TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
OF THE PROFESSIONAL AFFAIRS COMMITTEE
OF THE BOARD OF DIRECTORS
August 11, 2016 – 12:00 p.m. – Assembly Room 1
Tri-City Medical Center, 4002 Vista Way, Oceanside, CA 92056

The Committee may make recommendations to the Board on any of the items listed below, unless the item is specifically labeled "Informational Only"

	Agenda Item	Page Nos.	Time Allotted	Requestor/ Presenter
1.	Call To Order/Opening Remarks		2 min.	Chair
2.	Approval of Agenda	1-2	2 min.	Chair
3.	Public Comments NOTE: During the Committee's consideration of any Agenda item, members of the public also have the right to address the Committee at that time regarding that item.		5 min.	Standard
4.	Ratification of minutes of the July 2016 Meeting	3-8	2 min.	Committee
5.	New Business			
a.	Consideration and Possible Approval of Policies and Procedures	9		J. Piearson
	Patient Care Services			
	1. Billiary Drain, Care of Percutaneous Procedure.	10-11		J. Piearson
	2. Patient Classification (Acuity) Procedure	12-13		
	Administrative Policies and Procedures:			
	1. Signage 215	14-15		All
	Unit Specific			
	Infection Control			
	1. Bed Bugs, Identification and Control	16-17		
	2. Bloodborne Pathogen Exposure Control Plan	18-34		
	3. Scabies and Lice	35-42 43-45		
	Women and Newborn Services			
	1. Infant Baptism	46		
6.	Review and Discussion of CLINICAL Contracts- NO Contracts To Review (*Discussion/ Possible Action*)		10 min.	Chair
7	Review and Discussion of PAC Charter	47-50	10 min.	Cheryle Bernard-Shaw
7.	Motion to go into Closed Session		2 min.	Committee
8.	CLOSED SESSION a. Reports of the Hospital Medical Audit and/or Quality Assurance Committee (Health & Safety Code Section 32155) b. Conference with Legal Counsel – Significant exposure to litigation (Government Code Section 54956.9(b))		30 min.	Chair
9.	Reports from the Committee Chairperson of any Action Taken in Closed Session (Government Code, Section 54957.1)		10 min.	Chair

10.	Comments from Members of the Committee		5 min.	Committee
11.	The next meeting of the Professional Affairs Committee of the Board is on September 8, 2016.		1 min	Chair
12.	Adjournment		1 min	Chair

DRAFT

Tri-City Medical Center
Professional Affairs Committee Meeting
Open Session Minutes
July 14, 2016

Members Present: Director Laura Mitchell (Chair), Director Larry Schallock, Director Ramona Finnila, Dr. Marcus Contardo, Dr. Gene Ma, Dr. Johnson and Dr. Scott Worman.

Non-Voting Members Present: Steve Dietlin, CEO, Kapua Conlery, COO/ Exe. VP, Sharon Schultz, CNE/ Sr. VP, and Cheryle Bernard-Shaw, Chief Compliance Officer.

Others present: Jody Root, General Counsel, Marcia Cavanaugh, Sr. Director for Regulatory and Compliance, Jami Piearson, Director for Regulatory Compliance, Cli. Quality and Infection Control, Jeremy Raimo, Steve Young, Patricia Guerra and Karren Hertz.

Members Absent: None.

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
1. Call To Order	Director Mitchell called the meeting to order at 12:05 p.m. in Assembly Room 1.		Director Mitchell
2. Approval of Agenda	The committee reviewed the agenda and there were no additions or modifications.	Motion to approve the agenda was made by Dr. Contardo and seconded by Director Schallock.	Director Mitchell
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Mitchell read the paragraph regarding comments from members of the public.		Director Mitchell

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
4. Ratification of minutes of June 2016.	Director Mitchell called for a motion to approve the minutes from June 9, 2016 meeting.	Minutes ratified. Director Schallock moved and Director Finnila seconded the motion to approve the minutes from June 2016.	Karren Hertz
5. New Business a. Priority Project Dashboard	**Falls** Jami briefly discussed the measures recently implemented to reduce falls in the units. A small team was formed to pinpoint challenges and form resolutions to address the issue on falls. Michelle Hardin, who is heading the group used the JC tool to clearly identify the factors leading to falls and made recommendations to improve these issues. **Patient Throughput (ED)** It was noted that the community feedback on the new triage is positive. Patients are liking it as the patient flow gets better and wait times get shorter from ED arrival to departure or admission.	Informational	Jami Piearson
b. Outcomes Dashboard	**HAPUs** Sharon and Jami reported that the nurses will soon have iPods for clearer pictures of affected areas for HAPU documentation. The iPods will come in August. The state recommends taking a picture within 24		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
	hours of admission and having all the information in one page. The images can be scanned directly from the iPods into the patient's chart. **Sepsis** Dr. Worman mentioned that the hospital is doing well in trending sepsis. Melanie Bruce from IT created a template to track sepsis patients accurately. Dr. Ma reiterated that dealing with sepsis involves a lot of information and processes that is why it is not a very easy process to deal with.		
c. Consideration and Possible Approval of Policies and Procedures **Patient Care Policies and Procedures:** 1. Advanced Care Technicians (ACT) Assignments and Shift Routines for telemetry and Acute Care Services (ACS)	It was decided by the committee to pull out this policy since there is a name change for the Forensics unit as well as there is a need to clarify some of the duties of the ACTs.	**ACTION:** The Patient Care Services policies and procedures were approved with the exception of the policy on ACT Assignment and Shift Routines. Dr. Contardo moved and Director Finnila seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
2. Alcohol Withdrawal Symptom Management	The alcohol screening is currently done in the ED but will also be done on admission starting in August. It was suggested that a footnote be added regarding the medication for pregnant/lactating women in the tool.		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
3. Chain of Command Policy	The term TCMC was changed to TCHD in this policy.		Patricia Guerra
4. Emergency Cart, Cardiopulmonary Arrest	There was a question if the emergency cart is different from a crash cart. It was agreed upon by the group that the whole policy should say emergency cart all throughout for uniformity purposes. It was further clarified that the procedure outlined on page 35 does not have to be done consecutively.		
5. Family Presence During Resuscitation	This policy was added to the nursing tool for assessment as it is a JC requirement. The term "based on available staff" should be added in the definition on the family support person list.		
6. Postural (Orthostatic) Vital Signs, Obtaining	Dr. Johnson made some clarifications on some of the procedure steps adding "any one or more" on the statement on when will the physician be notified. Jami also added "approximately" on one of the procedural steps as it is recommended by the JC requirements.		
7. Stool Management (Rectal Tube) Dignicare Stool Management	This policy is not used very often in the units. It is mostly utilized in the ICU Department.		
Unit Specific Medical Staff			

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
1. Credentialing Policy; Porocessing Medical Staff Reappointments	The committee made a recommendation to change the requirement on the professional references to go back as far as 10 years (this was later on changed to 5 years to streamline TCHD processes as recommended by Colleen Thompson).	**ACTION:** The Medical Staff policy was approved with changes as moved by Director Finnila and seconded by Dr. Worman.	Patricia Guerra
Formulary Requests 1. Bridion- Trade Name/ Sugammadex-Generic Name	The Pharmacy and Therapeutics Committee has approved this medication more exposure and is also costly so there is a limit imposed on the providers who prescribe this drug.	**ACTION:** The formulary requests were approved as moved by Dr. Contardo and seconded by Direvctor Schallock.	Patricia Guerra
2. Emend- Trade Name/Aprepitant-Generic Name	This drug is indicated for nausea and vomiting, especially for post operative nausea and vomiting as well as the nausea/vomiting associated with chemotherapy.		
3. Veltassa- Trade Name/ Sorbitex Calcium- Generic Name	This medication is preferred for patients who do not need additional sodium (e.g. chronic renal failure, cardiac patients). As a powder, it can be mixed in any liquid for administration.		
6. Clinical Contracts	No contracts were reviewd for this month.	**ACTION:** No action taken.	Director Mitchell
7.Review and Discussion of PAC	Cheryle Bernard-Shaw reviewed the PAC	**ACTION:** Jody Root suggested	Cheryle

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Charter	Charter with the committee. There was a number of recommendations that the committee suggested: • It should say provide health care delivery oversight (and not governance oversight) • Performance of clinical service providers should be elaborated as suggested by the physicians • The administrative policies should be taken out as PAC reviews all policies. Tricia will give out all the categories so they will be enumerated accordingly in the PAC Charter.	tha the PAC charter need to be revised. Karren will send an email to the committee for all to review and send proposed changes. This charter will be presented again next meeting.	Bernard-Shaw
7. Closed Session	Director Mitchell asked for a motion to go into Closed Session.	Directir Finnila moved, Director Schallock seconded and it was unanimously approved to go into closed session at 12:50 PM.	Director Mitchell
8. Return to Open Session	The Committee return to Open Session at 2:22 PM.		Director Mitchell
9. Reports of the Chairperson of Any Action Taken in Closed Session	There were no actions taken.		Director Mitchell
10. Comments from Members of the Committee	No Comments.		Director Mitchell
11. Adjournment	Meeting adjourned at 2:24 PM		Director Mitchell

PROFESSIONAL AFFAIRS COMMITTEE
August 11th, 2016

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Biliary Drain, Care of Percutaneous Procedure	3 year review, practice change	
2. Patient Classification (Acuity) Procedure	3 year review, practice change	
Administrative Policies & Procedures		
1. Signage 215	3 year review, practice change	
Unit Specific		
Infection Control		
1. Bed Bugs, Identification and Control	NEW	
2. Bloodborne Pathogen Exposure Control Plan	1 year review, practice change	
3. Construction	3 year review, practice change	
4. Scabies and Lice	3 year review, practice change	
Women and Newborn Services		
1. Infant Baptism	DELETE	

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**BILIARY DRAIN, CARE OF PERCUTANEOUS**
Purpose:	To outline the nursing responsibilities in the care of percutaneous biliary drains.
Supportive Data:	A biliary drain is used for the treatment of biliary stone disease, biliary strictures, biopsy of biliary ducts, and relief of obstructive symptoms due to unresectable malignant tumors.
Equipment:	1. Gloves 2. Face Shield or Mask or Goggles 3. Collection Container 4. Biohazard disposal bag available.

