List of Hospital-wide/Departmental Policies and Procedures Submitted for JCC Approval on January 9, 2024

Status	Dept.	Policy #	Title	Notes
Revised	_LHHPP	22-05	Handling Resident's Property and Prevention of Theft and Loss	1. Added "and at Time of Death" 2. Deleted sections 4.a - 4.else 3. Changed resident to patient/resident throughout the document.
Revised	_LHHPP	22-13	Bed Rail Use	1. Added "When the bed rail keeps a resident from voluntarily getting out of bed in a safe manner – due to his/her physical or cognitive inability to lower the bed rail independently - is considered a physical restraint" 2. Removed "Facility Services staff is responsible for the proper installation of bed rails and tracking completion of annual prevention maintenance on the bed used by the resident" 3. Removed "Nursing staff is responsible for notifying Facility Services when they find a bed that is paste due for preventative maintenance."
Revised	_LHHPP	24-04	Trauma Informed Care	1. Deleted "It is the policy of this facility to" 2. Added "Laguna Honda Hospital and Rehabilitation Center (LHH) shall" 3. Replaced "The facility" with "LHH" throughout the document. 4. Deleted "identify how communication will occur with the resident" 5. Added "provide staff with the tools and resources to effective communication with the resident" 6. Deleted "5.In some cases, if the facility has more than one resident who experienced trauma, social services will make a good faith effort at establishing a support group that is run by a qualified professional or allow a support group to meet in the facility. If a group cannot be run/meet at facility, social services will assist the resident in locating a support group in the community as appropriate and feasible."
Revised	_LHHPP	24-07	Resident Visitation	1. Added "at Laguna Honda Hospital and Rehabilitation Center (LHH)" 2. Replaced "his or her" with "their" throughout the document. 3. Replaced "The facility" with "LHH" throughout the document. 4. Added "Resident" 5. Replaced "lobby" with "Pavilion Lobby" 6. Replaced "nursing neigborhood" with "unit"
Revised	_LHHPP	72-01 A01	Authority of Infection Control Committee	1. Deleted "committees" 2. Deleted "Scope of the"
Revised	_LHHPP	72-01 A02	Infection Prevention and Control Program	1. Deleted "governing the use of PPE 2. Added "and procedures" after facility policy throughout the document. 3. Deleted "the leader of" 4. Added "a consultant and support person for " 5. Added "who leads antibiotic stewardship efforts with physician support at LHH" 6. Added "nursing staff" 7. Added "or resident representatives" and "accept or" and "a Influenza of Pneumococcal vaccination, and change their decision based on current guidance." 8. Added "b. Staff will have the opportunity to receive the Influenza or Pneumococcal vaccination or apply for a religious or medical exemption to the vaccine for facility consideration as per current guidelines and facility policy" 9. Replaced "whether or not the resident received the vaccine" with "acceptance of declination of immunizations."
Revised	_LHHPP	72-01 A03	Infection Preventionist	1. Minor punctuation change
Revised	_LHHPP	72-01 A04	Infection Reporting Policy	1. Deleted "7.The IPC will communicate the type of precaution (e.g., contact, droplet, airborne) ordered for the resident, and room number, to all departments, the Director of Nursing/ Chief Nursing Officer, and Administrator, the in-house communication methodology." 2. Added "Lab through CalREDIE, Physician, or "
Revised	_LHHPP	72-01 A05	Infection Control Surveillance Program	1. Deleted "Long Term Care Criteria" 2. Added "in both the acute and long term care areas" 3. Removed "All" fro "All residents" 4. Deleted "Revisiting the McGeer Criteria available at:"

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Revised	_LHHPP	72-01 A07	Reportable Communicable Diseases	1. Added "Regulatory" throughout the document. 2. Added "L&C" 3. Added "during business hours or the next working day if after hours, weekends, or holidays.)" 4. Replacde "ICN at 415-327-4850" with administrative on-call contact"
Revised	_LHHPP	72-01 A08	Outbreak/Epidemic Investigation Protocol	1. Replaced "makes a determination" with "decides" 2. Added "Surge: Medical surge capacity refers to the ability to evaluate and care for a markedly increased volume of patients—one that challenges or exceeds normal operating capacity. The surge requirements may extend beyond direct patient care to include such tasks as extensive laboratory studies or epidemiological investigations." 3. Added "or House Supervisor" 4. Added "U.S. Department of Health and Human Services"
Revised	_LHHPP	72-01 A09	Contact/Exposure Investigation	1. Added "6. LHH COVID HICS operations is responsible for coordinating/conducting COVID19 contact exposure investigations for staff and patient cases through the contact investigation team (CIT) using established department workflows. This team liaises with the ICN by communicating event case details." 2. Deleted "3. Time is critical to the contact investigation to identify and/or remove the potential infection source. Identifying contacts and ensuring they do not interact with others is critical to protect communities from further spread. Empiric use of Transmission-Based Precautions (quarantine) is recommended for patients who have had close contact with someone with SARS-CoV-2 infection if they are not up to date with all recommended COVID-19 vaccine doses." 3. Deleted "c. ICN will arrange to set up a phone/virtual contact investigation interview for the employee to determine recent contact at the facility as soon as possible" 4. Added "Nursing Home" 5. Deleted "Hazardous" 6. Changed "HICS" to "NHICS"
Revised	_LHHPP	72-01 A11	Water Management	1. Added "designee of the" 2. Added "assist with testing" 3. Added "web-based" 4. Replaced "definite" with "suspected and/or confirmed" 5. Added "web-based platform for" 6. Added "Legionellosis"
Revised	_LHHPP	72-01 B01	Standard Precautions	1. Deleted "a set of infection control practices" 2. Added "include" and "respirator" 3. Deleted "or sterilize" 4. Replaced "do not respond to" with "are not destroyed by" 5. Added "or known" and "at a minimum" 6. Added "PPE is not intended for extended use or reuse unless there is a significant shortage of supplies. In the event this occurs, communication will be sent out to impacted staff and education around contingency expectations provided." 7. Added "around PPE use" and "and perform hand hygiene" 8. Added "contingency" 9. Addd "only" 10. Added "using an EPA registered hospital grade disinfectant wipe" 11. Added "laundry" to linen throughout the document.
Revised	_LHHPP	72-01 B02	Hand Hygiene	Updated link to WHO Guidelines on Hand Hygiene

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Revised	_LHHPP	72-01 B03	Antimicrobial Use Guideline	1. Added "to ensure the" and "Efforts should be focused on the reduction" and "to prevent drug resistant infections and to improve infection related outcomes." 2. Deleted section 2 of Purpose 3. Added "1. Utilize the CDC Core Elements for Antibiotic Stewardship in Nursing Homes to drive improvement activities. These include: Leadership Commitment, accountability, drug expertise, action, tracking, reporting, and education." 4. Added "Example activities include:" and " regular" and "to partners and stakeholders" 5. Deleted "for the ASP proposals to garner for C Suite support" 6. Replaced "(data) presentation" with "sharing" 7. Replaced "is published timely and" with "reflects current resistance/susceptability treands and is" 8. Deleted "Support management and staff to analyze ICP concerns, and help to mitigate IPC issues" 9. Added "Provide feedback/recommendations based on antiotic use and trends" 10. Deleted "Round with the teams to prevent inappropriate antibiotic use" 11. Deleted "Report and communicate health department outbreak data with the ASP team as appropriate" 12. Replaced "Assist with the development of" with "Develope antibiotic use" 13. Replaced "ordering antibiotics order sets for clinical staff or order entry criteria to decrease antibiotic uses" with "common infections to streamline the antibiotic ordering"
Revised	_LHHPP	72-01 B09	Infection Control Post-Mortem Care Guidelines	1. Added "under the direct guidance of the treating provider and in consultation with the local/state health department(s)" 2. Replaced "respiratory therapist" with "properly trained clinical staff member" 3. Replaced "visible tubes" with "indwelling devices" 4. Deleted "using all proper Standard and appropriate Transmission based precautions. 5. Deleted "Airborne /Droplet precautions such as masks/respirators may not be required by HCP as there is no exhaling of infectious material from the decedent that may transmit the disease." 6. Deleted"If applicable, Contact and blood/body fluid precautions should continue to be observed during post mortem care and noted on records for transfer to mortuary."
Revised	_LHHPP	72-01 B14	Visitors Guidelines For Infection Prevention	1. Added "always 2. Deleted "at all times" 3. Replaced "California" with "SFDPH continues to require" 4. Updated URL for LAIV to "https://www.cdc.gov/flu/prevent/nasalspray.htm"
Revised	_LHHPP	72-01 B14 Attachment	Visitors Guidelines For Infection Prevention	1. Replaced "Visitor Sign" with "Get Vaccinated" 2. Replaced Attachement A image
Revised	_LHHPP	72-01 B24	Respiratory Hygiene/Cough Etiquette	1. Added "singing" 2. Replaced "able" with "tolerated" 3. Added "unless specific guidance is received from local or state health department during a respiratory outbreak. In the event that occurs, staff, residents and families will be educated regarding expectations." 4. Updated Hygiene/Cough URL
Revised	_LHHPP	72-01 B25	Isolation Cart Use	1. Deleted "top drawer of" 2. Replaced "an" with "a"
Revised	_LHHPP	72-01 C17	Pediculosis (Lice) Management	1. Deleted "(also called nits)" 2. Replaced "come into contact with" with "encounter" 3. Deleted "(130°F)" 4. Deleted "(at least 130°F)"
Revised	_LHHPP	72-01 C23	Pneumococcal Immunization	1. Replaced "has the opportunity to" with "can" 2. Replaced "benefits" with "risks" 3. Replaced "risks" with "benefits"

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Revised	_LHHPP	72-01 C24	Employee Influenza Vaccination	1. Deleted "implemented by SFDPH."
Revised	_LHHPP	72-01 C26	Guidelines for Prevention and Control of Tuberculosis	1. Replaced "shall adhere" with "adheres" 2. Deleted "Effective September 1, 2021, CDPH is following the latest CDC guidance for tuberculosis (Tuberculosis Control Branch, Tuberculosis Guidelines and Regulations.)" 3. Added "is diagnosed" 4. Replaced "are capable of spreading" with "can spread" 5. Added "and includes an assessment for:" 6. Deleted "a CXR and TB" 7. Changed "Readmission" to "Admission after Community Discharge" throughout the document. 8. Changed "re-admitted" to "discharged to a community setting and are" and "back to LHH " 9. Added "The medical provider will determine whether additional TB diagnostic testing is indicated."
Revised	_LHHPP	72-01 C27	Care of the Persistently Non-adherent Tuberculosis Patient Placed on Civil Detention	1. Deleted "with less restrictive alternatives," and "non-infectious" 2. Deleted "However, detention may be necessary for certain patients for the period during which they are infectious and where respiratory isolation is possible in some long-term care sites."
Revised	_LHHPP	72-01 C28	COVID-19 Immunization	1. Added "IMMUNIZATION" 2. Deleted "Approved or authorized vaccination options available in the United States currently are Pfizer-BioNtech, Moderna, Novavax and Johnson & Johnson Janssen." 3. Added "https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html" 4. Deleted "(last updated July 10, 2022) at https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html?s_cid=11758:covid%20vaccine%20names:sem.ga:p:RG:GM:gen:PTN:FY22" 5. Replaced "referral team" with "licensed nurse" 6. Added "b.The physician assesses resident eligibility for vaccination. A reasonable attempt will be made to determine prior vaccination history. Resident with unknown or unsure vaccination status will be considered not immunized. For those not vaccinated, the reason will be documented." 7. Deleted "and partially vaccinated (i.e. only received one dose from a two-dose series)" 8. Deleted "or Pharmacist" and "(CDC, 2021)" 9. Deleted "and partially vaccinated (i.e. only received one dose from a two-dose series or require a booster dose) staff" 10. Added "CDC (2023) Intermin Clinical Considerations for Use of COVID-19 Vaccines in the United States." 11. Added "Department of Health and Human Services, Centers for Medicare & Medicaid Services, CMS-20054 Infection Prevention, Control & Immunizations." 12. Deleted "CDC (2022) Stay up to date with your vaccines. All about Covid vaccines."
Revised	_LHHPP	72-01 D01	Pre-employment and Annual Screening of Employees	Minor punctuation change
Revised	_LHHPP	72-01 D04	Evaluation of Communicable Illness in Health Care Workers	Minor formatting edits

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Revised	_LHHPP	72-01 E14	Rehabilitation Services	1. Replace "Respiratory" with "Rehabilitation" 2. Deleted "in collaboration with the Infection Preventionist (IP), including isolation precautions that are not included in the annual hospital-wide mandatory in-services." 3. Deleted "members", "respiratory" and "2. Staff Responsibilities" 4. Deleted "e.Collaborate with the Infection Preventionist (IP) for infection control policy, education, and training to reduce the transmission of infectious diseases during the care of the patient with respiratory needs." 5. Deleted "a.Understand the general principles of Standard and Transmission-based Precaution (TBP) and be familiar with 3 types of TBP: Contact, Respiratory (droplet) and Airborne Precautions and the associated PPE and precautions for each" 6. Deleted "b.Adhere to Standard and Transmission-based precautions as directed" 7. Deleted "c.Collaborate and report to manager and IP, for infection control concerns" 8. Replaced "when in the facility include use of required PPE" with "during resident encounters/therapy" 9. Deleted "the infectious period." 10. Deleted "iii. TBP's include Respiratory/Droplet Precautions, Contact Precautions and Airborne Precautions" 11. Deleted "iv.Rooms will be clearly marked with signage for TBP and Isolation (ISO) carts will be in close proximity of the room with needed PPE supplies." 12. Deleted "a.Notify the nursing staff if these items are not present or if supplies need to be replenished" 13. Deleted "b.Strict adherence is required" 14. Deleted "if the wound can be adequately covered" 15. Added "on a case by case basis in consultation with the ICN and RCT team." 16. Deleted "g.All body substances and fluids are considered to be potentially infectious. i.Use gloves for anticipated exposure to mucous membranes and body substances from all residents. ii.Dispose of sharps carefully in puncture-resistant containers. h.For potential or anticipated exposure to body substances or fluids, staff must wear gloves. Hands must be washed or sanitized before and after glove use." 17. Replaced "hand hygiene, and cough /sneeze hygiene" with "standard precautions
Revised	_LHHPP	72-01 E22	Department-Specific Infection Control Procedures	1. Updated policy names 2. Removed old policy references
Revised	_LHHPP	72-01 F01	Renovation/Construction Infection Control Guidelines	1. Deleted "at a minimum" 2. Added "specific recommendation are in place. This information will be shared with" 3. Deleted "area to report back to"
Revised	_LHHPP	72-01 F02	Isolation Room Disinfection	1. Deleted "If concerns, contact the Infection Control Nurse (ICN) for guidance." 2. Replaced "removed" with "performed" 3. Updated policy name in reference section
Revised	_LHHPP	72-01 F03	Handling Resident's Personal Clothing	Minor punctuation change
Revised	_LHHPP	72-01 F04	Linen Handling	1. Added "Please refer to the Standard Work on Resident Laundry for additional details regarding the handling of resident clothing/laundry." 2. Added "Laundry"
Revised	_LHHPP	72-01 F10	Blood Spill Clean Up	1. Replaced "from" with "on each unit." 2. Added "maintains additional kits for replenishment or for spills where more kits are required for containment. Each kit contains" 3. Deleted "and contain" 4. Deleted "(These should be on each floor for immediate use)" 5. Updsted policy name and number in reference section.
Revised	_LHHPP	72-01 F11	Classification of Reusable Medical Devices and Processing Requirements	1. Removed Outpatient policies C4, C5 and C6 from references, they are being deleted.

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Revised	_LHHPP	72-01 F13	Cleaning and Disinfecting Non-Critical Resident Care Equipment	1. Corrected formatting 2. Deleted "Laguna Honda Hospital and Rehabilitation Center (LHH) staff is responsible for routine cleaning and disinfection of non-critical resident care equipment according to established facility procedures and manufacturer guidelines" 3. Added "Non-critical patient care equipment (touch intact skin) must receive low-level disinfection with a hospital grade disinfectant after use on each patient. Surfaces must be pre-cleaned when visibly soiled before being disinfected. Disinfection is performed following the manufacturer's instruction for use (IFU) using EPA registered disinfectant. " 4. Replaced "transmission of pathogens during use of non-critical resident care equipment." with "transmitting infections, between patients or employees, via contact with equipment that may be contaminated" 5. Deleted "The standard hospital-wide approved disinfectant are hydrogen peroxide-based disinfectant wipes. These shall be used for cleaning and disinfecting non-critical resident care equipment unless otherwise noted in attachment LHH Non-Critical Resident Care Equipment Disinfectant Exceptions." 6. Deleted "The sodium hypochlorite-based (bleach) disinfectant wipe must be used for disinfection of equipment used by residents infected with pathogens that cannot be killed with hydrogen peroxide, such as Clostridioides difficile (C. diff.)." 7. Deleted "1.Multi-resident use equipment (touch intact skin) must receive low-level is cleaned and/or disinfected after each resident use. a.Perform hand hygiene and don clean gloves. b.Using the appropriate disinfectant, staff will wipe down all hard surfaces, tubings, connections, and cords of the equipment until visibly wet. c.Ensure the surface is wet (avoid excessive solution) for the minimum contact time for disinfection with a. d.Remove gloves, perform hand hygiene." 8. Deleted "2.Dedicated equipment is cleaned daily and as needed by Nursing staff to reduce the spread of pathogens while in use. Single use or dedicated equipment used for one resident is obtained from Central Processing Department (CPD) when first ordered for the resident." 9. Deleted "e.At the conclusion of the prescribed treatment, any disposable tubing, attachment, and devices are discarded, and the equipment is disinfected by Nursing staff
Revised	_LHHPP	72-01 F14	Instrument Recall Policy	1. Deleted "from the microbiol¬ogy lab" 2. Deleted "b.Sterilization labs will perform their own monitoring for breaches prior to distribution and reprocess those items per lab standards" 3. Removed invalid link
Revised	_LHHPP	72-01 F15	Storage of Supplies (Clean/Sterile)	1. Minor punctuation change
Revised	_LHHPP	73-16	Confined Space Program	1. Changed "Laguna Honda" to "LHH" throughout the document 2. Added "is each of the following" 3. Added "For the permit required confined spaces in Appendix A, LHH will alert exposed employees and other employees performing work in the area, by posting danger signs or by any other equally effective means, of the existence, location of and the danger posed by the permit spaces. Using a sign reading "DANGER -- PERMIT-REQUIRED CONFINED SPACE, DO NOT ENTER" " 4. Removed 5 pages of section 4 5. Added "Industrial Hygienist" 6. Added "and using a gas detector with " 7. Added "There may be no hazardous atmosphere within the space whenever any employee is inside the space" 8. Moved 4vi to 4 vii and 4viii 9. Rearranged content in section 5 10. Replaced "Workplace Safety staff, the Chief Engineer" with "the Safety Engineer or the Senior Safety Engineer" 11. Update referenced policy title for 73-01

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Revised	_LHHPP	75-07	Theft and Lost Property	1. Added For lost or stolen property belonging to residents or patients, a grievance must be filed in addition pursuing the claims process. 2. Added MSW and RCT role to Claims and Liability section
Revised	Clinical Nutrition	1.16	Nutrition Screening and Documentation Process	1.Minor grammatical updates
Revised	Clinical Nutrition	1.19	Acute Medical/Rehab Admissions & Transfers	1.Minor grammatical updates
Revised	Clinical Nutrition	1.20	Nutrition screening and Assessment Documentation for Acute Admissions in the HER	1.Minor grammatical updates
Revised	Clinical Nutrition	1.23	Discharge Diet Instruction	1.Minor grammatical updates
Revised	Clinical Nutrition	1.25	NPO or Clear Liquid diets greater than 3 days	1. Minor grammatical updates and reorganized the information.
Deletion	Clinical Nutrition	1.11	Nutritionally adequate meals	Request to delete.
Deletion	Clinical Nutrition	1.8	Menu Program	Request to delete, obsolete information added to 1.06 Advanced Menu Planning
Revised	Nursing	K 01.0	Pressure Ulcer	1. Added where in EHR to document presence and risk of pressure injury on admission 2. Removed details about positioning for pressure injury prevention 3. Specified WOCN and trained wound care champions to assess pressure injuries when
Revised	Nursing	K 2.0	Wound Assessment & Management	Added to documentation for wound assessment the documentation of wound edges, wound bed and condition of surrounding tissues
Revised	Nursing	NPP I 5.0	Oxygen Administration	1.. Revised labelling and changing of disposable oxygen tubing devices to the following: a. Daily and PRN: sterile water for humidifier, tracheostomy tubing and tracheostomy mask b. Weekly and PRN: Nasal cannula oxygen tubing, suction tubing, suction cannister, Yankauer nebulizer set (mask and tubing) and reusable humidifier bottles. 2. Specified equipment to obtain from Central Supply for either rooms with oxygen vs room with wall oxygen 3. Added documentation in EHR
Deletion	OP Clinic	C4	High-Level Chemical Disinfection	Request to delete.
Deletion	OP Clinic	C5	Flexible Nasopharyngeal Laryngoscope	Request to delete.
Deletion	OP Clinic	C6	Steam Sterilization	Request to delete.

Revised Hospital-wide Policies and Procedures

HANDLING RESIDENT'S PROPERTY AND PREVENTION OF THEFT AND LOSS

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) maintains each resident's right to be free from misappropriation of property. There shall be a method of accounting for and safeguarding resident's property while the resident is at LHH and until the property is safely returned to the resident or legally authorized person.

PURPOSE:

To ensure the proper handling of a resident's personal property and valuables and to prevent loss or theft of these items.

DEFINITION:

"**Misappropriation of property**": the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent.

