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SoHum Health

Subject:	Manual:
Persons who are Deaf, Hard of Hearing, or Blind	**Clinic**

PURPOSE:

The purpose of this policy and procedure is to ensure effective communication with patients/clients involving their medical conditions, treatment, services and benefits. All necessary auxiliary aids and services shall be provided without cost to the person being served.

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to take appropriate steps to ensure that persons with disabilities, including persons who are deaf, hard of hearing, or blind, or who have other sensory or manual impairments, have an equal opportunity to participate in our services, activities, programs and other benefits.

PROCEDURE:

Identification and assessment of need:

- When an individual self-identifies as a person with a disability that affects the ability to communicate or to access or manipulate written materials or the individual requests an ~~a~~auxiliary aid or service, Southern Humboldt Community Clinic (SHCC) staff will consult with the individual to determine what aids or services are necessary to provide effective communication in particular situations.

Provision of Auxiliary Aids and Services:

- SHCC shall provide the following services or aids to achieve effective communication with persons with disabilities:
    - **For Persons Who Are Deaf or Hard of Hearing:**
        - For persons who are deaf/hard of hearing and who use sign language as their primary means of communication, SHCC staff member is responsible for providing effective interpretation.
        - Some persons who are deaf or hard of hearing may prefer or request to use a family member or friend as an interpreter. However, family members or friends of the person will not be used as interpreters unless specifically requested by that individual and *after* an offer of an interpreter at no charge to the person has been made by the facility. Such an offer and the response will be documented in the person's file. If the person chooses to use a family member or friend as an interpreter, issues of competency of interpretation, confidentiality, privacy and conflict of interest will be

considered. If the family member or friend is not competent or appropriate for any of these reasons, competent interpreter services will be provided.

- **NOTE: Children and other residents will <u>not</u> be used to interpret, in order to ensure confidentiality of information and accurate communication.**

- **For Persons Who are Blind or Who Have Low Vision:**
  - Staff will communicate information contained in written materials concerning treatment, benefits, services, waivers of rights, and consent to treatment forms by reading out loud and explaining these forms to persons who are blind or who have low vision.
  - Staff is available to assist persons who are blind or who have low vision in filling out forms and in otherwise providing information in a written format.

- **For Persons with Manual Impairments:**
  - Staff will assist those who have difficulty in manipulating print materials by holding the materials and turning pages as needed, or by providing one or more of the following:
    - Note-takers
    - Other methods that help to ensure effective communication by individuals with manual impairments.

DEFINITIONS:
None

SoHum Health

Subject: Contrast Administration and Supervision	Manual: 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

Subject: Radiation Dosimeter Badge	Manual: Mammography

PURPOSE:

The purpose of this policy and procedure is to record radiation exposure levels and monitor them for compliance.

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to provide to Radiology personnel with personal dosimetry badges in order to determine radiation exposure. The results shall be monitored by the department manager monthly.

PROCEDURE:

Personal radiation monitors shall be provided and maintained as follows:

- All technologists shall wear a radiation dosimetry badge for monitoring purposes.
- The badge shall be worn at collar level.
- Badges are to remain within Radiology Services when not in use.
- Badges will be exchanged and submitted to a dosimeter reading company for interpretation.
- Records for each employee shall be maintained in Radiology and be reviewed by the Radiology Manager upon receipt.
- The California Department of Health Services, Radiological Health Branch shall be notified of any unexplained excess radiation exposure.
- Employees may be subject to disciplinary action if radiation safety policies have not been followed.

DEFINITIONS:

None

SoHum Health

Subject: Quality Control Equipment	Manual: Mammography

PURPOSE:

A Quality Assurance and Quality Control (QA/QC) policy for mammography equipment ensures consistent, high-quality images for accurate cancer detection while minimizing patient radiation dose. It ensures compliance with MQSA federal standards, identifies equipment performance degradation over time, and optimizes the imaging chain (acquisition, display, and processing).

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") that quality assessment/quality control is performed within the standards and guidelines provided by the FDA, MQSA and mammography equipment manufacturer.

QUALITY ASSESSMENT EQUIPMENT:

- Gammex ACR Phantom with small disk.
- Hologic flat field acrylic phantom.
- Gammex compression scale.
- Specialized Hologic paddle(s).
- Appropriate forms.

PROCEDURE:

QA/QC tests, maintenance, and calibration must follow the specific instructions provided by the equipment manufacturer and will be specific to mammography equipment.

DEFINITIONS:

None

SoHum Health

Subject: Qualified Responsible Personnel	Manual: Mammography

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to provide a list of responsible qualified personnel.

QUALIFIED PERSONNEL RESPONSIBLE FOR THE FOLLOWING:

Lead Interpreting Physician	Atul Patel, MD 1770 Iowa Ave Suite 280 Riverside, Ca 92507 Phone (951) 786-0801 Fax (951) 680-1989
Audit Reviewing Physician	Atul Patel, MD 1770 Iowa Ave Suite 280 Riverside, Ca 92507 Phone (95) 786-0801 Fax (951) 680-1989
Facility #'s	EIN #94-2664285 Medicare Outpatient #050482 Medi-Cal #HSP40482G
Physicist	Bhujanga Lankipalli Medical Physics Consulting Service, Inc. 104 Southwind Drive Pleasant Hill, CA 94523 Phone (925) 674-2769 Fax (925) 372-0673
QA/QC Technologist	Lora Simone, Radiology Director Phone (707) 923-3921 ext 1242
Patient Reminders/Results	Radiology Department Phone (707) 923-3921 ext. 1242
Hospital Administrator/Chief Executive Officer:	Matt Rees Phone (707) 923-3921 ext. 1260

Chief Financial Officer	Paul Eves Phone (707) 923-3921 ext. 1291
Hologic Service/Repair	Hologic Phone (877) 371-4372
Emergency Repair	Guy Vitello Biomed Engineer Phone (707) 923-3921 ext. 1277
Technical Support	Hologic Phone (877) 371-4372

PROCEDURE:
N/A
DEFINITIONS:
None

SoHum Health

Subject: Patient History	Manual: Mammography

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") that all mammography patients, with the assistance of the technologist, shall be required to complete a *Mammography Questionnaire* form.

PROCEDURE:

- All mammography patients to *Jerold Phelps Community Hospital* will be requested to complete the questionnaire form with the technologist.
- The technologist shall review previous mammograms and/or inquire if the patient has implants.
- The technologist shall attempt to retreive outside priors if available.~~review previous mammograms and/or inquire if the patient has implants.~~
- The form shall include the following information:
  - ~~Previous mammogram, location, and date.~~
    - Childbirth history.
    - Family history of breast cancer with age of onset if available.
    - Use of hormones.
    - All skin changes, including moles, bruises, thickening, dimpling, or nipple inversion.
    - Previous biopsies.
    - Previous radiation or chemotherapy treatments.
    - Prior breast cancer and date.
    - Presence of breast implants or breast reduction surgery.
- The history form shall be sent to OnRad with outside prior reports. Notes shall be documented in electronic medical record.

DEFINITIONS:

None

SoHum Health

Subject: OnRAD Teleradiology Mammography Protocol	Manual: Mammography

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") that all mammograms will be sent to OnRad Teleradiology, via PACS (Picture Archive and Communication System), for written interpretation.

PROCEDURE:

Mammography Images and Reports:

- Completed mammograms will be sent to OnRad for interpretation.
- All studies will include:
  - Current and previous films/reports from previous two (2) mammograms.
  - Patient Mammography questionnaire.
- Completed reports will be faxed to Jerold Phelps Community Hospital Radiology.
  - Reports indicating abnormal or questionable findings (BiRads 4 or 5) will be called and faxed to Jerold Phelps Community Hospital Radiology as soon as possible.
- The Radiology Department will contact the patient's provider with all abnormal Mammography findings.
- Patients requiring additional procedures will be contacted via telephone by outside facility to arrange scheduling.
- All patients will receive written results and personal breast density information in lay terms in accordance with standard policies, state, and federal laws.
- Annual and short-term follow-up reminders will be sent at appropriate intervals.

