:

- A backorder occurs anytime the requested/needed quantity of a stock item is not available to be issued.

- A stock backorder can be caused by a variety of situations:
  - Items are on backorder from the supplier/manufacturer.
  - Items have been received but not yet submitted into stock.
  - Items are in transit and expected to be delivered or an expected delivery is late.
  - There is an error in the inventory and items have not been ordered or were ordered late.

- In the event of a backorder, the Materials Management team will determine the reason for the backorder and the expected time that stock will be available.
  - If the backordered item is not at a zero balance and the restock quantity is expected to be delivered and available before the item's on-hand quantity reaches zero balance no action is necessary.
  - If the backordered item will likely reach zero balance before the stock quantity is available and demand for the item is likely due to the item's Average Daily Usage (ADU), the Materials team will notify department managers of the shortage and will list item on backorder list posted on the Materials Management office door.
    - If the item is not critical, simple~~y~~ notification may be sufficient.
    - If sufficient quantities are available in other departments, it may be appropriate to transfer inventory~~move some~~ from one department to another.
    - If other items may be used instead, these will be provided.
    - If the need is critical and items are not available elsewhere, the manager will:
      1. Work with the supplier, manufacturer, and/or unit staff to identify and procure a functionally equivalent substitute item.
      2. Contact other local health systems and attempt to borrow the item on an emergency basis until the backorder is filled.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Infection Control	**Materials Management**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to support the organization-wide effort to reduce or eliminate hospital-acquired infections through strict adherence to good infection control practices.

PROCEDURE:

- Employees will maintain good personal hygiene, including clean uniforms and personal cleanliness.
- Employees will wash hands frequently. Hands will always be washed before and after meals, after use of the restrooms, and before and after any contact with movable patient equipment.
- Employees will use care when handling sterile supplies so that the sterile barrier is not compromised.
- Whenever possible, supplies will be removed from excessively soiled shipping containers before being stored. Alternately, the shipping containers will be wiped down to remove soil.
- All supply storage areas will be cleaned periodically, including ~~to~~the ~~include~~ dusting of shelves.

DEFINITIONS:
None

Subject: Inventory	Manual: Materials Management

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to make sure all inventory will be maintained to ensure adequate supplies are available for general patient care.

PROCEDURE:

- Materials Management will maintain ~~hold~~ all supplies needed to ensure adequate inventory for all patient care services of the district~~Hospital, Clinic and SNF patient care~~.

- Materials Management team will establish PAR levels for all materials according to inventory ~~drug~~ usage report.

- Reordering will be accomplished through ~~Evident EMR~~ reports of PAR levels and past ordering through primary wholesaler.
    - If for any reason a material is unavailable from primary wholesaler an alternative item may be ordered with approval of Operations Manager.
    - Any item needed to ensure adequate materials for the patients of SHCHD may be ordered from alternative wholesaler if not available from primary wholesaler. Operations manager approval is needed prior to ordering.

  Items will be stored in Materials using ~~by~~ shelf and row labeling. Materials Management will maintain a list of all materials in Materials room and their locations. This list will be kept in the pocket folder attached to supply room door.

- Operations manager along with department managers will determine what items are kept in Materials. If new inventory items are requested by department managers, the following guidelines will be considered before ordering:
    - Items used by multiple departments
    - Items used by multiple patients
    - Fast moving items
    - Slow moving items used as a necessity with no other alternative available

- Items will not be deleted from inventory without prior notification to any known users of the item. If an item is no longer used it will be inactivated not deleted in the inventory control system in use.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Organizational Structure	**Materials Management**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to be directly responsible for the following activities and shall have a uniform structure for the department's operation and management. There will be a specified chain of command for departmental employees.

PROCEDURE:

- The Materials Management Department is composed of the following sections:
  - Shipping, Receiving Services Section
  - Supply, Equipment, Cart Services Section

- The Operations Manager holds overall responsibility for the direction and administration and strategic planning of all department activities and reports to the COO. In the absence of the Operations Manager, the Materials Technician will have overall responsibility.

- Individual job descriptions for all positions are located in shared departmental files under HR and in the employee's file.

- Currently the Materials Management Department consists of a Materials Technician and Operations Manager.

- Employees are encouraged to direct all problems or suggestions to their direct supervisor. However, employees are free to contact anyone in the chain of command and/or Human Resources in situations where contact with the direct supervisor would not be appropriate.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Departmental Access/Visitor	**Materials Management~~Managment~~**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") ~~to~~ that access to Materials Management areas ~~will~~ be restricted to authorized personnel. Controlling access to departmental areas is necessary for the personal safety and security of employees and patients, and the safeguarding of organizational property.

PROCEDURE:

- Access to departmental areas:
  - The Materials Management Department working areas (including the shipping, receiving and distribution section, equipment and cart services section) are restricted to authorized hospital staff and vendors only.
  - Both the receiving area and Materials room are locked by coded entry pads. Only authorized personnel are given the access codes.

- Visitors:
  - Personal visitors are not allowed in the department without approval of Materials Manager.
  - Vendors must be accompanied by authorized staff.

- Security of goods and equipment:
  - No one will be allowed to remove supplies or equipment from departmental areas without proper authorization.
  - Anyone observing an individual acting suspiciously or carrying items from the departmental areas will contact the duty Security Officer or the Materials Manager.

DEFINITIONS:
None

Subject:	Manual:
Equipment Inspection	**Engineering ~~Clinic~~**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to inspect all medical equipment on premises for safety, operation, and reliability.

PROCEDURE:

1. Equipment covered under the scope of work for Southern Humboldt Community Healthcare District shall be inspected ~~and logged on six-month intervals~~ annually and or as per manufacture recommendation.
2. Upon discovery of an equipment problem, the equipment will be assessed by engineering department at SHCHD and SHCHD staff to determine how to proceed. From there the equipment will be removed from service and either repaired in house, sent to biomedical services office, or sent out to the manufacturer/ third party.
3. Facility services will track the repair until it has either been repaired and returned to service, or deemed not suitable for repair at which point it will be disposed of.
4. Non biomedical equipment shall be inspected by SHCHD staff or third-party inspector if required. Equipment shall be inspected upon acquisition, annually and as per manufacture recommendation.
5. Repairs and inspections done on all medical equipment shall be logged and records kept by facility staff.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Approved Cleaning Products	**Environmental Services**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide a list of approved cleaning supplies used in the hospital for cleaning and disinfection.

DEFINITIONS:

List of Approved Cleaning Products

AREA	METHOD	PRODUCT USED	EPA Number	Cleaning or Disinfectant
FLOORS	DAMP MOP	QC35	912388-03	Cleaning
	FLAT MOPS	QC35	912388-03	Cleaning
TOILETS	BRUSH BOWL	Clorox Toilet Bowl Cleaner	5813-00	Disinfectant
	WIPE	AF3 Sani Wipes	9480-9	Disinfectant
SINKS	SCRUB	Bar Keepers Friend	N/A	Cleaning
	WIPE	AF3 Sani Wipes	9480-9	Disinfectant
SHOWERS	RINSE	Clorox Healthcare Bleach Germicidal Cleaner	56392-7	Disinfectant
	SPRAY & WIPE	Clorox Healthcare Bleach Germicidal Cleaner	56392-7	Disinfectant
	FLOOR	Clorox Healthcare Bleach Germicidal Cleaner	56392-7	Disinfectant
BATHROOM	WIPE	AF3 Sani Wipes	9480-9	Disinfectant
BATHROOM	SCRUB	Bar Keepers Friend	N/A	Cleaner
WINDOWS	SPRAY	Peroxide Disinfectant and Glass Cleaner	1677-251	Disinfectant
WALLS	SCRUB	Mr. Clean Magic Eraser	3573-63	Cleaner
EMPLOYEE DISHES	WASH	Seventh Generation Dish Soap	Safer Choice Certified	Cleaner
PATIENT LAUNDRY	WASH	Eco's Laundry Soap	Safer Choice Certified	Cleaner

PATIENT CARE AREAS	C. DIFF AND NOROVIRUS	Sani-Cloth Bleach Wipes	9480-8	Disinfectant
FACILITY WIDE	See Dept. Policy	Clorox Bleach	5813-100	Disinfectant
RADIOLOGY CT SCANNER	WIPE	Seventh generation Dilution 20:1	Safer Choice Certified	Cleaner
RADIOLOGY MACHINE	WIPE	Seventh generation Dilution 20:1	Safer Choice Certified	Cleaner
ULTRASOUND MACHINE	WIPE	Seventh generation Dilution 20:1	Safer Choice Certified	Cleaner
MAMMOGRAPHY	WIPE THE MACHINE AND COMP AFTER EACH USE	Seventh generation Dilution 20:1	Safer Choice Certified	Cleaner
DIETARY SINK	SCRUB	Bar Keepers Friend	N/A	Cleaner
DIETARY STAINLESS STEEL	SCRUB	Bar Keepers Friend	N/A	Cleaner
ISOLATION ROOMS	WIPE	Sani-Cloth Bleach Wipes	9480-8	Disinfectant
WOW'S (Workstations on Wheels)	WIPE	AF3 Sani Wipe	9480-9	Disinfectant

PROCEDURE:
N/A

SoHum Health

Subject:	Manual:
Medical Waste Management	**Environmental Services**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") that all waste generated within the hospital be properly and safely segregated and disposed of in compliance with all applicable state and federal regulations.

This facility is registered with the State of California as a "~~Small~~ Large Quantity Generator." (The monthly volume of medical waste generated is ~~less~~ more than 200 pounds. There is no on-site treatment of medical waste. All medical waste is removed by a registered medical waste hauler (Shred Aware).

Facility Contact: Operations Manager or Engineering/Environmental Services Manager

NOTE: The term Medical Waste includes biohazardous/infectious waste, sharps, trace chemotherapy, pathology, and pharmaceutical waste. The terms biohazardous waste and infectious waste are synonymous.

The purpose of this policy is to provide for the safe handling of biohazardous waste from points of origin through final disposal.

REGULATORY COMPLIANCE:

Procedures written regarding the definition, handling, storage, treatment, and disposal of biohazardous waste comply with:

- Title XXII, California State Administrative Code
- Humboldt County Department of Public Health
- OSHA Bloodborne Pathogen Standard CFR 1910.1030
- State of California, Department of Public Health, Medical Waste Management Act of 2017.

DEFINITIONS:

Medical waste: any biohazardous, pathologic, pharmaceutical, or trace chemotherapy waste not regulated by the federal Resource Conservation and Recovery Act of 1976 (Public Law 94-580), as amended. It includes the following:

- Sharps and trace chemotherapy wastes generated in a health care setting in the diagnosis, treatment, immunization, or care of humans or animals
- Waste generated in autopsy or necropsy
- Waste generated during the preparation of a body for final disposition such as cremation or interment
- Waste generated in research pertaining to the production or testing of microbiological materials or substances
- Waste generated in research using human or animal pathogens
- Sharps and laboratory waste generated in the inoculation of animals in commercial farming operations that pose a potential risk of infection to humans
- Waste generated from the consolidation of home-generated sharps; and
- Waste generated in the cleanup of trauma scenes.

Laboratory waste: includes (but is not limited to) all the following:

- Human specimen cultures from medical and pathologic laboratories
- Cultures and stocks of infectious agents from research and industrial laboratories

- Wastes from the production of bacteria, viruses, or the use of spores, discarded live and attenuated vaccines, and culture dishes and devices used to transfer, inoculate, and mix cultures
- Waste containing any microbiological specimens sent to a laboratory for analysis.

Body fluid waste: discarded materials contaminated with excretion, exudates, or secretions from humans who are required to be isolated (by the infection prevention staff, the attending physician, or the local health officer) to protect others from highly communicable diseases (Biosafety Level III or higher). Body fluid waste also means items containing large amounts of liquid blood or body fluids, e.g., suction containers, and chest drainage units. If a solidifier is used it must be managed as pathology waste.

Sharps waste: any device having acute rigid corners, edges, or protuberances capable of cutting or piercing, including, but not limited to, all of the following:
- Empty Hypodermic needles, syringes with needles, blades, and needles with attached tubing.
- Broken glass items such as Pasteur pipettes and blood vials contaminated with other medical waste.

Pharmaceutical waste: a pharmaceutical, as defined in Section 117747, including trace chemotherapy waste, which is a waste, as defined in Section 25124. For purposes of this part, "pharmaceutical waste" does not include a pharmaceutical that meets either of the following criteria:

- The pharmaceutical is being sent out of the state to a reverse distributor, as defined in Section 4040.5 of the Business and Professions Code that is licensed as a wholesaler of dangerous drugs by the California State Board of Pharmacy pursuant to Section 4161 of the Business and Professions Code.
- The pharmaceutical is being sent by a reverse distributor, as defined in Section 4040.5 of the Business and Professions Code, offsite for treatment and disposal in accordance with applicable laws, or to a reverse distributor that is licensed as a wholesaler of dangerous drugs by the California State Board of Pharmacy pursuant to Section 4160 of the Business and Professions Code and as a permitted transfer station if the reverse distributor is located within the state.

Mixed waste: mixtures of medical and non-medical waste. Mixed waste is considered medical waste except for medical waste which is mixed with hazardous waste and is subject to regulation as specified in the statutes and regulations applicable to hazardous waste.

PROCEDURE:

- **LOCATIONS OF MEDICAL WASTE IN THE HOSPITAL:**

    - Areas of the hospital that generate biohazardous/infectious waste include but are not limited to the following. Waste from these areas is collected in "red" biohazardous/infectious waste bags.
        - Laboratory (specific areas):
            a. Microbiology section
            b. Blood Bank Section
            c. Any other laboratory area where specimens or human tissue wastes are discarded as defined in this policy.
            d. Sharps containers used at the point of blood draw.
            e. Chemistry section
            f. Hematology/coagulation section
            g. Serology/Urinalysis/Point-of-care section

        - Hospital
            a. All suction containers containing liquid blood or body fluid from general acute care beds and skilled nursing facility beds.
            b. All sharps containers in patient rooms, med room, and utility room.
            c. All pharmaceutical waste containers in the Acute nurse station.
            d. Isolation Rooms (when occupied by patients known or suspected to be infected with highly communicable diseases)

        - Emergency Department
            a. Emergency Department trauma rooms where large amounts of blood disposal are expected.

b. All sharps containers
c. All pharmaceutical waste containers

- Clinic
  a. All sharps containers in exam rooms
  b. Nurse station
  c. Pharmaceutical waste containers in nurse station.

- Drug room
  a. Pharmaceutical waste containers

Important Notice: The State of California law clearly states: Waste that is not biohazardous, such as paper towels, paper products, articles containing non-fluid blood, and other medical solid waste products commonly found in the facilities of medical waste generators may be disposed of as non-hazardous, non-infectious waste.

- **Authorized Personnel**
  - The collection, transport, storage, and storage of all biohazardous waste is the responsibility of the Environmental Services Department.
  - All Environmental Services personnel are trained to safely handle, transport, and dispose of biohazardous waste.
  - Training is documented and kept on file in the employee Relias profile.

- **Containment of Medical Waste**
  - A biohazard bag that is used to collect medical waste within a facility shall be manufacturer-certified to meet the ASTM D1709 dart drop test, provided that when the bag is prepared for transport offsite, it is placed into a USDOT-approved container lined with a biohazard bag that is ASTM D1709 and ASTM D1922 certified. The bags shall be securely tied to prevent leakage or expulsion of contents during storage and handling.
  - Sharps shall be contained for disposal in leakproof puncture-resistant containers that are tightly lidded or closed to preclude loss of the contents. The containers will be labeled with the words "Infectious" or "Biohazardous" and have the international biohazard symbol on the container. Containers are considered "FULL" at 2/3 capacity. Lids are snapped closed according to the manufacturer's recommendations. Taping is optional based on the likelihood of the container opening during transport or storage.
  - All bags used for containment and disposal of biohazardous waste are red in color and may be labeled with the words "Infectious" or Biohazardous Waste." Also must be ASTM D1709 and ASTM D1922.
  - Medical waste will be kept separate from other waste at the point of generation.
  - Environmental Services personnel will clean biohazard (red bag) containers in the various departments. After emptying, these will be cleaned whenever visibly soiled or emits an odor (per section 118295) by using a hospital-approved quaternary ammonia product (at least 400 ppm).

- **Transportation of Medical Waste**
  - Red biohazardous waste bags collected at the point of origin are deposited into rigid portable containers with tight-fitting lids labeled with the words "Biohazardous Waste", with the international biohazard symbol and the word "Biohazard" on the lid and sides to be visible from any lateral direction. Used exclusively for this purpose.
  - The waste containers are transported out of the hospital to the designated waste storage area where biohazardous waste is kept.
  - After emptying, transport containers are cleaned with a hospital-approved quaternary ammonia product (at least 400 ppm) when visibly soiled or emitting odor.

- **Storage of Medical Waste**
  - The biohazardous waste storage container is located behind the hospital-on-hospital property.
  - The storage container is constructed to afford protection from animals, rain, and wind, and does not provide a breeding place or food source for insects or rodents.
  - The storage building is secured with locked doors to deny access to unauthorized persons.
  - The door on the storage container is posted with a warning sign in both English and Spanish reading *"Caution – Biohazardous Waste Storage Area – Unauthorized Persons Keep Out."* The sign is readable from a distance of 25 feet.
  - Storage of biohazardous waste in the storage areas shall not exceed seven (7) days if it is kept at or above 32°F.
  - The storage container is cleaned and decontaminated as needed, or, at the time of a spill or visible leakage from a red bag.

- **Treatment and Disposal of Medical Waste**
  - On-site treatment – there is no on-site treatment of medical waste.

  - Off-site Disposal: The facility will use "off-site" disposal for all medical waste.

    - The biohazardous waste is transported to an approved disposal site or facility by a licensed contracted hauler. The hauler under contract to the facility is:
      Bio Waste Resources
      2237 3rd St.
      Eureka, CA 95501
      (707) 445-0500

      The waste is treated at an approved off-site treatment facility. The facility used by Bio Waste Resources is:
      HealthWise Services
      4800 E Lincoln Avenue
      Fowler, CA 93625
      (559) 834-3333

    - Each load of biohazardous waste to be transported off-site is documented. A manifest is kept on record in the Environmental Services Department and by the licensed transporter and disposer.

- **Biohazardous Spills (Blood/Body Fluids**
  - All visible blood and body fluid spills will be covered immediately with absorbent material by the employee who is present. A liquid solidifier (such as Isolyzer) may be used for large spills. If a solidifier is used it must be managed as pathology waste to ensure proper disposal.
  - Gloves are worn by the healthcare worker while cleaning up the spill. Both the gloves and the spill kit should be discarded into a red bag.
  - Environmental Services should be contacted to complete the cleaning process following the procedure outlined in the Bloodborne Pathogens Exposure Control Plan.
  - If nursing personnel is urgently needed for patient care, environmental services staff may be asked to complete steps A and B.

- **Record Keeping**
  - Medical Waste tracking document ~~logs~~ are kept in the Environmental Services Department for a period of not less than 3 years. Documents are scanned into EVS policies and the end of each year.

- **Emergency Action Plan**
  - In case of an emergency SHCHD will follow the following steps to ensure the continued handling of medical waste.
  - Alternative action plan includes retention of medical waste for not more than 7 days from the point of generation (above 32°F.) The following agencies will be contacted to ensure waste management disposal goes uninterrupted.

- The Department of Health Services, Medical Waste Management Program may be contacted for guidance at (916) 449-5671.

Bio Waste Resources LLC
PO Box 2339, McKinleyville CA 95519
kyle@biowasteresources.com | BioWasteResources.com
Phone: 707/445-0500 Fax: 707/633-3122

SoHum Health

Subject:	Manual:
Occupied Room Cleaning	**Environmental Services**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to provide occupied rooms with daily cleaning as follows:

PURPOSE:

To maintain a safe and clean environment for our patients, visitors, and staff.

PROCEDURE:

- Before occupied room cleaning:
  - Check for isolation status.
  - Always perform hand hygiene
  - Don appropriate PPE
  - Check Sharps container. Change if necessary.
  - Empty the trash container. Handle plastic bags from the top.

- Patient room: Clean and disinfect using a currently approved cleaning agent.
  - Raise and wipe down arm rails – high touch area.
  - Wipe the foot of the bed.
  - If the call box or phone is on the bed wipe down at this time
  - Ledges (below shoulder height)
  - Door handles, knobs – high touch area
  - Light switches- high touch area
  - Call box – high touch area
  - Telephone – high touch area
  - Windowsills and ledges
  - In-room patient sink and faucet – high touch area
  - In-room soap dispenser and paper towel dispenser
  - Biohazard can
  - Overbed table – high touch area
  - Bedside tables – high touch area
  - All other easily accessible wall-mounted equipment

- Do not wear dirty gloves outside of the room or in hallway.

If you must leave the room after you have started a room clean, remove your gloves and perform hand hygiene. Put a new pair of gloves on to resume cleaning. PATIENT ROOM: Clean and disinfect using a currently approved cleaning agent.

- Patient restroom
  Clean and disinfect using a currently approved cleaning agent. Light switches – high touch area
  - Door handles, knobs – high touch area
  - Handrails – high touch area
  - Spot walls

- Cleaning Toilet: start with a new wipe/rag before cleaning the toilet.
  - Toilet paper dispenser
  - Toilet flusher – high touch area
  - Toilet seat – high touch area
  - Under the bowl

    - Toilet rim
    - Clean the inside of the bowl with disinfectant cleaner and a toilet brush.
    - Clean commode frame and seat cover LAST.

- Before leaving the room
    - Remove gloves and perform hand hygiene.
    - Restock supplies.
    - Place wet floor sign in doorway
    - Sweep and Mop the floor – never shake the mop.
    - Perform hand hygiene.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Terminal Cleaning	**Environmental Services**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to provide a patient care environment throughout the facility that will be maintained in a state of cleanliness that meets professional standards to protect patients and healthcare personnel from potentially infectious microorganisms. Environmental cleaning is a team effort. Personnel responsible for cleaning the environment and equipment will receive education and training on proper environmental cleaning and disinfection methods, agent use and selection, and safety precautions.

PURPOSE:

To maintain a clean environment for patients and minimize the risk of patient and healthcare personnel exposure to potentially infectious microorganisms.

DEFINITIONS:

Terminal cleaning of inpatient areas occurs after the patient is discharged/transferred, includes the patient zone and the wider patient care area, and aims to remove organic material and significantly reduce and eliminate microbial contamination to ensure that there is no transfer of microorganisms to the next patient.

PROCEDURE:

Personal protective equipment (PPE) must be worn according to the Occupational Safety and Health Administration (OSHA) Blood-Borne Pathogen Standard when disposing of waste that could result in exposure to blood-borne or other potentially infectious microorganisms and hazardous material.