A. **POLICY:**

1. **Maintenance**
   a. Ensure locking mechanism of drainage tube is in locked position to maintain proper and secure placement of drain or as ordered by physician
   b. Secure drainage bag to prevent tension or accidental dislodgement.
2. **Bathing**
   a. No shower or bath for 72 hours~~While biliary drain is in place, ensure insertion site remains dry.~~
   b. Remove dressing, clean area with soap and water, pat dry and replace dressing
      ~~a.~~**i. It is normal to have small-crusted area appear around the site, just soften with water and remove**

B. **PROCEDURE:**

1. **Emptying the Drainage Bag**
   a. Empty drainage bag when it becomes half full or every shift.
   b. Don clean gloves. If splashing is anticipated wear mask, eye protection, and/or gown.
   c. Empty drainage bag into a measuring container and carefully avoid touching the spout of the drainage container.
   d. Dispose of drainage in the toilet; avoid splashing contents.
   e. Document the amount and type of fluid drained in the medical record.
2. **Changing the dressing**
   a. Change biliary drain dressing every other day and PRN or as ordered.
   b. Perform hand hygiene
   c. Don clean gloves
   d. Place the following supplies on a clean surface:
      i. Tegaderm bandage
      ii. Chlorhexadine swab
      iii. Drain gauze
   e. Remove the soiled dressing
   f. Change gloves as necessary
   g. Assess insertion site for redness and oozing of fluid. Notify the primary care or Interventional Radiology (IR) provider if these signs are noted.
   h. Using Chlorhexadine swabs (or povidone iodine swabs if the patient is allergic to chlorhexadine), scrub a circular pattern around the exit site for 30 seconds. Allow to dry for 60 seconds.
   i. Place drainage gauze around insertion site.
   j. Apply Tegaderm on top of the gauze and over the tube, and apply additional tape to secure tube as needed to prevent dislodgement.
   k. Write the date and time of dressing change and your initials on the dressing.
   l. Document in the medical record.

Department Review	Clinical Policies & Procedures	Nursing Executive Council	Department of Radiology	Medical Executive Committee	Professional Affairs Committee	Board of Directors
06/09, 10/10, 02/11, **11/14**	02/11, **12/14**	03/11, **12/14**	**08/15**	04/11, **01/16**	05/11	08/09, 05/11

3. **Removal of Drains**
   a. If drain was removed by IR or other physician, maintain dressing over drain site until site is healed. Secure gauze dressing with tape and change PRN.
   b. If drain was removed accidentally:
      i. Cover drain site with gauze and dressing.
      ii. Notify IR and primary care physician.
      iii. Collect drain, tubing and other associated products to send with patient to IR.
      iv. Contact Risk Management regarding accidental withdrawal.
      v. Document incident in medical record.

C. **REFERENCES:**

1. Ohio State University Medical Center. (2008, March 18). Biliary drainage. Retrieved May 30, 2009, from http://medicalcenter.osu.ed/PatientEd/Materials/PDFDocs/diagnost/gastro/biliary.pdf
2. Kocher M, Cerna M, Havlík R, Kral V, Gryga A, Duda M. Percutaneous treatment of benign bile duct strictures. *Eur J Radiol.* May 2007;62(2):170-4.
3. Link BC, Yekebas EF, Bogoevski D. et al. Percutaneous transhepatic cholangiodrainage as resuce therapy for symptomatic biliary leakage without biliary tract dilation after major surgery. J. Gastroinest surgery. Feb 2007; 11 (2): 166-70
4. Gottrup, F., Nix, D. P. & Bryant, R. A. *The multidisciplinary team approach to wound management.* In R. A. Bryant, & D. P. Nix (Eds.), Acute & chronic wounds: Current management concepts (3rd ed., pp. 23-38). St. Louis, MO: Mosby.

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**PATIENT CLASSIFICATION (ACUITY)**
Purpose:	To provide an assessment of the care needs intensity of each patient per shift to assist in determining the appropriate staffing based on acuity and ratios
Supportive Data:	In accordance with the rules and regulations of Title 22 and Joint Commission

A. **RESPONSIBILITIES:**

1. The Managers, Assistant Nurse Manager (ANM) or designees are responsible to ensure that licensed staff complete Patient Classifications (Acuity) for their patients each shift.
   a. Each patient's classification should reflect the patient's actual care intensity and Activities of Daily Living (ADL) needs for the current shift.
2. Nursing is responsible for Patient Classification utilizing the Cerner Acuity Powerform; this includes Acute Rehab, 1 North, 2 Pavilion, ~~3 Pavilion,~~ 4 Pavilion, Behavioral Health Unit (BHU), Intensive Care Unit (ICU), Mother Baby, ~~Nursery,~~ Neonatal Intensive Care (NICU), Telemetry and ~~Forensics~~ **Inpatient Progressive Care Unit**.
3. The Emergency Department and Labor & Delivery will utilize a census based tracking form.

B. **PROCEDURE FOR THOSE UTILIZING THE CERNER POWERFORM FOR ACUITY:**

1. A task will be triggered at 1200 and midnight each day to the nurse assigned to the patient on their unit.
2. The primary **Registered Nurse** (RN) is required to complete the acuity on the patient by 1300 and 0100 or the task will be noted as overdue.
   a. There are care intensity and ADL indicators.
      i. The Care Intensity indicator is defined by minimal, moderate, high, 1:1 and 2:1 levels.
      ii. The ADL indicator is defined by minimal, moderate and high.
      iii. Each care intensity and ADL indicator is unit specific based on the patient population and has a weight associated to it that assists in determining the acuity of the patient.
3. The ANM or designee is responsible to verify that all acuities are completed each shift.
4. ~~The ANM or designee will complete the Staffing Calculator by 1500 and 0300 which reflects the acuity of the patients as completed by the licensed staff and the minimum number of staff required based on the acuity and minimum staffing ratios.~~
5. ~~This information is submitted electronically to Staffing Resource Center if completed by the times specified.~~
   a. ~~If the ANM or designee is late in completing the Staffing Calculator, they are responsible for faxing a copy of their completed Daily Summary Reports which reflects this information to staffing as soon as possible.~~

C. **PROCEDURE FOR THOSE UTILIZING CENSUS BASED TRACKING (EMERGENCY DEPARTMENT AND LABOR & DELIVERY):**

1. The coder will document on the Acuity Daily Report the Emergency Department census at 0700 and 1900. **A daily Emergency Department (ED) Activity Log is generated at 0700 for the previous 24 hours which reflects the total patients seen, Patients Left Without Treatment, ICU admissions and hospital admissions in the last 24 hours. Emergency Severity Index (ESI) acuity levels are documented in Firstnet when patients arrive in Triage**.
2. The **Labor and Delivery** ANM or designee will document on the ~~Acuity Daily Report~~**Daily Staffing Sheet** the Labor & Delivery census at 0700 and 1900. **The ANM or designee will fax this 24 hour retrospective report to staffing by 0900 for filing.**

Department Review	Clinical Policies & Procedures	Nursing Executive Council	Medical Staff Department / Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
11/12, 07/16	12/12, 07/16	12/12, 07/16	n/a	n/a	4/12, n/a	04/13	04/13

~~3. The ANM or designee will fax this 24-hour retrospective report to staffing by 0900 for filing.~~

D. **INTER-RATER RELIABILITY PROCESS:**

1. The purpose of this process is to ensure the consistency among the registered nurses in the interpretation and use of the Patient Classification (Acuity) powerform.
2. Each shift ~~a task will be triggered by Cerner to~~ the ANM or designee ~~to~~ **will** complete an Acuity Validation on patients within their department.
   a. ~~The task is set to randomly pick~~ **Two (2)** patients per department for 1N, 2P~~, 3P~~, 4P, BHU & Rehab.
   b. ~~The task is set to randomly pick~~ **One (1)** patient per custom location for ICU, Tele ~~and~~ Mother Baby **and Inpatient Progressive Care Unit**.
   ~~c. If a patient isn't assigned to the bed randomly chosen for that shift, a replacement validation order will not be triggered.~~
   ~~3. One Acuity Validation per day will be completed by the ANM/or designee for Patients on 3 N/S (Forensics)~~
4. ~~3.~~ This information will be monitored on a monthly basis and reported as appropriate.

~~E. **FORMS REFERENCED WHICH CAN BE LOCATED ON THE INTRANET:**~~

~~1. Acuity Daily Report - Labor & Delivery~~
~~2. Acuity Daily Report - Emergency Department~~

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE:	**07/86**	**SUBJECT:**	**Signage**
REVISION DATE:	**5/88; 6/94; 5/03, 8/06, 5/09, 8/12**	**POLICY NUMBER:**	**8610-215**

Department Approval:	**07/16**
Administrative Policies & Procedures Committee Approval:	**~~07/12~~07/16**
Professional Affairs Committee Approval:	**08/12**
Board of Directors Approval:	**08/12**

A. **PURPOSE:**

1. To act in accordance with applicable statutory or regulatory requirements, Tri-City ~~Medical Center (TCMC)~~**Healthcare District (TCHD)** will post or display signs and informational notices within the facility. To provide consistent signage, while ensuring a safe and aesthetically pleasing environment for our patients, guests and employees.

B. **DEFINITIONS:**

~~B.~~1. **Permanent signage/signs: Signs that are mounted with the intention of being a permanent or long term fixture. Examples: Directional way-finding signs, wall pictures, no smoking signs, regulatory signage.**

2. **Temporary signage/signs: Signs or postings that are put up with the intention of being in place for a limited amount of time. Examples: Educational class notices, Foundation or Auxiliary fundraising events, temporary detour directional signs, seasonal flu advisory notices.**

C. **POLICY:**

1. ~~TCMC~~ **TCHD** will post and maintain signage as required by the California Department of Public Health, Title 22 California Code of Regulations, other California law, and The Joint Commission and Medicare Conditions of Participation requirements.
2. All **requests for permanent** ~~sign requests~~**signage/signs** must be approved by the ~~Vice President of Support Services~~**Chief Operating Officer (COO)/designee.**
3. **Prior to any signs being posted in the facility, whether permanent or temporary they will need to be approved by the Environment of Care/Safety Officer to ensure they meet approved specifications and regulatory requirements. (Exceptions listed below: 4.a-c)**

~~D.~~4. **All advertising and marketing materials designed for an internal or external audience, that contain the Tri-City Healthcare District or Tri-City Medical Center name and logo must be created and/or approved by the Chief Marketing Officer/designee. This includes all brochures, calendars, fliers, handouts, pamphlets, stationary, website and broadcast production, etc.**

a. **Education related flyers used to promoted educational opportunities, classes, Hot Topics, etc. only require the approval of the Director of Education, Clinical Informatics and Staffing.**

b. **Union Materials: No material shall be posted until approved and initialed by the Chief Human Resources Officer (CHRO)/designee. Approved postings are to be displayed on designated bulletin boards. Postings outside of designated areas are prohibited.**

c. **Temporary signs/flyers posted within department break rooms, lounges, and educational boards only require the approval of the department director, manager or departmental designee.**

~~2. Paper signage may not be posted in fire corridors unless it is laminated, or framed, or printed on fully synthetic paper.~~

~~3. Prior to signs being posted in the facility they will need to be approved by the TCMC Sign Committee to ensure they meet approved specifications.~~

5. The Facilities department is responsible for the installation and maintenance of all permanent interior and exterior signs, pictures, signposts, and directional signage.

~~4.~~6. Paper signage may not be posted in fire corridors unless it is laminated, framed, or printed on fully synthetic paper. Contact the Environment of Care/Safety Officer for guidance and clarification.