PROCEDURES:

1. General Guidelines

a. Upon admission, relocation, annually, and transfer or discharge from LHH, nursing staff and the resident and/or his/her representative shall complete an inventory of the resident's property. Inventory of the resident's property shall be recorded on a form entitled "Inventory of Resident's/Patient's Property" (Form Nos. MR311 and MR311b (hereinafter IRP).

b. The completed IRP shall be printed and signed by the resident or the resident's representative, and by a staff member on behalf of LHH. The signed document shall be scanned into the electronic health record.

   i. If the resident is unable to sign, the resident shall mark an "X" with two witnesses signing. If the resident is unable to mark an "X" then the nurse shall write, "resident unable to sign" with two witnesses signing. If the resident understands and can express consent, the nurse shall write, "resident expresses consent" with two witnesses signing.

   ii. If the resident is unable to participate in the process i.e., because of cognitive deficits, the legal representative shall sign on behalf of the resident with one witness signing. If the resident does not have a legal representative present, the nursing staff shall note that the "resident is unable to participate in the inventory process and there is no legal representative present" with two

witnesses signing.

c. A copy of the IRP shall be provided to the resident or the person acting on the resident's behalf. Thereafter, a copy of a current inventory shall be made available upon request to the resident, responsible party or other authorized representative. This can be obtained by printing the IRP from electronic health record.

d. A unit staff member shall instruct the resident and his/her legal representative to leave valuables at home or send them home with family or friends.

   i. If the resident decides to keep the valuables with him/her and not in LHH's safe, the resident may do so after signing the "Acknowledgment and Waiver" on the IRP, releasing LHH from liability for loss or damage.

e. LHH reserves the right to exclude property on the unit, such as perishables, firearm/weapons, hazardous waste, toxics, lighters, matches, electronic cigarettes (e-cigarettes), and other devices that ignite, light, or fuel a flame, and/or other property that endangers the safety and welfare of others.

f. Staff shall notify the San Francisco Sheriff Office (SFSO) at LHH (ext. 4-2319) of the resident's firearms or other dangerous objects and shall document the disposition of the items in the resident's IRP.

   i. Dangerous objects shall be confiscated by SFSO at the direction of LHH staff, catalogued by LHH staff, and transported by SFSO for proper destruction.

   ii. Should there be indication that the dangerous object(s) is of sentimental value, the item(s) shall be bagged, labeled by nursing staff, and secured by SFSO for safekeeping.

g. The Admission and Eligibility (A&E) Staff and/or the neighborhood nurse shall notify the resident, on or before admission to LHH, on the number of belongings that LHH can accommodate. The resident's property must fit into the bedside table and a wardrobe.

   i. The resident shall be encouraged to disclose all items for a complete inventory. If the resident refuses to have his/her property inventoried after all reasonable efforts have been made to enlist the resident's cooperation, the resident shall have a reasonable opportunity to dispose of the property or the Nursing Director shall be notified, and the property shall be secured and removed to an outside storage facility with resident's permission until discharge.

h. LHH provides a locked resident bedside drawer. A key is provided to the resident and a second key is kept by the Nurse Manager or designee.

i. Subsequent items brought into or removed from the facility shall be added to or deleted from the IRP in electronic health record by a staff member. LHH shall not be liable for property that has not been included in the IRP or for property that has been deleted from the IRP. Personal property not subject to addition or deletion from the IRP because of frequent delivery and/or removal from LHH, such as personal clothing or laundry, need not be listed, and such status of those properties shall be noted on the IRP. Friends or relatives who are asked to take property home shall sign the printed IRP and the form shall be scanned into the electronic health record.

j. Nursing staff shall label or mark all resident's property listed on the IRP. Property shall be marked with an indelible ink pen, identifying the resident's name. Nursing staff shall be required to permanently label personal items (such as prosthetic devices and small appliances).

k. Resident dentures shall be engraved by dental services for identification purposes.

   i. Residents who have dentures shall have a referral made to the dental clinic for the dentures to be engraved for identification purposes.

   ii. Loss or damage of dentures shall be the responsibility of LHH and may not be charged to the resident for the loss or damage in accordance with LHH policy (LHHPP 24-27 Denture Replacement).

   iii. Residents shall be promptly referred by his or her physician, within 3-days, for dental services if dentures should be lost or damaged. If a referral should not occur within 3-days, nursing staff shall provide documentation of care plan adjustments to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay.

   iv. If necessary or requested, LHH staff shall assist the resident in making appointments and/or arranging transportation to and from the dental services location.

l. It is important that details of the resident's property be recorded. Examples: Record the color of various articles of clothing, brand names of radio, electric razor, watch, personal wheelchair or television set, and serial number of wheelchairs or television sets, when describing jewelry, document the color of the metal and stones i.e., "one yellow metal ring with clear glass stone. Do not guess at the nature of the metal, i.e., gold color metal vs. pure gold.

m. Place resident's soiled clothes in resident's soiled linen hamper in the soiled utility room. Clean clothing is stored in the resident's individual space, such as a wardrobe locker/closet or bedside stand. If the resident's clothing is damaged or unable to be adequately cleaned, or needs to be disposed, consult with the

resident. If disposal of property is then agreed upon, document the disposal and the basis for doing and update the IRP in the electronic health record.

n. Staff must not accept or ask a resident to borrow personal items or money, nor should they attempt to gain access to a resident's holdings, money, or personal possessions through persuasion, coercion, request for a loan, or solicitation.

2. Resident's Property on Relocation

a. Nursing staff shall assist the resident in collecting his/her property before the resident relocates. ~~The~~The resident's bedside stand and locked drawer shall be checked for properties belonging to the resident. The IRP shall be updated to reflect any property that is no longer present or new property. Nursing staff shall review the IRP with the resident and the resident and nursing staff shall sign the printed form and scan into the electronic health record indicating that the property is relocating with the resident to the new neighborhood, with the date. The receiving neighborhood shall validate IRP and complete the section on relocation. If valuables are found that exceed a value of $50, the resident shall be reminded to store them in the secure area at the A&E office.

3. Resident's Property on Transfer and Discharge and at Time of Death

a. Nursing staff shall assist the resident with gathering the resident's property from the resident's bedside stand, locked drawer, and wardrobe.

b. The IRP in the electronic health record shall be updated to include property not previously listed and those that are not present with stated disposition of the property date and a signature.

c. The resident and nursing staff shall review the IRP and the resident / surrogate decision maker and staff shall sign off, signifying return of the property to the resident or his/her surrogate decision maker.

d. Valuables not taken by the resident upon discharge shall be listed by nursing staff on the IRP and the property shall be placed in an envelope labeled with the resident's name, unit, medical record number, contents and date of discharge and brought to the A&E office.

e. Any property not claimed by the resident on the date of discharge shall be placed in a paper bag, bag, or box and stored in the facility for up to 45 days. The Medical Social Worker (MSW) shall send a letter addressed to the resident or the resident's representative instructing them to retrieve the resident's property within thirty (30) days from the date of the letter. The letter shall also state that unclaimed property will be donated or otherwise discarded if not claimed within 30 days. A copy of the letter shall be scanned to the Health Information Management (HIM) Department for filing in the resident's electronic health record.

f. If a resident is discharged, is not anticipated to return or cannot be contacted, and there is no known representatives or heirs, A&E personnel shall immediately provide written notice to the San Francisco Public Administrator as specified by Section 7600.5 of the CA Probate Code. A&E staff shall follow the San Francisco Health Code Section 127 and Civil Code Section 1862.5 in the disposition on of unclaimed personal property.

Note: If absent without leave (AWOL) or against medical advice (AMA), refer to LHHPP 20-01 Admission to LHH and Relocation between LHH SNF Units.

~~**4. Resident's Property at the time of Death**~~

~~a. Nursing staff shall assist with gathering the resident's property from the resident's bedside stand, locked drawer, and wardrobe.~~

~~b. The IRP in the electronic health record shall be updated to include property not previously listed and those that are not present with stated disposition of the property date and a signature.~~

~~c. The nursing staff shall review the IRP with the surrogate decision maker and both parties shall sign off, signifying return of the property to the surrogate decision maker.~~

~~d. Valuables not taken shall be listed by nursing staff on the IRP and the property shall be placed in an envelope labeled with the resident's name, unit, medical record number, contents and date of expiration and brought to the A&E office.~~

~~e. Any property not claimed shall be placed in a paper bag, bag, or box and stored in the facility for up to 45 days. The Medical Social Worker (MSW) shall send a letter addressed to the resident's representative instructing them to retrieve the property within thirty (30) days from the date of the letter. The letter shall also state that unclaimed property will be donated or otherwise discarded if not claimed within 30 days. A copy of the letter shall be scanned to the Health Information Management (HIM) Department for filing in the resident's electronic health record.~~

~~f.~~g. Within 30 days following the death of a patient/resident, except in a coroner or medical examiner case, all money and valuables of that patient/resident which have been entrusted to the licensee shall be surrendered to the person responsible for the patient/resident or to the executor or the administrator of the estate in exchange for a signed receipt. Whenever a patient/resident without known heirs dies, written notice within five working days, shall be given by the facility to the public administrator of the county as specified by Section 1145 of the California Probate Code and a copy of said notice shall be available in the facility for review by the Department.

~~5.~~4. Residents Returning from Out on Pass

a. When a resident returns from being Out on Pass, s/he shall be reminded by nursing staff to disclose new items brought into the hospital so that the IRP can be updated. If the resident refuses to have his/her property inventoried after all reasonable efforts have been made to enlist the resident's cooperation, the resident shall have a reasonable opportunity to dispose of the property or the property shall be inventoried by staff.

~~6.~~5. Reporting Stolen or Lost Property

a. Staff shall complete an Unusual Occurrence (UO) Report for missing, stolen or lost property.

   i. For lost and stolen property, the neighborhood staff notified of the loss shall complete an online UO Report and include the following information: (1) a description of the article (2) its estimated value (3) the date and time the theft or loss was discovered (4) if determinable, the date and time the loss or theft occurred, and (5) the action(s) taken. Quality Management staff shall maintain a documented theft and loss record for the past 12 months. The record shall be made available to the State Department of Health Services, the county health department, or law enforcement agencies and to the office of the State Long-Term Care Ombudsman when requested.

b. When staff or resident has reason to believe that a resident property has been stolen, they shall report the loss immediately to the charge nurse or Nurse Manager (LHHPP 22-01 Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response). The Nurse Manager or Nursing Supervisor shall report immediately and no later than two (2) hours to:

   i. San Francisco Sheriff Office (SFSO)

   ii. California Department of Public Health (CDPH)

   iii. Quality Management Department

   iv. Chief Executive Officer or Administrator on Duty

c. Staff shall assist ~~the~~the~~the~~ resident/patient or complete a grievance form on their behalf for any lost or stolen property.

d. Resident theft and loss prevention monitoring shall be included in the LHH Quality Assurance Performance Improvement (QAPI) Plan.

~~7.~~6. Resident Notification

a. Upon the resident's admission, Social Services staff shall provide a resident guide which includes information relating to LHH's theft and loss prevention program.

b. A copy of LHH's theft and investigative procedures are posted in each neighborhood.

~~8.~~7. Claims and Liability

a. The resident may file a claim for loss of property, by completing a claim form entitled "Claim Against the City and County of San Francisco". The filing of a claim form does not guarantee reimbursement for the lost or stolen property. The Medical Social Worker or any member of Resident Care Team (RCT) may assist resident in completing claims form.

b. The ~~MSW~~MSW~~MSW~~ or any member of the ~~RCT~~RCT~~RCT~~ shall assist the resident/patient with or complete a grievance on their behalf that have a loss of property.

c. LHH is liable for damage or loss of the personal property of a resident, but only if negligence or willful wrongdoing on the part of LHH or its employee is shown. LHH may also deny liability when reasonable efforts to safeguard the resident's personal property has been provided and the resident chooses to take other actions or the property is not listed on the resident's IRP. Liability is subject to the amounts provided by law, including Civil Code sections 1840, 1859.

ATTACHMENT:
None.

REFERENCE:
LHHPP 20-01 Admission to Laguna Honda Acute & SNF Services & Relocation between Laguna Honda SNF Units
LHHPP 22-01 Abuse and Neglect Prevention, Identification, Investigation, Protection, Reporting and Response
LHHPP 24-06 Resident/Patient Visitor Complaints and Grievances
LHHPP 22-12 Clinical Search Protocol
LHHPP 24-27 Denture Replacement
LHHPP 75-07 Theft and Lost Property
"Claim Against the City and County of San Francisco" City Attorney FORM2 (rev. 2/01),

https://www.sfcityattorney.org/wp-content/uploads/2023/03/Claims-Form-03-27-23-1.pdf
~~http://www.sfgov.org/site/cityattorney_index.asp?id=460~~

Revised: 06/04/03, 12/09/25, 15/07/14, 19/05/14, 19/07/09, 20/09/08, 21/02/08, 22/05/10~~, 23/10/10~~ (Year/Month/Day)
Original adoption: 92/05/20

BED RAIL USE

POLICY:

1. Prior to bed rail use, Resident Care Team must consider the use of appropriate alternatives (see policy 7) The resident assessment must include an evaluation of the alternatives that were attempted prior to the installation or use of a bed rail and how these alternatives failed to meet the resident's assessed needs. Bed rails may only be used after careful assessment by the Resident Care Team (RCT) reviewing the risks and benefits of bed rail use.

2. Safety assessments shall be completed for residents who use bed rail(s).

3. A new safety assessment, order, and consent shall be completed when:

   a. the resident uses a different type of bed;

   b. there is a change in condition or functional status; and/or

   c. there are safety concerns with the quarterly assessment and the RCT has discussed continued use of bed rails after reviewing risks and benefits.

4. ~~When the bed rail keeps a resident from voluntarily getting out of bed in a safe manner , – due to his/her physical or cognitive inability to lower the bed rail independently - . They fall under the definition of~~is considered a physical restraint. ~~If they are not necessary to treat medical symptoms, and less restrictive interventions have not been attempted and determined to be ineffective, bed rails used as restraints should be avoided~~ A bedrail is a physical restraint if it keeps a resident from voluntarily getting out of bed in a safe manner, due to his/her physical or cognitive inability to lower the bed rail independently. A bed rail may only be considered if it is necessary to treat medical symptoms AND after less restrictive interventions have been attempted and determined to be ineffective. If the bed rail meets the definition of a physical restraint, the hospital-wide policy and procedures outlined in LHHPP 22-07 Restraint Free Environment shall be followed.

5. Continued bed rail use requires at a minimum, a quarterly bed rail safety assessment by the RCT.

~~6. Facility Services staff is responsible for the proper installation of bed rails and tracking completion of annual preventive maintenance on the bed used by the resident.~~

~~7.~~6. Appropriate Alternatives: ~~Facilities~~ RCT must attempt to use appropriate alternatives prior to ~~installing~~ requesting or using bed rails. "Alternatives include roll guards, foam bumpers, lowering the bed and using concave mattresses that can help reduce rolling off the bed." Additionally, alternatives that are attempted

should be appropriate for the resident, safe and address the medical conditions, symptoms, or behavioral patterns for which a bed rail was considered. For example, a low bed or concave mattress may not be an appropriate alternative to enable movement in bed for a resident receiving therapy for hip-replacement. If no appropriate alternative was identified, the medical record would have to include evidence of the following:

a. purpose for which the bed rail was intended and evidence that alternatives were tried and were not successful

b. assessment of the resident, the bed, the mattress, and rail for entrapment risk (which would include ensuring bed dimensions are appropriate for resident size/weight), and

c. risks and benefits were reviewed with the resident or resident representative, and informed consent was given before installation or use.

PURPOSE:

To ensure safe and appropriate use of bed rails.

DEFINITIONS:

1. Entrapment: is an event in which a resident is caught, trapped, or entangled in the space in or about the bed rail.

2. Freedom of movement: any change in place or position for the body or any part of the body that the person is physically able to control or access.

PROCEDURE:

1. A safety assessment shall be completed by the RCT and documented via electronic health record (EHR) by the Registered Nurse taking into consideration the resident's current medical diagnosis, physical condition (size and weight), functional ability (bed mobility, transfer, ability to toilet self), cognition, communication, sleep habits, medication(s), physical and/or behavioral symptoms.

2. For beds with rails that are incorporated or pre-installed, the facility must determine whether or not disabling the bed rail poses a risk for the resident. Some considerations would include, but are not limited to

   a. Could the rail simply be moved to the down position and tucked under the bed

   b. When in the down position, does it pose a tripping or entrapment hazard?

c. Would it have to be physically removed to eliminate a tripping or entrapment hazard?

3. Facilities should follow manufacturers' recommendations/instructions regarding disabling or tying rails down. If bed rails are not appropriate for the resident and the facility chooses to keep the bed rail on the bed, but in the down position, raising the rail even for episodic use during care would be considered noncompliance if all of the requirements (assessment, informed consent, appropriateness of bed, and inspection and maintenance) are not met prior to the episodic bedrail use for the resident.

4. The safety assessment takes into consideration the following:

   a. Risk of entrapment,

   b. Bed's dimensions are appropriate for the resident's size and weight,

   c. Fall risk,

   d. Bed rail safety assessment,

   e. Potential negative physical outcomes such as decline in function for activities of daily living and skin integrity issues, and

   f. Potential negative psycho-social outcomes such as an undignified self-image, low self-esteem, and feelings of isolation, anxiety or agitation.

5. Use of bed rails shall be ordered by the physician via EHR. Physician will complete consent.

   a. What assessed medical needs would be addressed by the use of bed rails;

      i. The resident's benefits from the use of bed rails and the likelihood of these benefits;

      ii. The resident's risks from the use of bed rails and how these risks will be mitigated.

6. The Resident or Resident Representative shall consent to bed rail use by signing the informed consent. Consent is to be renewed annually at a minimum.

~~7. Nursing staff is responsible for notifying Facility Services when they find a bed that is past due for preventive maintenance.~~

~~8.~~7. The RCT is responsible for on-going monitoring and supervision of residents who use bed rails and for conducting a quarterly safety assessment and documenting the assessment in the RCT meeting notes.

~~9.~~8. For new admissions, the RCT shall review and consider the alternatives listed under and determine if any of the suggested interventions are appropriate as an alternative to bed rail use.

REFERENCE:

LHHPP 22-07 Physical Restraints

MR 820 Non-Restrictive Bed Rail Consent Form (revised 10/2019)

https://www.fda.gov/medical-devices/bed-rail-safety/recommendations-consumers-and-caregivers-about-bed-rails

https://www.fda.gov/media/71460/download

https://www.fda.gov/media/88765/download

Centers for Medicaid and Medicare Services: 42 CFR Part 482 Medicare and Medicaid Programs; Hospital Conditions of Participation: Patients' Rights; Final Rule
http://www.cms.hhs.gov/CFCsAndCoPs/downloads/finalpatientrightsrule.pdf

Bed Rail Assessment Tool (Epic)

Revised: 10/11/10, 16/09/13, 18/03/13, 19/03/12, 20/10/13, 21/10/12, 22/12/13, 23/08/08 (Year/Month/Day)

Original adoption: 08/21/09

TRAUMA INFORMED CARE

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH) shall~~It is the policy of this facility to~~ provide care and services which, in addition to meeting professional standards, are delivered using approaches ~~which~~ that are equitable, culturally-competent, account for experiences and preferences, and address the needs of those who have experienced trauma by minimizing triggers and/or re-traumatization.

DEFINITIONS:

1. "**Trauma**" results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. Common sources of trauma may include, but are not limited to:

    a. Natural and human caused disasters

    b. Accidents

    c. War

    d. Physical, sexual, mental, and/or emotional abuse (past or present)

    e. Rape

    f. Violent crime

    g. History of imprisonment

    h. History of homelessness

    i. Traumatic life events (death of a loved one, personal illness, etc.)

2. "**Trauma-Informed Care**" is an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures and practices to avoid re-traumatization.

3. "**Culture**" is the conceptual system that structures the way people view the world—it is the set of beliefs, norms, and values that influence ideas about the nature of relationships, the way people live their lives, and the way people organize their world.

4. "**Cultural competency**" is a developmental process in which individuals or institutions achieve increasing levels of awareness, knowledge, and skills along a cultural competence continuum. Developing cultural competence involves the on-going process of~~:~~ valuing diversity, conducting self-assessments, avoiding stereotypes, managing the dynamics of difference, acquiring and institutionalizing cultural knowledge, and adapting to diversity and cultural contexts in communities.

5. "**Health Equity"** is the state in which everyone has a fair and just opportunity to attain their highest level of health.

PROCEDURE:

1. ~~The facility~~LHH will work to facilitate the implementation of trauma informed care based on the following trauma-informed principles:

   a. Understanding Stress and Trauma: Understanding trauma and stress allows actions with compassion and leads to well-informed steps toward wellness.

   b. Cultural Humility and Responsiveness: Understanding that all residents come from diverse social and cultural groups that may experience and react to trauma differently allows for responding sensitively so that residents may feel understood and enhance wellness.

   c. Safety and Stability: Trauma unpredictably violates our physical, social and emotional safety resulting in a sense of threat and need to manage risks. Increasing stability in our residents' daily lives and having these core safety needs met can minimize their stress reactions and allow ~~to~~ focus on ~~our~~ resources ~~on~~ for wellness.

   d. Compassion and Dependability: Trauma is overwhelming and can leave residents feeling isolated or betrayed, which may make it difficult to trust others and receive support. When residents experience compassionate and dependable relationships, they may reestablish trusting connections with others that foster mutual wellness.

   e. Peer support and mutual self-help: If practicable, assist the resident in locating and arranging to attend support groups (potentially hosted by the facility) which are organized by qualified professionals.

   f. Collaboration and Empowerment: Trauma involves a loss of power and control that makes us feel helpless. When residents are prepared for and given opportunities to make choices for themselves and their care, they may feel empowered and can advocate for their own wellness. It also places an emphasis on partnering between residents and/or his/her/their representative, and all staff and disciplines involved in the resident's care in developing the plan of care.

g. Resilience and Recovery: Trauma can have a long-lasting and broad impact on residents' lives that may create a feeling of hopelessness. When residents are able to focus on their strengths and clear steps, they can take toward their wellness they are more likely to be resilient and recover.

2. ~~The facility~~LHH will use a multi-pronged approach to identifying a resident's history of trauma, as well as ~~his/her/~~their cultural preferences. This will include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event, as well as screening and assessment tools such as the Resident Assessment Instrument (RAI), Admission Assessment, the history and physical, the social history/assessment, and others.

3. If the resident is non-English speaking, ~~the facility~~LHH will ~~identify how communication will occur with the resident~~provide staff with the tools and resources to effective communication with the resident. If indicated, language assistance services will be arranged for the resident. The care plan will identify the language spoken and tools used to communicate. ~~(See Culturally Competent Care Policy).~~

4. ~~The facility~~LHH will collaborate with residents who have experienced trauma, and as appropriate, the resident's family, friends, the primary care physician, and any other health care professionals (such as psychologists and mental health professionals) to develop and implement individualized care plan interventions.

~~5. In some cases, if the facility has more than one resident who experienced trauma, social services will make a good faith effort at establishing a support group that is run by a qualified professional or allow a support group to meet in the facility. If a group cannot be run/meet at facility, social services will assist the resident in locating a support group in the community as appropriate and feasible.~~

~~6.~~5. ~~The facility~~LHH will identify triggers which may re-traumatize residents with a history of trauma. Trigger-specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident and will be added to the resident's care plan. While most triggers are highly individualized, some common triggers may include, but are not limited to:

a. Experiencing a lack of privacy or confinement in a crowded or small space.

b. Exposure to loud noises, or bright/flashing lights.

c. Certain sights, such as objects that are associated with their abuser.

d. Sounds, smells, and physical touch.

~~7.~~6. Trauma-specific care plan interventions will recognize the interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders,

depression, and anxiety. These interventions will also recognize the resident's need to be respected, informed, connected, and hopeful regarding their own recovery.

~~8.~~7. ~~The facility~~LHH will evaluate whether the interventions have been able to mitigate (or reduce) the impact of identified triggers on the resident that may cause re-traumatization. The resident and/or ~~his/her/~~their family or representative will be included in this evaluation to ensure clear and open discussion and better understand if interventions must be modified.

~~9.~~8. ~~The facility~~LHH will engage the services of an interpreter to monitor or evaluate the effect of cultural interventions for non-English speaking residents.

~~10.~~9. In situations where a resident who experienced trauma is reluctant to share their history, ~~the facility~~LHH will still try to identify triggers which may re-traumatize the resident, and develop care plan interventions which minimize or eliminate the effect of the trigger on the resident.

ATTACHMENT:
~~NONE~~None.

REFERENCE:
What is Health Equity? | Health Equity | CDC

Trauma Transformed- Overview of Trauma Informed Systems

State Operations Manual Appendix PP – Guidance to Surveyors for Long Term Care Facilities section 483.25(m) Trauma Informed Care

Original adoption: 22/12/13 (Year/Month/Day)

RESIDENT/PATIENT VISITATION

POLICY:

1. Residents'/Patients' visitors at Laguna Honda Hospital and Rehabilitation Center (LHH) shall be accommodated, without compromising the safety of the facility, residents/patients, and staff, or the care or the well-being of residents/patients at the facility.

2. Every resident/patient has the right to receive visitors of ~~his or her~~their choosing at the time of ~~his or her~~their choosing, subject to the resident's/patient's right to deny visitation when applicable and in a manner that does not impose on the rights of another resident/patient.

3. ~~The facility~~LHH shall provide access to a resident/patient by individual(s) that provides health, social, legal, or other services to the resident/patient, subject to reasonable clinical and safety restrictions and the resident's/patient's right to deny or withdraw consent at any time. This includes the following individuals:

    a. Treating physician(s);

    b. Immediate family, other relatives and friends of the resident/patient;

    c. Resident/patient representative;

    d. Representative(s) of the Health and Human Services Secretary;

    e. Representative(s) of the State;

    f. Representative(s) of the Office of the State long term care ombudsman,

        i. Any representative of the protection and advocacy systems, as designated by the state~~,~~; and ~~A~~any representative of the agency responsible for the protection and advocacy system for the developmentally disabled individuals;

        ii. Any representative of the agency responsible for the protection and advocacy system for individuals with mental disorder as established under the Protection and Advocacy for the Mentally Ill Individuals Act of 2000. Any representative of the agency responsible for the protection and advocacy system for individuals with mental disorder.