- **Terminal cleaning of each patient room will be completed upon discharge of the patient and as needed for SNF and Swing bed patients. Unused rooms should be cleaned once weekly because personnel entering unused rooms and moving equipment and supplies in and out of the room can increase the risk of environmental contamination:**
    - Clean hands and put on gloves.
    - Clean and disinfect lights and ceiling tracks.
    - Clean and disinfect all door handles, push plates, light switches, and controls.
    - Clean and disinfect telephones.
    - Spot wash all walls.
    - Clean and disinfect all exterior surfaces of machines and equipment.
    - Clean and disinfect all furniture including wheels/casters.
    - Clean and disinfect the exterior of cabinets and doors, especially around handles.
    - Clean and disinfect all horizontal surfaces.
    - Clean and disinfect the bed.
    - Clean the floor making sure the bed is moved and the floor is washed underneath; move all furniture to the center of the room and continue cleaning the floor.
    - Replace all furniture and equipment in its proper location.
    - Collect and remove all soiled linen.
    - Collect and remove waste.
    - Damp wipe waste receptacles, dry thoroughly, and re-line
    - Place a cautionary 'Wet Floor' sign at the entrance to the room.
    - Remove gloves and clean hands.
    - Clean and store cleaning equipment

- Report any needed repairs.

- **Other patient care areas and environmental surfaces that come in direct contact with patients will be cleaned daily with a facility-approved cleaning supplies:**

  - Assemble supplies.
    - Ensure an adequate supply of AF3 wipes is available.
    - Prepare fresh mopping solution according to the manufacturer's instructions.
  - Clean hands and put on gloves.
  - Remove dirty linen, then remove gloves and clean hands.
  - Apply clean gloves and clean the room, working from clean to dirty and high to low areas of the room cleaning each patient's bed space and completing the cleaning of each bed space before moving to the next.
    - Start by cleaning doors, door handles, push plates, and touched areas of the frame.
    - Check walls for visible soiling and clean if required.
    - Clean light switches and thermostats
    - Clean wall-mounted items such as alcohol-based hand rub dispensers and glove box holder
    - Check privacy curtains for visible soiling and replace them if required.
    - Clean all furnishings and horizontal surfaces in the room including chairs, windowsill, television, telephone, computer keypads, tables, or desks. Lift items to clean the tables. Pay particular attention to high-touch surfaces.
    - Wipe equipment on walls such as the top of the intercom and blood pressure manometer as well as the IV pole
  - Clean the bed.
    - Clean the top and sides of the mattress, turn it over, and clean the underside.
    - Clean the exposed frame.
    - Clean headboard, footboard, bed rails, call bell, and bed controls; pay particular attention to areas that are visibly soiled, and surfaces frequently touched by staff.
    - Clean all lower parts of the bed frame, including casters.
    - Allow the mattress to dry.
  - Clean floors
  - Disposal
    - Place soiled cloths in the designated container for laundering or disposal.
    - Check the sharps container and change when ¾ full (do not dust the top of a sharps container)
    - Remove soiled linen if the bag is full.
    - Place obvious waste in receptacles
    - Remove waste.
  - Remove gloves and clean hands; if hands are visibly soiled, wash them with soap and water.
  - Replenish supplies as required (e.g., gloves, ABHR, soap, paper towel)
  - Clean hands

- **Clean bathrooms, working from clean areas to dirty areas:**

  - Remove soiled linen from the floor; wipe up any spills; remove waste.
  - Clean door handle and frame, light switch
  - Clean wall attachments
  - Clean inside and outside of the sink, sink faucets, and mirror; wipe plumbing under the sink; apply disinfectant to the interior of the sink; ensure sufficient contact time with disinfectant; rinse sink and dry fixtures.
  - Clean all dispensers and frames.
  - Clean call bell and cord
  - Clean support railings, ledges/shelves
  - Clean bedpan support, entire toilet including handle and underside of flush rim; ensure sufficient contact time with disinfectant.
  - Change all waste bags, clean waste can if dirty.
  - Remove gloves and wash hands.
  - Replenish paper towels, toilet paper, waste bag, soap, and ABHR as required.

- **Reprocessing and other sterile storage areas are to be cleaned according to the following schedule:**

    - Clean all counters and floors daily.
    - Clean shelves daily in sterilization, preparation, packing, and decontamination areas.
    - Clean shelves every three months in sterile storage areas
    - Clean case carts after every use
    - Clean walls every six months
    - Clean light fixtures, sprinkler heads, and other fixtures every six months

- **Personnel responsible for cleaning must perform hand hygiene:**

    - Before initial patient environment contact (e.g., before coming into the patient bed space);
    - After potential body fluid exposure (e.g., after cleaning the bathroom, handling soiled linen, equipment, or waste); and after patient environment contact (e.g., after cleaning patient bed space; after cleaning equipment such as stretchers; after changing mop heads).
    - Gloves must be removed on leaving each patient's bed space. Personnel must **clean their hands after removing gloves** as gloves do not provide complete protection against hand contamination.

SoHum Health

Subject:	Manual:
Communications During a Disaster	**Safety and Emergency Preparedness**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to maintain and/or re-establish communications during a disaster.

PURPOSE:

The purpose of this policy and procedure is to provide guidelines for all hospital staff to maintain communication during a disaster.

DEFINITIONS:

Emergency communications: Mmay include alerts and warnings; directives about evacuation, curfews, and other self-protective actions; and information about response status, family members, available assistance, and other matters that impact response and recovery.

PROCEDURE:

Internal Communications

Phone Lines (Including Intercom System) are operating:

- Employees use phones lines minimally. Utilize texting /cell phones, and runners for messages – keep lines open only for the most urgent communications.

Phone Lines are not operating:

- Utilize runners for messages.
- Walkie-Talkie, CB's, hand heldhandheld radios.
- Personal cell phones may be used by staff as appropriate.

Internet/e-mail as it is still functioning.

External Communications

Phone Lines Not Operating:

Med-Net Radio to:

- EMS Systems
- Redwood Memorial Hospital/St. Joseph Hospital
- Humboldt County Multi-Casualty Incident (MCI) Channel

HAM Radio to:

- Volunteers from SHARC (Southern Humboldt Amateur Radio Club) have agreed to come to the hospital in the event of a disaster to set up communications. They will establish communications with OES in Eureka and forward all our needs and requests by radio/computer.
- Hospital employees, who are trained in the use of HAM radio operations, will enable SHCHD to communicate locally and with outlying areas.

KMUD Radio Station

- Runner will deliver messages from the hospital to KMUD. KMUD will broadcast disaster information to the community i.e., personnel needed, road conditions, damage

assessment, etc. Hospital employees should know how to tune in to KMUD (FM 91.1) for information on whether they are needed at the hospital.

SoHum Health

Subject:	Manual:
Electrical Power Outages	**Safety and Emergency Preparedness**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide a plan to maintain district services in the event of an electrical power outage.

PURPOSE:

The purpose of this policy and procedure is to delineate the process in which the electrical power outage plan will be implemented.

DEFINITIONS:

PA ~~p~~ower Oo~~o~~utage ~~-~~(also called a power cut, a power out, a power failure, a power blackout, a power loss, or a blackout): is the loss of the electrical power network supply to an end user.~~.~~

Public Safety Power Shutoff (PSPS):~~)~~ may occur whenever PG&E believes there is a significant threat of wildfire.

Procedure:

1. Emergency exit signs equipped with floodlights are installed at every exit in the facility. The floodlights will come on throughout the facility whenever electrical power is disrupted.

2. The hospital is equipped with a ~~propane~~ diesel generator which operates via an automatic transfer switch. ~~All patient care areas from Radiology to the end of the Skilled Nursing Facility (SNF) unit are equipped with at least one emergency backup outlets. These outlets are either red or have a red outlet cover~~ All outlets throughout the facility including the clinic, regardless of color, are on emergency power. ~~-~~The Engineering/Environmental Services Manager~~/Engineer~~ is responsible for maintenance of this generator and emergency power outlets. Computed Radiography is **NOT** included in the emergency generator coverage.

3. Critical equipment in patient care areas, including the Emergency Room and Room 109, should operate as normal during power interruptions.~~,~~ ~~will be remain plugged into the emergency power outlets.~~ Nursing staff is ~~will be~~ responsible for ensuring that ~~making sure~~ all ~~other~~ necessary equipment is ~~plugged into these outlets~~ operable ~~once~~ whenever power has been ~~is~~ disrupted - including SNF air bed mattresses. ~~Environmental Services maintains a stock of extension cords on the wall outside their office for use during a power outage.~~

4. All departments within the organization~~, including Radiology, Laboratory and Dietary,~~ will follow their established power outage protocols.

~~5.~~ ~~The Clinic has a separate gasoline powered generator that emergency power is fed through the main hospital generator and is maintained by Environmental Services Engineering Department. In the event of a power outage, the Clinic Reception Area, Patient Exam Rooms 2, 5, 6, 7 and 8 will be powered using the generator and extension cords. The Clinic will follow their established power outage protocols.~~

~~7.~~5. During power disruption involving a catastrophic generator failure, the Administrator and ~~Supervisors Managers~~ Engineering Manager will determine the extent to which the facility is able to ~~will~~ continue to

function and which ~~the necessity of~~ staff should be ~~being~~ present or called in.~~present. Staff may or may not be sent home during the outage.~~

SoHum Health

Subject:	Manual:
Extension Cords and Adapters	**Safety and Emergency Preparedness**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide the safe use of electrical equipment.

PURPOSE:

The purpose of this policy and procedure is to delineate the process in which the extension cords and adapters will be implemented.

DEFINITIONS:

Extension Cord, power extender, drop cord: a length of flexible electrical power cable (flex) with a plug on one end and one or more sockets on the other end.
Adapter: a device for connecting electrical equipment to a power supply, or for connecting different pieces of electrical or electronic equipment together.

Procedure:

~~Extension cords and or adapters of a hospital grade may be used on a **temporary** basis for hospital equipment that are used in a location without a nearby receptacle, emergencies, and during a power outage **only** with the permission of the Engineering/Maintenance Department.~~
~~Extension cords and adapters used will meet the following restrictions:~~

- ~~Wire gauge will be 12 gauge or heavier, with a ground.~~
- ~~Adapters will be of hospital grade.~~

~~All cord cap replacements shall be of hospital grade.~~

Hospital-grade extension cords and/or adapters may be temporarily used for hospital equipment in locations without a nearby receptacle, in emergencies and during power outages **only** with the permission of the Engineering Department.

Extension cords and adapters used will meet the following requirements:

- Wire gauge will be 12 gauge or heavier, with a ground. Engineering will confirm the appropriateness of the application before use.
- Adapters and connectors will be hospital-grade.
- All cord cap replacements shall be hospital-grade.

SoHum Health

Subject:	Manual:
Dishwashing	**Dietary**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District "SHCHD" or "District") to make sure all dishes, trays, utensils, pots and pans are cleaned and sanitized according to established procedures. All utensils for eating, drinking, and in the preparation and service of food and drink shall be cleaned and sanitized or discarded after each use. Clean and sanitized dishes, utensils, pots and pans are a part of the department's safeguards against food borne illness.

DEFINITIONS:

Nesting": This is the term that describes when spoons scope area is fully in contact with each other. Thus, no space for water or air to run over the surface of the spoon to allow for adequate cleaning.

PROCEDURE:

Procedures for washing, rinsing, and sanitizing shall follow the manufacturer's directions and those established by the industry as safe.

The patient tray cart is returned to the hallway outside the dish room door. The cart with dirty dishes cannot come into the food preparation area. The soiled, dirty dishes are removed from the cart as soon as possible in dish room area on designated "dirty side." Once the dishes and trays are removed, the cart must be sanitized with 1/2 oz. chlorine sanitizer to 1 gallon of water following manufacturer's instructions.

Gross food particles shall be removed by scraping and pre-rinsing in running water. All food scraps will be disposed of in the garbage disposal being careful not to put bones, paper products or food scraps determined not appropriate for the disposal unit.

Silverware is placed utensil side down in soapy water in utensil holder. Food particles are rinsed, soaked, or scrubbed and placed utensil side up in the utensil holder on flat racks. **Do not overload utensil holder.** Be sure spoons are not "nesting" and that there is sufficient room for water circulation. Run through dish machine and let dry. Turn silverware into empty holder without touching utensils.

Use appropriate racks for plates, bowls, silverware, etc. Do not overload racks and be sure sufficient room exists for all items to be washed and rinsed thoroughly. Plates, bowls, and dessert dishes are not to be washed on flat rack, as this prevents adequate washing and drying.

The dish machine must operate at temperatures adequate to sanitize dishes. Wash temperature must be minimally 140˚F, hot water must be a minimal of 180˚F at the manifold on the final rinse, or 160˚F at the plate. Temperatures of the final rinse will be checked two times daily ~~using the temperature indicators run through the machine~~. ~~These will be attached to the dish machine log to document that the machine is operating at an appropriate temperature to sanitize the dishes.~~ Read wash guage and rinse gauge, record in Dishmachine log, enter initials of employee who obtained readings.

If temperature check of dish machine rinse cycle is below 180°F minimum it will be turned off. Out-of-order sign will be placed on dish machine and dietary manager will be notified. Dietary staff will then follow the three-compartment sink method using chlorine sanitizer. All disposable dishes and utensils will be used to serve food.

Employees will be very attentive to the danger of cross contaminating the dishes from handling dirty dishes and then clean dishes. Hands must be thoroughly washed between handling clean and dirty dishes.

Dishes will be allowed to drain and air dry on non-absorbent surfaces. Drying towels will not be used on any dish, utensil, pot or pan.
Employees will not touch any eating or food contact surface with bare hands while handling clean dishes.

The tray cart will be cleaned after every meal with a solution of bleach sanitizer mixed to manufacturer's recommendations.

If the dish machine is not operational, the dishes will be washed using approved methods to insure sanitation. The three-compartment sink method will be followed:

1st Compartment **Wash** → 2nd Compartment **Rinse** → 3rd Compartment **Sanitize** → **Air Dry**

The manufacturer's recommendation will be followed:

- 1 ounce of bleach to 2 gallons of water; immersed for at least 2 minutes.

Chlorine test strips will be used to measure 220ppms and logged on form above the three-compartment sink.

Directions + log form for three-compartment sink method will be posted above the three-compartment sink.

Plastic ware, china and glassware that is unsightly, unsanitary, or hazardous because of chips, cracks, or loss of glaze will be discarded.

Cooking equipment or utensils that are rusted, cracked, or in any way have the surface scarred in a manner that makes sanitation difficult, will be discarded.

A contract for preventative maintenance on the dish machine will be maintained with Eco-Labs or a similar company to check the dishwasher monthly to insure the proper operation and delivery of chemicals.

~~**DEFINITIONS:**~~

~~Nesting": This is the term that describes when spoons scope area is fully in contact with each other. Thus, no space for water or air to run over the surface of the spoon to allow for adequate cleaning.~~

SoHum Health

Subject:	Manual:
Cooling Large Cuts of Meat	**Dietary**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District Dietary Department to assure that foods are prepared following established food safety guidelines, specifically when large cuts of meats are prepared the day prior to service, the cooling process is closely monitored to prevent bacterial growth, which leads to food borne illness.

PROCEDURE:

- Roasts will be cooked to appropriate temperatures as per policy.
- Final cooking temperature will be documented.
- Roasts will be cut into pieces no more than 5-6 inches thick.
- Roasts may be allowed to cool at room temperature until they reach approximately 180ºF, but never below 140ºF.
- Roasts are transferred to the refrigerator uncovered for the cooling process. The time and temperature must be documented when the roast is put into the refrigerator.
- In two hours after putting the roast into the refrigerator, the time and temperature must be checked. The roast must have cooled to 70ºF. If it has not cooled down to 70ºF, the roast must be reheated to 165ºF and cut into smaller pieces. The cooling process would begin again; therefore, the temperature of roast would have to be checked at or before 2 hours has passed and must be 70º F or below.
- The temperature is again checked at or before additional 4 hours has passed. The temperature must go from 70ºF to 41ºF within these last four hours. Time and temperature must be documented when it reaches 41ºF or below.
- At this time, it is covered, labeled, and dated and stored in the refrigerator.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Dietary Disaster Plan	**Dietary**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide a dietary disaster plan to supply food and nutritional support to patients, personnel, and volunteers in the event of a disaster. This plan is based on a need to feed a total of 75 persons for 3 days; 26 patients, 36 staff, 13 volunteers and/or family members. Only staff members that are required to stay will be provided with food. Other staff members are expected to go home after their shift and supply their own food. Community members volunteering are expected to supply their own food, but extra water is stored to meet their needs.

PROCEDURE:

Meals for All, Inc. Copyright 2015 3-day meal plan and food supplies are stored in the dietary department. A binder containing the emergency menus/procedures is kept with disaster food supplies in dry storage room. The binder contains detailed instructions on how to prepare emergency food items. The disaster emergency water supply is stored in Materials Management Department.

DEFINITIONS:

Meals for All, Inc is an outsourced company that makes non-perishable food supplies along with nutritional analysis and recipes for using preparation of non-perishable foods.

SoHum Health

Subject:	Manual:
Dietary Employee Health	**Dietary**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") that the Dietary Department will monitor employee health to prevent an outbreak of food borne illness and comply with the regulations set forth in the California Retail Food Code. Older adults and people with compromised health are more prone to the development of food borne illness. Adherence to this policy protects the health of our patients.

PROCEDURE:

- Dietary staff will be instructed on food safety annually.
- Dietary staff is required to report the following to their supervisor.
    - A diagnosis of:
        - Salmonella typhi
        - Salmonella spp.
        - Shigella spp.
        - Entamoeba histolytica
        - Enterohemorrhagic or Shiga toxin producing Escherichia coli
        - Hepatitis A virus
        - Norovirus
        - Other communicable diseases that are transmissible through food
- An open or draining wound or lesion that is:
    - On the hands or wrists, unless the lesion has an impermeable cover, and a disposable glove is worn over the cover. These gloves must be changed every time the employee is required to wash their hands
    - On exposed portions of the arms, unless the lesion is protected by an impermeable cover.
    - On other parts of the body, unless the lesion is covered by a dry, durable tight-fitting bandage.
- The Certified Dietary Manager of Dietary Department will notify the Infection Preventionist when:
    - The supervisor is aware that a food service employee has been diagnosed with any of the above infectious agents.
    - When two of more of the staff are experiencing symptoms of acute gastrointestinal illness such as nausea, vomiting and diarrhea. This must be reported immediately, even if there is no specific diagnosis at that time.
- Infection Preventionist will notify the local health department.
- The local health department will exclude the employee from the workplace if they are diagnosed with any of the above infectious agents and are still considered infectious. The employee will not be allowed to return to work until receiving written clearance from the health department.
- If the employee was not diagnosed with any of the above infectious agents, the supervisor may allow them to return to work if they have been symptom free of any gastrointestinal illness for 24 – 48 hours. The supervisor may also allow them to remain in the facility if they are assigned duties that do not involve working with exposed foods; clean equipment, utensils or linens; and unwrapped single

service or single use articles. The employee should be reminded about hand washing procedures and observed closely.

- Food service staff will comply with the exclusions or restrictions as required by the CDM Dietary Department manager/Infection Preventionist or the local health officer.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Dietary Policy and Procedure Manual	**Dietary**

POLICY:

This policy of Southern Humboldt Community Healthcare District (SHCHD) is to have all Dietary related policies reviewed by all departments affected by the content prior to approval by the Governing Board.

PURPOSE:

The purpose of this manual is to provide guidelines for all dietary department employees to follow while providing nutritional care including planning, preparation, and service of food. It clarifies the interdepartmental responsibilities related to this process to form a basis of understanding between departments.

PROCEDURE:

Policies deal with broad areas and basic issues. They represent the decisions of the Governing Board as to the direction and philosophies of the organization. Therefore, policies may only be changed with the approval of the Governing Board.

Procedures are detailed descriptions of the way in which policies are implemented. They are usually not subject to central approval, therefore, are more flexible than dietary policies.

Procedures may be changed with the expressed agreement of all departments involved, and the approval of Administration.

- Objectives:
    - To provide comprehensive nutritional care to our patients and residents meeting the standards set by Title XXII, FDA Food Code, HIPAA, Critical Access Hospital regulations, California Retail Food Code, OSHA, and all other appropriate regulatory agencies.
    - To plan and provide meals to meet the nutritional and therapeutic needs of the patients and residents in accordance with the Registered Dietitian's recommendations and physician orders.
    - To assess and monitor the patient/resident's nutritional status and make appropriate recommendations to ensure their nutritional needs are met.
    - To provide nutritional counseling and support to patients/residents regarding their diet and food choices.
    - To prepare and serve attractive and wholesome meals under high standards of sanitation, meeting all federal, state and local requirements.
    - To operate within the department budget set by Administration.
    - To develop a spirit of cooperation among all dietary department employees and with other departments to effectively carry out these objectives.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Dietary Purchasing	**Dietary**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD" or "District") that all food and supplies to be used in dietary will be purchased from sources approved or considered satisfactory, by federal, state, and local authorities. All food and/or supplies will be purchased within the facility guidelines, utilizing the vendors of the current group purchasing organization contracted with the hospital. Price, service, delivery, and availability will always be considered in purchasing products.

PURPOSE:

The purpose is:

- To provide safeguards that all foods have been handled safely prior to arrival at SHCHD.
- To be certain all products purchased are the best value for the price.
- To assure that food and equipment are appropriate for the menu.

PROCEDURE:

- Food and Supply Purchasing:
    - Certified Dietary Manager (CDM) is responsible for purchasing all food and supplies.
    - To the maximum extent possible, food and supplies will be purchased from vendors who are associated with the hospital group purchasing organization.
    - Dietary staff only allowed to charge from local market with permission from CDM/CFFP in rare occasions. This keeps cost controlled and food is inspected/approved prior to purchase.
    - All deliveries will be checked upon delivery for quality and to assure that the delivery slip matches the items received.
    - Food and supplies will be stored according to policy: "Food Preparation and Storage."
    - CDM will verify that all vendor charges correspond to the receipts.
    - Credit slips will be turned into accounts payable.
    - Vendors list of names and phone number are posted in dietary.
    - CDM will compare prices and service between vendors when more than one approved vendor carries the same product.

- Purchasing of Small Equipment:
    - Small equipment will be defined as dishes, silverware, small storage containers, thermometers, etc. totaling under $1,000 per item.
    - Registered Dietitian (RD) will consult with the CDM on specifications of small equipment needed. CDM will, in conjunction with Materials Management, be responsible for checking prices and ordering the equipment.
    - Dishes and other small equipment will be replaced when they are cracked, chipped, rusted, have no appropriate handles, or has lost the glaze.
    - CDM will be responsible for regularly checking all small wares to be sure they are safe for the employee to use and can be properly sanitized.

- Purchasing Enteral Feeding and Medical Nutritional Supplements:
    - Materials Management will be responsible for purchasing all enteral feeding products and infant formula products.
    - RD will consult with the Materials Management Manager to coordinate available products with recommendations to the physician.
    - To the maximum extent possible, physician orders will comply with products that are available through the group purchasing organization.