Quality Assurance:

- The Quality Control (QC) Technologist will perform all required tests and maintain results at Jerold Phelps Community Hospital.
- The QC Technologist will be responsible for scheduling annual procedures (preventive maintenance, physicist's survey) and maintaining documentation.
- Outcome data will be compiled by the QC Technologist.
- Current data (CEU, licenses, exams interpreted, etc.) for all interpreting physicians will be obtained annually and maintained for inspections.
- A current Policy and Procedure Manual will be maintained by the QC Technologist and reviewed in accordance with hospital policy.
- Qualifications of new or temporary personnel will be evaluated by the Lead Interpreting physician.

- Questions regarding safety, reliability, clarity and accuracy of mammography services performed at this facility will be directed to the Lead Interpreting Physician or Physicist as appropriate.

Professional Supervision:

- The Lead Interpreting physician will provide professional review and feedback to the Mammography Technologist at least quarterly.
- Review should include:
  - Clinical Image Quality.
  - Quality Assurance procedures.
  - Quality Control documentation.
- All feedback will be documented on the Mammography Quarterly Review Form and signed by the radiologist.
- All “unsatisfactory” findings will be corrected immediately or in accordance with American College of Radiology (ACR) guidelines.

DEFINITIONS:
None

SoHum Health

Subject: Augmented Breast Mammogram	Manual: Mammography

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to provide complete high quality mammographic evaluation of patients with prosthetic implants.

PURPOSE:

Mammography views and techniques shall be modified to provide optimal visualization of all breast tissue.

DEFINITIONS:

AEC: Automatic Exposure Control

PROCEDURE:

- Presence of breast implants will be determined prior to the mammographic exam based on clinical questions at time of scheduling. An Implant Disclosure and Consent Form shall be read and signed by the patient **prior** to the exam.

- A minimum of one (1) hour shall be allotted for the mammogram.

- A complete study should include craniocaudal **(CC)** and mediolateral oblique **(MLO)** views with implants in place **and** with the prosthetic implant manipulated away from the surrounding breast tissue **(ID)**.
  - AEC (phototiming) shall not be used with implant in place. AEC cell shall be adjusted to manual when imaging the breast and implant. The AEC shall be adjusted to auto filter when implant displaced **(ID)** views are performed.
  - Manual exposure factors shall be determined from the current mammography technique chart.

- Additional views shall be obtained at the direction of the Radiologist.

SoHum Health

Subject: Diagnostic Mammography	Manual: Mammography

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") that ***effective September 5, 2007, no diagnostic mammography shall be performed at this facility.***

PURPOSE:

To provide appropriate referrals to patients with known or suspected breast abnormalities.

PROCEDURE:

- All patients or providers attempting to schedule diagnostic mammography referral shall be advised to contact a facility that maintains an on-site radiologist.
    - A list of local facilities may be provided as needed.
    - To provide continuum of care, all previous mammograms and/or reports should be requested from Radiology in order to forward needed information to that facility.

- Patients requiring additional films to evaluate a suspicious area seen on the screening mammogram shall be contacted by their provider and advised to schedule an appointment at an appropriate facility.

- Unilateral diagnostic orders will be accepted for mastectomy patients for screening purposes only.

DEFINITIONS:
None

SoHum Health

Subject: Image Quality (Phantom)	Manual: Mammography

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to ensure that consistent density, contrast, uniformity, and resolution are maintained within the mammography imaging system.

PURPOSE:

Mammography imaging systems must undergo weekly phantom image quality tests using an FDA-approved phantom to ensure proper performance.

FREQUENCY:

Weekly (when in use) or as needed for suspected changes in image quality, such as after service or relocation of equipment.

EQUIPMENT:

- Radiation Measurement, Inc. (RMI) phantom, capable of demonstrating the following:
  - Nylon fibers of 0.40 -1.56 mm.
  - Calcium carbonate, aluminum, or similar calcifications of 0.16 - 0.54 mm.
  - Masses of 0.25 - 2.00 mm.

- Acrylic disc

PROCEDURE:

- Place phantom as follows:
  - Phantom edge aligned to chest wall edge of image receptor.
  - Nipple marker away from chest wall edge.
  - Acrylic disc placed on marked area of phantom.
  - Compression paddle in contact with phantom.

- Exposure factors:
  - Automatic Exposure Control (AEC) on Auto Filter
  - Acquire image using ACR Phantom Conv. view.

- View image on the monitor to determine the following:
  - Presence of artifacts.
  - Areas of non-uniform density.

- Number of simulated masses, speck groups and fibers.

- Score phantom:
  - Fibers -1 point if full length or 0.5 if more than half is visible.
  - Speck Groups -1 point if 4 or more specks or 0.5 if 2-3 specks visible.
  - Masses -1 point for generally circular border or 0.5 if density difference seen
    - but circular shape indistinct.
  - Artifacts - Deduct artifactual fiber specks or masses from their appropriate
    - group (-0.5 to -1.0 points)

- Record date, exposure factors, and scoring of phantom and plot results on Phantom Control Chart and Phantom Control Chart (Tomosynthesis Option).

- Obtain SNR (Signal to Noise Ratio) and CNR (Contrast to Noise Ratio). Record results in Technologist's Data Collection Worksheet. Plot results into SNR and CNR Control Chart.

- If criteria are not met, recheck procedure and retest.

CRITERIA:

- Acceptance Score for Tomosynthesis ACR Phantom Image minimum passing score:
  - 4 fibers
  - 3 speck groups
  - 3 masses

- Acceptance Score for Conventional ACR Phantom Image minimum passing score:
  - 5 fibers
  - 4 speck groups
  - 4 masses

- Allowable CNR deviation = ± 15%. SNR must not fall below 40.

CORRECTIVE ACTION:

- Recheck procedure and retest.
  - Criteria met - resume mammography service and document findings.
  - Criteria not met - discontinue mammography service and:
    - Determine cause, if possible, and correct problem.
    - Contact Hologic, Inc. or physicist as needed.
    - Document action taken and retest.

DEFINITIONS:
None

SoHum Health

Subject: Mammography Technique Chart	Manual: Mammography

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to provide consistent density for all breast thicknesses.

PURPOSE:

The purpose of this policy and procedure is to provide consistent density for all breast thicknesses, kVp ranges and breast conditions requiring manual techniques.

PROCEDURE:

- Use Automated Exposure Control (AEC)Modea at setting "**Auto Filter,**" except for the following conditions:
  - Implant views.
  - As requested by the radiologist.
- Refer to technique chart as needed.
- Update with the aid of the medical physicist during annual evaluation

DEFINITIONS:
None

SoHum Health

Subject: Disposal of Contrast Media and Components	Manual: Radiology

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to properly dispose of CT contrast (oral and iodinated) and the components used for injection.

PURPOSE:

The purpose of this policy and procedure is to ensure that contrast agents and associated components are disposed of properly.

DEFINITIONS:

CT: Computed Tomography

IV: Intravenous

PROCEDURE:

- All oral and IV contrast used in CT is considered medication and will be disposed of as medical waste in properly marked containers.
- All contrast bottles with remaining unused contrast and disposable power injector syringes filled with contrast shall be placed in a pharmaceutical waste bin for incineration after each use.

Subject: Patient Selection Criteria	Manual: Mammography

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to provide patient selection criteria for screening mammography.

PROCEDURE:

- Mammography will not be performed on pregnant or lactating women at this facility.
- Screening mammograms will only be performed once a year unless otherwise recommended by the Radiologist.
- Presence of breast implants will be determined prior to the mammographic exam.
- All patients shall be asked clinical questions at time of scheduling to assist in verification of criteria.

DEFINITIONS:

None

SoHum Health

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

POLICY:

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

PROCEDURE:

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

DEFINITIONS:

None

SoHum Health

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

POLICY:

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

PURPOSE:

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

PROCEDURE:

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

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

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

DEFINITIONS:
None

SoHum Health

Subject: Lead Interpreting Physician	Manual: Mammography

POLICY:

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

1. Be licensed to practice medicine.

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

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

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

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

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

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

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

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

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

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

    b. Develop protocol for standard mammographic views and techniques.

