SoHum Health

Subject:	Manual:
Definitions of Healthcare Associated Infections	**Infection Prevention**

POLICY:

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

PROCEDURE:

The following guidelines will be used whenever a determination of healthcare associated infection is being considered within the facility's acute care, swing bed, or Skilled Nursing Facility departments:

General acute care and swing bed guidelines are titled "CDC/NHSN Surveillance Definitions for Specific Types of Infections," updated ~~January~~ 2025~~3~~. These were developed by the CDC and are available at the CDC website www.cdc.gov.

The Skilled Nursing Facility utilizes the revised McGeer Criteria for determination of healthcare associated infections. These guidelines are titled "Surveillance Definitions of Infections in Long-Term Care Facilities: Revisiting the McGeer Criteria" and were developed jointly by the CDC and Society for Healthcare Epidemiology (SHEA). They are also available at www.cdc.gov

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Glucometer Cleaning	**Infection Prevention**

POLICY:

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

PROCEDURE:

- The district uses Roche Accu-Chek GTS Data System ™, a CLIA-waived point of care blood glucose testing system. This system consists of a base unit, which is plugged into electrical power, and an individual patient bedside meter. There are three systems in the facility: one in the Emergency Room, one in the Hospital Nurses' Station, and one in the Rural Health Clinic. The meters are multi-patient use.

- In accordance with the California Department of Public Health and Center for Disease Control and Prevention guidelines, the facility uses the manufacturer's recommendations to clean the meters AFTER EACH PATIENT TEST. The inside of the base (where the meter is housed) is cleaned before each quality control testing.

- The base is NEVER taken into the patient room. The nurse should visit the patient, explaining that he/she will be doing a test. The appropriate site should be assessed at that time. The nurse returns to the glucose monitoring system and programs the machine, so the meter is ready to perform, placing a strip into the machine. The nurse takes the handheld meter into the patient's room and performs the test.

- Before the meter is returned to the base, it must be cleaned with an ammonium chloride product (Sani Cloth germicidal disposable wipe), being careful NOT to wet the meter-base connectors or base circuitry.

  Note: Although other cleaning products are approved by the manufacturer for use on this equipment, only Sani-cloths are approved by the EPA as being effective against Hepatitis B. **Never** use another product (i.e.: bleach, alcohol) and **Never** spray anything onto the meter that could get inside its circuits. If circuits get wet, immediately dry with a tissue.

- **Important**: the cleaning solution must remain **Wet** on the meter for three minutes. Reapply germicide with a fresh wipe if the first application dries before three minutes.

- Additional infection prevention guidelines when performing bedside blood glucose testing include:
  - Hand hygiene is performed by the nurse before and after testing.
  - Gloves are worn by the nurse during the procedure (perform hand hygiene after removing gloves)
  - A different lancet is used for each patient.
  - Used lancets and test strips are deposited in sharps containers.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Hand Hygiene	**Infection Prevention**

POLICY:

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

GUIDELINES:

Hand hygiene is required:

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

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

When to preferentially use soap and water to cleanse hands:

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

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

Artificial Nails:
Artificial nails harbor more organisms and are harder to clean than natural nails. Therefore, artificial nails for patient care staff are discouraged. However, because SHCHD has no high-risk areas (such as a Burn Unit or Neonatal Intensive Care Unit), artificial nails are not prohibited.
It is recommended that natural nail tips be no longer than ¼ inch.

Hand Lotions*:*
An important aspect of the Hand Hygiene program is ensuring that a high-quality hand lotion is readily available to patient care staff. Frequent hand hygiene removes natural oils from the hands and can lead to dryness, chafing, and fissuring of the skin. These breaks in the skin barrier are painful and discourage appropriate hand hygiene. They can also be portals of entry for bacteria.
Daily or more frequent use of hand lotion is strongly encouraged to prevent skin breakdown. Dermatitis or other skin problems that do not resolve with the regular use of hand lotion should be reported to the Infection Preventionist.

Hand lotion containers with pump dispensers are stocked in the ED, the Hospital Nurses' Station, and the Clinic. To prevent contamination, avoid touching the opening of the pump when dispensing lotion.
The use of personal hand lotion products brought from home is discouraged and carrying lotion containers in one's pockets is not allowed. These practices can result in contaminated containers and subsequently, contaminated hands.

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

Hand Hygiene Compliance Monitoring:
Staff adherence with recommended hand-hygiene practices is monitored as recommended by the CDC. When observations of compliance or non-compliance are made by Department Managers, immediate feedback to staff is required. Infection Control literature shows this to be an effective method for improving compliance. The Infection Preventionist reports data on staff performance to Medical Staff and Nursing Staff at least quarterly. Improving and maintaining staff compliance with the Hand Hygiene policy is the responsibility of Department Managers.

PROCEDURE:

Hand Hygiene Procedure with Alcohol-based Hand Sanitizer:

The purpose of alcohol-based hand antisepsis is to kill transient microorganisms on the hands.

- Use the metered dose of sanitizer received from the dispenser.
- Apply product to palm on one hand.
- Rub hands together.
- Cover all the surfaces of the hands and fingers, focusing on fingertips, fingernails, and webs of fingers until the hands are dry.

Hand Washing Procedure:
The purpose of hand washing is to remove dirt, organic material and transient microorganisms from the hands.

- Stand near wash basin but avoid touching it with the hands. Turn water on warm and wet hands and lower forearms with water.
- Apply soap.
- Vigorously rub the hands together for at least 20 ~~15~~ seconds generating friction on all surfaces of the hands and fingers. Be sure to include the backs of hands and fingers, and around the fingernails.
- Rinse hands and forearms under running water.
- Dry with clean paper towels.
- Use paper towels to turn faucets off.

Note: Please refer to individual department policy and procedure manuals for more specific policies related to that department in regard to hand hygiene.

DEFINITIONS:
None

SoHum Health

Subject: Infection Prevention Education	Manual: Infection Prevention

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to educate all staff, volunteers, contracted workers, and physicians in the basic principles and practices of infection prevention, as appropriate to their job description in this facility.

PURPOSE:

The purpose of this policy and procedure is to delineate the methods for education in infection prevention.

PROCEDURE:

- All newly hired employees will receive basic infection prevention information before their work assignment commences. This basic information is in online format, or DVD format. The online format will be provided by Human Resources Manager, or the DVD format by the Infection Preventionist.

  In addition, all new employees will complete the self-study and quiz on Influenza Vaccination at the beginning of the flu season.

- The infection prevention orientation will be completed by the new employee on the first day of employment. This information is contained in the self-study modules in Relias Information includes:

  - Infection Prevention Policies, including:
    - Community Acquired Infections (CAI)
    - Hospital Acquired Infections (HAIs)
    - Hand hygiene

  - Standard Precautions, including:
    - Personal Protective Equipment
    - Respiratory Hygiene
    - Cleaning and disinfection

  - Transmission Based Isolation Precautions
    - Airborne, including use of N-95 particulate respirator, if applicable
    - Contact
    - Droplet

  - Aerosol Transmissible Disease Exposure Control Plan

  - Bloodborne Pathogen Exposure Control Plan

- Each employee will attend an annual in-service update on infection prevention. This may be done in the form of presentation of information on storyboards, classes, DVDs, internet, or online. Completion of a post-test is required. The information presented is basically the same as a new employee orientation. The purpose of this is to reinforce previously learned knowledge. The information, is however, updated according to new standards and applicable laws.

- Periodic in-services: If at any time throughout the year it is determined there is a staff knowledge deficit in the area of infection prevention, an in-service will be provided as appropriate. This may be due to the introduction of new products, information from surveillance and prevention activities, new or changed

policies, or regulatory compliance issues. Training needs will be assessed by the Infection Preventionist to determine required in-services.

- Certain departments require specialized education. This is done by either/or both the Department Manager and the Infection Preventionist.
    - Environmental Services Department (EVS):
        - All new employees in the EVS Department will be educated in the following
            a. the role of the environment in infection prevention
            b. appropriate mixing and use of various chemical disinfectants
            c. more in depth education in isolation precautions
            d. waste management
            e. soiled and clean linen management
            f. donning and doffing of personal protective equipment
        - Continuing employees will have this information reinforced annually.
        - All employees who will be responsible for cleaning and sterilizing instruments and equipment must have specific training in this before they may do these procedures.

    - Laboratory personnel: It is assumed that laboratory staff, by the nature of their basic education in the laboratory sciences, know and understand the concepts of preventing the spread of disease via specimen vectors, understand standard precautions and use of personal protective equipment.

      All Laboratory Department will be educated in the following upon hire:
        - specific laboratory waste management streams
        - the district's method of monitoring refrigerator and freezer temperatures
        - preparation of cultures for the reference laboratory
        - review of bloodborne pathogen standard and aerosol transmissible disease standard
        - N-95 particulate respirator fit testing (performed by appropriately trained staff)
        - safe handling of sharps
        - donning and doffing of personal protective equipment

    - Nursing Department: All new nursing department employees will meet with the Infection Preventionist and be educated in the following upon hire (see attached Orientation Checklist). Annually, nursing department employees will be updated on:
        - N-95 particulate respirator fit-testing (performed by appropriately trained staff)
        - use of personal protective equipment (PPE).
        - hand hygiene

    - Radiology Department: All new radiology department employees will be oriented to Infection Prevention as per departmental orientation policy. Annually, radiology department employees will be updated on:
        - N-95 particulate respirator fit-testing (performed by appropriately trained staff)
        - use of personal protective equipment (PPE)
        - hand hygiene

    - Dietary Department: All new dietary department employees will be oriented to Infection Prevention as per departmental orientation policy. Annually, dietary department employees will be updated on:
        - use of personal protective equipment (PPE)
        - hand hygiene

    - F. Ambulatory Clinic: all new Clinic employees will be oriented to Infection Prevention as per departmental orientation policy. Annually, clinic employees will be updated on:
        - the use of the N-95 particulate respirator
        - use of personal protective equipment (PPE)
        - hand hygiene

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Infection Prevention Performance Improvement Program	**Infection Prevention**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to continuously improve activities related to infection surveillance, prevention, and control.

PURPOSE:

The purpose of this policy and procedure is to describe the components and organization of the Infection Prevention Program and its Performance Improvement plan.

