SoHum Health

Southern Humboldt Community Healthcare District

Policy Packet

Date: December 10, 2025

SoHum Health

Subject: Medical Outcomes and Audits	Manual: Mammography

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to ensure the reliability, clarity, and accuracy of the interpretation of mammograms.

PURPOSE:

To ensure high-quality care and continuous improvement in the screening process.~~To follow-up positive mammographic assessments and correlate pathology results with the interpreting physician's findings, available outcome data and pathology reports shall be collected and reviewed.~~

PROCEDURE:

- Outcome data shall be collected and documented by the Lead Mammography ~~Quality Control (QC)~~ Technologist monthly.
  - Copies of all mammography reports shall be reviewed by the Lead Mammography~~submitted to the QC~~ Technologist.
  - Patients requiring additional imaging evaluation (BI-RADs O) shall be entered into the *Mammography ~~Follow-Up~~ Log* ~~until outcome is determined~~.
  - ~~All positive mammograms shall be entered into the *Mammography Follow-Up Log*. and additional data be obtained by the QC Technologist.~~

  Positive mammograms are those with final assessment categories of "Suspicious" (BI-RAD code 4) or "Highly suggestive of malignancy" (BI-RAD code 5).
    - ~~The patient's provider shall be contacted to obtain referral or surgical information.~~
    - ~~If a biopsy was performed, copies of the pathology report shall be requested from the hospital or surgical office.~~
    - ~~If a biopsy was not done, copies of surgical/oncology recommendations, results of follow-up mammography or other data shall be requested from the appropriate facility.~~
    - ~~If follow-up results are unavailable, an explanation shall be noted on the log.~~
    - ~~Patients known to have developed breast cancer following "negative" or "benign" mammography shall be entered into the log and follow-up initiated.~~

- The Lead Interpreting Physician shall be responsible for reviewing audit results annually.
  ~~This review shall include~~ The outcomes audit must include the calculation of the following metrics:
  - Positive predictive value.
  - Cancer detection rate.
  - Recall rate.~~:~~

  and also include:
  - Dates of audit period.
    - ~~Analysis of audit results.~~
  - Notification and results of other interpreting physicians.
    - ~~Documentation of follow-up actions, if necessary.~~
    -
- Medical outcomes audit data must be retained until the MQSA annual inspection following the facility's analysis of that information.~~Medical outcomes, audit data and supporting documentation shall be maintained for a minimum of seven (7) years~~.

DEFINITIONS:

None

SoHum Health

Subject: Consumer Complaints	Manual: Radiology

POLICY:

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

PURPOSE:

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

PROCEDURE:

- Patients who express **verbal** dissatisfaction will be directed to the Lead Technologist on shift, ~~/or~~ Radiology ~~Department~~ Manager, Radiology Director or Jerold Phelps Community Hospital administrator, whichever is appropriate.
- Patients wishing to **document** serious complaints in writing will be provided with the name and address of the hospital administrator and/or the hospital's accreditation bodies.
- Complaints received by administration will be handled as follows:
  - Administration will contact the technologist and/or radiologist as appropriate.
  - Copies of written complaints or brief notations regarding verbal complaints will be provided to the department.
  - The patient will be contacted by appropriate personnel in an attempt to resolve the issue.
  - If resolution cannot be achieved at the facility level, the patient will be provided with the address of the accreditation bodies.
- Patients with serious complaints they feel cannot be resolved at the facility level, or who wish to contact the accreditation bodies directly, will be provided with all necessary information.
- Printed instructions for patients who believe they have suffered a "serious adverse event" will be posted in the CT suite.
- All complaints will be addressed and resolved as soon as possible.
- All unresolved serious complaints will be reported to the *American College of Radiology* and/or the *State of California, Department of Public Health*.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
CT Scheduling	**Radiology**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") that scheduling protocols in radiology shall be maintained to provide optimum patient service and safety.

PROCEDURE:

- Radiologic procedures requiring appointments shall be scheduled through the scheduling department.
    - Patients will be given the first available appointment, unless otherwise requested.
    - Specific requests will be honored if possible.
    - Appointments may be made by the physician, patient or patient representative.

- Patients with certain conditions or medical history are at a greater risk for contrast reaction. The risk of reaction may be lessened with premedication for conditions indicted with an asterisk (*). Contraindications to the use of IV contrast include:
    - *allergies to iodine
    - *prior contrast reactions or severe allergic reaction (anaphylaxis) to any medication
    - *asthma
    - *hypertension
    - *extremely high anxiety
    - *certain cardiac conditions including congestive heart failure or advanced cardiac disease
    - *diabetes mellitus
    - sickle cell anemia
    - renal insufficiency

- Patients with a predisposition for contrast reaction should be pre-medicated prior to the exam to lessen the possibility of contrast reaction. The pre-medication medications will be prescribed by the ordering provider. The two most frequently used regimens are:
    - Prednisone – 50 mg by mouth at 13 hours, 7 hours and 1 hour before contrast media injection plus Diphenhydramine (Benadryl®) – 50 mg by mouth 1 hour before contrast media injection.

      OR
    - Methylprednisolone (Medrol®) – 32 mg by mouth 12 hours and 2 hours before contrast media injection. An antihistamine (as listed in option "a") may also be added to this regimen.

- Recent (within 30 days of scheduled exam) laboratory tests including creatinine with eGFR are **required** for patients with certain conditions prior to a CT exam with IV contrast. If any imaging with contrast has been performed after labs are drawn, new lab tests must be obtained prior to scheduled study. Conditions requiring laboratory tests are:
    - $\geq$ 50 years of age
    - hypertension
    - certain cardiac conditions including congestive heart failure or advanced cardiac disease
    - renal insufficiency/disease
    - diabetes mellitus
    - anyone who has received IV contrast within the last 30 days of scheduled exam

- If the order is incomplete, the patient will be scheduled and a request for an amended order will be sent to the provider. Completed orders must be received at least 48 before the scheduled exam. If a completed order is not received, the patient will be rescheduled.

- Routine Examinations: During regular department hours (8:00 a.m. to 5:00 p.m.), all examinations will be performed as soon as possible after requisition is received.
    - No routine examinations will be performed after these hours.

- Outpatient Service: Non-scheduled outpatient examinations are performed between 8:00 a.m. and 5:00 p.m. seven days a week in the order patients are registered and available.

- Priorities: Because this is an acute care facility, patients may not be seen in order of their arrival or at their scheduled time. Prioritization will be as follows:
    - emergency room patients
    - STAT in-house patients
    - scheduled outpatients
    - routine outpatients
    - routine inpatients

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Personnel Verification	**Radiology**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to verify personnel working in the Radiology department have valid and current licensure and are not included on the Office of Inspector General's exclusion list.

PROCEDURE:

- All potential candidates for employment effecting radiology (interpreting physician, technologist, physicist) shall have all licenses/certificates checked using primary source verification from appropriate accrediting body/issuing organization.
- In addition to license/certificate checks with issuing bodies, verification of personnel that they are not included on the Office of Inspector General's exclusion list.

DEFINITIONS:
None

SoHum Health

Subject: Exams with IV Contrast	Manual: Radiology

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") that CT exams requiring intravenous (IV) contrast follow strict guidelines.

PROCEDURE:

- Prior CT contrast questions are strongly advised to~~naire~~ **~~MUST~~** be filled out prior to scheduling and performing CT exams with IV contrast. Contraindications to the use of IV contrast include:
  - Allergies to iodine
  - Prior contrast reactions or severe allergic reaction (anaphylaxis) to any medication
  - Asthma
  - Renal insufficiency
  - Certain cardiac conditions including
  - Extremely high anxiety
  - Sickle cell anemia
  - Diabetes mellitus
  - Dehydration

- Patients with a predisposition for contrast reaction should be pre-medicated prior to the exam to lessen the possibility of contrast reaction. The premedication medications will be prescribed by the ordering provider. The two most frequently used regimens are:
  - Prednisone – 50 mg by mouth at13 hours, 7 hours and 1 hour before contrast media injection plus Diphenhydramine (Benadryl®) – 50 mg by mouth 1 hour before contrast media injection. **OR**
  - Methylprednisolone (Medrol®) – 32 mg by mouth 12 hours and 2 hours before contrast media injection. An antihistamine (as listed in option "a") may also be added to this regimen.

- Recent (within 30 days of scheduled exam) laboratory tests including creatinine with eGFR are **required** for patients with certain conditions prior to a CT exam with IV contrast. If any imaging with contrast has been performed after labs are drawn, new lab tests must be obtained prior to scheduled study. Conditions requiring laboratory tests are:
  - ≥50 years of age
  - Hypertension
  - Certain cardiac conditions including congestive heart failure or advanced cardiac disease.
  - Renal insufficiency/disease
  - Diabetes mellitus
  - Anyone who has received IV contrast within the last 30 days of scheduled exam.

Laboratory tests including creatinine with eGFR may be required prior to a CT exam with IV contrast.

- The creatinine level may vary according to muscle mass and size of patient. In men, a normal level is 0.7-1.3 mg/dL, in women a normal 0.6-1.1 mg/dL.
- An eGFR<29 indicates a high risk of kidney damage and contrast material is not recommended.
- A Contrast Media Consent form **must** be filled out **prior** to the injection of any contrast media.
- Adults: IV catheter 20 gauge or greater into antecubital area or forearm. If a 22 gauge IV catheter is used, power injector rate shall not exceed 5ml/sec.
- Pediatrics:
  - Contrast dose will be determined by weight ~~using the Breslow tape~~.
  - Contrast will be administered at a dose of 2ml/kg of patient weight.
  - If using the power injector, flow rate will be reduced.
  - Use of 24 gauge IV catheters in pediatrics is acceptable if a 22 gauge IV catheter is unable to

be inserted.
- Contrast may need to be hand injected not to exceed a rate of 2ml/sec, all infants are to be hand injected only.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Contrast Administration and Supervision	**Radiology**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to delineate aspects of contrast administration and to ensure that all contrast media agents are properly stored, handled, and administered.

PROCEDURE:

- All diagnostic contrast agents are considered to be medication and therefore must be securely stored, safely handled and properly labeled prior to administration.
- The Emergency Department (ED) Physician on duty will have supervision of a patient during and after contrast is administered.
- If a reaction to intravenous (IV) contrast occurs, the patient will be treated by the ED Physician on duty.
    - A crash cart will be readily available in the CT suite at all times.
    - Oxygen will be readily available in the CT suite at all times.
- All contrast media will be stored in locked cabinets/refrigerator, accessible by CT or pharmacy personnel only.
- All contrast will be labeled upon transference from the original packaging to another container including a syringe, power injector or a cup.
- The Pharmacist will be available by phone for contrast related questions.
- All contrast CT study protocols shall be reviewed and approved by the interpreting radiologist or interpreting radiologist group annually or as needed.
- All contrast injected via the power injector shall be into an intravenous catheter inserted into the forearm or antecubital space and shall be a minimum of 22 gauge (with the exception of pediatric patients).

Site Limitations:

- No PICC (peripherally inserted central catheter) lines shall be used for contrast injection by technologist.
- No IO (intraosseous) lines shall be used for contrast injection.
- No port-a-cath lines shall be used for contrast injection by technologist.
- No infants shall be injected using the power injector.

Extravasation:

- In the rare case of extravasation (including amount, type, and site), incident and treatment will be documented in the exam report and in the patient's medical record. The ordering provider will also be notified.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Physician Orders for Life-Sustaining Treatment (POLST)	**Nursing**

POLICY:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD" or "District") to have the admitting physician fill out a Physician Orders for Life-Sustaining Treatment (POLST) form for all patients on observation and all patients admitted to an acute, swing or SNF bed.
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PURPOSE:

The purpose of this policy and procedure is to outline the rules surrounding the Physician Orders for Life-Sustaining Treatment (POLST) form in order to outline the interventions that the patient would like to have done, in the event that life-sustaining interventions are needed. This form does not replace the Advanced Directive but compliments it and serves as basic instructions if there is no Advanced Directive on file.

DEFINITIONS:

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:

The physician is responsible for discussing the efficacy or appropriateness of the treatment options with the patient, or if the patient lacks decision-making capacity the patient's legally recognized healthcare decision-maker. Once the POLST form is completed, it must be signed by the patient, or if the patient lacks decision-making capacity the resident's legally recognized healthcare decision maker and the attending physician.

1. The POLST form will be completed on all patients within 24 hours of admission to acute care, observation, or Swing bed.

2. At the time that it is decided that a patient will be admitted to the hospital for observation, acute stay, or swing bed the admitting physician will meet with the patient and fill out the Physician Orders for Life-Sustaining Treatment (POLST) form per the patient's wishes or if the patient lacks decision-making capacity the resident's legally recognized health care decision maker. In the event that the patient is discharged or transferred for any reason, the original POLST form will go with the patient

and a copy will be put in the patient's medical records.

3. After the POLST form is completed, the nurse will document the existence of the POLST form on the admission assessment and review the form for completeness (e.g., signed by patient or legally recognized healthcare decision maker, and by a physician).

4. Once reviewed, the original POLST should be placed in the patient's chart with all areas on the form filled out completely and a patient sticker attached to the form along with the advanced directive if needed.

5. If the patient is transferred to another facility, the original pink POLST, and copies of the patient's advance directive should always accompany the patient. A copy of the POLST must be obtained and submitted to Medical Records.

6. At any time, the patient with decision-making capacity can revoke the POLST form or change his/her mind about his/her treatment preferences by executing a verbal or written advance directive or, after consultation with the patient's physician, a new POLST will be created. The new POLST form must be signed by the physician and the patient and the revoked POLST must be voided.

7. All discussions about revising or revoking the POLST should be documented in the resident's medical record. This documentation should include the time and date of the discussion, the parties involved, the essence of the conversation, and plans for follow-up action if needed.

8. To void POLST, draw a line through the entire Section A through D and write "VOID" in large letters. The original POLST marked "VOID" should be signed and dated.

CONFLICT RESOLUTION:

If there are any ethical concerns or conflicts about the POLST orders, appropriate resources e.g., risk management, care conferences, legal, or other administrative or medical staff resources- may be utilized to resolve the conflict.