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

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

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

PROCEDURE:
N/A

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Scope of Practice in CT	Radiology

POLICY:

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

PROCEDURE:

- The CT department will be open for scheduled outpatient exams from 8:30 a.m. to 5:00 p.m. Monday through Sunday. Emergency exams always take precedence and are available 24 hours a day, 7 days a week. After normal business hours, the CT tech will be available on-call for the Emergency Department (ED).

- The CT department will accept patients of all ages with a valid physician's order and authorization (as needed). No patients requiring sedation during the CT exam will be performed at this facility.

- In the event that the CT scanner is down or no CT tech is available, the ED shall be notified immediately to ensure proper patient care.

- ~~Also, i~~In the event that the CT scanner is down or no CT tech is available, all scheduled exams will be rescheduled.

DEFINITIONS:
None

SoHum Health

Subject:	Manual:
Responsibilities of Quality Assurance Personnel	**Mammography**

PURPOSE:

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

POLICY:

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

PROCEDURE:

LEAD INTERPRETING PHYSICIAN:

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

MAMMOGRAPHY QUALITY CONTROL TECHNOLOGIST:

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

MAMMOGRAPHY PHYSICIST:

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

    - Breast entrance air kerma
    - Radiation output rate

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

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

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

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

Ensure that Quality Assurance records are maintained on:

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

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

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

DEFINITIONS:
None

SoHum Health

Subject: Critical Findings	Manual: Radiology

PURPOSE:

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

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

PROCEDURE:

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

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

DEFINITIONS:
None

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

POLICY:

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

PROCEDURE:

- Patients shall be instructed to self-address an envelope at the time of their mammography appointment.

- The envelope shall be used to mail the patient their negative BI-RADS (category 1, 2 or 3) results letter. All patients will be informed about breast density. The patient's personal density findings shall be included in the report.. All reports shall be mailed within 30 days of the date of examination.

- Negative/benign (category 1 or 2) mammography interval is generally one year. Interval for follow-up for "Probably Benign" BI-RADS category 3 is generally 6 months but shall be determined by the Radiologist's recommendation.

DEFINITIONS:
None

SoHum Health

Subject: Fluoroscopy	Manual: Radiology

POLICY:

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

PURPOSE:

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

PROCEDURE:
N/A

DEFINITIONS:
None

SoHum Health

Subject: Confidentiality/Patient Privacy	Manual: Radiology

POLICY:

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

PROCEDURE:

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

PRIVACY:

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

DEFINITIONS:
None

SoHum Health

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

POLICY:

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

PROCEDURE:

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

DEFINITIONS:

None

SoHum Health

Subject: Compression	Manual: Mammography

PURPOSE:

Adequate compression increases contrast, improves image sharpness and decreases radiation exposure, and this policy describes the procedure to ensure the mammography machine has adequate compression.

POLICY:

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

FREQUENCY:

Semi-annually or if reduced compression is suspected.

EQUIPMENT:

~~Bathroom scale or~~ Compression scale ~~I~~
~~Towels~~
18 x 24 cm flat compression paddle

PROCEDURE:

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

CRITERIA:

A compression force of at least 25 pounds must be provided.
The maximum compression force for the initial power drive must be between 25 pounds and 45 pounds.

DEFINITIONS:
None

SoHum Health

Subject: Ultra Sound Scheduling	Manual: Radiology

POLICY:

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

PROCEDURE:

- Ultrasound examinations require a valid order and 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.

- Completed orders must be received at least 48 before the scheduled exam. If a completed order is not received, the patient will be rescheduled.

- Scheduled Exams: Scheduled examinations are performed between 8:15 a.m. and 5:3045 p.m. Mondays, Tuesdays, Thursdays, and Fridays, excluding major holidays.* Schedule subject to change based on sonographer availability.~~Wednesday exams offered at discretion of department~~.

- Add-on Exams: Add-on examinations are performed between 8:15a.m. and 5:45 p.m. Mondays, Tuesdays, Thursdays, and Fridays, excluding major holidays, when space in the daily schedule is available.

- Priorities: Prioritization will be as follows:
  - ED exams
  - scheduled exams
  - add-on exams

DEFINITIONS:
None

SoHum Health

Subject: Corrective Action	Manual: Radiology

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to monitor radiographic equipment, maintain Quality Assurance (QA) and service data, and provide appropriate corrective action as necessary.

DEFINITIONS:
CT: Computed Tomography
PACS: Picture Achieving and Communications System
QA: Quality Assurance
US: Ultrasound

PROCEDURE:

- The Department Manager or designated personnel shall perform QA procedures.
- All data shall be charted on the appropriate form.
- Results noted to be outside the acceptable limits for each test shall be followed by appropriate corrective action to include:
    - Retest to confirm results and/or to isolate the source of the problem.
    - Remove damaged equipment if possible.
    - Contact GE Healthcare for CT repair.
    - Contact GE Healthcare for US repair.
    - Contact Carestream for portable machine repair.
    - Contact Sectra through OCHIN for PACS .
    - Consult with medical physicist or radiologist as needed.
    - After appropriate service, repeat QA procedures prior to exposing a patient to ionizing radiation (CT and X-ray).
    - Discontinue patient exposure until corrective actions are completed.
- Minor variations, within acceptable parameters, with respect to image quality shall be brought to the attention of appropriate personnel.
- For all problems, corrective actions and results shall be noted.

SoHum Health

Subject:	Manual:
Portable Radiography	**Radiology**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to provide high quality bedside radiographs and minimize radiation exposure to the patient. Protective guidelines shall be followed by technologist and other personnel.

PROCEDURE:

- The technologist will stand at sufficient distance from the X-ray tube to minimize exposure to scatter radiation. All mobile units will have a six foot cord from the X-ray machine to the exposure switch.
- The technologist will collimate the X-ray field to the film size or body part.
- The technologist will notify nursing personnel to leave the area before making an X-ray exposure.
- The technologist will wear a lead apron or stand behind a protective barrier during the exposure.
- A dosimetry film badge must be worn by the technologist.
- If nursing or other personnel are required to assist the patient during the exposure (i.e. trauma patients, etc. in the emergency room), adequate protection will be provided (i.e., lead apron, thyroid shield, etc.).
- Every effort will be made to clear visitors and non-essential personnel from the radiation area.

DEFINITIONS:

None

SoHum Health

Subject:	Manual:
Radiation Safety and Protection for Pregnant Technologists	**Radiology**

PURPOSE:

The purpose of a radiation protection policy for pregnant technologists is to limit the fetus's radiation dose to safe levels (typically 0.5 rem). This protects the fetus from increased sensitivity to radiation damage, reducing risks of cancer and developmental abnormalities, while ensuring compliance with As Low As Reasonably Achievable (ALARA) principles.

POLICY:

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to provide radiation protection and monitor does to both the pregnant female technologist and her unborn fetus.

PROCEDURE:

After the technologist has declared her pregnancy **in writing**, a fetal radiation dose badge shall be issued in addition to the normal radiation badge. The fetal radiation badge will be worn at waist level and closely monitored.

At the time of declaration, dose equivalent to embryo/fetus shall be calculated using the deep-dose equivalent of the declared pregnant worker.

At time of declaration, if embryo/fetal dose has exceeded the 0.5rem limit or is within 0.05rem, then dose shall not exceed 0.05rem additional dose past the current dose limits (0.5 rem) during the remainder of the pregnancy

Definitions:
NONE

SoHum Health

Subject: Radiation Protection for Radiology Personnel	Manual: Radiology

PURPOSE:

The primary purpose of radiation protection for radiology personnel is to minimize exposure to ionizing radiation, preventing acute injuries and reducing long-term risks such as cancer. It ensures safety by keeping occupational doses As Low As Reasonably Achievable (ALARA) using time, distance, and shielding.

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to provide radiation safety equipment and practices for radiology personnel.