4. Residents/patients (or the resident/patient representative, where appropriate) shall be informed of their visitation rights through review of the Resident Handbook on admission and periodically thereafter as necessary.

5. ~~The facility~~LHH will inform each resident/patient and/or resident/patient representative of ~~his or her~~their visitation rights and related facility policies and procedures, including any clinical or safety restriction or limitation of such rights, in a manner ~~he or she~~they understand~~s~~.

6. ~~The facility~~LHH will inform each resident/patient of the right, subject to his or her consent, to receive the visitors whom he or she designates as well as deny visitation, including but not limited to:

   a. A spouse, including a same-sex spouse

   b. A domestic partner, including a same-sex domestic partner

   c. Another family member

   d. Adoptive/foster family members

   e. A friend

7. Visitation privileges shall not be denied based on race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.

PURPOSE:

To encourage visitation of residents/patients while protecting resident/patient rights and health needs.

PROCEDURE:

1. ~~The facility~~LHH will provide immediate access to a resident/patient by immediate family and other relatives of the ~~resident~~ resident/patient, subject to the resident's/patient's right to deny or withdraw consent at the time. Resident's/patient's family members are not subject to visiting hour limitations or other restrictions not imposed by the resident,/patient except for reasonable clinical and safety restrictions, placed by the facility based on recommendations of CMS, CDC, or the local health department.

   a. Recommended visiting hours for LHH are daily, from 10:00 a.m. to 9:00 p.m. Visits outside of the recommended visiting hours can be arranged with the Resident Care Team.

2. ~~The facility~~LHH will provide immediate access to a resident/patient by others who are visiting with the consent of the ~~resident~~ resident/patient, subject to reasonable clinical and safety restrictions and the resident's/patient's right to deny or withdraw consent at any time.

3. ~~The facility~~LHH will provide reasonable access to a ~~resident~~ resident/patient by any entity or individual that provides health, social, legal, or other services to the ~~resident~~ resident/patient, subject to the resident's/patient's right to deny or withdraw consent at any time. ~~Facility~~ LHH staff will provide space and privacy for these visits. All visitors must check in and sign in at the Pavilion Lobby~~lobby~~ and the ~~nursing neighborhood~~unit upon arrival. (Cross Reference: LHHPP 75-02 Public Access and Night Security).
4. Visitors are not allowed personal items. Visitors may have a phone or wallet but cannot enter with a bag, purse, or any other personal item. Visitors are advised to leave personal belongings in their vehicles. If the visitor does not have a vehicle, staff will provide a secure locker for their belongings.

    a. If a visitor has personal medications that must be on their person, (such as blood pressure medication, allergy medication, seizure medication, etc.), they are permitted to carry this on their person.

5. All items and packages brought for residents/patients are subject to search. Searches shall be conducted by trained staff and follow standard protocol. If inappropriate items are found, they will be disposed of per facility policy.

6. If a resident's/patient's physician has determined that having visitors would not be in a resident's/patient's best interest on a given day, this shall be explained to the family. When only family visits are permitted (as determined/requested by the resident/patient), friends shall be so advised and not given entrance. (Cross Reference: LHHPP 75-03 Disorderly or Disruptive Visitors and LHHPP 75-10 Security Services Standard Operating Procedures Appendix H)

7. If isolation precautions are required in a resident's/patients room or the care unit, visitors shall be advised of this by the unit's nursing personnel and instructed as to the necessary precautions. (Cross Reference: LHHPP 72-01 Infection Control Manual, B14 Visitors Guidelines for Infection Prevention)

8. If visitors object to any general restrictions or specific ones imposed on the resident's/patient's behalf, they should be referred to the Nursing Office for special consideration.

ATTACHMENT:
None.

REFERENCE:
LHHPP 72-01 Infection Control Manual, B14 Visitors Guidelines
LHHPP 75-02 Public Access and Night Security
LHHPP 75-03 Disorderly or Disruptive Visitors
LHHPP 75-10 Security Services Standard Operating Procedures Appendix H

Appendix PP/Guidance to Surveyors for Long Term Care Facilities, F172 Section 483.10 (f) (4) (vii) – (xi)
Cal. Code Regs. Tit. 22, § 70707 - Patients' Rights 70707 (b)(17)

Revised: 92/05/20, 12/09/25, 16/11/08, 17/09/12, 22/06/14, 22/12/13 (Year/Month/Day)
Original adoption: 88/01/22

AUTHORITY OF INFECTION CONTROL COMMITTEE

POLICY:

1. The Infection Control Committee (ICC) is an interdisciplinary committee responsible for the oversight of Laguna Honda Hospital's infection prevention and control (IPC) program and activities. Infection control policies and procedures, and clinical care guidelines shall be approved by the ICC medical staff prior to implementation.

PURPOSE:

1. The purpose of the ICC ~~committee~~ is to:

    a. Develop and monitor policies, procedures, and practices which promote consistent adherence to evidence-based IPC practices.

    b. Provide IPC program oversight that includes planning, organizing, implementing, operating, monitoring, and maintaining all the elements of an effective IPC program.

    c. Provide oversight and guidance to the IPC team to implement evidence-based practices within the facility in accordance with the local regulators including San Francisco Department of Health (SFDPH), the state regulators of California Department of Public Health (CDPH) and national regulations including Centers for Disease Control and Prevention (CDC) and Centers for Medicare & Medicaid (CMS) guidelines and recommendations to prevent the transmission of disease.

DEFINITIONS:

1. **Healthcare-associated infection (HAI):** Infections that occur while receiving care in any healthcare setting, including in the long-term care or skilled nursing facility environment.
2. **Community-associated infection (CAI)**: Infections that initially occur outside of a healthcare setting but may be transmitted to patients from others with whom the patient may come into contact with including staff, visitors, contractors, volunteers, or others

Environmental Protection Agency (EPA): An independent Executive agency of the United States federal government tasked with environmental protection matters. Including the manufacturing, processing, distribution, and use of chemicals in the environment.

PROCEDURE:

1. Composition of the ICC

The ICC consists of the following interdisciplinary team members, as described in the Medical Staff Bylaws, who shall have duties as infection control officers for their respective departments:

a. At least two physician members of the active Medical Staff will be appointed on an annual basis by the Chief of Staff, one of whom will be appointed as Chair and one Vice-Chair of the committee. Additional representatives may include:

b. Director of Quality Management

c. Infection Control Nurse

d. A representative from Central Processing Department

e. An administrative representative appointed by the Executive Administrator

f. A representative from Nursing Services appointed by the Chief Nursing Officer

g. A Pharmacist appointed by the Director of Pharmacy

h. A representative from Environmental Services appointed by a member of senior leadership (C-suite)

i. A Director of Nutrition Services or designee

j. A Respiratory Therapy Supervisor or designee

k. Other department representatives or consultants deemed advisable by the Chief of Staff

2. Functions of the ICC

a. To develop and recommend to the Medical Executive Committee (MEC) written standards based on evidence-based infection control standards to prevent, reduce, or eliminate to the extent possible, the transmission of disease across every department. Such standards shall include a definition of infection outbreaks for the purpose of surveillance, as well as specification indications of the need for, and the procedures to be used to reduce transmission of disease within the facility including personal protective equipment (PPE), isolation and quarantine procedures in accordance with federal, state, and local guidelines.

b. To be responsible for quality improvement in developing, evaluating, and revising the procedures and techniques for meeting established sanitation and asepsis standards, including the routine evaluation of materials used in the hospital's sanitation program. The evaluation may be based upon data supplied from evidence-based sources or upon in-use tests performed within the hospital.

c. To develop a surveillance system for infection prevention measures to identify early clusters, outbreaks, and trends for the purpose of reducing the transfer of infectious diseases to others through appropriate isolation, treatment, and environmental controls. The ICC will identify potential sources, develop monitoring systems and work with other departments to reduce the spread of disease.
d. To develop and monitor infection control policies based on current best practices and guided by the CDC and CMS in cooperation with the MEC, for antibiotic resistant bacteria, influenza, and tuberculosis.

e. Guide staff education related to current infection control issues.

f. To guide quality improvement activities related to the appropriate use of antibiotics. The ICC will provide a summary of the findings of these activities at least quarterly to the Medical Quality Improvement Committee that will be used to guide future practices.

g. To report at least quarterly to the MEC on activities and findings.

h. To request a specific review of individual medical staff practices through the Chief of Staff, as appropriate.

3. ~~Scope of the~~ IPC Program Duties

a. Surveillance for infection clusters and/or outbreaks based on standardized skilled nursing criteria using NHSN (National Healthcare Safety Network) criteria.

b. Data analysis including collection and dissemination to appropriate committees and disciplinary teams.

c. Reporting internally to appropriate committees and disciplinary teams and externally to local and state health departments as required.

d. Implementation of ICP interventions and education and communication to management, staff, residents, and visitors as needed.

e. Consult with and provide oversight for all departments regarding cleaning and disinfection using EPA approved products and guidelines.

f. Provide expertise for policies and guidance for immunization of staff and residents including but not limited to influenza, and other emerging healthcare concerns.

g. To liaison with the local and state health departments for reporting outbreaks and other reportable concerns and to provide guidance for tuberculosis (TB) testing, reporting and follow up of patients and staff as required by local, state and federal agencies.

h. Policy and procedure creation and annual review of infection control policies.

i. Outbreak investigation in accordance with local city and state health departments as required.

j. Provide consultation services for antibiotic stewardship program, disaster planning, and other services related to IPC and hospital-wide projects including but not limited to admissions, hospital readmissions, construction/renovation for safe practices, and emergency drills.

ATTACHMENT:
None.

REFERENCE:
Medical Staff Bylaws
Haque, M., Sartelli, M., McKimm, J., & Abu Bakar, M. (2018). Health care-associated infections - an overview. *Infection and drug resistance*, *11*, 2321–2333. https://doi.org/10.2147/IDR.S177247
Association for Professionals in Infection Control & Epidemiology (APIC). (2013). *Infection Preventionist's Guide to Long-Term Care*. Washington DC, WA: Association for Professionals in Infection Control & Epidemiology.

Revised: 15/03/10, 20/08/16, 20/10/13 23/01/10 23/08/31 (Year/Month/Day)
Original adoption: 05/11/01

INFECTION PREVENTION AND CONTROL PROGRAM

POLICY:

This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national, state, and local standards and guidelines.

DEFINITIONS:

"**Staff"** includes all facility staff (direct and indirect care functions), contracted staff, consultants, volunteers, others who provide care and services to residents on behalf of the facility, and students in the facility's nurse aide training programs or from affiliated academic institutions.

PROCEDURE:

1. The Infection Preventionist is responsible for oversight of the program and serves as a consultant to staff on infectious diseases, resident room placement, implementing isolation precautions, staff and resident exposures, surveillance, and epidemiological investigations of exposures of infectious diseases.
2. Staff are responsible for following policies and procedures related to the ICP program.
3. Surveillance:
    a. A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon a facility assessment and accepted national, state, and local standards.
    b. The Infection Preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility and reports surveillance findings to the facility's Quality Assessment and Assurance Committee.
    c. The clinical staff participate in surveillance through assessment of residents and reporting changes in condition to the residents' physicians and management staff, per protocol for notification of changes and in-house reporting of communicable diseases and infections.
4. Standard Precautions:
    a. Staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services.
    b. Hand hygiene shall be performed in accordance with the facility's established hand hygiene policy and procedures.

c. Staff shall use personal protective equipment (PPE) according to established facility policy and procedures~~governing the use of PPE~~.
d. Licensed staff shall adhere to safe injection and medication administration practices, as described in relevant facility policies and procedures.
e. Environmental cleaning and disinfection shall be performed according to facility policy and procedures using approved EPA cleaning and disinfection products. All staff have responsibilities related to the cleanliness of the facility~~,~~ and are to report concerns outside of their scope to the appropriate department.

5. Isolation Protocol (Transmission-Based Precautions):
   a. A resident with an infection or communicable disease shall be placed on transmission-based precautions in consideration of local, state, and CDC guidelines in consultation with their physician and the ICP practitioner.
   b. Residents will be placed on the least restrictive transmission-based precaution for the shortest duration possible under the circumstances.
   c. When a resident on transmission-based precautions must leave the resident care unit/area, the charge nurse on that unit/area shall communicate to all involved departments the nature of the isolation and shall prepare the resident for transport in accordance with current transmission-based precaution guidelines.
   d. Residents with tuberculosis disease (not latent tuberculosis) are placed on airborne precautions and placed in a special room that is equipped with special air handling and ventilation capacity. If no such room is available, the resident(s) will be discharged to a facility with such capabilities.
   e. Immunocompromised and myelosuppressed residents shall be placed in a private room if possible and shall not be placed with any resident having an infection or communicable disease.

6. Antibiotic Stewardship:
   a. An antibiotic stewardship program will be implemented as part of the overall infection prevention and control program.
   b. Antibiotic use protocols and a system to monitor antibiotic use will be implemented as part of the antibiotic stewardship program.
   c. The Infection Preventionist, with oversight from the Director of Nursing, serves as a consultant and support person for~~the leader of~~ the antibiotic stewardship program. This is ~~in~~ consultation with ~~the~~ pharmacy leadership who leads antibiotic stewardship efforts with physician support at LHH.
   d. The Medical Director, consultant pharmacist, nursing staff and laboratory manager will serve as resources for the antibiotic stewardship program.
7. Influenza and Pneumococcal Immunization:
   a. Residents will be offered the influenza vaccine each year between October 1 and March 31, unless contraindicated or received the vaccine elsewhere during that time or if the local health department determines a longer season for that year with recommendations to extend.
   b. Residents will be offered the pneumococcal vaccines recommended by the CDC upon admission, unless contraindicated or received the vaccines elsewhere.

c. Education will be provided to the residents and/or representatives regarding the benefits and potential side effects of the immunizations prior to offering the vaccines.

a. Residents or resident representatives will have the opportunity to accept or refuse a Influenza of Pneumococcal vaccination, and change their decision based on current guidance.

~~d.~~b. Staff will have the opportunity to receive the Influenza or Pneumococcal vaccination or apply for a religious or medical exemption to the vaccine for facility consideration as per current guidelines and facility policy~~immunizations~~.

~~e.~~c. Documentation will reflect the education provided and details regarding acceptance of declination of~~whether or not the resident received the~~ immunizations.

8. COVID-19 Immunization:

a. Residents and staff will be offered the COVID-19 vaccine when vaccine supplies are available to the facility.
b. Residents and staff will be screened prior to offering the vaccination for prior immunization, medical precautions, and contraindications to determine candidacy for the vaccination.
c. Education about the vaccine, risks, benefits, and potential side effects will be given to residents or resident representatives and staff prior to offering the vaccine.
d. Residents or resident representatives will have the opportunity to accept or refuse a COVID-19 vaccination, and change their decision based on current guidance.
e. Staff will have the opportunity to receive the COVID-19 vaccination or apply for a religious or medical exemption to the vaccine for facility consideration as per current guidelines and facility policy.

~~f.~~ Documentation will reflect the education provided and details regarding acceptance of declination of immunizations.~~whether or not the resident or staff received the vaccine.~~

a.

9. Equipment Protocol:

a. All reusable items and equipment requiring special cleaning, disinfection, or sterilization shall be cleaned in accordance with current procedures governing the cleaning and sterilization of soiled or contaminated equipment.
b. Single-use disposable equipment is an alternative to sterilizing reusable medical instruments. Single-use devices must be discarded after use and are never used for more than one resident.
c. Reusable items potentially contaminated with infectious materials shall be cleaned and disinfected using hospital approved disinfectants after each use or when visibly soiled.

10. Supplies Protocol:

a. Sterile supplies shall be appropriately packaged and sterilized or purchased prepackaged and sterile from the manufacturer.
b. Sterile supplies are routinely checked for expiration dates and are replaced as necessary.

c. Prepackaged sterile items are considered sterile until opened or damaged. Packaging shall be inspected prior to use.
d. Non-sterile supplies are stored and maintained as clean prior to use.

11. Linens:

a. Laundry and direct care staff shall handle, store, process, and transport linens to prevent spread of infection.
b. Clean linen shall be separated from soiled linen at all times.
c. Clean linen shall be delivered to resident care units on covered linen carts with covers in place to protect the linens.
d. Linen shall be stored on all resident care units on covered carts, shelves, in bins, drawers, or linen closets.
e. Soiled linen shall be collected at the bedside and placed in a linen bag. When the task is complete, the bag shall be closed securely and placed in the soiled utility room. Soiled facility linen shall not be kept in the resident's room or bathroom.
f. Environmental services staff shall not handle soiled linen unless it is properly bagged.

12. Resident/Family/Visitor Education and Screening:

a. Residents, family members, and visitors are provided information relative to the rationale for the isolation, behaviors required of them in observing these precautions, and conditions for which to notify the nursing staff.
b. Information on various infectious diseases is available from the Infection Preventionist.
c. Isolation signs are used to alert staff, family members, contractors, volunteers, and visitors of transmission-based precautions.
d. Passive screening, such as signs, are posted at the facility entrances and in the facility to alert family members and visitors to adhere to handwashing, respiratory etiquette, and other infection control principles to limit spread of infection from family members and visitors.
e. More active screening, such as the completion of screening tools or questionnaires that elicits information related to recent exposures or current symptoms may be used as per facility policy.

13. Staff Communicable Disease Screening and Immunization:

a. Direct care staff shall comply with physical examinations and immunization screening requirements upon employment, and annually.
b. Direct care staff shall be tested for TB upon hire and screened annually per local and state health department requirements.
c. Influenza vaccine shall be offered annually to the staff, at no cost.
d. Tetanus, Diphtheria, and Pertussis (Tdap) vaccine shall be offered to those employees who have not previously received this vaccine. Tetanus-Diphtheria vaccine shall be offered as a booster dose as needed (i.e. every ten years).
e. Hepatitis B vaccine and education~~,~~ shall be offered to all staff that have the potential for contact with blood/body fluids, or other potentially infectious materials.
f. Varicella vaccine shall be offered to all staff that are serologically non-immune to varicella.

14. Staff Referral to Treatment Centers/Services:

a. Staff shall be referred to the appropriate medical treatment center/service when he/she:
   i. Is feverish and appears to be in the infectious stages of an illness.
   ii. Experiences an occupational exposure to blood/body fluids.
   iii. Has been exposed to a communicable disease.
   iv. Exhibits infected skin lesions.
b. Based on the specific circumstances, employees with a communicable disease or infected skin lesion will be prohibited from direct contact with residents or their food, if direct contact will transmit the disease.
c. The Infection Preventionist shall coordinate screening procedures in case of widespread exposure of staff to any infectious disease.

15. Staff Education:

a. All staff shall receive training, relevant to their specific roles and responsibilities, regarding the facility's infection prevention and control program, including policies and procedures related to their job function.
b. All staff shall demonstrate competence in relevant infection control practices.
c. Direct care staff shall demonstrate competence in resident care procedures established by our facility.

16. Water Management:

a. A water management program has been established as part of the overall infection prevention and control program.
b. Control measures and testing protocols are in place to address potential hazards associated with the facility's water systems.
c. The Maintenance Director serves as the leader of the water management program with the IP serving as consultant.

17. Annual Review:

a. The facility will conduct an annual review of the infection prevention and control program, including associated programs and policies and procedures based upon the facility assessment which includes any facility and community risk.
b. Following review, the infection and prevention control program will be updated as necessary.

ATTACHMENT:
NONE

REFERENCE:
Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities. (October 2022 Revision) F880 – Infection Prevention and Control. 42 C.F.R. §483.80(a)(1)(2)(4)(e)(f).

Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long

Term Care Facilities. (May 2021) F887 – COVID-19 Immunization. 42 C.F.R. §483.80 (d)(3)(i-vii).

Original adoption: 22/12/13 23/08/31(Year/Month/Day)

INFECTION PREVENTIONIST

POLICY:

The facility will employ one or more qualified individuals with responsibility for implementing the facility's infection prevention and control program.

DEFINITIONS:

"Infection Preventionist" is defined as the individual(s) designated by the facility to be responsible for the infection prevention and control program who has been appropriately trained and educated according to CMS requirements.

PROCEDURE:

1. The facility will designate a qualified individual as Infection Preventionist (IP) whose primary role is to coordinate and be actively accountable for the facility's infection prevention and control program to include the antibiotic stewardship program and consult with the water management program as needed.
2. The facility will ensure the Infection Preventionist is qualified by education, training, experience, or certification.
3. The IP must be professionally-trained in nursing, medical technology, microbiology, epidemiology, or other related field. These may include:
    a. A professionally-trained nurse with a certificate/diploma or degree in nursing;
    b. A professionally-trained medical technologist (also known as a clinical laboratory scientist) that has earned at least an associate's degree in medical technology or clinical laboratory science;
    c. A professionally-trained microbiologist that has earned at least a bachelor's degree in microbiology;
    d. A professionally-trained epidemiologist that has earned at least a bachelor's degree in epidemiology;
    e. Other related fields of training such as physicians, pharmacists, and physician's assistants.
4. The IP will have the knowledge to perform the role and remain current with infection prevention and control issues and be aware of national organizations' guidelines, as well as those from national/state/local public health authorities.
5. The facility will ensure that the individual selected as the IP has the background and ability to fully carry out the requirements of the IP based on the needs of the resident population, such as interpreting clinical and laboratory data.
6. The IP must be employed at least part-time and the amount of time should be determined by the facility assessment, to determine the resources it needs for its IPCP. Designated IP hours per week may vary based on the facility and its resident population.

7. The facility, based upon the facility assessment, will determine if the individual functioning as the IP should be dedicated solely to the IPCP. The IP must have the time necessary to properly assess, develop, implement, monitor, and manage the IPCP for the facility, address training requirements, and participate in required committees such as QAA.
8. The IP will physically work onsite in the facility.
9. The IP must be sufficiently trained in infection prevention and control. Specialized training in infection prevention and control may include care for residents with invasive medical devices, resident care equipment (e.g., ventilators), and treatment such as dialysis as well as high-acuity conditions. If the facility's resident population changes, the IP may need to obtain additional training for the change in the facility's scope of care, based upon re-evaluation of the IP's knowledge and skills.
10. The IP must have obtained specialized IPC training beyond initial professional training or education prior to assuming the role and must provide evidence of training through a certificate(s) of completion or equivalent documentation. Specialized training should include the following topics:
    a. Infection prevention and control program overview;
    b. Infection preventionist's role;
    c. Infection surveillance;
    d. Outbreaks;
    e. Principles of standard precautions (e.g., content on hand hygiene, personal protective equipment, injection safety, respiratory hygiene and cough etiquette, environmental cleaning and disinfection, and reprocessing reusable resident care equipment);
    f. Principles of transmission-based precautions;
    g. Resident care activities (e.g., use and care of indwelling urinary and central venous catheters, wound management, and point-of-care blood testing);
    h. Water management;
    i. Linen management;
    j. Preventing respiratory infections (e.g., influenza, pneumonia);
    k. Tuberculosis prevention;
    l. Occupational health consideration (e.g., employee vaccinations, exposure control plan and work exclusions);
    m. Quality assurance and performance improvement (QAPI);
    n. Antibiotic stewardship; and
    o. Care transitions.
11. The Infection Preventionist reports to the Chief Nursing Officer.
12. Responsibilities of the Infection Preventionist include but are not limited to:
    a. Develop and implement an ongoing infection prevention and control program to prevent, recognize and control the onset and spread of infections in order to provide a safe, sanitary and comfortable environment.
    b. Establish facility-wide systems for the prevention, identification, reporting, investigation and control of infections and communicable diseases of residents, staff and visitors.

c. Develop and implement written policies and procedures in accordance with current standards of practice and recognized guidelines for infection prevention and control.
d. Oversight of and ensuring the requirements are met for the facility's antibiotic stewardship program.
e. Oversight of resident care activities (i.e., use and care of urinary catheters, wound care, incontinence care, skin care, performing fingersticks, medication administration, etc.)
f. Review and/or revise the facility's infection prevention and control program, its standards, policies and procedures annually and as needed for changes to the facility assessment to ensure they are effective and in accordance with current standards of practice for preventing and controlling infections.
g. Review/revise and approve infection prevention and control training topics and content, and ensure facility staff are trained on IPCP. The infection preventionist is not necessarily required to perform the IPCP training if the facility has designated staff development personnel.