SoHum Health

Subject:	Manual:
Employee Group Health and Life Insurance Benefits	**Human Resources**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD," "District," "SoHum Health") to adopt and incorporate by reference the regulations and procedures contained in the Southern Humboldt Community Healthcare District employee benefit plan adopted on January 1st, 2026. Benefits are subject to change annually.

Full-time employees: Southern Humboldt Community Healthcare District offers the following group insurance benefits to regular *active* full-time employees: Medical, dental, vision, and life/AD&D (accidental death and dismemberment). The amount the District contributes to the cost of health coverage for the regular full-time employee is determined by the Board of Directors annually. Eligible spouse and/or dependents may be added to the group medical, dental, and vision plans at the employee's expense.
Advanced practitioners: Southern Humboldt Community Healthcare District offers the following group insurance benefits to *active* advanced practitioners regularly scheduled to work three days or more per week: Medical, dental, vision, and life/AD&D (accidental death and dismemberment). Determining the amount the District contributes to the cost of coverage for the advanced practitioner: the advanced practitioner shall be considered to have the same status as a full-time employee. Eligible spouse and/or dependents may be added to the group medical, dental, and vision plans at the employee's expense.
Part-time employees: Southern Humboldt Community Healthcare District offers regular active part-time employees group medical benefits. Determining the amount the District contributes to the cost of medical coverage for the part-time employee: the part-time employee shall receive the same consideration as a full-time employee. Eligible spouse and/or dependents may be added to the medical benefit at the employee's expense. Part-time employees may purchase group vision and dental benefits at their own expense, and eligible spouse and/or dependents may be added to the group dental and vision plans at their own expense.

DEFINITIONS:

Full-time: means regularly scheduled to work a minimum of thirty (30) hours per week on a routine basis.
Part-time: means regularly scheduled less than 30 hours per week but more than 19 hours per week, or more than 40 hours per pay period, on a routine basis.
Advanced practitioners: Physician Assistants and Family Nurse Practitioners who are scheduled to see patients in the hospital or clinic at least three days or twenty-four (24) hours per week on a routine basis.

PROCEDURE:

Group Health and Life Insurance Benefits Enrollment
Human Resources provides enrollment forms for medical, dental/vision, and life insurance coverage to eligible employees. Eligible employees must enroll themselves and spouse and/or eligible dependents or decline to enroll in the District's group health benefits plans no later than the 30th calendar day of employment or re-employment following a break in service of at least one whole month, or of a change of status which qualifies the employee for benefits. Coverage begins the first day of the month following the hire date and the receipt of properly completed enrollment forms by Human Resources.
An eligible employee who fails to return completed enrollment forms to Human Resources within the period specified above, or who declines or cancels enrollment for self or dependents, may request enrollment with a qualifying event at any time as a late enrollee, or may enroll during annual Open Enrollment.

Continuation of Health Benefit

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") allows a temporary extension of group health insurance benefits for the employee, spouse, and/or dependents, if any, who lose insurance benefits due to a qualifying event such as the employee's termination, reduction in work hours, death, divorce or legal separation, or entitlement to Medicare benefits. Covered dependents' coverage may be continued if coverage is lost due to loss of dependent child status due to attainment of the eligibility age limit, or loss of dependent child status for any other reason. All covered employees are notified by Human Resources of their rights and their spouse and/or dependents ' rights to continue coverage under the requirements of the Act. The cost of continuation coverage is borne solely by the employee/former employee. To ensure continuation of health benefits during an approved leave of absence of more than 30 days, other than a leave of absence that qualifies under the California Family Leave and Pregnancy Disability leave regulations and/or the Federal Family and Medical Leave Act (*see* Human Resources Policy Leaves of Absence/Vacation), the covered employee must:

- Use accrued PTO to maintain group status; or
- Arrange to pay the costs of their own and their dependents' health benefits coverage before beginning leave of absence.

Changes to the benefit plans
Human Resources will submit recommendations for changes to the Administration, and changes supported by the Administration will be presented to the board for review and approval.

SoHum Health

Subject:	Manual:
Smoke Free Policy	**Whole Facility**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SoHum Health", "District", "SHCHD") to prohibit smoking of any substance, electronic smoking devices or e-cigarettes, tobacco products, or~~and~~ marijuana products on SoHum Health property and within 25 feet of any property owned by the District.

DEFINITIONS:

Electronic smoking devices or e-cigarettes: designed to deliver nicotine or other substances to the user in the form of a vapor. They are composed of a rechargeable, battery-operated heating element, a replaceable cartridge that may contain nicotine or other chemicals, and an atomizer that when heated converts the contents of the cartridge into a vapor. The vapor has a light odor that dissipates quickly. E-cigarettes are not considered smoking devices, and their heating element does not pose the same dangers of ignition as regular cigarettes.

Smoking: the burning of, inhaling from, exhaling the smoke from, or the possession of a lighted cigar, cigarette, pipe or any other matter or substance which contains tobacco or any other matter that can be smoked, or the inhaling or exhaling of smoke or vapor from an electronic smoking device.

SoHum Health property: all indoor and outdoor SoHum Health owned or leased property including, but not limited to, buildings, parking lots, driveways, vehicles, and personal vehicles on SoHum Health property.

PROCEDURE:

SoHum Health shall be a smoke, tobacco, and marijuana free facility. Residents, patients, employees, family members, visitors, and others shall not be permitted to smoke anywhere within SoHum Health property. Smoking shall not be permitted within 25 feet of SoHum Health property.

A sign indicating that smoking or the use of an electronic smoking device is prohibited on SoHum Health property shall be posted prominently at each public entrance to each facility.

The smoking policy shall be presented to patients, residents, and/or family members during the pre-admission process and to employees during the orientation and/or training period.

Employees shall not take extra breaks or mealtimes to smoke or use tobacco products and shall adhere to all policies and procedures including break, meal, and grooming policies and procedures. Consistent with District policy, employees must pay special attention to personal hygiene and present themselves in a manner that maintains the comfort and confidence of patients, family members, other employees and the public. This requirement includes not having a strong odor of smoke on their person when working.
Enforcement of this policy shall be the shared responsibility of all staff. If a staff member feels uncomfortable approaching violators of this policy, they may approach security personnel, managers, or administrators with their concern.

Staff violations of this policy should be reported to human resources.

Patient and visitor violations of this policy should be reported to security or the department manager. Violators smoking or using tobacco products inside SoHum Health buildings should be asked to stop immediately and materials should be removed and disposed of properly. The manager should be notified

immediately if violations of this policy are found in their department. If the manager is unavailable, another manager or administrator should be notified immediately.

Patients in the emergency department, acute inpatient, or observation status will be informed that leaving the campus while admitted will not be allowed. Leaving campus while admitted is classified as leaving "against medical advice" and subject the patient to being discharged for refusal of care.

Residents in the swing bed program or distinct part skilled nursing facility will have tobacco items placed in a secure location until discharge.

All patients and residents will be provided with cessation treatment options.

Prior patient refusal to comply with this policy may be grounds for declining to accept the patient for future care, except as required by policy or law for emergent care.

Violations of this policy in vehicles or outdoors, but on SoHum Health property, should be reported to security immediately.

Employees who violate this policy will be subject to the District's disciplinary action policy.

Employee tobacco cessation assistance: while not obligated to do so under this policy or other employment conditions, District management may authorize the provision of assistance to employees to encourage and aid them in becoming and remaining tobacco free.

SoHum Health

Subject: Commute/Commuter Pay	Manual: Human Resources

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD," "District," or "SoHum Health") to provide mileage reimbursement (and/or hourly pay in certain circumstances for non-exempt staff) for employees commuting from their place of residence to any District office that is not their regular job site.

DEFINITIONS:

Commute: Standard travel time between an employee's home and their primary workplace.

Hours Worked: Time during which a non-exempt employee is under the employer's control, including all time they are permitted or required to work.

Compulsory Travel Time: Travel time that the employer controls (e.g., dictates the route, method, or location), which is typically considered ~~compensable~~ compensable for non-exempt employees.

Travel to Different Work Sites: If an employer requires a non-exempt employee to travel to multiple job sites in a day or on a short-term basis, any additional travel time and mileage beyond their normal commute may be compensable.

Temporary Reassignment: If a non-exempt employee is temporarily assigned to a different location and the commute is longer than usual, the additional time and mileage may be compensable.

PROCEDURE:

Commute reimbursement to your regular job site is offered as a benefit, not an obligation.
For travel related to out-of-town business, training, or conferences, please refer to the **Travel and Travel Reimbursement Policy.**

If a non-exempt employee commutes to a District office that is not their regular job site and the commute exceeds their typical travel time, they will be compensated at their regular hourly rate for the additional time. Both non-exempt and exempt employees will be reimbursed mileage at the current California mileage rate for the additional distance.

Special circumstances must be submitted in writing and approved by both Human Resources (HR) and the Chief Executive Officer (CEO).

Commute pay for the District falls into three categories:

1. **Round-trip commute of 200 miles or less to the regular job site for both exempt and non-exempt staff**

    - Commute pay is claimed per trip via the payroll software under "Adjustments."
    - One adjustment is allowed per round trip, with a maximum of 200 miles.
    - Pay is offered at $0.20 per mile and is taxed as wages.
    - Mileage is calculated based on the distance between the employee's current physical address and their designated primary job site.

- Employees should update any change of address with Payroll or HR as soon as possible to ensure accurate calculations.

2. Regular commute exceeding 200 miles round-trip to the regular job site for both exempt and non-exempt staff

- The District will reimburse travel expenses with approved gas or airfare receipts, up to $2,500.00 per year. Please refer to the District's **Travel and Travel Reimbursement Policy and Procedure** for more information regarding Per Diem rate or other guidelines.

3. Commute to an irregular job site (e.g., temporary on-site assignment for a remote employee)

- The District will compensate employees for travel to an irregular job site or out-of-town business and/or training as required by law.

- **For non-exempt employees:**

- If the commute to a non-regular job site is longer than their usual commute, the additional time will be paid at their regular hourly rate.

- Travel time is considered compensable when:

    - The employer requires the employee to meet at a designated location other than their normal job site

    - The employer provides transportation to/from the work-site; and The employee is not permitted to use their own transportation.

    - Compulsory travel time beyond a non-exempt employee's normal commute

    - If a remote employee is temporarily reassigned to an on-site location, any travel time that exceeds their normal commute is commensurable~~compensable~~.

- If an employee has no regular job site, travel to a new job site each day is also not compensable.

Additional Guidelines:
Under California law, employers must reimburse employees for all necessary expenses incurred in the direct performance of their duties. This includes mileage and other travel-related expenses for non-regular work locations, training, or business meetings. Refer to the **Travel and Travel Reimbursement Policy** for Per Diem meal limits and further guidelines.

Employees must report travel time to their manager before the payroll deadline. The manager is responsible for ~~approving~~ entering the ~~entering the~~ travel time for non-exempt employees into the payroll system.

Reimbursable expenses must be submitted to Accounts Payable ~~HR~~ with receipts and a signed check request prior to the close of the pays cycle.

Compulsory travel time to irregular job sites must be pre-approved by the employee's manager, HR, and Accounts Payable to ensure proper compensation.

SoHum Health

Subject:	Manual:
Employee Immunization and Tuberculosis (TB)Screening Program	**Employee Health**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to provide a safe, healthful work environment for its employees. In order to achieve this goal the District may require employees to receive certain vaccinations or screenings as a condition of employment.
The purpose of this policy and procedure is to establish a program to ensure the health and safety of employees at Southern Humboldt Community Healthcare District by offering certain vaccinations and screenings be given to employees based upon their position/occupational exposure risk.

DEFINITIONS:

Health Care Personnel (HCP): all paid and unpaid persons working in healthcare settings who have the potential for exposure to patients and/or to infectious materials, including body substances, contaminated medical supplies and equipment, contaminated environmental surfaces, or contaminated air. HCP might include (but are not limited to) physicians, nurses, nursing assistants, therapists, technicians, emergency medical service personnel, dental personnel, pharmacists, laboratory personnel, autopsy personnel, students and trainees, contractual staff not employed by the health-care facility, and persons (e.g., clerical, dietary, housekeeping, laundry, security, maintenance, administrative, billing, and volunteers) not directly involved in patient care but potentially exposed to infectious agents that can be transmitted to and from HCP and patients.

High Risk HCP: employees of the following departments: nursing, physicians, mid-level providers, laboratory, patient financial services, environmental services, radiology, and clinic.

PROCEDURE:

Vaccines

- Healthcare Personnel (HCP) are considered to be at substantial risk for acquiring or transmitting hepatitis B, influenza, measles, mumps, rubella, pertussis, varicella and COVID-19.
- **Hepatitis B (HBV):**
    - HCP should be tested for HBV surface antibody (anti-HBs) to determine infection status.
    - High Risk HCP should show evidence of either having had the three-vaccine series for HBV or a positive titer indicating immunity to HBV.
    - Employees who cannot provide evidence of vaccination or immunity will have titers drawn at the District's laboratory.
    - If test results show the employee has antibodies to HBV, he/she will be considered immune, and no further steps will be taken. If no antibodies are found, the employee will be offered the HBV vaccine series.
    - The HBV series is not mandatory. Employees may decline the HBV series initially and later change their mind and receive the series.
- **Influenza:**
    - All HCP, not just those with direct patient care duties, should receive an annual influenza vaccination.
    - Employees will be offered the influenza vaccination annually.

- The influenza vaccine is not mandatory. Employees may decline the influenza vaccine initially and later change their mind and receive the immunization.
- *See Influenza Immunization policy and procedure.*

- **Measles, mumps, and rubella (MMR)**
  - History of disease is no longer considered adequate presumptive evidence of measles or mumps immunity for HCP.
  - HCP should show presumptive evidence of immunity by either:
    - Having written documentation of the two dose vaccine series for MMR administered at least 28 days apart, OR
    - Laboratory evidence of immunity of disease, OR
    - Laboratory confirmation of disease, OR
    - Birth before 1957.
  - Employees who cannot provide evidence of vaccination or immunity will have titers drawn at the District's laboratory.
  - If test results show the employee has antibodies to MMR, he/she will be considered immune to MMR, and no further steps will be taken. If no antibodies are found, the employee will be offered the MMR vaccine series.
  - The MMR series is not mandatory. Employees may decline the MMR series initially and later change their mind and receive the series.