- Capital Equipment:
    - Capital equipment will be defined as any single piece of equipment costing more than $1,000.
    - All capital equipment purchases will be purchased by COO and approved by Administration.
    - Materials Management will be consulted for possible vendors through the group purchasing organization.
    - Engineering department will be consulted for electrical and maintenance specification, and ease of accessing service and repair.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Equipment Maintenance	**Dietary**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") that equipment maintenance is necessary to prevent employee injuries and to prevent unnecessary equipment repair and replacement costs.

All equipment will be subjected to preventative maintenance procedures to prevent accidents due to faulty electrical or mechanical functioning and extend the life of the equipment.

PROCEDURE:

- The Dietary Department manager is responsible for:
    - Training all employees in the proper use and cleaning of the equipment.
    - Establishing equipment cleaning schedules and monitoring employee compliance.
    - Instructing employees in the proper method of reporting equipment failure and/or issues to department manager and engineering department. If department manager is unavailable, report to Chief Operating Officer (COO).
    - Conducting a periodic visual inspection of all equipment noting condition, efficiency, loose parts, or excessive wear of the equipment.
    - Routine inspection of kitchen for safety and efficiency of equipment.
    - Dietary Department manager will notify engineering department when equipment issues arise and place work order.
- The Engineering Department is responsible for:
    - Recording the following information on all equipment:
        - Brand name
        - Model and serial number
        - Phone number of servicing agent
        - Dates of repair/service
    - Prompt and efficient emergency repair of equipment and preventative maintenance
    - Conducting periodic service inspections of all equipment and schedule for maintenance of equipment

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Food Preparation and Preparation Area	**Dietary**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District (SHCHD) to make sure the Dietary Department maintains a clean, sanitary, and safe food production area and food handling procedures. The purpose of this policy is to prevent foodborne illnesses in patients and residents resulting from cross contamination and failure to hold foods at appropriate temperatures.

~~**Safe Food Handling Processes to Decrease Cross Contamination & Holding Foods at Safe Temperatures**~~

PROCEDURE:

Facility:

- Dish and utensil cleaning area is located in a separate area from the food production area.
- Handwashing facilities in the kitchen are separate from the food preparation and dishwashing equipment and include hot and cold water with soap dispenser and disposable towel rack, and step-on trash cans.
- All floors in the food preparation and storage area are washable and have a non-slip finish. Walls are also painted with a washable paint.

Food handling of cold foods:

- When preparing cold foods, chill all ingredients thoroughly before mixing. This will aid in slowing the growth of bacteria.
- Protect all products from contamination by segregating items from raw meats, fish, chicken, and unwashed fruits and vegetables.
- Use sanitized utensils and avoid hand contact. Wear plastic gloves when mixing products or use long-handled utensils.
- After mixing food such as protein containing salads, cool in 2-inch-depth containers until it reaches 40°F. After it reaches 40°F, cover, label, date, and store to maintain temperature at 40°F or less.
- Store and thaw all raw meats on the lowest shelves of the refrigerator to prevent blood contamination. If blood does contaminate other foods in the refrigerator that will not be cooked to a minimum of 165°F, discard immediately.
- Thoroughly wash all produce before using by holding produce under cold, running water, being sure all folds, crevices, and surfaces are free of dirt and contamination. Do not soak produce in a sink. Wash your hands before and after handling unwashed produce.

Cooling of hot foods:

- Rapid cooling of hot foods is essential to prevent foodborne illness. Hot foods will be put into pans no more than 2 inches deep.
- Large cuts of meat will be cooled according to Policy ~~#DMV-9 (“~~Cooling Large Cuts of Meat~~”)~~.
- Plastic acts as an insulator, so foods should be cooled in metal containers. If not cooled in metal containers, the temperature must be checked in two hours until it is known that the food will cool in plastic within the allowable time.
- Cover and date foods after they reach 40°F. Plastic wrap and lids act as insulators and delay the cooling process.
- Never mix hot foods with cold foods during storage.

Holding hot foods:

- To ensure safety, hot foods must be held at 140°F or above.
- Reheat all foods to 165°F for 15 seconds.
- After food is reheated, any unused portion must be discarded.
- Foods should be rapidly reheated.
- Frequently stir foods that are being held to distribute temperature evenly. The top portion will cool faster than the food closer to the heat source.
- Cover foods being held to maintain heat and prevent contamination.
- Serving utensils will not be left in the food while it is being held.

Thawing foods:

- All meats must be thawed in the refrigerator at 40°F or less.
- Employees must check the menus ahead to pull the meats needed to allow time for defrosting.
- Do not leave meat in the sink to thaw at room temperature.
- All meat must be thawed on the lowest shelves of the refrigerator and other foods must be protected from blood contamination.
- All foods must be thawed by one of four acceptable methods:

    - In the refrigerator is the strongly preferred method
    - During the cooking method is also acceptable if the end product is not affected
    - In the microwave; or
    - Under cold, running, potable water. This product must be closely observed.

Cutting boards:

- Food grade, hard rubber or acrylic boards are preferred, however current research indicates that wood boards are also acceptable.
- Separate boards must be labeled for use with raw meats, cooked meats, and vegetables. They must be labeled or color-coded.
- All cutting boards must be sanitized after every use. They are washed and sanitized in the dishwasher.
- They must be free of seams and cracks.
- They must be non-toxic and non-absorbent.
- They must be discarded when they are stained and cannot be bleached.
- They must be discarded when the surface is worn, and sanitation cannot be assured.

Use of disposable gloves:

- Gloves must be used whenever you are in direct contact with food that will not be cooked prior to service.
- Gloves must be discarded after every use.
- Hands must be thoroughly washed before putting on gloves and after removing.
- Handwashing policy is the same when wearing gloves, i.e., gloves removed, and hands washed in all situations requiring handwashing.
- Plastic gloves should not be worn when working around hot surfaces.
- Gloves do not have to be worn when serving food with utensils that do not necessitate direct contact with food.

Sanitation of food contact surfaces:

- All food contact surfaces will be sanitized at the beginning of each shift.

- Food contact surfaces must be sanitized after every task, i.e., handling raw foods that will be cooked, cooked foods, unwashed raw foods, ready-to-serve raw foods, and after non-food items that are not sanitized have been in contact.

- Sanitation buckets will be located in the dish room and in the three-compartment sink with a bleach solution of ½ ounce, or 1 tablespoon of bleach solution to one gallon of water per manufacturer's recommendation.
- Each sanitizer bucket will be marked at the one-gallon mark. The cleaning cloths will be stored in sanitizer solution buckets and used to sanitize food contact surfaces.
- The sanitizer buckets will be changed twice daily in the a.m. and p.m. Chlorine test strips will be used to measure parts per million (ppm). Chlorine test strips must read 200 ppm and results recorded in log.
- Any other sanitizer must be approved for food contact surfaces.

Trays do not leave the kitchen unless the staff is assured the food has been handled appropriately and the food looks appetizing.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Food Preparation and Storage	**Dietary**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD," "District," "SoHum Health") to prepare and store food in a safe manner and to store chemicals and other toxic substances separately from food according to recognized standards for food handling.

PROCEDURE:

DEFINITIONS:

Potentially hazardous foods are food items that require time and/or temperature control for safety to limit pathogenic microorganism growth or toxin formation.

FIFO (First In, First Out) is a method for inventory management that prioritizes using older foods or supplies before moving past their use-by dates.

Food Preparations

- Food is prepared to retain nutritional value, flavor, appearance, and absence of bacteria associated with food borne illness. Store, prepare, distribute, and serve food in accordance with professional standards for service safety.
    - ~~Foods prepared for acute patients on regular diets are generally low in fat and sodium.~~
    - ~~Foods prepared for Skilled Nursing Residents often have added fats and calories to decrease the incidence of weight loss.~~
    - Foods will be prepared according to patient's diet order, recommendations from Registered Dietitian, and dietary staff following menus/recipes approved by Registered Dietitian.
    - Vegetables are prepared in as little water as is practical to retain nutrients and color.
    - All meats are cooked to the recommended safe temperature to prevent food borne illness.
    - All produce is thoroughly washed under cold running water and inspected for dirt and insects prior to use.
    - Eggs are not served raw or undercooked.
    - Temperatures of all potentially hazardous foods are recorded at the time of service.
    - Temperatures of all refrigeration units are recorded in the morning and afternoon, daily.
    - No potentially hazardous food shall be in the danger zone of (41°F to 140°F) for longer than a total of four hours including delivery, processing, and service time. As a practical means, no potentially hazardous food should sit at room temperature for longer than 45 minutes during preparation and service. Any questionable foods will be discarded.
    - All foods brought to patients or residents from home by family or visitors must meet the same storage and handling specifications as foods being prepared by the dietary department staff. Foods must be marked with the patient's name, date and time of arrival and must be disposed of after 24 hours if not consumed. These food items must only be stored in resident refrigerator (if perishable) or resident

kitchen.
    - Food storage areas are clean at all times.

Food Storage

- **Receiving:**
    - All food delivered is checked against the delivery slip. Food is checked for correct quantity, quality, and sanitation of the containers.
    - If unacceptable, the product is returned at the time of delivery.

- **Dry Storage:**

    - Food is arranged in dry storage according to groups, i.e., vegetables, fruits, dry products, seasonings, etc.
    - All groceries are stocked on the shelves according to FIFO (First In, First Out). New items are always placed behind the older product. All labels are facing forward. All cans are dated when they are received to facilitate this process.
    - Flour, sugar and dry bulk products are stored in plastic containers with tight fitting lids to prevent insect and rodent contamination. All containers are labeled with product name, and date the container was filled on the container, not the lid. The containers are washed and sanitized prior to refilling.
    - Bread will be stored in freezer or dry storage areas. Bread is to be used within 7 days of open/defrost date.
    - All products are stored away from the walls, 6" off the floor.
    - All dry products are dated when they are opened and stored in closed containers.
    - The heaviest items should be stored on the middle shelves to prevent back injury when lifting.

- **Refrigerated Storage:**

    - All refrigerated units must have a working thermometer.
    - All refrigerators will operate at or below 41° F. Temperatures are recorded during the AM and PM shifts. To ensure the thermometer in the refrigerator is accurate, the temperature of the milk will be taken every morning and recorded. The temperature of the milk must be 41° F or below. If an inappropriate temperature is found, it is immediately reported to maintenance.
    - All freezers will operate at 0°F or below. Temperatures are recorded during the AM and PM shifts. Inappropriate temperatures are immediately reported to maintenance.
    - The doors of the refrigeration units must be securely closed as soon as possible after opening to maintain appropriate temperatures.
    - All refrigerated and frozen foods are rotated according to FIFO (First In, First Out).
    - Foods must be stored and packed loosely to maximize the air circulation within the unit.
    - Heaviest items should be stored on the middle shelves to prevent back injury when lifting.
    - All foods must be covered and dated and identified if not in the original packaging.

Pointers for the Storage of Certain Foods:

- **Dairy:**

    - Cheese must be tightly wrapped to prevent drying and dated when opened. It must be inspected for mold regularly, and discarded if any mold is present or if it has reached the expiration date.
    - Milk should be stored in original carton, except when poured into glasses for service to patients. Cartons will be dated when opened and discarded in 7 days. Unopened cartons will be disposed of on expiration date.
    - Yogurts, cottage cheese, and other similar products will be dated when opened and discarded on the expiration date. Cottage cheese should be checked for freshness

every time it is served.

- **Eggs:**
    - Eggs must be stored in the original carton.
    - Eggs must be refrigerated and used by the expiration date on the package.
    - Eggs must not be stored above any food. A cracked raw egg could contaminate, i.e., any food to be served raw or the outside of a container.

- **Fruits and Vegetables:**
    - Cases of fruits and vegetables are generally heavy and should be stored on the lower shelves.
    - Fruits and vegetables need to be in sealed containers to avoid rapid decline in quality and nutrients contents.

- **Meats:**
    - Meats should be loosely wrapped and stored on the lowest shelves to prevent contamination of other food products with dripping blood.

- **Foods With Best By/Expiration Dates:**
    - Best By Dates:
        - Best By dates are the manufacturer's quality assurance date and are not an indicator of food safety. Therefore, foods do not need to be discarded after the date has passed unless there is an apparent change of quality (i.e., discolored, texture change, bad odor, off taste, etc.).
        - Expiration Dates: Foods that have an expiration date shall be discarded after the specified date.
    - Freezing, Thawing and Refreezing Food Products:
        - Previously frozen meat that has been thawed is never refrozen unless it has ice crystals on the outside or has been cooked.
        - Shellfish and fish are never refrozen.
        - Precooked foods should never be refrozen after they are defrosted.
        - All meats must be thawed in the refrigerator on the bottom shelf. If necessary, defrosting under cold running potable water is acceptable.
    - Acceptable Storage Times for Refrigerated Products:

Leftover cooked meats	3 days
Leftover cooked poultry	3 days
Raw meats	3 days
Raw fish	1-2 days
Gravies	3 days
Leftover canned fruit	3 days
Cut fresh fruit	7 days
Leftover cooked vegetables	3 days
Puddings, custards	3 days
Protein or potato salads made on site	2 days
Commercial potato salad	5 days
Fruit juices	7 days
Jello	5 days
Cold cuts, deli meats, hot dogs	3-5 days of opening package

- Milk, yogurt, cottage cheese — 7 days
- Feta cheese, Brie — 7 days of opening package
- Condiments: catsup, mustard, bottled salad dressing, pickles — 4 months
- Frozen leftovers — 30 days

All leftovers must be clearly labeled with product name and date prepared. Product must be in a plastic container with a tight-fitting lidfe, or securely wrapped.

- Chemicals and Non-Food Items and storage of chemicals and other toxic substances separately from food to ensure that contaminates are not accidentally mixed with food, resulting in food borne illness:
  - Pesticides will not be stored in the kitchen.
  - Only those poisonous and toxic chemicals that are required to maintain sanitation in the kitchen will be stored in dietary.
  - Dishwashing and cleaning chemicals will be stored in the cabinet or on the shelf in the dish room.
  - All cleaning chemicals will be stored separately from food, including unopened containers.
  - All containers of poisonous or toxic materials will be stored in original containers with prominent labels for easy identification.
  - Bactericides, cleaning compounds, or other compounds intended for use of food contact surfaces will be used in accordance with manufactures instructions, and in a manner that does not constitute a hazard to patients or employees.
  - Paper goods will be stored on separate shelves from food.
  - Employee's clothing and coats will not be stored on shelves containing food.
  - Dietary department manager will ensure that all hazardous chemicals and employee clothing is stored appropriately.
  - Department will maintain Safety Data Sheets (SDS) on all hazardous chemicals. These will be stored in a place that is accessible to all employees. All new employees will be instructed of the availability and use of SDS. Page 4 of 4
  - Dietary department manager is responsible for securing SDS on all new chemicals introduced to the department, and the education of all dietary employees as to use and safety precautions.
  - A container previously used to store poisonous or toxic materials may not be used to store, transport, or dispense food. All cleaning/sanitizing buckets will be clearly marked for use.

DEFINITIONS:

Potentially hazardous foods are food items that require time and/or temperature control for safety to limit pathogenic microorganism growth or toxin formation.

FIFO (First In, First Out) is a method for inventory management that prioritizes using older foods or supplies before moving past their use-by dates.

SoHum Health

Subject:	Manual:
Garbage and Rubbish Disposal	**Dietary**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD" or "District") that garbage and rubbish shall be disposed of in accordance with current laws regulating such matters.

PROCEDURE:

- All garbage and rubbish containing food wastes shall be kept in containers with tight fitting lids.
- Lids must remain on all containers when not in continuous use.
- After being emptied, the containers must be cleaned. This must be done outside the kitchen to avoid contamination of food, equipment, utensils, or food contact surfaces.
- All garbage containers in the kitchen will be lined with plastic bags. The bags will be changed every time the trash is emptied.
- Trash must be removed from the kitchen at the end of every shift. Bags must be tied and placed in outside dumpster.
- Garbage and rubbish containing food waste shall be stored so it is inaccessible to vermin.
- Outside dumpsters must be kept closed and free of litter around the dumping area.

DEFINITIONS:
None

SoHum Health

Subject: Hiring, Orientation and Training of Dietary Employees	Manual: Dietary

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD" or "District") that all employees will receive initial orientation and training when hired and will complete an annual in-service provided for all hospital employees. In addition, all Dietary employees will complete quarterly in-services provided by the Certified Dietary Manager. All content of in-services provided will have prior review/approval by consultant Registered Dietitian. These will maintain the efficiency of the department and ensure the accuracy of prescribed medical nutrition therapy; all employees will be thoroughly trained before allowed to work unsupervised.

DEFINITIONS:

CDM means Certified Dietary Manager.
RD means Registered Dietitian.
Food Safety Manager Certification communicates to the food service and retail industry that a manager has the knowledge, skills, and abilities necessary to oversee the safe storage, preparation, and service of food in the workplace.

PROCEDURE:

- All candidates must follow the hospital personnel procedures for application.
- ~~2.~~ Personnel will screen all applications. Applications of eligible candidates are forwarded to CDM.
- ~~3.~~ The RD interviews all eligible candidates for the CDM position.
- ~~4.~~ All eligible candidates for cooks are interviewed by the CDM. The RD will be available to assist with interview and/or screening as needed.
- ~~5.~~ On-the-job training is scheduled for all cooks minimally for the first week and up to the first month depending on the background and skills of the new employee. This training will be under the direction of the CDM.
- ~~6.~~ If not providing the direct training, the CDM will meet minimally weekly with the new employee to discuss progress and concerns for the first three months. A written work schedule for all dietary employees will be maintained by the CDM. Orientation in-service will be given to all new dietary employees by the CDM within one month of start date.
- ~~7.~~ All new employees will be evaluated by the CDM before being allowed to work a shift unsupervised.
- ~~8.~~ The CDM periodically checks the comprehension and completion of duties of all Dietary staff.
- ~~9.~~ The CDM will provide in-service training to dietary staff on a quarterly basis. All in-service content/training will have been reviewed and approved by consultant RD.
- ~~10.~~ The CDM will maintain a record of all in-services provided for each employee including date and topic.
- ~~11.~~ The CDM will maintain a Food Safety Manager Certification. This must be renewed every five years.
- ~~12.~~ The CDM will participate in hospital management training when available.
- ~~13.~~ The RD will maintain the registration with the Commission of Dietetic Registration. RD will ~~and~~ provide services on a consultant basis and oversight to the dietary department. This will include review and approval of all dietary policies and procedures. The CDM will maintain credential and work full-time as the department manager.
- ~~14.~~ A written work schedule for all dietary employees will be maintained by the CDM. Work schedules will be posted in the dietary department with employee's name and title. It is the responsibility of each employee to check their work schedule daily.

~~DEFINITIONS:~~

~~CDM means Certified Dietary Manager.~~
~~RD means Registered Dietitian.~~
~~Food Safety Manager Certification communicates to the food service and retail industry that a manager has the knowledge, skills, and abilities necessary to oversee the safe storage, preparation, and service of food in the workplace.~~

SoHum Health

Subject:	Manual:
Nutrition Orders Managed by the Registered Dietitcian (RD)	**Dietary**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide guidelines for timely and effective nutrition therapy during a patient's hospital stay. It is our policy to establish a means to delegate authority to the qualified Registered Dietitian (RD) for ordering or modifying a patient's prescribed diet order or other medical nutrition therapy interventions in order to provide patients with optimal nutrition care in a timely fashion. The qualified RD is one who has maintained current Commission on Dietetic Registration indicating ongoing education and has competency evaluations per facility policy. The qualified RD may initiate specific nutrition interventions consistent with the dietitian's scope of practice for the State and which do not contradict medical patient care orders. The medical staff, with approval by the hospital governing body, will grant specific nutrition care order writing privileges to the RD through approved guidelines to facilitate implementation of patients' medical nutrition care plan. Competency to perform this function is validated during initial orientation and documented in the personnel file.

California B&P section 2586: …"a registered dietitian, or other nutritional professional meeting the qualifications set forth in subdivision (e) of Section 2585 may, upon referral by a health care provider authorized to prescribe dietary treatments, provide nutritional and dietary counseling, conduct nutritional and dietary assessments, and develop and recommend nutritional and dietary treatments, including therapeutic diets, for individuals or groups of patients in licensed institutional facilities or in private office settings. …"

PROCEDURE:

Diet orders are initiated by the physician. The physician may order the RD to manage specific dietary treatments by ordering: "Tube feeding per Dietitian," "Diet per Dietitian" or other specific function.

The RD may initiate, with appropriate documentation in the medical record, approved interventions utilizing evidence-based patient care guidelines. RD order entry will not take the place of communication with the interdisciplinary care team. The RD will communicate face to face, via telephone or electronically with the medical team regarding proposed order changes.

The RD may initiate nutrition related orders and/or via telephone or in person discussion from the physician or licensed independent practitioner. Orders must be signed in a timely manner according to hospital policy. Orders include but are not limited to:

- Therapeutic Diet Orders
- A measured height and weight of patient
- Add free water when no fluid restriction is present
- Order nutrition-related laboratory values
- Initiate or ~~/order/~~modify enteral nutrition orders
- Discontinue a tube feeding when there is no enteral access available
- Initiate a calorie count
- Modify a diet texture
- Liberalize diet restrictions within the diet category (i.e. 2 gram Sodium to No added salt)
- Eliminate diet restrictions
- Add high calorie/high protein foods to meals and snacks
- Alter the meal schedule

- Add supplemental foods and snacks
- Add supplements, such as protein modular or medical nutritional supplements
- Speech Therapy consultation/treatment
- Occupational Therapy consultation/treatment
- The RD may NOT initiate orders for medications or parenteral nutrition support (IVF, PPN, TPN).

Nutrition-related laboratory values: The RD may order the following nutrition related laboratory values. Note, that whenever possible, the RD is to contact the medical provider prior to ordering laboratory values.

- Basic Metabolic Panel (BMP)
- Comprehensive Metabolic Panel (CMP)
- Complete Blood Count (CBC)
- Phosphorus
- Magnesium
- Triglycerides
- Prealbumin ~~Definitions:~~

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Nutrition Risk Screening and Assessment for Acute, Swing Bed and SNF Patients	**Dietary**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to ensure Acute, Swing Bed and Skilled Nursing Facility patients, coming from outside this facility, will have their nutritional status screened upon admission to determine nutritional risk and the need for nutritional care and monitoring. The assessment will be repeated as needed based on any change in condition. Patients are to receive adequate nutrition support while hospitalized to attain or maintain the patient's highest feasible nutrition status.

DEFINITIONS:

- Note formats of SOAP (subjective, objective, assessment, plan) or ADIME (assessment, diagnosis, intervention, monitoring, evaluation) will focus on nutrition related components for documentations of the comprehensive nutrition assessment of an individual.

- Nutrition risk is a health problem, medical condition, diet deficiency or other issue that can affect the health of a patient.

PROCEDURE:

- Initial Assessment:
    - All admitted patients will be referred to a Registered Dietitian (RD) either by licensed nurse or dietary manager.
    - A nutrition assessment will be completed by a RD within one week from admission.
    - The Nutrition Assessment will be documented in the electronic medical record by using a note format of SOAP or ADIME. Nutrition assessment will minimally include objective data, nutritional assessment, and nutrition interventions or recommendations. RD or nursing will communicate the dietary recommendations to physician.
    - Dietary Staff can visit patients for food preferences and honor requests that comply with the physician diet order.