13. The Infection Control Preventionist will participate on and is part of the quality assessment and assurance committee (QAA) and will report regularly on the infection prevention and control program activities.

ATTACHMENT:
NONE

REFERENCE:
Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities. (October 2022 Revision) F882 – Infection Prevention and Control. 42 C.F.R. §483.80(b)(1)-(4)(c).

Original adoption: 22/12/13 23/08/31 (Year/Month/Day)

INFECTION REPORTING

POLICY:

It is the policy of this facility to timely report suspected incidents of communicable disease or infections to appropriate personnel or authorities.

PROCEDURE:

1. Any staff member must, and any resident, family member, or visitor may report changes in a resident's condition to the resident's nurse or physician when a possible infection is suspected.
2. A nurse with responsibility for the resident will assess the resident, document findings, and report any changes in condition or signs and symptoms of infection to the physician in accordance with the facility's Notification of Changes policy.
3. The resident or resident's representative will be notified of the findings and the practitioner's orders.
4. Changes in condition and/or signs and symptoms of infection will be notated on the 24-hour shift report by the nurse and communicated to the oncoming nurse at shift change.
5. New orders for antibiotics or new lab orders, such as to obtain cultures, will be notated on the 24-hour shift report.
6. Positive culture results will be reported to the physician and IPC nurse in accordance with the facility's Lab Notification policy in a timely manner.

~~7. The IPC will communicate the type of precaution (e.g., contact, droplet, airborne) ordered for the resident, and room number, to all departments, the Director of Nursing/ Chief Nursing Officer, and Administrator, the in-house communication methodology.~~

~~8.~~7. Transmission-based precautions (TBP) will be noted with a sign on the resident's door for the duration the resident is on transmission-based precautions.

~~9.~~8. The Infection Preventionist will review medical records and lab reports. Any infection or communicable disease that is a reportable disease will be reported to public health authorities by the Lab through CalREDIE, Physician, or IPC /IPC team.

~~10.~~9. The Infection Preventionist will report findings of surveillance activities, including at a minimum, incidence rates and types of infections, to the QAA committee, physicians, and other appropriate staff.

ATTACHMENT:

NONE

REFERENCE:

Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities. (October 2022 Revision) F880 – Infection Prevention and Control. 42 C.F.R. §483.80(a)(1)(2)(4)(e)(f).

Original adoption: 22/12/13 23/08/31 (Year/Month/Day)

INFECTION SURVEILLANCE PROGRAM

POLICY:

1. Laguna Honda Hospital (LHH) will implement an ongoing infection prevention and control (IPC) surveillance program that provides for a systematic collection, analysis, and interpretation of healthcare-related data essential to planning, implementation, and evaluation of the resident care services to identify trends and inform decisions for care ~~in an effort~~ to reduce transmission of disease in this population.

2. An annual risk evaluation that includes IPC trends and findings will provide the baseline to guide care, treatment, and services to this population.

3. LHH will utilize NHSN criteria for long-term care/skilled nursing facilities (SNF) and National Healthcare Safety Network (NHSN) criteria for acute care facilities to define surveillance criteria, identify specific data collection methods, as well as determine what qualifies as ~~in~~ an infection to use consistently and accurately.

4. LHH recognizes that surveillance definitions are not the same as clinical definitions and that NHSN criteria do not define clinical diagnosis or treatment. Ultimately, only the medical provider will provide the medical/clinical diagnosis and treat accordingly. LHH will consistently use NHSN criteria ~~for NHSN~~, local, and state reporting requirements.

Definitions:

"Infection surveillance" refers to an ongoing systematic collection, analysis, interpretation, and dissemination of infection-related data.

"Outcome measure" is a mechanism for evaluating outcomes or results, such as tracking specific infection events.

"Process measure" is a mechanism for evaluating specific steps in a process that lead, either positively or negatively, to a particular outcome metric. Also known as performance monitoring, a process measure is used to evaluate whether infection prevention and control practices are being followed.

Policy Explanation and Compliance Guidelines:

1. The Infection Preventionist serves as the leader in surveillance activities, maintains documentation of incidents, findings, and any corrective actions made by the facility and reports surveillance findings to the facility's Quality Assessment and Assurance Committee, and public health authorities when required.

2. The staff participate in surveillance through assessment of residents and reporting changes in condition to the resident's physicians and management staff, per protocol for notification of changes and in-house reporting of communicable diseases and

infections. Examples of notification triggers include, but are not limited to:

a. Resident develops signs and symptoms of infection.

b. A resident is started on an antibiotic.

c. A microbiology test is ordered.

d. A resident is placed on isolation precautions, whether empirically or by physician order.

e. Microbiology test results show drug resistance.

3. An annual infection control risk assessment will be used to prioritize surveillance efforts, as documented in the facility's *Infection Surveillance Action Plan*. In turn, surveillance data will provide information for subsequent infection control risk assessments.

4. The CDC's National Healthcare Safety Network (NHSN) ~~Long Term Care Criteria~~ will be used to define infections in both the acute and long term care areas. For MDS purposes, specific guidance in the RAI manual will be followed when coding for infections (i.e., UTI).

5. Surveillance activities will be monitored facility-wide, and may be broken down by department or unit, depending on the measure being observed. A combination of process and outcome measures will be utilized.

6. The facility will collect data to properly identify possible communicable diseases or infections before they spread by identifying:

   a. Data to be collected, including how often and the type of data to be documented, including:

      i. The infection site, pathogen (if available), signs and symptoms, and resident location, including summary and analysis of the number of residents (and staff, if applicable) who developed infections:

      ii. Observations of staff including the identification of ineffective practices, if any; and

      iii. The identification of unusual or unexpected outcomes, infection trends and patterns.

b. How the data will be used and shared and with appropriate individuals (e.g., staff, medical director, director of nursing, QAA committee) when applicable, to ensure that staff minimize spread of the infection or disease.

7. The facility will communicate via email communications, the Daily Situational Stat (DSS report) and clinical huddles to staff and/or prescribing practitioners information related to infection rates and outcomes in order to revise interventions/approaches and/or re-evaluate medical interventions as indicated.

8. Monthly time periods will be used for capturing and reporting data. Line charts will be used to show data comparisons over time and will be monitored for trends.

9. ResidentAll resident infections will be tracked. Separate, site-specific measures may be tracked as prioritized from the infection control risk assessment. Outbreaks will be investigated.

10. Employee, volunteer, and contract employee infections will be tracked, as appropriate and as known, such as influenza or gastrointestinal infection outbreaks.

11. Data to be used in the surveillance activities may include, but are not limited to:

    a. 24-hour shift reports

    b. Lab reports

    c. Antibiograms obtained from lab

    d. Antibiotic use reports from pharmacy

    e. Medication regimen review reports

    f. Skills validations for hand hygiene, PPE, and/or high risk procedures

    g. Rounding observation data

    h. Self-reported concerns

    i. Resident and employee immunization data

    j. Documentation of signs and symptoms in clinical record

    k. Transfer/discharge summaries for new or readmitted residents for infections.

12. Formulas used in calculating infection rates will remain constant for a minimum of one calendar year and will require discussion in QAA meetings before changes in the formulas are made.

ATTACHMENT:
None.

REFERENCE:
Surveillance Definitions of Infections in Long-Term Care Facilities: ~~Revisiting the McGeer Criteria available at:~~
https://www.jstor.org/stable/10.1086/667743#metadata_info_tab_contents
CDC/NHSN Surveillance Definitions for Specific Types of Infections available at:
https://www.cdc.gov/nhsn/PDFs/pscManual/17pscNosInfDef_current.pdf
Association for Professionals in Infection Control & Epidemiology (APIC). (2013). *Infection Preventionist's Guide to Long-Term Care*. Washington DC, WA: APIC Association for Professionals in Infection Control & Epidemiology.

Revised: 14/03/17, 15/07/30, 15/11/09, 18/11/13, 20/10/13, 22/12/13 23/08/31 (Year/Month/Day)
Original adoption: 05/11/01

REPORTABLE COMMUNICABLE DISEASES AND CONDITIONS

POLICY:

It is the policy of Laguna Honda Hospital and Rehabilitation (LHH) to comply with California state law requiring certain diseases or conditions to be reported to the local health department by the healthcare facility in a timely manner.

PURPOSE:

To provide guidance and reporting procedures and protocols that comply with California state law for mandated communicable diseases and conditions reporting.

PROCEDURE:

1. California Code of Regulations, Title 17, Section 2505 requires laboratories to report laboratory testing results, including molecular and pathologic results, suggestive of diseases of public health importance to the local health department. Laboratories must report any initial findings as well as any subsequent findings.

2. Laboratories will also notify the facility and infection control nurse (ICN) of suggestive disease findings when known and the facility or ICN will notify the physician in an expedited manner.

3. In the event a physician suspects but has not received lab confirmation of a reportable disease as listed in the California Department of Public Health (CDPH), the physician will notify the infection control nurse to take protective measures to prevent transmission to others that may include isolation, source mask control, quarantine or others.

4. For CDPH Reporting: utilize the online CDPH portal available at: https://www.cdph.ca.gov/Programs/PSB/Pages/CommunicableDiseaseControl.aspx

5. The ICN is responsible for notifying the Chair of the Infection Control Committee, Chief Medical Officer, Chief Nursing Officer, and the Regulatory/Risk Management Nurse for any reported diseases or conditions to San Francisco Department of Public Health (SFDPH) Communicable Disease Control Unit.

    a. The Regulatory~~Risk~~ Management Nurse is responsible for notifying CDPH Licensing &Certification branch if required beyond SFDPH notification by the ICN.

6. For SFDPH Reporting: For business hour (business days from 8:00am to 5:00pm) and non-urgent off-business hours (business days from 5:00pm to 8:00am as well as the entire weekend and holidays) reporting, the ICN reports to SFDPH Communicable

Disease Control Unit at 415-554-2830 (see reference link for additional SFDPH contact information) during business hours or the next working day if after hours, weekends, or holidays.~~).~~

7. For urgent off-business hour (5:00pm to 8:00am as well as the entire weekend and holidays) reporting, the Nursing Operations Manager reports to SFDPH Communicable Disease Control Unit at 415-554-2830 (see reference link for additional SFDPH contact information).

8. In an emergency during off-business hours, the Nursing Operations Manager may page the administrative on-call contact~~ICN at 415-327-4850~~ for additional assistance.

9. The ICN may contact SFDPH Communicable Disease Control Unit at 415-554-2830 in an emergency if additional consultation is needed, such as identifying a new communicable disease not listed on the current reportable diseases and conditions list (see reference link for additional SFDPH contact information).

ATTACHMENT:
None.

REFERENCE:

California Department of Public Health Division of Communicable Disease Control Reportable Diseases and Conditions available at:
https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Reportable-Disease-and-Conditions.aspx

San Francisco Department of Public Health Communicable Disease Control Unit 24/7 Disease Reporting Information for Clinicians available at:
https://www.sfcdcp.org/communicable-disease/disease-reporting/

San Francisco Department of Public Health Communicable Disease Control Unit Disease Reporting: Additional Information for Medical Providers available at:
https://www.sfcdcp.org/communicable-disease/disease-reporting/medical-providers/

Revised: 08/01/2022, 14/11/25, 16/07/12, 17/09/12, 18/09/11, 19/05/14, 20/10/13 23/08/31 (Year/Month/Day)

Original adoption: 05/11/01

OUTBREAK/EPIDEMIC INVESTIGATION PROTOCOL

POLICY:

It is the policy of this facility that LHH will comply with the local and state health departments for reporting unusual occurrences that many constitute an outbreak or epidemic occurrence. Health facilities licensed by California Department of Public Health (CDPH) Licensing and Certification (L&C) including LHH, are required to report outbreaks and unusual infectious disease occurrences to the local public health officer and their respective District Office (DO).

Upon receipt of a report of an outbreak or unusual occurrence, the local public health department recommends control actions and may conduct an epidemiologic investigation. The DO decides~~makes a determination~~ on regulatory follow-up action, which may include an onsite survey. The CDPH Healthcare-Associated Infections (HAI) Program is available to local public health authorities and L&C for consultation on infection control and containment measures. The ICP will coordinate services with both the LHD and CDPH to mitigate transmission of the disease to others.

When necessary, the Hospital Incident Command (HIC) will be activated should the occurrence/outbreak reach a level that requires extraordinary measures for containment or additional services to meet the safety needs of the facility. Protocols specific to HICs will be followed for public communication dissemination, reassignment of staff as needed and protection of supply chain.

If in doubt of reporting a specific concern, report it.

Designated members of the Infection Control Committee (ICC) have the responsibility for investigating outbreaks/epidemics and developing policies aimed at preventing the spread and control of healthcare-associated infections.

The threshold for determination of an outbreak is based on All Facilities Letter (AFL) 19-18. LHHPP 72-01 C1 Alphabetical List of Diseases/Conditions with Required Precautions, and outbreak definitions established by the ICC. Two or more of a similar infection in a period of 72 hours occurring on one neighborhood shall trigger an investigation of a possible outbreak.

DEFINTIONS:

California Department of Public Health (CDPH) defines an outbreak as the occurrence of cases of a disease (illness) above the expected or baseline level, usually over a given period of time, in a geographic area or facility, or in a specific population group. The number of cases indicating the presence of an outbreak will vary according to the disease agent, size and type of population exposed, previous exposure to the agent, and the time and place of occurrence.

Thus, the designation of an outbreak is relative to the usual frequency of the disease in the same facility or community, among the specified population, over a comparable period of time. For example, a single case of measles in this population may be considered an outbreak.

A single case of a communicable disease long absent from a population or the first invasion by a disease not previously recognized requires immediate reporting and epidemiologic investigation. The Infection Control Nurse (ICN) in conjunction with the ICC Chair will provide guidance when an outbreak /epidemic is occurring or suspected.

Epidemic: Centers for Disease Control and Prevention (CDC) defines an epidemic as an increase, often sudden, in the number of cases of a disease above what is normally expected in that population in that area. For example, 15 new cases of tuberculosis (TB) in the entire facility.

Outbreak: Outbreak carries the same definition of epidemic but is often used for a more limited geographic area. For example, 1 case of pertussis (whooping cough) on a neighborhood.

Cluster: Cluster refers to an aggregation of cases grouped in place and time that are suspected to be greater than the number expected, even though the expected number may not be known.

Transmissible: The ability of a disease/pathogen to be transmitted from one person or organism to another. Respiratory pathogens are more transmissible (more easily transmitted) than those transmitted by other means (mosquito bites, for example).

Virulent: CDC defines virulence as the relative capacity of a pathogen to overcome body defenses; that is, the ability of the pathogen to cause severe harm or infection.

PURPOSE:

The purpose of this policy is to provide staff with information to identify and report when information becomes known that a resident(s) may be infected with a pathogen that is highly transmissible and/or virulent and how to reduce transmission.

PROCEDURE:

1. The neighborhood Charge Nurse (CN) or House Supervisor is responsible for contacting the ICN when there are two or more of a similar infection in a period of 72 hours occurring on the neighborhood or when there is a single case involving a highly transmissible and/or virulent pathogen.

2. The lead ICN shall determine whether the situation is an infectious outbreak and collaborate with the ICC Chair, to determine whether the situation is an infectious outbreak or cluster that poses a threat to the health and safety of residents and

employees. Once the lead ICN and ICC Chair determines that an outbreak has occurred, the neighborhood and other appropriate individuals shall be notified, and an Unusual Occurrence (UO) report shall be submitted by the lead ICN. If there is doubt, report to CDPH for further consultation.

3. If investigation indicates that an outbreak or epidemic exists, the ICN or designee shall notify the San Francisco Department of Public Health (SFDPH) Communicable Disease Unit and the Risk Management Nurse shall notify CDPH when appropriate.

4. The ICN and ICC Chair will remain in contact with local and state departments for similar outbreaks in the surrounding areas. The ICN nurse will work in conjunction with the local health department investigations for contact tracing and implement recommendations to prevent further transmission.

5. An interdisciplinary team may be convened to provide a rapid response to the outbreak including the ICN team members. If the outbreak involves a high potential for morbidity and/or mortality based upon the local, state, and/or federal health departments, the Hospital Incident Command System (HICS) shall be initiated. The HICS Incident Commander will determine membership of their team, assign roles in the HICS structure, and include subject matter experts as needed.

6. The HICS Incident Commander may call an immediate meeting of such individuals and disciplines to:

   a. Clarify the nature and extent of the potential problem.

   b. Discuss proposed investigative steps.

   c. Determine and assign responsibility of each department; determine who shall collect and record specific data.

   d. Anticipate questions that may arise and develop a frequently asked question (FAQ) fact sheet.

7. Decisions involving a major disruption of services affecting large numbers of residents, personnel, or considerable expense (such as "closing" a neighborhood), shall be made in conjunction with the investigating personnel, attending staff, and administration.

8. In the event that prophylactic or therapeutic medication is required for residents, the prescribing physicians shall be notified by the ICC Chair.

9. The frequency of interdisciplinary meetings will be determined on a case-by-case basis.

10. The ICN shall collaborate with clinical members of the ICC to write the investigation report and distribute the report to involved departments. Communication with upline and downline stakeholders will be developed either by the HICS team and/or in conjunction with the ICN and ICC Chair and provided on a regular basis.

11. A summary of the investigation will be provided by the ICC to the Performance Improvement and Patient Safety (PIPS) Committee/Risk Committee for follow up. Recommendations will be reviewed for implementation.

12. Refer to Standard Work and protocols for the prevention and management of influenza and norovirus outbreaks on LHH intranet under Infection Control.

ATTACHMENT:
None.

REFERENCE:
CDPH AFL 19-18 Requirements to Report Outbreaks and Unusual Infectious Disease Occurrences
(https://www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/AFL-19-18.pdf)
Centers for Disease Control (http://www.cdc.gov)
U.S. Department of Health and Human Services LHHPP 70-01 B1 Emergency Response Plan
LHHPP 70-01 C5 Emergency Responder Antibiotic Dispensing Plan
LHHPP 72-01 A9 Contact/Exposure Investigation
LHHPP 72-01 C1 Alphabetical List of Diseases/Conditions with Required Precautions
LHHPP 72-01 C26 Guidelines for Prevention and Control of Tuberculosis
LHHPP 73-07 Aerosol Transmissible Disease Exposure Control Plan

Revised: 2014/11/25, 2019/03/12, 2019/07/09, 2020/06/23, 22/10/11 23/08/31 (Year/Month/Day)

Original adoption: Est. 2005/11/01

CONTACT/EXPOSURE INVESTIGATION

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) shall implement a contact and exposure investigation protocol for priority cases for highly transmissible and/or highly virulent pathogens that are identified within the facility for the purpose of preventing further transmission to others. Contact tracing will be in alignment with the CDC guidelines for an effective case investigation.

2. The Infection Control Nurse (ICN) is responsible for coordinating/conducting contact/exposure investigation when a patient(s) is suspected to have been in contact or exposed to a communicable disease.

3. Not every infection requires a contact exposure investigation. The determinate factor(s) include but are not limited to the organism involved, the rate and mode of transmission of the pathogen, the at-risk population, whether a cluster or outbreak is occurring in the community, the morbidity and mortality rates and whether current tests and treatment are available. Some infections such as measles, tuberculosis (TB), and Coronavirus Disease 2019 (COVID-19) are highly transmissible and can have severe outcomes if left unchecked. Other infections can be treated at the source to reduce the potential of spreading to others using standard and/or transmission-based precautions.

4. LHH shall protect patient privacy during the investigations by only informing contacts that they may have been exposed to someone with the infection. They are not told the identity of the person who may have exposed them.

5. In addition to health care staff, the ICN shall assess interactions between patients and staff, including but not limited to activity therapists, food service staff, and sanitation management.

6. LHH COVID HICS operations is responsible for coordinating/conducting COVID19 contact exposure investigations for staff and patient cases through the contact investigation team (CIT) using established department workflows. This team liaises with the ICN by communicating event case details.

DEFINITIONS:

- **Contact tracing**: The processes of supporting patients with suspected or confirmed infection. The ICN team members will work with a patient to help them identify close contacts during the timeframe while they may have been infectious.

- **Close contact**: Centers for Disease Control and Prevention (CDC) defines as someone who was within 6 feet of an infected person for at least 15 minutes

starting from 48 hours before illness onset until the time the patient is isolated.

- **High-risk exposure**: Contact with someone who is infected with a highly transmissible pathogen, that if exposed could quickly spread to a vulnerable population quickly and cause high levels of morbidity and/or mortality.

PURPOSE:

The purpose of this policy is to provide guidance and direction for evaluating and managing exposures or potential exposures of patients in the facility for the purpose of diagnosis, treatment, and isolation in order to prevent the transmission of the disease to others. Contact tracing is not limited to SarsCoV-2 infections and universal contact tracing is not recommended by the CDC except for priority cases (such as SarsCoV-2) in the congregate settings. LHH will remain in close communication with the local health department during outbreaks for determination of implements contact tracing and investigation.

PROCEDURE:

1. LHH will follow specific processes for contract tracing that provides for recent contact activity, locations, immunity, and other mitigating risk factors and will be administered in an equitable and professional manner to those identified as recent contacts.

2. Once a patient has been determined to be exposed to a contagious or potentially contagious pathogen, the ICN team and physician/Chief Medical Officer (CMO) will be notified immediately (no later than 24 hours after the exposure is identified.) Prompt initiation of prophylaxis and/or quarantine may be required for some exposures. Document all healthcare worker contacts.

~~3. Time is critical to the contact investigation to identify and/or remove the potential infection source. Identifying contacts and ensuring they do not interact with others is critical to protect communities from further spread. Empiric use of Transmission-Based Precautions (quarantine) is recommended for patients who have had close contact with someone with SARS-CoV-2 infection if they are not~~ up to date ~~with all recommended COVID-19 vaccine doses.~~

~~4.~~3. Contact investigations will be initiated for the following high-risk exposures:

a. Severe Acute ~~udden active~~ Rr~~r~~espiratory Ss~~s~~yndrome Ce~~o~~ronavirus 2 (SARS-CoV-2), the virus that causes (COVID-19); this is subject to change based on discovery of future variants and their rate of transmissibility.

b. Active pulmonary tuberculosis

c. Rubella (German measles)

d. Rubeola (measles)

e. Varicella (chicken pox)/disseminated varicella

f. Meningococcemia/ meningococcal meningitis

g. Pertussis

h. Invasive Hemophilus influenza disease

i. Norwegian scabies

j. Any other highly communicable diseases as determined by the local or state health department.

~~5.~~4. For Patients: In the event a contact investigation is required, the ICN initiates/coordinates the investigation as follows:

a. Confirms that a communicable disease exposure has occurred by reviewing the electronic medical record for confirmation that a communicable disease is/was present at the time of exposure.

b. Determines if an outbreak is occurring by verifying the diagnosis, signs and symptoms and other clinical assessments of other patients and determine linkage if possible.

c. Interviews the patient or patient representative to determine the scope of the exposure (time, closeness, contacts, etc.). Potential sources may include:

i. Persons within departments with whom the patient had contact.

ii. Other patients with whom the source had contact.

iii. Family members and community contacts whom the source exposed.

d. Informs the Chair of the Infection Control Committee, the Employee Health Service, the Industrial Hygienist from the department of Workplace Safety and Emergency Management (WSEM), and the appropriate public health communicable disease division.

e. Notifies the department directors/managers involved, provides the exposure definition, dates of exposure, and name of the index case/source when appropriate.

f. Determines if other patients were exposed according to the exposure definition.

g. In the event of an extensive contact investigation involving many patient neighborhoods or services, as determined by the ICN team, a multi-disciplinary team may be assembled to determine the specific course of action.

~~6.~~5. For Staff:

a. When a known high-risk pathogen is identified in staff, the first step is to isolate the source of the pathogen by having the staff member remain out of the facility until a full clinical assessment is completed by their primary care provider.

b. Contact investigation for exposed employees shall be conducted by Employee Health and Workplace Safety and Emergency Management. Please refer to LHHPP 73-07 Aerosol Transmissible Disease Exposure Control Plan.