- **Pertussis:**
  - If they have not previously received a Tdap vaccine, HCP, regardless of age, should receive a single dose of tetanus toxoid, reduced diphtheria toxoid and acellular pertussis (Tdap) vaccine as soon as possible.
  - The minimal interval was removed, and Tdap can now be administered regardless of interval since the last tetanus or diphtheria-containing vaccine.
  - Employees who cannot provide evidence of vaccination will be offered the Tdap vaccine.
  - The Tdap series is not mandatory. Employees may decline the Tdap initially and later change their mind and receive the vaccine.

- **Varicella:**
  - HCP should show evidence of immunity by either:
    - Written documentation with 2 doses of vaccine, OR
    - Laboratory evidence of immunity or laboratory confirmation of disease, OR
    - Diagnosis of history of varicella disease by health-care provider, or diagnosis of history of herpes zoster by health-care provider.
  - Employees who cannot provide evidence of vaccination or immunity will have titers drawn at the District's laboratory.
  - If test results show the employee has antibodies to varicella, he/she will be considered immune to varicella, and no further steps will be taken. If no antibodies are found, the employee will be offered the varicella vaccine series.
  - The varicella series is not mandatory. Employees may decline the varicella series initially and later change their mind and receive the series.

- **COVID-19:**
  - HCP should show evidence of immunization against COVID-19 by either
    - Written documentation with up to date vaccine, OR
    - Copy of CDC vaccination card or CAIR documentation.
  - If the HCP is not vaccinated or cannot provide proof of vaccination, a vaccine will be offered.
  - If the HCP declines the vaccine, a Declination Form will be completed and placed in the Employee file. In addition, information will be given to the employee delineating the efficacy of being immunized against COVID-19.
  - At a later time, if the HCP who has declined the vaccine wishes to be vaccinated, it can be given at the district.

- HCPs who remain unvaccinated will follow all current CDPH, CDC, Humboldt County Public Health Department and district requirements for testing, masking, and social distancing.

Employee Health Record:

- Should reflect immunity status for indicated vaccine-preventable diseases (i.e., documented disease, vaccination history, or serology results)
- Should reflect vaccinations administered during employment and any documented episodes of adverse events after vaccination.
- Accurate vaccination records can help to rapidly identify susceptible HCP (i.e., those with no history of vaccination or lack of documentation of immunity) during an outbreak situation and can help reduce costs and disruptions to health-care operations.
- HCP should be provided a copy of their vaccination records and encouraged to keep it with their personal health records so they can readily be made available to future employers.

Vaccination Procedure:

- Identify an employee's need for vaccination using the above information and the provided recommendation schedules. *See attached documents for current recommendations: "Recommended Immunization Schedule for Adults Aged 19 Years and Older".*

- Screen all patients for contraindications and precautions to the specific vaccine(s) they will be receiving.
  See attached document: "Guide to Contraindications and Precautions to Commonly Used Vaccines"
  See attached document: "Guide to Contraindications and Precautions to Commonly Used Vaccines in Adults".

- Perform Hand Hygiene.

- Administer the vaccine(s) per directions.
  See attached document: "Administering Vaccines: Dose, Route, Site, and Needle Size".

- Document each employee's vaccine administration information in their Employee Health Chart:
  - Record the date the vaccine was administered, the manufacturer and lot number, the vaccination site and route, and the name and title of the person administering the vaccine and the edition and distribution date of the language-appropriate Vaccine Information Statement (VIS) provided to the vaccine at the time of vaccination. If vaccine was not given, record the reasons(s) for non-receipt of the vaccine (e.g., medical contraindication, patient refusal).
- Employee teaching:
  - Review the common side effects for the vaccine(s) administered. Common side effects are printed on the VIS forms.
  - Review signs of a serious allergic reaction and when to seek medical help. This includes high fever, difficulty breathing, weakness, hoarseness or wheezing, a fast heartbeat, hives, dizziness, paleness, or swelling of the throat.
  - Inform the employee verbally and written, when the next vaccination is due according to the recommended guidelines.
  - Provide all patients (parent/legal representative) with a copy of the most recent federal Vaccine Information Statement (VIS). These are available online at the CDC.
  - Document the education that was given.
- Be prepared for management of a medical emergency related to the administration of vaccine.
- For all employees with a suspected adverse reaction to an immunization:
  - An electronic Quality Review Report (QRR) indicating a possible adverse reaction must be completed by the staff member involved.
  - The Risk Manager or Infection Prevention Nurse or Clinic Nurse Manager will report to the federal Vaccine Adverse Event Reporting System (VAERS) at www.vaers.hhs.gov or by calling (800) 822-7967.

Surveillance:

- To ensure that all HCP are up to date with respect to recommended vaccines, the District should review HCP vaccination and immunity status at the time of hire and on a regular basis (i.e., at least annually) with consideration of offering needed vaccines, if necessary, in conjunction with routine annual disease-prevention measures (e.g., influenza vaccination or tuberculin testing).

TB Screening:

Tuberculosis (TB) transmission has been documented in health care settings where workers and patients come in contact with people who have TB disease. Periodic testing of HCP is recommended as part of a TB Infection Control Plan and is required by state regulations. TB testing program include anyone working or volunteering in health-care settings who have face to face contact or potential exposure to TB through shared air or space with infectious patient(s).

There are two types of testing for TB in HCP. Initial baseline testing upon hire: Two-step testing with a TB skin test (TST) or TB blood test called Interferon-gamma release assays (IGRA) and an Annual or serial screening: determined by state regulations or risk assessment outcomes. The district uses an IGRA, QuantiFERON Gold test.

New Employee (Initial Baseline Testing):

- TB Symptom Screen and CXR
    - Symptom Screen must be performed prior to employment. *See TB Symptom Screening Questionnaire.*
    - Any HCP with TB symptoms (productive cough for greater than 3 weeks, fever, anorexia, weight loss, etc.) must have a CXR performed and a medical evaluation to rule out active disease.
    - HCP with documented history of positive TST recorded in millimeters or positive IGRA or history of active TB Disease:
        - A CXR must be performed. If the HCP provides a written report of a negative CXR done in the United States within 90 days of hire, a CXR is not necessary.
    - In the case of an abnormal CXR, the HCP must be referred to their healthcare provider for evaluation. The HCP must not be allowed to work until they are determined not to have infectious TB and provide written medical clearance.
- No documented history of TST/IGRA
    - Employment TST/IGRA
        - TST: A two-step TST procedure is not routinely done at the district.
        - IGRA: A single test is required.
        - If the IGRA is positive, the HCP should be restricted from working until a CXR is obtained to rule out active disease.
    - All HCPs with a positive IGRA, normal CXR and no history of treatment for latent TB infection (LTBI) should be encouraged to see their healthcare provider for evaluation and treatment recommendations.
- Documented history of negative TST/IGRA
    - Employment TST/IGRA: All new employees must get an QFG test upon hire even if they have a recent previous negative TST or IGRA. Employees are encouraged to bring copy of previous tests to use as a comparison in case the new employee screening is positive.
- All HCPs with a positive TST/IGRA, normal CXR and no history of LTBI treatment should be encouraged to see their healthcare provider for evaluation and treatment recommendations.
- Documented history of positive TST recorded in millimeters or positive IGRA or history of active TB Disease
    - HCPs with a history of active TB disease must provide documentation of completion of an adequate course of treatment and have medical clearance prior to start of employment.
    - No further TST/IGRA is required.
    - All HCPs with a positive TST/IGRA, normal CXR and no history of treatment for latent tuberculosis infection (LTBI) should be encouraged to see their healthcare provider for evaluation and treatment recommendations.

Annual Screening:

- Documented history of negative TST/IGRA
    - Have a single TST/IGRA and a symptom-screen questionnaire annually by face-to-face interview.
- Documented history of positive TST recorded in millimeters or positive IGRA or history of active TB Disease
    - Receive a symptom-screen questionnaire annually by face-to-face interview.
    - If the questionnaire is positive, (i.e., HCP has one or more unexplained symptoms) the HCP must be excluded from work until active TB disease is ruled out by a medical evaluation. An annual CXR for TST/IGRA-negative or asymptomatic TST/IGRA-positive employees is no longer required.

HCP TST/IGRA Conversions:

- HCPs who convert their IGRA from negative to positive during employment must have a symptom-screen questionnaire and a CXR within one week and be promptly referred to a healthcare provider or the local health department for treatment recommendations.
- Symptomatic HCPs (i.e., HCP has one or more unexplained TB related symptoms) must be excluded from work until active TB disease is ruled out by a medical evaluation.

Post-exposure HCP Screening:

- Following notification of the local health department, at a minimum, all HCPs who have an exposure to a confirmed case of active pulmonary TB disease must receive a symptom-screen questionnaire.
    - Symptomatic HCPs must have a CXR immediately and be referred for medical evaluation.
    - Asymptomatic TST/IGRA-negative HCPs should be tested as follows:
        - If a TST/IGRA was negative within 3 months prior to the last exposure date, test the HCP in 8-10 weeks following the last exposure date.
        - If a TST/IGRA was negative greater than 3 months prior to the last exposure date, administer a TST/IGRA as soon as possible. If the new TST/IGRA is negative, repeat the TST/IGRA in 8-10 weeks following the last exposure date.

Employee Health Record:

- Should reflect current TB screening status.
- Should reflect TB screening procedures done during employment and any documented episodes of adverse events or follow-up care required.
- Accurate TB screening records can help to rapidly identify susceptible HCP (i.e., those with no history of conversion) during an outbreak situation and can help reduce costs and disruptions to health-care operations.
- HCP should be provided a copy for their records of their TST, IGRA, CXR, and/or TB symptom-screen and encouraged to keep it with their personal health records so they can readily be made available to future employers.

All costs associated with this policy will be borne by the District.

SoHum Health

Subject: Blood, Body, or Substance Exposure and Management	Manual: Employee Health

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", ~~or~~ "District", or "SoHumHealth") to provide a safe work environment. Minimizing blood and body fluid exposures is important in this regard and can be done through use of (a) sharp safety equipment, (b) adherence to safe handling and disposal practices, (c) the provision and use of personal protective equipment, and (d) staff immunization.

PURPOSE:

The purpose of this policy and procedure is to detail the recommended evaluation, initiation of prophylactic therapy, and necessarily follow up care needed in the situation of workplace blood and body fluid exposure.

DEFINITIONS:

- **Body fluids considered infectious:** substances that have been implicated in the transmission of HIV and viral hepatitis, i.e., blood, cerebrospinal, synovial, pleural, peritoneal, pericardial, and amniotic fluids. Breast milk, semen and vaginal secretions are known as infectious agents but have not been implicated in occupational settings as a mechanism of transmission unless they are contaminated with VISIBLE blood.
- **Body fluids considered non-infectious if no visible blood present:** sputum, nasal secretions, saliva, sweat, tears, urine, feces, and emesis (gastric fluids).
- **Blood borne Pathogens:** for the purpose of this policy blood borne pathogens refer to human immunodeficiency virus **(**HIV), hepatitis B virus (HBV), and hepatitis C virus (HCV).
- **Healthcare Personnel (HCP):** HCP refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances (e.g., blood, tissue, and specific body fluids); contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. These HCP may include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the health care facility, and persons (e.g., clerical, dietary, environmental services, laundry, security, maintenance, engineering and facilities management, administrative, billing, and volunteer personnel) not directly involved in patient care but potentially exposed to infectious agents that can be transmitted among from HCP and patients.

Consultation:

- It is recommended that all practitioners caring for health care workers who have had a possible exposure call the Clinician Consultation Center **PEPline (1-888-448-4911)**, which offers advice on occupational needle sticks, splashes, and other potential exposures to HIV, and hepatitis B and C. In addition, PEP Quick Guide is available to guide urgent PEP decision-making online at http://nccc.ucsf.edu when phone consultation is unavailable.

PROCEDURE:

Immediate Treatment

Percutaneous (needle sticks/sharp objects) Injury (where there is the slightest suggestion that the integrity of skin has been broken by a potentially contaminated item)

- Wash wound thoroughly with sudsy soap and running water. If water is not available, use alcohol. Betadine soap, not Betadine solution, is acceptable for this step. (This first step with soap directly reduces the virus's ability to infect).

- Remove any foreign materials embedded in the wound.
- If not allergic, disinfect wound with Betadine solution.

Non-intact Skin Exposure

- Wash skin thoroughly as in #1 above.
- If not allergic, disinfect with Betadine solution.
- There is no evidence that squeezing the wound or applying topical antiseptics further reduces the risk of viral transmission.

Mucous Membrane Exposure

- Irrigate copiously with tap water, sterile saline, or sterile water.

Intact Skin Exposure

- Exposure of intact skin to potentially contaminated material carries no significant risk and is not considered an exposure. Thoroughly clean and wash exposed intact skin.

Post Exposure

- **Transmission of blood borne pathogens**
    - For transmission of blood borne pathogens (HIV, HBV and HCV) to occur, an exposure must include both of the following:
    - (1) Infectious body fluid
        - Blood, semen, vaginal fluid, amniotic fluid, breast milk, cerebrospinal fluid, pericardial fluid, peritoneal fluid, pleural fluid and synovial fluid.
        - Saliva, vomitus, urine, feces, sweat, tears and respiratory secretions <u>do not</u> transmit HIV (unless visibly bloody).
    - (2) A portal of entry (percutaneous, mucous membrane, cutaneous with non-intact skin).
    - If both factors are not present, there is no risk of transmission and further evaluation is not required.

Education

- Exposed person (EP) shall be counseled about the risks involved by the appropriate healthcare provider.

Potential exposure to HIV

- Whenever a worker has been exposed to potentially blood borne pathogens, PEP is indicated. For these exposures, prompt initiation of PEP followed by telephone or in-person consultation with a clinician experienced in HIV PEP is recommended. See above *Consultation*.