PROCEDURE:

1. Technologists shall not be used to hold x-ray patients or the image receptor except in an emergency or if a patient's safety is in question and no other personnel are available.
2. The technologist will use the appropriate operator protection devices provided, e.g., lead apron, lead shield, etc.
3. Personnel monitoring devices (radiation dosimetry badge) must be worn when using ionizing radiation. The monitoring device must be worn on the collar and outside of the apron when a lead apron is worn.
    a. The radiation dosimetry report will be checked and displayed in the Radiology Manager's Office bi-monthly, for review by personnel.
    b. The radiation dosimetry report will be reviewed and monitored by the Radiation Safety Officer and the Radiology Supervisor/Operator.
    c. The annual dose limit is 5 rems for the total effective dose, 15 rems for lens and 50 rems for shallow-dose of the skin or whole body.
        i. Any technologist who reaches 2 rems total effective dose, 5 rems for lens or 15 rems for shallow-dose of the skin or whole body (level 1) shall receive counseling regarding radiation exposure.
        ii. Any technologist who reaches 4 rems total effective dose, 10 rems for lens or 30 rems for shallow-dose of the skin or whole body (level 2) shall receive counseling and possible investigation regarding radiation exposure.
        iii. Any technologist who exceeds these limits will be removed from the floor immediately for the remainder of the year.
4. The technologist must adhere to any special radiation safety instructions relating to a specific machine or procedure.
5. A lead apron (0.25mm lead equivalent) should be worn when doing portable radiography.

6. Radiographic equipment will be operated only by individuals having a valid California license (C.R.T.) or supervisor's permit.

DEFINITIONS:
NONE

SoHum Health

Subject: Influenza Immunization Program	Manual: Infection Prevention

POLICY:

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

PURPOSE:

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

BACKGROUND:

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

PROCEDURE:

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

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

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

A Consent/Declination form will be signed by all healthcare personnel, including contract staff,

volunteers, and students. District employees will have this form kept in their Employee Health file.

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

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

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

Residents and Patients:
When the vaccine is available, residents of the Skilled Nursing Facility and Swing bed units (or their guardians) will be informed. A consent form must be obtained. This is coordinated by the Infection Preventionist. A physician order is not needed.

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

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

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

Adverse Reactions
May include:

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

- Serious adverse reactions should be reported to the "Vaccine Adverse Event Reporting System" (VAERS) via their web site (vaers.hhs.gov) or by calling 1-800-822-7967.

DEFINITIONS:
None

SoHum Health

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

POLICY:

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

PURPOSE:

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

Scope:

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

Program Organization:

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

PROCEDURE:

Infection Prevention Function

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

- To lend support and clinical/medical perspective to the program.
- To disseminate infection prevention information to the other members of the medical

staff.

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

Departmental Responsibilities

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

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

Surveillance

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

Historically:

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

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

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

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

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

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

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

The IP position is 1.0 FTE position. Employee education is an important IP role. The IP is responsible for new employee orientation in infection prevention. Annual education in hand hygiene, healthcare associated infections (HAI), personal protective equipment (PPE), blood borne pathogens (BBP), aerosol transmissible disease (ATD), and other infection prevention topics, as needed, is provided by the IP.

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

Analysis and Reporting of Infection Data
Data from the various sources is analyzed by the IP. Rates are calculated and compared when possible, to the facility's historical benchmarks. When sufficient data exists to make meaningful

comparisons, rates are also compared to benchmarks from national databases such as the NHSN. Department managers and the Medical Staff members receive the data to use in planning ongoing educational activities as well as to plan for improvement in patient outcomes. Infection data is reported to the following persons and/or entities:

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

Evaluation, Review, and Revisions

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

DEFINITIONS:

None

SoHum Health

Subject:	Manual:
Fire Response Plan	**Safety and Emergency Preparedness**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD" or "District") to maintain an organized hospital-wide response in the event of a fire or the need for evacuation.

PURPOSE:
The purpose of this plan is to delineate the priorities, actions, and responsibilities when there is a fire in the facility or there is a need for evacuation.

PROCEDURE:

General Instructions:

If ~~When~~ a fire occurs~~strikes~~, the actions taken during the first few minutes make the difference between containment and catastrophe. It is with the training of personnel that proper action can be taken during these very important first few minutes and disaster averted. An intelligent and productive procedure before the arrival of the fire department depends on:

- Immediate response.
- Training and coordination.
- Designated assignments.

In a hospital, staff must be prepared for the possibility of fire and/or other emergencies. In addition to providing medical and nursing care, we have a responsibility to safeguard our patients in case of an emergency. The facility's Fire and Safety Manual provides a basic plan of protection for patients and employees. Department Managers are required to be thoroughly familiar with the contents of the Fire Response Plan. It is the responsibility of the Managers to disseminate the information contained therein to all employees under their supervision. Employees may anticipate periodic fire drills to ascertain their familiarity with the procedures outlined. Each employee has the responsibility of knowing the duties they may be called upon to perform during an emergency.

1. Person Discovering Fire:
    a. If a fire occurs ~~When the alarm sounds~~ **~~be~~ do your best to remain calm.~~A~~ The person discovering ~~finding the~~ a fire will ~~must~~ follow first person response procedure (RACE) as follows:**
        i. **R**emove all patients and visitors from immediate danger.
        ii. **A**ccess the fire alarm system in your designated area.
        iii. **C**ontain fire (close doors and windows).

iv. **E**xtinguish the flames with an extinguisher located in your designated area.

b. Notify all facility personnel of the location of the fire. This can be accomplished in two ways:
   i. Using the telephone, call Admitting at extension 1249. The admitting clerk will page overhead announcing a "Code Red and location."
   ii. If the switchboard cannot be reached, using the telephone, ~~(press "Page" and dial "04" (all page)~~ Dial 8000 and announce a "Code Red and location~~.~~", three times. Dial 911 immediately and give the location of the fire. (Back up Fire notification.)

2. All Other Personnel:
   a. All available personnel will report to the scene of the fire with the fire extinguisher from their area, in hand. If necessary, they will return to their work areas of responsibility and assist with evacuation.
   b. The first responder will direct these personnel as appropriate, assuring that **RACE** is followed, and the Fire Department has been called.
   c. Persons remaining in their department, will close doors and windows and shut off equipment that might spread fire and stand by until the Fire Department arrives to direct them to the scene of the fire.

3. Department-Specific Responses:
   Remember: The safety of the patients is always the first priority
   a. Patient Care Areas:
      i. Nurse or employee in charge of unit:
         - Will direct activities of all personnel on his/her unit.
         - Will see that all oxygen valves are turned off and all portable tanks are removed to a safe area.
         - Will see that all patients are accounted for.
         - Will be responsible for patient files.
   b. Department Staff:
         - Report to the manager/charge nurse for instructions.
         - Close all windows and doors in patient rooms, bathrooms, corridors, etc.
         - Shut off valves on oxygen tanks at the scene of the fire and in adjacent rooms.
         - Help fight the fire with an extinguisher if possible.
         - Evacuate patients from adjoining areas as indicated by the spread of fire and smoke.

BED FIRES:
Bed fires are dangerous.
Ambulatory patients' first impulses are to run if they are able.

If there is any question of responsibility in removing someone from traction, just remember that there is always a chance of recovering from an aggravated fracture, but never from cremation or asphyxiation.
Non-Ambulatory patients will often try to get out of bed. Do not be surprised to find the patient on the floor. If the patient is supposed to be in the room and you cannot see or feel them, look under the beds or in the closets, or elsewhere.
Upon discovery of the patient's bed in flames, the nurse shall immediately:

1. Remove the patient from the bed to a safe area such as another bed or a chair, or a blanket on the floor.
2. Extinguish any flames on the patient by rolling them in a blanket. Follow the above RACE procedures.
3. Use fire extinguishers, as necessary.
4. Have the burned mattress removed from the building and placed on the ground. This is to be done by the Fire Department Personnel only. Do not place the mattress in a hallway or closet.
5. Mattresses are difficult to extinguish and often rekindle after the fire is apparently out. The Fire Department will respond and extinguish the mattress by removing all burned portions and soaking it in water.

Administration, Business Office, Central Supply, Hospital Information Systems, Laboratory, Medical Records and Pharmacy:

Shut down all electrical equipment but **leave all lights on**.