~~c. ICN will arrange to set up a phone/virtual contact investigation interview for the employee to determine recent contact at the facility as soon as possible~~

~~d.~~c. High risk contacts identified by the interview will be contacted by the facility and interviewed for symptoms and/or contact with the source providing only enough information to ascertain contact. The interviewer will not provide any more protected healthcare information than is necessary to determine contact risk (e.g., such as current health status of the source, treatments, where or who they may have become infected, etc.)

~~e.~~d. Provide contacts with resources and education regarding the potential infection for care with a healthcare provider.

~~f.~~e. Provide testing if available at no cost to the staff.

~~g.~~f. Provide information needed for return to work (RTW) criteria required based upon that infection and in collaboration with local and state health departments and CDC recommendations for health care personnel (HCP).~~)~~

~~h.~~g. In the event of an extensive contact investigation involving many patient neighborhoods or services, as determined by the ICN team, a multi-disciplinary team may be assembled to determine the specific course of action.

~~i.~~h. ICN will report findings to the local and state health departments as required for mandatory reporting procedures.

7. Contact Investigation Protocol for Exposed Patients:

a. Isolation or quarantine will be implemented for exposed patients based upon the specific mode of transmission of the pathogen, clinical signs and symptoms or lack, and /or testing if available.

b. The ICN develops a contact list of exposed patients and notifies the Chief Medical Officer and Chief Nursing Officer.

c. Testing, prophylaxis, and treatment if available and warranted based upon clinical evaluation of each patient, will be initiated by the medical staff in coordination with pharmacy, ICN and nursing staff.

d. A line listing is initiated by the ICN to identify and document patient symptoms, movement, treatments, diagnostics, and testing. This list is reviewed and updated daily by the ICN to determine if the pathogen is being transmitted to others and the information is shared with providers and quality risk managers.

e. In the event that an outbreak progresses to the epidemic and/or pandemic state, the Nursing Home~~Hazardous~~ Incident Command System (NHICS~~HICS~~) will be initiated. Information from the contact listing will be shared with this team until the situation as resolved.

f. For patients in the facility, the ICN shall notify the physician of the exposure and required follow-up for that may include prophylaxis treatments.

g. For cases involving discharged patient exposure to local health department reportable infections, the facility and local health department will assistance in contacting patients. The ICN, Social Services, and local health department shall coordinate to ensure the patient is notified.

8. Upon completion of the contact investigation, the Infection Control Committee (ICC) provides a summary of the case investigation to the Performance Improvement and Patient Safety (PIPS) Committee, including the Chief Medical Officer and Chief Nursing Officer for follow up and need, if any, for additional prevention measures.

ATTACHMENT:
None.

REFERENCE:
Centers for Disease Control (CDC)
~~https://www.cdc.gov/coronavirus/2019-ncov/php/principles-contact-tracing.html~~
Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 | CDC
San Francisco Department of Public Health Population Health Division Disease Prevention and Control (SFDPH)
https://www.sfcdcp.org/
LHHPP 72-01 A8 Outbreak Investigation Protocol

LHHPP 72-01 C26 Guidelines for Prevention and Control of Tuberculosis
LHHPP 73-07 Aerosol Transmissible Disease Exposure Control Plan

Revised: 2014/11/25, 2018/09/11, 2019/05/14, 2020/06/23, 2022/09/13 2023/08/31 (Year/Month/Day)
Original adoption: Est. 2005/11/01

WATER MANAGEMENT PROGRAM

POLICY:

It is the policy of this facility to establish water management plans for reducing the risk of legionellosis and other opportunistic pathogens (e.g. Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi) in the facility's water systems based on nationally accepted standards (e.g., ASHRAE, CDC, EPA).

DEFINITIONS:

"Control limits" are the maximum value, minimum value, or range of values that are acceptable for the control measures being monitoring to reduce the risk for Legionella growth and spread.

"Control measures" are things done in the building water systems to limit growth and spread of Legionella, such as heating, adding disinfectant, or cleaning.

"Control points" are locations in the water systems where a control measure can be applied.

"Definite healthcare-associated Legionnaires' disease" refers to a case of Legionnaires' disease in a resident who spent the entire 10 days prior to onset of illness in the facility.

"Legionellosis" refers to two clinically and epidemiologically distinct illnesses: Legionnaires' disease, which is typically characterized by fever, myalgia, cough, and clinical or radiographic pneumonia; and Pontiac fever, a milder illness without pneumonia (e.g., fever and muscle aches). Legionellosis is caused by Legionella bacteria.

"Possible healthcare-associated Legionnaires' disease" refers to a case of Legionnaires' disease in a resident who spent only part of the 10 days before symptoms began in the facility.

"Water management plans" refer to the documents that contain all the information pertaining to the development and implementation of the facility's water management activities for reducing risk of Legionella and other opportunistic pathogens.

PROCEDURE:

1. A water management (WM) team has been established to develop and implement the facility's water management program, including facility leadership, the Infection

Preventionist, maintenance employees, safety officers, risk and quality management staff, and designee of the Chief Nursing Officer.

a. Key team members have been educated on the principles of an effective water management program, including how Legionella and other water-borne pathogens grow and spread. Education is consistent with each team member's role.
b. The water management team has access to water treatment professionals, environmental health specialists, and state/local health officials.

2. LHH will employ outside expert water management services to assist/consult with the WM program, provide professional assessments and make recommendations, assist with testing as well as educate staff on options for remediation as appropriate.
3. The Maintenance Director maintains documentation that describes the facility's water system. A copy is kept in the water management program binder and/or on the web -based platform.
4. A risk assessment will be conducted by the water management team annually to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility's water systems. The risk assessment will consider the following elements:

a. Premise plumbing: This includes water system components as described in the documentation of the facility's water system.
b. Clinical equipment: This includes medical devices and other equipment utilized in the facility that can spread Legionella through aerosols or aspiration.
c. At-risk population – This facility's entire population is at risk. High risk areas shall be identified through the risk assessment process. Supporting documentation of any areas or resident population that exhibit greater risk than the general population shall be kept in the water management program binder.

5. Data to be used for completing the risk assessment may include, but are not limited to:

a. Water system schematic/description
b. Legionella environmental assessment
c. Resident infection control surveillance data (i.e. culture results)
d. Environmental culture results
e. Rounding observation data
f. Water temperature logs
g. Water quality reports from drinking water provider (i.e. municipality, water company)
h. Community infection control surveillance data (i.e. health department data)

6. Based on the risk assessment, control points will be identified. The list of identified points shall be kept in the water management program binder/web -based platform.
7. Control measures will be applied to address potential hazards at each control point. A variety of measures may be used, including physical controls, temperature management, disinfectant level control, visual inspections, or environmental testing for pathogens. The measures shall be specified in the water management program action plan.

8. Testing protocols and control limits will be established for each control measure.
    a. Individuals responsible for testing or visual inspections will document findings.
    b. When control limits are not maintained, corrective actions will be taken and documented accordingly.
    c. Protocols and corrective actions will reflect current industry guidelines (i.e., ASHRAE, OSHA, CDC, EPA).
9. The water management team shall regularly verify that the water management program is being implemented as designed. Auditing assignments will reflect that individuals will not verify the program activity for which they are responsible.
10. The effectiveness of the water management program shall be evaluated no less than annually. Routine infection control surveillance data, water quality data, and rounding data shall be utilized to validate the effectiveness.
11. All cases of healthcare-associated legionellosis or other opportunistic waterborne pathogens shall be reported to local/state health officials, followed by an investigation.
    a. The Infection Preventionist will investigate all cases of suspected and/or confirmed~~definite~~ healthcare-associated Legionnaires' disease for the source of Legionella.
    b. The Infection Preventionist will also investigate for the source of Legionella when two or more possible healthcare-associated Legionnaires' disease are identified.
    c. Elements of an investigation may include:
        i. Reviewing medical and microbiology records
        ii. Actively identifying all new and recent residents with healthcare-associated pneumonia and testing them for Legionella using both culture of lower respiratory secretions and the Legionella urinary antigen test
        iii. Developing a line list of cases
        iv. Evaluating potential environmental exposures
        v. Performing an environmental assessment
        vi. Performing environmental sampling, as indicated by the environmental assessment
        vii. Subtyping and comparing clinical and environmental isolates
        viii. Decontaminating environmental source(s)
        ix. Working with local and/or state health department staff to determine how long heightened disease surveillance and environmental sampling should continue to ensure an outbreak is over
        x. Reviewing and possibly revising the water management program, with input from local and/or state health department staff
12. The facility may utilize outside resources such as microbiologists, environmental health specialists, or state/local health officials for investigations and revising the water management program in consultation with the IP team .
13. The facility will conduct an annual review of the water management program as part of the annual review of the infection prevention and control program, and as needed, such as when any of the following events occur:
    a. Data review shows control measures are persistently outside of control limits,

b. A major maintenance or water service change occurs (including replacing tanks, pumps, heat exchangers, distribution piping, or water service disruption from the supplier to the building),
c. One or more cases of disease are thought to be associated with the facility's systems, or
d. Changes occur in applicable laws, regulations, standards, or guidelines.

14. In the event of an update to the water management program, the water management team shall:
    a. Update the water system schematic/description, associated control points, control limits, and any pre-determined corrective actions.
    b. Train those responsible for implementing and monitoring the updated program.
15. Documentation of all the activities related to the water management program shall be maintained with the water management program binder/web -based platform for a minimum of three years.
16. The water management team shall report relevant information to the QAPI Committee.

ATTACHMENT:
NONE

REFERENCE:
American Society of Heating and Air-Conditioning Engineers (ASHRAE). ANSI/ASHRAE Standard 188-2015: Legionellosis~~Legionelellosis~~: Risk Management for Building Water Systems, Normative Annex A - Health Care Facilities. Located at www.ashrae.org. (Note: 2018 version is available, but CDC's toolkit references 2015 version. This is a voluntary standard.)

Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services. State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities. (October 2022 Revision) F880 – Infection Prevention and Control. 42 C.F.R. §483.80(a)(1)(2)(4)(e)(f).

U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings. Located at www.cdc.gov/legionella/WMPtoolkit. Accessed April 2022.
U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. QSO-17-30-Hospitals/CAHs/NHs. (July 6, 2018 revision.).

Original adoption: 22/12/13 (Year/Month/Day)
Revised: 23/09/18

STANDARD PRECAUTIONS

POLICY:

1. Laguna Honda Hospital (LHH) staff will adhere to ~~the~~ established principles of safe infection control practices known as Standard Precautions.

2. Standard Precautions are ~~a set of infection control practices~~ used to prevent transmission of disease that may be acquired by contact with blood, body fluids with non-intact skin, and mucous membranes.

3. Standard Precautions will be used during the care of all residents in all settings in which healthcare services are rendered regardless of suspected, confirmed, or presumed infection status.

PURPOSE:

The purpose of this policy is to provide guidance to healthcare workers for consistent implementation of Standard Precautions to prevent or reduce the spread of transmission of infectious microorganisms. This policy does not include every possible use of Standard Precautions but provides a basic summary of each type that is required by all staff during patient care.

DEFINITIONS:

Standard Precautions:

Standard Precautions are based on the principle that all blood, body fluids, secretions, excretions (except sweat,) nonintact skin, and mucous membranes may contain transmissible infectious agents. Standard Precautions include a group of infection prevention practices that apply to all patients, regardless of suspected or confirmed infection status, in any setting in which healthcare is delivered. These include~~:~~ hand hygiene; use of gloves, gown, mask, respirator, eye protection, or face shield, depending on the anticipated exposure; and safe injection practices. Also, equipment or items in the patient environment likely to have been contaminated with infectious body fluids must be handled in a manner to prevent transmission of infectious agents (e.g., wear gloves for direct contact, contain heavily soiled equipment, properly clean and disinfect ~~or sterilize~~ reusable equipment before use on another patient). (CDC, 2019)

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PROCEDURE:

1. Hand Hygiene

Hand hygiene is the single most important measure to prevent transmission of infection and is the cornerstone of an infection prevention and control (IPC) plan. When hands are

not visibly soiled, alcohol-based hand rubs (ABHRs) is the preferred method of hand hygiene. When hands are visibly soiled, washing hands with soap and water for at least 20 seconds is required.

Some microorganisms produce spores that are~~do~~ not destroyed by~~respond to~~ ABHRs. Therefore, hand hygiene is ~~to be~~ performed using soap and water when caring for residents with potentially or known infectious diarrhea (e.g. *Clostridioides difficile*, norovirus).

Hand hygiene (HH) will be performed at a minimum:

a. Before donning gloves

    i. Rationale: Decontamination of hands prior to donning gloves is necessary because gloves are not donned using sterile technique and contamination of the outside of the glove occurs when donning.

b. After removing gloves

    i. Rationale: Gloves may contain micro-tears that allow staff hands to be contaminated or the staff may contaminate their hands upon glove removal. Performing HH after removal gloves removes any potential contamination.

c. Before and after direct contact with a resident or resident's environment

d. Between each resident's care

e. Before performing an aseptic task

f. After any contact with blood, body fluids, non-intact skin, rashes, mucous membranes, or potentially contaminated items

2. Personal Protective Equipment (PPE)

PPE are designed to protect the wearers skin, eyes, mucus membranes, airways, and clothing from possible contact with infectious agents.

1. Proper PPE usage is based on the task being performed and the anticipated level of exposure.

2. PPE components maybe used alone (gloves) or in combination (gloves, gown, mask, and eye protection) to prevent exposure.

3. PPE should be properly fitted and donned to cover exposed areas completely.

4. In the event staff are unsure of the appropriate PPE to use, they should contact

their direct supervisor or the infection control team for guidance before performing a task.

5. PPE includes gloves, gown, masks, respirators, face shields, goggles, or other protective gear based upon job tasks.

6. PPE must be worn and used according to manufactures recommendations. PPE is not intended for extended use or reuse unless there is a significant shortage of supplies. In the event this occurs, communication will be sent out to impacted staff and education around contingency expectations provided.

7. Staff education around PPE use~~is~~ provided upon hire, annually, and as needed with PPE product changes and/or usages.

   a. **Gloves:** Perform hand hygiene prior to donning gloves and after removing gloves.

      i. Don gloves prior to performing tasks that require direct contact with a resident's non-intact skin, body fluids or mucus membranes or the resident's environment.

      ii. Gloves must be changed, and hand hygiene performed between tasks and procedures on the same resident after contact with material that may contain microorganisms (e.g. after perianal care or respiratory care procedures, and after care of any infected sites) that could be transferred to non-infected sites.

      iii. Change gloves when tears or holes are noted; perform hand hygiene and don new gloves

      iv. Remove contaminated gloves and perform hand hygiene prior to leaving the resident care area.

      v. Do not wear gloves or other PPE outside of resident care areas, including common areas unless under specific quarantine precautions or if there is a high risk of coming in contact with blood, body fluids, or infectious materials.

      vi. Perform hand hygiene immediately after removing gloves.

   b. Eye Protection: Face Shield/Goggles: eye protection with face shield is worn for high-risk procedures to cover mucous membranes of the eyes, nose and mouth for droplet-or airborne transmitted infections.

      i. During procedures and resident care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, or excretions.

      ii. When caring for residents with suspected or confirmed droplet-or airborne

transmitted infections, such as influenza or rhinovirus, or SarsCoV-2 (Covid 19).

c. Masks/Respirators:

i. **A respirator** (e.g. N95) is a specific type of mask that filters the air breathed in by the wearer of fine particles that may cause disease. A respirator is fitted to the wearer to provide optimum protection for respiratory infections that are categized as airborne (e.g. tuberculosis, COVID-19); fit-testing is required annually and as needed when facial characteristic change such as weight loss, facial hair, surgery etc. N95 respirators must be worn according to manufacturer's specifications for fitting with frequent seal checks performed by the wearer. Respirators are single use items and are not to reused or worn for extended use unless specifically directed (i.e., crisis/contingency standards of care are in place due to equipment and/or supply shortages.

ii. **An Isolation/Surgical Mask**: A hospital issued surgical mask is made to contain droplets and particles you breathe, cough, or sneeze out to prevent the spread of disease-causing organisms. A well-fitting surgical mask provides the wearer some protection from particles spread by others including Covid-19. Change masks when damp or soiled and between patients.

iii. Cloth masks are not considered PPE in a healthcare setting and may not be used in patient care areas.

iv. Staff will only use PPE (including masks and respirators) issued by the facility due to established quality and safety levels

d. **Isolation gowns**: Gowns are to be worn to protect clothing and prevent contamination and soiling of clothing during close contact or procedures likely to generate splashes or splatter of blood or other body fluids. Use an isolation gown when caring for residents with suspected or confirmed contact-transmitted infections, such as *Clostridioides difficile* or norovirus. Food service plastic aprons are not to be worn for any resident care. Gowns are single-use items and not to reused or extended for use unless specifically identified by an emergency response action.

3. Safe Injection Practices

Safe injection practices include the use of Standard Precautions, hand hygiene and appropriate PPE use. In addition, staff will utilize the CDC recommendation and best practice of One Needle, One Syringe, Only One Time. Staff will practice caution at all times when handling and/or disposing of needles and sharps including IV cannulas. All

staff using needle safety devices are to be educated regarding proper use on orientation and when a new device is introduced.

When using needles, scalpels, and other sharp instruments or devices:

a. Use needleless devices where possible

b. LHH will provide needles with built in safety features such as over-the-needle sheath protective devices or retractable needles

c. Do not bypass needle safety devices

d. Do not attempt to clean contaminated sharps or needles

e. Dispose of needles/sharps properly immediately after use in a puncture resistant bio-hazard designated box with self-closing lid; Needles and sharps are single-use only, including when using medication pens (e.g. insulin pens)

f. Place sharps container near work area to avoid excess walking with a contaminated needle or sharp

g. Do not overfill sharps containers; replace at the fill line and do not allow sharps to stick out. Replace sharps containers when ¾ full

h. Do not recap needles; in the event a needle must be recapped, use the one-handed scoop method or a mechanical device

i. Do not break off or bend needles

j. Do not remove contaminated needles from the hub

k. Do not re-use needles even with same resident; needles are a single one-time use device

l. Activate needle guards immediately after use

4. Practice Cough etiquette or Respiratory Hygiene

a. Covering the mouth/nose with a tissue when coughing (alternatively, cough into your elbow / sleeve and perform hand hygiene as soon as possible

b. prompt disposal of used tissues followed by hand hygiene

c. Hand hygiene after contact with respiratory secretions

d. using surgical masks on the coughing patient when tolerated and appropriate

e. spatial separation where feasible (6 feet)

f. Oral airways, resuscitation bags, and other ventilation devices are to be maintained in areas where the need for resuscitation is anticipated.

g. Direct mouth-to-mouth resuscitation is to be avoided

5. Environmental Controls

a. **Resident care equipment:** Used resident-care equipment soiled with blood or other body fluids is to be handled in a manner to prevent skin or mucous membrane exposures, and to prevent contamination of clothing or other objects.

   i. Reusable equipment that is soiled or potentially contaminated is not to be used for the care of another resident until it has been cleaned and disinfected appropriately.

   ii. Single use items are to be discarded immediately after use.

   iii. Resident care equipment that is used for multiple residents will be disinfected between use following the manufacturer's recommendations using an EPA registered hospital grade disinfectant wipe.

b. **Environmental cleaning:** Environmental cleaning will be performed according to the specific needs of the area/infection and per environmental cleaning policies. General environmental cleaning includes three levels of cleaning: Routine, Terminal and Scheduled cleaning. Environmental cleaning includes but is not limited to:

   i. General cleaning practices will be performed daily for resident care areas and common areas.

   ii. EPA-registered disinfectants will be used in accordance with the manufacturer's instructions

   iii. Keep housekeeping surfaces (e.g., floors, walls, and tabletops) visibly clean on a regular basis and clean up spills promptly

   iv. Clean and disinfect high-touch surfaces (e.g., doorknobs, bed rails, light switches, and surfaces in and around toilets in patients' rooms) on a more frequent schedule than minimal touch housekeeping surfaces.

   v. Detergent and water are adequate for cleaning surfaces in nonpatient-care areas (e.g., administrative offices) unless otherwise indicated

vi. Clean walls, blinds, and window curtains in patient-care areas when they are visibly dusty or soiled.

vii. Avoid dusting methods that disperse dust (e.g., feather-dusting).

viii. Cleaning should always start from the least soiled areas (cleanest) first to the most soiled areas (dirtiest) last and from higher levels to lower levels so that debris may fall on the floor and is cleaned last. Detergent and/or disinfectant solutions must be discarded after each use.

ix. Specific cleaning for additional transmission-based precautions will include but not be limited to high touch areas, frequent use resident items, horizontal surfaces, bathroom disinfection will follow specific infection precautions procedures for product and frequency of cleaning based on CDC recommendations

x. Specific cleaning and disinfection protocols are department-specific; refer to department-specific policies.

xi. Follow manufacture's recommendations for specialized equipment.

c. **Linen:** Used linen/laundry may be soiled with blood or other body fluids. Soiled linen/laundry is to be transported and handled in a manner to prevent skin or mucous membrane exposure and to prevent contamination of clothing or other objects.

i. Handle contaminated textiles and fabrics with minimum agitation to avoid contamination of air, surfaces, and persons
ii. Bag or otherwise contain contaminated textiles and fabrics at the point of use Do not sort or prerinse contaminated textiles or fabrics in patient-care areas

iii. Use leak-resistant containment for textiles and fabrics contaminated with blood or body substances
iv. Hold all linen away from body/uniform to prevent contamination.

v. Clean linen must remain covered on the cart when not in use.

vi. Do not move clean or soiled linens from one resident care area to another.

vii. Do not store clean linens in resident drawers/closets. Take only the linen needed for each resident in each room and discard unused linens in hamper before exiting room. Place unused linen found in common areas such as shower room in hamper and do not return to clean cart.

ATTACHMENT:

None.

REFERENCE:

LHHPP 72-01 B2 Hand Hygiene
LHHPP 72-01 B5 Transmission-Based Precautions and Resident Room Placement
LHHPP 72-01 F13 Cleaning and Disinfecting Non-Critical Resident Care Equipment
Association for Professionals in Infection Control & Epidemiology (APIC). (2013). *Infection Preventionist's Guide to Long-Term Care*. Washington DC, WA: Association for Professionals in Infection Control & Epidemiology.

Centers for Disease Control and Prevention (CDC) and the Hospital Infection Control Advisory Committee (HICPAC), 2007. Guideline for Isolation Precautions in Hospitals.

Occupational Safety and Health Administration (OSHA), 2012. Occupational Exposure to Blood borne Pathogens; Final Rule, Federal Register, 29 CFR Part 1910.1030.

CDC (2019). Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007). https://www.cdc.gov/infectioncontrol/guidelines/isolation/precautions.html#IIIa

Revised: 08/03/2022, 13/11/21, 16/01/12, 20/10/13, 22/09/13 2023/09/05 (Year/Month/Day)
Original adoption: 05/11/01

HAND HYGIENE

POLICY:

It is the policy of this facility to adhere to the infection prevention and control (IPC) practices for hand hygiene as established by the Centers for Disease Control & Prevention (CDC) to prevent the transmission of disease-causing illnesses to others. Gloves are not intended to be a replacement for proper hand hygiene. Hand hygiene will be performed at a minimum:

- Prior to beginning work shift
- Before eating
- After using the bathroom
- After sneezing/coughing/tissue use
- Before donning/doffing personal protection equipment (PPE)
    - PPE includes: gloves, gown, mask, face/eye shield

Before and after providing direct resident contact

- Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices
- Before moving from work on a soiled body site to a clean body site on the same patient
- After contact with blood, body fluids, or contaminated surfaces
- After touching a patient or the patient's immediate environment
- When hands are visibly soiled

PURPOSE:

The purpose of this policy is to provide information regarding hand hygiene practices and to guide staff in the use of proper hand hygiene standards at LHH. Proper hand hygiene has been identified as the single most important factor in reducing the transfer of infectious disease to others. Cross contamination and transfer of infectious organisms to from one person to another causing disease is well documented. Proper hand hygiene also includes proper drying of hands to avoid wet /damp hands during care which has been shown to increase the transfer of disease-causing microbes greater than a thousand times more than dry hands (MMWR, 2003).