Testing

- All exposed individuals will be given the opportunity to have their blood tested for HBV, HCV, and HIV.
- If EP refuses, they will be given the option of having a sample of their blood drawn and frozen for 90 days if they should decide they would like HBV or HIV testing within that time period.
- Determination of source person's (SP) infection status should be assessed as soon as possible after exposure through blood tests offered by SHCHD.
- All blood tests from the SP and EP require consent for testing.
- Baseline testing should be performed at the time the exposure is reported or within 3 days of the exposure.
    - **Source Person (SP)**

        - HBV: HBsAg
        - HCV: HCV antibody
        - HIV: HIV antibody
        - NOTE: If the source of an exposure is an infant less than 15 months old, determine the risk status of the mother. If blood testing is indicated, use mother's blood.

    - **Unknown SP**

        - Evaluate the likelihood of exposure to a source at high risk for HBV, HCV, or HIV infection.

    - **Exposed Person (EP)**

        - HBV: Anti-HBs titer if vaccine status is unknown.
        - HCV: Anti-HCV antibody and ALT
        - HIV: HIV antibody

Post-Exposure prophylaxis (PEP)

- Give PEP as soon as possible, preferably within 24 hours.
- Offer pregnancy testing to all women of childbearing age not known to be pregnant; PEP can be given to pregnant women.
- Seek expert consultation if viral resistance suspected.
- Advise exposed persons to seek medical evaluation for any acute illness occurring during follow-up.

See Attached: Recommended Laboratory HIV Testing Algorithm for Serum or Plasma Specimens

HBV

Post-Exposure prophylaxis (PEP)

Recommendations

- Vaccination and antibody response status of exposed person:
    - Unvaccinated
        - Source HBsAg positive
            - HBIG x 1 and initiate the hepatitis B vaccine series
        - Source HBsAg negative
            - Initiate hepatitis B vaccine series
        - Source Unknown or not available for testing
            - Initiate hepatitis B vaccine series
    - Previously Vaccinated
        - Known responder
            - Source HBsAg positive, HBsAg negative, or Unknown or not available for testing
                - No Treatment
        - Known non-responder
            - Source HBsAg positive
                - HBIG x 1 and initiate reactivation or HBIG x 2
            - Source HBsAg negative
                - No treatment
            - Source Unknown or not available for testing
                - If known high risk source, treat as if source were HBsAg positive
        - Antibody response unknown
            - Source HBsAg positive
                - Test exposed person for anti-HBs
                    - If adequate, no treatment necessary
                    - If inadequate, HBIG x 1 and vaccine booster
            - Source HBsAg negative
                - No treatment

- Source Unknown or not available for testing
    - Test exposed person for anti-HBs
        - If adequate, no treatment necessary
        - If inadequate, HBIG x 1 and vaccine booster

Terms
- Hepatitis B immune globulin (HBIG); dose is 0.06mL/kg intramuscularly
- Hepatitis B surface antigen (HBsAg)
- Responder: person with adequate levels of serum antibody to HBsAg (i.e., anti-HBs ≥10mIU/mL)
- Non-responder: person with inadequate response to vaccination (i.e., serum anti-HBS <10mIU/mL)
- Antibody to HBsAg (anti-HBs)

Follow-Up Testing
- Test for anti-HBs 1 – 2 months after last dose of vaccine series or vaccine booster
- Follow-up not needed if exposed person immune to hepatitis B or received HIBG PEP.

HCV

Post-Exposure prophylaxis (PEP)

Recommendations
- No prophylaxis treatment indicated.

Follow-Up Testing
- If initial Anti-HCV test negative:
    - Test HCV RNA ≥ 3 weeks after exposure
        - Positive: Refer to specialist for further evaluation and treatment.
        - Negative: No further testing required.
- If initial Anti-HCV test positive:
    - Perform Reflex HCV RNA test
        - Positive: refer to specialist for preexisting chronic infection.
        - Negative: Perform follow-up testing as stated above under Anti-HCV test negative.

HIV

Post-Exposure prophylaxis (PEP)

Recommendations
- PEP is generally recommended when an exposure to an HIV positive person has occurred. Additional source person information (e.g., the SP's current or most recent viral load, HIV treatment, history of resistance to HIV medications) can be helpful. Additionally, for an HIV positive SP who has been durably suppressed on HIV medications, transmission risk to the exposed person is significantly lowered.
- PEP is generally not warranted in cases of an unknown source person. However, consider PEP in settings where exposure to HIV-infected persons is likely.
- If it is uncertain whether the exposure constitutes a significant risk and consultation is not available within a few hours, PEP can be started and then consultation may be obtained at a later time, although timely and comprehensive assessment is key.
- If the source person's HIV test is negative at the time of the exposure, they are generally considered uninfected and HIV PEP is not recommended.
    - The "window period" for HIV Ab seroconversion (the period between initial HIV acquisition/infection and development of detectable HIV antibodies) can cause patient and provider anxiety. The Guidelines state, "To date, no transmission to health care workers from an exposure source during the window period has been detected in the United States."
    - Therefore, investigation of whether a source person might be in the "window period" is unnecessary for determining whether HIV PEP is indicated **unless** acute HIV is clinically suspected, or recent (within the previous 1-2 months) high-risk exposure has occurred. If acute HIV is highly suspected, PEP should be started while an HIV RNA PCR ("viral load") is sent from the source person.

Route of exposure	Risk of exposure when source person is HIV positive	Factors increasing risk
Percutaneous	~ 1/435 episodes (0.23%)	hollow bore needles, visibly bloody devices, deep injury, and device used in an artery/vein
Mucous membrane	~ 1/1000 episodes (0.09%)	large volume
Cutaneous	< 1/1000 episodes (0.09%)	must involve non-intact skin integrity

Note: These estimates are from exposures to blood; risk for transmission from infectious fluids other than HIV-infected blood is probably considerably lower than for blood exposures.

Initiation of HIV PEP

- PEP if indicated should be started without waiting for the results of the HIV test.
- If the result from testing the source patient is not immediately available or a complete evaluation of the exposure is unable to be made within 2 hours of the exposure, PEP should be initiated while source testing and further evaluation are underway.
- A negative HIV test only demonstrates that the exposed worker was not previously infected with HIV before the exposure occurred; the baseline HIV test *cannot* determine whether the exposed worker was infected as a result of the exposure.
- First Dose should be given as soon as possible. Optimal time to start PEP is within hours of exposure, rather than days. The PEP line considers 72 hours post-exposure as the outer limit of opportunity to initiate PEP; however, a delay of that scale is believed to compromise PEP efficacy.
- Decisions regarding initiation of PEP beyond 36 hours post exposure should be made on a case-by-case basis with the understanding of diminished efficacy when timing of initiation is prolonged.
- When the source patient is confirmed to be HIV-negative, clinicians should discontinue the PEP regimen before completion.
- If the exposed worker's baseline test shows evidence of HIV infection acquired before the exposure and initiation of PEP, decisions regarding continuation of Antiretroviral Therapy (ART) should be based on current treatment guidelines. However, the PEP regimen should not be discontinued until the positive result is repeated with a confirmatory assay.
- If the exposed worker's week 4 post-exposure HIV test results are indeterminate or the exposed worker has symptoms suggestive of acute HIV infection, clinicians should continue ART beyond 28 days until a definitive diagnosis is established.

HIV PEP

- Preferred HIV 3-Drug Occupational PEP Regimen (medication carried by SHCHD)
    - Truvada [Tenofovir DF 300mg & emtricitabine 200mg] by mouth once daily PLUS
    - Raltegravir 400mg by mouth twice daily
    - Duration 28 days, unless source person is determined to be HIV negative then medication regimen can be stopped before 28 days.
- Alternative regimens available; however, other medications are not available at the District.

Monitoring HIV PEP

HIV Meds	Adult Dosing	Combination Form	Toxicity Monitoring
Tenofovir DF	300 mg by mouth daily	Truvada	BUN, Creatinine, LFTs
Emtricitabine	200mg by mouth daily		Rash
Raltegravir	400 mg by mouth twice daily		Nausea, headache

HIV Exposures in Pregnant Women

- Starting PEP in pregnant exposed persons should be based on considerations similar to those of non-pregnant exposed persons.
- When deciding to start PEP, treating physician should discuss with the pregnant EP should discuss with the potential risks of exposing her fetus to antiretroviral (ARV) medications.
- All pregnant women starting ARVs should be entered in the Antiretroviral Pregnancy Registry, a database designed to collect information on the outcomes of ARV-exposed pregnancies regardless of HIV status: http://www.apregistry.com.
- Acute HIV in pregnancy incurs a high risk of vertical transmission.

- The use of most PEP medications can be justified when the benefits outweigh the risk of infant (and maternal) exposure to ARVs.
- Based on limited data, use of ARVs in pregnancy, including in the first trimester, does not appear to increase the risk of birth defects compared to the general population.
- Toxicities from currently recommended PEP medications are not thought to be increased in pregnancy.

HIV PEP options in pregnancy

- If PEP is to be started in a pregnant exposed person, reasonable options include:
    - Truvada [Tenofovir DF 300mg & emtricitabine 200mg] by mouth once daily PLUS Raltegravir 400mg by mouth twice daily.
    - Duration 28 days, unless source person is determined to be HIV negative then medication regimen can be stopped before 28 days.
        - Pros Include: well-tolerated, TDF/FTC and RAL are both preferred agents in treating HIV+ pregnant women per current DHHS Perinatal Guidelines, very low potential for drug-drug interactions.
        - Cons Include: need for twice daily dosing with RAL.
- Other PEP options may be considered in the event of intolerance, source persons with resistant virus, medication access challenges, or EP preference. In these instances, providers should seek expert consultation.

HIV exposures in Lactating Exposed Persons

- Breastfeeding is not a contraindication for PEP.
- When deciding to start PEP, lactating exposed persons should discuss with the treating clinician the potential risks and benefits of infant exposure to antiretroviral (ARV) medications through breastmilk. The decision to take PEP and/or continue breastfeeding is complex and individualized, and expert consultation is recommended.
- Acute HIV in a breastfeeding mother greatly increases the risk of HIV transmission to her infant.
- There are somewhat limited data on PEP medications in breastmilk:
    - Tenofovir DF and emtricitabine (TDF and FTC, components of Truvada™) and protease inhibitors can be detected in breastmilk only in very limited amounts.
    - Raltegravir (RAL, Isentress®)—unknown extent of breastmilk penetration.
    - For women who choose to take PEP, pumping and discarding is an option to allow continuation of lactation while preventing infant ARV and (possible) HIV exposure.
    - For women who choose not to take PEP, pumping and storing breastmilk while waiting for the source person's HIV testing results is an option. This allows continuation of lactation while not exposing infants to PEP medications or potentially to HIV.

Treatment Procedure

- The duration of treatment is four weeks (28 days). Prescriptions should be written for one week at a time in case the medication is able to be discontinued due to negative source patient HIV results.
- The exposed person should be seen in the emergency room and have a complete medical history, review of systems, and baseline physical examination. Laboratory studies: baseline HIV antibody, Complete Blood Count (CBC) and differential, platelet count, BUN, serum creatinine, total bilirubin, ALT, AST, amylase, and electrolytes.
    - Pregnancy Test: even though PEP has been proven to be safe for pregnant and lactating women, all women of childbearing age must have a blood pregnancy test before starting treatment. Exposed persons with positive pregnancy tests should be referred to a specialist (i.e., Infectious Disease) consultant to manage their PEP.
- Informed Consent: the HCP must review the information regarding PEP and sign the Informed Consent before starting PEP. Individuals under 18 must have parental consent.

Follow-up

- If unknown HIV status or high-risk exposure returns negative, treatment can be discontinued.
- For follow-up on positive HIV exposures, it is advised that the treating practitioner consult with an Infectious Disease specialist.
- Employee should be evaluated by a practitioner at 2-, 4-, and 6-weeks post exposure. The main purpose of these visits is to elicit any signs or symptoms related to either drug toxicity or acute HIV infection.

- A focused physical examination should be performed at the 6-week visit. The EP should be encouraged to report any symptoms to their physician between their regularly scheduled visits.

Follow-up laboratory studies

- Obtained at weeks two and six following initiation of treatment CBC with differential, platelet count, BUN, serum creatinine, total bilirubin, ALT, AST, amylase, and electrolytes. Additional blood tests may be ordered as needed based on any abnormalities that develop during treatment.

Follow-up HIV testing

- If SP is HIV negative, no follow-up testing is clinically indicated for the EP.
- If SP is HIV positive, re-test EP for HIV at 6 weeks and at 3-4 months.
- Note: Follow-up testing (as opposed to baseline testing) can be with either a 3rd or 4th generation HIV test. Both reliably identify if HIV infection has occurred, although the 4th generation HIV Ag/Ab test is preferred for diagnosing acute HIV. A 4th generation test would not necessarily provide important advantages in post-exposure follow-up beyond the first month (or so) after an exposure. Follow-up HIV testing is not needed out to 6 months, as final testing at 3-4 months is sufficient to identify whether transmission has occurred. These PEPline recommendations are slightly different from the USPHS occupational PEP Guidelines, and consistent with the more recent USPHS non-occupational PEP Guidelines.
- Extended HIV testing to 12 months is indicated only for EP who actually acquire HCV infection after exposure to an HCV-HIV co-infected source person.
- If SP cannot be tested for HIV or SP is unknown, testing should be as above.
- Symptoms of acute HIV should prompt immediate evaluation.
- Infectious Disease Specialist Consultation is HIGHLY recommended for the following circumstances:
    - The source patient is known to be HIV positive, or test results are positive in a previously unknown status.
    - Prior diagnosis of HIV in the EP.
    - Pregnant or lactating EP.
    - If the EP is currently being treated with any potentially myelosuppressive, hepatoxic, or nephrotoxic drugs.
    - Liver dysfunction as evidenced by bilirubin, ALT and/or AST greater than 5 times upper limit of normal.
    - Evidence of compromised bone marrow function as indicated by hemoglobin <9.5gm/dl, granulocytes <1,000, or platelets <50,000.
    - Any other significant underlying medical illness which may jeopardize the safety of the EP while taking PEP.