1. Clinic:
    a. Reception area:
    Gather patients, children, and anyone else in the reception area, and quickly with as little confusion as possible, have everyone leave out the front door, if safe, or out the nearest exit. **Leave all lights on.**
    b. Exam Rooms and Back Hall:
        i. Starting at the room closest to the front of the Clinic, close all hallway doors, bathroom doors, etc. after checking to make sure everyone is out of the exam rooms and bathrooms.
        ii. Leave out the Cedar Street door or hospital employee entrance (depending on the location of the hazard).
        iii. Everyone should come around the building to join the rest of the group so everyone can be accounted for. Clinic parking lot is the meeting area.
2. Dietary:
    a. Grease Fire:
        i. Turn off burners.
        ii. Smother with the lid of the pan.
        iii. Cover with flour.
        iv. **If still not out, use a fire extinguisher or pull the pin by the hood.**
        v. Turn off the air conditioner and exhaust fans. Close doors to hall, dishwasher, and pantry.

3. Emergency Room:
    a. Notify Environmental Services/Engineering to shut off air conditioning and/or shut off at control box behind the med cart.
    b. Remove the portable oxygen tank to a safe area. Remove records from the fire area.
    c. **Leave all lights on**.
4. Radiology:
    a. Shut down all electrical equipment including the portable x-ray machine, and computer.
    b. Turn off fans in the restroom.
    c. L**eave all lights on.**

If necessary, the District's Emergency Preparedness Plan may need to be activated. This plan utilizes the HEICS model and will require the highest-ranking Administrative Official to become the Incident Commander.

DEFINITIONS:
None

SoHum Health

Subject: Post-Clinical Trial Data Storage Policy	Manual: Compliance

POLICY:
It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to ensure regulatory compliance and confidentiality of all Clinical Trial Study Documentation for trials conducted at SoHum Health. The documents will be securely stored for the minimum period of no less than 3 years after study conduct has been completed, as mandated by the State of California and Federal regulations.

DEFINITIONS:
Active Directory: The underlying platform for file/folder permissions
Access Control List: Allows the definition of very granular security permissions, ranging from Full Access to Read/Write and Read Only. Located in the Active Directory.

PROCEDURE:
Study documentation:
- All study documentation (any and all data collection forms, workbooks, source documents, ect.) will be stored in a locked space accessible only to research staff.
- PHI binders and the Master Enrollment Log will be kept separately from the data files to maintain participants' confidentiality.
- Prior to document storage this policy and an attached addendum containing contact information will be printed and stored in a highly visible location with the paper records.

Data Storage Location:
- Electronic Data: The study documents will be stored in the share drive. The share drive is secured by the access control lists, which are security settings within Active Directory. Each folder is created and then locked down with a set of permissions that the folder's owner requests. The owner is the Site Principal Investigator, and the Research Coordinator and Research Assistants have access to the folders.
- Paper Records: Stored in a secure, access-controlled space.

Retention Period:
- Data shall be retained per:
    - Local IRB guidelines

- Institutional and sponsor requirements
- Local/national laws (e.g., HIPAA, FDA 21 CFR 312.62)

Destruction of Data:

- After the retention period, the Sponsor, funding agency, and Lead Investigators must be notified in writing, and acknowledgment in writing must be received by the District prior to the destruction or relocation of research records. Refer to attached addendum for Sponsor, funding agency, and Lead Investigator contact information.
- After the Sponsor, funding agency, and Lead Investigators have acknowledged the notification of destruction, the files will be destroyed securely using approved methods (e.g., shredding, digital wiping).

Subject:	Manual:
Smoke, Tobacco, and Marijuana Free Policy and Procedure	Administration

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, and marijuana products on SoHum Health property and within 25 feet of any property owned by the District.

Procedure:

SoHum Health shall be smoke, tobacco, and marijuana free. 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, Human Resources 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.

- **Such assistance may typically include teaching and learning experiences, peer or social support activities, tobacco cessation and nicotine replacement aids, or financial support of these and other methods such as prescription medications under the direction on the employee's medical provider.**
- **Accepting and using these measures is strictly voluntary, and employees assume all risks and responsibility, and hold the District and its employees and agents harmless from any and all claims related to use of these tobacco cessation or related assistance measures.**

***Note: Some Skilled Nursing Facility residents were admitted when this policy was not in place. Those patients have a separate protocol "SNF Resident Smoking Protocol".**

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.

PRE-OPERATION CHECK

ENGINE BREAK-IN PERIOD

During the engine break-in period, observe the following recommendations:

1. Change the engine oil and oil filter cartridge after the first 50 hours of operation. (See "ENGINE OIL" in ENGINE MAINTENANCE SERVICE SCHEDULE).

2. In ambient temperature above 32°F (0°C) approximately 3-5 minutes without a load is sufficient for engine warm up. Allow additional warm up time when temperatures are below 32°F (0°C) before placing an operating load on the engine.

DAILY CHECK

To prevent future engine problems from occurring, it is important to know and keep track of the engines condition. Below are items to be Inspected and Checked on a daily basis.

CAUTION:

To avoid personal injury:

- Be sure all safety shields and guards are attached to the engine when operating.
- To prevent a fire hazard, keep foreign materials, fuel and oil away from the battery, wiring, muffler and engine. Check and clear them daily. Be aware of the muffler and exhaust gas heat underneath the engine compartment, this heat may ignite grass or other flammable materials.
- Follow all safety precautions as outlined in the "SAFE OPERATION" section.

1. For accurate readings the engine should be on level ground when checking engine fluids.

2. Check fluids before starting the engine. (Cold Engine)

- Lubrication System: Check Engine oil level
  Check for Engine oil leaks

- Cooling System: Check coolant level and condition
  Check for coolant leaks
  Check for proper installation of the radiator cap

- Fuel System: Check for sufficient quantity of fuel
  Check for fuel leaks

3. Check engine after starting. (Warm Engine)

- Proper Operation: Check for easy engine start
  Check for fluid leaks
  Check for abnormal engine noises
  Check for abnormal exhaust gas

OPERATING THE ENGINE

ENGINE STARTING CONTROLS

1) Generator Main Switch must be in the ON position.
2) Hold Start/Stop Switch for 1 second and release.
3) Glow Plugs will preheat for 8 seconds. LED flashes slowly.
4) Preheating will cease during engine cranking cycle. LED continues flashing.
5) Engine begins an 8 seconds crank cycle, After 4 seconds of cranking the PT-ECU-63 will check for an AC signal from the generator. If an AC signal is verified the engine will start and the LED will remain ON during the normal run operation. If the AC signal is not verified the PT-ECU-63 will terminate the cranking cycle and LED will flash a fault code.
6) Starter disengages immediately after engine run is verified.
7) PT-ECU-63 deactivates the Low Oil Pressure and High Water Temperature Switches for 6 seconds, this will assure oil pressure build-up time. If oil pressure does not build-up the engine will immediately shut down and go into a fault mode. Likewise for a high temperature situation.
8) If engine will not start on the first attempt the PT-ECU-63 will initiate the start cycle 2 more times before going into a fault mode. Glow Plugs will preheat for 8 seconds per attempt. Engine will crank for 8 seconds per attempt.
9) To shut down the engine under normal operations, hold the Start/Stop Switch for 1 second and release.
10) If a fault occurs turn Generator Main Switch OFF and then ON to reset PT-ECU-63.

CHECKING ENGINE AFTER STARTING

1) Allow the engine to warm up 3 to 5 minutes before applying a load. In colder climates allow a few extra minutes longer.
2) Perform a visual inspection of all areas of the engine and generator.
3) Listen for any abnormal noises.
4) Check for any abnormal exhaust gases.

STOPPING THE ENGINE

It is recommended to disconnect or reduce the power load from the generator before shutting down the engine. Then follow the steps outlined above for normal shut down.

NOTE: The PT-ECU-63 is designed to operate on 12V DC power. In a low battery situation the PT-ECU-63 may not initiate the normal cranking cycle. To start the generator you can press and hold the Start/Stop Switch for approximately 10 seconds or until the engine starts. Once the engine starts the PT-ECU-63 will resume normal operations. If this situation re-occurs, charge or replace the battery.

IMPORTANT: Damage to the Starter Motor, Starter Solenoid, Run Solenoid or any generator component due to excessive or prolonged starting attempts attributed to an external Low Battery Control Monitoring or Auto-Start System will not be covered by the Power Technology Southeast, Inc. Limited Warranty.