~~E.~~D. REFERENCES:

1. **California Department of Public Health, Title 22 California Code of Regulations**
2. **The Joint Commission and Medicare Conditions of Participation**

Tri-City Medical Center
Oceanside, California

INFECTION CONTROL POLICY MANUAL

ISSUE DATE: NEW **SUBJECT: Bed Bugs, Identification and Control**

REVISION DATE(S):

Department Approval Date(s):	**07/16**
Infection Control Committee Approval Date(s):	**07/16**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**07/16**
Professional Affairs Committee Approval Date(s):	
Board of Directors Approval Date(s):	

A. **DEFINITION:**

1. Bed bugs (Cimex lectularius): small, flat, wingless, parasitic insects that feed solely on the blood of people and animals while they sleep.
   a. Adult bed bugs are 5-6mm (1/4 inch) & reddish brown in color, while young bed bugs are 1mm-4mm (1/16"-1/4") & translucent.
   b. Bed bugs do not transmit disease. Bed bug bites will cause red, raised itchy, reactions on the skin. Scratching can lead to secondary skin infections. Bed bugs are moved from infested areas to non-infested areas on clothing, luggage, furniture, or bedding. They hide during the day in places such as seams of mattresses and box springs, bed frames, dresser, tables and cracks and crevices or objects around the bed. Bed bugs can live several months without a blood meal.

B. **PURPOSE:**

1. Provide assistance in identifying and controlling bed bug infestation.

C. **POLICY:**

1. Movement of the patient to other areas of the hospital should be limited.
   a. Use disposable suit to provide containment as needed for infestations during transport throughout facility

D. **PROCEDURE:**

1. While in the **Emergency Department** (ED):
   a. Place patient in Contact Precautions upon realizing or suspecting the patient has bed bugs.
   b. Exam the patient to determine if bed bugs are present.
   c. Place patient in clean gown and linens upon orders for inpatient admission.
   d. Bag up all personal clothing & belongings and seal the bag tightly. Keep sealed until the patient is discharged. If the patient is being admitted, send clothes and personal belongings home with family if possible.
   e. Contact **Environmental Services** (EVS) to clean the room once patient has been discharged from bed space. Inform EVS room may have contained bed bugs.
2. Upon inpatient admission:
   a. Continue Contact Precautions.
   b. Continue to keep all clothes and personal belongings sealed tightly. Send clothes and personal belongings with family if possible.
   c. Have the patient shower if possible.

d. Place work order to notify Building Engineering once patient has been admitted to the room. Include the reason: potential bed bug infestation and will need to have pest control inspection once patient has been discharged from room.

3. Upon discharge:
   a. Once patient is discharged notify Building Engineering so they can contact Pest Control to inspect room.
   b. Once the room is cleared through Building Engineering (& Pest Control), contact ~~Environmental Services~~**EVS** to have room terminally cleaned.

E. **REFERENCE LIST:**

1. http://www.cdc.gov/parasites/bedbugs/faqs.html
2. http://www.cdph.ca.gov/healthinfo/discond/Pages/BedBugs.aspx
3. https://www.cdph.ca.gov/HealthInfo/discond/Documents/BedBugGuidelines.pdf

NYMPHS, OR BABY BED BUGS, ARE SLIGHTLY SMALLER AND NEARLY COLORLESS WHEN THEY FIRST HATCH, BECOMING DARKER AS THEY MATURE. ADULT BED BUGS DO NOT FLY, BUT CRAWL WHEN SEEKING REFUGE OR A HOST.

Tri-City Health Care District
Oceanside, California

Infection Control Policy Manual

ISSUE DATE: 9/01 **SUBJECT:** Bloodborne Pathogen Exposure Control Plan

REVISION DATE: 9/02; 9/03; 9/04; 9/05; 10/06, 10/07; 10/08; 10/09; 10/10; 10/12, 10/15

Infection Control Department Approval:	~~07/15~~07/16
Infection Control Committee Approval:	~~07/15~~07/16
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~09/15~~07/16
Professional Affairs Committee Approval:	10/15
Board of Directors Approval:	10/15

A. **INTRODUCTION:**

1. Legal mandates and regulatory agencies such as the California code of Regulation Title 8, Occupational Safety and Health Administration and the Centers of Disease Control and Prevention have set standards and published guidelines for the implementation of the Bloodborne Pathogen Exposure Control Plan.

B. **PURPOSE:**

1. The purpose of the Bloodborne Pathogens Exposure Control Plan is to reduce occupational exposure and transmission of Hepatitis B Virus (HBV), Hepatitis C Virus (HCV), Human Immunodeficiency Virus (HIV) and other bloodborne pathogens. The second purpose is to satisfy the Occupational Safety and Health Administration (OSHA) regulations (29 CFR 1910.1030). Our plan outlines the steps we take to protect our employees from the health hazards associated with bloodborne pathogens and to provide appropriate treatment and counseling after an exposure.

C. **SCOPE:**

1. This plan applies to all inpatient and outpatient services of Tri-City Healthcare District (TCHD)

D. **AVAILABILITY TO EMPLOYEES:**

1. To help them with their efforts, our facility's Bloodborne Exposure Control Plan is available to our employees at any time. The policy can be accessed in the Infection Control Manual located on the Intranet. Information is presented in the new employee orientation and during annual reviews.

E. **PROGRAM ADMINISTRATION:**

1. Employee Health Services is responsible for the implementation, maintenance, and administration of the Injury Prevention Program. In conjunction with the Iinfection Pprevention ist, she/he will review and update the Exposure Control Plan at least annually and whenever necessary to include new or modified tasks and procedures.
2. To assist the Director of Safety/ Environment of Care (EOC) in carrying out their duties, the Environmental Health and Safety (EHSC) Committee and following specific people will be contacted as needed.
   a. Infection Preventionist
   b. Employee Health
   c. Staff Educator
   d. Engineering
   e. Human Resources
   f. Environmental Service Managers
3. Department Directors, Managers, and Supervisors are responsible for compliance in their respective areas. They work directly with the Director of Safety/EOC, the Infection Control

Department, Education Department, Employee Health Nurse and our employees to ensure that proper exposure control procedures are followed.

a. Managers will support activities that encourage the active involvement of employees in education and safety programs. Managers will oversee employees so that initial training and annual review of bloodborne pathogens are completed prior to annual job evaluations.
b. Registry and contract staff are oriented to the hospital's exposure control plan prior to working.
c. Annually, managers will complete the template "Safer Work Practices" (see ~~Appendix A~~**Safer Work Survey**) with input from employees with respect to the procedures performed in their respective work areas or departments related to safe work practices, engineered safety devices and personal protective equipment (PPE).
d. Managers will counsel employees who do not use safe practices, PPE, and/or safety devices.
e. Managers will review quality review reports (RL Solutions) their employees complete to document why they did not use an available safety device.

4. The Director/Manager of Education and Training Services has been selected to be the facility's Education/Training Coordinator. He/she is responsible for providing information and training to all employees with potential for exposure to bloodborne pathogens including:
   a. Developing and scheduling suitable education/training programs.
   b. Periodically reviewing training programs with the Environment of Care Officer, Employee Health, Infection Control, and Department Managers/Supervisors to include appropriate new information.
   c. Training records are maintained for three years and available for examination and copying to our employees, as well as OSHA representatives. The records contain the following information, dates of all training sessions, contents/summary of the training sessions, and names and qualifications of the instructors as well as the names and job titles of employees attending.
5. Materials Management and Environmental Services will provide all necessary personal protective equipment (PPE), engineering controls (e.g., sharps containers and sharps safety devices), labels, and red bags as required by the standard.
6. ~~Products Standardization~~**Clinical Value Analysis Team** ~~Committee~~ has been identified as the multi-disciplinary group with primary responsibility for introducing sharps safety products to TCHD. The committee will provide guidance in product selection, seeking to provide cost-effective safety devices.
   a. Review and selection Sharps Safety Products will follow established routes and include input from non-managerial employees responsible for direct patient care who are potentially exposed to contaminated sharps and injury. See ~~Appendix B~~**Clinical Value Analysis Team Product Evaluation** and **User Product Evaluation.** ~~C.~~
   b. Product Selection will follow a hierarchy of risk (i.e. high-risk procedures and devices targeted first). The committee will act on recommendations from Environment of Care or Infection Control Committees related to health care injuries and need for alternative product.
   c. All products will be judged by specific criteria and selection will be guided by user recommendations.
   d. See ~~Appendix D~~**Product List** for a table of safety devices that have been adopted.
7. Employees who are determined to have occupational exposure to blood and other potentially infectious materials (OPIM) must comply with the procedures and work practices deemed appropriate. They are actively involved in reviewing and updating the exposure control plan with respect to the procedures performed in the course of their work.
   a. Our employees are expected to complete initial bloodborne pathogens training and annual review.
   b. They participate in updating the bloodborne pathogen standard with respect to the procedures performed in their work area or department. "Safer Work Practices" (~~Appendix A~~**Safer Work Survey**).
   c. Licensed healthcare professionals are required to complete a quality review report (RL

Solutions) when they do not use available Sharps safety devices during the care of a patient. The report will outline their determination of why using an engineering control would have jeopardized the patient's safety or the success of a medical, dental, or nursing procedure.

d. Employees will participate in the trial and selection of new safety devices.

8. The EHSC will compile and trend the information gathered above. August has been selected as the regular month for annual plan update.
   a. Safety rounds are conducted on an annual or biannual (for patient care units or departments) schedule.
   b. Information from the annual "Safer Work Survey" is compiled by the Director of Safety/EOC or designee and reported to Environment of Care, Infection Control, and Products Standards Committees.
   c. Risk, Legal and Regulatory Services forwards information from incident and Quality Review Reports to the Director of Safety/EOC as appropriate.
   d. The information will be used to update the Exposure Control Plan with respect to:
      i. Areas where engineering controls are currently employed.
      ii. Areas where engineering controls can be updated.
      iii. Areas currently not employing engineering controls, but where engineering controls could be beneficial.
   e. Area Safety Representatives will support safe work practices by participating in education efforts and reporting concerns.
9. Employee Health ~~, assisted by Work Partners, Emergency Department,~~ and Infection Control will be responsible for ensuring that all medical actions required are performed and that appropriate employee health and OSHA records are maintained. See the Employee Health Services policy "Occupational Exposure to Blood/Body Fluid Secretions."
   a. Hepatitis B vaccination series is available at no cost and employees are encouraged to be vaccinated. See the Employee Health Policy "Hepatitis B Vaccine Immunization Protocol."
   b. Exposure incidents are evaluated to determine if the case meets OSHA's Record keeping Requirements (29 CFR 1904). The maintenance of the OSHA log is an Employee Health responsibility.
   c. Medical records are maintained for each employee with occupational exposure in accordance with 29 CFR 1910.20, "Access to Employee Exposure and Medical Records." These confidential records are kept in Employee Health for at least the duration of employment plus 30 years and are provided upon request of the employee or to anyone having written consent of the employee within 15 working days.
   d. Employee Health identifies products involved in contaminated sharps injuries and reports this information to Material Management so that the number of those devices ordered in the previous year can be reported to the EHSC.
   e. Recommendations are made to the Product Standardization Committee- when a need for a safety device or alternative product is detected.
   f. Recommendations are made to service or department managers when issues related to unsafe work practices are identified. Referrals are made to appropriate Medical Staff Chairpersons.
   g. Employee Health will present sharps Injury data specific to TCHD at the Infection Control Committee meeting annually (i.e. safety devices, work practice changes or engineering).