- Reassessment
    - Nutritional screening reassessment will occur at least every 3 months for stable patients.
    - The RD will reassess patient within 1 week of consultation or change of patient's status. Consultation could be triggered by any of the following:
        - The priority level has changed
        - If the patient is consuming less than 50% of food offered for 5 or more days
        - If the patient is consuming less than 75% of food offered for 7 days or less than 75% of food offered for 1 or more months
        - If there is significant weight loss defined as loss of 1-2% body weight in 7 days, 5% body weight in 1 month, 7.5% body weight in 3 months, or 10% body weight in 6 months
        - If there is severe weight loss defined as loss of more than 2% body weight in 7 days, more than 5% body weight in 1 month, more than 7.5% body weight in 3 months, or more than 10% body weight in 6 months

        - If patient has been changed to liquids or NPO from a solid diet
        - If patient has a new NG tube
        - If patient develops a pressure ulcer.

    - Physicians, licensed nurses, and dietary staff are encouraged to contact the RD with any nutritional concern about a patient.

~~**DEFINITIONS:**~~

- ~~Note formats of SOAP (subjective, objective, assessment, plan) or ADIME (assessment, diagnosis, intervention, monitoring, evaluation) will focus on nutrition related components for documentations of the comprehensive nutrition assessment of an individual.~~

- ~~Nutrition risk is a health problem, medical condition, diet deficiency or other issue that can affect the health of a patient.~~

SoHum Health

Subject:	Manual:
Patient Meal Service	**Dietary**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD" or "District") that all patients and residents will be served nutritionally adequate meals and optional nourishments daily as part of the nutritional care. As possible, their preference and cultural considerations will be incorporated into the menu. Meal timing follows regulation guidelines.

DEFINITIONS:

Dietary reference intakes (DRIs) are a set of scientifically developed reference values for nutrients.

PROCEDURE:

- Diet Manual:
    - The approved diet manual for the Southern Humboldt Community Healthcare District (SHCHD) is the Nutricopia Food and Nutrition Services Diet Manual.
    - The approved diet manual is reviewed annually and revised at least every 5 years.
    - It is to be used as a guide for physicians/mid-level providers to order diets.
    - The dietary department will use it as a guide to serve therapeutic diets.
- Non-Specific Diet Orders:
    - Diet orders must be specific and complete.
    - The following orders are not specific, and will be interpreted as follows:
        - *Liquid* will be interpreted as *Full Liquid,*
        - *Low Sodium or Low Salt* will be interpreted as *NAS (no added salt).*
        - *Puree* will be interpreted as a *Dysphagia Level I, without the thickened products/liquids.*
        - *As Tolerated* will be interpreted as regular, patient will receive communication from dietary staff/nursing staff to determine preferences.
        - *Renal Diet* will be interpreted as *80 gram* protein, *2 gram* potassium, *2 gram* sodium. This is appropriate for mild renal failure. For severe renal disease or a long-term care resident, physician must contact nephrology for a tailored diet.
- Orders for Enteral Feedings:
    - A commercial product for tube feeding is used for all patients/residents.
    - All orders for enteral feeding must include the total calories, concentration, product to be used, delivery method, and a feeding schedule.
    - The Registered Dietitian (RD) is to be immediately notified of any new tube feeding.
- Meal/Nourishment Times and Ordered/Offered Nourishments between meals:
    - Meals will be planned with no more than 14 hours between a substantial evening meal and breakfast.
    - Meals will be served at:
        - Breakfast 0730
        - Lunch 1200
        - Dinner 1730
    - Nourishments: 1000, 1500, and 2000

- Patients without specific nourishment orders will be offered a variety of choices for between meal snacks/nourishments upon request from patient/resident. Food choices of patient/resident will be honored unless counter ordered by physician.
- Physician orders for between meal snacks/nourishments will be handled as a diet order. ~~"Ensure Plus" must be ordered by physician.~~
- Licensed nursing staff, the RD and Certified Dietary Manager (CDM) can order specific snacks/nourishments for patients/residents provided it is allowable within physician diet order. This includes such products as Health Shakes, a high calorie, vitamin/mineral enriched beverage.
- The order/requested nourishments/snacks will be posted in kitchen on Nourishment List Form.
- Food items will be maintained/stocked in resident kitchen/refrigerator available for patients/residents upon request.
- Resident refrigerator will be checked daily by dietary staff to remove leftover snacks, check for compliance of labeling and dating of patient food items by nursing staff and daily temperature check. Any food items left in refrigerator not dated or labeled correctly or outdated will be discarded immediately.

- Menu Development:
    - Our menus are provided by Nutricopia/Nutrition Ink and consist of four menu cycles with each cycle consisting of four weeks, changing with the seasons of Spring, Summer, Fall and Winter.
    - The non-selective menus are written by Nutricopia/Nutrition Ink to meet the Daily Reference Intakes (DRIs) for an adult male and follow the Dietary Guidelines for Americans and Food Guide Pyramid. The menu for the regular diet meets the DRIs for all nutrients except iron for females age 11-50 and calcium for adults over the age of 50. Facility consultant RD will review Nutricopia/Nutrition Ink Nutritional Analysis of menus at the beginning of each seasonal menu cycle and sign menu approval form.
    - Coffee will be served to residents/patients upon request only.
    - The current week's menu is dated and posted in the kitchen. All menus are retained for one year after service.
    - The current weekly menu is posted on the Skilled Nursing Facility (SNF) Bulletin Board. Residents/patients are allowed to call dietary department's extension to request food substitutions and snacks. Patient/resident preferences will be honored unless counter ordered by the physician.

- Menu Changes:
    - Menu changes are made only due to unavoidable circumstances such as food delivery failure. The RD or CDM will approve all menu changes and document the change and initials on the current dated menu. The RD will be contacted if there are questions as to how to modify the change for the therapeutic diets. The RD will review the changes at the regular visits. The RD will review the menu substitution log at each visit and sign/approve substitutions requested by patients/residents.
    - The CDM is responsible for developing the holiday and special event menus. If a patient receiving medical nutrition therapy does not have a physician order allowing him/her to eat foods not included in their diet prescription, and there are questions about the appropriate modification, the RD will be contacted. The RD will review the menu of such events periodically.
    - The CDM is responsible for obtaining all of the food to meet the menu requirements.
    - Standardized recipes are used to prepare all menu items. Recipes are provided by Nutricopia/Nutrition Ink.

- Recipes:
    - The RD will assure that standardized recipes to prepare the menus are available.
    - The cooks will know where to locate the needed recipes and will follow the recipe exactly. Any needed changes to the written recipe will be discussed with the CDM and/or the RD prior to making the change.

- Food Preparation:
    - Food will be prepared to conserve the nutritive value of the food.
    - Employees will follow all sanitation guidelines when preparing and handling foods.
    - Preparation of hot foods will be timed so the cooking process is completed within 15 minutes of service.
    - Cooks will taste all foods before they leave the department, using the approved method for taste testing: A clean spoon will be used to dish a small amount of the food into a clean dish. The cook will step away from the cooking area and taste the food. The dish and the spoon will be taken to the dish room immediately.
    - All sanitation policies and procedures will be followed during the preparation and service of food.

- Resident/Patient food preferences will be honored as much as is reasonable within the diet order, financial restraints, time restraints, and availability. It is the general guideline of this facility that residents/patients are better nourished if allowed to have favorite foods.
- All patients/residents are served on trays using the heat maintenance system. Cold beverages will be the last items placed on the tray, as the temperature is not maintained by insulated ware.
- Tray appearance should always be carefully arranged, neatly and artistically. Patients are more apt to consume the meal if it has an appealing appearance and aroma.
- Dietary employees are provided one meal for themselves while on duty.

- Adaptive Equipment:
  - Residents and patients will be provided with adaptive equipment to help retain their ability to feed themselves, and to ensure that the resident's independence is maintained for as long as possible.
  - Dietary will maintain a variety of adaptive silverware, plate guards, and cups.
  - If a resident/patient is having difficulty consuming the meal with the usual tableware, nursing will evaluate the need and request the adaptive equipment.
  - All adaptive equipment will be washed and sanitized by the dietary staff after every use.

- Infant and Tube Feeding Formulas:
  - Infant and tube feeding formulas are the responsibility of the nursing staff. The nursing staff will provide the infant and tube feeding formulas by ordering via Materials Management.

~~**DEFINITIONS:**~~

~~Dietary reference intakes (DRIs) are a set of scientifically developed reference values for nutrients.~~

SoHum Health

Subject:	Manual:
Potentially Hazardous Foods at Bedside	**Dietary**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District (SHCHD) to assure that all potentially hazardous foods will be removed from patient rooms and discarded after being held at room temperature for two hours or less depending on the source of the food. This will provide a prevention of food borne illness in a highly susceptible population.

DEFINITIONS:

Potentially hazardous foods are food items that require time and/or temperature control for safety to limit pathogenic microorganism growth or toxin formation.

HACCP – Hazard Analysis Critical Control Point- is a management system in which food safety is addressed through the analysis and control of biological, chemical, and physical hazards from raw material production, procurement and handling, to manufacturing, distribution and consumption of the finished product.

PROCEDURE:

- Foods Prepared and Served by Dietary Department
    - Potentially hazardous food prepared/served by dietary will meet HACCP guidelines for temperature control. Hot foods will be plated at 140° or above, and cold foods at 41° or below. At bedside/dining room, hot foods will be delivered to patient at 120° or above, and cold foods at 50° or less.
    - All foods that are potentially hazardous must be removed and discarded after two hours at bedside. This includes patient/resident food meal tray items must be discarded after two hours at bedside. Once food item has been brought into patient/resident room if not consumed must be discarded.
    - All fresh fruits and vegetables that are cut must be discarded after two hours.
    - All open juices must be discarded after two hours at bedside.
    - Common nourishments that are not potentially hazardous and may remain at bedside for 24 hours include wrapped bread, crackers, and cookies.

- Foods Brought to Patients from Family and Outside Sources:
    - All potentially hazardous foods prepared by the family must be discarded after two hours at bedside. All food provided by the patient and stored in the patient refrigerator must be covered tightly, labeled with the patient's name, date the food was received and what the food is if not labeled by the manufacturer. Dietary Staff will discard potentially hazardous foods from resident refrigerator after 24 hours of storage.
    - Foods reheated in a microwave must be covered, stirred halfway through reheating and stand for two minutes before serving to obtain equilibrium. Temperature must be a minimum 165 degrees F. Temperature must be checked in the thickest part, in a minimum of two places. The temperature must be logged on the provided chart. A thermometer will be stored in the nourishment kitchen to be used for this purpose. During temperature monitoring, thermometers should be sanitized between each food; you may use an alcohol swab. Between monitoring times, thermometers should be washed, rinsed, sanitized and allowed to air dry.
    - All whole fresh fruits and vegetables that have been provided by the family must be washed under cold running water before serving to the patient.

~~**DEFINITIONS:**~~

~~Potentially hazardous foods are food items that require time and/or temperature control for safety to limit pathogenic microorganism growth or toxin formation.~~

~~HACCP – Hazard Analysis Critical Control Point- is a management system in which food safety is addressed through the analysis and control of biological, chemical, and physical hazards from raw material production, procurement and handling, to manufacturing, distribution and consumption of the finished product.~~

SoHum Health

Subject:	Manual:
Processing Diet Orders in Dietary	**Dietary**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District (SHCHD) to assure that all patients receive the diet as ordered by the practitioner. Provision of nutritious meals and/or Medical Nutrition Therapy is recognized as an integral part of the medical treatment.

DEFINITIONS:

Medical Nutrition Therapy (MNT) is an evidence-based medical approach to treating certain chronic conditions through the use of an individually tailored nutrition plan. This nutrition plan is ordered and approved by a primary care physician and implemented by a Registered Dietitian.

ED- emergency department.

PROCEDURE:

- Nursing will deliver the diet order to dietary as part of the admission via electronic record and written dietary communication form signed by licensed nurse.
- The Dietary manager or cook on duty will make a tray card for each patient including patient's name, room number, diet order, allergies, and adaptive equipment needed.
- The Tray identification card is completed and placed on the tray.
- If the diet order is not clearly understood by the department manager or cook on duty, he/she will ask the nurse for clarification and/or contact the consultant Registered Dietitian.

Orders to Hold Tray:

If the patient/resident is scheduled for fasting laboratory tests at 0800 or later, the tray should not be prepared until dietary receives notice from nursing that the patient is ready to eat. The breakfast should be prepared according to the menu for that day until 1000. After 1000 a light breakfast of cold cereal, milk, juice and fruit may be offered. The Dietary manager is responsible for assuring all substituted foods are appropriate.

ED Observation and ED Patients:

Patients may be held under ED observation. Patients will be provided food as part of the emergency room treatment. Diet order will be communicated electronically and written dietary communication form will be completed by licensed nurse and given to Dietary department.

~~**DEFINITIONS:**~~

~~Medical Nutrition Therapy (MNT) is an evidence-based medical approach to treating certain chronic conditions through the use of an individually tailored nutrition plan. This nutrition plan is ordered and approved by a primary care physician and implemented by a Registered Dietitian.~~

~~ED- emergency department.~~

SoHum Health

Subject: Records, Maintenance, and Retention Time	Manual: Dietary

POLICY:

Basic records are maintained and used to prepare monthly/quarterly and annual reports to be used to meet all state and Federal regulatory requirements and efficient management and evaluation of the department. To define the needed records and retention periods.

DEFINITIONS:

CNO is Chief Nursing Officer.
DON of SNF is Director of Nursing of Skill Nursing Facility at Southern Humboldt Community Healthcare District.
COO is Chief Operations Officer.
I.P. is Infection Preventionist.

PROCEDURE:

To define the needed records and retention time periods.

Report	Responsible Person	Due Date	Send To	Retention Period
Daily Patient Census Report	Dietary Department Manager	Recorded daily	Accounting at fiscal year end	TBD by Accounting Department
Purchasing Records	Dietary Department Manager		Accounts payable	1 year
Menus as served	Dietary Department Manager		Stored in Dietary	1 year
Quality Reports and Spreadsheets	Dietary Department Manager	Monthly and quarterly	Compliance Officer	TBD by Compliance Department
Food Temperature Records	Dietary Department Manager	Daily	on File in Dietary	1 year
Temperature Records for Freezers and Refrigerators	Dietary Department Manager	Daily	on File in Dietary	1 year
Dishwasher Temperature Records	Dietary Department Manager	2X/day	Stored in Dietary	1 year
Registered Dietitian (RD) Reports	Consultant Dietitian (emailed)	Monthly	CNO, DON of SNF, COO, I.P.	6 years
Dishwasher Maintenance Reports	Dietary Department Manager	Monthly	On file in Dietary	1 year
In-Service Records for employees	Dietary Department Manager		On file in Dietary	Until employee separates from employment
Employee Schedules	Dietary Department Manager		Current schedule posted in dietary department	

Patient/Resident diet orders Stored electronically	Ordering physician	On admissio n		
Equipment maintenance Records	Maintenance		Stored in Maintenance	TBD by engineering department

Other items stored in Dietary shall include:

- Equipment Manufactures Operating Instructions on equipment
- Recipes/Menus

~~**DEFINITIONS:**~~

~~CNO is Chief Nursing Officer.~~
~~DON of SNF is Director of Nursing of Skill Nursing Facility at Southern Humboldt Community Healthcare District.~~
~~COO is Chief Operations Officer.~~
~~I.P. is Infection Preventionist.~~

SoHum Health

Subject:	Manual:
Safe Cooking Temperatures	**Dietary**

POLICY:

All potentially hazardous foods will be prepared according to the HACCP guidelines, and final cooking temperature will be taken and recorded on every food. Cooking destroys pathogens in food, ensuring the food reached a safe temperature is necessary to prevent food borne illness.

DEFINITIONS:

Potentially hazardous foods are food items that require time and/or temperature control for safety to limit pathogenic microorganism growth or toxin formation.

HACCP – Hazard Analysis Critical Control Point- is a management system in which food safety is addressed through the analysis and control of biological, chemical, and physical hazards from raw material production, procurement and handling, to manufacturing, distribution and consumption of the finished product

PROCEDURE:

- Measure internal temperature of foods by inserting the thermometer probe into the center (thickest part) of the food.
- Recipes indicate a final cooking temperature.
    - Take two readings in different locations of the food
    - Wait at least 15 seconds for final reading. If food item does not reach minimum cooking temperature, it will be placed back on stove, in oven, or on grill until each reaches minimum cooked temperature.
- Final cooking temperature is recorded on food temperature log of all cooked items
- A clean sanitized thermometer is used. During temperature monitoring, thermometers should be sanitized between each food; you may use an alcohol swab. Between monitoring times, thermometers should be washed, rinsed, sanitized and allowed to air dry.
- All leftover foods or foods prepared the previous day will be reheated to an internal temperature of 165° F, for 15 seconds in a minimum of two places. Foods can be reheated once, and then any leftovers will be discarded.
- All foods will be retained above 135° F until ready to serve.
- Temperature records for all foods served will be maintained for one year.

~~**DEFINITIONS:**~~

~~Potentially hazardous foods are food items that require time and/or temperature control for safety to limit pathogenic microorganism growth or toxin formation.~~

~~HACCP – Hazard Analysis Critical Control Point- is a management system in which food safety is addressed through the analysis and control of biological, chemical, and physical hazards from raw material production, procurement and handling, to manufacturing, distribution and consumption of the finished product.~~

SoHum Health

Subject:	Manual:
Safety Precautions – General & Dietary Specific	**Dietary**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD" of "District") to educate dietary employees in order to prevent injury.

PROCEDURE:

General Precautions:
The following safety precautions have been developed for dietary personnel to follow. We expect you to follow these precautions, as well as other precautions that may become necessary and appropriate.

- Remove, cut off, or hammer down all protruding nails and slivers when unpacking boxes, supplies, etc.
- When carrying items, approach corners with caution.
- When carrying items down stairwells, do not obstruct your vision. Make more trips. Do not overload yourself.
- Handle drums with caution. Use gloves or mittens to protect your fingers and hands.
- Use proper tools for the job.
- Do not use equipment that is not safe.
- Place heavy objects on the bottom of the load.
- Do not leave equipment or supplies in passageways or exits.
- Do not use benches, tables, chairs, boxes, etc., as stepladders.
- Keep floors dry of spills. Clean up immediately.
- Do not leave work areas unattended where supplies or equipment are being used.
- Do not place items where they will protrude into a room or hallway.
- Keep cords from crossing hallways or rooms.
- Use only equipment that you have been trained to use.
- When cleaning/washing floors, leave a dry area for persons to walk on safely.
- Use gloves when working with steel wool.
- Follow manufacturer's directions when using chemicals, equipment, and other supplies.
- Report all unsafe acts or conditions to your supervisor or maintenance a soon as practical.
- Pick up debris from the floor. Wipe up spills as soon as practical.
- Report all injuries, no matter how minor they may be.
- Do not run in the building.
- Do not engage in horseplay or practical jokes.
- Learn the right way to do the job. If you are not sure about a task, ask your supervisor for instructions.

Food Service Specific Precautions:

The following safety precautions have been established for dietary personnel to follow in the preparation of food and serving of food.

- Handle pots, pans and equipment in or around cooking surfaces as though they are extremely hot. Handle these items with tongs, proper tools, or appropriate pads. Be sure a place has been made to put these items before you remove them.
- Use dry pads/holders for handling hot utensils.
- Be sure your hands are dry and free from grease when handling pots, pans, and knives.
- Place containers of hot food where they will not be tipped over or spilled.
- Do not move heavy containers of food alone. Get assistance on anything that puts a strain on one person.

- When removing pot lids, tilt them so that the steam will be directed from your face.
- Be sure that handles of cooking utensils do not stick out over the edge of the stove.
- Use long handle spoons and forks for stirring food in kettles or testing foods in the oven.
- Test hot water before putting your hands in it.
- When lighting a gas oven, open the oven door for a few moments before lighting. This allows for leakage to escape.
- Keeps guards on meat slicers, bread cutters, vegetable slicers, etc., in place at all times.
- Keep exhaust hoods, flues, and canopies clean to reduce the danger of fire.
- Know the location of the nearest fire extinguisher and how to use it.
- Mop up spills immediately. Pick up debris such as produce leaves, paper, peelings, etc.
- Do not store dishes, glassware, or other articles where food is being prepared.
- Do not attempt to catch a falling knife. Never try to catch anything that is sharp.
- When knives are used, place the handle at the edge of the table.
- Do not put your hands into the garbage disposal unit. Use only the equipment designed for these units.
- Before cleaning or adjusting power equipment, turn the switch **off** and **unplug the unit**.
- Make sure that power equipment is properly grounded.
- Cut away from your hands and body. Never hack or chop with a knife.
- Keep cutlery in good condition. When not in use store in their proper place.
- When handling hot liquids or foods, move carefully to prevent collisions. Give a warning when passing behind someone.
- Set trays, dishes, pots pans, etc., away from the edge of the counter.
- Do not place serving spoons or handles of pots in a position where they will stick out into passageways.
- Do not leave drawers or cupboard doors open.
- Do not place glassware into pot sink.
- Should glassware break in a sink, drain the sink and remove the broken glass before continuing with washing procedures.
- Should glass fall on the floor, pick it up at once. Use the dustpan and brush. Do not use your fingers to pick up the glass.
- Do not open doors during evacuation until proper procedures are completed.
- Smoke only in designated areas.
- Do not put cigarettes in trash cans.
- Be sure fire extinguishers are in designated locations.
- Be sure proper fire extinguisher is available.
- Report all hazardous conditions and safety violations.

Electrical Precautions:

The following electrical safety precautions have been established for dietary personnel to follow. These precautions are not all-inclusive.

- Dry hands before using an electrical device.
- Do not use electrical devices while standing on a wet floor.
- Pull electrical cords out by the plug. Never yank the cord.
- Do not use any electrical device that has shocked anyone – no matter how mild the shock was.
- Report any plug that is broken, bent or loose.
- Report switches that are loose or do not snap into proper position.
- Report all worn, cut frayed, spliced, exposed, or burned power cords.
- Unplug any electrical device that appears to be overheating by smell or touch.
- Do not use any electrical device that has been dropped or abused, or if any liquid has spilled into it. Wait until it has been checked and declared safe for use.
- Report control knobs that are loose or do not turn smoothly.
- Report loose wall receptacles.
- Do not use electrical appliances where oxygen is being administered or stored.
- Use only receptacles that are properly grounded (three-wire type).
- Do not overload circuits. Use only **UL-approved** adapters.
- Do not remove the ground plug from electrical cords.
- Report any, and all, unsafe electrical hazards to your supervisor immediately.

- Tag all defective equipment, outlets, electrical cords, etc. so that others will not use it.
- Turn **off** and unplug machinery before cleaning, clearing jams, or making repairs.