ENGINE SPECIFICATIONS

MODEL	Kubota D1105-EBG1	Kubota V1505-EBG1
Continuous Output	13.6HP @ 1800 rpm	17.9HP @ 1800 rpm
Cubic Capacity	68.53 in³ (1.123.L)	91.41in³ (1.498L)
Bore and Stroke	3.07" x 3.09" (78.0 x 78.4mm)	3.07" x 3.09" (78.0 x 78.4mm)
Cylinder Arrangement	3 In-Line	4 In-Line
Firing Order	1-2-3	1-3-4-2
Compression Ratio	22:1	22:1
Engine Oil Capacity	5.38qts. (5.1L)	6.34 qts. (6.0L)
Coolant Capacity	3.27qts. (3.1L)	4.22qts. (4.0L)
Fuel and Type	Diesel No. 2-D 4 Cycle	Diesel No. 2-D 4 Cycle
Minimum Fuel Consumption	See Specification Chart	See Specification Chart

SERVICE PARTS

Power Technology Part #

Filters:

- Oil ---------- 01FO05S
- Fuel ---------- 08FF081
- Air ---------- 04FA221

Belts:

- With Alternator or Idler Pulley----------03BF1305
- Without Alternator or Idler Pulley----------03BF7305

Thermostat----------03THM0305NEW

Engine Maintenance Service Schedule

Maintenance Service Item	*See Note	Daily	Min. Every 25 Hours	Every 100 Hours	Every 250 Hours	Every 500 Hours	Every 1000 Hours	Remarks
Engine Oil Level Deterioration & Leakage		X						
Engine Oil Change	*			X				Or Once a Year
Oil Filter Change				X				Or Once a Year
Coolant Level		X						
Coolant Leakage		X						
Coolant Change							X	Or Once a Year
Fuel Level		X						As Necessary
Fuel Leakage		X						
Fuel Filter Re-placement						X		Or Once a Year
Air Filter Re-placement	**					X		Or Once a Year
Damaged Worn Or Loose Belts		X						Or Every Two Years
Replace Fuel Hoses							X	Or Every Two Years
Check Radiator Hoses & Clamps						X		Once a Year
Abnormal Engine Noise		X						
Abnormal Generator Noise		X						
Muffler Condition		X						
Exhaust Gas Condition		X						

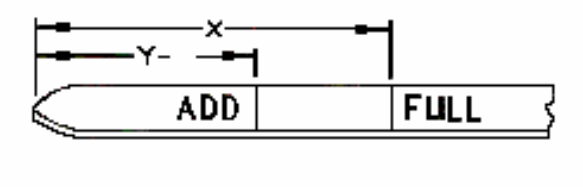
* Engine oil and filter must be changed after the first 50 hours of operation. Then every 100 hours or once a year whichever comes first.

** Air filter replacement interval will vary depending on operating conditions. Adverse conditions may require frequent service.

NOTE: Under normal operation items such as Belts, Hoses and Filters are not covered by Power Technology Southeast, Inc. Limited Warranty.

ENGINE OIL MAINTENANCE

CHECKING ENGINE OIL LEVEL



(Y) “ADD” mark. (X) “FULL” mark.

1. Maintain the engine oil level between “ADD” mark and “FULL” mark on oil level gauge. Do not fill crankcase above “FULL” mark.

2. Remove the oil filler cap and add oil, if necessary. Clean the oil filler cap. Install the oil filler cap.

The refill capacities for the engine crankcase Reflect the approximate capacity of the crankcase or sump plus a standard oil filter. Auxiliary oil filter systems will require additional oil.

LUBRICATING OIL SPECIFICATION

Use only good quality lubricating oil, which meets the following Specification

API Class
CF
Engine Oil

KUBOTA ENGINE REFILL CAPACITIES

Crankcase Oil Sump and Filter	D1105-EBG1 5.38Qts. (5.1L) V1505-EBG1 6.34Qts. (6.0L)

LUBRICATING OIL VISCOSITY RECOMMENDATIONS

The minimum ambient temperature during cold engine start-up and the maximum ambient temperature during engine operation determine the proper SAE viscosity grade of oil.

Refer to the Engine Oil Viscosity Table below (Minimum Temperature) in order to determine the required oil viscosity for starting an engine in cold conditions.

Refer to the Engine Oil Viscosity Table below (Maximum Temperature) in order to select the oil viscosity for engine operation at the highest ambient temperature that is anticipated.

Ambient Temperature	Oil Viscosity
Above 25°C (77°F)	SAE 10W-30 SAE 30 or SAE 10W-40
0 to 25°C (32° to 77°F)	SAE 10W-30 SAE 20 or SAE10W-40
Below 0°C (32°F)	SAE 10W-30 SAE 10W or SAE 10W-40

ENGINE COOLANT MAINTENANCE

COOLANT RECOMMENDATIONS

For optimum performance, Power Technology recommends a 1:1 mixture of water / glycol.

NOTE: Use a mixture that will provide protection against the lowest ambient temperature.
NOTE: 100 percent pure glycol will freeze at a temperature of –23°C (-9°F).

Most conventional heavy-duty coolant / antifreezes use Ethylene Glycol. Propylene Glycol may also be used in a 1:1 mixture with water. Ethylene and Propylene Glycol provide similar protection against freezing and boiling. See the tables below.

ETHYLENE GLYCOL

Concentration	Freeze Protection	Boil Protection
50 Percent	-36°C (-33°F)	106°C (223°F)
60 Percent	-51°C (-60°F)	111°C (232°F)

PROPYLENE GLYCOL

Concentration	Freeze Protection	Boil Protection
50 Percent	-29°C (-20°F)	106°C (223°F)

NOTE: Do not use Propylene Glycol in concentrations that exceed 50 percent glycol because of Propylene Glycol's reduced heat transfer capability. Use Ethylene Glycol in conditions that require additional protection against boiling or freezing.

CHECKING RADIATOR COOLANT LEVEL

Remove the radiator cap after the engine has completely cooled and check to see that coolant reaches the supply port.

1. Fill to the bottom of the fill neck and check after every 25 hours of operation.

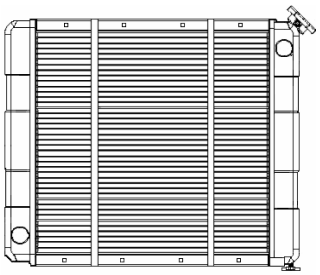
COOLANT SERVICE LIFE

Coolant Type	Service Life
Commercial Heavy-Duty Coolant/Antifreeze that Meets "ASTM D5345"	3000 Service Hours or Two Years
Commercial Heavy-Duty Coolant/Antifreeze that Meets "ASTM D4985"	3000 Service Hours or One Year

NOTE: Do not use a commercial coolant/antifreeze that only meets the ASTM D3306 or D4656 specification. This type of coolant/antifreeze is made for light duty automotive applications.

CHECKING RESERVOIR TANK COOLANT LEVEL

(At a Minimum of 25 Hours of Operation) Ensure that the coolant level of the radiator reservoir tank is between the upper limit (FULL) and the lower limit (LOW) on the side of the reservoir tank.