F. **EXPOSURE DETERMINATION:**

1. The State of California (Cal/OSHA) requires employers to perform an exposure determination concerning which employees may incur occupational exposure to blood or other potentially infectious materials (OPIM). The exposure determination is made without regard to the use of personal protective equipment (i.e., employees are considered to be exposed even if they wear personal protective equipment).
2. See ~~Appendix E~~**Potential Blood Exposure by Job Category** for a list of the job classifications in our facility where all or some employees handle human blood and OPIM, which may result in possible exposure to bloodborne pathogens.

3. Since not all of the employees in these categories would be expected to incur exposure to blood OPIM, examples of tasks/procedures that would cause these employees to have occupational exposure are listed in ~~Appendix E~~**Potential Blood Exposure by Job Category**.

G. **ENGINEERING CONTROLS:**

1. One of the key aspects to our Exposure Control Plan is the use of Engineering Controls to eliminate or minimize employee exposure to bloodborne pathogens. On December 17, 1998 the Cal/OSHA Standards Board adopted emergency regulation revisions to Title 8, Section 5193 to meet mandates of Assembly Bill 1208. On January 2001, Federal OSHA was instructed to add sharps safety to national requirements. The major purpose of the revisions is to increase protection from sharps injuries by supplying employees with engineered sharps safety devices.
   a. If available, needleless systems are required for withdrawal of body fluids after the initial venous or arterial access is established administration of medications or fluids, and other procedures with potential for exposure to a contaminated needle.
   b. If needleless systems are not used then needles with engineered sharps injury protection are required for withdrawal of body fluids, accessing a vein or artery, administration of medication or fluids, and other procedures with potential for exposure to blood or OPIM.
   c. Other sharp devices with potential for contamination with blood or body fluids (e.g. scalpels, lancets, broken capillary tubes, and drills) are also required to have engineered sharps protection.
   d. TCHD is exempt from implementation if at least one the following is applicable.
      i. The device is not available in the marketplace.
      ii. A licensed healthcare professional directly involved in a patient's care determines that the use of the engineering control will jeopardize patient care or safety.
      iii. An objective product evaluation has been completed indicating that the device is not more effective in reducing sharps injuries than the device currently used by TCHD;
      iv. There is a lack of sufficient information to determine whether a new device on the market will effectively reduce the chances of a sharps injury and an objective product evaluation is being conducted.
   e. See the table on ~~Appendix D~~**Product List** for a review of the Sharps Safety Devices that have been adopted.
   f. Contaminated needles and other contaminated sharps are not sheared or broken. They are not bent, recapped, or removed unless it can be demonstrated that there is no feasible alternative. Recapping or needle removal is accomplished using a mechanical device or a one-handed technique.
   g. Containers for contaminated sharps are easily accessible to personnel and located as close as is feasible to the area where sharps are used or can be reasonably anticipated to be found.
      i. Contaminated reusable sharps are placed in appropriate containers immediately, or as soon as possible, after use.
      ii. Sharps containers have the following characteristics: rigid, puncture-resistant, portable, if it is necessary to ensure easy access by user, color-coded and labeled with a biohazard warning label, and leak-proof on the sides and bottom. These containers lock when closed and do not reopen easily
      iii. The sharps containers for single use items are disposable and are not opened, emptied, or manually cleaned. In the event of a special circumstance when it would be necessary to access the container, it would be reprocessed or decontaminated.
      iv. The containers are maintained upright throughout use and are replaced as needed when ¾ full. A contract service is responsible for replacing containers as needed.
   h. In addition to the engineering controls identified on these lists, the following engineering controls are used throughout our facility.
      i. Hand washing facilities and waterless hand cleansers are readily accessible to employees with potential for exposure.

ii. Specimen containers are leak-proof. No special label/color coding is required for intra-facility specimens as Standard Precautions are utilized in the handling of all specimens and containers are recognizable as containing specimens.
iii. Secondary containers are used if the specimen could puncture primary container or outside contamination.

H. **WORK PRACTICE CONTROLS:**

1. In addition to engineering controls, our facility uses a number of Work Practice Controls to help eliminate or minimize employee exposure to bloodborne pathogens.
   a. Employees follow Standard Precautions with every patient. As a result, we treat all human blood and the following other potentially infectious materials (OPIM) as if they are known to be infectious for HBV, Hepatitis C Virus (HCV), HIV, and other bloodborne pathogens:
      i. Semen
      ii. Vaginal Secretions
      iii. Peritoneal fluid
      iv. Tissue and Organs
      v. Amniotic fluid
      vi. Synovial fluid
      vii. Pleural fluid
      viii. Saliva with visible blood
      ix. Pericardial fluid
      x. Cerebrospinal fluid
   b. Eating, drinking, smoking, applying cosmetics or lip balm and handling contact lenses is prohibited in work areas where there is potential for exposure to bloodborne pathogens.
      i. Food and drink are not kept in refrigerators, freezers, on countertops or in other storage areas where blood or other potentially infectious materials are present.
      ii. For example, eating and drinking is not allowed at nurses stations, in patient rooms, on patient bedside tables, or other places where patients, specimens, or dirty instruments/devices might have touched.
   c. Mouth pipetting/suctioning of blood or other infectious materials is prohibited.
   d. All procedures involving blood or other infectious materials are performed to minimize splashing, spraying or other actions generating droplets of these materials.
   e. Equipment, which becomes contaminated, is cleaned with a hospital-approved disinfectant as soon as possible.
      i. If shipping of equipment for repairs is required, the device will be cleaned or an appropriate biohazard-warning label is attached to any contaminated equipment, identifying the contaminated portions.
      ii. Information regarding the contamination is conveyed to all affected employees, the equipment manufacturer, and the equipment service representative.

I. **PERSONAL PROTECTIVE EQUIPMENT:**

1. The employee's 'last line of defense' against bloodborne pathogens. Because of this, our facility provides (at no cost to our employees) the Personal Protective Equipment that they need to protect themselves against such exposure. See ~~Appendix F~~**Standard Precautions-Personal Protective Equipment Table** for tasks/PPE suggested. This equipment includes, but is not limited to:
   a. Gloves
   b. Fluid resistant gowns
   c. Glove liners
   d. Laboratory coats
   e. Face shield
   f. Resuscitation bags
   g. Masks
   h. Hoods

i. Safety glasses/goggles
j. Shoe covers
k. Mouthpieces
l. Pocket masks

2. Personal Protective Equipment is stocked on supply carts, Pyxis dispensing stations, or available from Materials Management.
   a. Reusable PPE is cleaned, laundered, or decontaminated as needed. The hospital provides laundry services for laboratory coats designated as PPE.
   b. Single-use PPE (or equipment that cannot, for whatever reason, be decontaminated) is disposed in the regular waste container. Only items saturated and/or dripping with blood are disposed of in 'red-bag' trash.
3. Protective clothing (such as gowns and aprons) is worn whenever potential exposure to the body is anticipated. See ~~Appendix F~~**Standard Precautions-Personal Protective Equipment Table**.
   a. Any garments penetrated by blood or other infectious materials are removed immediately or as soon as feasible and all personal protective equipment is removed prior to leaving a work area.
   b. Surgical caps/hoods and/or shoe covers/boots are used in any instances where gross contamination is anticipated (such as autopsies, deliveries, and orthopedic surgery).
4. Gloves are worn as outlined in Standard Precautions and ~~Appendix F~~**Standard Precautions-Personal Protective Equipment Table**.
   a. Hypoallergenic gloves, glove liners, and similar alternatives are readily available to employees who are allergic to the gloves our facility normally uses.
   b. Utility gloves are decontaminated for reuse. If they are cracked, peeling, torn or exhibit other signs of deterioration they are discarded.
5. Masks and eye protection (such as goggles, face shields, etc.) are used whenever splashes or sprays may generate droplets of infectious materials. See Standard and Transmission Based Precautions and ~~Appendix F~~**Standard Precautions-Personal Protective Equipment Table**.

J. **ENVIRONMENTAL SERVICES:**

1. Environmental Services plays an important role in maintaining our facility in a clean and sanitary condition and is an important part of our Bloodborne Pathogens Compliance Program.
2. The Supervisor of Environmental Services is responsible for setting up our cleaning and decontamination schedule and making sure it is carried out within our facility.
3. To facilitate this, we have set up a written schedule for cleaning and decontamination of the various areas of the facility. See the Environmental Services Unit Specific Standards.
   a. All employees are responsible for maintaining a clean work area, equipment, and have hospital-approved disinfectants readily available to use on small spills. Environmental Services is called for assistance as needed with larger spills or special cleaning.
   b. All equipment and surfaces are cleaned and decontaminated after contact with blood or other potentially infectious materials. Patient care equipment and devices are cleaned between patients and after the completion of medical procedures. Work surfaces that may have been contaminated are cleaned at the end of the work shift.
   c. All pails, bins, cans and other receptacles intended for use are routinely inspected, cleaned and decontaminated as soon as possible if visibly contaminated.
   d. Potentially contaminated broken glassware is picked up using mechanical means (such as dustpan and brush, tongs, forceps, etc.). Only broken glass is placed in a Sharps Container.
4. All regulated waste is safely handled by staff according to TCHD policies and procedures. Disposal of all regulated waste is in accordance with California, State, and local regulations. See the Environment of Care Manual (formerly Safety Manual) - Waste Management Plan section and Infection Control Policy Waste Management.
   a. See the Decision Table for Medical Waste in ~~Appendix G~~**Decision Table for Medical Waste**
5. Environmental Services is responsible for the collection and handling of our facility's contaminated waste until our outside contractors pick it up for off-site processing. Environmental

services aides hold the bags away from their bodies when removing use heavy gloves to protect their hands from possible sharps injury and do not push down on trash in garbage containers.

6. Regulated waste is placed in containers that are closable, constructed to contain all contents, and prevent leakage. They are labeled or color-coded (see Labels to follow) and closed prior to removal to prevent spillage or protrusion of contents during handling.
7. All used linen is presumed contaminated and placed in appropriate containers labeled 'soiled linen'. All linen is handled as little as possible and is not sorted or rinsed where it is used. Plastic bags are used to contain potential contaminants and these soiled linen bags are transported in secondary containers to prevent leakage.
   a. Employees who contact contaminated linen wear appropriate protective equipment (gloves and gowns if soiling of clothes is possible).
   b. Plastic soiled linen bags can be taken into a patient's room to contain used linen. These bags are then placed in the hamper or directly in the soiled linen room.
   c. Linen hampers lined with the plastic bags can also be used. When hampers are ¾ full, nursing staff will remove the bag, tie it off, and take it to the soiled linen room.
   d. Environmental Services is responsible for the collection and handling of our facility's contaminated waste until pick-up by our outside contractors for off-site processing.