Reporting

- Report the exposure immediately to the supervisor in charge, Chief Nursing Officer (CNO), Clinic Nurse Manager (CNM), or the Employee Health Nurse (EHN), who will assess exposure and refer exposed person to Emergency Department (ED) or Clinic for further treatment.
- If exposed during non-business hours and the above individuals are not available, the EP will be seen and evaluated in the ED by the physician on duty. In addition, the CNO, CNM, or the EHN will be contacted by phone to report exposure.
- The EP will:
    - Complete the "Notice for Injured Workers" form and return to Human Resources.
    - Complete the incident report through the facility electronic incident reporting system and include the following:
        - Date and time of the exposure.
        - Details of the procedure being performed and the use of protective equipment at the time of the exposure.
        - The type, severity, and amount of fluid to which the worker was exposed
        - Details about the SP.
        - Whether consent was obtained for HIV testing of the SP.
        - Any medical documentation that provides details about post-exposure management.
        - Any other pertinent information.

See Employee Injuries Policy and Procedure in Human Resources Section.

Documentation

- Recording Information Following Occupational Exposure
    - When an occupational exposure occurs, the following information should be recorded in the EP confidential medical record:
        - Date and time of the exposure.
        - Details of the procedure being performed and the use of protective equipment at the time of the exposure.
        - The type, severity, and amount of fluid to which the worker was exposed
        - Details about the SP.
        - Whether consent was obtained for HIV testing of the SP.
        - Medical documentation that provides details about post-exposure management.
    - If the EP declines PEP, this decision should be documented in the worker's medical record.

SoHum Health

Subject:	Manual:
Employee Health Policy and Procedures	**Employee Health**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide a safe work environment that helps prevent the occurrence of occupational illness or injury.

PROCEDURE:

SHCHD does not have a formal Employee Health Department. In the event that the Employee Health Nurse requires medical assistance regarding an employee health issue the Clinic Medical Director, or the Chief of Medical Staff, or the emergency room physician is available as a resource.

New Employees

- Human Resources can provide new employees with the *New Employee Health Handout* prior to their Pre-Employment physical.
- Pre-Employment Health Examination
    - Each post-offer applicant will receive a pre-employment health examination by an Advance Practitioner(s) or Medical Doctor(s) at SHCHD to determine that the person is sufficiently free of disease to perform assigned duties and does not have any health condition that would create a hazard for self, fellow employees, or patients or visitors. The health examination will include a medical history and physical evaluation. The Clinic Medical Director OR Hospital Medical Director will co-sign all employment health examinations within 30 days of examination.
    - Candidates who pass this examination may be hired.
    - Newly hired persons will have tuberculosis (TB) screening completed, if documentation is not available for previous testing within the last year (90 days for Skilled Nursing employees*).*
      See Employee Immunization and Tuberculosis (TB) Screening Policy and Procedure
    - Immunization screening and completion of immunization program participation forms will be done by the Employee Health Nurse or designee. All employees will be screened for positive titers, documented past history of infection, or evidence of immunization for the following: Measles, Mumps, and Rubella (MMR), Varicella (chicken pox), Hepatitis B, Tetanus, Diphtheria, Pertussis (Tdap), and COVID-19.
      See Employee Immunization and Tuberculosis (TB) Screening Policy and Procedure
    - All appropriate staff will be fit-tested for the N-95 particulate respirator masks.
      See Respiratory Protection Program Policy and Procedure

Employee Annual Screening

- Tuberculosis screening will be done on all employees, volunteers and licensed independent practitioners.
- Influenza vaccine will be offered to all employees.
- N-95 respiratory device fit testing to appropriate staff.
- Physicians, Licensed Independent Practitioners, and contracted persons:
    - Health requirements for these individuals may include:
        - Annual TB screening; this may be done at the district or at another facility
        - Annual Influenza Program participation; this may be done at the district or at another facility
        - Annual N-95 particulate respirator masks fit-testing participation if patient-care services are provided.
    - It is recommended that these individuals provide evidence of immunity to Hepatitis B as well as evidence of Tdap, MMR, and Varicella immunization; however, it is not the

responsibility of the district to provide the evidence or the immunizations if titres are negative.

Employees Injured on Job

- Complete both the "Notice of Injured Worker Form" and the "Worker's Compensation Claim Form (DWC 1)" as soon as possible after the incident. Both forms are forwarded to the Human Resources Manager who will manage any Worker Compensation Claims and make appropriate OSHA reporting. Employees who require treatment for their injury are referred to either the clinic or the Emergency Room where they are registered as a patient and appropriate care given.
  See Employee Injuries Policy and Procedure

Infectious/Contagious Outbreaks and/or Exposures

- The Employee Health Nurse, or designee, is responsible for managing outbreaks and employee exposures with the assistance of the Infection Preventionist and will arrange for employees to get the appropriate tests and any follow up as needed, including determining work restrictions, if necessary.
  See Outbreak Management Policy and Procedure

Registration

- Employees will register at the Admitting Department for all employee health procedures that cannot be completed within the facility (i.e., radiologic imaging and laboratory specimens).
  - A fact sheet and consent will be generated and will go to the appropriate department.
  - The Employee Health Nurse or designee will enter the appropriate order into the EMR/CPOE/Future Orders, using the Chief of Staff as ordering physician, as a Protocol order.
  - If a procedure is done after hours by the Employee Health Nurse, the employee will sign and outpatient consent. This consent and a copy of the documentation will be forwarded to Admitting, so the employee can be registered during normal business hours.
  - Employees will be registered using Service: Outpatient (12), Primary Insurance: 2/2062 (SHCHD), Secondary Insurance: none, Guarantor: the employee's name, Admitting Diagnosis: Employee Health, Admitting physician: (Current Chief of Staff).

Employee Health Department

- Will keep an active, confidential Employee Health File for each employee in either an electronic file on the server or paper file locked in file cabinet.
- Separated employee(s) from the District will be archived in either an electronic file on the server or paper file locked in designated file cabinet for 10 years following separation from SHCHD.
- Records containing information regarding an employee's exposure to blood borne pathogens will be kept by the district for a total of 30 years after employee separation.
- Access to Employee Health files are limited to the Employee, the Employee Health Nurse or designee, the Chief Nursing Officer, Chief of Staff, and the Chief Executive Officer.
- Employees may obtain copies of all their files by completing a Release of Information form and forwarding it to the Employee Health Nurse. Whenever possible, records will be made available to the employee within one week.

Miscellaneous

- SHCHD is a latex-free glove facility per recommendations of The National Institute for Occupational Safety & Health (NIOSH).
- The Employee Health Program, which includes the Employee Health Nurse, is responsible for:
  - Pre-employment and new hire health screening and testing
  - Employee and Contracted Persons Immunizations
  - TB Screening Program
  - N-95 Particulate Respirator Fit Testing

- Monitoring employee exposures to blood and body fluids, as well as adherence to Standard Precautions and post-exposure protocols. Providing counseling, referrals, and assistance following post-exposure.
- Maintaining employee database of communicable diseases and immunizations
- Determining communicability of transmissibility of employees with infections processes in conjunction with other department(s) (i.e., Infection Prevention)
- Employee exposure management
- Employee Health Records maintenance
- Employee education and training in areas of employee health information and safety
- Providing employee health statistical data to assist with plans for risk reduction programs
- Active member of Safety Committee
- Resource to other departments in matters related to employee health
- Interfaces with the Medical Staff

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Respiratory Protection Program	**Employee Health**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD" or "District") to provide respiratory protection devices to all staff whenever there is a possibility of exposure to an Aerosol Transmissible Disease (ATD).

RESPIRATORY PROTECTION DEVICES (RPD):

- The primary respiratory device selected for use in this facility is a particulate filter respirator (PFR N-95) which is approved by the National Institute for Occupational Safety and Health (NIOSH).

- Medical Evaluation for Fit Testing:
  - Staff who will wear RPDs will be evaluated for any condition that may preclude its use.
  - Personnel will be screened upon employment and on an annual basis.
  - General screening for pertinent medical conditions will be conducted prior to fit-testing. Each employee will complete a general medical screening questionnaire.
  - A medical provider will approve each employee for use of a respirator.
  - Further medical evaluation will be done on any employee who may have difficulty wearing the RPD while performing his/her duties or when adverse health effects result.

- Employee Fit Testing:
  - Qualitative fit testing is performed using a saccharin or bitter technique on all designated employees.
  - Will be done at the time of hire and annually, using the same make and model of RFD that the employee will use in the workplace.
  - Whenever a new make or model is introduced, fit-testing to the new RPD must be done.
  - If the specific type of RPD cannot be fitted properly to an individual, either another brand will be obtained or the employee will be asked to stay away from individuals who could carry ATDs.
  - Employees are encouraged to inform their manager if an RPD no longer appears to fit him/her properly.
  - Employees with facial hair or other conditions that interfere with obtaining an adequate fit will not be permitted to wear a respirator. This will preclude his/her working with certain patients known or suspected of having an ATD unless he/she is trained to use a PAPR (powered air purifying respirator). *See policy "Use of Powered Air Purifying Respirators."*

- Re-donning of masks in not permitted at the District, except in certain circumstances when the Administration deems otherwise.

HIGH RISK INDIVIDUALS/PROCEDURES:

- Staff who are considered at high risk for being exposed to Aerosol Transmissible Diseases include:
  - Registered nurses, licensed vocational nurses, certified nursing assistants, activities workers, radiology staff, laboratory staff, admitting staff, housekeeping staff, rural health clinic staff, and engineering staff.

- Procedures performed in this facility which can be considered high-risk include:
  - Endotracheal intubation, gastric intubation, respiratory treatments, sputum inductions, and respiratory tract suctioning.

- Use of Negative Isolation Rooms:
    - The hospital does NOT have a negative isolation room. Patients requiring isolation must be transferred to a facility with these rooms. Because not all ATDs require negative isolation rooms, not all of these patients will be transferred and therefore all employees who may interact with inpatients need to be familiar with these respirators.

PROCEDURE:

- Only personnel who have received specific education on ATDs, have been fit-tested for a Respiratory Protective Device (RPD), and have undergone training regarding the use and wearing of RPD may assist with procedures being performed on a patient with a known or suspected ATD.
- Before use of the RPD, the employee should perform a fit check, which has been demonstrated in the training session.
- Management of Possible ATD Patients:
    - All suspected or confirmed ATD whose condition requires an isolation room will be transferred promptly to a facility with a negative pressure room.
    - Outpatients:
        - Place suspected ATD patient in separate waiting area, away from other patients. Place patient in room equipped with the recommended ventilation, if available.
        - Place a surgical mask (N-95 respirator may be used) on the patient and instruct patient to keep mask on.
        - Provide the patient with tissues with instructions to cover mouth or nose when coughing or sneezing.
        - Schedule suspected ATD patients at a time to avoid contact with immunocompromised patients.
        - Tuberculosis precautions must be followed for patients known to have active TB, but who have not completed treatment until they are known to be non-infectious.
    - Emergency Medical Services:
        - The patient should wear a surgical mask (N-95 respirator may be used) when being transported if an ATD is suspected or confirmed.
        - The healthcare worker should wear RPD.
        - Emergency-response personnel are responsible for their own respiratory protection program.
    - DP/SNF:
        - All new residents require TB symptom screening and Interferon-Gamma Release Assays (IGRAs)
        - All new residents with a previous positive-tuberculin skin test (TST) reaction require testing through Interferon-gamma release assays (IGRA) and/or chest x-ray (CXR) AND TB symptom screening.
        - Residents shall be evaluated annually for through appropriate testing (i.e., TST, CXR and/or IGRA) and TB symptom screening.
        - TST conversions will receive further diagnostic testing by the provider and require notifying the facility's Infection Preventionist.
        - After suspected exposure to TB, negative TST residents will require a repeated TST 10 weeks after exposure.
        - Residents with suspected and confirmed cases of TB will require prompt transfer and treatment at the receiving facility.

DEFINITIONS:
None

SoHum Health

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

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to organize and maintain immediate access to supplies and medications used in emergency situations with the use of crash carts. To help save valuable time, crash carts shall be easily movable, and all sides of the cart shall be easily accessible during a crisis. A list of crash cart medications and quantities shall be hung on the side of the cart for viewing and restocking purposes. Crash carts will be sealed by nursing or pharmacy in such a manner that a seal must be broken to gain access to the medications. Pediatric medications and supplies are segregated in a separate crash cart dedicated only for pediatrics. All crash carts should be checked and replenished immediately after use.

DEFINITIONS:
Crash Cart- A crash cart is a means of storing and transporting vital equipment and drugs which may be required during a Code Blue (cardiac emergency) to the location of the emergency.

PROCEDURE:
- Crash carts will be located in each unit where it is accessible and known to all staff.
- Crash carts must be checked by head nurse/staff nurse at every shift.
- Checks should be documented on the lists maintained on the crash cart.
- All nurses should be familiar with the crash cart contents and layout.
- New employees will be oriented to all emergency bags/kits/carts and procedures.
- Crash carts will be inventoried and restocked after each use and checked at least monthly and documented by nursing staff or the pharmacist.
- Nursing shall test defibrillators daily.
- Nursing shall be responsible for communicating the restocking and replacement needs in writing to Pharmacy and Material department.
- Back-up emergency supplies shall be kept in the med room Main Pyxis.
- During operating hours, Pharmacy is responsible for restocking medications in drawers 1 & 2 in the crash carts as soon as possible and sealing them with a red plastic lock.
- Materials will be restocked by the Materials Department.
- Outside of normal operating hours, nursing shall be responsible to replenish the contents of the crash carts.
- In the absence of pharmacy staff, nursing staff will restock the cart using the Pyxis machine under the patient listed as "Crash Cart" and seal it with a yellow lock.
- The lock number on the seal will be recorded in the crash cart log along with the date and initial of the pharmacy staff who refilled it.
- The pharmacy staff will then verify all yellow seals and replace the seal with a red lock as outlined above.
- Pharmacy shall check crash carts monthly for expiry dates.
- Training programs will be provided to maintain competency in emergency response.

SoHum Health

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

POLICY:

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

Drugs shall be administered by licensed personnel authorized to administer drugs upon the order of a person lawfully authorized to prescribe. The order for drugs shall include the name of the drug, the dosage, and the frequency of administration, the route of administration, and the date, time and signature of the prescriber.

Orders for drugs should be written by the prescriber. Verbal orders are strongly discouraged and shall be limited to situations which would result in delayed care.