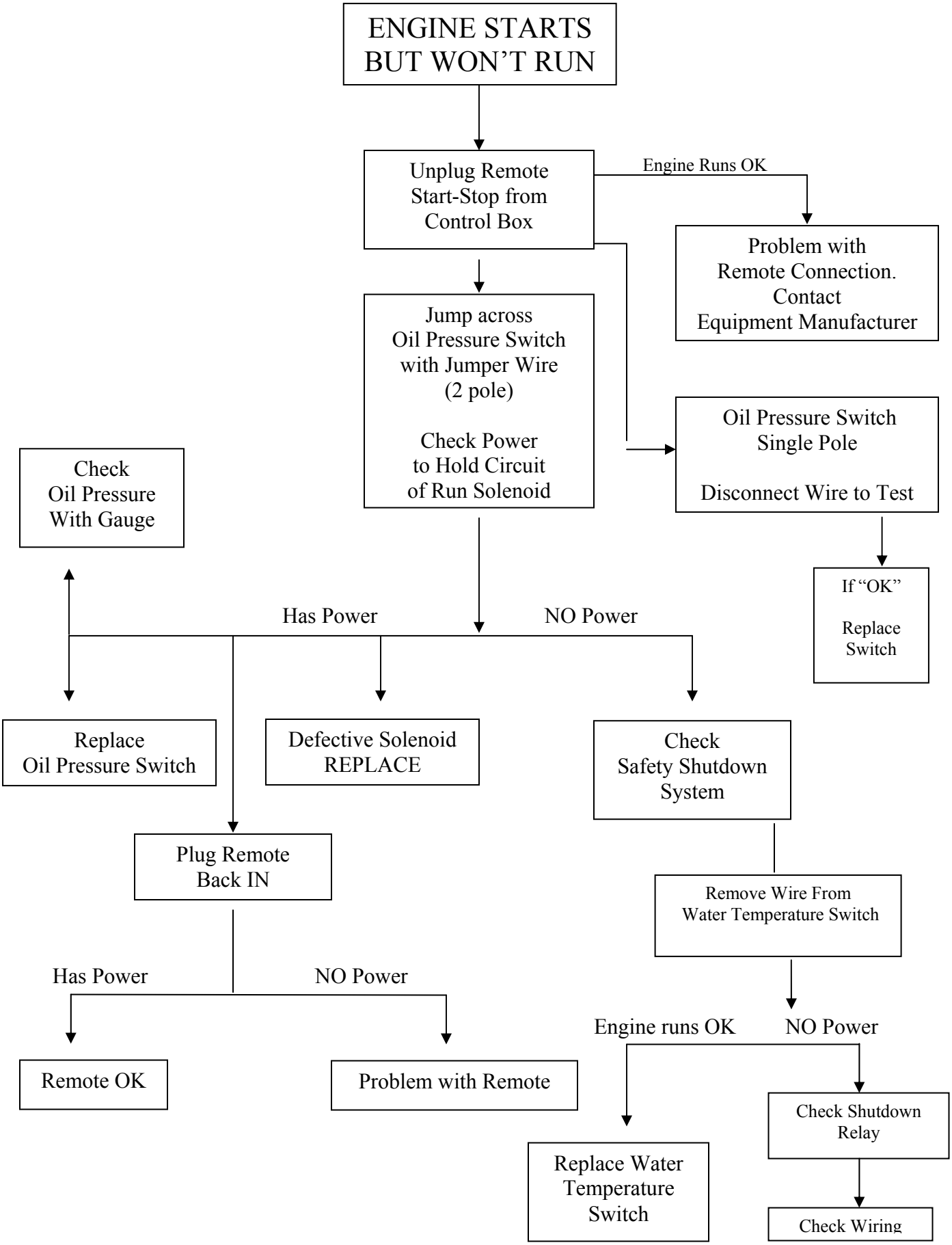
CLEANING RADIATOR CORE

Visually inspect the core for any obstructions such as dirt or debris. Use running water to clean particles from between fins.
IMPORTANT: Never use hard objects to clean radiator core, damage to core could result.

OPERATING HOURS and SERVICE LOG

THIS SERVICE LOG IS PROVIDED TO HELP YOU KEEP AN ACCUMULATIVE RECORD OF OPERATION HOURS ON YOUR GENERATOR SET AND THE DATES REQUIRED SERVICES WERE PERFORMED. ENTER TIME TO THE NEAREST HOUR.

OPERATING HOURS			SERVICE RECORD	
DATE	HRs. RUN	CUMLATIVE	DATE	SERVICES


ENGINE STARTS BUT WON'T RUN
Unplug Remote Start-Stop from Control Box
Engine Runs OK
Problem with Remote Connection. Contact Equipment Manufacturer
Jump across Oil Pressure Switch with Jumper Wire (2 pole)
Check Power to Hold Circuit of Run Solenoid
Oil Pressure Switch Single Pole
Disconnect Wire to Test
If "OK"
Replace Switch
Check Oil Pressure With Gauge
Has Power
NO Power
Replace Oil Pressure Switch
Defective Solenoid REPLACE
Check Safety Shutdown System
Plug Remote Back IN
Remove Wire From Water Temperature Switch
Has Power
NO Power
Engine runs OK
NO Power
Remote OK
Problem with Remote
Check Shutdown Relay
Replace Water Temperature Switch
Check Wiring

SoHum Health

Subject:	Manual:
DEF Tank - Hydraulic Lift pump	**Transportation**

POLICY:

It is the policy of Southern Humboldt Community Healthcare District (“SHCHD”, “District”, “SoHum Health”) to designate the security department to maintenance and proper operation of the DEF tank as well as hydraulic lift pump that operates the wheelchair lift and the hydraulic entry steps.

PROCEDURE:

The DEF tank does not require maintenance unless the tank is leaking, dripping, or causing lights on the dash to illuminate. In the case of service, a freight liner service provider will need to be contacted and service will need to be contracted out for the repair work. The DEF tank operates the same way a fuel tank operates. The dashboard has a display that will tell the operator the level of the DEF tank. The fill spout for the tank is located in exterior storage box 1, and will require a key to access.

-ONLY BLUE DEF FLUID SHOULD BE USED WITHIN THE DEF TANK-

The hydraulic lift pump is designed to be self priming and service may only be performed by a reputable engineer. The posted directions give a brief outline of use, including how to prime and relieve in the case of emergency.

DEFINITIONS:

None

SoHum Health

Subject: Travel and Travel Reimbursement	Manual: Human Resources

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") that there may be opportunities for outside training, attending conferences and participation in SHCHD events. Some of these events, employees may voluntarily choose to attend, in which case wages will not be paid. For other events, employees will be asked to attend as part of his/her job duties and to perform work at the event.

PROCEDURE:

Employees in **non-exempt positions** who are required to travel as part of their job will be paid for all time "worked" while traveling. Recognizing that while traveling by vehicle or plane, the employee may be unable to engage in his/her own personal pursuits, the employee may consider such time as time worked and will be compensated accordingly.
Employees in **exempt positions** are paid a pre-determined salary for all work performed in a week, and therefore are not provided additional compensation if travel time extends into days that are not part of the employee's regular work schedule. All business travel must be approved in advance by management. An itinerary including destination, nature of business, estimated length of time away and contact numbers to reach you, must be provided to your supervisor prior to commencing the business travel. The company will reimburse employees for reasonable travel expenses incurred while on assignments away from the normal work location, please see below for reimbursement guidelines.

Transportation

Airfare

Travelers are expected to obtain the lowest available airfare that reasonably meets business travel needs. Airfare may be prepaid by the business office. Travelers are encouraged to book flights at least 30 days in advance to avoid premium airfare pricing. First-class tickets are not reimbursable unless a reasonable accommodation is requested through the Human Resources Department. Coach class or economy tickets must be purchased for domestic or international flights (defined as flight time totaling less than five consecutive hours excluding layovers). A higher-priced coach ticket cannot be purchased for a subsequent upgrade in seating. A less-than-first-class ticket (i.e., business class) may be purchased at SHCHD's discretion for domestic or international flights (defined as flight time exceeding five consecutive hours excluding layovers). Airfare may be purchased with a credit card or check through the business office with a Request for Payment form.

Rail transportation

SHCHD will prepay rail transportation provided that the cost does not exceed the cost of the least expensive airfare or that the employee requires an accommodation to Rail transportation instead of airfare.

Personal Vehicle Use
Mileage will be reimbursed at the IRS current mileage reimbursement rate from the employees home or primary worksite to the business destination. When expenses/travels are completed, employees should submit completed expense reports and submit them to management for the pay period in which they were incurred.

Rental vehicles
SHCHD will pay for approved use of a rental vehicle. Reimbursement for a commercial rental vehicle as a primary mode of transportation is authorized only if the rental vehicle is more economical than any other type of public transportation, or if the destination is not otherwise accessible. Vehicle rental at a destination city is reimbursable. Original receipts are required. SHCHD authorizes reimbursement for the most economic vehicle available. In certain circumstances larger vehicles may be rented, with prior supervisory approval. Drivers must adhere to the rental requirements, and restrictions must be followed. Original receipts are required. When vehicle rentals are necessary, SHCHD encourages travelers to purchase collision damage waiver (CDW) and loss damage waiver (LDW) coverage. SHCHD will reimburse the cost of CDW and LDW coverage; all other insurance reimbursements will be denied. Drivers should be aware of the extent of a coverage (if any) provided by his or her automobile insurance company for travel that is business or not personal in nature.