SCOPE:

The program includes the acute care hospital, the distinct part skilled nursing facility (SNF), and the Community Clinic, encompassing each department or service that interacts with patients and employees including inpatient services, outpatient services, clinic services, and support services. The program interfaces in varying degrees with sterilization and disinfection, hazardous waste management, employee health, orientation, and education, environmental services, policies and procedures, traffic control, product selection, integration of new services or personnel, applicable laws, Public Health Department, medication use, nutrition services, laundry and linen services, and engineering. The Infection Prevention Performance Improvement Program is a component of the hospital-wide *Plan for Improving Organizational Performance*.

PROGRAM ORGANIZATION:

The Infection Prevention Program is the responsibility of the hospital Infection Preventionist (IP). The authority for instituting surveillance, prevention, and control measures lies with the Medical Staff. The Infection Prevention Program and all its accompanying policies and procedures are housed in the Infection Prevention Manual, available to all departments on the hospital computer system. In addition, many departments have policies and procedures which are specific to the activities of that department. These are located in each department's specific policy and procedure manual. The IP maintains a master copy of all hospital IP policies.

PROCEDURE:

Infection Prevention Function

The Infection Prevention function is performed by the Medical Staff. Its purpose is:

- To lend support and clinical/medical perspective to the program.
- To disseminate information to the other members of the medical staff.
- To approve surveillance techniques and hospital infection prevention policies including an annual review of all policies and procedures.
- To analyze trends in infection issues, including antibiotic resistance.
- To assist in the development of action plans for identified problems or when there are opportunities to improve care or reduce risk.
- To provide guidance and assistance for the purchase of equipment and agents pertaining to the sterilization or cleaning of hospital supplies and areas.
- To define which infections are hospital-associated and which are community-associated.
- To lend support and clinical/medical perspective to the employee health policies, concerns, trends, and problems.

Departmental Responsibilities

All individual hospital departments have responsibilities in the prevention and control of infection. These include:

- Adherence to all hospital-wide infection prevention policies/procedures.
- Development of policies and procedures specific to the areas served. These must be approved by the IP and the Medical Staff.
- Implementation and monitoring of the above policies to assure compliance.
- Notification of any suspected or defined infections in patients to the IP as soon as possible.
- Adherence to employee health policies regarding employees with communicable or infectious conditions.
- Assuring notification of Public Health authorities of any reportable condition, by reporting these to the IP promptly.
- Educational needs assessment of staff in regard to infection prevention issues, including on-going education.

Surveillance
SHCHD is a Critical Access Hospital (CAH) comprised of an acute care facility and a Rural Health Clinic (95-210). The acute care facility has nine acute beds and a "distinct part" 8-bed Skilled Nursing Facility. Historically:

- Infection rates are low.
- There is a predominantly geriatric population.
- Average length of stay is approximately three days for acute patients.

Due to the small size of the facility and historically low infection rates, total house (rather than targeted) surveillance is performed.

Although daily surveillance is the responsibility of the nursing staff and the IP, sentinel event notification is the responsibility of the individual who discovers the infection. However, charge nurses or department managers (in non-nursing areas) are ultimately responsible for reporting these events to the IP.

Infections acquired in the hospital are sometimes not evident until after discharge. Post-discharge infection surveillance is done by having physicians, clinic or ER personnel report any infections that occur within one week of discharge to the Infection Preventionist. The IP will contact the IP at the referring facility when a patient is admitted with an infection from the other facility.

Process Monitoring
A process measure focuses on a process or the steps in a process that leads to a specific outcome. Process monitoring is used to evaluate compliance with these infection prevention processes. The Infection Prevention program monitors hand hygiene, sterile processing procedures, and any other processes determined to warrant active monitoring. Process monitors are typically selected based on the identification of an infection risk (real or potential). Monitoring is done monthly or quarterly. Compliance rates are calculated and reported to the Quality Assurance Performance Improvement committee (QAPI) or the Medical Staff (depending on the particular process monitor) with direct feedback to frontline staff and department managers. QAPI measures are continuously assessed and modified using Plan-Do-Study-Act (PDSA) cycles and SMART goals: specific, measurable, attainable, realistic, and time-bound.

Infection Preventionist
The IP is a registered nurse with education and experience in principles and practices of infection prevention. All employee infections and patient infections are analyzed by the IP. Utilizing the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) definitions for community associated and hospital associated infections, the IP trends and presents the data to the Medical Staff as appropriate.

Follow-up recommendations and action plans recommended by the Medical Staff are the responsibility of the IP. Items requiring action are placed on a pending list by the Administrative Assistant and returned to the agenda for the next meeting. The IP is available as a resource to any department manager in the development of department-specific infection control policies. Public Health guidelines are made available to staff as needed. The Public Health Hotline is available for contacting Public Health as a resource or to report a reportable disease.

The IP position is 1.0 FTE position. Employee education is an important IP role. The IP is responsible for new employee orientation in infection prevention. Annual education in hand hygiene, healthcare associated

infections (HAI), personal protective equipment (PPE), blood borne pathogens (BBP), aerosol transmissible disease (ATD), and other infection prevention topics, as needed, is provided by the IP.

Department managers are responsible for ongoing educational needs assessment with consultation with the IP. Yearly mandatory updates are the responsibility of the Safety Committee.

Analysis and Reporting of Infection Data
Data from the various sources is analyzed by the IP. Rates are calculated and compared when possible, to the facility's historical benchmarks. When sufficient data exists to make meaningful comparisons, rates are also compared to benchmarks from national databases such as the NHSN. Department managers and the Medical Staff members receive the data to use in planning ongoing educational activities as well as to plan for improvement in patient outcomes. Infection data is reported to the following persons and/or entities:

- Specific and summary data is discussed at the Medical Staff, as appropriate.
- Infection issues that are safety related are presented to the Safety Committee by the IP.
- Infection issues that are nursing related are presented to the nursing staff by the IP.
- A report of infection prevention surveillance and performance improvement activities is presented to the Medical Staff and the Governing Board quarterly.
- As required by law, specific HAI data is submitted quarterly to NHSN with data access rights granted to the Centers for Medicare and Medicaid (CMS) and the California Department of Public Health (CDPH).

Evaluation, Review, and Revisions
As part of hospital-wide efforts toward continuous improvement, the IP Program is evaluated on a yearly basis, emphasizing the effectiveness of activities designed to reduce risk. Changes are made in the program as needed; an annual work plan is developed. Policies and procedures are reviewed and revised yearly, or as necessary, to ensure that they are current, applicable, and provide the guidance for which they were intended. Demographic data is collected by the IP on the patient and staff population to assist with determining the priorities for the next year. New services are assessed for IP intervention. Previous year's problems and areas for improvement are analyzed and a new plan for surveillance, risk reduction, and improvement is delineated yearly.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Influenza Immunization Program	**Infection Prevention**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to offer the influenza vaccine to all healthcare personnel (at no cost), patients, and residents annually.

PURPOSE:

The purpose of this policy is to outline the District's seasonal Influenza Immunization Program.

BACKGROUND:

Influenza (flu) is a viral infection of the respiratory system that can affect persons of any age. Outbreaks usually occur in the United States from November to April. Although most people are only ill for a few days, some, particularly the very young and the elderly and/or debilitated, may be ill enough to require hospitalization. Thousands of people die each year in the United States from flu and related complications. Viruses that cause flu frequently change (mutate) and immunity produced by the vaccine decreases over time. The Advisory Committee on Immunization Practices (ACIP) recommends that all healthcare personnel (HCP) should be vaccinated annually against influenza.

PROCEDURE:

Staff:
Influenza education will be provided to all staff annually at the beginning of flu season. A post-test will be completed and returned to the EHN. Education will include information about influenza illness (including signs, symptoms, mode of transmission, isolation precautions, diagnosis, and treatment), benefits of influenza vaccination and the potential health consequences of influenza illness for themselves and their patients.

Staff will be informed when the vaccine is available, and the Employee Health Nurse (EHN) will actively encourage vaccination. The most current Vaccine Information Statement (VIS) will be made available.

Depending on availability, direct patient care staff will have priority over non-patient care staff, as the Centers for Disease Control and Prevention (CDC) recommends that healthcare workers who can spread the influenza to high-risk patients be among those who receive the vaccine as soon as it is available.

A Consent/Declination form will be signed by all healthcare personnel, including contract staff, volunteers, and students. District employees will have this form kept in their Employee Health file.

The vaccine is routinely administered by the EHN and Infection Preventionist. It is also available at the SHCC clinic. Every effort will be made to offer the vaccine at times convenient for staff, including weekends and evenings when needed.

The EHN will maintain a list of all staff consents and declinations. Persons who decline the vaccine may, at any time, rescind that declination and be immunized, if vaccine is still available.

Annually, at the end of influenza season, the EHN will report aggregated vaccination data to the California Department of Public Health as required by law. Reporting is done through the National Healthcare Safety Network (NHSN) reporting system. The EHN will also report the overall influenza vaccination rate to the Medical Staff.

Residents and Patients:
When the vaccine is available, residents of the Skilled Nursing Facility and Swing bed units (or their

guardians) will be informed. A consent form must be obtained. This is coordinated by the Infection Preventionist. A physician order is not needed.

Vaccine Dosage and Administration
The recommended dosage for adults is 0.5 ml intramuscularly. The deltoid is the preferred site.

Warnings, Precautions, Contraindications
The vaccine is contraindicated for persons with a history of severe allergic reaction to the vaccine or any of its components. Most, but not all, types of flu vaccine contain a small amount of egg protein.

Persons with a past history of Guillain Barré syndrome should consult with their doctor before being vaccinated.

Adverse Reactions
May include:

- Less than 1/3 of individuals vaccinated experience soreness for up to 2 days at the injection site.
- Fever, malaise, and myalgia may affect persons who have had no exposure to the virus antigens in the vaccine. Symptoms may last up to 2 days.
- Immediate allergic reactions such as hives, allergic asthma, or systemic anaphylaxis are extremely rare. Epinephrine (1:1000) should be available for immediate use should an anaphylactic reaction occur.
- Guillain Barré syndrome (GBS): There may be a small increased risk of Guillain-Barré Syndrome after receiving inactivated flu vaccine. This risk has been estimated at 1 or 2 additional cases per million people vaccinated.
- Serious adverse reactions should be reported to the "Vaccine Adverse Event Reporting System" (VAERS) via their web site (vaers.hhs.gov) or by calling 1-800-822-7967.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Pre-Hospital Emergency Personnel Exposures to Infectious Diseases	**Infection Prevention**

POLICY:

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

DEFINITIONS:

Pre-hospital emergency medical care personnel: per California and federal law, these are mobile intensive care nurses (MICN), emergency medical technicians (EMT), paramedics, lifeguards, firefighters, peace officers, physicians, pre-hospital volunteers, and all others as delineated by law. Per federal law, these individuals are called "emergency response employees" (EREs).
Reportable disease or condition: In California, these diseases are listed in California Code of Regulations, Title 17, Section 2500 Federal Law divides these into four categories and lists them in 76 Federal Register 67742 Refer to the Mandatory Disease Reporting policy.
Designated Officer (DO): Federal law requires each state's Public Health Officer to designate an official or officer of the employer of the ERE as the DO. This is the person to whom the ERE reports a possible exposure, and to whom the hospital reports an infectious condition. In California, the employer, rather than the Public Health Officer, designates this person.