Verbal orders for drugs shall be given only to a registered nurse, licensed vocational nurse, or pharmacist by a person lawfully authorized to prescribe and shall include a readback for verification. They shall also be recorded promptly in the patient's medical record, noting the name of the person giving the verbal order and the signature of the individual receiving the order. The prescriber shall countersign the order within 48 hours.

When available, medications will be dispensed as pre-mixed IV bags or in unit-dose packaging both directly prepared by the manufacturer.

PROCEDURE:

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

- Medication orders shall be entered into EPIC by the ordering provider.
- The pharmacist reviews the prescriber orders and interprets it to ensure accuracy and suitability of the dosage form, timing of medication administration, duplication, interactions, or allergies.
- The pharmacist clarifies any problems or questions on the order, consulting with the prescriber when necessary.

DEFINITIONS:
None

SoHum Health

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

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to implement strategies and safeguards for high alert medications. High-Risk Medications are medications that have an inherent narrow therapeutic index and/or have the potential to cause serious adverse events when administered incorrectly.

Several strategies and safeguards are instituted to ensure high alert medications are procured, stored, prepared, dispensed, and administered safely.

PROCEDURE:

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

- Adrenergic agonists IV (epinephrine, norepinephrine)
- Adrenergic antagonists IV (metoprolol, labetalol)
- Anesthetics / Sedatives (ketamine, midazolam, propofol)
- Antithrombotics and specific anticoagulant agents (heparin, warfarin)
- Concentrated electrolyte solutions
- Hypertonic Solutions (NaCl 3%)
- Hypoglycemics (glipizide, glyburide)
- Inotropoics (digoxin)
- Insulin (SC and IV)
- Neuromuscular blocking agents (succinylcholine, rocuronium)
- Opioids

We strive to improve patient safety by proactively employing additional safety measures to protect patients from harm related to High-Risk Medications, which bear a heightened risk of harm.

Current risk reduction strategies for High-Risk Medications include:

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

DEFINITIONS:
None

SoHum Health

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

POLICY:

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

PROCEDURE:

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

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

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Loss and Diversion	**Hospital Pharmacy**

POLICY:

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

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

PROCEDURE:

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

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

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

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

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

DEFINITIONS:
None

SoHum Health

Subject: Managing Temperature Excursion	Manual: Hospital Pharmacy

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to manage temperature excursions of medications and vaccines stored in the facility. Temperature excursions can occur due to a variety of factors, such as malfunction in the storage unit, long power outages, unit door being left ajar and so on. These excursions can take a toll on the potency of the medication or vaccine, leaving them ineffective. In situations wherein a temperature excursion is observed, it is important to take immediate remedial actions.

Once a temperature excursion is detected, as defined in our *Medication Monitoring and Storage Policy*, the process outlined below for managing temperature excursions shall be followed.

DEFINITIONS:

Temperature Excursion- temperature excursion, usually referring to any temperature reading outside the manufacturer's recommended storage range.

PROCEDURE:

1. Initial Response
    a. Any staff member who hears an alarm, receives an alert message, or notices a temperature excursion should notify pharmacy personnel immediately or report the problem to a supervisor.
    b. Isolate any products affected by the temperature excursion to prevent further distribution.
    c. For room temperature excursions, quarantine the affected stock and attach a "DO NOT USE" label.
    d. For fridge temperature excursions, quarantine the affected stock within the fridge and attach a"DO NOT USE" label.

2. Document the Event
    a. The person reporting the problem should document the description of the event by completing the *Medication Storage Troubleshooting Record Form* (see attached form~~Appendix A~~) and retain for record keeping.
    b. Name of the person completing the report.
    c. Date and time of the temperature excursion.
    d. Inventory of affected products.

3. Take corrective action to prevent reoccurrence
    a. Check obvious causes such as, the fridge door having been left open or a power switch having been turned off.
    b. Ensure the fridge is functioning correctly. The fridge should be returned to use only once it has been confirmed to be functioning correctly.
    c. Confirm the temperature is within range or has returned to the normal range.
    d. Where no obvious rectifiable cause can be identified, notify Engineering and take the fridge out of use until an investigation into the cause of the excursion has been concluded.
    e. Only the pharmacist shall assess the product by using the stability data and manufacturer recommendations to determine if the product is still useable.
    f. Medications without any off-label stability data will be disposed.

~~Looking For appendix A~~

Medication Storage Troubleshooting Record (check one): Refrigerator ☐ Freezer ☐

Use this form to document any unacceptable storage event, such as exposure of refrigerated vaccines to temperatures that are outside the manufacturers' recommended storage ranges.

Date & Time of Event If multiple, related events occurred, see Description of Event below.	**Storage Unit Temperature** At the time the problem was discovered		**Room Temperature** At the time the problem was discovered	**Person Completing Report**	
Date:	Temp when discovered:		Temp when discovered:	Name:	
Time:	Min. temp:	Max. temp:	Comment (optional):	Title:	Date:

Description of Event *(if multiple related events occurred, list each date, time, and length of time out of storage.)*

- General description (i.e., what happened?)
- Estimated length of time between the event and last documented reading of storage temperature in an acceptable range (2° to 8°C[36° to 46°F] for refrigeration; -50° to -15°C[-58° to 5°F] for freezer)
- Inventory of affected medications/vaccines, including (1) lot #s and (2) whether purchased with the public (for example, VFC) or hospital stock?
- At the time of the event, what else was in the storage unit? For example, were there water bottles in the refrigerator and/or frozen coolant packs in the freezer?
- Prior to this event, have there been any storage problems with this unit and/or with the affected items?
- Include any other information you feel might be relevant to understanding the event.

Action Taken *(Document thoroughly. This information is critical to determining whether the item is viable!)*

- When were the affected items placed in proper storage conditions? (Note: do not discard the item. Store the item in proper conditions and label it "do not use" until after you can discuss it with your state/local health department and /or manufacturer[s].)
- Who was contacted regarding the incident? (for example, supervisor, state/local health department, manufacturer – list all.)
- IMPORTANT: What did you do to prevent a similar problem from occurring in the future?

Results

- What happened to the affected item(s)? Was it able to be used? If not, was it returned to the distributor?

SoHum Health

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

POLICY:

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

PROCEDURE:

- Only active medications determined by the attending physician, prescribed by a lawfully authorized licensee, shall be administered.
- Medication administrations are to be documented only using the electronic MAR (EMAR).
- Patients shall be identified prior to the administration of all medications by verifying 2 patient identifiers. Identifiers include name, medical record number, date of birth, phone number, social security number, address, and photo.
- Only medications listed in the hospital formulary and approved non-formulary medications brought from home may be used for administration.
- Only licensed personnel shall prepare, administer, and document administrations.
- The administration documentation shall include details including the patient's symptoms, route, time, effect, and signature.
- No one shall administer, prepare, or document for another licensee.
- Under the direct supervision of a licensed medical personnel unlicensed persons who demonstrate competence may administer topicals not associated with treatment of eyes, ears, nose, mouth, or genitourinary tract during training or after completion of training.
- Compounded sterile products must be administered within 1 hour from the start of the preparation time.
- If a compounded sterile product is not administered within 1 hour, it shall be discarded.
- Single dose vials or preparations of any kind shall be used for only one patient and discarded immediately after use.
- Multidose injectables shall have a beyond-use-date per the manufacturer's expiration date or 28 days after opening, whichever is sooner.
- Multidose tablets or liquids shall have a beyond use date of 1 year from opening.
- Medications shall be administered within one hour on either side of the time it is due for administration.
- Oral medications shall be witnessed by the administering nurse and not allowed to remain at the bedside.
- Medications supplied for one patient shall not be administered to another patient.
- If a medication is not administered, the licensee shall document it in the chart along with the cause.
- No samples will be administered to patients of the District.
- Investigational drugs must be authorized by the FDA for Emergency Use to be administered.
- Medication errors and/or drug reactions are immediately reported to the attending physician, charted in detail on the nurse's notes, and described in the electronic event reporting system.

Medication Administration Schedule

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

Daily - 0800	PO/IV meds
BID - 0800; 2000	PO/IV meds
TID - 0800; 1400; 2000	PO meds
QID - 0800; 1200; 1800; 2100	PO meds

Q6H – 0000; 0600; 1200; 1800	IV meds
Q8H - 0800; 1400; 2000	IV meds
QHS - 2000	PO/IV meds

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

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

DEFINITIONS:
None

SoHum Health

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

POLICY:

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

PROCEDURE:

Monitoring of Medications

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

Wireless Temperature Monitoring (Medication)

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

Temperature Ranges

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

United States Pharmacopeia (USP)10.30.60

"Controlled Room Temperature" indicates a temperature maintained thermostatically that encompasses the usual and customary working environment of 20 to 24 degrees C (68 to 77 degrees F); that results in a mean kinetic temperature calculated to be not more than 25 degrees C; and that allows for excursions between 15 and 30 degrees C (59 and 86 degrees F) that are experienced in pharmacies, hospitals, and warehouses. **Provided the mean kinetic temperature remains in the allowed range, transient spikes up to 40 degrees C (104 F) are permitted as long as they do not exceed 24 hours. Spikes above 40 degree C may be permitted if the manufacturer so instructs.** Articles may be labeled for storage at "controlled room temperature" or at "up to 25 degree" or other wording based on the same mean kinetic temperature. The mean kinetic temperature is a calculated value that may be used as an isothermal storage temperature that simulates the non-isothermal effects of storage temperature variations.

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

Storage of Medications

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

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

DEFINITIONS:
None

SoHum Health

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

POLICY:

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

PURPOSE:

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

PROCEDURE:

- The procedure below outlines the steps taken:
    - Medications from home may only be accepted if there is a current active order for a non-formulary or out of stock medication.
    - Upon accepting home medications, the receiving nurse shall enter a note in the patient's profile detailing which medications were received and when.
    - Prescription medications must be presented in a vial with the original label from the pharmacy to be accepted as a home medication. Loose tablets or unlabeled vials will not be accepted.
    - A physician or pharmacist shall verify the identity and integrity of all home medications at the time of their drop-off. If neither are available to verify a medication, a nurse may verify the medication through the use of Lexicomp's "Drug I.D." function.
    - Once verified, their medications will be labeled with a yellow, "MEDICATION FROM HOME TAKEN TO PHARMACY" sticker and initialed by the verifying agent.
    - ED home meds will be stored at the ED nurse's station.
    - Inpatient home meds will be stored in the appropriate cart (Swing or SNF) at the inpatient nurse's station.
    - If the directions stated on the home medication differs from current orders in EPIC, the directions within EPIC shall be followed. A white, "DIRECTIONS CHANGED REFER TO CHART" sticker shall also be placed on the home medication to ensure accurate administration throughout their stay.
    - The medications will be marked in the electronic record as home medications to avoid improper charges.
    - If a home medication is discontinued, it shall be placed in a security bag and sealed. A registration label with the patient's name shall be placed on the bag and kept in the appropriate drawer labeled "Patient's own discontinued medications".
    - A label stating "MEDICATION FROM HOME TAKEN TO PHARMACY" shall be placed on the Personal Belongings Listing form as a reminder to review any home medications taken from the patient on arrival and return them upon discharge.
    - If the patient is in Long Term Care then a prescription shall be sent to the contracted pharmacy for the ordered medication. Home medications shall be used until the pharmacy furnishes the order and is available on site.
    - Home medications for a controlled substance shall be recorded to include the name, quantity, and dates for accuracy. They will be stored inside the safe in the Nurse's Station.
    - A signature is required for controlled substances dropped-off and picked up at discharge.

- No medications will be administered which do not meet proper labeling or integrity requirements.
- Nurses are not to administer home medications that have not been verified.
- If the stored medications have not been picked up within 14 days of discharge or in the event the patient expires, nursing staff will follow the procedure laid out in the Disposition of Medications Policy.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
District Prescription Blanks	**Hospital Pharmacy**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to sign up all providers to E-prescribe all medications. All efforts will be made to complete the registration process for Imprivata and MFA in order to prevent the use of paper prescriptions. Prescriptions shall only be printed if E-prescribing is not possible.

In order to prevent fraudulent use, the prescription blanks shall be stored in a locked drawer in approved locations. The District will keep an inventory and account for which prescription blanks are stored in each printer device.

The procedure for the ordering, storage, use, and monitoring of the District's blank prescription pads is as follows:

PROCEDURE:

- Ordering
    - Prescription blanks will be ordered and inventoried by the Pharmacy Department.

- Storage
    - Overstock prescription blanks will be locked inside the Med Room and replenished by pharmacy.
    - Prescription blanks in use will be in approved printers that will be locked.
    - The number of the blanks will be documented in a separate spreadsheet title "Prescription Blanks".

- Use
    - Printed prescription blanks must be signed and dated in ink by a licensed independent practitioner authorized to prescribe medications.

- Monitoring Loss or Theft prescription blanks
    - Loss or theft must be reported to the local law enforcement and create an incident report.
    - After the discovery of loss or theft, the physician shall immediately report to the Department of Justice (DOJ) Controlled Substance Utilization Review and Evaluation System (CURES) program. Email SecurityPrinter@doj.ca.gov
    - The physician shall notify the California State Board of Pharmacy by email to BOPcomplaint@dca.ca.gov
    - The physician shall notify the Medical Board by email to complaint@mbc.ca.gov

DEFINITIONS:
None

SoHum Health

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

POLICY:

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

PROCEDURE:

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

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

DEFINITIONS:
None

SoHum Health

Subject: Downtime Procedures	Manual: Hospital Pharmacy

POLICY:
N/A

PROCEDURE:

All Pyxis MedStations should be plugged into emergency power outlets, if available, to ensure electricity will be available to operate the stations during a power outage. If a MedStation experiences a loss of power or loss of communications, check the power plug and data plug first. Contact the pharmacy during hours of operation for help. Should a Pyxis Medstation ever become inoperable when the pharmacy is closed, Nursing should contact Pyxis Support directly at (1-800-727-6102). If Pyxis Support is unable to resolve the issue, contact the on-call pharmacist.