K. FORMS:

1. **Safer Work Survey**
2. **Clinical Value Analysis Team Product Evaluation**
3. **User Product Evaluation**
4. **Product List**
5. **Potential Blood Exposure by Job Category**
6. **Standard Precautions – Personal Protective Equipment**
7. **Decision Table for Medical Waste**

~~K.~~L. RELATED DOCUMENTS:

1. Employee Health and Wellness Policy: Injury **and Illness** Prevention Program
2. Employee Health and Wellness Policy: Occupational Exposure to Blood/Body Fluid Secretions
3. Environment of Care Manual: Hazardous Material and Waste Management and Communication Plan
4. Environment of Care Manual: Hazardous Waste Management
5. Infection Control Manual: Hand ~~Antisepsis~~ **Hygiene**
6. Infection Control Manual: Standard and Transmission Based Precautions

~~L.~~M. REFERENCES:

1. Cal OSHA BBP Standard §5193. Bloodborne Pathogens, Subchapter 7. General Industry Safety Orders Group 16. Control of Hazardous Substances Article 109. Hazardous Substances and Processes 1998.
2. Medical Waste Management Act, California Health and Safety Code, Sections 117600 – 118360 California Medical Waste Management Program Information Copy — January 2000 www.cadhs.gov
3. Grota, P. (Ed.). (2014) APIC Text of Infection Control and Epidemiology (4th ed). Washington DC: Association for Professionals in Infection control and Epidemiology, Inc.
4. Wenzel, RP & Nettleman, MD, Principles of Hospital Epidemiology in: Mayhall G. ed. Hospital Epidemiology and Infection Control. 2nd ed. Philadelphia: Lippincott, Williams & Wilkins; 1999:1357 - 1366.
5. Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings http://www.cdc.gov/ncidod/dhqp/pdf/isolation2007.pdf

TRI-CITY HEALTHCARE DISTRICT
SAFER WORK SURVEY

The Centers for Disease Control and Prevention (CDC) estimates that between 100,000 and 1,000,000 sharps injuries occur each year. Various studies have estimated the risk of developing occupationally acquired bloodborne pathogen infections: HCV (3% - 10%), HBV (2% - 40%), and HIV (0.3%) following sharps exposure. The risk of transmission increases if a device visibly contaminated with blood causes the percutaneous injury, is used to puncture the vascular system, or causes deep injury.

1. Safety Devices

Do you have suggestions for sharp devices with built in protection that would make your job safer?
Comments: _____

_____

_____

_____

_____

_____

_____

2. Safe Work Practices

Do you have suggestions for adoption of safer user actions? (Examples: neutral or safe zone for sharps, second layer of gloves, and avoid handling dirty trays)
Comments: _____

_____

_____

_____

_____

_____

_____

3. Personal Protective Equipment

Do you have suggestions for use of personal protective equipment? (Examples: double gloving, heavy leather gloves for trash handling, effective eye and face protection)
Comments: _____

_____

_____

_____

_____

_____

_____

~~Appendix B~~

~~TCHD: Products Standardization Committee~~
Clinical Value Analysis Team Product Evaluation

1. Manufacturer of Product_____
2. Name of Product_____
3. Distributed by_____Sales Rep_____
4. Description of Use_____
5. Will this device replace a high-risk device (hollow-core, blood-filled, or capable of deep injury)? ☐ Yes ☐ No
6. Product would be used? ☐ House-wide ☐ Lab ☐ OR ☐ Specialty Unit _____
7. What items would this replace?_____
8. Cost _____Standard item cost_____
9. Has TCHD rejected the device in the past? ☐ Yes ☐ No _____
10. Does the device have a passive safety mechanism? ☐ Yes ☐ No
11. Can the safety mechanism be activated with one hand? ☐ Yes ☐ No
12. Can the user tell when the safety mechanism has been activated? ☐ Yes ☐ No
13. Are minimal changes in technique and use required? ☐ Yes ☐ No

_____

14. Is this product dependent on other products or items? ☐ Yes ☐ No
    Identify:_____
15. Is the device compatible with products currently in use? ☐ Yes ☐ No
16. Does the system/device require a minimal number of parts? ☐ Yes ☐ No
17. Is the product available in typical size ranges? ☐ Yes ☐ No
18. Is the product on contract ☐ Yes ☐ No
19. Product rep available for 24hrs/day in-service? ☐ Yes ☐ No
20. Does the manufacturer supply free trial products? ☐ Yes ☐ No
21. Does the manufacturer have adequate supply capability? ☐ Yes ☐ No

APPROPRIATE FOR TRIALS ☐ **REJECTED** ☐

COMMENTS_____

_____

_____

_____

~~TCHD:~~ User Product Evaluation

Name_____ Date_____

Dept/Unit_____

How would you rate this product compared to other similar products you have used?

CRITERIA	BETTER	SAME	WORSE
Easy to open package			
Ease of assembly			
Ease of use			
Comfortable feel for user			
Length of time required for use			
Activation of safety feature			
Safety feature can't be defeated			
Has minimum failure rate and functions as intended			
Good for use with different patients			
Safe for healthcare workers			
Safe for patients			
Patients complaints			
Doctors complaints			
Easy to dispose			
Compatible with other products			
Will reduce the risk of injury			
Reasonable number of parts			
Available in the sizes you need			

How many times did you use the product?_____

Would you recommend purchasing this device? ☐ Yes ☐ No

Is there another safety device you would rather use? ☐ Yes ☐ No

Specify:_____

Comments? _____

_____

_____

_____

_____

_____

PRODUCT LIST					
PRODUCT TYPE	**SPECIFIC DEVICE**	**M/M EVAL.**	**RECOMMENDATION**	**USER EVAL. DATES**	**IMPLEMENTATION & COMMENTS**
1. **Needleless IV**	All I.V. Tubing Alaris Needleless I.V. System	N/A	Alaris I.V. needleless system and tubing recommendation by Nursing Operations Managers Council.	2/2005	3/2005, Alaris Medley pumps w/ Guardrails introduced as standard. Contractual changes for pump and product changes. Minimum 5-year agreement.
2. **ABG Kits**	1-ml ABG Kit 3-ml ABG Kit	N/A	Pulmonary Department selection of Sims Portex products	5/2001	reviewed 10/2005
3. **Blood Lancet**	Heel stick, Tenderfoot Fingerstick, Glucolet	N/A	Products utilized hospital-wide.	< 1996 1/2001	< 1996 1/2001 1/2002 reviewed 10/2005
4. **IV Starts** • Angiocaths • Butterfly	Insyte Autoguards, various Gauges Saf-T E-Z Set, various gauges	N/A N/A	Nursing Council selection to replace Johnson & Johnson I.V. Catheters with Becton Dickinson products Nursing Council selection to replace Becton Dickinson non-safety products w/ Becton Dickinson safety products	10/2000 10/2000	10/2000 reviewed 10/2005 10/2000. Catalog changes, 08/2001 reviewed 10/2005

PRODUCT TYPE	SPECIFIC DEVICE	M/M EVAL.	RECOMMENDATION	USER EVAL. DATES	IMPLEMENTATION & COMMENTS
Pre-filled syringe	*Code Drugs* *Vit K* *Hepatitis B vaccine*	*Dec 2002*	Recommends/stocks Sims needles as alternative and Product Standards approved Safety standard approved	07/01	07/01 *8/31/2002* reviewed 10/2005
6. Blood Collection • Tubes • Vaccutainer • Butterfly needle • Needle/Syringe • Cord blood	Vaccutainer Tubes w/ Top	N/A	Laboratory selection of Becton Dickinson products to replace rubber stopper tops	< 1992	< 1992
	Vaccutainer Eclipse Blood Ion Needle	N/A	Laboratory selection of Becton Dickinson products to replace Bio-plexes puncture Guard	< 2000	2000
	Vaccutainer Safety-lok Blood Collection Set		Laboratory selection of Becton Dickinson products to Replace non-safety butterfly	< 1999	2000
	Safety-glide, various gauges		Nursing and Laboratory selection of Becton Dickinson products to replace Non-safety products. Safety standard approved	< 09/01 05/01 07/01 *8/02*	09/2001 05/01 07/01 reviewed 10/2005

• blood culture • line sampling • transfer device	Bactec Media Bottles See Needleless System Diff-safe blood dispenser blood *BD- Blood transfer devices*	N/A N/A N/A	Laboratory selection of Becton Dickinson product BD Luer-Lok Access device/ BD SafetyLok Blood Collection Set; BD Luer-Lok Tip Syringes	< 1996 09/2001 < 1996	On going < 1996: Used in Phlebotomy to eliminate use of needles to make slides. Changed in 2001 Reviewed 11/9/05 LLT Changed to BD luer loc access devices for direct draw 4/1/08
7. IV injections Regular syringes Pre-filled syringes Contrast in Dx. Imag	Refer to Needleless System Safety-lok, various gauges	N/A	Nursing Council selection of Becton Dickinson products	< 9/01	09/2001
8. Scalpel	Personna Safety Scalpel Personna Safety Blades	N/A N/A	Safety blades in Microbiology & Cytology ER, SPD, ACCU recommended change to Persona safety scalpels	01/2001 09/2001	03/2002 Reviewed 11/2005 LLT 03/2002 Reviewed 8/08
9. Suture needle	Safe work practices adopted. Stapling devices used when possible.				
10. Non coring needle for implanted vascular access	Bard Smith	N/A	Provide safety device only for non-coring needles	3/08	4/08

~~Appendix E~~

JOB CLASSIFICATIONS WHERE 'ALL' OR 'SOME' EMPLOYEES
HANDLE HUMAN BLOOD AND OTHER POTENTIALLY INFECTIOUS MATERIALS.

'ALL' EMPLOYEES	'SOME' EMPLOYEES (TASKS PERFORMED WITH RISK)
Administrative Coordinator Advanced Care Technician	Case Managers/ Clinical Social Worker (during patient interviews or family conferences)
Biomedical Tech Mechanic I & II	Chaplain (during patient or family ministrations)
Cardiac Rehabilitation Coordinator	Food Service Worker (during tray delivery, pick-up, or cleaning)
Certified Nursing Assistant	Clinical Dietician
EEG Tech and EEG coordinator	Security Officer
EKG Tech	
Environmental Service Aide and Supervisor	
Emergency Medical Technician	
Employee Health Nurse Occupational Health Nurses & Manager	
Infection Control Specialist	
Laboratory Assistant/Phlebotomist Operations Manager Clinical Laboratory Scientist Histology Lab Tech	
Licensed Vocational Nurse	
Lift Team	
Nurse Practitioner Physicians Assistant	
Occupational Therapist and Rehab Aid	
OR Tech/Sterile Processing Tech/Perioperative Aide/Surgical Instrument Aide	
Perfusionist	
Phlebotomist	
Physical Therapist	
Physicians	
Pulmonary Services Operations Manager	
Radiology Operations Manager & Tech	
Registered Nurse	
Rehabilitation Services Manager	
Respiratory Care Practitioner I, II & III	
Security Officer	
Wound Care Nurses	