PROCEDURE:

- **Notification to the hospital of a potential exposure by emergency personnel**: If an Emergency Response Employee (ERE) believes he or she may have been exposed to an infectious disease, the ERE must provide his/her name and telephone number to the receiving hospital *at the time the patient is transferred from their care* to the admitting health facility. If he/she later determines there may have been an exposure, the ERE should request that his/her DO review the circumstances surrounding the potential exposure. If the Designated Officer (DO) determines that the ERE may have been exposed to one (or more) of these infectious diseases, the DO must submit a request for response to the hospital to which the patient was transported. This request must be in writing, contain a statement of the facts surrounding the circumstances of the potential exposure, and be signed by the DO.

- **Evaluation and Response by the hospital to a Notification of Exposure:** When the hospital receives a request for a response, the hospital must determine 1) if the ERE was or was not exposed to one of the specified infectious diseases, 2) that the hospital lacks sufficient medical information to determine whether or not the patient had a listed infectious disease, and/or 3) if there are sufficient facts in the request to determine whether or not the ERE was exposed to an infectious disease. As additional information comes to light, re-evaluation by the hospital is required.

According to California law, the hospital must notify the County Public Health (PH) Officer whenever it receives a request for response to a potential exposure to an infectious disease, and it is the PH Officer who contacts the DO. Federal law requires the hospital report to the DO. Therefore, the hospital must communicate clearly with the County PH Officer to determine who will contact the DO, as it is required to be done in writing as soon as practicable, but not later than 48 hours after receiving the request. Notification should include the name of the infectious disease involved and the date on which the patient was transported by the ERE to the hospital, or the fact that there was no exposure to an infectious disease. Per confidentiality laws, **no other information should be released.**

If the DO requests, he/she may ask the County PH Officer to review the data the hospital used for a determination and make an independent determination of the exposure. The County PH Officer may submit a

request to the hospital for a re-review. The hospital must re-review the facts and provide the DO with an appropriate response.

- **Notification of Exposure by the hospital to a DO:** The hospital must initiate notification to the DO of an ERE, as well as the county PH Officer, upon determining that the person provided care by the ERE has been diagnosed with a reportable communicable disease or condition that may have been transmitted during the provision of care. This notification must be made immediately if the reportable communicable disease or condition has an urgency reporting requirement on the list of reportable diseases or conditions, or if the conditions of the exposure may have included direct contact between the unprotected skin, eyes, or mucous membranes of the ERE and the blood of the person afflicted with the reportable disease. If the reportable disease does not meet these criteria, the health facility infection control officer must notify the DO consistent with Title 17 of the California Code of Regulations section 2500. The hospital must inform the DO of the name of the reportable communicable disease or condition involved, and the date on which the patient was transported by EREs to the hospital. No other information, including the name of the patient, should be released. If the required notification to the DO is made by mail; the hospital must inform the DO that the notification has been sent; the DO must, within 10 days, inform the hospital whether the notification has been received. If the patient dies at or before reaching the hospital, the medical facility ascertaining the cause of death (such as the coroner) must make the required notification.

- **Limitations of the Hospital's Responsibilities:** The duties of the hospital terminate at the end of the period during which the facility provides medical care to the patient for conditions arising from the emergency, or at the end of the 60 day period beginning on the date on which the patient is transported by EREs to the facility, **whichever period is shorter,** except that the facility's duties will continue if a request is received within 30 days of the applicable period. The hospital is not required to test patients for any infectious disease. The hospital is not required, and not permitted, to disclose identifying information with respect to a patient or an ERE.

- **Additional Information:** If an ERE claims an exposure and requests care from the Emergency Room, he/she must be registered as an ER patient and seen as a worker compensation case. Billing is made to the ERE's employer and a Doctor's First Report must be completed as appropriate. There should be NO mention of the source patient's name or medical record number on the ERE's ER Record. The ERE should be referred to his/her private physician for follow-up testing; it is not the responsibility of the hospital to see that this is completed.

Testing done on the source patient is noted on his/her medical record with an indication that it is being done due to a "caregiver exposure," without mention of a name or position of the caregiver in the source patient's medical record. Most insurances cover the cost of these tests.

It is the responsibility of the Infection Preventionist (IP) to report to the County PH Officer and/or the DO as appropriate. In the event the IP is not available, and reporting would be beyond the required timeframe, the ER staff should contact the ER Nurse Manager or the Chief Nursing Officer to assure timely reporting.

SoHum Health

Subject:	Manual:
Contract Laundry Services	**Infection Prevention**

POLICY:

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

PROCEDURE:

- On-site visits will be made to the contract laundry service by the Infection Preventionist on an as needed basis.
- The purpose of the visit is to assure compliance with all applicable laws and standards. California Administrative Code Title XXII, Section 70825, Laundry Service, defines parameters for hospital laundry services. Item (a)(8) indicates that when a hospital does not have its own laundry, the commercial laundry utilized shall meet the provisions of this section.
- The visit will consist of a walkthrough of the facility including intake areas, wash areas, drying areas, folding areas, storage areas, and transport vehicles. Each of the points listed in Section 70825 will be reviewed and discussed with the service manager. Concerns will be discussed at the time of the visit and a preliminary plan for correction will be formulated.
- The Infection Preventionist will send a written report of findings to the laundry service manager within two weeks of the visit. It will reiterate the action plans discussed at the visit.
- A repeat visit to the laundry to assure compliance will be at the discretion of the Infection Preventionist. If a follow-up visit determines that the service is not in compliance, the Infection Preventionist will discuss these concerns with the service manager and indicate that non-compliance will be reported to the District Administrator immediately. The Administrator will contact the manager to discuss the situation. If necessary, the Administrator will direct that other arrangements be made for the provision of laundry services.
- Hospital linen service personnel will informally monitor the quality of the service provided by the contract laundry service. Any concerns noted in regard to cleanliness or non-compliance with applicable laws and standards should be brought to the attention of the Manager of the Operations, and ultimately to the Infection Preventionist who may initiate in-house monitoring or scheduled/unscheduled visits of the laundry facility as appropriate.

DEFINITIONS:
None

SoHum Health

Subject: Guidelines for Patient Placement	Manual: Inpatient Prevention

POLICY:

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

PROCEDURE:

- There are three basic choices when placing patients known or suspected to be infected with transmissible, disease-causing organisms.
-
    - Best option: Potentially infectious patients should be placed in a private room whenever possible.
        - Patients requiring droplet or airborne precautions must be placed in a private room or cohorted with someone with same respiratory pathogen (see next section).
    - Second best: When a private room is not available, an infected or colonized patient can be placed with another patient having the same organism. This is called "cohorting" and is done to confine care to one area and prevent contact with other patients. It is acceptable as long as neither patient is known to have additional organisms that could put the roommate at risk. For example, if one patient has MRSA and a second patient has MRSA and VRE (or any other MDRO), they should not be roomed together.
        I. Cohorting can be especially useful in an outbreak situation when several patients have the same illness. (e.g. influenza or COVID-19)
    - Third option: When neither of the first two options is possible, the infected patient can share a room with a patient whose risk of infection is low. The goal is to avoid pairing the infected or colonized patient with a patient at high risk for infection. If possible, avoid placing an infected or colonized patient with a roommate who has the following:
        - Factors that increase infection risk for the non-infected patient include the following:
            1. Immunosuppression (resulting from chemotherapy, leukemia, AIDS, or other conditions)
            2. Severe illness, debilitation
            3. Breaks in the skin such as surgical incision or open wound
            4. Presence of invasive devices such as central lines, indwelling urinary catheters, or dialysis access devices.
            5. Extremes of age (very old or very young)
        - The infected or colonized patient's potential infectiousness should also be assessed as described in the next section.
- When deciding the placement of an infected patient consider patient-specific factors that promote or minimize transmission risks regardless of the specific infecting organism.
    - Patient-specific factors that increase the risk of transmission for infections, especially those spread by contact, include inability to follow instructions, the presence of draining wounds, incontinence, diarrhea, and other uncontrolled secretions.
        - Example: A private room with separate handwashing and toilet facilities is highly recommended for patients infected with an organism transmitted by contact (e.g., MRSA) if that patient has poor hygienic habits, cannot follow instructions, or cannot be expected to assist in maintaining infection control precautions. This applies to children and patients with altered mental status or dementia.

        - Conversely, a patient that is infected with an MDRO (e.g., MRSA) but has no draining wounds and is willing and able to perform hand hygiene represents a relatively low transmission risk.

- Refer to the Transmission-Based Precautions policy and the MDRO policy to determine whether isolation precautions (contact, droplet, or airborne) are indicated for a particular patient.

    - The district does not have a reverse airflow room. Patients who require "Airborne Precautions" will be transferred to an appropriate facility as soon as possible. While awaiting transfer the patient will be placed in a private room with a Hepa filtration unit running and the door kept closed at all times.

- Criteria permitting placement of MDRO **colonized** patient with a **non-colonized** roommate:

    - The non-colonized resident is not immunosuppressed, does not have broken skin (including fresh post-operative wounds), and does not have indwelling lines such as a central line or foley catheter.
    - Both roommates are able to clean their hands.
    - Neither roommate has a draining wound.
    - The colonized patient is not incontinent of urine or feces, particularly if colonized by organisms that are shed in the stool such as multidrug-resistant gram negative rods (e.g.,ESBL) or vancomycin resistant enterococcus (VRE).

- When there is a history of multidrug-resistant organisms, avoid rooming the patient with anyone at high risk for infection (see list above) unless current colonization can be ruled out by laboratory screening. Refer to the MDRO policy for additional guidance.

DEFINITIONS:
None

SoHum Health

Subject: Isolation Supplies	Manual: Infection Prevention

POLICY:

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

PROCEDURE:

- When a patient is suspected to have a contagious or infectious condition that requires transmission-based precautions ("Isolation") in addition to standard precautions, nursing staff will follow the guidelines set forth in the policy, "Transmission-Based Isolation Precautions" located in the Infection Prevention Manual. The addendum to that policy lists the various conditions and the appropriate precautions required for each.