Lifting Precautions (Dietary Only):

The following safety precautions have been established for dietary personnel to follow when lifting or handling heavy objects. These precautions are not all-inclusive. Others may be added or amended as necessary.

- Never lift a heavy object until you have obtained an idea of how heavy it is.
- Inspect materials for slivers, jagged edges, protruding nails, rough or slippery surfaces, etc., before lifting the object.
- Be sure your hands are free of greasy substances before lifting an object.
- Grip objects with the palm of your hands, not just with your fingers.
- Keep your fingers away from pinch points.
- Wear glasses as necessary.
- Be sure you have good footing. Spread your feet naturally and comfortably before lifting any object.
- Bend at your knees. Grasp the weight. Squat instead of stooping when lifting heavy objects.
- Keep the center of the object close to you. Get a firm hold. Move with smooth, steady motions, avoid sudden jerks.
- Keep your arms and back as straight as possible. **Never** try to lift from a position where your spine is twisted.
- Lift gradually by straightening your legs.
- If the weight is too heavy or bulky for one (1) person to lift, seek assistance. Do not try to lift it alone.
- When working in unison, lift on the count of **"1, 2, 3, go."**
- Be sure you have room to move freely. Do not hurry the procedure.
- To set the load down, bend the knees using your legs and back muscles. When the load is securely positioned, release it.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Sanitation and Safety Standards for Dietary Employees Policy	**Dietary**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District (SHCHD) that in addition to employee personnel policies, dietary employees will be required to comply with all sanitation requirements. Food borne illness can often be traced to human error.

PROCEDURE:

- Hairnets must be worn at all times while on duty in the dietary department.
- All vendors and/or contract workers entering the dietary area to complete a delivery or perform a service must first don a hairnet that will be available by the backdoor. The dietary manager or supervisor for the day will be responsible for monitoring all employees, vendors and contract workers for compliance of donning a hairnet before entry into the department.
- Hair must be restrained and long hair must be up off the shoulders.
- Dietary personnel are not permitted to wear artificial fingernails, nail polish, or costume jewelry while on duty.
- Employees are required to bath daily and keep their hair clean.
- Fingernails must be short and clean.
- Employees must wear closed in shoes as a safety precaution to protect their feet and provide support.
- Shirtsleeves must be short and close fitting, to protect against dragging them through food as it is being prepared or being caught in equipment while in use.
- For employee comfort, they may wear a clean sweater if the sleeves are close fitting, and can be pushed up to keep them dry and away from the food.
- Shorts are not allowed.
- Dietary personnel must avoid personal habits such as nose picking, nail biting, hair twisting, clearing throat and blowing their nose while on duty.
- Gum chewing, dipping snuff, smoking, and tobacco chewing will not be permitted in the food preparation areas.
- Combing or arranging of hair or applying make-up will not be permitted in the food preparation area.
- Dietary employees are permitted to eat one meal while on duty. This meal should be consumed at the supervisor's desk, outside, or in the Dimmick Room. Food or beverage cannot be consumed while standing at the cook's table, or in close proximity to food preparation.

- Hands must be washed frequently while preparing food and working in the kitchen. Hand sanitizer is not a substitute for handwashing in the dietary department. The following represents various situations when washing is necessary:

    - Before beginning work
    - After every trip to the restroom
    - After leaving storage rooms
    - After touching your hair, skin, mouth, and nose and after touching other people
    - After touching dirty dishes
    - Before touching clean equipment and dishes
    - After visiting patient or touching anything outside the Dietary Department
    - Before touching any food, even if it is to be cooked
    - After touching menus, manuals, or any surface that is not sanitized for food contact
    - Before and after removing gloves
    - After any contact with food that has been in patients' room, and
    - Before and after eating.

- Hands must be washed using the following procedure:

    - Hands must be washed in a handwashing sink.
    - Do not wash your hands in a food preparation sink.
    - Apply soap to your hands and lather your hands and upper arms.
    - Pay particular attention to the areas around your nails and between your fingers.
    - You need to lather and vigorously rub your hands for 20 seconds, or the amount of time it takes to sing "Row, Row, Row Your Boat," two times.
    - Rinse thoroughly in warm water.
    - Dry your hands with paper towels.
    - Throw the paper towel away.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Cleaning Procedures	**Dietary**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD" or "District") that all equipment will be cleaned according to approved procedures. To ensure a clean and safe environment in the Dietary Department. Proper cleaning and maintenance of equipment is an effective means of preventing employee accidents, preventing cross-contamination, and extending the life of the equipment.

PROCEDURE:

As follows for specific equipment:

- Oven Cleaning - Frequency: Once per month is adequate. Twice per month is optimal.
    - Dietary staff will follow manufacturer cleaning instructions. May access on-line and kept in file on dietary manager's desk labeled cleaning procedures for oven/stove.

- Range Cleaning - Frequency: Once per month is adequate. Twice per month is optimal.
    - Dietary staff will follow manufacturer cleaning instructions. May access on-line and kept in file on dietary manager's desk labeled cleaning procedures for oven/stove.

- Grill Cleaning - Frequency: After every use. Sign compliance monitoring report when completed
    - Turn the unit off and allow to cool for 10 minutes. Must wear dishwashing gloves during cleaning process.
    - Pour oven cleaner on the grill and scrub.
    - Using hot water, rinse oven cleaner off. Wipe the grill with disposable cloth, being certain all the oven cleaner is removed.
    - Pour 1-2 cups of lemon juice on the grill, rinse with hot water wipe with a damp cloth.

- Cleaning the Refrigerators - Frequency: Minimally weekly
    - Remove the food from the refrigerator as practical.
    - Clean the walls and shelves with a bleach solution of 1 tablespoon Chlorine to 1 gallon of water – 200 ppm.
    - Put food back into refrigerator and close doors as quickly as possible. Allow the unit to cool until it has returned to 41°F, fastest method is to avoid opening the doors during this time if possible.

- Cleaning Freezers - Frequency: Monthly
    - Remove the food from the freezer.
    - Wipe inside with a sanitizer solution, 1 tablespoon of chlorine to 1 gallon of water – 200 ppm.
    - Mop any water that collects on the floor immediately to prevent falls.
    - When the freezer is clean turn it back on, put the food back, and close the door. Avoid opening the door until the unit has returned to 0°F.

- De-Liming the dish machine - Frequency: Every other week
    - Follow prompts with automated dish machine for deliming process.
    - Read manufactures instructions on back label of deliming product for use in dish machine. Use the amount stated on manufactures label in dish machine.
    - Allow dish machine to reach minimum temperatures prior to use.

- Cleaning the Blender - Frequency: After every use.
    - Disconnect the cord from the electrical outlet.
    - Disassemble carefully. Handle blades with extreme caution.
    - Wash the bowl, lid and blades in the dishwasher after every use. It is not necessary to wash and sanitize between pureeing products for the same meal. Rinse any remaining food from the bowl, and puree the next foods needed.
    - Allow to air dry thoroughly before re-assembling.
    - After reassembling, sanitize the base with the chlorine and water solution, 1 tablespoon bleach to 1 gallon of water -200 ppm.
- Can Opener - Frequency: Daily.
    - The can opener must be washed in the dish machine daily, or after every meal used.
- Cleaning the Cabinets and Drawers - Frequency: Monthly.
    - Remove the dishes/pans from shelves. Empty drawers. Check the condition of all dishes and utensils while unloading, and report to supervisor anything that seems of questionable quality.
    - Clean with sanitizer solution of 1 tablespoon of chlorine to 1 gallon of water – 200 ppm.
- Cleaning Stainless Steel Surfaces - Frequency: Daily.
    - Wash surface with a warm detergent solution. To avoid scratching the surface, DO NOT use metal or abrasive scratch pads on the surface.
    - Rinse with clean water using a clean cloth.
    - Sanitation buckets are located in the dish room and near the pot and pan sink with a chlorine solution of 1 tablespoon to 1 gallon water – 200 ppm.
    - Allow to air-dry. May use stainless steel polish to minimize finger marks and improve the appearance of the stainless-steel surface such as refrigerator doors, freezer doors, sides of sinks. DO NOT use Stainless steel polish on food contact surfaces.
- Cutting Boards - Frequency: After every use.
    - All cutting boards must be washed and sanitized after every use. A cutting board is never used for cooked food after it is used for raw foods. This is to prevent cross-contamination of bacteria from raw to cooked foods.
    - All cutting boards are washed in the dish machine.
- Non-Slip Floor Mats - Frequency: Daily
    - Clean any significant spill immediately.
    - When mopping the floor:
        - Pick up mat and mop underneath.
        - Mop the top of the mat.
- Cleaning the Floors - Frequency: Daily.
    - Sweep the floor, pushing all debris forward. Use a dustpan to remove the debris as it accumulates.
    - All floor space in the kitchen, including the dish room and the storeroom, will be mopped daily.
    - Prepare chlorine water solution. In the mop bucket, per manufacturer recommendations, mix 3/4 cup chlorine to 1 gallon of water. The mop bucket should have a mop press.
    - All mobile equipment should be removed from the area being mopped.
    - Mop the floor with a back-and-forth motion until the area is clean.
    - Mop under and around equipment, along walls and in corners. Wipe all splash and soil marks from the baseboard and walls.
    - The wet floor should not be walked on until it is thoroughly dry.

- Wipe all spills as they occur.

- Care of Dirty Floor Cleaning Equipment

  - Must change and discard mop head in trash as least two times per week.
  - Replace with clean mop head.
  - Mop bucket and press must be emptied, cleaned, and allowed to air dry daily.
  - When dried, store the floor care equipment in its designated place outside behind dietary department.
  - Mops and buckets used in dietary must not be used in any other part of the facility.

- Hoods must be cleaned once per month to prevent buildup of grease and dust.

  - Clean inside and outside by:
    - Wash hood with detergent solution using a cloth.
    - Remove the filters and wash the retainer bracket.
    - Wash the hood grease trench with a detergent solution, using a cloth.
    - Rinse the hood with hot water. Absorb the excess water with a cloth.
    - Polish hood with stainless steel polish using a paper towel or cloth.

- Filters

  - Because of potentially high fire hazard, it is important that hood filters be washed once a month.
  - Cleaning procedure:
    - Remove filters from hood.
    - Clean with oven cleaner or degreaser, using a brush to remove the grease. Rinse in the dish room.
    - After the oven cleaner or degreaser is rinsed completely from hood filters.
      - Allow the filters to air dry before returning to the hood.

- Hood Shafts

  - Hood shafts will be maintained by the engineering department to maintain the safety and meet the local fire code requirements.

DEFINITIONS:

PPM is Parts Per Million. For kitchen use, this indicates the concentration of chlorine in water that is adequate for sanitation.

SoHum Health

Subject:	Manual:
Policy: Laboratory Testing	**MCN / Laboratory**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") that laboratory testing services will be performed in compliance with laws, regulations, accreditation standards, and good laboratory practices.

Analytic System

The laboratory will monitor and evaluate the overall quality of the analytic systems and correct identified problems.

- Laboratory personnel will define, monitor, and document essential conditions for operation of the laboratory's test systems.
    - Document water quality, temperature[1], and humidity when applicable to any test.
    - Document other essential conditions when any exist.
    - Implement protection of equipment from power fluctuations and interruptions.
    - Document corrective actions when essential conditions are not met.
- Reagents, QC materials, calibrators, media, and other materials and supplies must be labeled, stored, and used properly.
    - Labels must include:
        - Identity
        - Concentration
        - storage requirements
        - dates of receipt[2], preparation, opening, and expiration; and
        - other pertinent information.
    - Store all materials under the correct conditions.
    - Do not use materials that have expired[3], have deteriorated, or are of substandard quality.
    - Do not interchange components of reagent kits of different lots, unless otherwise specified by the manufacturer.

Procedure[4] Manual

A written procedure manual will be available to and followed by laboratory personnel.

- Procedures for performing testing will include, as applicable:

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[1] See also: **Policy: Laboratory Facilities, Environment, and Safety**.

[2] Dates received and opened are not required by CLIA/ACHC, unless they change storage/stability requirements. SoHum Health lab voluntarily follows this practice in most cases.

[3] Exceptions may apply to immunohematology reagents. See **Policy: Blood Banking and Transfusion Services**.

[4] Within the context of the SoHum Health QMS, a distinction is made between "procedures", which are general instructions for how tasks are performed and require review by the governing board, and "protocols", which are detailed guides to the steps of a technical process for use by professionals performing their job duties. Both kinds of documents are "procedures" as defined and understood by CLIA and accreditation agencies, and both must conform to regulations and standards for laboratory procedures.

    - Patient preparation;
    - Specimen collection, labeling, storage, preservation, transportation, processing, referral, and identification of aliquots;
    - Criteria for specimen acceptability and rejection;
    - Microscopic examination, including detection of incorrectly prepared slides;
    - Step-by-step performance of the procedure, including test calculations and result interpretations;
    - Preparation of materials used in testing;
    - Calibration and calibration verification procedures;
    - Reportable range;
    - QC procedures, including type, identity, and number of QC specimens; frequency of QC testing; control limits; and QC acceptability criteria;
    - Troubleshooting and corrective actions when calibration or QC fail acceptability, or when a test system becomes inoperable[5], including reference to backup testing procedures;
    - Limitations, including interfering substances;
    - Reference intervals (a.k.a. normal values)[6];
    - Critical values[7]; and
    - Pertinent literature references[8].
- The documents in the procedure manual will be created, approved, stored in and accessed via the district's current controlled-documents system[9]. For details, see **Policy: Laboratory Quality Management System**.
- Procedures will be available to all laboratory personnel in the work area.
- Backup copies of the documents in the procedure manual will be available in the case of power loss, network downtime, or other interruption of access to the controlled-document system.
    - Save copies of documents to the local storage drive of a computer accessible by all laboratory personnel.
    - Label the storage location "P&P Backup Files – DOWNTIME ONLY".
    - Update the backup copies every time a procedure is approved, revised, or retired.
- Manufacturer-provided instructions for use must be followed and may be included as procedures in the procedure manual.
- For methods of ensuring that laboratory personnel follow the procedure manual, see **Policy: Competency Assessment of Laboratory Personnel**.

Selection and Implementation of Test Systems

Laboratory personnel will select the test systems used to perform patient testing and establish their use for patient testing according to applicable regulations and standards.

- For the laboratory personnel responsible for selecting and establishing test systems in the laboratory, see **Policy: Laboratory Personnel** and **Director Approval: Delegation of Laboratory Duties**.

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[5] Procedures must identify, by position title, whom to notify if a test system or the Laboratory Information System (LIS) stops performing correctly.

[6] Reference values, once established, are documented in the current Laboratory Information LIS / Electronic Medical Record (EMR). Laboratory technical supervisors will update the reference intervals in the LIS/EMR when indicated.

[7] A summary of all critical values is allowed but not sufficient. The critical value of each test must appear in its procedure.

[8] Most tests will refer to the test manufacturer's instructions for use, which should be incorporated into each test's procedure by reference.

[9] Currently MCN

- Laboratory personnel will verify[10] the performance specifications of FDA-cleared or approved test systems before putting them into use for patient testing.
    - Verify the following performance characteristics:
        - Accuracy (correct results);
        - Precision (reproducible results), including day-to-day, run-to-run, and within-run variation, as well as interoperator variation for partially or fully manual systems;
        - Reportable Range (if applicable).
    - Verify that the reference intervals[11] are appropriate for the laboratory's patient population by testing an appropriate number of specimens to verify the reference intervals.
    - Verification testing should be performed among all operators and on different days.
    - Results above and below the reportable range must be reported as > or <, respectively.
    - The laboratory director[12] and clinical consultant will attest that the performance characteristics as verified are adequate to meet the needs of healthcare providers ordering the tests and using the results.
    - Verification must be performed on each instrument, analyzer, or device, even if multiple identical devices are in use, including when a "loaner[13]" device is temporarily provided for use during downtime of a primary device.
    - If anyone other than laboratory personnel performs verification, the laboratory must demonstrate that its personnel's test performance correlates with this verification[14].
    - If a test system is relocated, the laboratory will determine whether its performance specifications have been affected.
    - When using calibrator specimens for verification, the laboratory will demonstrate that there is a minimal matrix effect and that use of the calibrator is appropriate for calibration verification.
    - Calculations in the LIS must be verified immediately after programmed in the LIS and again prior to initial calculation of patient results.
    - Documentation of verification of performance specifications must include the actual measurements taken, reactions, and/or observations recorded.
- Laboratory personnel will determine the test system's calibration and QC procedures.
    - Calibration and QC frequency will be at least as frequent as specified by the test system's manufacturer.
    - The frequency, type, number, and concentration of calibration and QC materials will be determined during verification of performance characteristics, then re-evaluated again as indicated throughout the period that the test system is in use.
        - The laboratory must consider:
            - Test system instrument/reagent stability, including relocation;
            - Frequency with which the test is performed; and
            - Training, experience, and competency of technical personnel.
    - The laboratory must document all activities associated with establishing the frequencies.
        - Documentation of calibration and QC parameters must include the actual measurements taken, reactions, and/or observations recorded.

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[10] Establishment of performance specifications, as described in ACHC Standard 06.03.01, applies only to tests developed or modified by the laboratory. Such LDTs are not in use at SoHum Health.

[11] May use manufacturer-provided ranges, or if none are provided, published ranges.

[12] Delegation of such duty, if permitted by CLIA and accreditation, must be in writing.

[13] For loaners identical to what is being temporarily replaced, verification may be limited to running and comparing at least two levels of QC and previously tested patient or proficiency specimens.

[14] The method of correlation is not specified, but an example given by ACHC is testing "known" specimens.

Operational Readiness

Laboratory personnel will perform and document activities necessary to maintain and verify the good working order of test systems.

- The manufacturer's requirements for maintenance checks must be followed.
    - Determine the maintenance required and recommended by the manufacturer.
    - Determine maintenance requirements for peripheral equipment[15] used in the testing process.
    - Perform all required maintenance at least as frequently as required by the manufacturer.
    - Document all maintenance activities.
        - Routine and scheduled maintenance should be documented as performed as indicated in the test system's procedure.
        - Document all repairs as well as any maintenance performed by outside personnel[16] as indicated by the nature of the work performed.
- The manufacturer's requirements for function checks[17] must be followed.
- QC[18] testing must be performed according to manufacturer requirements, CLIA regulations, and accreditation standards.
- Function checks and QC must be within specified limits before conducting patient testing.
- Document all activities taken to maintain operational readiness.

Calibration & Calibration Verification

Laboratory personnel will perform calibration and calibration verification procedures as specified by the manufacturer and determined during implementation of the test system.

- Calibration will be performed:
    - Using calibration materials specified by the manufacturer;
    - At the calibration intervals and frequency determined during the implementation of the test;
    - As a corrective action when indicated in the judgment of laboratory personnel troubleshooting QC failures or other problems with test system performance.
- Calibration verification will be performed:
    - Following the manufacturer's calibration verification instructions, if given;
    - Using criteria verified or established by the laboratory;
    - Including at least three cal-ver specimen materials spanning the test system's reportable range;
    - At intervals at least as often as required by the manufacturer and regulations:
        - At least every six months;
        - When a complete change[19] of reagents occurs;
        - Following major preventative maintenance or replacement of critical parts that may influence test performance;
        - When evaluating QC failures after other means of troubleshooting have failed; and
        - More frequently if indicated by the test system's verification of performance specifications;
    - Unless an exception applies, including:

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[15] Includes incubators, centrifuges, biological safety cabinets, microscopes, etc.

[16] A contract must be in place that specifies the service to be performed and its frequency.

[17] Function checks refers to any activities performed by operators or automatically by the test system that evaluate critical operating characteristics. QC may be regarded as a function check, particularly by accreditation standards, because it checks characteristics like calibration and instrument stability.

[18] For additional information about QC, see **Policy: Laboratory Quality Control and Quality Assurance**

[19] This "complete change" term is vague in the CLIA regs. ACHC seems to interpret it to mean "reagent lot change", and that is the definition adopted by the SoHum lab. Cal ver is not required in this case if the lab demonstrates that the change does not affect the range of reportable patient results and QC values.

        - Assays calibrated using at least three levels (low, mid, and high) at least every six months;
        - Automated cell counters, when following manufacturer instructions for instrument operation and testing two or more levels of control material per day of patient testing, provided the control materials meet the laboratory's criteria for acceptability;
        - Automated chemistry analyzers testing three or more levels of QC materials more than once per day, when the control material results are traceable to National Institute of Standards and Technology reference materials;
        - Assays using reagents of the same lot and received in the same shipment as the lot-shipment of reagent used in a successful calibration verification within the preceding six months;
        - Test systems that are factory- or manufacturer-calibrated;
        - Test systems that non-quantitative[20], including assays measured in units of time, such as prothrombin time.
    - Retaining records of the measurements, reactions, and/or observations used in determining acceptability of calibration verification.

Test Records

Laboratory personnel will ensure that records of testing activities are complete and available.

- The record system will include:
    - Positive identification of the specimen, which must include the patient's name;
    - Date and time of specimen collection and receipt;
    - Condition and disposition of specimens not meeting the laboratory's acceptability criteria;
    - Dates of each step of testing[21];
    - Records and dates of all specimen testing, including the identity of testing personnel;
- Corrected laboratory results will include the originally reported result marked as incorrect or amended the date corrected, and the identity of the person who corrected the result.
- Laboratory records must be indelible, and information must not be obliterated[22].
- Test records will be retained for a minimum of three[23] years.

CLIA Waived Testing

Tests that have been classified as CLIA Waived complexity by the Food and Drug Administration (FDA) may be used in the laboratory under its CLIA Certificate of Accreditation. For each waived test, the laboratory will:

- Maintain a current copy of the manufacturer's instructions for use;
- Follow manufacturer instructions, if applicable, for:

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[20] The regulatory language surrounding this exception muddles the underlying science. Calibration and cal-ver are not required because there is no calibration. Rather than connect an unmeasurable quantity of interest (such as analyte concentration) to an arbitrary but measurable quantity (such as absorbance at 340 nm) by assaying materials of known analyte concentration and calculating a calibration curve, the assays covered by this exception are making a quantitation of a property of clinical interest (such as time to clot detection, or millimeters of erythrocyte sedimentation) without mathematical respect to any particular property of the material (such as fibrinogen concentration, or concentration of C-reactive protein).

[21] For example, records must include the date blood culture media are inoculated, Gram stains performed on positive bottles, subculture isolates identified from plate media, etc.

[22] No records may be made in pencil or other easily erasable media, and information once recorded must not be erased, destroyed, or otherwise made unreadable. This applies to electronic records as well as physical ones.

[23] ACHC and CLIA standards mandate two years, but California law requires three years. For additional information, see **Policy: Retention of Records, Specimens, and Other Laboratory Materials**.

- appropriate specimen;
- adding reagents in the proscribed order and amount;
- storage and handling;
- expiration dating;
- quality control testing;
- calibration and function checks;
- confirmatory testing;
- result reporting;
- instrument maintenance; and
- timing of incubation, interpretation, and other steps.

See also **Policy: Laboratory Personnel, Policy: Competency Assessment of Laboratory Personnel**, and **Policy: Laboratory Quality Control and Quality Assurance**.