~~Appendix F~~Standard Precautions-Personal Protective Equipment Table

Standard Precautions
Personal Protective Equipment Table

R = Required A = Available N/A = Not Applicable	Exposed Body Parts						Contamination of Clothing								
	Hands			Face			Soiling			Saturation			Dripping		
	Gloves			Face Shield or Mask & Goggles			Cloth Gown			Water-proof Gown			Shoe Covers		
	R	A	N/A	R	A	N/A	R	A	N/A	R	A	N/A	R	A	N/A
REMOVING, OPENING AND MANIPULATING OR ASSISTING WITH THE REMOVAL OF HOLLOW CORE BLOOD OR BODY FLUID FILLED TUBES, NEEDLES OR CATHETERS															
• Abdominal paracentesis catheter • Angiograph catheter • Bronchoscope (as above & to clean) • Central venous catheter • Chest tube/vent • Endoscope (as above & to clean) • Intravascular catheters • Thoracentesis • Urine catheter	*			*				*			*			*	
ASSISTING WITH PROCEDURES															
Angiography	*			*					*	*				*	
Bone marrow asp/bx	*				*			*			*				*
Bronchoscopy	*			N95				*			*				*
Bronchoscopy (R/O TB)	*			PAPR				*			*				*
Central venous catheter insertion	*				*			*			*				*
Chest tube/vent placement	*				*			*			*				*
Childbirth	*			*					*	*				*	
Endoscopy	*			*			*				*				*
Intubation	*			*				*			*				*
L.P. (holding R/O meningitis)	*			*				*			*				*
Morgue Release	*					*			*						*
Proctosigmodoscopy	*				*			*			*				*
Suture or stapling (within 3 ft. of wound)	*			*				*			*			*	
Assisting with Surgery														*	
Thoracentesis ass.	*				*			*			*				*
SPECIMEN COLLECTION															
ABG	*				*			*			*				*
Blood glucose test	*				*			*			*				*
Clean catch urine specimen	*				*			*			*				*
Dipstick urine test	*				*			*			*				*
Gastric occult. blood test	*			*				*			*				*
Nose/throat (R/O infection)	*			*				*			*				*
Sputum for AFB or TB culture	*			N95				*			*				*
Stool	*				*			*			*				*
Stool occult blood test	*				*			*			*				*
Urine	*				*			*			*				*
Urine specific gravity	*				*			*			*				*
Vaginal or urethral	*				*			*			*				*
Venipuncture for blood	*				*			*			*				*
Wound or wound drainage	*				*			*			*				*

~~Appendix F~~Standard Precautions-Personal Protective Equipment Table

R = Required A = Available N/A = Not Applicable	Exposed Body Parts						Contamination of Clothing								
	Hands			Face			Soiling			Saturation			Dripping		
	Gloves			Face Shield, Mask & Goggles			Cloth Gown			Water-proof Gown			Shoe Covers		
	R	A	N/A	R	A	N/A	R	A	N/A	R	A	N/A	R	A	N/A
SPECIMEN PROCESSING	*			per S.O			Lab coat								
CLINICAL TASKS															
Ambu bag: usage	*			*				*			*				*
Bladder irrigation	*			*				*			*				*
Blood or blood products administration	*				*			*			*				*
Blood warmer	*				*			*			*				*
Cleaning used instruments	*			*				*			*				*
Urine catheter: insert	*				*			*			*				*
Colostomy irrigation	*			*				*			*				*
Condom catheter application	*				*			*			*				*
Contact lense care	*				*				*			*			*
Dressing change	*				*			*			*				*
Emerson pump: use	*				*			*			*				*
Endoscope / Bronchoscopy cleaning	*			*			*				*				*
Enema administration	*			*				*			*				*
Enteral feeding tube (insert or manipulate)	*			*				*			*				*
Fecal disimpaction	*			*				*			*				*
Fecal or gastric occult blood test	*				*			*			*				*
Foley cath insertion	*				*			*			*				*
Gastric lavage	*			*					*	*					*
Hemovac drains-manipulate, empty / DC	*			*				*			*				*
Injections	*				*				*			*			*
Intravenous catheter insertion	*				*			*				*			*
J-P drain care	*				*			*			*				*
Nasogastric tube insertion and DC	*			*				*			*				*
Neonatal suck evaluations (latex-free)	*				*			*				*			*
1st. Newborn bath	*			*				*			*				*
Normal Saline or Heparin lock irrigation	*				*			*				*			*
O2 therapy w/ mucus membrane touch	*				*				*			*			*
Open suctioning of airway or airway tube	*			*				*			*				*
Oral care	*			*				*				*			*
Oral/nasal airway insertion or DC	*			*				*			*				*
Pleur-evac care	*				*			*			*				*
Postural drainage	*				*			*			*				*
Rectal tube insertion	*				*			*			*				*
Resp. Tx, cough inducing	*			*				*				*			*
Restraint placement		*			*			*				*			*
Seizing patient		*			*			*				*			*
Sputum Induction for AFB	*			N95				*				*			*
Sputum Induction for AFB R/O tuberculosis	*			PAPR				*				*			*
Total parenteral nutrition administration	*				*			*				*			*
Urine bag emptying	*			*				*				*			*
Vital signs and Weighing patients		*			*			*				*			*
Wound care (without irrigation)	*				*			*			*				*
Wound irrigation Pulsevac Tx	*			*				*			*				*

Decision Table for Medical Waste

Type of Waste	Red Bag	Regular Bag	Sharps Container
Fluid blood, blood elements, vials of blood, specimens for culture, used culture media, and stock cultures.	X		
Bloody body fluids or disposable drapes dripping and/or saturated with bloody body fluids such as CSF, synovial, pleural, pericardial, amniotic.	X		
Bloody body fluid filled containers from nursing units, ED, PACU, outpatient areas not treated with Premicide.	X		
Materials used to clean up fluid blood or bloody body fluid spills that are dripping and/or saturated.	X		
Surgical specimens.	X		
Wound dressings, bandages, and wrappings dripping and/or saturated with blood.	X		
Food waste such as soda cans, paper cups, cutlery, including food or service items from isolation rooms.		X	
Empty urine and stool containers, empty colostomy and urinary drainage bags, empty bedpans, breathing circuits, surgical drapes.		X	
Gastric washings, dialysate, vomitus, feces, urine, diapers. Please empty in toilet.		X	
Tracheal and bronchial secretions, sputum, IV tubing without the needles.		X	
Soiled but not dripping and/or saturated items such as dressings, bandages, cotton balls, peripads, chux, cotton swabs.		X	
Suction Canisters, treated with solidifying agent.	X		
Used gloves, aprons, masks, goggles, and respirators.		X	
Broken glass, guide wires.			X
Uncapped Needle/syringe units, needles, scalpels, vials from live, or attenuated vaccines.			X

ISSUE DATE: 9/1998
~~NEXT REVIEW DATE: 10/2016~~
REVISED: 04/01, 06/03, ~~and~~ 4/07, 10/07, 10/13

SUBJECT: **Construction**
~~STANDARD NUMBER: IC. 13.2~~

Department Approval Date(s):	**07/16**
Infection Control Committee Approval Date(s):	**07/16**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**07/16**
Professional Affairs Committee Approval Date(s):	
Board of Directors Approval Date(s):	

~~CROSS REFERENCE:~~
~~Surveillance Program IC. 2~~
~~Epidemiologic Investigation of a Suspected Outbreak IC. 3~~
~~Facility Acquired (Nosocomial) Infections, Defined IC. 4~~
~~Reducing Facility Acquired Infections IC.13~~
~~Participation of Staff in the Infection Control Program IC. 7~~
~~APPROVAL: Infection Control Committee 10/2013~~

A. **INTRODUCTION**

1. Multiple published studies have linked healthcare associated infection with the dispersal of microorganisms during construction. Before construction begins, the focus of preparations should be on isolation of the construction and/or renovation area. Planning is required prior to projects that are expected to generate a moderate to high levels of dust or require demolition or removal of any fixed building components and systems as well as new construction projects to assure patient and staff safety. A multidisciplinary team approach will be used.

B. **PURPOSE**

1. The matrix grid format adopted by our facility identifies the number and types of controls and Infection Control interventions necessary to protect patients and decrease dust generation.

C. **PROCEDURE**

1. Infection Preventionist and Environment of Care Officer will:
   a. Participate in planning to address needs such as handwashing facilities, storage and equipment cleaning areas, appropriate surface finishes and specific products with infection control and worker safety implications (i.e. sharps disposal unit placement and accommodation for personal protection equipment).
   b. Review indication for environmental cultures or volumetric air sampling.
1. Engineering will:
   a. Include Infection Preventionist and Environment of Care Officer early in the planning of construction and renovations in the hospital.
   b. Assist in the coordination of efforts by completing the ~~Pre-Project Site~~ Assessment **of the Impact of Construction Projects** ~~(Appendix A)~~ prior to or during early planning meetings with the Area Director. **The Assessment of the Impact of Construction Projects will be filled out for projects that require a building permit or will take longer than one (1) week.** ~~The Managers Assessment, Pre-Construction (Appendix B) form will be given to the area Director to complete.~~
   c. Obtain Infection Control Construction Permit prior to beginning work ~~(Appendix C)~~.
   d. Review infection control measures prior to construction with the staff and contract workers. Explain expectations to contractors. Ensure that infection control policies

are followed during the construction.

e. Direct traffic away from the construction site.

f. Notify the Infection Preventionist and the Safety Officer if mold is encountered during a construction/renovation project and implement precautions in **Infection Control** Policy**: Mold Abatement** IC 13.3.

g. To isolate renovation areas from occupied areas, use airtight barriers. If visquine must be substituted, ensure it is fire retardant and sealed tightly.

h. Construction or renovation projects that fall into the Class III or IV category will have containment performed by qualified personnel. **(see Infection Control Construction Permit** Reference table on page 2~~of Appendix C~~**)**.

i. Adequate window seals should be obtained maintained to prevent outside air from entering the room.

j. Check cleanliness of intake filters in the ventilation system.

k. Reusable barrier cubes are cleaned after each use. Take outside and hose off both the inside and outside of the container. Spray and wipe with hospital-approved disinfectant and allow the plastic to air dry.

2. Environmental Services (Common Areas) and Nursing (Patient Care Areas)

c. Damp dusting should be done on a regular basis to prevent the accumulation of dust on horizontal surfaces. Use disposable damp cloth and discard immediately rather than return to the cleaning solution to prevent disseminating spores.

d. Ceiling tiles and air-duct grates should be cleaned regularly when rooms are not occupied.

e. Newly constructed areas should be cleaned thoroughly before admitting or readmitting patients.

2. Nursing

a. Minimize exposure of high-risk patients to construction activities. If possible, diagnostic procedures may be done in the patient's room.

b. Transport patients via an alternate route or schedule transport and procedures during periods with minimal construction activity. Patients can be masked or provided with other barriers (e.g. covering open wounds).

c. Report infection control risks such as unsealed barriers, visible dust, opened doors, etc. to Infection Control or the Environment of Care Officer.

d. Coordinate construction and/or renovations with patient relocations.