- Infection Prevention supplies available in each room at all times include:
    - Exam gloves
    - Sharps containers
    - Alcohol-based hand sanitizer
    - Hand washing sink and soap
    - Disinfectant wipes

- To facilitate isolation procedures, an Isolation Cart is stocked and available for use. The cart is placed outside the patient room until the precautions have been discontinued.
    - Never discontinue isolation precautions without the knowledge and agreement of the Infection Prevention nurse.
    - To assure that isolation supplies continue to be available, nursing staff will notify Materials Management staff when a patient is put into Isolation and inform them of the type of isolation.
    - For patients on Contact Precautions, anything that goes into the isolation room should stay in the room if possible.
        - Try to dedicate patient care equipment to that patient and room for the duration of precautions.
        - Use disinfectant wipes to clean any equipment that must be left in the room and used for other patients.
    - Contents of the Cart:
        - Top of Cart: disinfectant wipes and exam gloves
        - 1st drawer: Isolation signs and extra gloves
            1. The appropriate sign is attached beside the door on the wall outside the patient's room.
            2. Signs are available for Droplet Precautions, Full Contact Precautions, Modified Contact Precautions, ~~and~~ Airborne Precautions and enhanced barrier precautions.
                a. This facility does not have a reverse airflow isolation room, so true Airborne Precautions cannot be accomplished and patient must be transferred to an appropriate facility ASAP.
        - 2nd drawer: Temp-A-Dots, disposable BP cuffs and/or reusable isolation BP cuff and manometer, isolation Stethoscope, surgical/procedure masks and mask/face shields, Eye protection, N-95 respirators
        - 3rd drawer: Isolation gowns, yellow bags for soiled linen.
    - Back of cart: Correct sequence for donning and doffing PPE, Instructions for use of Temp-A-Dots

- When Patient has been discharged or moved
    - Notify Environmental Services (EVS) inform that a terminal cleaning of the room is needed, including laundering of privacy curtains.
    - The isolation sign and cart should remain in place until the room cleaning has been completed
    - Wipe down the cart with germicidal wipes
    - Wipe down the isolation sign, stethoscope and BP cuff/manometer with germicidal wipes, allow to dry, and return them to the proper drawers
    - Place a "CLEAN" tag on the cart
    - Fully restock the cart so that it's ready for its next use
    - Return it to its storage location.

DEFINITIONS:
None

SoHum Health

Subject: Laundry Services (On Site)	Manual: Infection Prevention

POLICY:

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

PURPOSE:

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

DEFINITIONS:

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

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

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

PROCEDURE:

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

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

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

- Normal laundry cycles are to be used in accordance with the washer and detergent manufacturer's recommendations.
- Resident laundry and other washable medical devices will be laundered following Centers for Disease Control (CDC) and/or manufacturer recommendations.
    - Use of hot water of at least 160 degrees F (71 degrees F) for a minimum of 25 minutes unless manufacturer recommendations state otherwise.
    - Disinfectant is generally not needed when soiling is at low levels.
    - Use of disinfectant will be on a case-by-case basis, depending on the origin of the soiled linen (e.g., linens from an area on contact precautions).
    - Damp textiles will not be left in machines overnight.

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

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

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

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

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

SoHum Health

Subject:	Manual:
Linen Handling	**Infection Prevention**

POLICY:

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

PROCEDURE:

- Soiled Linen
  - All soiled linen shall be handled with gloves and bagged at the site of collection in impervious yellow plastic bags by nursing.
  - Handle soiled linen with a minimum of agitation to prevent potentially infectious aerosols (never shake).
  - Do not sort or rinse soiled linen at the place where it was used.
  - If the linen is very wet, it may be necessary to double bag it to prevent leakage.
  - Close yellow bag, remove gloves, and perform hand hygiene. Take the bag to the department's soiled linen container, holding the bag away from the body. Perform hand hygiene.
  - Soiled linen in isolation rooms is treated the same as linen in non-isolation rooms.
  - Radiology, Acute, SNF and Emergency Room departments: when the department's soiled linen bag is full, close it and place it in the linen hamper in the soiled linen closet on the acute side.
  - Soiled linen bags will be removed from the soiled linen closet by contract linen personnel for transport to the off-site laundry facility on their scheduled days (Mon-Wed-Fri).
  - In the Clinic and Physical Therapy there is a soiled linen container that is removed by the contract linen personnel during regular pick-up times.
  - District personnel shall receive training regarding the handling of clean and soiled linen, consistent with the OSHA Bloodborne Pathogen standards, which includes the use of gloves when handling soiled linen.
- Clean Linen
  - All clean linen is returned to the facility by the contract laundry personnel. It is delivered by cart, wrapped and covered, to the clean linen room. Hospital staff place the clean linen in the two linen closets and the Emergency Room. The linen cart is to be empty for the next delivery of clean linen.
  - Staff should take only the amount of linen into a patient's room that is needed for that day. Upon discharge, all leftover linen in the patient's room is considered soiled and must be sent to the laundry.
  - Sheets sent by the contract linen service that do not fit the District's beds, will be placed in a separate container to be returned to the laundry service.
  - Linen that is torn or otherwise unusable should be held for the Director of Operations as some of this linen belongs to the District and other belongs to the laundry service. Torn linen should not be returned to the laundry service as "dirty" linen because the District will be charged for it and it might continue to be returned as is.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Mandatory Disease Reporting	**Infection Prevention**

POLICY:

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

PROCEDURE:

All healthcare providers are required by law to report known or suspected cases of specific diseases or conditions to the jurisdiction in which the patient resides. The required reporting format is the California Morbidity Report (CMR).

- CMRs that require immediate reporting must be called into Public Health within one working day. Reports on Clinic or Emergency Room patients will be completed by whomever is made aware of the reportable condition, the Clinic Nurse or ER Nurse, respectively.
- CMRs that require reporting within seven (7) calendar days will be done by the Infection Control Nurse.
- The laboratory will send copies of all appropriate laboratory results to the Infection Control Nurse who uses this data to determine who requires a report.
- Some conditions may be diagnosed and reported before laboratory results are available or may not require verification by laboratory tests.
- An Online form is available at http://www.humboldtgov.org/DocumentCenter/View/52309 Additional forms for reporting can be found http://humboldtgov.org/DocumentCenter/Index/2967 These forms must be printed and faxed to (707)445-7346. The current timeline for response can be viewed in the link provided.

Title 17, California Code of Regulations (CCR) §2500 2812 requires that healthcare providers report known or suspected cases of disease or condition, listed below, to the jurisdiction in which the patient resides. Failure to report is a misdemeanor (Health & Safety Code §120295) and is a citable offense under the Medical Board of California Citation and Fine Program (Title 16, CCR, §1364.10 and 1364.11).

DEFINITIONS:

None

SoHum Health

Subject:	Manual:
Respiratory Hygiene or Cough Etiquette	**Infection Prevention**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to follow Respiratory Hygiene/Cough Etiquette practices as recommended by the Centers for Disease Control and Prevention (CDC) to limit the spread of infectious organisms from persons entering the facility with possible respiratory infection.

BACKGROUND:

In 2007, the CDC incorporated Respiratory Hygiene and Cough Etiquette practices into Standard Precautions. These interventions are targeted at patients and visitors with respiratory symptoms and apply to any person entering a healthcare setting with signs of respiratory illness including cough, congestion, rhinorrhea (runny nose), or increased production of respiratory secretions. To be effective, these infection control measures need to occur at the first point of entry within the healthcare setting and maintained throughout the duration of the visit.

PROCEDURE:

Respiratory Hygiene/Cough Etiquette

- The following measures to contain respiratory secretions are required for all individuals with signs and symptoms of a respiratory infection.
    - Cover the nose/mouth when coughing or sneezing.
        - Cough or sneeze into a sleeve, **not** into hands
    - Use tissues to contain respiratory secretions and dispose of them in the nearest waste receptacle after use.
    - Perform hand hygiene after contact with respiratory secretions or contaminated surfaces as described below.

- Materials for adhering to Respiratory Hygiene/Cough Etiquette are available in waiting areas and at entrances for patients and visitors:
    - Tissues and no-touch receptacles for used tissue disposal.
    - Hand Hygiene
        - Hand hygiene is performed after having contact with respiratory secretions or contaminated objects/materials.
        - Hand wash with soap and water or use alcohol-based hand sanitizer if hands are not visibly soiled.
        - Hand sanitizer is readily available at every facility entrance on the Respiratory Hygiene stands and is available in wall mounted, touch-free dispensers throughout the facility.
    - Respiratory Hygiene stations are located at all three public entrances and the employee entrance.
        - These stations are stocked with a Respiratory Hygiene instruction sign, tissues, masks, and alcohol hand sanitizer.
        - Environmental Services or material management stocks the stations daily.

- Visual Alerts (signage)
    - Signs are posted at the entrances to the Emergency Room, Skilled Nursing Facility, and outpatient Clinic instructing patients and persons who accompany them (e.g., family, friends) to inform healthcare personnel of symptoms of a respiratory infection when they first register for care.
    - Each Respiratory Hygiene station has a sign with instructions to cover coughs, contain secretions with

tissue, wear mask if respiratory symptoms present and perform hand hygiene.

- Masking and Spatial Separation of Persons with Respiratory Symptoms
  - Masks are offered to persons who are coughing.
    - Especially during periods of increased respiratory infection activity in the community (e.g., when there is increased absenteeism in schools and work settings and increased medical office visits by persons complaining of respiratory illness)
  - Either procedure masks or surgical masks may be used to contain respiratory secretions
    - Respirators such as N-95 or above are not necessary for this purpose.
  - When space and chair availability permit, Nursing and Registration staff will encourage patients or visitors with respiratory symptoms to sit at least 3 feet apart from other people in common waiting areas (e.g., ER, Clinic, Lab/Radiology). Distance may be increased to 6 feet apart during COVID-19 pandemic or increase in local COVID-19 rates of transmission.
  - Healthcare personnel (HCP) with respiratory illness should avoid providing direct patient care.
    - If cleared by Employee Health or Infection Prevention to provide direct patient care, HCP with respiratory signs or symptoms will wear a barrier mask.

- Droplet Precautions
  - Healthcare personnel will observe Droplet Precautions (i.e., wearing a surgical or procedure mask for close contact) in addition to Standard Precautions, when examining a patient with symptoms of a respiratory infection, particularly if fever is present.
  - These precautions should be maintained until it is determined that the cause of symptoms is not an infectious agent that requires Droplet Precautions.