Provider-Performed Microscopy Testing

SoHum Health does not perform PPM testing. Tests that would otherwise qualify as PPM are performed by laboratory personnel as moderate-complexity testing in the laboratory.

PROCEDURE:

N/A

DEFINITIONS:

N/A

SoHum Health

Subject:	Manual:
Policy: Compliance with California Laboratory Laws and Regulations	**MCN / Laboratory**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") that the laboratory will comply with all applicable California laws and regulations governing clinical laboratory operations. The laboratory will ensure that all personnel, procedures, and practices adhere to the requirements established by the state, including those specified in the California Business and Professions Code (BPC) and other relevant statutes.

- The laboratory manager, working with the laboratory director, Quality and Compliance department, and other district personnel, will create and maintain protocols that ensure there is no violation of California law.
- The district will abide by California laws regarding ownership and directorship of a clinical laboratory.
    - The district will maintain its eligibility to own a clinical laboratory under California law.
    - The laboratory will continuously employ a qualified laboratory director (see below) or cease testing operations.
    - District personnel will report major changes in ownership[1], directorship, name, or location of the laboratory to CDPH-LFS[2,3] within 30 days.
    - The district and the laboratory director will be jointly and severally liable for compliance with California laboratory laws.
- The district will continuously employ[4] laboratory personnel in the following roles who meet CLIA and California qualifications.
    - Laboratory Director: a board-certified clinical and anatomic pathologist[5] licensed to practice medicine in the State of California.
    - Technical Supervisors: for each CLIA specialty performed in the laboratory, a California-licensed clinical scientist holding a baccalaureate degree or higher in biology, chemistry, clinical laboratory science, or a closely related field[6] and four years of experience performing high-complexity clinical testing in the supervisor's specialty.
    - General Supervisors: California-licensed clinical scientists meeting CLIA requirements for education and experience.
    - Testing Personnel (high complexity): California-licensed clinical laboratory scientists in any specialty (except cytology), or clinical specialist scientists within their specialty; may perform all moderate- and waived-complexity procedures.

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[1] A major change is defined as a change in 50 percent or more of the total ownership stake.

[2] California Department of Public Health Laboratory Field Service Branch

[3] See also Policy: Laboratory Licensing and Accreditation for other notification requirements.

[4] Failure to continuously employ a laboratory director, technical supervisor, general supervisor, and testing personnel are citable as CLIA condition-level deficiencies, may result in a finding of immediate jeopardy, and in the case of the laboratory director may require the laboratory owner to cease testing operations.

[5] Under CLIA, a doctorate of clinical laboratory science may serve as director. This qualification will only be accepted at SoHum Health if permitted under accreditation standards and any AABB standards incorporated into California law.

[6] California law does not recognize a degree in nursing as a degree in science fulfilling this requirement.

- Phlebotomy personnel[7]: Persons holding certificates appropriate to the phlebotomy procedure performed, including:
    - Skin Puncture: Limited Phlebotomy Technician (LPT), Certified Phlebotomy Technician I (CPT-I), and Certified Phlebotomy Technician II (CPT-II)
    - Venipuncture: CPT-I and CPT-II
    - Peripheral Venous Catheter Collection[8]: CPT-I and CPT-II with special training
    - Arterial Puncture: CPT-II, or CPT-I under the direct supervision of a qualified training preceptor.

- The district may, with approval of the laboratory director, employee supplemental laboratory and testing personnel.
    - Laboratory Testing Personnel (moderate complexity): a person licensed in California as a medical laboratory technician, registered nurse, or other associate-level healthcare practitioner whose scope of practice under BPC includes moderate-complexity clinical laboratory testing may perform moderate-complexity and waived testing but are excluded from high-complexity testing.
    - Laboratory Testing Personnel (waived complexity): a person employed in California as healthcare personnel meeting at least one of the qualifications under BPC § 1206.5(a).
    - Point-of-Care Testing[9] Personnel: a person licensed in California as a healthcare practitioner under BPC, certified as a phlebotomy technician, employed as a technician in the emergency department, or employed as a medical assistant in the clinic may be employed as supplemental testing personnel only for CLIA-waived POC tests performed within the person's setting of practice[10].
    - Phlebotomy personnel: a registered nurse, vocational nurse, or respiratory care practitioner licensed under BPC;
- Unlicensed laboratory personnel will act only within the limits of California law and CLIA.
    - Unlicensed personnel will work under direct, constant supervision and control of licensed personnel the entire time they are assisting in the activities considered to be pre-analytical and post-analytical procedures, including specimen preparation;
    - Unlicensed personnel may:
        - Transcribe test results previously recorded by licensed personnel or an automated testing instrument;
        - Set up qualitative and semi-quantitative "spot, tablet, or stick" tests;
        - In the microbiology specialty, may inoculate primary culture media, prepare and stain slides for microscopy, and subculture from liquid media;
        - Set up specimen testing using mechanical or electronic instruments and transcribe results automatically generated by these instruments;
    - Unlicensed personnel may not:
        - Record[11] test results;
        - Read and interpret the results of qualitative and semi-quantitative "spot, tablet, or stick" tests;
        - Perform any part of a test that involves quantitative measurement of the specimen or reagent, or any mathematical calculation;

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[7] Phlebotomy students externing at SoHum Health through an approved training program with an active affiliation agreement may perform skin puncture and venipuncture.

[8] See BPC § 1246(a)(3) for details.

[9] The California definition of POC testing is found in BPC § 1206(a)(14).

[10] See BPC § 1206.5 for details.

[11] "Record" in this sense means to verify patient test results in the LIS / EMR.

        - Perform any phase of testing in immunohematology beyond initial specimen collection and centrifugation;
        - Perform calibration, standardization, or quality-control evaluation of test systems.
- Application for accreditation by an agency with deemed status[12] will accurately state the names and addresses of all laboratory owners and directors.
- Laboratory personnel will maintain and properly display the laboratory's clinical laboratory license from CDPH-LFS, along with the licenses and certificates of all laboratory personnel holding California laboratory personnel licenses or certifications.
- The laboratory director will notify CDPH-LFS of the names of testing personnel as required by CCR 17, §1045[13].
- Records will be maintained for three[14] years.
- The laboratory director will ensure that the laboratory follows California requirements for proficiency testing.
    - The PT provider must be California-approved.
    - The laboratory must authorize the PT provider to disclose the results of testing to the State of California via its electronic monitoring system.
    - **Referral of PT specimens to another laboratory must never occur**.
- If autoverification of test results is implemented, laboratory personnel will comply with California's requirements for autoverification.
- Laboratory personnel will comply with California laws regarding testing infectious diseases and reporting their results.
    - Reportable findings of tests performed[15] in the laboratory will be transmitted to the county public health officer via electronic interface to CDPH, or manually to Humboldt County[16] Public Health's Office of Communicable and Infectious Diseases when an interface is unavailable.
    - HIV testing if offered will be performed:
        - Without requiring proof of written consent[17];
        - Using and FDA-cleared test kit;
        - Confirming all positive and indeterminate results before reporting them as positive[18];
        - Under a QA program that includes personnel competency and proficiency testing.
- When Rh(D) typing is performed on pregnant patients, the laboratory will ensure that the result report includes the statement, "State law requires that the woman tested be informed as to the rhesus (Rh) typing test results."

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[12] CMS CLIA and CDPH-LFS separately deem certain laboratory accreditation agencies' standards and enforcement to be at least equivalent to their own. Accredited laboratories qualify for a CLIA certificate of accreditation and California clinical laboratory license.

[13] The submission of the LAB 116 during annual license renewal meets this requirement.

[14] Certain testing requires longer retention but is not performed at SoHum Health. See **Policy: Retention of Records, Specimens, and Other Laboratory Materials**.

[15] SoHum Health does not report presumptive findings of specimens that will be sent for confirmatory testing, nor any results of testing performed by outside laboratories. HCPH CID has verified that such reporting is neither required nor desired.

[16] Interfaced reports are routed by CDPH to the patient's county of residence and to other recipients as indicated.

[17] This requirement must be understood in its historic context. It does not prohibit SoHum Health from requiring written consent to admit patients for services. It bars special consent for HIV testing.

[18] SoHum lab reports its positive HIV tests as "Presumptive Positive" and sends the specimens for confirmation, meeting this requirement.

PROCEDURE: NONE

DEFINITIONS:

- CMS: Centers for Medicare and Medicaid Services
- CLIA: Clinical Laboratory Improvement Amendments of 1988; administered by the CLIA Program Office of CMS through state public health agencies, including CDPH-LFS.
- LIS: Laboratory Information System
- EMR: Electronic Medical Record

SoHum Health

Subject:	Manual:
Policy: Retention of Records, Specimens, and Other Laboratory Materials	**MCN / Laboratory**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") that laboratory personnel will retain records, specimens, and other laboratory materials in compliance with laws, regulations, accreditation standards, and good laboratory practices. See **Table 1**, below.

- Records, specimens, and other materials must be stored under conditions necessary for preservation.
  - All materials must be securely stored.
  - Facilities prevent destruction of materials by humidity, temperature extremes, vermin, bright light, and other sources of degradation.
  - Results on thermal paper are transcribed to prevent the fading or wiping out of results over time.
- The district will ensure retention of records in the event of the laboratory's closure.
  - Retention timeframes must all be met.
  - Notification must be made to physicians expected to be impacted by loss of access to the records.

Table 1: Laboratory Retention Periods

Record	Retention Period
Quality control and patient testing records[1], including original[2] records generated by automated test systems[3]	3 years[4]
Test system performance verification data, evaluation, and approval	3 years, or two years after the end of use of the test system, whichever is longer
Proficiency testing records	3 years
Laboratory quality system assessments	3 years
Test result reports, including preliminary, final, and corrected reports	3 years
Clinical laboratory specimens[5]	Blood specimens, general: 3 days Immunohematology specimens: 14 days Urine specimens: 2 days Other body fluids: 7 days Microscopy slides: 180 days
Anatomic pathology specimens (slides, tissue blocks, etc.)	N/A – SoHum Health laboratory does not perform testing on these specimens

[1] Includes instrument charts, graphs, printouts, transcribed data, and manufacturer's assay information sheets for QC and calibration materials. For a comprehensive list of all covered activities, refer to 42 CFR §493.1252 through §493.1289.

[2] Physical records may be transformed to electronic copies for retention, provided no data is obliterated.

[3] Instrument printouts of test results do not need to be retained for instruments with an interface to the LIS. In this case, the LIS includes Epic Beaker, Bio-Rad Unity RealTime, and any other electronic laboratory record system(s) that may be in place, provided they are retained as required in this policy.

[4] ACHC and CLIA standards mandate two years for most records, but California law mandates three years.

[5] Specimens referred to an outside laboratory and not tested at SoHum Health laboratory may not be retained.

PROCEDURE:

N/A

DEFINITIONS:

N/A

SoHum Health

Subject:	Manual:
Laboratory Use of Epic, Beaker, and Other Information Systems	**Laboratory**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") that laboratory personnel will use the Epic electronic medical record (EMR), Beaker laboratory information system (LIS), and other electronic record-keeping systems in ways that support the provision of laboratory services and maintain compliance with regulations, standards, and best practices.

General Records Systems

Laboratory personnel will follow the policies and procedures of the District regarding the use of the EMR, LIS, and other record systems. These include but are not limited to:

- Epic EMR;
- Beaker LIS;
- Performance Health, or the current system for reporting nonconformances, incidents, and complaints;
- Communication systems including Webex and Outlook;
- Internal and external trouble-ticketing systems, such as SoHum IT Tickets and the OCHIN JIRA system;
- District-owned computers, including laptops;
- Personal devices, such as cell phones; and
- Manual / analog records systems, including forms, log books, and printed labels.

Laboratory Policies Regarding EMR & LIS

Laboratory personnel will follow these additional policy provisions when using the EMR and LIS.

LIS Scope

For purposes of this policy, the LIS comprises the Beaker module of the Epic EMR and other elements of Epic that relate to the preanalytical, analytical, or postanalytical phases of testing. The LIS excludes:

- Computers, calculators, software applications, and other data processing systems that are not used directly in the phases of testing; and
- Computerized components that are part of an analytic system[1].

LIS Suitability and Validation

The laboratory manager, in consultation with other District managers, laboratory team, and laboratory director, will ensure the that the LIS meets the functional, system, and operational requirements of the laboratory and the clients served by the laboratory, across all activities of pre-analytic, analytic, and post-analytic phases of laboratory testing.

The manager is responsible for ensuring appropriate District and contract/external personnel conduct and document:

- Validation of proper performance when the LIS is first installed;
- Validation of changes made to the LIS[2] once in use;

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[1] Unless indicated in the procedure / protocol for a test system, its computerized components are validated by the device's 510(k) clearance and the manufacturer's instructions for use.

[2] In this context, the LIS includes interfaces such as between analyzers and the LIS and between the LIS and external entities, such as Quest and the CalREDIE state-reportable result system.

- Capturing screenshots of each step of any LIS process used for immunohematology and transfusion-medicine activities;
- With all validations approved by the laboratory manager as the laboratory director's designee.

Calculations performed within the LIS will:

- Be verified before being put into use;
- Reverified
    - Annually;
    - Before use for patient results when a system change occurs that could affect a calculation; and
    - Whenever indicated by a particular test system procedure/protocol, such as when changing lots of Prothrombin Time/INR reagent.

LIS Security

The laboratory manager will coordinate with appropriate District and contract/external personnel to develop and enact procedures / protocols that:

- Incorporate adequate security measures to ensure confidentiality of patient data;
- Include defined security mechanisms for data protection, such as firewalls and data encryption;
- Provide network security when using public networks (including cloud storage of data) to exchange or send patient information;
- Define authorized users of the LIS;
- Utilize access codes[3] to limit access to only those functions staff are authorized to use, with security mechanisms[4] to manage access codes.

LIS Operation

Laboratory personnel will have written policies and sufficiently detailed procedures / protocols available to enable them to conduct proper operation of LIS hardware and software, including:

- Startup and shutdown sequences;
- Data entry[5]; and
- Data retrieval.

LIS Maintenance and Troubleshooting

The laboratory manager will coordinate with appropriate District and contract/external personnel to develop and enact procedures / protocols that:

- Direct personnel to perform and document LIS maintenance and back-up activities, including all manufacturer-required maintenance of:
    - LIS computers and peripherals;
    - Networking hardware and systems;
    - Function checks stated by the LIS manufacturer; and
- Ensure notification of LIS users of downtime when required for LIS maintenance; and
- Provide instructions for troubleshooting and reporting hardware/software failures.

[3] In the context of the Epic EMR / Beaker LIS, this policy is met by the definition of user roles and the District's application of user roles to personnel only as they apply to each person's duties.

[4] Surveyors will look for signs of passwords and other access information written on or around workstations with LIS access and may cite the laboratory if they are found.

[5] Procedures for data entry may be included in specific test procedures.

LIS Downtime

Procedures, protocols, and materials will be prepared and available to continue laboratory services during LIS downtime events. These will include:

- Protocols for performing and documenting all phases of testing when the LIS is not operational, including:
  - Communication of laboratory orders;
  - Documentation of specimen collection and receipt into the laboratory;
  - Operation of LIS-connected test systems during downtime; and
  - Reporting results during downtime.
- Protocols for recovery of the LIS after downtime, including:
  - Verification[6] of function of the LIS;
  - Retrospective entry of orders and results into the LIS; and
  - Quality assurance activities related to the downtime event, including:
    - Review of a sampling of data files present before the downtime to verify that no alterations have occurred that would affect results for patient care; and
    - Review of a sampling of records created during downtime and transcribed into the LIS after it was restored to rule out systematic or widespread errors of data entry.

LIS Retention

The laboratory manager will coordinate with appropriate District and contract/external personnel to develop and enact procedures / protocols that:

- Ensure retention and ongoing availability of the data in the LIS;
- Enact written procedures / protocols for preserving and restoring data in the event of disruption or disaster, which must describe:
  - Steps to limit the interruption of access to data;
  - Periodic backing up and storing of information;
  - Offsite storage of backup data; and
  - Restoring information from backup media;
- Create a mechanism for retrieving data after the LIS is upgraded or replaced, including:
  - Test results;
  - Reference ranges in effect when the test results were reported;
  - Interpretive information including report comments and footnotes;
- Retain records and accessibility for:
  - Two years after ending use of the LIS; or
  - Ten years from the date of reporting of all records related to immunohematology and transfusion services.

PROCEDURE:

N/A

DEFINITIONS:

N/A

[6] Verification is intended to be a straightforward demonstration that the LIS is functioning as expected, not a full revalidation. See verification protocol.

SoHum Health

Subject:	Manual:
Policy: Referring Specimens to Outside Laboratories	**MCN / Laboratory**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") that the laboratory will only refer specimens to outside laboratories for testing when referral is legal and compliant with laboratory regulations and accreditation standards.

Referral Laboratory Qualifications

- SoHum Health will only refer specimens for clinical testing to laboratories holding a current, valid CLIA certificate, unless the laboratory meets CMS-determined requirements for CLIA equivalency, including:
    - Laboratories operated by the Veterans Administration;
    - Department of Defense laboratories; and
    - CLIA-exempt laboratories.
- The referral laboratory must offer a current service manual[1] containing the reference laboratory's specimen requirements for the test to be performed, including:
    - Patient preparation if indicated;
    - Specimen collection, labeling, processing, storage, and preservation;
    - Criteria for specimen acceptance and rejection; and
    - Transportation instructions.

Accepting Specimens Referred to SoHum Health

- SoHum Health laboratory may engage in reference-laboratory services for other laboratories[2].
- Before specimens are accepted for testing, laboratory personnel will:
    - Verify that the referring laboratory holds a current, valid CLIA certificate, or is a laboratory meeting CMS-determined requirements for CLIA equivalency;
    - Execute a laboratory services agreement and BAA with the referring laboratory;
    - Obtain written approval from the SoHum laboratory director of the laboratory services agreement;
    - Provide the referring laboratory a current service manual or equivalent information for the testing to be performed; and
    - Establish a tracking system to ensure that all specimens submitted from remote sites are received in the laboratory.

[1] For community laboratories providing intermittent services, such as emergency backup testing, the "service manual" may be provided at the time arrangements are made for sending specimens and limited to the tests to be performed.

[2] Not to be confused with accepting specimens from submitters – non-laboratory healthcare providers collecting specimens as part of their provision of healthcare services and submitting them directly to SoHum Health for testing.

Self-Referral and Antikickback Considerations

- All reference laboratory arrangements will comply with federal and state laws[3] against self-referral, kickback payments, and other prohibited inducements.
- No personnel of SoHum Health will offer or accept payments, gifts, or anything of value in exchange for specimen referrals to of from our laboratory.
- Physicians and other healthcare providers of SoHum Health will not create referrals to laboratories in which they or people with specified relationships to them have a financial interest.

Packaging and Shipping of Referral Specimens

- All personnel engaged in the packaging and shipment of infectious and diagnostic materials will have the necessary training to adhere to federal, state, and local shipping regulations.
    - Training should include requirements set out by the US Public Health Service, US Department of Transportation, and US Postal Service (if specimens are sent via post), as well as state or local requirements when such apply.
    - Training must occur at least once every three years.
- Above requirements may be waived when the specimens are shipped via private couriers.

PROCEDURE:

N/A

DEFINITIONS:

N/A

[3] See 42 USC § 1395nn (Federal Stark Law), 42 USC § 1320a-7b(b) (Federal Antikickback Statute), 18 USC § 220 (EKRA), California Business and Professions Code § 650.01 (California Stark Law), and Cal BPC § 650 (California Antikickback Law). Others may apply.

SoHum Health

Subject: Policy: Laboratory Quality Assurance	Manual: MCN / Laboratory

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") that the laboratory will establish and maintain quality control (QC) and quality assurance (QA) practices.

Establishment of the Laboratory~~QC and~~ QA Program~~s~~

- The laboratory will create and maintain a~~QC and~~ QA program~~s~~ that will include:
  - Monitoring of the quality of laboratory services in ways that identify quality failures as they occur in all phases of the testing process – preanalytical, analytical, and postanalytical.
  - Checking for acceptable analytical performance of each test system in use;
  - Remedial actions taken when significant deviations from the lab's quality criteria occur; and
  - Documentation of these ~~QC & QA~~ activities.
- The laboratory director will be responsible[1] for the establishment of the lab's ~~QC &~~ QA program~~s~~, and for its~~their~~ integration into the districtwide QA program[2].

Quality Assessment

- Laboratory personnel will conduct an ongoing review of processes, including:
  - All facets of the laboratory's technical and non-technical functions;
  - All phases of the testing process – preanalytical, analytical, and postanalytical;
  - All locations and sites where testing is performed; and
  - Laboratory interactions with and responsibilities to patients, ordering providers, referral laboratories, and internal SoHum laboratory customers.
- QA activities should include:
  - Privacy/confidentiality practices[3];
  - Specimen requisitioning, collection, identification, handling, processing, storage, and integrity[4];
  - Referral of specimens[5];
  - Complaint investigations[6];
  - Communications, such as faxed results, critical-value calls, and result reports[7];
  - Personnel competency[8];
  - Proficiency-testing performance[9]; and

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[1] The director may delegate the performance of tasks to satisfy these responsibilities, but the director remains personally responsible for them.

[2] See **Policy: Quality Assurance Performance Improvement (QAPI) Program** in the SoHum Quality Manual for details.

[3] See **Policy: Confidentiality and Patient Privacy** in the SoHum HIM Manual for details.

[4] See **Policy: Laboratory Orders and Specimens** for details.

[5] See **Policy: Referral of Specimens to Outside Laboratories** for details.

[6] See **Policy: Complaints, Incidents, and Nonconformances** for details.

[7] See **Policy: Laboratory Test Results** for details.

[8] See **Policy: Competency Assessment of Laboratory Personnel** for details.

[9] See **Policy: Proficiency Testing** for details.

    - Verification of LIS functions to include calculations, interfaced results, and patient-specific data.
- QA activities must be documented and retained[10].

Corrective Actions

- Potential problems discovered through QA activities must be investigated and remedied.
    - Prompt corrective actions involving all pertinent laboratory personnel must be implemented to prevent harm and unacceptable test results.
    - Sustainable corrective actions, such as improvement plans and new/updated policies or procedures, must be implemented and monitored.
        - Corrective action plans and new policy/procedure/protocol documents will be in writing and approved as required[11].
        - Personnel impacted by remedial actions must receive documented training.
        - Policies and procedures changed because of QA corrective actions must have this reason for the change noted[12].
- Corrective actions must be monitored over time, including:
    - Effectiveness of actions taken;
    - Changes made to policies and procedures; and
    - Discussion of QA reviews with laboratory staff.

PROCEDURE:

N/A

DEFINITIONS:

N/A

[10] See **Policy: Retention of Records, Specimens, and Other Laboratory Materials** for details.

[11] See **Policy: Laboratory Quality Management System** for details.