D. RELATED DOCUMENTS

1. **Infection Control Policy:** Epidemiologic Investigation of a Suspected Outbreak IC. 3
2. **Infection Control Policy: Healthcare Associated**~~Facility Acquired (Nosocomial)~~ Infections, Defined IC. 4
3. **Infection Control Policy: Mold Abatement IC 13.3**
4. **Infection Control Policy:** Surveillance Program IC. 2
5. ~~**Infection Control Policy:** Reducing Facility Acquired Infections IC.13~~
   ~~Participation of Staff in the Infection Control Program IC. 7~~

E. FORMS

1. **Assessment of the Impact of Construction Projects**
2. **Infection Control Construction Permit**
3. **Infection Control & Construction Fact Sheet for Employees and Patients**

F. REFERENCES

1. Bartley, J.M., APIC State of the Art Report: The role of infection control during construction in healthcare facilities. Am J Infect Control 2000; 8 156-69.
2. Centers for Disease Control and Prevention, Healthcare Infection Control Practices Advisory Committee (HICPAP) Guideline for Environmental Infection Control in Healthcare Facilities, 2008. On-line at APIC.com
3. APIC Infection Control Tool Kit Series: Construction and Renovation, 1999

Tri City Medical Center

Assessment of the Impact of Construction Projects

Project:	Location(s):	Start Date:	End Date:

Project Coordinator:	Contractor:

Category	Factors	Risk Evaluation
(A) Noise	Impact, duration, scheduled time of work	
(B) Air / Dust	Cutting, Grinding, Sanding, etc.	
(C) Infection Control	Category of Risk: [_] 1 – 2 – 3 – 4	
(D) Vibration	Tool use, demolition, distance	
(E) Life Safety impact	Hot work, disabling alarms, penetrations, exit modifications, smoking	
(F) Security	Site security, access control	
(G) Disruption of utilities	Planned shutdowns, Construction near utility system supplies	
(H) Emergency Services	Obstruct access to fire lanes or fire dept.?	

Brief description of work to be performed:

List areas of forecasted concerns for any/all of the Categories listed above	List appropriate measure(s) recommended for limiting disruption / code violation / potential adverse outcome.
(A)	
(B)	
(C)	
(D)	
(E)	
(F)	
(G)	
(H)	

Pre-Project Site Assessment

Department And/Or Building Location	Date Done		
Inspector(s)	Project Name		
QUESTION	Yes	No	N/A
A. Will construction affect exit route from occupied areas adjacent to the construction site?			
1. Traffic control and alternative routes for delivery reviewed.			
B. Are any of the following environmental hazards present?			
1. Asbestos			
2. Hazardous chemicals (MSDS attached)			
3. Confined spaces			
C. Managers Assessment completed on (date)			
D. Will any of the following systems be adversely affected?			
1. Fire Alarm			
2. Sprinkler			
3. Electrical			
4. Domestic water			
5. Oxygen			
6. Sewage			
7. HVAC			
E. Infection Control Evaluation			
1. Location and type of dust barriers reviewed with Project Manager			
2. HEPA filter placement reviewed			
3. Plan for debris removal and control evaluated			
4. Construction rated as: Class I, II, III, IV			
Comments			

Managers Assessment Pre-Construction

Please review and complete the following:

Department And/Or Building Location	Today's Date		
Question	Yes	No	N/A
1. Are there patients or staff members in the area of the project? If no, skip to question 5.			
2. Do the patients or staff members have any immunocompromising conditions, pulmonary conditions or both?			
3. Are there patients or staff members with sensitivity to dust and molds or have allergies, asthma or both?			
4. Are patients or staff members in your area sensitive to noise or vibration?			
5. Are there procedures, work processes or testing that is conducted in the area that are sensitive to noise or vibration?			
6. Are there supplies in areas where dust may be produced?			
7. Are there times when the workers cannot be in your area? Specify			
8. When can an in-service about the health hazards of construction and interim life safety measures be conducted with your staff? (Dates/Times)			
9. Will you have a designee available as a contact person if you are not available? Who?			

Project Title	Project Start Date
TCMC Project Coordinator	Estimated Completion Date
General Contractor Pager #	OSHPD Permit #
Contractor Superintendent	Superintendent Telephone #

CONSTRUCTION ACTIVITY MATRIX: Infection Control Permit required for Class III and Class IV rated projects

RISK LEVEL	TYPE A	TYPE B	TYPE C	TYPE D
Group 1	I	II	II	III / IV
Group 2	I	II	III	IV
Group 3	I	III	III / IV	IV
Group 4	II	III / IV	III / IV	IV

CLASS I	1. Execute work by minimizing raising dust from construction operations. 2. Immediately replace any ceiling tile displaced for visual inspection. 3. Rapid cleanup and disposal of waste to minimize dispersal of dust.
CLASS II	1. Provides active means to prevent airborne dust from dispensing into atmosphere. 2. Water mist work surfaces to control dust while cutting. 3. Seal unused doors with duct tapes. 4. Block off and seal air vents. 5. Wipe work surfaces with disinfectant. 6. Contain construction waste before transport in tightly covered containers 7. Wet mop and/or vacuum with HEPA filtered vacuum before leaving work area. 8. Place dust mat at entrance and exit of work areas. 9. Remove isolation and Isolate the HVAC system in areas where work is being performed.
CLASS III DATE INITIALS	1. Obtain Infection Control Permit before construction begins. 2. Isolate HVAC system in area where work is being done to prevent contamination of duct system 3. Complete all critical barriers or implement barrier cube before construction begins. 4. Maintain negative air pressure within work site utilizing HEPA equipped air filtration units. 5. Do not remove barriers from work area until complete project period is thoroughly cleaned by Environmental Services 6. Vacuum work with HEPA filtered vacuum. 7. Wet mop area with disinfectant. 8. Remove barrier materials carefully to minimize spreading of dirt and debris. associated with construction. 9. Contain construction waste before transport in tightly covered containers. 10. Cover transport receptacle or carts. Tape covering. 11. Remove or isolate HVAC system in areas where work is being performed.
CLASS IV DATE INITIALS	1. Obtain Infection Control Permit before construction begins. 2. Isolate HVAC system in area where work is being done to prevent contamination of duct system. 3. Complete all critical barriers or implement barrier cube before construction begins. 4. Maintain negative air pressure within work site utilizing HEPA equipped air filtration units. 5. Seal holes, pipes, conduits, and punctures appropriately. 6. Construct anteroom and require all personnel to pass through this room using a HEPA vacuum cleaner before leaving the work site or they can wear cloth or paper coveralls that are removed each time they leave the work site 7. All personnel entering a work site are required to wear shoe covers. Shoe covers must be changed each time the worker exits the work site. 8. Do not remove barriers from work area until completed project is thoroughly cleaned by the Environ. Services Depart. 9. Vacuum work area with HEPA filtered vacuums. 10. Wet mop with disinfectant. 11. Remove barrier materials carefully to minimize spreading of dirt and debris. 12. Contain construction waste before transport in tightly covered containers. 13. Cover transport receptacles or carts. Tape covering. 14. Remove isolation of HVAC system in areas where work is being done.

Date Initials	12 hour uninterrupted exchange required	Date Initials	Exceptions/Additions to this permit are noted by attached memoranda
Permit Requested By:		Permit Authorized By:	
Date:		Date:	

CONSTRUCTION ACTIVITY TYPES

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

INFECTION CONTROL RISK GROUPS

Group 1 Lowest	Group 2 Medium	Group 3 Medium High	Group 4 Highest
X Office areas X Storage Rooms without patient care equipment or supplies X Waiting Rooms X Assembly Rooms	X Cardiac Rehab. X Pulmonary Rehab X Linen room X Materials Storage X Admission areas	X Emergency Room X Imaging/MRI X PACU/SPRA X Postpartum X Newborn Nurseries X Nuclear Medicine X Discharge units X Physical Therapy - tank areas X Food Preparation Center X Cafeteria X All Nursing Units except those listed in Group 4	X All Operating Rooms X Sterile Processing Areas X Adult Critical Care Units X Cardiovascular Recovery X Labor and Delivery X NICU X Cardiac Cath. Lab X Interventional Imaging X Dialysis X Oncology X Laboratory X All endoscopy areas X Pharmacy Admixture

Tri-City Medical Center

Infection Control & Construction
Fact Sheet for Employees and Patients

What is the concern?
Aspergillus is a mold that is present almost everywhere, but is most often found around decaying cellulose debris, water and dust. The spore most often attaches itself to dust particles to become more buoyant and allows for airborne spread. It is a very adaptable germ; it can tolerate almost any temperature and needs only 2-3 days to grow in a water source. Patients can breathe in these spores and become colonized or infected. Invasive disease (Aspergillosis) in high-risk patients can lead to death. In general, the higher the concentration of spores in the air, the higher a patient's risk of acquiring infection.

Who is at risk?
In general, only high-risk immunocompromised patients acquire invasive disease leading to death. The patients highest at risk for construction-related Aspergillosis are the following:

- Bone marrow transplant (BMT) patients
- Patient with hematologic malignancy
- Patient receiving a solid organ transplant
- AIDS patient with a CD4 count < 50 AND one of the following:
  Prolonged neutropenia
  Chronic steroid use

How do you prevent acquisition?
Dust prevention methods are the most efficient means of preventing colonization and infection in patients. Controlling the dust related to construction activities is imperative. Infection Control is involved in all construction activities that potentially affect high-risk patients, including inside and outside projects. Dust control measures are recommended by Infection Control for each project and monitored for compliance.

What are some common dust control measures?

- Wet mopping a construction area with disinfectant at the end of each workday.
- Use of walk-off mats to collect dust and prevent the spread throughout the hospital.
- Use of floor to ceiling partitions.
- Covering debris removal containers and only transporting them during low activity.
- Spraying of water or chemical onto construction site to decrease amount of dust in air.
- Sealing windows that surround construction sites to prevent leakage of dust.
- More frequent checking and changing of air handling filters.
- Avoiding use of carpets in clinical areas, especially areas of frequent spillage.

What are other ways to prevent the spread of Aspergillus?

- Recognition of mold growth areas and proper decontamination of these areas.
- Prevention of freestanding water sources, which promote mold growth.
- High-risk patients are instructed to wear masks when being transported on campus.