During ~~COVID-19 pandemic,~~ an increase in local respiratory illness rates such as COVID-19, influenza and RSV rates of transmission, or other times deemed necessary by the local health department, California Department of Public Health, or Centers for Disease Control, masks may be required regardless of respiratory symptoms.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Safe Injection Practices	**Infection Prevention**

POLICY:

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

PROCEDURE:

The following procedures apply to the use of syringes, needles, cannulas that replace needles, and intravenous delivery systems.

- Medication preparation and withdrawal
    - Perform hand hygiene (hand washing with soap and water or use of alcohol-based hand rub) prior to medication preparation and administration.
    - Injections and infusions are prepared using aseptic technique in a clean area free from contamination or contact with blood, body fluids, or contaminated equipment.
    - Disinfect the rubber septum on all vials prior to each entry, even after initially removing the cap of a new, unused vial.
    - Disinfect the neck of glass ampuls with a 70% alcohol swab before inserting a needle or breaking the ampul.
    - Disinfect catheter hubs, needleless connectors, and injection ports before accessing.
        - Vigorously apply mechanical friction with a 70% alcohol swab
    - Draw up medication into a syringe as close to administration time as feasible.
        - Inject within 1 hour (or as soon as feasible) after drawing up the medication.
    - Label all syringes containing medication if not immediately administered.
        - Include patient identification information, names, and amounts of all ingredients, and the name or initials of the person who prepared it.
    - Use a filter needle or filtered transfer device to draw medications from an ampule into a syringe to prevent glass shard and/or potential microbial contamination.
    - Never leave a needle in the septum of a medication vial for multiple medication draws.
        - This provides a direct route for microorganisms to enter the vial and contaminate the fluid.
    - In certain circumstances (e.g., when reconstituting medications or vaccines) more than one vial may need to be entered with the same syringe and needle.
        - In these circumstances, aseptic technique must be followed, and reconstitution should be performed in a designated clean medication area that is not adjacent to areas where potentially contaminated items are placed.

- Proper use of sterile, single use items
    - Needles, cannula, and syringes are sterile, single-use items.
        - They should never be reused for more than one patient.
    - Consider a syringe or needle/cannula contaminated once it has been used to enter or connect to a patient's intravenous infusion bag or administration set.
    - Never administer medications from a single syringe to multiple patients, even if the needle or cannula on the syringe is changed.
    - Use fluid administration sets (intravenous bags, tubing, and connectors) for one patient only.

- Never use a container of IV solution (bag, bottle) to obtain flush solutions for more than one patient.
- Use single-dose vials for parenteral medications whenever possible.
- Do not administer medications from single-dose vials or ampules to multiple patients or combine leftover contents for later use.

- Multi dose vials
  - If multi dose vials must be used, both the needle or cannula and syringe used to access the multi dose vial must be sterile.
    - Enter the vial with a new needle and a new syringe even when obtaining additional doses for the same patient.
  - Multi-dose vials must be dated when they are first opened and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial.
  - Dedicate multi dose vials to a single patient whenever possible.
  - Multi-dose vials to be used for more than one patient are kept in a centralized medication area and do not enter the immediate patient treatment area (e.g., patient room/cubicle).
    - If multi-dose vials enter the immediate patient treatment area, they should be dedicated for single patient use and discarded immediately after use.
  - Discard medication any time sterility may have been compromised.
    - Discard any vial that has been placed on a known or visibly contaminated surface or a used procedure tray.
    - Following an emergency event, discard all opened or needle-punctured vials of sterile parenteral products, IV solutions, and single-use containers, such as bags, bottles, syringes.

- Administration of multiple injections to the same patient (e.g., in the case of numbing a large area of skin or to provide incremental doses of intravenous medication)
  - When administration of incremental doses to a single patient from the same syringe is an integral part of the procedure, use of a new needle and syringe for each injection may not be feasible.
    - In such situations, reuse of the same syringe and needle for the same patient should occur as part of a single procedure with strict adherence to aseptic technique.
    - In such situations it is essential that the syringe never be left unattended and that it be discarded immediately at the end of the procedure.

- Point of care fingerstick glucose procedure
  - Prepare medications such as insulin in a centralized medication area.
    - Multi dose insulin vials should be assigned to individual patients and labeled appropriately.
  - Perform hand hygiene prior to performing fingerstick glucose monitoring.
  - Wear gloves during fingerstick glucose monitoring.
    - Remove and discard gloves into trash after fingerstick blood sampling.
    - Perform hand hygiene immediately after removal of gloves and before touching other medical supplies intended for use on other residents.
  - Avoid handling test strip containers with soiled gloves to avoid contamination.
    - If a new test strip is needed, discard soiled gloves, and perform hand hygiene before obtaining a new test strip.
  - Dispose of used fingerstick devices at the point of use in an approved sharps container.
  - Glucometer surfaces should be decontaminated per facility policy any time contamination with blood or body fluids occurs or is suspected.
    - If a glucometer that has been used for one patient must be reused for another patient, the device will first be cleaned and disinfected per facility policy.
  - Maintain supplies and equipment such as fingerstick devices and glucometers within individual patient rooms whenever possible.

    - Because of possible inadvertent contamination, unused supplies and medications taken to a patient's bedside during fingerstick monitoring or insulin administration should not be used for another patient.

- Lumbar puncture and joint injections
    - Use a mask to contain respiratory droplets when preparing and injecting solution into an intracapsular space (joint), the spine and during lumbar puncture.

- Transporting medications
    - Medications should not be transported in healthcare worker pockets.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Standard Precautions	**Infection Prevention**

POLICY:

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

PURPOSE:

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

BACKGROUND:

Standard Precautions are the foundation for preventing the transmission of microorganisms in healthcare settings. These guidelines were introduced in 1991 with the issuance of the Occupational Safety and Health Administration (OSHA) Blood Borne Pathogen Standard. They address the potential for transmission of infection through unprotected contact with patients' blood and body fluids or from contact with their mucous membranes or non-intact skin. Transmission of infection requires a source of infection, a mode of transmission, and a vulnerable host. Application of Standard Precautions is intended to break the cycle and prevent the transmission of microorganisms between healthcare personnel (HCP), patients, and the environment.
The effectiveness of Standard Precautions depends on the adherence of HCP to all of its key components: hand hygiene, appropriate use of personal protective equipment, disinfection of surfaces and equipment, safe injection practices, Respiratory Hygiene/Cough Etiquette, and appropriate patient placement.

PROCEDURE:

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

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

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

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

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

        - Fluid-resistant gowns worn when HCP anticipate performing patient care activities or procedures in which exposed skin or clothing are likely to be exposed to any patient blood, body fluids, secretions, or excretions.
        - Gloves: worn when HCP anticipate touching the mucous membranes or non-intact skin of a patient or any patient blood, body fluids, secretions, or excretions.
            i. Gloves should also be worn when handling or touching equipment or environmental surfaces that have been contaminated.
            ii. Hand hygiene should always be practiced immediately when gloves are removed.
    - Barrier masks or barrier masks with shields: worn when HCP anticipate sprays of blood or body fluids, particularly respiratory secretions. HCP, patients, or visitors in healthcare settings also wear barrier masks to limit the spread of potentially infectious respiratory secretions.
    - Surgical masks: worn by HCP to protect the patient from infectious agents in the HCP's nose or mouth during sterile procedures such as insertion of catheters or injections into spinal or epidural spaces during lumbar puncture procedures.
    - Goggles/face shields: worn by HCP to protect the eyes and face of the wearer from sprays of respiratory secretions, blood, or body fluids. They should be worn when the HCP anticipate participating in a procedure that has the potential to generate splashes or sprays of blood, body fluids, secretions, or excretions. Personal eyeglasses or contact lenses do not provide adequate protection and are not considered acceptable eye protection. The use of face shields allows HCP to wear their own personal eyeglasses and increase protection to other areas of the face, including the eyes.
    - **Disinfecting Surfaces and Equipment between patient uses**
        - All patient care items used for multiple patient contacts must be disinfected between uses
        - Clean and disinfect surfaces that are likely to be contaminated with pathogens, including those that are in close proximity to the patient.
        - Refer to the Cleaning and Repair of Patient Equipment Policy and Procedure.

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

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

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

Related policies:

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

DEFINITIONS:

None

SoHum Health

Subject: Urinary Catheters, Indwelling	Manual: Infection Prevention

POLICY:

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

DEFINITIONS:

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

Indwelling urinary catheter: a thin, hollow tube inserted through the urethra into the urinary bladder to collect and drain urine.

PROCEDURE:

- **The most effective way to prevent catheter-associated urinary tract infections (CAUTI) is not to use an indwelling urinary catheter.**

- **Practices and Interventions that may prevent CAUTI**
  - Use indwelling urinary catheters **only when necessary**. Indications at this facility include:
    - Urine output monitoring in critically ill patients or those receiving diuretics where accurate intake and output are essential (such as in the congestive heart failure patient).
    - Management of acute urinary retention and/or urinary obstruction.
    - Assistance in pressure ulcer/wound healing for incontinent patients/residents.
    - Patient/family request for comfort at end-of-life (an exception).

    Note: Management of incontinence in Skilled Nursing Facility (SNF) residents is NOT an indication for a catheter.

  - Consider alternatives such as intermittent catheterization or use of external catheters such as female external catheter or condom-style catheters, if appropriate.

  - Use aseptic insertion technique with appropriate hand hygiene and gloves.

  - Allow only trained healthcare providers to insert catheters. At this facility, that includes RNs, LVNs, and physicians.

  - Properly secure catheters after insertion to prevent movement and urethral traction~~s~~.

    - When available, a padded, swiveling device (e.g., StatLock) is preferred for patient comfort and catheter stabilization. Change the StatLock type device every 7 days and as indicated. Prior to securing the catheter, fully extend the hip, failure to do so, will cause undue traction on the catheter. Follow manufacture instructions to secure the stabilization device.
      a. Leg bands are acceptable.
      b. Tape may be used if necessary.
  - Maintain a sterile closed system.
    - The catheter insertion products purchased by the District have a closed system with an included attached bag.

        - A specific port is available on the catheter for access to obtain urine for sampling. This port must be cleansed with an alcohol swab before accessing it aseptically using a sterile syringe and needle.
            a. If a CAUTI is suspected, the best practice is removal of the old catheter before obtaining a specimen for culture in order to eliminate the confounding factor of possible catheter biofilm.
            b. Never collect a sample from a drainage bag to be submitted for analysis.