[12] The accreditation standard that this policy element is based on is vague. Laboratory supervisors will operationalize it as seems appropriate in each circumstance, such as with revision notes in the lab's controlled documents system or in footnotes in the revised documents.

SoHum Health

Subject: Data Governance	Manual: Compliance

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD," "District," "SoHum Health") to establish a framework for managing and prioritizing data to ensure data is managed efficiently, securely, and in alignment with the District's goals and compliance requirements.

A Data Governance Committee (DGC) will be formed as a sub-committee of the Compliance Committee to ensure the establishment of standards for data quality, classification, security, usage, and ensure these standards are practiced across the District.

The DGC will consist of specific District staff members who are in positions that govern data usage and/or frequently work with data. The DGC will ensure that the District delivers accurate data by following procedures related to the creation, distribution, and application of data. It will also ensure that data management processes and procedures align with the District's existing policies, regulatory requirements, and data management goals. If necessary, the DGC will recommend updates to existing policies and procedures or the creation of new ones.

PROCEDURE:

Data Governance Committee Structure

- **Frequency of Meetings**:
    - The DGC will meet on an ad-hoc basis, depending on the needs of the District
- **Committee Members**:
    - The DGC will be comprised of the following District personnel:
        - Director of Information Technology
        - Chief Quality and Compliance Officer
        - Health Information Manager
        - ESA Lead/EHR Support Analyst
- **Designees**:
    - A member of the DGC may send a designee in their place if they are unable to attend a meeting
- **Committee Responsibilities**:
    - The DGC will:
        - Review and examine existing policies, procedures, and other regulatory documentation pertaining to data governance to ensure that they are current, effective, and compatible with District operations and the software programs used by the District.
- **Documentation Updates and Creation**:

  If the need arises to update or create new documentation, the DGC will:

    - For existing documentation that is approved by the appropriate governing bodies:
        - Recommend to the head of the department that an update be made.
    - For new documentation:

- Recommend the creation of a new policy, procedure, or other documentation if the DGC determines it falls within a department's purview.
- Create a new policy, procedure, or other documentation if it falls within the DGC's purview.

Definitions:
None

SoHum Health

Subject: Empanelment	Manual: Clinic

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to Empanel~~assign~~ patients to a Primary Care Provider (PCP). Empanelment is the assignment and maintenance of patients to specific provider. ~~and maintain the PCP panels.~~ Empanelment supports quality of care, access to care, coordination of care, population health management, and ensures patients receive comprehensive care from providers that are familiar with their medical history. ~~other primary care home features.~~

PROCEDURE:

New Patients

New patients are empaneled with a provider that has availability.~~an open panel. The panel is assigned based on availability,~~ Availability will be assessed based on the needs of the community, ~~the~~ patient~~'s~~ preferences, provider workload,~~demographic~~s, and other factors as ~~needs~~ identified.

Patients assigned by a~~the~~ health plan, but unseen by the practice will not~~are not assigned a PCP~~ be empaneled prior to ~~. They are assigned to the clinic only and will be assigned a PCP when they~~ establishing care.

Active Patients

Active patients, those that have been seen within three years, will be empaneled~~assigned to the provider with~~ to the provider with whom they initially established care. The patient profile in our Electronic Health Record (EHR) will be reviewed and updated with PCP assignment at time of scheduling, if patient is not already assigned.

Changing PCP

Patients and/or providers can request the patient's PCP ~~changes~~be updated verbally or in writing.~~, which are~~ These requests will be forwarded to the C~~c~~linic ~~m~~Manager for coordination and approval. The Clinic Manager will communicate any approved changes to Patient Access so the patient profile can be updated. ~~The clinic manager reviews these requests and consults with the other providers to determine if the request can be facilitated.~~

Panel Maintenance

The Clinic Manager, and/or designee, and Patient Access staff will~~Patient Financial Services (PFS) and the clinic manager~~ monitor the provider's panels. They will be~~are~~ monitored for ~~mostly~~ appointment availability to determine if the provider's panel w~~l~~ll be~~is~~ open or closed. Provider's panels will stay open until the provider requests it be closed, or it is determined due to volume. ~~Providers determine when their panel is closed.~~

When it is determined that a provider's panel needs to be updated~~is to be opened or closed~~, the C~~c~~linic M~~m~~anager, or designee, will email~~s the information to registration (PFS).~~ Patient Access staff.

If a~~that~~ provider is no longer with the district, their panel will be assigned to a new provider based on the patient's demographics and needs.

A new provider's panel is determined by their scope of practice ~~and their wants~~.

DEFINITIONS:

Panel: A~~The~~ group of patients assigned to each provider for primary care.

Active Patient: A patient that has been seen within the last three~~3~~ years.

Empanelment: The process of assigning patients to panels and managing providers' workloads.

SoHum Health

Subject:	Manual:
Compassionate Access to Medical Cannabis	**Hospital Pharmacy**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to adhere to the legislative requirements set forth in the Compassionate Access to Medical Cannabis Act (Senate Bill 988). The District shall permit patient use of medicinal cannabis and shall carry out all of the following described in the corresponding procedure.

BACKGROUND:

Senate Bill (SB) 311 (Chapter 384, Statutes of 2021) established the Compassionate Access to Medical Cannabis Act requiring health care facilities to allow terminally ill patients to access medicinal cannabis under specified conditions.
SB 988 provides revisions to the Act.
Effective January 1st, 2023, SB 988 reiterates that for purposes of the Act the definition of a "health care facility" does NOT include, among other things, the emergency department of a General Acute Care Hospital. This means that the Act does NOT require the District's emergency department to permit terminally ill patients access to medicinal cannabis.

DEFINITIONS:

Patient – means an individual who is terminally ill, NOT an individual receiving emergency services and care.
Terminally ill – a medical condition resulting in a prognosis of life of one year or less if the disease follows its natural course.

PROCEDURE:

Per Senate Bill 988, the Skilled Nursing and Swing sections of SoHum Health District are in the scope of the Compassionate Access to Medical Cannabis Act. As such, they must follow the guidelines set forth by the Act:

- The patient or primary caregiver is explicitly responsible for acquiring, retrieving, and administering the medicinal cannabis.
- Healthcare professionals and facility staff are prohibited from administering medicinal cannabis or retrieving it from storage.
- Medicinal cannabis shall be securely stored at all times in a locked container in the patient's room, other designated area, or with the patient's primary caregiver.
- Smoking or vaping are not permittable methods of use.
- Upon discharge, patients or primary caregivers are responsible for the removal of the medicinal cannabis.
- If they are unable to remove the medicinal cannabis, it will be disposed of by a nurse and require a witnessing nurse or Pharmacist.
- Any warranted dispositions shall be documented in Pyxis in the electronic health record.

It must be stated that the Act does not require the facility to provide a patient with a recommendation to use medicinal cannabis or include medicinal cannabis in a patient's discharge plan.

SoHum Health

Subject:	Manual:
Compounding Medications	**Hospital Pharmacy**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to ensure accuracy and consistency of the pharmaceuticals compounded in our hospital. No medications will be compounded in the facility, with the exception of IV admixtures. Reconstitution of powdered parenteral medications does not constitute compounding.

PROCEDURE:

- No medication will be compounded in the facility as there is no acceptable method available to determine the integrity of the product or to monitor the adequacy of the compounding process with the exception of IV admixtures.
- Compounding of sterile preparations in this facility means mixing medications into parenteral IV solutions. This process may be done only by properly trained registered nurses, pharmacists, physicians, physician assistants and nurse practitioners.
- Compounding of IV admixtures shall be performed using aseptic technique only at designated areas in the facility: med carts in the ER, Acute, SNF, nursing units; med room in clinic.
- Compounding area surfaces will be cleaned and disinfected at least daily, when in use, with a hospital approved germicide.
- Compounding areas will be free of clutter and obvious sources of contamination (for instance, sinks)
- Hand hygiene must be performed prior to preparation of IV admixtures.
- No products will be compounded using non-sterile chemicals.
- Compounded products will be used immediately. Administration will begin within 1 hour of starting the compounding process. There will be none stored in refrigerators for later use.
- The CNO is responsible for education of staff in regard to proper compounding of IV admixtures.
- To the maximum extent possible, commercially prepared, premixed parenteral products are used versus manually compounded sterile products.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Crash Cart	**Hospital Pharmacy**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to properly maintain and store emergency medications in our crash carts. By doing so we will ensure that our crash carts are always supplied with emergency medications and sealed properly.
Cardiac arrest medications, and medications used in medical emergencies, are immediately available in the crash cart in the emergency room, between bed 1 and 2; and the crash cart in room 109 on the Acute Floor. The Pediatric crash cart is located in the emergency room by bed 4. During a pediatric code blue, staff is to utilize the pediatric crash cart supplies in conjunction with the medications in either of the other two crash carts. The emergency drug supply is stored in a clearly marked portable container which is sealed by the pharmacist in such a manner that a seal must be broken to gain access to the medications. Contents of the medication drawers of the emergency crash cart, shall be the responsibility of the pharmacy staff or the nursing staff when the pharmacist is unavailable. Materials shall be responsible for the rest of the cart.

PROCEDURE:

- Nursing staff will be responsible to notify the pharmacy and materials departments via email that the crash cart has been opened.
- During operating hours, Pharmacy is responsible for restocking medications in drawers 1 & 2 in the crash carts as soon as possible and sealing them with a red plastic lock.
- The lock number on the seal will be recorded in the crash cart log along with the date and initial of the pharmacy staff who refilled it.
- In the absence of pharmacy staff, nursing staff will restock the cart using the Pyxis machine under the patient listed as "Crash Cart" and seal it with a yellow lock.
- The pharmacy staff will then verify all yellow seals and replace the seal with a red lock as outlined above.
- Materials will be restocked by the materials department.

DEFINITIONS:
None

Subject:	Manual:
Defective Medications	**Hospital Pharmacy**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to monitor medications to assure they are not defective by assuring that defective drug products are not used, and that they are reported through the proper channels.

PROCEDURE:

If a drug product is suspected to be defective, contaminated, or unfit for use for any reason, the following procedures will be followed:

- Stop the use of the product in question.
- If the product has been used, notify the prescriber immediately and document.
- Notify the pharmacist and place it in the Return Bin, identifying the drug as defective.
- Pharmacy Staff will inform the drug product manufacturer if appropriate.
- Notify the FDA through the FDA-Drug Quality Reporting System if appropriate at
- https://www.fda.gov/safety/medwatch-fda-safety-information-and-adverse-event-reporting-program

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Disposition of Medications	**Hospital Pharmacy**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to (Your Policy Here)

PROCEDURE:

Disposal of discontinued medications will be divided into two categories:

- All medications will be discarded into the Cactus Smart Sink. Controlled Substances will require a witnessing nurse or Pharmacist and documented in Pyxis and or on patient log sheet.
- When a residents' order is discontinued, the medications are disposed immediately by the nurse who receives (or is made aware of) the discontinued order.
- Used medication vials and inhalers will be discarded into the blue and white pharmaceutical incineration bins, which are collected by Environmental Services when full and taken to locked storage to be picked up weekly by a licensed hauler.

Pharmacy strives to dispense only single dose vials (SDV) whenever possible to limit waste. Multi-dose vials (MDV) may be treated as single dose vial and discarded following initial use in most cases. True MDV's are good until their beyond use date (BUD) after opening, or the manufacturer's expiration date, whichever comes first. Beyond use dates for injectables will be 30 days or less than 30 days according to the manufacturer.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Drug Recall	**Hospital Pharmacy**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to describe the process for handling drug recalls. By doing so we will prevent the use of recalled pharmaceuticals and process them appropriately.

PROCEDURE:

The following procedure will be carried out when merchandise is recalled by the manufacturer:

- The notification will be received by Pharmacy Services that such medication has been recalled for specified reason.
  - **Class I recall:** a situation in which there is a reasonable probability that the use of or exposure to a violative product will cause serious adverse health consequences or death.
  - **Class II recall:** a situation in which use of or exposure to a violative product may cause temporary or medically reversible adverse health consequences or where the probability of serious adverse health consequences is remote.
  - **Class III recall:** a situation in which use of or exposure to a violative product is not likely to cause adverse health consequences.
  - **Market withdrawal:** occurs when a product has a minor violation that would not be subject to FDA legal action. The firm removes the product from the market or corrects the violation. For example, a product removed from the market due to tampering, without evidence of manufacturing or distribution problems, would be a market withdrawal.
  - **Medical device safety alert:** issued in situations where a medical device may present an unreasonable risk of substantial harm. In some case, these situations also are considered recalls.

- All inventory, including floor stock, will be checked to see if the district has that item or lot number in question in all areas of the hospital or clinic.

Areas to check for recalls:
- Patient's cubicles
- Pharmacy Services
- ER medication and crash carts
- Acute medication and crash cart
- Clinic
- SNF Medication cart

- If recalled medication(s) are found, all stock from Pharmacy Services and other areas where the medications are kept will be removed.
- The procedure for returning or disposing of the medication(s) as requested by the manufacturer is followed.
- If the recalled item(s) in question, is not in stock, the recall sheet is kept for a two-week period so all shipments, either direct or from the wholesaler, can be checked. Then, it is filed under "Drug Recalls".
- If drug recalled is in stock, the amount to be returned is indicated on recall letter and dated, and then returned to manufacturer. The recall letter is filed under "Drug Recalls".
- The "Drug Recall Disposition" chart is completed (located in the Drug Recall file) indicating the method of disposition, etc.
- Recall Procedure:
  - Notify the pharmacist of the recall.
  - Pharmacy staff shall check for any balance on hand of the recalled medication and remove from all locations.
  - The pharmacist shall check patient profiles for recent dispensation of the recalled agent.

- The pharmacist shall notify the patient's physicians of the recall and discuss therapy alternatives.
- The pharmacist will complete a Quality Review Report (QRR), indicating the drugs and steps that were followed.
- The pharmacist will notify nursing and the medical staff to be alert to possible Adverse Drug Events.

- The Recalls, Market Withdrawals, & Safety Alerts Verification are available on FDA's website for three years at: https://www.fda.gov/safety/recalls-market-withdrawals-safety-alerts

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
End-of-Life Comfort Care	**Hospital Pharmacy**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to maintain the dignity of the patient through pain control and symptom control by supporting the best possible quality of life for patients living with a serious, chronic, or terminal illness.
Comfort Care begins when treatment or life-prolonging therapy is no longer curative, the patient or medical decision-making representative has agreed to this prognosis and the focus turns toward palliative or comfort measures. At this juncture, the Comfort Care order set will be initiated by the attending physician.

The hospital will ensure that the patient and family receive counseling regarding the interest and needs of the patient and family in a manner in which they can understand. If a health care provider does not wish to comply with his or her patient's request for information on end-of-life options, the health care provider shall transfer the patient to another health care provider that shall provide the requested information.

PROCEDURE:

This is accomplished by holding early discussions with patients and their families regarding end-of-life issues, their preferences of care and honoring their advance directives. The following

- Code status is addressed asap on admission.
- Educate and support patient and family on the disease process, treatment options, advance health care directives, and community support resources in a timely manner.
- Provide information about what behaviors to expect as patient progresses through the terminal stages of the disease as well as the grieving process. Instruct significant others as to the possible signs of approaching death:
    - Reduced level of consciousness
    - Reduced urine output
    - Cool, mottled extremities
    - Sometimes confusion or anxiety
    - Labored breathing or periods of no breathing
- End of Life Comfort Care orders implemented, if ordered.
- Medicated per physician's orders to maintain comfort.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Furnishing Medication Orders	**Hospital Pharmacy**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to provide adequate pharmacy services to meet the needs of the patients and institution, as determined by the Medical Staff Pursuant to Federal and State laws.

Drugs shall be administered by licensed personnel authorized to administer drugs upon the order of a person lawfully authorized to prescribe.

Medication dispensed to inpatients will be by the unit dose system when available (oral, IM, IV, Rectal). All medications are to be prepared from a physician's order.

Verbal orders will also contain the name of the person giving and the signature of the individual receiving the order. Verbal orders for administration of medications shall be received and recorded only by those whose scope of licensure authorizes them to receive orders for medication. The prescriber shall countersign the order within 48 hours.

PROCEDURE:

The following procedure to be followed in furnishing of medication orders.
Medications Orders:

- Provider enters all new medication orders into EMR.
- The pharmacist reviews the prescriber orders and interprets it to ensure accuracy and suitability of the dosage form, timing of medication administration, duplication, interactions, or allergies.
- The pharmacist clarifies any problems or questions on the order, consulting with the prescriber when necessary.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
General Medication Room Operations	**Hospital Pharmacy**

POLICY:

This policy of SHCHD is to provide adequate pharmacy services from our Medication Room to meet the needs of the patients of the District as determined by the Medical Staff pursuant to Federal and State laws. The hospital pharmacy is staffed by a registered pharmacist who is delegated the Director of Pharmacy and will attend Medical Error Reduction Program (MERP) meetings, Medical Staff meetings and other meetings as needed.
The pharmacist is responsible for operating the pharmacy efficiently and smoothly and will provide the best possible service to the patient in all areas of medication utilization. In the absence of the pharmacist, a fully qualified registered pharmacist will fill in and will be given the responsibility for the operation of the pharmacy services. The pharmacist will be supported by a pharmacy technician to properly conduct Pharmacy Services in compliance with the established guidelines.
General Medication Room hours are M-F from 8:00am -4:30pm. A registered pharmacist will be available 24 hours each day for consultation.
The District has established the following Policy and Procedures outlining the general operations of the Med Room and staff**.**

PROCEDURE:

See Crash Carts Policy
See Defective Medication Product Policy & Procedure
See Drug Recalls Policy & Procedure
See End of Life Comfort Care Policy & Procedure
See Furnishing Medication Orders Policy & Procedure
See High Risk Medications Policy & Procedure
See Investigational Drugs Policy & Procedure
See Impaired Licensee Policy & Procedure
See Medication Administration Policy & Procedure
See Medication Procurement and Administration Policy
See Medication Monitoring and Storage Policy
See Patient's Own Medications Policy & Procedure
See Prescription Policy & Procedure
See Pyxis Policy & Procedure
See Use of Illicit Drugs (Unaffiliated Persons) Policy & Procedure

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
High-Risk Medication	**Inpatient Pharmacy**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to implement strategies and safeguards for high alert medications. High-Risk Medications are medications that have an inherent narrow therapeutic index and/or have the potential to cause serious adverse events when not used appropriately.
Several strategies and safeguards are instituted to ensure high alert medications are procured, stored, ordered, prepared, dispensed, and administered safely.

PROCEDURE:

The following medications and medication classes have been identified as being high alert at our facility:

- Adrenergics (epinephrine, norephrineine)
- Anesthetic / Sedative (ketamine, propofol)
- Antithrombotics and specific anticoagulant agents (heparin, warfarin)
- Concentrated electrolyte solutions
- Hypertonic Solutions (NaCl 3%)
- Insulin (SC and IV)
- Neuromuscular blocking agents (succinylcholine, rocuronium)
- Opioids

To improve patient safety by proactively employing additional safety measures to protect patients from harm related to high-risk medications, which bear a heightened risk of causing significant patient harm when used in error.
Current risk reduction strategies for High-Risk Medications include:

- Limiting available concentrations of these medications
- Limiting available concentrations of these medications
- Using barcode technology at the patient's bedside
- Stocking smaller size vials
- Avoid stocking look-alike/ sound alike medications next to each other
- Using high-alert labels to identify high-risk medications
- Relevant and appropriate monitoring therapy (aPTT, INR)
- Improving access to information about these drugs (Lexi-Comp, Redbook in ER)
- Limit verbal orders for high-risk medication to true emergencies

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Impaired Pharmacy Licensee	**Hospital Pharmacy**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to adhere to all legislative requirements for handling chemical, mental, or physical impairment of Pharmacy Services staff and, theft, diversion, or self-use of dangerous drugs among licensed individuals employed or contracted with the District [B&P Code 4104(a)].

PROCEDURE:

In the event that the District administration reasonably suspects chemical, mental or physical impairment of a licensed pharmacy individual, or, of theft diversion, or self-use of dangerous drugs the procedure below will be followed as outlined below.

- Immediately send the employee for laboratory testing and place this person on Administrative Leave until further investigation is completed.
- Investigation will follow standard procedures as outlined in the Human Resources Manual for other breaches of policy. The individual may be disciplined, up to and including termination of employment or contract.
- The District shall report to the Board of Pharmacy within 14 days of receipt or development of the following information regarding any licensee employed by or contracted with the district to work with pharmaceuticals:
    - Any admission by a licensed individual of chemical, mental, or physical impairment affecting his/her ability to practice.
    - Any admission by a licensed individual of theft, diversion, or self-use of dangerous drugs.
    - Any termination of employment or contract of a licensed individual based on chemical, mental or physical impairment to the extent it affects his/her ability to practice.
    - Any termination of employment or contract of a licensed individual due to theft, diversion, or self-use of dangerous drugs.

DEFINITIONS:
None

SoHum Health

Subject: Loss and Diversion	Manual: Hospital Pharmacy

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to guide all SoHum Health activities related to loss, prevention, monitoring, and reporting of Controlled Substance Diversion. Controlled Substances are medications class, identified as Schedule II through V by the U.S. Drug Enforcement Agency (DEA) and/or applicable state law. Diversion means intentionally or without proper authorization using or taking possession of a medication or medical gas, including but not limited to theft, using, or taking a medication without a valid order or prescription, forging or inappropriately modifying a prescription, and taking possession of medication waste.

SoHum Health will investigate all reports of potential diversion, involving and cooperating with law enforcement as required. We will offer an intervention program to employees found diverting medications. Pharmacy, medical staff, nursing, administration, human resources, employee health, risk management, and security work together to create systems to prevent and/or detect drug Diversion of Controlled Substances. A coordinated interdisciplinary effort is necessary to ensure proper control of Controlled Substances and thorough investigation of Diversion.

PROCEDURE:

The prevention, detection, and reporting of drug Diversion is the responsibility of all SoHum Health employees.

- SoHum Health monitors activities related to prevention, monitoring, and reporting of Controlled Substance Diversion.
- SoHum Health will investigate all reports of potential diversion, involving and cooperating with law enforcement as required.
- If an individual becomes aware of, or suspects diversion is/has occurred, it is to be immediately reported for investigation to the Pharmacy Director, Human Resources Director, and the Chief Nursing Officer.
- Pharmacy and nursing will perform detailed audits on CS utilization & waste performed by the suspected employee.
- They will review the initial reported or observed event/behavior to determine what documentation and/or intervention is required.
- Suspected employees are sent for employee laboratory testing, assessed by a medical provider, and are placed on a temporary leave of absence.
- Additional actions that may follow include an interview with the employee, suspension and/or termination, and reporting of findings to required respective regulatory agencies.
- A root cause analysis of the incident will be conducted to assist in finding opportunities for improvement. An action plan will be developed, implemented, and evaluated as appropriate.
- If an investigation reveals that an employee on leave has diverted, they will be directed to Human Resources prior to returning to their respective departments.
- We will offer an intervention program to employees found diverting medications.