- Keys to allow access to the MedStation(s) in case of an emergency will be kept in a lock box near the Main Pyxis Medstation. The Pharmacy Director or designee will have access to initiate down time procedures or to allow Pyxis Support access for repairs.
- Downtime Scenarios and Responsibilities
  - **EPIC is not functional.** Symptom: Recent patient ADT information and ordered medications are not appearing at the MedStation.
    - Pharmacy Responsibilities
      i. From the Pyxis ES Server, transition Pyxis Medication stations to critical override mode.
      ii. Pharmacy staff will generate and review the Pyxis override report to ensure that Physician orders are present for all medications dispensed during downtime procedures as soon as possible.
    - Nursing Responsibilities
      i. Medications ordered during downtime will be accessed via Pyxis override.
      ii. For patients admitted during downtime procedures, the nurse may admit the patient at the MedStation from the main menu. Select "All Available Patients", "Select Add Temporary Ppatient" and enter the information, select "Save" and then remove medications under the override function for the Profile Stations with a witness.
      iii. Providers or their nurse will process order entry for all medication orders received during downtime as soon as EPIC is operational.
  - **Pyxis Medstation is not functional.** Symptom: MedStation is not responding or responding inappropriately.
    - Pharmacy Responsibilities
      i. Attempt to troubleshoot the problem. See Pyxis Operator's Manual, Troubleshooting
      ii. If the problem is not resolvable, contact Pyxis Customer Support immediately (1-800-727-6102).
      iii. If the downtime is expected to be lengthy, the pharmacy should consult with the nursing service to determine if a 24-hour supply of non-controlled medication is desired or if the nurses prefer to obtain the medication from a nearby Pyxis MedStation.
      iv. In critical situations, the on-call pharmacist will come onsite to physically access the medications within the Pyxis to provide patient care.
    - Nursing Responsibilities
      i. If possible, obtain medication from another nearby MedStation until the problem can be corrected.
      ii. Immediately contact your pharmacy department to inform them about the issue and discuss alternative medication retrieval methods.
      iii. If unable to reach pharmacy personnel, contact Pyxis support 24 hours a day at (1-800-727-6102)
  - **EPIC and Pyxis MedStation is not functional**. Symptom: General power failure
    - Pharmacy Responsibilities

i. Contact Engineering to notify of power failure and/or verify possible downtime duration.
ii. Contact IT to notify of Pharmacy Computer downtime.
iii. In critical situations, the on-call pharmacist will come onsite to physically access the medications within the Pyxis to provide patient care.

- Nursing Responsibilities
  i. Report the problem to the Pharmacy immediately.
  ii. If possible, obtain medication from another nearby MedStation until the problem can be corrected
  iii. Medications will be removed from the Main or ER Pyxis MedStations by a nurse.
  iv. The nurse will document all medications dispensed with patient name, Episode Number, patient location, time and date of dispensation, as well as the nurse receiving the medication.
  v. Medication charges will be reconciled using the downtime Medication Administration Record (MAR) and the Pyxis override report.

- If the Pyxis ES Server will be down for greater than 24 hours, an All Device Events Report will be run at each MedStation as well as a Refill Report to refill each unit.
- Pharmacy staff will reconcile all Controlled Medications (CS) following Pyxis downtime.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Pyxis Education	**Hospital Pharmacy**

POLICY:
N/A

PROCEDURE:

Education

- Training modules will be assigned to nursing and pharmacy staff by Human Resources as part of the onboarding process.
- Annual training of pharmacy and facility staff will be completed to ensure proper use of the Pyxis Medstations and reduce possible errors.
- Education and feedback will be provided by pharmacy to help address recurrent or possible recurrent issues.
- Immediate education will be provided by pharmacy for urgent issues or concerns.

DEFINITIONS:
None

SoHum Health

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

POLICY:
N/A

PROCEDURE:

Maintaining Pyxis Formulary, Station Inventory, and Refilling Medications

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

Remote Access

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

Medication Access - Expire, Waste, Recall

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

Refilling

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

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Pyxis Reports and Data	**Hospital Pharmacy**

POLICY:
N/A

PROCEDURE:

Reports - The following reports will be setup in Pyxis.

- Discrepancy Report- Run daily on weekdays in the pharmacy and notify the pharmacist of any open discrepancies. The pharmacist is responsible for ensuring that the discrepancy gets resolved.
- Pick and Delivery Report - This report is used to identify which medications need to be restocked in the Pyxis machines. Run daily on weekdays for all medications stocked in the MedStation. Pharmacy technicians will use this report when refilling the MedStation.
- Ordered Medications Not Loaded - Medication(s) will appear on this report each time a medication is entered into the pharmacy computer system and is eligible for being stocked in the Pyxis MedStation but is currently not stocked there. Pharmacy will use the report to identify medications warranted for formulary addition review.
- Profile Override - This report is used for audit purposes to verify that the medications that were obtained from the MedStation via "override" have an order written and entered into the pharmacy computer system.
- Outdated Inventory - This report is run in the middle of the month to alert the technicians when there is going to be outdated medication through the first day of the following month. The technician is responsible for checking the medication to ensure the date is correct and removing any expiring medications.
- All Devices Events – This report captures all Pyxis station events pertaining to Controlled Substance events. It will be reviewed to assist in any discrepancy resolution.
- Proactive Diversion Report- Will assist in quality assurance to aid in investigating discrepancies.

Archiving of Data
Pyxis ES Data is archived daily, with access to reports for 90 days from the ES Server and then in Knowledge Portal going back to 10 years. CS documentation is readily retrievable and maintained onsite for 3 years.

DEFINITIONS:
None

SoHum Health

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

POLICY:
N/A

PROCEDURE:

- The following SoHum Health staff are provided access to Pyxis in the Patient care area(s) in which they are assigned.
    - ER Physicians
    - Licensed Vocational Nurse
    - Medical Assistant
    - Medical Provider
    - Nurse Practitioner
    - Optometrist
    - Pharmacist
    - Pharmacy Technician
    - Physician Assistant

- It is the responsibility of Department Managers to inform Information Technology (IT) of staff changes in a timely manner. Information Technology (IT) shall review all Pyxis access modifications routinely to maintain the integrity of Pyxis Technology and medication security.
    - Pyxis will contain both Unit and Multi-Dose medications. Certain multi-dose medications will be treated as a single dose and discarded once opened. These are identified upon dispensation with SDV or MDV.
    - Bulk fluids such as NaCl, D5W, Lactated Ringers, and fluids for reconstituting will be stored as Floor Stock outside the Pyxis.
    - Some refrigerated medications will be available through Pyxis and their location in Pyxis will be designated "Remote Manager" with a Pyxis lock on the fridge.
    - There are 3 Medication Override groups assigned:
        - Basic
        - Critical Care
        - Vaccines
    - Use of Pyxis MedStations are restricted to removing medications for hospital, Swing, Skilled Nursing Facility and Clinic patients only. No medications may be removed for staff or visitors who are not registered patients. Medications are dispensed only on a valid order from a licensed practitioner.
        - The system prompts the user to remove the quantity appropriate to the medication order.
        - If the medication is not available at the current MedStation, the medication may be dispensed from another MedStation.
        - Override medications will appear on the Pyxis Override Report. Pharmacy staff will review this report to ensure that each override has a corresponding physician's order in EPIC. It is expected that the user utilize the comment field to explain the need for each override.
        - Any remaining balances in the Emergency Department from the use of injectable multi-dose vials will be returned to the Pyxis stock.
        - Medications not administered to a patient will be returned to the Pyxis return bin if the medication packaging is intact.
        - Controlled Substance removal and waste documentation requires a witness with Pyxis access.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Pyxis User Maintenance Procedure	**Hospital Pharmacy**

POLICY:
N/A

PROCEDURE:

To detail the function, maintenance, integrity, and security of Pyxis Technologies at Jerold Phelps Community Hospital.

- The Pharmacy Director identifies individuals who will be responsible for assigning and maintaining formulary changes and user identification.
- Pyxis access is requested by Departmental Managers via emailing the Pyxis Administrator who will then grant access based on notifications from the IT Security Team.
- New users are added into the Active Directory by IT, which then adds them to the Pyxis User Group. Both the USERID Login and initial password is created by IT. The user would then need to login to one of the hospital PC's to change their password, which, in turn, is then changed in Pyxis.
- The Pharmacy Director will assign the Roles/Areas to the end user.
- Department Managers shall inform Information Technology (IT) and Pharmacy by email when their respective employee contract has been completed or terminated.
- Human Resources will notify Information Technology (IT) and Pharmacy by email when a Pyxis end user is terminated.
- Pharmacy will then immediately remove access privileges if IT has not done so yet.
- Changes in access privileges require the Departmental Manager to contact the Pharmacy Director via e-mail.
- New nursing personnel will be assigned Pyxis training on Relias as part of their orientation.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Immediate use Compounding	**Hospital Pharmacy**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") that all compounded sterile products be performed for immediate use only. Immediate Use Compounding of sterile preparations is for administration to a patient within one hour of the start of the compounding process. This process involves following aseptic techniques and meeting certain criteria to minimize the risk of contamination and errors. Efforts will be made to purchase commercially prepared, premixed parenteral products to limit all Immediate Use Compounding. This process may be done only by properly trained registered nurses, pharmacists, physicians, physician assistants and nurse practitioners.

DEFINITIONS:

CSP (Compounded sterile products)- Sterile compounding is the method of preparing medications for patients in a sterile environment to prevent contamination and ensure patient safety. It involves combining, admixing, diluting, pooling, reconstituting, repackaging, or otherwise altering a drug product to create a sterile preparation.

PROCEDURE:

- Document the time at which the start of the compounding process has begun.
- The medication administration must begin within one hour and be completed within four hours of preparation. Ideally, there are no steps between compounding and administration.
- The preparation should involve no more than three different sterile products.
- Hazardous drugs should not be used.
- Any unused components from single-dose containers should be discarded after preparation.
- If the medication is not administered within 1 hour of compounding, it should be discarded.
- The medication should be prepared in close proximity to where it will be administered.
- Compounding of sterile products shall be performed only at designated areas in the facility: med carts in the ER, Acute, SNF, nursing units; treatment room in clinic.
- Compounding area surfaces will be cleaned and disinfected at least daily, when in use, with a hospital approved germicide.
- Compounding areas will be free of clutter and obvious sources of contamination (for instance, sinks).
- Hand hygiene must be performed and gloves must be worn prior to compounding sterile products.
- No products will be compounded using non-sterile products.
- The CNO is responsible for education of staff regarding proper compounding of IV admixtures.

The CSP must be labeled with the following:
Names and amounts of all active ingredients,
Name or initials of the person who prepared the preparation,
The 1-hour time period within which administration must begin (beyond-use date).

The following examples are not considered Immediate Use Compounding:
Reconstitution of powder in a vial and drawing it up for administration in a syringe,
Drawing up a liquid from a vial for administration.

SoHum Health

Subject:	Manual:
Patient Transport and Vehicle Safety	**Security and Transportation**

Policy:

It is the policy of the Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to ensure the safe operation of district-owned vehicles, reduce the risk of vehicle-related liabilities, and ensure that the district's process for referring, transferring, or discharging patients includes an understanding of their transportation needs while receiving services from the district. This policy applies to all employees who operate district-owned vehicles.

Procedures:

Employees operating a district-owned vehicle shall comply with applicable state and federal regulations.Department managers or their designee must provide the Human Resources (HR) Manager with the following information by completing the *Automobile Driver/Vehicle form* for any employee using district-owned vehicles:

- Date of request
- Name of the employee
- Employee's date of birth
- A copy of the employee's valid driver's license

This information will be maintained on file in the HR office. HR will ensure the above information is sent to the district's insurance carrier and included in the DMV Pull Notice Program.
Employees without current information on file are prohibited from using district-owned vehicles.

General Requirements:

All employees operating district-owned vehicles must meet the following requirements:

- Complete a physical, including drug testing, which assesses their fitness for vehicle operation.
- Maintain an appropriate class and valid California driver's license, which must be in their possession while operating a district-owned vehicle.
- Have a district ID in their possession while operating a district-owned vehicle.
- Report any on/off-duty traffic citations incurred to the HR Manager.
- Failure to comply with these requirements could result in job reassignment, disciplinary action, or discharge.

Safety Requirements: :

The following requirements apply when using either district-owned **or when using contracted services.**

- All occupants must wear seat belts while driving or riding in district-owned vehicles.
- Only authorized passengers may be carried in district-owned vehicles.
- District-owned vehicles must be locked whenever unattended.
- All employees operating district-owned vehicles must exercise caution and safe defensive driving behavior.
- Use of illegal drugs, prescription medications that modify alertness, or alcohol within eight (8) hours of operation is strictly forbidden, and use may result in immediate termination of the employee.

- Vehicle inspections are to be made daily, before and after vehicle use. Inspections shall ensure the safe operating condition of the vehicle. Check fluid levels and function of lights, brakes, horn, and steering; check tire pressure and tread, and any items required by local, state, or federal regulations.
- Any defects, unsafe conditions, or damage must be reported immediately to Security and Transportation when noticed or incurred.
- All vehicle loads must be adequately secured before beginning any trip. Loads must be inspected and secured to avoid movement, damage, or loss during transport.
- Providing transportation to hitchhikers is prohibited.
- Personal use of district-owned vehicles is prohibited.
- Smoking in district-owned vehicles is prohibited.
- Cellular phone use is prohibited while driving a district-owned vehicle. Drivers should pull off the road in a safe area to make or answer calls.
- Appropriate measures shall be taken to protect the vehicle and its contents from theft or vandalism. Any occurrences of theft or vandalism must be reported to the Security and Transportation Department immediately. An Incident Report is to be completed as soon as practical.
- Abuse of any district-owned vehicle justifies removing an individual's driving privileges.
- All transport vehicles utilized by the district shall comply with the infection control program.

Accident Procedures:

Report all accidents involving district-owned vehicles immediately to the Security and Transportation Department and the Chief Operations Officer. The district will subsequently notify the insurance carrier of the accident.