        - Antibiotic-coated and/or antiseptic-coated urinary catheters are not available at this facility.
    - Maintain good hygiene at the catheter-urethral interface: Cleanse with soap and water daily.
        - Antibiotic ointments and antiseptic solutions should not be used.

    - Maintain an unobstructed urine flow: extra tubing should be curled on the bed with straight, unkinked tubing going from bed to drainage bag.
    - Maintain urine drainage bag below the level of the bladder at all times. Bags are attached to the side of the bed (never the bed rail). Bags are covered to promote dignity.
    - Remove catheters that are no longer needed.
        - Nursing staff will document continued necessity daily in the medical record
          a. In unusual situations where a catheter is expected to remain in place for an extended period (e.g., for end-of-life comfort), the daily review of necessity can be waived. Such exceptions will be determined on a case-by-case basis and need approval of the Nurse manager.
        - Use reminder systems to target opportunities to remove catheter.
        - Nursing staff will discuss continued need for catheter use with physician on scheduled rounds and document indications for continued use.

    - When available, use portable ultrasound bladder scans to detect residual urine amounts.
    - Do not change indwelling catheters or urinary drainage bags routinely or at arbitrary fixed intervals.

- **Monitoring**
    - The Infection Preventionist will monitor all patients who have indwelling urinary catheters.
        - Monitoring will be done to assure the continued need for the catheter.
        - Monitoring will be done to assure nursing staff compliance with practices outlined in this policy and procedure.
    - CAUTI rates are calculated according to National Healthcare Safety Network (NHSN) standards.
    - CAUTI rates are reported to:
        - NHSN
        - the Medical Staff meeting
        - the Governing Board Meeting.
    - Urine culture reports are reviewed by nursing staff and the Infection Preventionist to assure the patient/resident is receiving the appropriate antibiotics.
    - Reports of CAUTIs and compliance with the indications as stated in section II above will be presented to the nursing staff at a Nursing Staff meeting quarterly.

SoHum Health

Subject:	Manual:
Use of Powered Air Purifying Respirators (PAPRs)	**Infection Prevention**

POLICY:

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

BACKGROUND:

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

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

EQUIPMENT:

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

TRAINING:

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

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

SAFETY:

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

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

- These PAPRs are for use in oxygen environments only when biological material may be present.

They should not be used when entering rooms filled with gases, fire, or other strong contaminants, such as cleaning products as they do not provide protection against these contaminants.

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

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

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

SUPPLIES:

Versaflo TR-600 PAPR
PAPR hood
Blower and battery pack

Airflow indicator
Breathing tube, covers, twist ties

Disposable gloves
Disinfecting wipes
Disposable gown

Clean towel or blue pad (for cleaning after use)

PROCEDURE: INSTRUCTIONS FOR THE HEALTHCARE WORKER FOR DONNING THE PAPR

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

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

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

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

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

- The power button is located on the top far left of the motor; it should be turned on at this time. It will begin to run through a self-test start up sequence; each of the lights will flash and every light has a designated meaning. The battery charge lights are located on the battery-shaped indicator. The filter status indicator is the set of lights directly to the right. If all are green, it means it has a new filter with full capacity. If only the bottom light is illuminated red, it means the filter is depleted and needs replacing. This is the responsibility of Engineering.

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

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

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

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

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

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

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

PROCEDURE:

INSTRUCTIONS FOR THE HEALTHCARE WORKER FOR DOFFING THE PAPR

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

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

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

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

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

- The motor and belt should be disinfected on all sides and set aside on the clean towel/pad.
- The battery is separated from the motor and wiped down with a disinfecting wipe. The four pins on the bottom of the battery should not be cleaned. These are coated with a special material.
- When all items are fully dry, they can be returned to the case. The case should be returned to the storage area and put battery back into charger properly.

Note: Per this procedure, the PAPR is cleaned before AND after use.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Brain Death	**Emergency Department**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") not to diagnose Brain Death. Pursuant to AB 2565, effective January 1, 2009, the District enacts the following provisions.

PURPOSE:

The purpose of this policy and procedure is to provide guidelines for the nursing staff ~~to provide guidance~~ for patients diagnosed with brain death.~~assist with abdominal paracentesis.~~

~~**Equipment:**~~

- ~~Sterile paracentesis tray and gloves~~
- ~~Local anesthetic~~
- ~~Drape or cotton blankets~~
- ~~Collection bottle (vacuum bottle)~~
- ~~Skin preparation (antiseptic)~~
- ~~Specimen bottles and laboratory forms~~

PROCEDURE:

- Patients who present to the Emergency Room in full cardiac arrest, or who arrest during their ED stay, will have resuscitation procedures initiated /continued following appropriate guidelines.
- In the event the patient is not resuscitated; that is, does not regain a spontaneous heartbeat and respirations, the patient is pronounced dead by the physician.
- In the event the patient's resuscitative efforts result in the patient exhibiting signs of brain death, without cardiopulmonary death, the facility will transfer the patient to a higher level of care. The facility does not have the technology or the trained medical personnel to determine brain death. Ventilator support will continue if appropriate.
- Attempts will be made to have appropriate family or next of kin at the patient's bedside after resuscitation efforts have ceased.
- If reasonable for this patient, special religious or cultural practices or concerns will be met at this time. In determining what is reasonable, the facility will consider the needs of other patients and prospective patients in need of urgent care.
- All requirements for distribution of policies pursuant to HSC 1254.4 (c.) will be done by the receiving facility since Brain Death would be determined there.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Admission of the Patient to IP, SWG or SNF~~LTC~~	**Nursing**

POLICY:

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

PURPOSE:

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

DEFINITIONS:
None

PROCEDURE:

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

SoHum Health

Subject: Chemical or Physical Restraint	Manual: Nursing

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to implement emergency intervention procedures for behavior control. The policy describes ~~the~~ ~~I means those~~ the techniques that may be used in the management of patients who exhibit severe aggressive or explosive behavior which pose an immediate threat of bodily harm to themselves ~~patient~~ or ~~to~~ others.

PURPOSE:

To keep patients safe who may be displaying behaviors that may cause harm to themselves or ~~to~~ others in the healthcare setting.

Note: Restraints, physical or otherwise, will not be used on any patient admitted to an In-patient bed, Swing Bed patient or Skilled Nursing Facility Bed. ~~Resident~~.

DEFINITIONS:

1. "Restraint" means control of the patient's ~~client's~~ behavior or activities through the use of physical or pharmaceutical means. ~~other than postural support.~~
2. "Behavioral restraint" means "mechanical restraint" or "physical restraint" and is used as an intervention when a person presents an immediate danger to self or to others. It does not include restraints used for medical purposes, including, but not limited to, securing an intravenous needle or immobilizing a person for a surgical procedure.
3. "Containment" means a brief physical restraint of a person for the purpose of effectively gaining quick control ~~of a person~~ who is aggressive or agitated, and ~~or who is~~ a danger to self or others.
4. "Mechanical Restraint" means the use of a mechanical device, material, or equipment attached or adjacent to the person's body that he or she cannot easily remove and that restricts the freedom of movement of all or part of a person's body, or restricts normal access to the person's body, and that is used as a behavioral restraint.
5. "Physical restraint" means the use of a manual hold to restrict freedom of movement of all or part of a person's body, or to restrict freedom of movement of all or part of a person's body, or to restrict normal access to the person's body, and that is used as a behavioral restraint. "Physical restraint" is staff-to-person physical contact in which the person unwillingly participates. "Physical restraint" does not include briefly holding a person without undue force in order to calm or comfort or physical contact intended to gently assist a person in performing tasks or to guide or assist a person from one area to another.
6. "Serious injury" means significant impairment of the physical condition as determined by qualified medical personnel, and includes but is not limited to, burns, lacerations, bone fractures, substantial hematoma, or injuries to internal organs.
7. "Chemical restraint" means the use of psychotherapeutic or behavior-modifying drugs used to prevent a patient ~~client~~ from exhibiting an identified maladaptive behavior.

PROCEDURE:

SHCHD ED may not use:

1. A physical restraint or containment technique that obstructs a person's respiratory airway or impairs the person's breathing or places pressure on a person's back or places his or her body weight against the person's torso or back.
2. May not use a pillow, blanket, or other item covering the person's face as a part of a physical or mechanical restraint or containment process.

3. May not use physical or mechanical restraint or containment on a person who has known medical or physical condition, and where there is reason to believe that the use would endanger the person's life or seriously exacerbate the person's medical condition.
4. May not use prone mechanical restraint on a person at risk for positional asphyxiation as a result of one of the following risk factors that are known to the provider:
    a) Obesity
    b) Pregnancy
    c) Agitated delirium or excited delirium syndromes
    d) Cocaine, methamphetamine, or ETOH intoxication
    e) Exposure to pepper spray
    f) Preexisting heart disease, including, but not limited to, an enlarged heart or other cardiovascular disorders.
    g) Respiratory conditions, including emphysema, bronchitis, or asthma
5. Staff shall not place a person in a facedown position with the person's hands held or restrained behind the person's back.
6. Medication shall not be used as punishment, as a substitute for a program, or for the convenience of staff.
7. No restraints with locking mechanisms shall be used.
8. Patients shall not be placed in a room that is locked or where the door is held closed by any means.

Restraints may be used for:

1. The protection of the patient during treatment and diagnostic procedures, such as intravenous therapy, tube feeding, and catheterization.
2. To protect the aggressive, assaultive, acutely disturbed, or severely confused patient from injuring himself or others in the Emergency Department.

In consideration of applying restraints, SHCHD staff will:

1. Make sure that physical restraints are designed and used in such a way as not to cause physical injury to the patient ~~client~~ and to ensure the least possible discomfort to the patient. ~~client~~.
2. Whenever possible, the staff member monitoring the person shall not be involved in restraining the person.
3. Shall afford to persons who have restrained the least restrictive alternative and the maximum freedom of movement, while ensuring the physical safety of the person and others and shall use the least number of restraint points.
4. Will ensure that restraints of any form are not imposed as a means of coercion, discipline, convenience, or retaliation by staff. This right includes but is not limited to, the right to be free from the use of a drug used in order to control behavior or to restrict the person's freedom of movement if that drug is not a standard treatment for the person's medical or psychiatric condition.
5. Careful consideration shall be given to the methods by which the restraints may be speedily removed in the event of fire or other emergency.
6. Patients placed in restraints shall be observed by qualified treatment personnel at least every 15 minutes. This observation shall be noted and initialed in the patient's health record following each observation.
7. Opportunity for motion and exercise shall be provided for a period of not less than ten minutes every two hours in which restraint is applied. The exercise periods shall be documented in the patient's record.
8. Restraints of any kind will not continue for any period longer than that necessary to control the behavior for which such restraint is employed.
9. Ensure that patients shall be restrained only in an area that is under the supervision of staff and shall be afforded protection from other patients who may be in the area.
10. When drugs are used to restrain or control behavior or to treat a disordered thought process, the following shall apply:
    a) The specific behavior or manifestation of a disordered thought process to be treated with the drug is identified in the patient's medical record.

    b) The plan of care for each patient specifies data to be collected for use in evaluating the effectiveness of the drugs and the occurrence of adverse reactions.