PROCEDURE:

Hand Hygiene is the term used for thoroughly cleaning your hands by using either the soap and water technique for handwashing, using an antiseptic hand wash or antiseptic hand rub or gel (i.e. alcohol-based hand sanitizer [ABHR] including foam or gel), or by using the techniques for surgical hand antisepsis (CDC, 2021)

1. In the clinical setting, hand sanitizers must contain between 60%-95% isopropanol or ethanol alcohol to be effective at reducing infectious organisms.

2. Centers for Disease Control and Prevention (CDC) recommend ABHR as a primary means of hand hygiene because it is faster, usually contains emollients to prevent dried, cracked (non-intact) skin, and is likely to be used more frequently than soap and water. Soap and water must be used instead of ABHR for hand hygiene when:

- Caring for residents with *C. diff*, norovirus, potentially infectious diarrheal diseases, or other spore-forming organisms that do not respond to ABHR.
- When hands are visibly soiled.

Hand sanitizers/ABHR:

Mechanism of Action:

- The alcohol in hand sanitizers act to denature or destroy the proteins of the microorganism serving to inactivate their ability to cause disease

Procedure:

- Apply adequate product to the hands and rub hands and fingers together. Cover all surfaces on both hands, front and back, and between digits. Allow to air dry before donning gloves or providing care for others

Handwashing with soap and water:

Mechanism of Action:

- Soaps are detergent based and when combined with water form a soapy lather of bubbles. A good soapy lather forms pockets called micelles that trap and remove germs, harmful chemicals, and dirt from your hands.

Procedure:

- Roll up sleeves to expose skin above wrists
- Turn on faucet and wet hands with running water
- Use an adequate amount of liquid dispensed soap and thoroughly distribute over hands creating sudsing effect
    i. Vigorously rub hands together for at least 20 seconds, generating friction on all surfaces of the hands and fingers including the sides of the hands and fingers, between fingers, under fingernails, and around cuticles. Microbes are more prevalent on the tips of fingers and under the nails.
- Thoroughly rinse hands under running water without touching sink or faucet, holding hands downward to allow water to run off fingertips
- Adequately use paper towels to dry all surfaces of the hands and wrists including between each finger space as moisture harbors bacteria and can cause skin breakdown to allow entrance of organisms. Wet hands transfer more microorganisms than do dry hands. Take enough time to dry hands thoroughly.
- Using a paper towel, turn off faucet without touching surfaces of the sink or handles of faucet which are contaminated with disease causing organisms.
- Discard the paper towel into a waste container
    ii. Use a clean paper towel to open door, if appropriate, and discard

2. Important Points for LHH; Liquid soaps are recommended over bar soap as bar soaps can collect disease causing microbes over time. Plain soap is effective for hand hygiene and antimicrobial soaps are not necessary as the goal is to capture the microorganisms in the soap, not destroy them. Liquid soap dispensers must be replaced when empty. Liquid soap should not be added (or "topped off") to partially filled containers due to the potential for contamination and support of microbial growth.

3. Responsibility for monitoring staff hand hygiene compliance is a joint effort between the Infection Control, the Department Head or supervisor of each specific neighborhood or department.

Staff are responsible for complying with hand hygiene guidelines. Staff should report irritation, dermatitis or other skin weakening issues that may impact hand hygiene to their direct supervisor and infection control nurse for follow up and other options.

4. Hand lotion may be used to alleviate skin dryness associated with hand hygiene. Lotions are personal items and should not be stored in patient care areas.

5. Fingernails should be short enough to allow thorough cleaning and not cause glove tears. Artificial nails harbor bacteria, create wounds in fragile skin and do not conform to the LHH infection control protocol.

ATTACHMENT:
CDC hand hygiene resources and the APIC guide to glove use

REFERENCE:

CDC Hand Hygiene in Healthcare Settings for Healthcare Providers available at https://www.cdc.gov/handhygiene/providers/index.html

HICPAC and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force (2009). Guideline for Hand Hygiene in Health-Care Settings. MMWR (Morbidity and Mortality Weekly Report), Vol. 51, No. RR-16, October 2002 available at: https://www.cdc.gov/mmwr/PDF/rr/rr5116.pdf

World Health Organization (2009). WHO Guidelines on Hand Hygiene in Health Care available at:
https://www.who.int/teams/integrated-health-services/infection-prevention-control/hand-hygiene
~~http://whqlibdoc.who.int/publications/2009/9789241597906_eng.pdf~~

Revised: 14/09/09, 15/09/08, 20/10/13 22/09/30, 23/01/10, 23/09/05 (Year/Month/Day)
Original adoption: 05/11/01


TECHNIQUE MATTERS WHEN CLEANING YOUR HANDS
It only counts if you use the right amount, the right way.
Use enough alcohol-based hand sanitizer to cover all surfaces of your hands.
You might need more than one pump.
For alcohol-based hand sanitizer, your hands should stay wet for around 20 seconds if you used the right amount.
ALCOHOL-BASED HAND SANITIZER


Hands that look clean can still have icky germs!
1 Wet
2 Get Soap
SOAP
WASH YOUR HANDS!
3 Scrub
4 Rinse
5 Dry
www.cdc.gov/handwashing
CDC

ANTIBIOTIC STEWARDSHIP AND INFECTION CONTROL

POLICY:

An integrated approach for the control of emerging antibiotic resistance will be conducted through the antibiotic stewardship team with ongoing collaboration and cooperation of Medical Services, Pharmacy, Infection Prevention and Control, (,(IPC) Infection Control Committee (ICC), and Pharmacy and Therapeutics Committee.

PURPOSE:

1. The purpose of the antibiotic stewardship program (ASP) is to provide oversight and guidance to ensure thefor appropriate use of antimicrobials. Efforts should be focused on the reduction of , reduce empirically-prescribed antimicrobials which canthat promote broad spectrum overuse,use, and to reduce the total number of antibiotic days, to prevent drug resistant infections and to improve infection related outcomes.

2. The role of the IPC (Infection Prevention and Control) in the antibiotic stewardship program is to support the ASP program providing expertise and consulting services for identification of knowledge and skill gaps for educational and compliance purposes, garnering support from front line staff and provide data for the antibiotic stewardship committee.

PROCEDURE:

1. Utilize the CDC Core Elements for Antibiotic Stewardship in Nursing Homes to drive improvement activities. These include, Leadership Commitment, accountability, drug expertise, action, tracking, reporting, and education.
1. 2. Example activities include: Providing regularProvide healthcare associated infection data to partners and stakeholders Assistingfor the ASP proposals to garner for C-Suite support.
2. Assist ASP team members with data analysis and sharing(data) presentation
3. EnsuringPartnering with the facilityresponsible department, work to ensure the antibiogram reflects current resistance/susceptibility trends and is published timely and accessible to providers.
4. Support management and staff to analyze ICP concerns, and help to mitigate IPC issues
5.4. Educate nursing services personnel in collaboration with department of education team (DET)
6.5. Assist with and develop educational material for providers. and staff
7.6. Observe prescribing practices.practice while rounding
8.7. Provide feedback/recommendations based onRound with the teams to prevent inappropriate antibiotic use and trends

~~9.~~8. Reporting~~Report~~ HAI surveillance data and practice measures to the ASP team that may affect activities of the ASP (increasing drug resistant microorganisms, local outbreaks etc.)

~~10.~~Develop antibiotic use~~Report and communicate health department outbreak data with the ASP team as appropriate~~

~~11.~~9. ~~Assist with the development of~~ algorithms for common infections to streamline the **a**ntibiotic ordering process.~~antibiotics, order sets for clinical staff, or order entry criteria **to** decrease antibiotic use~~

ATTACHMENT:
None.

REFERENCE:
LHHPP 25-07 Antimicrobial Stewardship Program
UCSF/ZSFG/LHH Lexicomp® e-Formulary available at:
http://www.crlonline.com/lco/action/home/switch
Joint UCSF/ZSFG/VASF Infectious Diseases Management Program (IDMP) available at:
https://idmp.ucsf.edu/guidelines-empiric-antimicrobial-therapy

Manning, M. L., & Pogorzelska-Maziarz, M. (2018). Health care system leaders' perspectives on infection preventionist and registered nurse engagement in antibiotic stewardship. *American journal of infection control*, *46*(5), 498–502. https://doi.org/10.1016/j.ajic.2017.10.024

Perri, L. (2017). The infection preventionist's role in antimicrobial stewardship programs. Infection Control Today. Retrieved October 17, 2022 from https://www.infectioncontroltoday.com/view/infection-preventionists-role-antimicrobial-stewardship-programs

Centers for Disease Control and Prevention (2021). Core Elements of Antibiotic Stewardship for Nursing Homes. Retrived on September 5th 2023 from: Core Elements of Antibiotic Stewardship for Nursing Homes | LTCF | CDC

Revised: 16/01/12, 18/11/13, 20/10/13, 23/01/10 2023/09/12 (Year/Month/Day)
Original adoption: 05/11/01

INFECTION CONTROL POST-MORTEM CARE GUIDELINES

POLICY:

Laguna Honda Hospital (LHH) will adhere to post-mortem care guidelines in accordance with Standard Precautions and transmission-based precautions as appropriate to minimize the transmission of infectious pathogens.

Any specific specimens required during post-mortem care for decedents that are diagnosed with a suspected or confirmed infectious disease will be obtained at the mortuary or by trained professionals under the direct guidance of the treating provider and in consultation with the local/state health department(s).-

PURPOSE:

Post-mortem care is provided for the purpose of preparing the decedent's body for a dignified viewing period by the family/significant others at the bedside immediately following death. This time may be used for mourning as part of a mental health transition, for religious, spiritual, or for cultural traditions and rituals. In addition, post-mortem care is useful for preserving the body for the mortuary staff.

Observing the proper use of personal protective equipment (PPE) is an essential element for post-mortem care by staff even after death has occurred. Standard Precautions will be observed when caring for any resident including those who are deceased. Any transmission-based precautions that are in effect at the time of death will continue to be observed with the appropriate PPE until the body has been transported to the morgue.

PROCEDURE:

1. Post-mortem care is outlined in the LHHPP Nursing PolicyFile: D8.0 Post-Mortem Care.

2. The attending physician of a deceased resident will notify the funeral director of any reportable communicable disease present at the time of death.

3. The attending physician or properly trained clinical staff memberrespiratory therapist will collect any post-mortem specimens that are required by SFDPH in a Health Order issued by the San Francisco Health Officer or other formal communication methods.

4. Nursing staff performs basic post-mortem care following the death of a resident whichthat includes removing indwelling devicesvisible tubes, bathing, and other tasks to prepare the body for viewing and pick up by the morgue. .. using all proper Standard and appropriate Transmission-based precautions.

~~5. Airborne /Droplet precautions such as masks/respirators may not be required by HCP as there is no exhaling of infectious material from the decedent that may transmit the disease.~~

~~6. If applicable, Contact and blood/body fluid precautions should continue to be observed during post mortem care and noted on records for transfer to mortuary.~~

ATTACHMENT:
None.

REFERENCE:
NPP D8.0 Post-Mortem Care

Revised: 15/09/08, 20/10/13, 23/01/10 2023-09-12 (Year/Month/Day)
Original adoption: 05/11/01

GENERAL INFECTION CONTROL VISITOR GUIDELINES

POLICY:

1. This facility will implement heightened surveillance activities for communicable disease during periods of transmission in the community, an outbreak in the facility, and/or during a declared public health emergency for the illness. The facility may modify visitation practices when there are infectious outbreaks or pandemics to align with current CMS guidance and CDC guidelines. Visitors will be expected to follow general infection control practices to protect a vulnerable population when visiting the facility. Visitation will always be permitted ~~at all times~~ with very limited exceptions to ensure that resident's rights are respected and prioritized.

PURPOSE:

The purpose of this policy is to provide information to minimize the transmission risk of infection from the community to the patients by using general control measures including hand hygiene, respiratory hygiene, vaccinations and masking to reduce the risk of disease transmission. When in the facility, visitors are expected to adhere to the core principles of infection prevention and follow the local, state, and federal requirements when outbreaks occur.

DEFINITION:

Visitor: For the purpose of this policy a visitor is defined as anyone who is not performing work in the facility at the request of the facility, whether paid or unpaid.

PROCEDURE:

1. Visitors that are Ill: Signage will be posted at entrances that indicate that visitors with a fever, respiratory, or gastrointestinal symptoms shall be asked to refrain from visiting LHH until they are afebrile for at least 24 hours (without the use of fever-reducing medication) and symptoms have resolved for at least 24 hours.

2. Practice Hand Hygiene: Visitors shall be encouraged to practice proper hand hygiene by staff and through signage placed throughout the facility and on neighborhoods conveying the importance of hand hygiene, how to do it correctly, and to perform hand hygiene frequently. Refer to LHHPP 72-01 B2 Hand Hygiene.

3. Transmission-based Precautions: A resident on additional transmission-based precautions will have signage placed outside the room alerting individuals prior to entering. Nursing shall explain the transmission-based precautions to the visitor before they enter the room for the first time and if further education and clarification is needed. Visitors will be asked to follow the personal protective equipment (PPE) requirements for the transmission-based precautions indicated by the signage when providing or assisting with patient care and reminded to practice hand hygiene upon

entering and exiting resident rooms. Visitors who fail to follow infection control requirement may be asked to leave the facility.

4. Annual Influenza Vaccine: Visitors shall be encouraged to get an annual influenza vaccine, which is recommended by Centers for Disease Control and Prevention (CDC) annually for everyone 6 months and older to protect against the influenza virus. Signage regarding the importance of a flu vaccine, respiratory/cough etiquette, and the mandatory masking period during the influenza season shall be visible throughout the facility and on neighborhoods.

    a. Masking: Visitors who have not received the current year's flu vaccine OR visitors vaccinated with the live attenuated influenza vaccine (LAIV) within 7 days shall be asked to wear a mask anytime s/he is within 6 feet of a resident. SFDPH continues to require~~California requires~~ masking by all~~al~~ individuals entering high risk settings. CDC has determined that those who receive the LAIV or "nasal spray" should avoid contact with immunocompromised persons for 7 days after getting the nasal spray vaccine.

    b. Practice Respiratory Hygiene: Visitors shall be asked to cover coughs and sneezes with a tissue. If tissues are not available, cover coughs and sneezes with the sleeve. Clean hands by using an alcohol-based hand rub or washing hands with soap and water immediately after.

Rare Exceptions and Limitations:

1 Visitation Alternatives: visitors may be asked and LHH will provide other forms of visitation including tele-visits, video visits, or outdoor visits for specific needs during a limited time to control disease transmission.

2. Holiday/High Volume Visitation: every effort will be made to provide a safe space for visitation during periods of high volume such as holidays. However, some accommodations may be required including staggering visiting hours to ensure physical distancing during outbreaks.
3. Compassionate Care Visitation: considerations will be made on a case-by-case basis to provide for a safe and compassionate visitation for all residents based upon their individual needs.

4. Outbreak Guidance: In the event of an outbreak/epidemic in the facility or community, more restrictive guidance may be implemented including but not limited to severe respiratory outbreaks such as Covid-19. Specific protocol management will be provided during pandemics.

ATTACHMENT:
Screening Signage

REFERENCE:

LHHPP 72-01 A8 Outbreak/Epidemic Investigation Protocol
LHHPP 72-01 B1 Standard Precautions
LHHPP 72-01 B2 Hand Hygiene
LHHPP 72-01 B5 Transmission-Based Precautions and Resident Room Placement
CDC Influenza (Flu) available at: https://www.cdc.gov/flu/index.htm
CDC Live Attenuated Influenza Vaccine [LAIV] (The Nasal Spray Flu Vaccine) available at: ~~https://www.cdc.gov/flu/about/qa/nasalspray.htm~~ https://www.cdc.gov/flu/prevent/nasalspray.htm
CMS: QSO-20-39-NH (revised 09/23/22). Nursing Home Visitation COVID-19 Revised

Revised: 16/09/13, 19/03/12, 20/10/13 22/09/29, 22/12/13, 2023/09/05 (Year/Month/Day)
Original adoption: 05/11/01

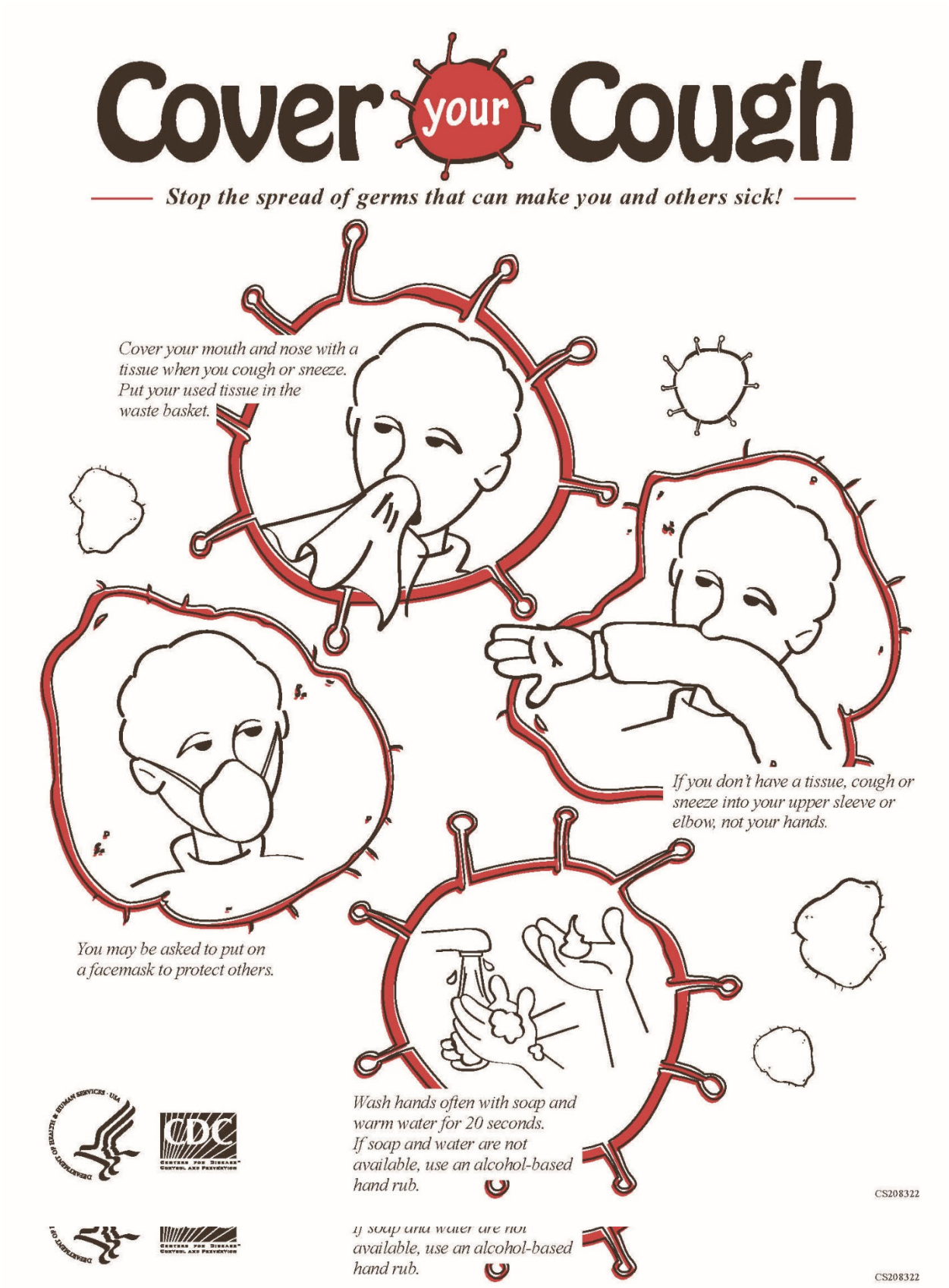
Attachment A: Get Vaccinated ~~Visitor Sign~~

Attachment B: Clean Hands Count – Hand Hygiene

Attachment C: Clean Hands Count for Everyone – Hand Hygiene

Attachment D: Clean Hands Count for Your Protection – Brochure

Attachment E: Cover Your Cough



RESPIRATORY HYGIENE/COUGH ETIQUETTE

POLICY:

1. Staff, residents, and visitors will practice respiratory hygiene, also known as cough etiquette, when in the facility. Practicing respiratory hygiene/cough etiquette has been shown to reduce the risk of transmission of respiratory microorganisms that are spread through droplets and aerosolized spray when talking, sneezing, singing, or coughing.

PURPOSE:

The purpose of this policy is to provide guidance for when and how to practice respiratory hygiene/cough etiquette to interrupt the spread of infection from the respiratory secretions.

Respiratory infections spread primarily through coughing and sneezing, are the leading cause of illness, morbidity, and mortality around the globe. Respiratory pathogens are easily transmitted between people. Despite the high virulence, these illnesses are preventable with good respiratory hygiene practices including but not limited to cough etiquette when used in conjunction with hand hygiene, social distancing, and protective masks.

Most infectious agents transmitted via large respiratory droplets through coughs and sneezes generally travel in a 3-foot radius of an infected person and quickly drop to the ground. However, aerosolized sprays, such as a sneeze, are much smaller in size and can travel up to 6 feet. These smaller particles can be transmitted on dust particles that “hang” longer in the air thus permitting more opportunities to come into contact with eyes, mouth, and nose to infect others.

If tolerated~~able~~, a surgical mask (source mask) may be used for patients who are coughing/sneezing to minimize exposure to respiratory secretions to others.

PROCEDURE:

1. Signage is posted for instructions for residents, staff, and visitors to practice respiratory hygiene/cough etiquette when in the facility and to encourage staying home if not feeling well. Instructions include, but are not limited to:

    a. Covering the mouth and nose with tissue when coughing or sneezing.

    b. Properly dispose of tissue in a waste container and perform hand hygiene.

    c. If no tissue is immediately available, the cough or sneeze particles can be directed into the upper sleeve or elbow but not directly into the hands.

d. Perform hand hygiene immediately either with soap and water or alcohol-based hand rub (ABHR).

e. Staff will wear a surgical mask (source control) when providing direct resident care if sneezing or coughing.

f. Ill staff should refrain from working and contact their direct supervisor for guidance.

g. Horizontal surfaces can become contaminated with respiratory secretions as droplets land and have been shown to survive on these surfaces for several hours. Touching contaminated surfaces and then touching mucous membranes or open wounds can transmit the pathogens. Cleaning surfaces frequently with an EPA registered disinfectant can stop the transmission of infection.

2. During periods of increased respiratory infection activity in the community offer masks to persons who are coughing. Surgical masks may be used to contain respiratory secretions. Respirators, such as a N95, are not necessary for this purpose unless specific guidance is received from local or state health department during a respiratory outbreak. In the event that occurs, staff, residents and families will be educated regarding expectations.

3. Encourage residents with respiratory symptoms to stay inside their room if possible. If non-compliant, encourage resident to physically distance from others by sitting at least six feet away from others in common areas

4. ABHR stands are available at entrance to the facility and neighborhood for residents, staff, and visitors.

5. Daily cleaning and disinfection of horizontal surfaces in the resident's environment is required. For those who are unable or unwilling to practice hand hygiene and cough etiquette for respiratory secretions, additional cleaning may be required. Use an~~and~~ Environmental Protection Agency (EPA) approved disinfectants and cleaners.

ATTACHMENT:
None.