ISSUE DATE: January 1992 SUBJECT: **Scabies and /Lice**

~~NEXT REVIEW DATE: 10/2016~~ ~~STANDARD NUMBER: IC. 6.4~~

REVISION DATE(S): 9/2004, 10/13

Department Approval Date(s):	**07/16**
Infection Control Committee Approval Date(s):	**07/16**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**07/16**
Professional Affairs Committee Approval Date(s):	
Board of Directors Approval Date(s):	

~~CROSS REFERENCE: Philosophy IC .1~~
~~Tuberculosis Exposure Control Plan IC. 10~~
~~Bloodborne Exposure Control Plan IC. 11~~
~~Standard and Transmission Based Precautions IC.5~~
~~Employee Health Services Policies~~
~~Administrative Policy #401 Injury Prevention Program~~

~~REVISED: 9/2004, APPROVAL: Infection Control Committee 10/2013~~

A. **PURPOSE**:

1. **Provide assistance in the management and identification of scabies and lice. To prevent transmission in the event of occupational exposure to scabies and or lice.** ~~Purpose: Provide treatment and prevent transmission in the advent of occupational exposure to Scabies and or Lice.~~

B. **INTRODUCTION**:

1. **Scabies is a parasitic ~~infestion~~infestation of the skin caused by the human itch mite, *Sarcoptes scabiei.* The microscopic scabies mite burrows into the upper layer of skin where it lives and lays eggs. The typical presenting symptom in most patients with scabies is intense itching (pruritus), which is usually more severe at night, and a pimple like (papular) rash. In the immune-compromised, elderly, disabled, homeless or debilitated patients a generalized dermatitis more widely distributed is seen with extensive scaling, vesiculation and crusting. "Norwegian" or crusted scabies presents as a crusty, scaly dermatitis usually of the hands and feet. Persons with crusted scabies have thick crusts of skin that contain large number of scabies mites and eggs. Itching is remarkably minimal.**
2. **Lice are parasitic insects that can be found on people's heads and bodies including the pubic area which can result in severe itching. Lice are host specific and those of animals do not infest humans. Human lice survive by feeding on human blood. Lice move by crawling; they cannot hop or fly. Three types of lice are:**
3. **Head lice are 2.1-3.3mm in length. Head lice infest the head and neck and attach their eggs to the base of the hair shaft.**
4. **Body lice are 2.3-3.6mm in length. They are rarely found on the body except when feeding, they are usually found on clothing. They are known to spread disease.**
5. **Pubic (crab) lice are 1.1-1.8mm in length. Pubic lice are typically found attached to hair in the pubic area but sometimes are found on coarse hair elsewhere on the body (ie: eyebrows, eyelashes, beard, mustache, chest and armpits, etc)**

C. **TRANSMISSION:**

1. **Scabies:**
   a. **The scabies mite usually is spread by direct prolonged skin to skin contact with a person who has scabies. Scabies can be indirectly spread by sharing articles of clothing, towels or bedding with and infested person. On a person, scabies mites can live for as long as 1-2 months. Scabies mites generally do not survive more than 2-3 days away from human skin.**
   b. **Persons with "Norwegian" or crusted scabies are highly contagious to other persons due to the large number of mites present in the exfoliating scales. Infestation can spread easily by brief direct skin to skin contact and by contamination of items such as clothing, bedding or furniture.**
2. **Lice:**
   a. **Transmission requires direct contact with an infested person & objects used by them (ie: shared clothing and head- wear) Lice crawl, but do not hop or fly. Eggs hatch within 7-10 days. Time of survival off host: Head lice: 2 days, Body lice: 4-7 days and Pubic (crab) lice 1 day.**

D. **POLICY:**

1. **Place patient in Contact Precautions upon realizing or suspecting the patient has scabies or lice.**
2. **Examination of the patient by nursing and medical staff to determine if scabies or lice are present.**
   a. **Bag up all personal clothing and belongings and seal the bag tightly. Send clothes and personal belongings with family if possible.**
3. **Provide topical treatment as prescribed per MD orders.**
4. **Continue Contact Precautions until 24 hours after effective treatment.**
5. **After patient is discharged and insects are visible in the room, place a work order for Building Engineering to contact Pest Control to inspect room.**
6. **Once room is cleared by inspection, have Environmental Services terminally clean room.**

E. **OCCUPATIONAL EXPOSURE:**

1. **Standard and Contact precautions should prevent the transmission of most cases of scabies and lice. If an exposure to a patient with scabies and or lice occur before Contact Precautions are applied and the patient is treated the employee should:**
   a. **Immediately report the exposure to their Supervisor, Charge Nurse or Manager as per Employee Health & Wellness policy: Guidelines for Reporting Exposure.**
2. **Employee Health Services will institute appropriate follow up as needed.**

F. **RELATED DOCUMENTS:**

~~2.~~**1. Employee Health and Wellness Policy Manual:** ~~Administrative Policy #401~~ Injury **& Illness** Prevention Program
2. **Employee Health and Wellness Policy Manual: Guidelines for Reporting Exposures policy**
~~3. Employee Health Services Policies~~
~~4.~~**3.** Infection Control: Bloodborne Exposure Control Plan ~~IC. 11~~
~~5.~~**4.** Infection Control: Philosophy ~~IC .1~~
~~6.~~**5.** Infection Control: Standard and Transmission Based Precautions ~~IC.5~~
~~7.~~**6.** Infection Control: Tuberculosis Exposure Control Plan ~~IC. 10~~

G. **REFERENCE LIST:**

1. **APIC Text of Infection Control and Epidemiology, 4th edition, 2014**
2. **Control of Communicable Diseases Manual, D.L. Heymann, MD, Ed. 19th edition 2008**
3. **http://www.cdc.gov/parasites/scabies/index.html**
4. **http://www.cdc.gov/parasites/lice/**

1. Transmission:

Scabies is a parasitic disease (infestation) of the skin caused by the human itch mite, Sarcoptes scabiei. Scabies is generally transmitted to the health care workers by direct skin-to- skin contact with an infested patient. Activities such as performing physical assessments, bathing and changing a patient's soiled linen are conducive to transmission because physical contact is often prolonged. The mite can only survive for a few hours on inanimate object such as dry surfaces, clothing or bedding.

2.2 Lice are ectoparasites, which infest head and body and may result severe itching. Lice are host specific and those of animals do not infest humans. Transmission requires direct contact with an infested person and objects used by them (for example, shared clothing and headgear).

2. Infestation:

3.1 Scabies: Following an incubation period of 2 days to 6 weeks, the infested person will complain of itching, which intensifies at bed time under the warmth of blankets. In previously infested persons, itching may be noticeable as soon as 48 hours following infestation. In typical scabies, the rash is generally characterized as red, raised bumps (papules). Skin lesions are generally seen on the hands, wrists, elbows, and folds of armpits, female breasts or the male genitals.

3.2 Lice: Under optimal conditions, eggs hatch within 7- 10 days. Body and head lice survive for a week without feeding off the host, crab lice only 2 days. Nymphs survive only 24 hours without food.

3. Standard Precautions should prevent the transmission of most cases of scabies and lice. If an exposure to patient with scabies or lice occurs before Contact Precautions are applied and the patient is treated the employee should:

1. Report and document exposure as per policy.

2. Treatment guidelines

Only employees who are symptomatic will be referred to WorkPartners for treatment unless the patient is diagnosed with Crusted or Norwegian scabies. In this instance, all caregivers will be treated even if they are not symptomatic.

3.2.1. Employees and their contacts should be treated at the same time.

3.2.2. Employees will be allowed to return to work following treatment.

Follow-up treatments are not necessary unless re-exposure or symptoms persistReferences:

1.a. Control of Communicable Diseases Manual, D.L.Heymann, Ed. 19th edition, 2008

8. APIC Text of Infection Control and Epidemiology, revised edition, 2005

Tri-City Medical Center	Distribution: Women's and Children's Services
PROCEDURE:	INFANT BAPTISM
Purpose:	To outline the steps in performing baptism of either
Supportive Data:	Infant baptism may be desired by parents of many Catholic, Anglican/Episcopalian, Lutheran, Presbyte
Equipment:	Sterile water

DELETE WNS Procedure - retitle PCS procedure Spiritual Care for Family of Critically Ill or Deceased Infant

A. **PROCEDURE:**

1. Ask the parents if they wish the infant to be baptized.
   a. Infant baptism is not common in Judaism or other non-Christian religions. However, there may be specific rites/prayers associated with a stillbirth or critically ill infant. Ask the parents about any particular rituals for this situation.
2. Attempt to reach appropriate clergy if the family has not already done so.
3. If clergy is unavailable, any member of the medical or nursing staff may perform an emergency baptism.
   a. It is preferable, but not necessary for the person performing the baptism to be of the same denomination as the family.
4. Pour small amount of sterile water over the head of the individual three times, saying: "I baptize you in the name of the Father, and of the Son, and of the Holy Spirit."
   a. If infant has been named, use full given name in place of "you".
   b. If possible, another staff member should witness the baptism.

B. **DOCUMENTATION:**

1. Document in the medical record and on the Checklist for Assisting Parent(s) Experiencing Neonatal Death/Stillborn that baptism was performed with date, time, and name of person who performed baptism.

Department Review	Clinical Policies & Procedures	Nurse Executive Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
5/03, 6/09, 5/12, 04/16	05/12, n/a	05/12, n/a	06/12, n/a	07/12	07/12

TRI-CITY HEALTHCARE DISTRICT

PROFESSIONAL AFFAIRS COMMITTEE CHARTER

The Professional Affairs Committee (the "Committee") of the Tri-City Healthcare District ("District") has multiple purposes and is delegated certain key responsibilities as enumerated herein.

I. Purpose

The Committee is to provide governance oversight and make recommendations to the Tri-City Healthcare District Board of Directors ("Board") regarding quality, patient safety, performance improvement, and risk management policies; oversee development and implementation of the Quality Assurance, Quality Improvement, and Patient Safety (QA/QI/PS) Programs; and provide oversight of processes relating to the reporting, monitoring, investigation, and appropriate responsive/corrective actions taken in connection with any issues identified at the meetings, including the following:

1. Quality. The Committee will review reports regarding quality of patient care, including:

    a. Hospital operating unit and quality intervention programs;

    b. Core measures and performance measures;

    c. Medical staff and contracted hospital-based physicians' reports.

2. Patient Safety. The Committee will review reports regarding patient safety, including:

    a. Patient safety improvement programs;

    b. Incidents reported to the California Department of Public Health (CDPH) including any findings;

    c. Surveys from The Joint Commission, Center for Medicare and Medicaid Services, and other regulatory agencies.

3. Performance Improvement. The Committee will review the following reports:

    a. Operating unit performance improvements;

    b. Performance of clinical service providers.

4. Risk Management. The Committee will review the District's risk management program, including:

    a. Summaries of incident reports;

b. Compliments and complaints;

c. Surveys from Joint Commission, CMS, and CDPH visits;

d. Sentinel Events/Root Cause Analyses;

e. Professional liability claims and lawsuits.

5. Oversight Duties and Responsibilities. In addition, the Committee will:

a. Review and reassess the adequacy of this charter annually, recommend any proposed changes to the Board for approval, and publish this charter in accordance with applicable regulatory authorities;

b. Review significant reports prepared by any individual performing significant quality assurance functions together with management's response and follow-up to these reports;

c. Review the District's Administrative policies and procedures as necessary.

d. Consult with appropriate Consultants as necessary to inform the deliberations and committee decisions as necessary.

II. Membership

The Committee shall consist of three Directors and four physicians. The CEO, COO, Risk Manager, and CNE shall support the Committee without vote but be counted towards a quorum as alternates.

Term of Committee Members: (Karen do you have the language for the term of the Committee Members?

III. Meetings

The Committee may establish its own meeting schedule annually. The Committee will adjourn into closed session to meet with the legal counsel and to hear reports of the Hospital and Medical Staff Quality Assurance Committees.

IV. Minutes

The Committee will maintain written minutes of its meetings. Draft minutes will be presented to the Board for consideration at its meetings. The Senior Executive Assistant or designee will provide assistance to the Committee in scheduling meetings, preparing agendas and keeping minutes.

V. Reports

The Committee will report regularly to the Board regarding (i) all determinations made or actions taken pursuant to its duties and responsibilities, as set forth above, and (ii) any recommendations of the Committee submitted to the Board for action.

VI. Conduct

Each Committee member i

s expected to read the District's Code of Conduct which can be found at http://www.tricitymed.org/about-us/code-of-conduct/ and shall comply with all provisions thereof while a member of this Committee.

Approved by BOD: 9/29/11
Approved by BOD: 3/28/13
Approved by BOD: 5/29/14