In consideration of Use of Physical and/or Chemical restraints for Pediatric Patients

1. Restraints for children either physical or chemical, must be used as a last resort and such use must be to the benefit of the ~~pediatric~~ patient.

2. It is recommended by the American Academy of Pediatrics that when restraint is needed, the use of anxiolysis or~~, and~~ mild sedation be used to avoid the use of physical restraints.

3. The decision to use physical restraint should be made by the physician~~,~~; but may be initiated by the Registered Nurse in extenuating circumstances.

4. Even with proper restraint, mental or cardiopulmonary status may deteriorate unexpectedly; pediatric patients are to be continuously monitored with the use of time-limited orders.

5. Frequent safety checks, vital sign monitoring, evaluation of limb neurovascular status and assistance with nutritional and bathroom needs are required.

6. Observation of the pediatric patient in restraints must be ongoing by nursing staff and at least every 15-minute checks with appropriate documentation of each safety check~~s~~.

Retrieval of Physician's orders for restraints

1. Orders for restraints are used as temporary emergency measures to protect the patient from injury to self or others and only upon a written or telephone order of a physician.
2. Telephone orders shall be recorded immediately in the patient's medical record and shall be signed by the prescriber within 48 hours.
3. ~~There are no~~ PRN (as needed) orders for physical restraints will not be used~~.~~
4. The patient's record shall include an entry noting the time of application and removal of restraints, justification for and authorization of all periods of restraints and signature of the person applying the restraints.
5. Orders for physical restraints shall be in force for not longer than 12 hours.

SoHum Health

Subject: Lippincott and Up-to-Date References	Manual: Nursing

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to use the Lippincott Manual of Nursing Practice or Up to Date as a general guide to basic procedures (guidelines), medication reference and nursing process (nursing process overview) as indicated.

KEY POINTS:

1. Any reference to diagnostic testing, including laboratory and other invasive and non-invasive diagnostic and imaging procedures,as well as medications~~, etc.~~,will only be initiated base on an order from a phycician, phycicia's assistant, or nurse practitioner for a specific patient. ~~which require a physician's~~, physician~~physicaian~~, assistant~~assitant~~ or nurse practitio~~ner's order will only be initiated upon a physician, physician's assistantassitant or nurse practitioner~~'s's order for a specific patient.~~

2. Relevant clinical content and guidelines are offered in a logical and readily accessible format online or in the reference manual.

3. Use of the nursing process provides a nursing frame of reference and continuity.

4. Included is the essential knowledge and understanding for monitoring the changing status of patients so that complications can be prevented, or their effects minimized

5. EBSCO IS ALSO AVAILABLE FOR FURTHER VERIFICATION.

DEFINITIONS:~~**5. EBSCO IS ALSO AVAILABLE FOR FURTHER VERIFICATION.**~~None

PROCEDURE:
NONE

SoHum Health

Subject:	Manual:
Pressure InjuryUlcer Prevention	**Nursing**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to follow accepted Evidence-Based Practice put forth by the National Pressure Injury Ulcer Advisory Panel to ensure that patients admitted for care and treatment to the Facility do not develop pressure injuries. ulcers.

PURPOSE:

The purpose of this policy and procedure is to set forth practice guidelines for the bedside nurse to adhere to as ascribed by the Agency for Healthcare Research and Quality (AHRQ) and adhering to recommendations from the National Pressure InjuryUlcer Advisory Panel (NPIUAP) for prevention of pressure injuriesinjuryulcers, treatment of pressure injuriesyulcers and treatment of pressure injuriesyulcers in "special populations", which refers to that population of patient most at risk for pressure injuriesyulcer.

DEFINITIONS:

Pressure Injury: Localized damage to the skin and underlying soft tissue, usually over a bony prominenceprominenece or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear

The Physician Order for Life-Sustaining Treatment (POLST) is a physician order form that complements an advance directive by converting an individual's wishes regarding life-sustaining treatment and resuscitation into physician orders. It is designed to be a statewide mechanism for an individual to communicate his or her wishes about a range of life-sustaining and resuscitative measures. It is designed to be a portable, authoritative, and immediately actionable physician order consistent with the individual's wishes and medical condition, which shall be honored across treatment settings.

The POLST form:

- Is a standardized form that is brightly colored (PINK) and clearly identifiable
- Can be revised or revoked by an individual with decision-making capacity at any time
- Is legally sufficient and recognized as a physician order
- Is recognized and honored across treatment settings
- Provides statutory immunity from criminal prosecution, civil liability, discipline for unprofessional conduct, administrative sanction, or any other sanction to a healthcare provider who relies in good faith on the request and honors a POLST

PROCEDURE:

A. Conduct A Thorough Risk Assessment on Admission That Is Inclusive of A Skin Assessment

1. Per policy all patients admitted to the facility will have a skin assessment completed in the first 8 hours of admission and then daily thereafter.
2. Skin inspection should include assessment for localized heat, edema, pain or induration (hardness), especially in individuals with darkly pigmented skin.
3. If a pressure injury ulcer is present on admission and/or a pressure injuryulcer develops while in the facility, the following is documented and reported; area of body where pressure injuryulcer is present, measurement and staging of area of injuryulcer inclusive of depth and whether any tunneling and/or undermining is present, color, and odor.

4. Consent to photograph will be obtained from the patient or patient advocate if the patient is unable to give consent and a photograph of the area will be taken and placed in the EMR.
5. If appropriate, additional photographs will be taken to demonstrate improvement and/or worsening of the affected area.

B. Assessment of Nutritional Status

1. Screen and assess the nutritional status of every individual at risk of pressure injury~~ulcers~~ in each healthcare setting.
2. Diabetic patients are especially vulnerable and should be closely monitored for pressure injury~~areas~~
3. Use a valid, reliable, and practical tool for nutritional screening that is quick and easy to use, and acceptable to both the individual and health care worker.
4. Provide nutritional support to each individual with nutritional risk and pressure ulcer risk, following the nutritional cycle. This should include:

- Nutritional Assessment
  - Estimation of nutritional requirements
  - Comparison of nutrient intake with estimated requirements
  - Provide appropriate nutrition intervention, based on the appropriate feeding route
  - Monitoring and evaluation of nutritional outcome, with a reassessment of status at frequent intervals while an individual is at risk.~~s while an individual is at risk~~

C. Repositioning for the Prevention of Pressure Injuries~~Ulcers~~

1. The use of repositioning should be considered in all at-risk individuals
2. Repositioning should be undertaken to reduce the duration and magnitude of pressure over vulnerable areas of the body
    a. High pressures over bony prominences, for a short period of time, and low pressures over bony prominences, for a long period of time, are equally damaging. In order to lessen the individual's risk of pressure injury ~~ulcer~~ development, it is important to reduce the time and the amount of pressure she/he is exposed to.

3. Repositioning frequency will be determined by the individual's tolerance, his/her level of activity and mobility, his/her general medical condition, the overall treatment objectives, and assessments of the individual's skin condition.
4. Assess the individual's skin condition and general comfort. If the individual is not responding as expected to the repositioning regime, reconsider the frequency and method of repositioning.
5. An individual should be repositioned with greater frequency on a non-pressure-redistributing mattress
6. Bed-bound residents and patients are to be turned every two hours with the assistance of two healthcare workers to avoid injury to the resident or patient as well as injury to healthcare workers.
7. Residents and patients are to be checked for incontinent episodes at each turn with appropriate undergarment change as well as appropriate linen change.

    a. Skincare and or dressing changes at each turn as appropriate and per provider order, with appropriate documentation entered into the EMR
    b. Reposition the individual in such a way that pressure is relieved or redistributed, avoid subjecting the skin to pressure and shear forces**.**
    c. Use transfer aids to reduce friction and shear. Lift — do not drag —the individual while repositioning. (Use two healthcare workers)
    d. Avoid positioning the individual on bony prominences with existing non-blanch~~-~~able erythema.
    e. Repositioning should be undertaken using the 30-degree tilted side-lying position (alternately, right side, back, left side) or the prone position if the individual can tolerate this and her/his medical condition allows. Avoid postures that increase pressure, such as the 90-degree side-lying position, or the semi-recumbent position.

8. Limit the time an individual spends seated in a chair without pressure relief.
    a. When an individual is seated in a chair, the weight of the body causes the greatest exposure to pressure to occur over the ischial tuberosity. As the loaded area in such cases is relatively small, the pressure will be high; therefore, without pressure relief, a pressure ulcer will occur very quickly.

D. Documentation

1. Documentation to include the following elements:
    a. A Four Eyes Skin Assessment to be completed and documented within 8 hours of admission
    b. Daily skin assessment to be documented in the EMR
    c. Presence of pressure injury ~~ulcer~~ on admission
    d. Area of the body that pressure injury ~~ulcer~~ is present, measurement and staging of pressure injury ~~ulcer~~ inclusive of depth and any tunneling present, color, and odor. If nurse is unfamiliar with staging pressure injuries, describe the wound and request assistance from another more experienced nurse to assist with staging.
    e. Documentation of developing pressure injury~~ulcer~~; with a report to the manager, request for pressure injury ~~ulcer~~ treatment from the primary care provider. ~~PCP~~
    f. Documentation of type of skin care, medication use, ~~and~~ type of dressing and frequency of dressing change
    g. Care plan to be opened that speaks to the pressure injury ~~ulcer~~ ASAP but within at least 24 hours of discovery

2. Record repositioning regimes, specifying frequency (at least every two hours for bed-bound residents and patients and every two hours at night for all residents and patients who cannot reposition themselves safely or adequately) and the position adopted, and include an evaluation of the outcome of the repositioning regime.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Unidentified Patient Naming Convention	**Health Information Management**

POLICY:

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

PURPOSE:

In the event a patient is not able to be identified then the Unidentified Patient Naming Convention will be used.