- If an employee is involved in an accident while driving a district-owned vehicle, their first concern should be for the safety of any passengers or pedestrians who might be injured. Seek first aid and request an ambulance if necessary.
- If the vehicle is off-campus and involved in a motor vehicle accident, report the accident to local law enforcement immediately.
- Complete an incident report for accidents involving a district-owned vehicle. Document the details of the accident. Complete all information prior to leaving the scene. This should include names, addresses, phone numbers, vehicle license numbers, and insurance information for drivers and vehicles involved. Record names, addresses, and phone numbers of any witnesses.
- Do not discuss the events with other parties involved. Do not accept responsibility for the accident, associated damage or injuries.
- Employees involved in an accident while in a district-owned vehicle must report to Employee Health.
- In the event of an emergency breakdown, notify Security and Transportation immediately. If this requires leaving the vehicle, secure the vehicle prior to leaving it at the roadside.
- Report the nature of the problem.
- Establish the exact location of the vehicle.
- Return to the vehicle as soon as possible.
- Assist in coordinating roadside repair or towing service.
- Abandon vehicles only as a last resort.

Employee Education Regarding District-Owned Vehicles:

- Employees required to operate district-owned vehicles regularly shall complete training requirements appropriate for their responsibilities:
  - Complete hospital orientation guidelines.
  - Receive and be thoroughly instructed in all district-owned vehicle policies and procedures.

- Supervisors shall periodically evaluate compliance with district-owned vehicle policies and procedures. This may include, but is not limited to:
  - Conducting regular driver safety meetings.
  - Spot safety inspections of assigned vehicles.
  - Annual "ride along" with each driver.

Maintenance Procedures:

- Vehicle preventive/scheduled maintenance is to be arranged by Security and Transportation according to manufacturer recommendations.
- A weekly inspection of each vehicle will be performed and documented on a checklist developed and maintained by Security and Transportation.
- Maintenance records for all vehicles will be scanned and stored in the Security and Transportation files. These records must include:
  - Nature of the maintenance performed.
  - Company or individual performing the work.
  - Date, mileage, and cost.
  - Any other information deemed pertinent.

Special Considerations:

Senior Life Solutions (SLS) staff shall oversee patient transport of their program patients to ensure patient care and safety, including the evaluation of and response to complaints regarding the transportation provided or arranged by this hospital, and communicate any issues to the Security and Transportation Chief Officer immediately.

A determination of the patient's transportation needs shall be completed when an intensive psychiatric outpatient is admitted into the SLS program.

Transportation services provided to district patients shall meet the patient's clinical needs.

DEFINITIONS:
NONE

Subject: Vehicle Maintenance	Manual: Security and Transportation

Policy:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD," "District," "SoHum Health") to allocate the performance of, or arrangement for, all maintenance of district owned vehicles to the Security and Transportation Department.

Definitions:

Mobile Unit (MU): vehicles used by the district that utilize gray and black water tanks, including but not limited to Mobile Clinic and Optometry vehicles.

Document Management System (MCN): any management system deemed appropriate for policy and procedure management at SHCHD.

Procedure:

The Procedure for Maintaining all District-Owned Vehicles is as Follows:

Security and Transportation will utilize manufacturer-recommended guidelines for regularly scheduled (time frame~~timeframe~~ or mileage-based) maintenance tasks.

Vehicle maintenance records will be scanned and maintained ~~and stored~~ in the SHCHD document management system and can be accessed by all district staff.

A certified repair facility will be used for vehicle maintenance beyond that outlined in the Operational Maintenance and Guidelines for Mobile Medical Unit Protocol.

Staff responsible for the operation of district mobile units will be trained to operate and maintain the specific systems and utility special functions, including tank filling, storing, and emptying protocols.

SoHum Health

Subject:	Manual:
Materials P&P Approval Process Protocol	**Materials**

PURPOSE:

This protocol serves as a general guide for developing and documenting approval processes for Policies and Procedures (P&Ps) within SoHum Health departments. It outlines the general framework for departmental approval of P&Ps, ensuring that each department follows a standardized approach while addressing its specific needs.

DEFINITIONS:

P&P: Policy and Procedure

PDC: Policy Development Committee

DSM: Designated Staff Member tasked with drafting or editing P&Ps for a department manager or administrator.

Medical P&P:

- These policies are directly focused on **clinical care** and patient outcomes. They outline **medical procedures**, guidelines for **treatment** protocols, **patient safety**, and **clinical decision-making**.
- The goal is to ensure that patient care is **evidence-based**, **safe**, and **effective**.
- **Example:** A policy for **medication administration**, **infection control**, or **patient assessment**.

Administrative Policies:

- These policies deal with the **non-clinical aspects** of healthcare facility management. They guide **administrative processes**, staffing, operations, and **resource allocation** that indirectly support the delivery of care.
- The goal is to ensure the **smooth operation** of the healthcare facility, **staffing efficiency**, **legal compliance**, and maintaining a positive **organizational culture**.
- **Example:** Policies for **visitor management**, **workplace safety**, **confidentiality and data privacy**, or **employee conduct**.

MCN Approval Group and Process Default Settings

Default

- Step 1
  - Manual Creator Editor = Manager or DSM
    - Multiple people may be added but must coordinate. Sign off from one = sign off for all in group.
    - Required
- Step 2
  - Review Step= Stakeholder Review

        - If **Medical P&P**, Med-Staff review and sign-off **is** required, and the Med-Staff Review Group should already be populated.
            - If Medical P&P, and Med-Staff Review Group **is not** pre-populated, **add** Med-Staff Review Group to Review Step.
        - If **Administrative P&P**, Med Staff Review should **not** be added.
    - Any department that reviews your P&Ps should be added to this step by adding the department's review group. **e.g.**
        - Consider departments that cross streams with your own, but aim to narrow the scope of the review by:
            - aligning review groups with regulatory requirements
            - aligning review groups for the purpose of coordination
        - If none, step can be removed.
        - If review is needed **add** review groups
    - If review **is** needed, **Manual Owner** must be **last** to approve.

- Step 3
    - P&P Coordinator Step = Checks for references, APA format, links, and major grammar issues.
        - Required, but may be removed after P&Ps pass through system at least 1 time
- Step 4
    - Administrator Sign Off = Department Admin
        - Required, but Admin may utilize a proxy.
- Step 5
    - Medical Staff, or Policy Development Committee Sign Off
        - Required
- Step 6
    - Governing Board Sign Off (Final Sign off)
        - Required

Current Materials Approval Template (5 Steps Total)

- **Step 1**
    - Manual Creator Editor = Manager or Designated Staff Member (DSM).
        - Multiple people can be added but must coordinate. Sign off from one = sign off for all in group.
            - Jennifer Gutierrez and Kent Scown (Department Manager or DSM)
            - Manual Creator-Editor last Sign-Off to Move P&P to Next Step.

- **Step 2**
    - **Review Step= Stakeholder Review**
        - If your P&Ps are medical in nature, Med-Staff review is required before reaching PDC or Med Staff.
            - If P&Ps are medical in nature and not pre-populated, add Med-Staff Group to Review Step, and step 2 can no longer be removed.
        - If P&P is administrative, Med Staff Review should not be added.
    - Any department that reviews your P&Ps should be added to this step
        - Consider departments that cross streams with your own, but aim to narrow the scope of the review by:
            - aligning review groups with regulatory requirements

            - aligning review groups for coordination purposes
        - If none, step may be **removed.**
        - If review is needed add review groups
    - If review is needed, Manual Owner must be last to sign off in review.

- **Step 3**
    - P&P Coordinator Step = Checks for references, APA format, links, and major grammar issues.
        - Required, but may be removed after P&Ps pass through system at least 1 time

- **Step 4**
    - Administrator Sign Off = COO
        - Required, but admin may use a proxy.
            - Kent Scown
- **Step 5**
    - Medical Staff, or Policy Development Committee Sign Off
        - Required
            - Chief of Staff (COS) or Vice Chief of Staff (VCOS) may approve during PDC or Med-Staff meeting.
                - Joseph Rogers (COS)
                - Carl Hsu (VCOS)
            - Med-Staff may approve P&Ps using consent agenda.
            - Med-Staff Coordinator or Board Clerk approves, rejects, and adds notes in MCN per Med-Staff Directive
- **Step 6**
    - Governing Board Sign Off (Final Sign off)
        - Board Clerk or Med-Staff Coordinator provides sign off for board in MCN
        - Required

Key

Variable

Required

Removed

SoHum Health

Subject: Use of Personal Social Media Accounts	Manual: Outreach

POLICY:

It is the policy of Southern Humboldt Community Healthcare District that employees who participate in social media must ensure their behavior aligns with the organization's Code of Conduct and protects patient confidentiality, when their affiliation with the District is apparent.

DEFINITIONS:

Social Media: For the purpose of this policy, social media shall be considered technology and software that allows user-generated content to be shared and exchanged online (e.g., blogs, Facebook, X, YouTube, Instagram, TikTok, Threads, News Outlets, review sites).

PROCEDURE:

- SoHum Health recognizes that the use of social media can provide a number of benefits for employees both professionally and personally. Within the organization, however, access to social media is restricted.
- Employees shall not engage with ~~-~~social media from district-owned electronics unless specifically related to their job duties.
- Use of social media on behalf of the district shall only be done by members of the Outreach department and authorized users.
- Personal use of social media does ~~not/is~~ not exempt individuals from legal or professional obligations related to the protection of patient privacy and industry secrets.
- When posting on social media outside of working hours, district staff and providers must adhere to patient privacy and confidentiality standards.
- To ensure HIPAA compliance, clinicians, behavioral health professionals, patient care and support staff are prohibited from communicating with patients on social media. All patient care communications should be conducted via secure avenues, including, but not limited to, phone calls, business email accounts, patient portals, and in-person interactions.
- Employees shall not disclose any confidential or proprietary information about SoHum Health, its affiliates, vendors, or suppliers, including but not limited to, business and financial information.
- Guidelines:

    1. Write in the first person: when your affiliation with SoHum Health is evident, you should make it clear that you are speaking for yourself and not on behalf of the organization.

2. Use a disclaimer: in instances when your affiliation to SoHum Health is evident, include a disclaimer, such as "The views expressed on this (blog; website; post) are my own and do not reflect the views of my employer."

3. Be respectful: do not post any content that is obscene, defamatory, profane, libelous, threatening, harassing, abusive, hateful, or embarrassing to another person or entity.

4. Always protect patient privacy: never reveal any information that would make the identity of a patient or client apparent.

5. Adherence to all laws and regulations: individuals publishing content on social media are reminded to adhere to all laws and regulations.

6. Confidential information: never disclose confidential information, either organizational or patient information, deliberately or inadvertently.

7. Identification: identifying yourself as an employee of an organization associates the content you publish with your place of work. Only create content that is consistent with the professional standard to which district providers and staff are expected to adhere.

8. Personal responsibility: individuals are responsible for any content they publish on social media.

- Sanctions:
  - Employees shall be sanctioned if it has been discovered that protected health information has been breached.
    - Any staff member who knowingly/willingly breaches confidentiality/security of data or information shall receive, at a minimum, a written disciplinary warning and, at a maximum, termination.
    - If the breach of confidentiality was committed accidentally, with no intent to violate confidentiality or security of data/information, all efforts shall be made to provide education to the responsible staff member to eliminate repeat incidents.

Sanctions shall be applied against employees who fail to comply with the security policies and procedures to ensure the integrity of protected health information.

SoHum Health

Subject:	Manual:
Managing Social Media Presence	**Outreach**

Policy:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") that the use of social media on behalf of SoHum Health and its subsidiaries shall only be done by authorized users in the Outreach Department in compliance with organizational procedures and Codes of Conduct.

DEFINITIONS:

Social Media: For the purpose of this policy, social media shall be considered to be technology and software that allows user-generated content to be shared and exchanged online (e.g., blogs, Facebook, X, YouTube, Instagram, TikTok, Threads, News Outlets, review sites).

PROCEDURE:

- Confidential information: Do not disclose any confidential information, either organizational or patient information, deliberately or inadvertently. All authorized social media users shall be aware of patient privacy and confidentiality standards and maintain those standards at all times when posting on behalf of the District online.

- Direct Communication: Do not communicate directly with patients or offer specific medical advice online. If a patient communicates directly or asks a specific question, they should be directed to phone or email SoHum Health through a secure means of communication. SoHum Health's Outreach Manager or designee holds the right to disable direct messaging on any social media platform to prevent a breach of patient privacy and confidentiality, slander, and intent to harm.

- Professionalism: All posts shall be reviewed by the Outreach Manager or designee prior to posting to ensure correct grammar, spelling, tone, and professionalism. Authorized users should not engage in long direct conversations on social media and should instead refer members of the public to visit the website or contact SoHum Health via phone or email to acquire further information.

- Medical Accuracy: Content for all social media posts should be acquired from reputable medical websites, publications, or directly from licensed medical staff to ensure it complies with the most recent medical standards and recommendations.

- Use of Photos: Authorized users shall comply with anti-plagiarism guidelines. It is preferred to use self-generated photos and images whenever possible. When using a photo someone else created, photo attribution must be included in the post. Seek photos that are public domain, open license, or creative commons.

- Accessibility: Every effort should be made to make social media posts accessible to those with disabilities and impairments. All videos and photos should include captions and images and should follow guidelines to maximize readability.

- Trolls/Blocking/Removing posts: Individuals who personally attack members of the SoHum Health staff on any organizational social media page, may be blocked to prevent further abuse. Posts should be carefully evaluated for slander and intent to harm prior to removal.

- Correcting Errors: From time to time a post may be made public that includes an error. If it is a simple spelling or grammatical error, staff may immediately correct the post. If it is an error in content resulting in misinformation about medical advice or services, a disclaimer must be added to the post, calling out the error and providing the corrected information.

- Personal responsibility: Individuals shall be responsible for any content they publish on social media. Those posting on behalf of SoHum Health are responsible for the reputation of the organization and must act with the highest regard for professionalism, accuracy, and approachability.

- Sanctions:

    1. SoHum Health has the right to monitor, prohibit, restrict, block, suspend, terminate, delete, or discontinue an employee's access to the District's social media at any time, without notice, for any reason, and in its sole discretion.

    2. Employees shall be sanctioned if it has been discovered that protected health information has been breached.

        a. Any staff member who knowingly/willingly breaches confidentiality/security of data or information shall receive, at a minimum, a written disciplinary warning and, at a maximum, termination.

        b. If the breach of confidentiality was committed accidentally, with no intent to violate confidentiality or security of data/information, all efforts shall be made to provide education to the responsible staff member to eliminate repeat incidents.

    3. Sanctions shall be applied against employees who fail to comply with policies and procedures to ensure the integrity of protected health information.