Parking
Original receipts are required for parking fees (including airport parking) totaling $25 or more. The lodging bill can be used as a receipt when charges are included as part of the overnight stay.

Tolls
Original receipts are required for tolls totaling $25 or more.

Miscellaneous transportation
Original receipts are required for Uber, Lyft, taxi, bus, subway, metro, ferry, and other modes of transportation if costs are $25 or more for each occurrence.

Lodging
The cost of overnight lodging (room rate and tax only) will be reimbursed to the traveler if the authorized travel is 60 miles or more from the traveler's home or primary worksite. Exceptions to this restriction may be approved in writing by the Administrator or by the Chief Financial Officer. SHCHD will reimburse lodging expenses at reasonable, single occupancy or standard business room rates. When the hotel or motel is located at the conference or convention site, reimbursement will be limited to the conference rate. Only single room rates are authorized for payment or reimbursement unless the second party is representing the agency in an authorized capacity. If the lodging receipt shows more than a single occupancy, the single

room rate must be noted. If reimbursement for more than the single room rate is requested, the name of the second person must be included.

Meals
Per-diem allowances are reimbursable for **in-state overnight travel** that is 60 miles or more from the traveler's home or primary worksite. Per diem allowances are applicable for all **out-of-state travel** that is 60 miles or more from the traveler's home or primary worksite. SHCHD per diem rates are based on the U.S. General Services Administration Guidelines. Those guidelines are found at the following website https://www.gsa.gov/travel/plan-book/per-diem-rates It is expected that the employee traveling will view those rates and follow them as closely as possible for the destination they are traveling to without exceeding $100 per day. Reimbursement of Alcohol is limited to one drink per meal. Gratuity is suggested at a rate of 15%. Pre-approval from a supervisor for a higher reimbursable rate due to a special circumstance needs to accompany all other documentation submitted.

Conference registration
If the conference fee was not prepaid, SHCHD will reimburse these fees, including business-related banquets or meals that are part of the conference registration. Original receipts to support the payment are required. If the conference does not provide a receipt, then a cancelled check, credit card slip/statement or documentation that the amount was paid is required for reimbursement.

Entertainment
Entertainment is defined in this policy as limited to entertainment when traveling on business. Employees will be reimbursed for the actual cost of entertainment when such expenses have been determined reasonable and beneficial to the Employee. (Example of beneficial entertainment: local attractions, museum, zoo, park, concert…) Entertainment must conform to current tax and legal requirements. Discretion must be used as to levels of entertainment. Unreasonable entertainment expenses will not be reimbursed. Spouses or partners expenses are not eligible for reimbursement. Entertainment budget is limited to $100 no matter the duration of the business travel. Employees must remember they are representing SHCHD while away on business if discretion is not shown to be used while choosing forms of entertainment not only will it not be reimbursable, but the employee can be subject to disciplinary action.

Business expenses
Business expenses, including faxes, photocopies, Internet charges, data ports and business telephone calls incurred while on travel status, can be reimbursed. Original itemized receipts are required.

Visa, passport fees and immunizations. If these items are required for international travel, their reimbursement is left to the discretion of your supervisor. If approved by the designated authority, original itemized receipts are required.

Company credit card use for travel

Employees may choose to charge business and travel expenses to the Company credit card or may choose to be reimbursed for expenses that have been personally paid for (personal credit card or cash). The Company is responsible for all charges placed on the card; therefore, personal use of the company credit card is not allowed. Employees who use the Company credit card for personal use or for business and travel expenses that were approved in advance, will be required to reimburse the Company – there may also be corrective action consequences, up to termination of employment.

Travel advances and reimbursement

Cash advance requests are authorized for specific situations that might cause undue financial hardship for business travelers. These situations are limited to staff traveling on behalf of SHCHD. A maximum of 80 percent of the total estimated cost can be advanced. The traveler must repay SHCHD for any advances in excess of the approved reimbursable expenses. The department initiating the travel is responsible for notifying the business office to deposit any excess funds into the appropriate departmental account. Travel advances are processed by submitting a completed Request for Payment form and Travel Request form to the business office.

Regular requests for reimbursements of travel-related expenses are submitted on a Travel Reimbursement form. This form must be accompanied by supporting documentation. If the requested reimbursement exceeds 20 percent of the total pre-trip estimate, the Travel Reimbursement form must be signed by the Administrator or the Chief Financial Officer. These forms must be submitted to the business office within two weeks after the trip is completed. Reimbursement of travel expenses is based on documentation of reasonable and actual expenses supported by the original, itemized receipts where required. Employees are expected to limit expenses to reasonable amounts, and receipts for all individual expenses should accompany expense reports and submitted to their direct supervisor. Abuse of this policy, including falsifying expense reports to reflect costs not incurred by the employee, can be grounds for corrective action, up to and including termination of employment.

Vacation in conjunction with business travel

In cases in which vacation time is added to a business trip, any cost variance in airfare, car rental or lodging must be clearly identified on the Travel Request form. SHCHD will not prepay any personal expenses with the intention of being “repaid” at a later time, nor will any personal expenses be reimbursed.

Exceptions

Occasionally it may be necessary for travelers to request exceptions to this travel policy. Requests for exceptions to the policy must be made in a form of writing and approved by the departments Administrator or by the Chief Financial Officer. Exceptions related to the Administrator’s, or the Chief Financial Officer’s expenses must be submitted to the opposite person for approval.

DEFINITIONS:

None

SoHum Health

Subject:	Manual:
Critical Access Hospital Policy Development Committee	**Medical Staff**

PURPOSE:

The purpose of this policy is to set forth guidelines for the Policy Development Committee and outline the process for the effective and consistent development, review, and approval of non-medical policies within the District.

POLICY:

It is the policy of Southern Humboldt Community Healthcare District ("SHCHD", "District", "SoHum Health") to utilize the services of a Policy Development Committee to develop and revise non-medical policies for use in the District, in accordance with the Medical Staff Bylaws.

DEFINITIONS:

Policy Development Committee (PDC): the regular standing committee responsible for advising on District non-medical policies.
Medical Policies: policies that govern clinical care, diagnostic or therapeutic decision making, credentialing/privileging pf providers, or patient care standards.
Non-medical Policies: policies that oversee administrative rules and guidelines that are non-clinical.

PROCEDURE:

It is the scope of the PDC to oversee the review, approval, and retirement of the District's non-medical policies and procedures.

The Committee shall be composed of members of the Administration department, the Policy and Procedure Coordinator, or other member of the Quality and Compliance department, and managers as ad hoc members who will attend meetings as appropriate based upon the policies being developed.

The PDC shall meet monthly, or as needed. Special meetings shall be called when policies require fast approval due to new rules, regulations, or laws, or when a specific policy is needed to comply with requirements for grants, equipment, or patient needs, or other urgent policy needs that cannot wait for the next scheduled meeting. Special meetings shall be scheduled with at least twenty-four-hour notice and will proceed only when a quorum is met. Policies due for approval, reapproval, or retirement shall be distributed at least seven days prior to the monthly meeting. A policy must be approved by all required departments/staff at least seven days prior to PDC meeting in order to be added to the PDC monthly agenda. If a policy does not have the necessary approvals prior to the closing of the agenda inclusion window (seven days before the meeting), it will not be included in that month's agenda and must wait for PDC

review until all approvals are met. Policies included for monthly review will, whenever possible, include a group of policies from one department at each meeting to allow for the best use of ad hoc members' time.

Minutes will be kept for each meeting and include the names of the members present, the date, and the action(s) taken. Minutes will also include the names of the policies developed/revised, and any specific changes.

New policies shall be determined by the department authoring the policy as to whether it is a medical or non-medical policy. This determination will be confirmed by the Policy and Procedure Coordinator, with input from Administration when necessary, prior to approval pathways being set.