PROCEDURE:

- When a patient is unable to be identified they will be registered using the Anonymous Patient workflow.
- Staff should make every attempt to provide as much identifying information in the chart as possible to help with future identification of the patient. This may include an estimated age, race, hair color, eye color, etc.
- Once patient identification has been obtained and verified registration will update the patient's chart.
- Health Information Management (HIM) will be notified via an EHR system action that an unidentified patient has been identified. HIM staff will review and finalize the updated chart.

DEFINITIONS:

None

REFERENCES:

California Administrative Code, Title XXII

SoHum Health

Subject:	Manual:
Unauthorized Disclosure of Protected Health Information (PHI)	**Health Information Management**

POLICY:
It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to ensure that the disclosure of a patient's Protected Health Information (PHI) complies with all applicable state and federal regulations.

PURPOSE:
The purpose of this policy and procedure is to describe the process for reporting and documenting any unauthorized disclosure of PHI.

PROCEDURE:

Should it be determined that a patient's PHI has been disclosed to an unintended recipient:

1. The unintended recipient must be contacted, notified of the error, and asked to destroy the PHI.
2. The incident must be reported to the California Department of Public Health (CDPH) as required.
3. An attempt must be made to call the patient to notify them of the situation.
4. A letter must be sent to the patient at their last known address notifying them of the disclosure.
5. An investigation of the situation must be fully documented, along with a correction plan that includes counseling the employee who made the disclosure.
6. Documentation of the investigation and determination shall be maintained in the District's Incident and Event reporting system.

DEFINITIONS:
None

REFERENCES:

HIPAA Breach Notification Rule – 45 CFR §§ 164.400-414
Health Information Technology for Economic and Clinical Health (HITECH) Act
Civil Code Section 1798.82
Health and Safety Code Section 1280.15

SoHum Health

Subject:	Manual:
Patient History	**Optometry**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to obtain an updated patient history annually. A patient history consists of reason for visit, patient demographics, current or former glasses/contact lens or interest in contact lenses, current medications, known allergies, current medical conditions, historical medical conditions/surgeries, family history of medical conditions, primary care provider, preferred pharmacy, social history, and Notice of Privacy Practices. Medical history may be obtained via paper forms or electronic format.

DEFINITIONS:

Notice of Privacy Practices: SoHum Health's document governing privacy practices across all district services.
Social History: Occupation, hobbies, and alcohol/tobacco/recreational drug use.

PROCEDURE:
When a new patient arrives, they will be given a form to fill out asking for the patient's medical history. When an existing patient arrives, they will be given a copy of their previous form and asked to review it and update it with any changes to their health history. All patients must sign the form acknowledging they were offered a copy of the Notice of Privacy Practices.

SoHum Health

Subject:	Manual:
Dilation and Irrigation	**Optometry**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to perform dilation and irrigation to assess the patency of the lacrimal drainage system. D&I consists of dilating the lacrimal punctum, inserting a lacrimal cannula into the canaliculus, and passing saline through the canal to check for and clear out blockages. Only TLG-designated optometrists may perform this procedure for patients of age 12 or older. D&I should not be performed in cases of acute dacryocystitis and acute canaliculitis.

DEFINITIONS:

D&I: Dilation and Irrigation
TLG designation: A specific California optometry license designation that indicates the optometrist is trained to perform lacrimal irrigation and dilation procedures for patients over the age of 12 years, as well as diagnose and treat primary open angle glaucoma in patients over the age of 18.

PROCEDURE:

Assess the cornea, conjunctiva, lids, and punctum before beginning to make sure the procedure is not contraindicated. Note any corneal abrasions. Use sterilized tools and saline. Reusable tools should be appropriately sterilized after each use and stored to maintain sterilization.

A numbing eyedrop (proparacaine 0.5%) is placed in the patient's eye. At the optometrist's discretion, numbing drops are soaked into a cotton swab, which is placed over the lacrimal punctum for 30-60 seconds. The patient may squeeze their eyes closed to keep the cotton swab in place.

Have the patient look away from the punctum being dilated (look up and to the right if dilating the right lower punctum.) Pull the lid temporally and gently insert the lacrimal dilator 1-2mm and twist it. Start with the smaller end of the dilator before switching to the larger end. Turn the dilator 90 degrees horizontally and continue to roll the dilator within the punctum.

Remove the dilator and insert the cannula attached to a saline-filled syringe: insert 1-2mm vertically with the lid pulled temporally; turn the syringe 90 degrees horizontally and insert an additional 8mm. Avoid hitting the nasal bone. Gently press the plunger to release the saline into the patient's lacrimal system. Check for regurgitation through the same punctum or the opposite punctum. Record the patency of the lacrimal system and the probable location of blockage, if any.

Attempt to remove the blockage with more forceful pressure on the plunger. If unsuccessful, discuss referring the patient to an ophthalmologist for lacrimal probing.

Subject:	Manual:
Epilation of Eyelashes	**Optometry**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to epilate eyelashes as needed. Epilation consists of removing eyelashes that irritate or injure the patient's eye.

DEFINITIONS:

Bandage contact lens: A contact lens with low refractive power approved by the FDA for extended wear for therapeutic use. Current approved brands as of 2024: Air Optix "plus Hydraglyde" (Alcon), Air Optix Night & Day, PureVision (Bausch & Lomb), Acuvue Oasys (Johnson & Johnson).
BCL: Bandage contact lens
Distichiasis: Abnormal, extraneous growth of eyelashes.
Trichiasis: Misdirected eyelashes growing toward the eye.

PROCEDURE:

Epilation of eyelashes may occur as part of a comprehensive eye exam or as its own visit. During an anterior segment examination, trichiasis or distichiasis may be observed. The optometrist should inform the patient of this discovery and, if epilation is indicated, obtain and document verbal consent before removing the offending eyelashes. Numbing eyedrops (proparacaine 0.5%) may be used at the optometrist's discretion. The eyelashes are removed using sterile jeweler's forceps or another appropriate tool. The forceps may be sterilized with an alcohol pad.

Cautery of offending eyelashes may not be performed by optometrists. If offending eyelashes regrow frequently, the patient should be informed that they can have the lashes cauterized by an ophthalmologist. If the patient chooses this option, the lashes should not be epilated so the ophthalmologist can see which lashes must be cauterized. The patient may be fitted with a bandage contact lens for comfort while waiting for their appointment with the ophthalmologist. A patient that has experience wearing contact lenses may be given additional BCLs to take home to wear and replace on a schedule determined by the optometrist. Inexperienced contact lens wearers should return to the optometrist to have the lens replaced. In their case, the optometrist should determine the risk of bacterial infection and prescribe topical antibiotics as needed.

If an underlying cause of the distichiasis or trichiasis is determined, that cause should be treated. Treatment may include topical or oral antibiotics and steroids, or a surgical procedure performed by an ophthalmologist.

SoHum Health

Subject:	Manual:
Photography and Tomography	**Optometry**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to perform photography and tomography for diagnosis and documentation as needed. Photography may be performed using a slit lamp attachment or a fundus camera. Tomography is performed using an Optical Coherence Tomography (OCT) machine.

DEFINITIONS:

Fundus Camera: iCam, 3nethra, VISUCAM 200, California Ultra-Widefield Retinal Imaging (Optos), etc…
OCT: Optical Coherence Tomography. Examples include SPECTRALIS, CIRRUS® 6000, etc…

PROCEDURE:
All images may be taken with or without dilation eyedrops (e.g. tropicamide 0.5%). Before instilling dilating eyedrops, the patient is informed of the side effects (light sensitivity and blurred near vision) and verbal consent is obtained and documented. 1-2 drops are instilled in each eye. The number of drops and concentration of tropicamide is at the discretion of the Optometrist. The eyes should be given enough time to dilate before images are taken (approximately 15 minutes).

Anterior Photography

Anterior photography may be performed at the discretion of the optometrist, provided the necessary equipment is available. A fundus camera or a slit lamp attachment may be used. Equipment parts that may contact the patient (chin rest, head rest) are sanitized using an alcohol pad. The patient is positioned so the area to be photographed is in focus of the camera. One or more pictures may be taken.

Fundus Photography

A fundus camera or a slit lamp attachment may be used. Equipment parts that may contact the patient (chin rest, head rest) are sanitized using an alcohol pad. The patient rests their head on the chin and forehead rests. The chin rest may be adjusted to better position the patient's head in the equipment. The table may be adjusted for patient comfort. Either the patient's head is moved, or the camera is moved, to bring the fundus into focus. The patient is instructed to look at the fixation light. The patient may blink normally. The image is captured. More than one image may be taken for each eye. The patient may be required to look in different directions to capture specific portions of the fundus. Images should be reviewed and retaken if the image is out of focus or has too many artifacts or shadows.

At the discretion of the optometrist, variations of fundus photography may be performed: color, red-free, autofluorescence, etc..

Anterior Segment OCT

If required by the machine, a pad is added to the forehead rest and an anterior segment lens attachment is placed on the front of the OCT camera. Equipment parts that may contact the patient (chin rest, head rest) are sanitized using an alcohol pad. The patient rests their head on the chin and forehead rests. The chin rest may be adjusted to better position the patient's head in the equipment. The table may be adjusted for patient comfort. Either the patient's head is moved, or the camera is moved, to bring the fundus into focus, following the test's specific guidelines for appropriate camera positioning. If applicable, the camera's auto-focus is used to further adjust the camera. The patient is instructed to look at the fixation light. The patient must keep their eyes open wide for this test but may blink normally between tests. The image is captured. More than one image may be taken for each eye. The patient may be required to look in different directions to capture specific portions of the anterior segment of the eye. Images should be reviewed and retaken if the image is out of focus or has too many artifacts or shadows. If an image is retaken, the unacceptable test should be deleted.

Posterior Segment OCT

Make sure the anterior segment lens is not placed on the front of the OCT camera. Equipment parts that may contact the patient (chin rest, head rest) are sanitized using an alcohol pad. The patient rests their head on the chin and forehead rests. The chin rest may be adjusted to better position the patient's head in the equipment. The table may be adjusted for patient comfort. Either the patient's head is moved, or the camera is moved, to bring the fundus into focus, following the test's specific guidelines for appropriate camera positioning. If applicable, the camera's auto-focus is used to further adjust the camera. The patient is instructed to look at the fixation light. The patient must keep their eyes open wide for this test but may blink normally between tests. The image is captured. More than one image may be taken for each eye. The patient may be required to look in different directions to capture specific portions of the anterior segment of the eye. Images should be reviewed and retaken if the image is out of focus or has too many artifacts or shadows. If an image is retaken, the unacceptable test should be deleted.