REFERENCE:
LHHPP 72-01 B1 Standard Precautions
LHHPP 72-01 B2 Hand Hygiene
LHHPP 72-01 B5 Transmission-Based Precautions and Resident Room Placement
LHHPP 72-01 B14 Visitors Guidelines for Infection Prevention
LHHPP 72-01 C26 Guidelines for Prevention and Control of Tuberculosis

Chavis, S., & Ganesh, N. (2019). Respiratory Hygiene and Cough Etiquette. *Infection Control in the Dental Office: A Global Perspective*, 91–103. https://doi.org/10.1007/978-3-030-30085-2_7
CDC. (2009, August 1). Respiratory Hygiene/Cough Etiquette in Healthcare Settings | CDC. Retrieved August 22, 2020, from ~~https://www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm~~ https://www.cdc.gov/infectioncontrol/guidelines/viral/prevent-viral.html

Revised: 20/10/13, 23/01/10, 2023/09/06 (Year/Month/Day)
Original adoption: 12/05/22

ISOLATION CARTS

POLICY:

1. Laguna Honda Hospital (LHH) will maintain a sufficient supply of mobile isolation carts in Central Processing Department (CPD) for deployment to neighborhoods when transmission-based precautions are implemented.

2. Pre-filled mobile isolation carts allow staff to implement specific precautions quickly and provide the proper personal protective equipment (PPE) based on resident need for point-of-care access.

3. Isolation carts are not necessary for isolation rooms with anterooms where adequate supply storage is available. Clinical staff in each unit should monitor PPE use and restock mobile isolation carts to ensure adequate supplies and sizes.

4. Mobile isolation carts must remain outside the room near the door entrance and are not to be moved inside the room for use. Cart labels and/or isolation signage will not contain any protected health information (PHI.) Carts should house the appropriate transmission-based precautions sign, not the specific organism or disease.

PURPOSE:

The purpose of this policy is to provide instructions on the procurement and use of isolation carts when use of Transmission-based precautions is required.

BACKGROUND:

Isolation carts provide a safe and clean portable storage base for adequate supply and point-of-care access for staff for the proper PPE for residents who have been placed on transmission-based precautions. Isolation carts provide quick access to PPE and help prevent cross contamination of supplies. Adequate PPE supplies in multiple sizes and at the point of care promotes safe use to reduce the transmission of microorganisms.

PROCEDURE:

1. Patients placed on transmission-based precautions (TBP) will prompt the charge nurse to contact CPD and request delivery of an isolation cart to the neighborhood.

2. Prior to deployment, the isolation cart will be prepared by CPD technicians by disinfecting and stocking the cart with PPE: disposable gowns, gloves in various sizes, surgical masks, face shields, goggles, and disinfectant wipes. Specific individualized PPE such as respirators (e.g. N95, PAPR units) will not be placed on the cart but will be obtained by stock supplies on the unit to meet specific fit-testing criteria.

3. Isolation carts are placed outside the residents' rooms and are to be kept clean and stocked by Nursing while in use until the TBP are discontinued.

4. Health care personnel (HCP) and others must perform HH prior to touching items on the cart for use.

5. If any items on the cart appear contaminated (wet, dirty, dust, debris) the item should be discarded and replaced.

6. Laminated transmission-based precautions signage will be found in the ~~top drawer of the~~ cart for placing on the resident's door front at room entrance by Nursing.

7. After transmission-based precautions have been discontinued, the charge nurse or designee will contact CPD for cart retrieval from the neighborhood. Prior to leaving the unit, Nursing will clean the exterior of the cart with EPA approved disinfectant wipes prior to returning the cart to CPD technicians. If the room requires a terminal clean, the cart should remain in place until after EVS cleans the room.

8. CPD technicians will return the cart to CPD for further disinfection of cart exterior and interior, restock the cart and prepare it for use.

9. For inventory tracking of carts, CPD technicians will ensure that each isolation cart is equipped with a~~an~~ tracking inventory tag.

ATTACHMENT:
None.

REFERENCE:
LHHPP 72-01 B1 Standard Precautions
LHHPP 72-01 B5 Transmission-Based Precautions and Resident Room Placement
LHHPP 72-01 F13 Cleaning and Disinfecting Non-Critical Resident Care Equipment
California Department of Public Health (CDPH) Enhanced Standard Precautions for Skilled Nursing Facilities (SNF), 2019 available at:
https://www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/Enhanced-Standard-Precautions.pdf

Revised: 18/11/13, 20/10/13, 23/01/10, 2023/09/06 (Year/Month/Day)
Original adoption: 13/11/21

PEDICULOSIS (LICE) MANAGEMENT

POLICY:

1. Admission screening is performed, including observing the skin and hair for abnormalities that may including evidence of lice infestation.

2. The Infection Control Nurse is to be informed of suspected or confirmed cases of lice for room placement options. Private room with a private bathroom is preferred.

3. Contact Precautions should be implemented when lice is suspected or confirmed and continued for 24 hrs. post-treatment. Re-treatment may be needed 9-10 days after initial treatment but Contact Precautions are not required after the initial treatment.

DEFINITONS:

There are three (3) distinct types of lice that are human parasites: body lice, head lice and pubic lice. Treatments will be specific to the type of lice after a diagnosis is made by a healthcare professional trained in identifying. Life cycle stages are important considerations for treatment options.

1. Live Cycle Stages:

    a. **Nits**: Nits are lice eggs. They can be hard to see and are found firmly attached to the hair shaft. They are oval-shaped and very small (about the size of a knot in thread), hard to see, and are usually yellow to white.

    b. **Nymph**: A nymph is an immature louse that hatches from the nit. A nymph looks like an adult head louse but is smaller.

    c. **Adult**: An adult hair and body louse is about the size of a sesame seed, has six legs, and is tan to grayish-white in color. An adult pubic louse resembles a miniature crab when viewed through a strong magnifying glass. Pubic lice have six legs; their two front legs are very large and look like the pincher claws of a crab. Pubic lice are tan to grayish-white in color.

2. Transmission and Disease:
    a. Head and pubic lice are not known to spread disease. The itching may lead to excessive scratching that can sometimes increase the chance of a secondary skin infection.
    b. Body lice can spread epidemic typhus, trench fever, and louse-borne relapsing fever, all which are no longer widespread.
    c. Body Lice: Spread through direct physical contact with a person who has body lice or through contact with articles such as clothing, beds, bed linens, or towels that have been in contact with an infested person.

d. Head Lice: Usually spread by head-to-head contact with an already infested person. Head lice can also be spread by sharing clothing or belongings. This happens when lice crawl, or nits attached to shed hair hatch, and get on the shared clothing or belongings.

e. Pubic Lice: Usually spread through sexual contact. Pubic lice can also be spread by close personal contact or contact with articles such as clothing, bed linens, or towels that have been used by an infested person.

3. Signs and symptoms

a. **Body Lice**: Intense itching or pruritus and rash caused by an allergic reaction to the louse bites are common symptoms. When body lice infestation has been present for a long time, heavily bitten areas of the skin can become thickened and discolored, particularly around the midsection of the body (waist, groin, upper thighs);
b. **Head Lice**: Tickling feeling of something moving in the hair, itching caused by an allergic reaction to the bites of the head louse, irritability and difficulty sleeping as head lice are most active in the dark, and sores on the head caused by scratching.
c. **Pubic Lice**: Itching in the genital area and visible nits (lice eggs) or crawling lice.

PURPOSE:

To promptly identify, treat, and report lice infestations to prevent transmission to others.

PROCEDURE:

Head Lice :

1. Do not transmit communicable diseases
2. Do not jump or fly; they can only crawl.
3. Prevalence of infestation is no different in individuals with long hair than in those with short hair; cutting hair is not necessary to control head lice
4. Seldom occur on eyebrows or eyelashes
5. Infest persons from all socioeconomic levels, without regard for age, race, sex or standards of personal hygiene.
6. Do not come from animals or pets
7. Not usually spread by contact with clothing (such as hats, scarves, coats) or other personal items (such as combs, brushes, or towels).
8. Is diagnosed best by finding a live nymph or adult louse on the scalp or hair of a person.
    a. Because nymphs and adult lice are very small, move quickly, and avoid light, they can be difficult to find.

b. Use of a magnifying lens and a fine-toothed comb may be helpful to find live lice.

9. Can also be diagnosed if crawling lice are not seen. Finding eggs (also called nits) firmly attached within a 1/4 inch of base of the hair shafts strongly suggests, but does not confirm, that a person is infested and should be treated.
10. Eggs ~~(also called nits)~~ that are attached more than 1/4 inch from the base of the hair shaft are almost always dead or already hatched.
11. Eggs are often confused with other things found in the hair such as dandruff, hair spray droplets, and dirt particles.
12. If no live nymphs or adult lice are seen, and the only eggs found are more than 1/4 inch from the scalp, the infestation is probably old and no longer active and does not need to be treated.
13. Diagnosis should be made by a healthcare provider, or other person trained to identify live head lice.

Treatment for HEAD LICE

1. Staff who are pregnant or nursing should not encounter~~come into contact with~~ topical medications containing Malathion~~malathion~~, Check the labels for ingredients and consider non-pregnant/ non-nursing staff for treatment options.
2. Treatment for head lice is recommended for patients diagnosed with an active infestation
3. Before applying treatment, remove clothing that can become wet or stained during treatment and use a hospital gown during treatment period.
4. Do Not shampoo hair prior to treatment; Follow the directions on the label. Many treatments must be applied to dry hair.
5. Don proper PPE including gown and gloves for Contact Precautions
6. Obtain lice medicine, also called pediculicide and use as directed.

    a. Review the directions contained in the box or printed on the label prior to beginning treatment; do not assume all treatments are the same as treatments vary by manufacturers.
    b. Improper application may result in the medication not being effective
    c. A second bottle of pediculicide may be required for very long hair (greater than shoulder length). Obtain a second bottle before beginning treatment if indicated.
    d. Follow the directions closely on the label or in the box regarding how long the medication should be left on the hair and how it should be washed out, usually after 8-12 hours .
    e. Use the full amount listed on the label to treat; do not attempt to “save” or “split the dose” of the medication
        i. Not using the proper amount may lead to the treatment not completely killing the lice

f. For liquid medications/lotions: generally, coat the hair until thoroughly wetted with the medication being particularly careful behind the ear and on the back of the head and neck
g. The manufacturer generally recommends leaving the medication on the hair, uncovered, for 8–12 hours.
h. Allow the hair to dry naturally; do not use an electrical heat source, including a hair dryer or curling iron while the hair is wet.
i. Do not cover the head with plastic or shower caps
j. Shoulders should be covered with a towel to prevent dripping
k. Have the patient put on clean clothing once the medication has been applied / dry.
    i. Consider treating just before bedtime allowing time for the lotion/medication to dry before retiring to bed, depending on hair length
    ii. Do not place medication / lotion on other areas of hair on the body (eyebrows, pubic area, chest, under arms)
    iii. Avoid medication near eyes
l. Remove and discard PPE after treatment; perform HH
m. In 8-12 hours or next morning, Don PPE for Contact Precautions prior to continuing treatment including gown and gloves
n. After 8–12 hours thoroughly shampoo the hair (the shower is preferred)
    i. rinse well and
    ii. use a fine-toothed nit comb, usually included in the package, to remove dead lice and nits from the hair.
    iii. if a second treatment is required, the physician will need to re-order the second application, either the same or a different type and use according to manufacturer's~~manufacturers~~ directions
o. Have the patient wear clean clothes and change the bed linens before re-entering the bed

7. **Retreatment of head lice**
    a. Is usually is recommended 9-10 days after initial treatment because no approved pediculicide is completely ovicidal (able to kill unhatched nits).
    b. To be most effective, retreatment should occur after all eggs have hatched but before new eggs are produced.
    c. The retreatment schedule can vary depending on the pediculicide used. Follow the directions on the label/ manufacturers directions.

8. **Laundry and EVS Measures:**

    a. Machine wash and dry clothing, bed linens, and other items that the patient wore or used during the 2 days before treatment using the hot water ~~(130°F)~~ laundry cycle and the high heat drying cycle.

b. Clothing and items that are not washable can be dry–cleaned **OR** sealed in a plastic bag and stored for 2 weeks.
c. Soak combs and brushes in hot water ~~(at least 130°F)~~ for 5–10 minutes. Do not share combs.
d. Vacuum the floor and furniture, particularly where the infested person sat or lay. However, the risk of getting infested by a louse that has fallen onto a rug or carpet or furniture is very small. Head lice survive less than 1–2 days if they fall off a person and cannot feed;
e. Nits cannot hatch and usually die within a week if they are not kept at the same temperature as that found close to the human scalp.
f. Do not use fumigant sprays; they can be toxic if inhaled or absorbed through the skin.

9. Document in the electronic health record procedures, medications used, description of the resident's skin and reaction to treatment. Record and describe any allergic symptoms.

10. If the resident has a reaction to treatment, nursing completes an Unusual Occurrence report. Include hair and skin description and any medication prescribed. If this is a newly admitted resident, include the name of the facility and the unit the resident came from.

Body Lice Treatment

~~a.~~ 1. Improved hygiene and access to regular changes of clean clothes is the only treatment needed for body lice infestations.

~~b.~~ 2. Contact Precautions will be in effect until the IP nurse/ team collaborate with the physician when precautions may be discontinued.

Pubic Lice Treatment

1. Contact Precautions should be in effect during the treatment period; Contact the IP nurse/ team to collaborate with physician when precautions may be discontinued
2. Treatments should be initiated as soon as possible after diagnosis is made
3. Don appropriate PPE for Contact Precautions including gown and gloves
4. Wash the infested area; towel dry.
5. Carefully follow the instructions in the package or on the label. Thoroughly saturate the pubic hair and other infested areas with lice medication. Leave medication on hair for the time recommended in the instructions. After waiting the recommended time, remove the medication by following carefully the instructions on the label or in the box.
6. Following treatment, most nits will still be attached to hair shafts. Nits may be removed by using a fine-toothed comb.
7. Have the patient put on clean underwear and clothing after treatment.

8. To kill any lice or nits remaining on clothing, towels, or bedding, machine-wash and machine-dry those items that the infested person used during the 2–3 days before treatment. Use hot water ~~(at least 130°F)~~ and the hot dryer cycle.
9. Items that cannot be laundered can be dry-cleaned or stored in a sealed plastic bag for 2 weeks.
10. All sex partners from within the previous month should be informed that they are at risk for infestation and should be treated.
11. Persons should avoid sexual contact with their sex partner(s) until both they and their partners have been successfully treated and reevaluated to rule out persistent infestation.
12. Repeat treatment in 9–10 days if live lice are still found.
13. Persons with pubic lice should be evaluated for other sexually transmitted diseases (STDs).
14. For lice or nits on the eyelashes, careful application of ophthalmic-grade petrolatum ointment to the eyelid margins 2–4 times a day for 10 days is effective. Regular petrolatum (e.g., Vaseline)* should not be used because it can irritate the eyes if applied.

ATTACHMENT:
None.

REFERENCE:
Centers for Disease Control and Prevention Lice available at:
https://www.cdc.gov/parasites/lice/index.html
Centers for Disease Control and Prevention Photograph of Actual Size of the Three Lice Forms Compared to a Penny available at:
https://www.cdc.gov/parasites/images/lice/headlice_penny.jpg
Centers for Disease Control and Prevention Body Lice available at:
https://www.cdc.gov/parasites/lice/body/index.html
Centers for Disease Control and Prevention Head Lice available at:
https://www.cdc.gov/parasites/lice/head/index.html
Centers for Disease Control and Prevention Pubic Lice available at:
https://www.cdc.gov/parasites/lice/pubic/index.html

Revised: 16/07/12, 19/03/12, 20/10/13, 23/01/10 2023/09/13 (Year/Month/Day)
Original adoption: 05/11/01

PNEUMOCOCCAL IMMUNIZATION

POLICY:

1. Laguna Honda Hospital (LHH) residents who meet the established Centers for Disease Control and Prevention (CDC) clinical criteria shall be screened or evaluated for the pneumococcal polysaccharide vaccine and/or pneumococcal conjugate vaccine as defined by most current pneumococcal vaccine recommendations.

2. Before offering the pneumococcal vaccine, the resident or responsible party can~~has the opportunity to~~ refuse the immunization.

3. The resident's electronic health record will include documentation indicating education provided and if the resident received the pneumococcal immunization or did not due to medical contraindication or refusal.

PURPOSE:

To reduce morbidity and mortality from pneumococcal diseases, residents who meet the clinical criteria established by the CDC will be vaccinated with the appropriate pneumococcal vaccine(s).

PROCEDURE:

1. The physician assesses resident eligibility for vaccination. A reasonable attempt will be made to determine prior vaccination history. Residents~~Resident~~ with unknown or unsure vaccination status will be considered unimmunized. For those not vaccinated, the reason will be documented.

2. The physician screens residents for contraindications and precautions to administer the pneumococcal vaccine:

   a. **Contraindications**: History of a serious allergic reaction (e.g. anaphylaxis) after a previous dose or severe allergy to any component of the pneumococcal vaccine.

   b. **Precautions**: Moderate or severe acute illness with or without fever. Consider vaccinating the residents after they have recovered unless the physician deems the risks~~benefits~~ of vaccination ~~to~~ outweigh the benefits~~risks~~.

3. The physician orders the appropriate pneumococcal vaccine.

4. The licensed nurse shall provide the resident or responsible party with the current Vaccine Information Statement (VIS) for the appropriate pneumococcal vaccine prior to administering the vaccine.

5. The licensed nurse documents the resident's vaccine administration and education provided in the electronic medical record. If the vaccine was not given, document the reason(s) it was not administered.

6. Nursing completes an Unusual Occurrence report and documents on the electronic health record if there are any unexpected or significant adverse events to the vaccine.

ATTACHMENT:
None.

REFERENCE:
Department of Health and Human Services, Centers for Medicare and Medicaid Services, Federal Register/Vol 70, No. 194, 42 CFR Part 483 Medicare and Medicaid Programs, Condition of Participation: Immunization Standard for Long Term Care Facilities.
CDC Pneumococcal Vaccine Recommendations available at:
https://www.cdc.gov/vaccines/vpd/pneumo/hcp/recommendations.html
CDC Pneumococcal Vaccination: Summary of Who and When to Vaccinate available at:
https://www.cdc.gov/vaccines/vpd/pneumo/hcp/who-when-to-vaccinate.html.
CDC Pneumococcal ACIP Vaccine Recommendations available at:
https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/pneumo.html
CDPH Pneumococcal Disease available at:
https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/Pneumococcal-Disease.aspx
CDC Vaccine Information Statements (VIS) available at:
https://www.cdc.gov/vaccines/hcp/vis/index.html
Immunization Action Coalition Vaccine Information Statements available at:
https://www.immunize.org/vis/

Revised: 11/07/26, 17/09/12, 19/03/12, 19/05/14, 20/10/13, 23/05/09 (Year/Month/Day)
Original adoption: 05/11/01

EMPLOYEE INFLUENZA VACCINATION

POLICY:

1. Laguna Honda Hospital (LHH) is required to adhere to the California state law (SB739) requiring hospitals and like facilities to offer influenza vaccines free of cost to all employees. Employees are required to either receive the annual influenza vaccine or sign a declination statement and follow additional precautions during periods of high viral circulation.

2. LHH will adhere to the local health department, San Francisco Department of Public Health (SFDPH), that requires all San Francisco hospitals, skilled nursing facilities, and other long-term care facilities to implement mandatory masking of unvaccinated employees in patient care areas during the defined influenza season for the current season.

3. All LHH employees shall be provided an influenza vaccine, unless medically contraindicated during the influenza season as defined by the local health department.

4. Directors, supervisors, and managers are responsible for enforcing and monitoring masking compliance by unvaccinated employees during the influenza season.

5. Repeated non-compliance with masking by an unvaccinated employee during the influenza season may result in disciplinary action as defined by the Human Resources departmental procedures for repeated non-compliance.

PURPOSE:

1. Provide explicit standards for all employees regarding required documentation of influenza vaccination or influenza vaccine declination.

2. Ensure directors, supervisors, and managers are informed of required influenza vaccination or declination procedures for the current influenza season. This communication can be conveyed, but is not limited to, the following methods: email, intranet web postings, meetings, memorandums, signage throughout the facility, and leadership messaging.

3. Ensure that unvaccinated employees are masking for the duration of the influenza season defined by SFDPH at all times in the hospital building, except for break rooms.

4. The rule announced a requirement for SNFs to report HCP influenza vaccination summary data beginning on October 1, 2022. Beginning with the 2022-2023 influenza season, SNFs must submit data for the entire influenza vaccination season (October 1 through March 31) to NHSN.

5. HCP influenza vaccination summary data submitted to NHSN by May 15 is reported by CDC to CMS for each SNF CMS Certification Number (CCN). CDC provides an HCP influenza vaccination percentage for each reporting SNF CCN.

BACKGROUND:

Influenza is a serious respiratory disease that kills approximately 36,000 persons in the United States every year. Hospitalized patients are particularly vulnerable to disease exposures. Influenza season is generally considered to be October through May for the highest circulation of the virus; however, influenza virus is now considered to be circulating year-round and clinicians should include influenza in any respiratory illness diagnostic consideration regardless of the season. The influenza vaccine reduces the risk of influenza by 40-60% when the vaccine is well matched with the circulating strain. The vaccination may not prevent influenza but can lessen the severity and hospitalization once infected. (CDC, 2022)

PROCEDURE:

1. Before the start of the influenza season, employees may obtain the influenza vaccine from the LHH Medical Clinic or provide proof of vaccination from another location (e.g. primary care provider) to the clinic. LHH Medical Clinic will make reasonable attempts to ensure influenza vaccination is available to all shifts and on weekends.

2. Employees who have not received the influenza vaccine elsewhere and decline receiving an influenza vaccine at LHH must complete a declination form and abide by mandatory masking~~. implemented by SFDPH.~~

3. Employees who have not received their influenza vaccine will be asked to physically distance themselves from others during eating and drinking (when universal masking protocols are not in place.)

4. Unvaccinated employees who are non-compliant with mandatory masking shall receive a verbal warning from their director, supervisor, or manager the first time they are observed without a mask or improperly wearing a mask. Directors, supervisors, and managers shall report further instances of non-compliance to Human Resources for further disciplinary action.

5. Vaccinated employees shall be given a sticker on their identification badge. LHH Medical Clinic maintains a list of employee influenza vaccination status.

6. Any local, state, or federal public health emergency guidance may supersede the above procedures outlined in this policy.

ATTACHMENT:
None.

REFERENCE:
LHHPP 72-01 A8 Outbreak/Epidemic Investigation Protocol
LHHPP 72-01 D4 Evaluation of Communicable Illness in Employees

Revised: 13/01/29, 14/11/25, 17/01/10, 17/09/12, 18/09/11, 19/03/21, 20/10/13, 23/01/10 2023-09-14 (Year/Month/Day)
Original adoption: 09/12/15

GUIDELINES FOR PREVENTION AND CONTROL OF TUBERCULOSIS

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) adheresshall adhere to regulations provided by Centers for Disease Control and Prevention (CDC), Centers for Medicare and Medicaid Services (CMS), California Department of Public Health (CDPH) California Tuberculosis Controllers Association (CTCA), and San Francisco Department of Public Health (SFDPH) TB Prevention and Control Program. Effective September 1, 2021, CDPH is following the latest CDC guidance for tuberculosis (Tuberculosis Control Branch, Tuberculosis Guidelines and Regulations.)

PURPOSE:

1. Design and implement a program for screening residents and staff for latent and active TB infection.

2. Reduce the transmission of TB through prompt detection and management of active tuberculosis disease.

3. Comply with federal, state, and local regulation.

DEFINITIONS:

Tuberculosis: According to the CDC, Tuberculosis (TB) is caused by the bacterium *Mycobacterium tuberculosis*. The bacteria usually attack the lungs, but TB bacteria can attack any part of the body such as the kidney, spine, and brain. Not everyone infected with TB bacteria becomes sick with symptoms. As a result, two TB-related conditions exist: latent TB infection (LTBI) and TB disease. If not treated properly, TB disease can be fatal.

Tuberculosis Disease (T.B.) (formerly known as active T.B) is diagnosed when): When TB bacteria are active (multiplying in the body), this is called TB disease. People with TB disease are sick and can spreadare capable of spreading the bacteria to others with whom they come into contact.

Latent TB infection: The TB bacteria can live in the body without causing symptoms. In most cases, those who breathe in the TB bacteria from others, become infected but the body is able to fight the bacteria to stop them from growing and causes TB disease with symptoms. Those with LTBI cannot spread the disease to others but may test positive for T.B. because the bacteria is in their body.