The following agencies must be formally notified within their specified timeline:

- The California Department of Health Services (Administrator or the CNO's responsibility).
- The Board of Pharmacy within 14 days using either the DEA Form 106 https:apps.deadiversion.usdoj.gov/ and the Pharmacy board email designated for reporting of CS Loss: DEA106@dca.ca.gov (Pharmacist's responsibility).

- The DEA will be notified directly via DEA Form 106 to report significant losses of Controlled Substances no later than one business day. The form can be found at https:apps.deadiversion.usdoj.gov (Pharmacist's responsibility - form DEA 106)
- The Chief of Staff (CNO's responsibility)
- The Chairperson of the Governing Board (Administrator or the CNO's responsibility)

DEFINITIONS:
None

Subject:	Manual:
Managing Temperature Excursion	**Hospital Pharmacy**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to (Your Policy Here)

PROCEDURE:

1) Take immediate remedial actions

Secure and quarantine affected stock

- Return to refrigerated storage any vaccine vials that have been exposed to temperatures outside of +2°C to +8°C
- For room temperature excursions quarantine the affected stock and attach a "DO NOT USE" label
- For fridge temperature excursions quarantine the affected stock within the fridge by attaching a "DO NOT USE" label

Rectify any obvious immediate cause

- Check obvious causes e.g. the fridge door having been left open or a power switch having been turned off
- Confirm the temperature is within range or has returned to the normal range and document. i.e. +2°C to +8°C and once documented,
- Reset the min/max fridge reading
- Where no obvious rectifiable cause can be identified, take the fridge out of use until an investigation into the cause of the excursion has been concluded. The fridge should be returned to use only once it has been confirmed to be functioning correctly.

2) Gather information

Establish the basics

Record as much as you can about the incident, for example:

- What happened overall
- How warm did it get
- How cold did it get
- The time period for the excursion

Record the details

- Complete the **Medication Storage Troubleshooting Record Form (see Appendix A) and retain for record keeping.**

3) Seek advice and inform

Contact Pharmacy

- Pharmacy will take appropriate action (contacting manufacturers) to determine whether these medications or preparations should be used, discarded, replaced, or re-dispensed.

4) Prevent reoccurrence

Train staff

Ensure staff are trained and competent for the fridge(s) being used.

Ensure the fridge is functioning correctly

To prevent reoccurrence of the temperature excursion, an investigation should be undertaken to identify its cause. Effective actions should be taken to address any causes identified. Areas for consideration within your investigation should include:

- Equipment – Is there a fault with the fridge or a thermometer? A refrigerator engineer may be required to review and correct technical faults with the equipment.
- Procedures – Are procedures for use of the fridge and management of the cold chain robust and clearly documented. Procedures may require updating if weaknesses identified have led to the excursion.
- Training – Are staff effectively trained against the procedures? Retraining of staff and assessment of their understanding in the use of the fridge and management of the cold chain may be required.

5) Record the outcome

All excursion incidences should be fully documented locally; as a minimum, record:

- The time and extent of the temperature excursion
- Details of the vaccines and batch numbers affected by the temperature
- Details of any advice taken and whom this was sought from
- Actions taken to prevent a future reoccurrence of the excursion

DEFINITIONS:

None

SoHum Health

Subject:	Manual:
Medication Administration	**Hospital Pharmacy**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to describe the basic elements of safe, efficient, medication administration at the highest standards of practice.

PROCEDURE:

- Active medications determined by the attending physician, prescribed by a lawfully authorized licensee, shall be administered.
- Medications are only to be administrated using the electronic MAR (EMAR).
- Patients shall be identified prior to the administration of all medications by verifying 2 patient identifiers. Identifiers include Name, Medical Record Number, Date of Birth, Phone Number, Social Security Number, Address, Photo)
- Only medications listed in the hospital formulary approved by the Medical Staff and approved non-formulary medications brought from home may be used for administration.
- Only licensed personnel shall prepare, administer, and document immediately AFTER each administration by the person who administered it.
- The administration documentation shall include details such as the patient's symptoms, route, time, effect, and signature.
- No one shall administer, prepare, or document for another licensee.
- Unlicensed persons may, under the direct supervision of a licensed medical personnel and demonstrated competence, may administer topicals not associated with treatment of eyes, ears, nose, mouth, or genitourinary tract during training or after completion of training.
- Medications are to be prepared for immediate use only. Preparation of doses for more than one scheduled administration at a time shall not be permitted.
- Injectable preparations must be administered within 1 hour from the start of the preparation time and 2 hours for oral preparation.
- Single dose vials shall be discarded immediately after use.
- Multidose injectables shall have a beyond use date per the manufacturer's expiration date or 28 days, whichever is sooner.
- Multidose tablets or liquids shall have a beyond use date of 1 year from opening.
- Medications shall be administered within one hour on either side of the time it is due for administration.
- Oral medications shall be witnessed by the administering nurse and not allowed to remain at the bedside.
- Medications supplied for one patient shall not be administered to another patient.
- If a medication is not administered, the licensee shall document it in the chart along with the cause.
- No samples will be administered to patients of the District.
- Investigational drugs must be authorized by the FDA for Emergency Use to be administered.
- Medication errors and/or 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.

Medication Administration Schedule

All scheduled medications will be administered as instructed below unless specified by the provider.

Daily - 0900	PO/IV meds
BID - 0900; 2100	PO/IV meds
TID - 0900; 1500; 2100	PO meds
QID - 0900; 1300; 1700; 2100	PO meds

Q6H - 0500; 1100; 1700; 2300	IV meds
Q8H - 0000; 0800; 1600	IV meds
QHS - 2100	PO/IV meds

Breakfast 0730 -- Lunch at 1200 -- Dinner at 1730

½ H AC- 0700; 1130; 1700
With Meals- 0730; 1200; 1730
½H PC- 0800; 1230; 1800
*Anti-seizure and pain medications given at evenly spaced timed intervals
*Thyroid medications (empty stomach meds) given 1 hour before first meal of the day 0600 as its absorption is decreased when taken with other medications or food.
* PPI's (Omeprazole, Pantoprazole) at 0700
*Ranitidine, Famotidine, and Metoclopramide at ½H AC 0700; 1130; 1700
*Ferrous sulfate/gluconate (Iron) given with meals
*MOM given 1 hour before or after PO medications as it may decrease the absorption of other PO medications.
*Daily Lantus or Basaglar given at 2100
*Warfarin daily doses will be scheduled at 1700 for accuracy of am labs

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Medication Monitoring and Storage	**Inpatient Pharmacy**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to ensure that all medications are secured, stored, and disposed of in accordance with state and federal Law, manufacturer guidelines, and clinical best practices. The Pharmacy department will routinely inspect medications located in each Patient Care Areas, Pyxis Technology, Emergency Carts & Kits. The Pharmacy is responsible for the storage, integrity, security, distribution, and dispensing of all medications in accordance with state and federal Pharmacy law.
Appropriate storage and monitoring of medications promote the availability of safe medications where and when needed, minimize the risk of medication diversion or adulteration, and to decrease the risk of potential medication errors.

PROCEDURE:

Monitoring of Medications

Pharmacy and nursing staff routinely inspects medication storage areas and removes expired, damaged and/or adulterated medications. Expired medications or those approaching expiration (30 days) will be returned to the pharmacy and placed in a designated location for processing by a reverse wholesaler. Pharmacy staff complete an inspection and assessment of each patient care area where medications are stored and dispensed.

Wireless Temperature Monitoring (Medication)

Wireless temperature monitoring will be used to track whether medications are exposed to temperature excursions which may impair integrity and potency. Engineering, Pharmacy, and applicable departments are notified of temperature excursions through an automated email.
All pharmaceutical refrigerators and freezers are connected to emergency power in the event power is interrupted. Pyxis Technology is connected to emergency power in the event power is interrupted. In the event these Technologies are unavailable, paper temperature logs will be utilized and retained.
Any medications identified or suspected to be exposed to temperature excursions will be quarantined until they are reviewed by Pharmacy staff to determine if they can be approved for administration. In the event of a temperature excursion, follow the *Managing Temperature Excursion Procedure and complete the Medication Storage Troubleshooting Record Form*.

Temperature Ranges

Controlled Room Temperature	20° to 25° C (68° to 77° F) 15° to 30° C (USP Excursions) NTE 40° C for 24 Hours (per USP)
Refrigeration	2° - 8° C (36° to 46° F)
Frozen	-25° to -10° C (-13° to 14° F)

United States Pharmacopeia (USP)10.30.60

"Controlled Room Temperature" indicates a temperature maintained thermostatically that encompasses the usual and customary working environment of 20 to 24 degrees C (68 to 77 degrees F); that results in a mean kinetic temperature calculated to be not more than 25 degrees C; and that allows for excursions between 15 and 30 degrees C (59 and 86 degrees F) that are experienced in pharmacies, hospitals, and warehouses. **Provided the mean kinetic temperature remains in the allowed range, transient spikes up to 40**

degrees C [104 F] are permitted as long as they do not exceed 24 hours. Spikes above 40 degree C may be permitted if the manufacturer so instructs. Articles may be labeled for storage at "controlled room temperature" or at "up to 25 degree" or other wording based on the same mean kinetic temperature. The mean kinetic temperature is a calculated value that may be used as an isothermal storage temperature that simulates the non-isothermal effects of storage temperature variations.

California State Pharmacy Law

4119.7 Health Care Facility; Inspection of Drugs; Furnishing Per Standing Orders, etc. (a) Notwithstanding any other law, a hospital pharmacy serving a health care facility licensed under subdivision (a) of Section 1250 of the Health and Safety Code may furnish a dangerous drug or dangerous device pursuant to preprinted or electronic standing orders, order sets, and protocols established under the policies and procedures of the health care facility, as approved according to the policies of the health care facility's governing body, if the order is dated, timed, and authenticated in the medical record of the patient to whom the dangerous drug or dangerous device will be provided. (b) **A health care facility shall store and maintain drugs in accordance with national standards regarding the storage area and refrigerator or freezer temperature, and otherwise pursuant to the manufacturer's guidelines. The health care facility's policies and procedures shall specify these storage parameters.** (c) An intern pharmacist under the direct supervision and control, as defined in Section 4023.5, of a pharmacist, may inspect the drugs maintained in the health care facility at least once per month. The health care facility shall establish specific written policies and procedures for inspections pursuant to this subdivision. (d) For purposes of this section, "health care facility" means a health facility licensed under subdivision (a) of Section 1250 of the Health and Safety Code.

Storage of Medications

At the time of initial purchase all products will be evaluated for required storage conditions prior to being stored into Pyxis. Controlled substances deliveries from a supplier, will be checked-in by the pharmacist. Medications will be stored accordingly to United States Pharmacopeia (USP), and/or manufacturer guidelines. Medications are stored in one of the following secure areas to prevent diversion or adulteration in accordance with state and federal laws.

- Hospital medications are stored inside the Medication Room located behind a locked door. Medications are available in unit dose form whenever possible. With the exception of bulk fluids, all medications are stored and distributed through Pyxis Technology. Emergency medications are stored Pyxis and in one of two Crash Carts located in the emergency department. The carts are locked with a seal at all times when not in use. The seal is inspected twice in a 24-hour period.
- Acute/Swing/Skilled Nursing Facility medications are stored in medication carts and refrigerator inside the Nurses' Station behind a locked door. They are also locked at all times, unless in use. Only authorized personnel (nursing and pharmacy staff) are permitted access to this room. Housekeeping will contact nursing staff for access for cleaning – nursing staff will remain present during cleaning. SNF overstock meds are to be stored separately based on external or internal routes. Overstock medications are to be stored separately from medications in use. The SNF and Acute/Swing medication carts may be taken into the hallway during a med pass. The cart must be locked each time a nurse leaves the cart unattended to go into a patient/resident room. At no time should the cart be left unattended if it is not locked. In addition, no medication may be left on top of the cart if it is unattended, even if it is locked. Emergency medications are stored in the Crash Cart in Room 109. This cart is locked at all times when not in use. The lock is inspected twice in a 24-hour period.
- Clinic medications are stored in a locked cabinet and a refrigerator at the Clinic Nurses' Station. The cabinet and the Nurses' Station are separately locked during the hours when the clinic is not open. Access to the cabinet is limited to Clinic Providers, Clinic Nurse Manager, Patient Care Coordinators, and pharmacy staff. This cabinet is kept locked, except during working hours. The Treatment Room door is also locked when the Clinic is not open. Additional medications for use in procedures are stored in a cabinet in the Treatment Room.
- Computed Tomography contrast agents such as Omnipaque and Visipaque for imaging stored in a locked cabinet in the computed tomography room.
- Staff will maintain the cleanliness of medication refrigerators and freezers located in each patient care area.
- Medications are handled and stored according to manufacturers' specifications, USP Guidelines

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Patient's Own Medication	**Hospital Pharmacy**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to abate the use of home medications while receiving treatment in the District by limiting its use to non-formulary items or unavailable medications which will result in delay of treatment. All efforts will be made to use the hospitals medication supply to ensure accuracy, consistency, and proper storage and handling of medication use.

PURPOSE:

The purpose of this policy is to describe the procedures for the use of medications brought into the District by a patient when a physician's order warrants it.

PROCEDURE:

- The procedure below outlines the steps taken:
    - Only non-formulary or out of stock medications with an active order can be used as home medication.
    - No medications will be administered which do not meet proper labeling or integrity requirements.
    - Prescription medications must be presented in a vial with the original label from the pharmacy to be accepted as a home medication. Loose tablets or unlabeled vials will not be accepted.
    - The physician or pharmacist shall verify the identity and integrity of all home medications prior to their drop-off for home medication use. If neither are available to verify a medication, a nurse may verify the medication through the use of Lexicomp's "Drug I.D." function.
    - Upon accepting home medications, the receiving nurse shall enter a Note in the patient's profile detailing which medications were received and when. Controlled medications shall be counted upon receipt, the quantity documented in the notes, and then placed in the Controlled Substances safe.
    - Once verified, their medications will be labeled with a yellow, "PATIENT'S OWN MEDICATION" sticker and initialed by the verifying agent.
    - ED home meds will be stored at the ED nurse's station.
    - Inpatient home meds will be stored in the appropriate cart (Swing or SNF) at the inpatient nurse's station.
    - Nurses are not to administer Home Medications that have not been verified.
    - If the directions stated on the home medication differs from current orders, a green, "NOTE DOSE STRENGTH" sticker shall be placed on the home medication to ensure accurate administration throughout their stay.
    - The medications will be marked in the electronic record as home medications to avoid improper charges.
    - A prescription shall be sent to the contracted pharmacy for the ordered medication. Home medications shall be used until the pharmacy furnishes the order and is available on site.
    - If a home medication is discontinued, it shall be placed in a security bag and sealed. A registration label with the patient's name shall be placed on the bag and kept in the appropriate drawer labeled for "Patient's own discontinued medications".
    - A label stating "MEDICATION FROM HOME TAKEN TO PHARMACY" shall be placed on the Personal Belongings Listing form as a reminder to review any home medications taken from the patient on arrival and return them upon discharge.

- Home medications for a controlled substance shall be recorded to include the name, quantity, and dates for accuracy. They will be stored inside the safe in the Nurse's Station. A signature is required for controlled substances dropped-off and picked upon discharge.
- If the stored medications have not been picked up within 14 days of discharge or in the unfortunate event the patient expires, pharmacy staff will destroy them appropriately in the pharmaceutical waste containers.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Prescription Pads	**Hospital Pharmacy**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to maintain control of provider prescription blanks to prevent fraudulent use. This policy will outline the procedure for the storage, issuance, use, and monitoring of the District's blank prescription pads is as following:

PROCEDURE:

- Ordering
  - Prescription pads will be ordered by the Operations Manager.
  - Prescription pads belonging to Emergency room providers will be stored in the med room.
  - Prescription pads belonging to clinic providers will be stored in a locked cabinet in the clinic manager's office.
  - Prescription pads are individualized for each provider and shall be used only by them.
  - Off-duty providers shall turn in their unused prescriptions pads to either the ER Nurse or Pharmacy Director who will store them until he/she returns.
  - Arriving physicians should contact the Pharmacy Director to retrieve their pad.
- Distribution
  - Each provider shall be given one prescription pad at a time.
  - Each provider is responsible for their own prescription pad. Pads must NEVER be left in a drawer in an exam room or in the ER.
  - When the pad is filled, the provider shall contact the Pharmacy Director, turn in the completed pad, and be issued a new one.
  - Final storage of the filled pads is the responsibility of the Pharmacy Director
- Use
  - All prescriptions must be written and signed in ink by a licensed independent practitioner authorized to prescribe medications.
  - A copy of the original shall be put into the patient's medical record rather than the carbon copy, which fades with time.
  - Carbon copies of the prescription pads shall be returned to the Pharmacy for storage when the pad is completed.
- Monitoring Loss or Theft
  - Loss or theft must be reported to the local law enforcement and create an incident report.
  - The physician shall report to the Department of Justice (DOJ) Controlled Substance Utilization Review and Evaluation System (CURES) program immediately after the discovery of the theft or loss. Email SecurityPrinter@doj.ca.gov
  - The physician shall notify the California State Board of Pharmacy at BOPcomplaint@dca.ca.gov
  - The physician shall notify the Medical Board by an email to complaint@mbc.ca.gov

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Procurement of Pharmaceuticals	**Hospital Pharmacy**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to obtain pharmaceuticals from reputable vendors to meet the needs of our residents and patients. SHCHD is a member of a group purchasing organization (GPO) and is therefore obligated to follow purchase agreements signed by the group.

PROCEDURE:

The following general specifications are considered in making the purchasing decisions:

- SHCHD shall strive to fully comply with the contracts and bid prices established by the District and the GPO.
- All drugs shall meet or exceed USP, NF or FDA requirements for potency and labeling.
- Ordering of products shall primarily be through the prime vendor relationship established by the District's contracts. Other items shall be ordered directly from the manufacturers as warranted.
- If a product is not available for the immediate needs of the patients, every attempt shall be made to prescribe, borrow, or purchase the product from either local hospitals or retail pharmacies.
- If all attempts are exhausted and a medication cannot be procured, the pharmacist shall call the physician and consult regarding alternative therapies.

DEFINITIONS:

None

SoHum Health

Subject:	Manual:
Pyxis Medication Maintenance and Access Procedure	**Inpatient Pharmacy**

POLICY:
N/A

PROCEDURE:

Maintaining Pyxis Formulary, Station Inventory, and Refilling Medications

- The pharmacy will replenish and monitor the MedStation inventories on a regular basis.
- The Pyxis Administrator will maintain the Pyxis formulary. MedStation inventories will be adjusted periodically based on usage patterns and the needs of the unit.
- The Pharmacy will print a Pick and Delivery Report and restock each Pyxis MedStation.
- Controlled medications will be dispensed from the Main Pyxis by the pharmacy staff and delivered to the ER MedStations.
- Outdate Tracking will be used on medications to track and replace expired medications.

Remote Access

The "Remote Manager" is used for medications that are stocked outside of the Pyxis MedStation in a refrigerator. These medications are tracked through Pyxis with a perpetual inventory.

Medication Access - Expire, Waste, Recall

- Unusable Controlled Substances (CS) will be immediately wasted with a witness.
- Expired CS Medications will be stored in an assigned Cubie in the Main Medstation under "ExpiredMeds" until they are processed via a Licensed Reverse Drug Distributer Pending Destruction by the Pharmacy Director.
- Recalled drugs will be segregated and stored an assigned Cubie in the Main Medstation under "ReCalledMeds" until they are ready to be returned.
- A Reverse distribution wholesaler will be utilized to process all expired and recalled medication for both Legend and CS Medications.

Refilling

- The Emergency Room Medstation is refilled throughout the day by the pharmacy staff from a scheduled report generated from Pyxis.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Pyxis	**Hospital Pharmacy**

POLICY:

This policy of SHCHD is to strictly manage access and privileges to the automated medication management system (Pyxis), ensure adequate security for medications that includes controlled substances, provide proper documentation of medication use, and maintain confidentiality of patient data.

PROCEDURE:
N/A

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Pyxis Technology Access Procedure	**Hospital Pharmacy**

POLICY:
N/A

PROCEDURE:

- The following SoHum Health staff are provided access to Pyxis in the Patient care area(s) in which they are assigned.
    - Registered Nurse
    - Licensed Vocational Nurse
    - Pharmacist
    - Pharmacy Technician
    - ER Physicians
- Information Technology (IT) reviews all Pyxis access modifications routinely to maintain the integrity of Pyxis Technology and medication security.
    - Pyxis will contain both Unit and Multi Dose medications. Certain multi dose medications will be treated as a single dose and discarded once opened and are identified upon dispensation with SDV or MDV.
    - Bulk fluids such as NaCl, D5W, Lactated Ringers, and fluids for reconstituting will be referred to as Floor Stock and not stored in Pyxis.
    - Some refrigerated medications will be available through Pyxis and their location in Pyxis will be designated "Remote Manager" with a Pyxis lock on the fridge.
    - There are 2 Medication Override groups assigned:
        - Basic
        - Critical Care
    - Use of Pyxis MedStations are restricted to removing medications for hospital, Swing, Skilled Nursing Facility and Clinic patients only. No medications may be removed for staff or visitors who are not registered patients. Medications are dispensed only on a valid order from a licensed practitioner.
        - The system prompts the user to remove the quantity appropriate to the medication order.
        - If the medication is not available at the current MedStation, the medication may be dispensed from another MedStation.
        - Override medications will appear on the Pyxis Override Report. Pharmacy staff will review this report to ensure that each override has a corresponding physician's order in Evident.
        - Any remaining balances in the Emergency Department from the use of injectable multi-dose vials will be returned to the Pyxis stock.
        - Oral multi-dose vials will be labeled with a Beyond Use Date then returned to a Remote/Tower of the Main Pyxis Medstation
        - If the patient is a resident, then a registration label with their name is placed on the medication and stored in the medication cart.
        - Medications not administered to a patient will be returned to the Pyxis return bin if the medication packaging is intact.
        - Medication wastage documentation is required whenever the complete unit dose removed from Pyxis is not being administered to the patient.
        - Controlled Substance removal and waste documentation requires a witness with Pyxis access.
        - All medication wastage should be documented at the time of removal, if it is known that only part of the dose will be administered to the patient.
        - If the amount of waste is unknown at the Pyxis removal, the user should return and document the portion wasted after administration with a witness. The waste must occur within 60 minutes of the medication administration.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Reporting Medication Errors and Adverse Events	**Hospital Pharmacy**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to report medication errors pertaining to the prescribing, administering, documentation of use of medications, and adverse reactions immediately to the manager on duty. Medication errors shall be researched to determine the root causes. State and federal agencies shall be notified according to statutory and regulatory requirements.

PURPOSE:

The purpose of this policy and procedure is to safeguard immediate care of patients in the case of a medication error or adverse drug reaction. It will enhance patient safety by identifying and also addressing errors and adverse reactions via a proper and timely approach. An RL Event will be completed for errors and that data collected will serve as continuous quality improvement for future deterrence.

PROCEDURE:
N/A

DEFINITIONS:
None