PROCEDURE:

1. LHH will follow the CDC three-tiered level of hierarchy to control tuberculosis in the facility:
    a. Administrative
    b. Environmental
    c. Respiratory Protective Equipment

2. Resident Admission, ~~Readmission~~ Admission after Community Discharge, and Annual Screening

    a. Residents with known~~Known~~ or suspected~~Suspected~~ TB Disease

        i. Residents who are known or suspected to have TB and are hospitalized or are residents of other healthcare facilities, may only be admitted with written approval of SFDPH TB Prevention and Control Program, or when they are no longer infectious.

    b. Residents with Documented History of Positive Tuberculosis Skin Test (TST) or Interferon Gamma Release Assay (IGRA), or History of Active TB Disease

        i. No further TST/IGRA required. Do not perform a skin test on someone with known TB. This could cause a severe reaction.

        ii. TB symptom ~~screen~~ review and assessment must be performed by the medical provider upon admission, w~~ and includes an assessment for:~~.

            - ~~Bloody sputum~~
            - ~~Hoarseness lasting 3 weeks or more~~
            - ~~Persistent cough lasting 3 weeks or more~~
            - ~~Unexplained excessive fatigue~~
            - ~~Unexplained persistent fever lasting 3 weeks or more~~
            - ~~Unexplained excessive night sweats~~
            - ~~Unexplained weight loss~~

        iii. Chest x-ray (CXR) must be performed, unless one was already done in the United States within 90 days prior to admission.

        iv. Residents shall receive TB symptom review ~~be screened~~ annually, and if indicated by symptom review, CXR will be ordered. ~~with a CXR and TB symptom screen and if~~ See Procedure 2.b. Room Placement if the CXR result is abnormal.

        ~~iv.~~v. If a change in condition suspicious for~~of~~ TB disease occurs, diagnostic TB testing and CXR will be ordered and acted upon by the medical provider.. ~~TB~~

~~screening will include a TB symptom screen and CXR, if indicated.~~ See Procedure 2.b. Room Placement if the CXR result is abnormal.

c. Residents with Documented History of Negative TST/IGRA or no Documented History

i. Only a single TST is needed if documentation of a previous negative TST is done and recorded within 12 months. The TST shall be read at 48 hours from placement.

ii. A single previous negative TST is acceptable if done and recorded within 90 days of admission.

iii. No additional TST/IGRA test is needed if documentation of a previous negative TST/IGRA is done and recorded within 90 days of admission.

iv. A two-step TST shall be administered to residents who have never been tested, or if more than 12 months have elapsed since the last documented negative TST. The TST shall be read at 48 hours from placement. The second TST shall be administered within 1 to 3 weeks after the first if the first TST is interpreted as negative. The results of the second TST shall be the reported result.

v. Residents who have received the Bacilli Calmette-Guérin (BCG) vaccine shall be considered for IGRA screening instead of TST screening.

vi. Residents shall ~~be screened annually with a~~receive TB symptom review and TST/IGRA annually. ~~and if a change in condition suspicious of TB disease occurs. TB screening will include a TB symptom screen and TST/IGRA, if indicated.~~.

vii. In uninfected residents, a positive result on any future TST shall be interpreted as a skin test conversion.

viii. Residents with positive TST results shall be referred to their attending physician for evaluation and treatment recommendations.

- Induration of ≥5mm is considered positive in:
  - Human immunodeficiency virus (HIV)-infected persons
  - Recent contacts of TB case patients
  - Persons with fibrotic changes on chest radiograph consistent with prior TB
  - Patients with organ transplants and other immuno-suppressed patients
- Induration of ≥10mm is considered positive in:
  - Residents of nursing homes and other long-term facilities for the elderly

ix. If a change in condition suspicious for TB disease occurs, diagnostic TB testing and CXR will be ordered.. See Procedure 2.b. Room Placement if the CXR result is abnormal.

d. ~~Readmission~~ Screening for Admissions After Community Discharge

i. All r~~R~~esidents who are discharged to a community setting and are ~~re-~~admitted back to LHH ~~to the facility within 90 days of discharge~~ require~~s a~~ TB symptom ~~screen~~review at time of readmission. Symptom review is to occur even in cases when the discharge period was brief.

ii. ~~Residents who have been discharged~~ If the community discharge period was for longer than 90 days. the medical provider will determine whether TB screening testing is also indicated ~~and are readmitted require a TB screen~~ based on prior TST/IGRA results, ~~and history of active~~ any TB disease history and any relevant risk factors for community TB exposure. ~~The medical provider will determine whether additional TB diagnostic testing is indicated.~~

3. Resident Conversions and Room Placement

a. Resident Conversions

i. Residents who convert from a negative to positive TST/IGRA result must have a TB symptom ~~screen~~ review done on the same day. Asymptomatic residents shall have a CXR within 24 hours or by the next business day. Symptomatic residents shall be transferred to isolation and have a STAT CXR.

ii. If the CXR result is negative, LTBI treatment shall be ~~offered~~ considered, and a TB symptom ~~screen~~ review shall be performed annually.

iii. Conversion cases shall be reported to the Infection Control Nurse during business hours and the Nursing Operations Manager during off-business hours by Nursing. If indicated, roommates and close contacts shall be screened for active TB.

b. Room Placement

i. If CXR result is abnormal, the resident shall be placed in airborne isolation. The case must be reported to SFDPH TB Prevention and Control Program within 1 working day. Per SFDPH TB Prevention and Control Program protocol, 3 sputum specimens shall be obtained for Acid-Fast Bacilli (AFB) smear and culture. In addition, one of the three sputum specimens, preferably the first sputum specimen, shall have a *Mycobacterium tuberculosis*/resistance to rifampicin (MTB/RIF) polymerase chain reaction (PCR) test (e.g. GeneXpert MTB/RIF) performed.

ii. For high and moderate suspicion cases with an initially positive AFB smear, airborne isolation may be discontinued after 3 negative AFB smears, 14 days of TB treatment is completed, and clearance is obtained from SFDPH TB Prevention and Control Program.

iii. For high and moderate suspicion cases with an initially negative AFB smear, airborne isolation may be discontinued after 3 negative AFB smears, 1 negative MTB/RIF PCR, 5 days of TB treatment is completed, and clearance is obtained from SFDPH TB Prevention and Control Program.

iv. For low suspicion cases, airborne isolation may be discontinued after 3 negative AFB smears, 1 negative MTB/RIF PCR, and clearance is obtained from SFDPH TB Prevention and Control Program. The resident shall be reassessed when cultures are final to determine latent TB treatment.

v. If an active TB case is identified, a contact investigation for residents and staff shall be conducted. Refer to LHHPP 72-01 A9 Contact/Exposure Investigation.

4. Employee New Hire and Annual Screening

a. Screening Schedule

i. Employees shall be screened for tuberculosis within 90 days prior to work, and annually thereafter.

ii. Employees will receive a notification from LHH Medical Clinic when his or her annual TB screening is due. A list of staff who are due for completing this annual requirement will be sent by the LHH Medical Clinic or Department of Education and Training (DET) to department directors, supervisors, and managers each month. Department directors, supervisors, and managers are responsible for follow up on annual health requirement non-compliances reported to them. Employees who are non-compliant for their annual TB screening will be followed up according to Human Resources departmental protocols.

b. Employees with Documented History of Positive TST/IGRA/History of Active TB

i. Employees with a history of active TB disease must provide documentation of completion of an adequate course of treatment and have medical clearance prior to start of employment.

ii. No further TST/IGRA required.

iii. TB symptom screen must be performed upon prior to employment.

- ~~Bloody sputum~~
- ~~Hoarseness lasting 3 weeks or more~~
- ~~Persistent cough lasting 3 weeks or more~~
- ~~Unexplained excessive fatigue~~
- ~~Unexplained persistent fever lasting 3 weeks or more~~
- ~~Unexplained excessive night sweats~~
- ~~Unexplained weight loss~~

iv. CXR must be performed, unless the employee provides a written report of a negative CXR done in the United States within 90 days of hire.

v. If results of the CXR is abnormal, the employee must be promptly referred to their healthcare provider for evaluation. The employee must not be allowed to work until they are determined not to have infectious TB. Written medical clearance must be provided.

c. Employee with Documented History of Negative TST/IGRA or no Documented History

i. Only a single TST is needed if documentation of a previous negative TST is done and recorded within 12 months of hiring.

ii. A single previous negative TST is acceptable if done and recorded within 90 days of hiring.

iii. No additional TST/IGRA test is needed if documentation of a previous negative IGRA is done and recorded within 90 days of hiring.

iv. A two-step TST shall be administered to employees who have never been tested, or if more than 12 months have elapsed since the last documented negative TST.

v. Employees who have received the Bacilli Calmette-Guérin (BCG) vaccine shall be considered for IGRA screening~~included in the TST screening program~~.

vi. In uninfected employees, a positive result on any future TST shall be interpreted as a skin test conversion.

vii. Employees with a positive TST/IGRA, normal CXR, and no history of treatment for latent TB infection shall be encouraged to see their healthcare provider prior to employment for evaluation and treatment recommendations.

5. Employee Conversions

a. Employee who convert from a negative to positive TST/IGRA result during employment must have a TB symptom screen and a CXR within 1 week and be

promptly referred to a healthcare provider or the local health department for treatment recommendations.

b. Symptomatic employees must be excluded from work until active TB disease is ruled out and written medical clearance is provided.

6. Employee Post-Exposure Screening

a. Employees who have been exposed to a confirmed case of active pulmonary TB disease must receive a TB symptom screen.

b. Symptomatic employees must have a CXR immediately and referred for medical evaluation.

c. If an employee is asymptomatic and has a negative TST/IGRA within the past 3 months of exposure to a confirmed case of active pulmonary TB disease, the employee shall be tested in 8-10 weeks following exposure.

d. If an employee is asymptomatic and has a negative TST/IGRA greater than 3 months of exposure to a confirmed case of active pulmonary TB disease, the employee shall be (TST/IGRA) tested as soon as possible, and the test repeated in 8-10 weeks following the last exposure.

7. Employee Reporting of Positive TSTs

a. Employees who test positive following initial negative TST/IGRA results upon hire are classified as conversations and shall be reported to Zuckerberg San Francisco General (ZSFG) Occupational Health Services (OHS), which oversees LHH Medical Clinic for employees.

8. Employee Training and Education

a. Employees are trained upon hire and annually in methods to identify, prevent, and control the transmission of TB.

ATTACHMENT:
None.

REFERENCE:
LHHPP 72-01 A9 Contact/Exposure Investigation
LHHPP 73-07 Aerosol Transmissible Disease Exposure Control Plan
CDPH – CTCA Joint Guidelines for Prevention and Control of Tuberculosis in California Long Term Health Care Facilities available at: https://ctca.org/guidelines/cdph-ctca-joint-guidelines/
SFDPH Communicable Disease Control and Prevention, TB Control, Information for Medical Providers available at: http://sfcdcp.org/tbinfoforproviders.html

CDPH Tuberculosis Control Branch (9/2021). Tuberculosis Guidelines and Regulations. https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/TB-Guidelines-and-Regulations.aspx

CDC.(5/2019).TB Infection '\Control in Healthcare Settings. https://www.cdc.gov/tb/topic/infectioncontrol/TBhealthCareSettings.htm

Revised: 15/11/09, 16/03/08, 16/07/12, 17/09/12, 18/09/11, 19/05/14, 19/07/09, 20/01/14, 20/10/13, 23/01/10, 23/08/31 (Year/Month/Day)
Original adoption: 05/11/01

CARE OF TUBERCULOSIS PATIENT PLACED ON CIVIL DETENTION

BACKGROUND:

The San Francisco Department of Public Health (SFDPH) Health Officer has authority under state law to detain a patient for the purposes of diagnosis, treatment, and/or isolation of tuberculosis infection. The California Department of Public Health (CDPH) and the California Tuberculosis Controllers Association (CTCA) have established guidelines for the civil detention of persistently non-adherent tuberculosis patients in California.

When the SFDPH Health Officer issues a civil detention order, the order must describe less restrictive alternatives attempted and only if those alternatives fail, and public safety is put at risk by a patient's continued non-adherence (including mental illness, homelessness, and substance abuse) ~~with less restrictive alternatives,~~ may detention be considered appropriate. Detention is a very costly intervention and shall only be used when less costly interventions have been unsuccessful.

The SFDPH shall initiate civil detention at SFDPH facilities after other less restrictive means to ensure compliance with examination/isolation/quarantine protocols have been exhausted, and it is determined that placement within a SFDPH facility is needed to ensure compliance with support from the San Francisco Sheriff's Department (SFSD) and to avert a health threat to the public.

POLICY:

1. The purpose of this policy detention is primarily to guide staff during the detention of ~~non-infectious~~ TB patients for the purpose of completing an adequate course of therapy. ~~However, detention may be necessary for certain patients for the period during which they are infectious and where respiratory isolation is possible in some long-term care sites.~~

2. Laguna Honda Hospital (LHH) shall admit and provide care to a person who has been placed on a civil detention order for persistently being non-adherent with their tuberculosis (TB) treatment, failed to complete their TB treatment when placed in a less restrictive environment, and poses a health threat to the public.

3. The decision on the appropriateness of admitting a patient under a civil detention order shall be made by the Chief Executive Officer (CEO), Chief Medical Officer (CMO), Infection Preventionist (IP), and Chief Nursing Officer (CNO) based on the facility's ability to provide quality care to the patient. The patient may or may not meet skilled nursing facility (SNF) level of care criteria.

4. These patients shall be admitted Monday to Friday excluding holidays secondary to the extra coordination between services that is required, and the limited availability of resources during those times.

5. LHH shall utilize the CDPH/CTCA joint guidelines when appropriate in providing care for the TB patient who is under a civil detention order.

6. LHH staff shall work collaboratively with staff from the SFDPH TB Prevention and Control Program to plan the patient's admission, ongoing care, and discharge plans

7. The conditions of civil detention shall be as therapeutic as possible and be designed to protect the rights of the individual, while at the same time balanced with the legal, ethical, and moral responsibilities of a health care provider to protect the public from TB.

8. A patient placed under a Health Officer's Civil Detention Order shall not be detained for more than 60 days without a court order authorizing detention.

9. The facility shall obtain a subsequent court review; within 90 days of the initial court order, and thereafter within 90 days of each subsequent court review; if the patient requires on-going detention to complete their TB treatment and continues to pose a health threat to the public

PURPOSE:

1. The purpose of this policy is to provide guidelines for the following considerations:

    a. Decision-making for appropriateness of patient placement at LHH,

    b. Room placement and additional transmission-based precautions as required,

    c. Supervision by personnel from the San Francisco Sheriff's Department,

    d. Patient's rights,

    e. Collaboration with SFDPH TB Prevention and Control Program on patient care management,

    f. Patient need for a higher level of care,

    g. Patient need for a lower level of care,

    h. Discharge planning, and

    i. Release from civil detention.

PROCEDURE:

1. The SFDPH Health Officer identifies a person in the community who has violated an examination or isolation order or has persistently been non-adherent to tuberculosis treatment and poses a health threat to the public. The Health Officer prepares and issues a "Civil Order of Detention and Completion Treatment for TB" to the patient and the SFDPH TB Prevention and Control Program refers the patient for placement at LHH.

2. The CEO, CMO, IP, and CNO reviews the information submitted by SFDPH TB Prevention and Control Program and if deemed appropriate for SNF placement, agrees to accept the patient for placement at LHH.

3. The patient shall be admitted to an airborne infection isolation room (AIIR) if still actively infectious or regular room if not deemed to be infectious by SFDPH TB Prevention and Control Program TB Controller or designee.

4. The patient who is placed under a Civil Detention order shall be monitored by staff from SFSD, who shall be stationed outside of the patient's room, and shall accompany the patient whenever they participate in activities held outside of the patient's room if the patient is not in respiratory isolation.

5. The SFDPH TB Prevention and Control Program shall be consulted for TB medication treatment orders and the frequency of acid-fast bacilli (AFB) sputum smears and cultures to determine the infectiousness of the patient.

6. The required SNF admission and continuing care orders and processes shall be completed in the same manner as other LHH patient admissions.

7. The required SNF comprehensive assessment, care planning, patient care conference meetings, informed consent and documentation processes shall be completed according to LHH policies and procedures.

8. If the patient requests release from detention, the request shall be communicated to SFDPH TB Prevention and Control Program, LHH Quality Management department and the Deputy City Attorney to enact the following:

    a. An application for a court order authorizing continued detention shall be made within 72 hours after the request.

    b. Patient detention shall not continue for more than 5 business days in the absence of a court order authorizing detention.

9. The patient with a civil detention order with or without a court order may be detained only until they complete treatment and cannot be forced to take medications.

10. Weekly reviews on the patient's progress with TB treatment and patient's expressed interests for activities or schedule at LHH shall be conducted by staff from Nursing, Medicine, and other members of the patient care team, Infection Control, SFDPH TB Prevention and Control Program, Deputy City Attorney and other members of the administrative team. The frequency of reviews may be decreased when deemed appropriate based on the consensus of the entire team.

11. Weekly reviews shall be conducted to determine appropriateness of continued placement at LHH. The frequency of reviews may be decreased when deemed appropriate.

12. Discharge planning back to the community shall be initiated when the SFDPH Health Officer or the SFDPH TB Prevention and Control Program TB Controller determines the patient has completed their course of TB treatment and civil detention is no longer necessary.

13. If civil detention is no longer required, the patient shall be discharged in conjunction with advice from SFDPH TB Prevention and Control Program to the appropriate level of care.

ATTACHMENT:
None.

REFERENCE:
CDPH/CTCA Joint Guidelines for the Civil Detention of Persistently Non-Adherent Tuberculosis Patients in California available at: https://ctca.org/wp-content/uploads/2018/11/FINLCivil_Detention092311_.pdf
LHHPP 20-01 Admission to LHH Acute and SNF Relocation Between SNF Units
LHHPP 72-01 B5 Transmission-Based Precautions and Patient Room Placement

Revised: 20/10/13, 23/01/10, 23/09/14 (Year/Month/Day)
Original adoption: 18/05/08

CORONAVIRUS DISEASE 2019 (COVID-19) IMMUNIZATION~~Immunization~~

POLICY:

1. Laguna Honda Hospital (LHH) shall offer patients and staff vaccination against COVID-19 when vaccine supplies are available to the facility. Screening individuals for prior immunizations, medical precautions, and contraindications is necessary for determining whether they are appropriate candidates for vaccination.

2. All patients and/or responsible parties and staff shall be educated on the COVID-19 vaccine they are offered, in a manner they can understand, and receive the appropriate COVID-19 vaccine handout based on the type of vaccine being offered.

3. If a patient or staff member requests vaccination against COVID-19 but missed earlier opportunities for any reason (including recent residency or employment, changing health status, overcoming vaccine hesitancy, or any other reason), LHH shall offer the vaccine to the individual as soon as possible.

4. If the vaccine is unavailable at LHH, the facility shall assist the patient or staff member on obtaining vaccination, such as the local health department or local pharmacy.

    ~~a.~~ a. If there is a manufacturing delay, LHH shall communicate the reason for the delay to impacted parties, including efforts to acquire subsequent doses as necessary.

5. Indications and contraindications for COVID-19 vaccination are evolving and LHH shall follow any new or revised guidelines issued by the Centers for Disease Control and Prevention (CDC), Food and Drug Administration (FDA), vaccine manufacturers, or other expert stakeholders.

6. LHH may offer but is not required to provide education and vaccination for individuals who enter the facility for a limited amount of time, such as delivery and repair personnel or volunteers who may enter the facility infrequently (meaning less than once weekly).

7. In accordance with FDA requirements, select adverse events for COVID-19 vaccines must be reported to the Vaccine Adverse Event Reporting System (VAERS), such as

vaccine administration errors, serious adverse events, multisystem inflammatory syndrome (MIS), and cases of COVID-19 that result in hospitalization or death. Any revised safety reporting requirements must also be followed.

PURPOSE:

The purpose of this policy is to provide guidance on vaccination immunization for the Sars CoV 2 virus that causes Covid-19 disease. Immunization can reduce morbidity and mortality from COVID-19 in patients and staff and reduce transmission to others.

Mandatory Covid 19 vaccination is required for all healthcare personnel/staff in California and strongly encouraged for all patients.

The Covid-19 vaccination/immunization environment is constantly changing. New vaccines and information regarding those vaccines is updated on the CDC website as new information is known. ~~Approved or authorized vaccination options available in the United States currently are Pfizer-BioNtech, Moderna, Novavax and Johnson & Johnson Janssen.~~ These vaccines vary in use by age group recommendations, by doses, by number of vaccines needed, by length of time between vaccines, by efficacy and by adverse events. Some vaccines are more readily available than others due to supply chain shortages and LHH will make every effort to provide the desired vaccine where possible.

The most updated information on vaccines in the United States can be located on the CDC website : *Stay Up to Date with Your Covid Vaccines* at https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html ~~(last updated July 10, 2022) at https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html?s_cid=11758:covid%20vaccine%20names:sem.ga:p:RG:GM:gen:PTN:FY22~~

DEFINITIONS:

Centers for Medicare and Medicaid Services (CMS) defines the following terms below used within this policy and procedure.

"**Staff**" means those individuals who work in the facility on a regular (that is, at least once a week) basis, including individuals who may not be physically in the facility for a period of time due to illness, disability, or scheduled time off, but who are expected to return to work. This also includes individuals under contract or arrangement, including hospice staff, outpatient clinic staff, or volunteers, who are in the facility on a regular basis, as the vaccine

is available.

"**Emergency Use Authorization (EUA)**" is a mechanism to facilitate the availability and use of medical countermeasures, including vaccines, during public health emergencies, such as the current COVID-19 pandemic. The EUA process is a way to ensure safety while still expediting approval in emergent situations.

PROCEDURE:

~~1.~~ 1. Patient Vaccination

a. The licensed nurse~~referral team~~ screens new patients prior to admission for COVID-19 vaccination.

b. The physician assesses resident eligibility for vaccination. A reasonable attempt will be made to determine prior vaccination history. Resident with unknown or unsure vaccination status will be considered not immunized. For those not vaccinated, the reason will be documented.

c. The physician offers COVID-19 vaccination for unvaccinated ~~and partially vaccinated (i.e. only received one dose from a two-dose series)~~ patients.

i. Patients and their responsible party have the right to refuse the COVID-19 vaccine in accordance with Patient Rights requirements at 42 CFR 483.10(c)(6) and tag F578.

ii. COVID-19 vaccination may be scheduled at a later time to cohort patient and/or staff to ensure no doses are wasted in a multi-use vial.

~~b.~~c. The Physician, Registered Nurse, or Licensed Vocational Nurse, ~~or Pharmacist~~ will obtain Patient/Surrogate decision maker (SDM) consent for vaccination. Physician or designated prescriber orders the appropriate COVID-19 vaccine dose(s) for accepting patients with no known contraindications.

~~c.~~d. The licensed nurse (LN) provides the patient or responsible party with the appropriate COVID-19 vaccine handout based on the type of vaccine being administered.

~~d.~~e. For each COVID-19 vaccine authorized under an Emergency Use Authorization (EUA), the Food and Drug Administration (FDA) requires that vaccine recipients or their caregivers are provided with certain vaccine-specific EUA

information to help make an informed decision about vaccination.

~~e.~~a. Where available, vaccine information sheets (VIS) will be provided.

f.

~~f.~~g. For vaccines still under the EUA, Fact Sheets will be provided prior to the administration of the immunization vaccine.

~~i.~~ i. The Fact Sheet is similar in purpose and content to vaccine information statements (VISs) for licensed vaccines but differs in that the EUA Fact Sheet is specific to each authorized COVID-19 vaccine, is developed by the manufacturer of the vaccine, and is authorized by the FDA. ~~(CDC, 2021)~~

~~g.~~b. The neighborhood LN documents the patient's vaccine administration and education provided in the electronic health record. If the vaccine was not given, document the reason(s) it was not administered.

h.

~~h.~~i. The physician shall complete an Unusual Occurrence report and document on the electronic health record if there are any unexpected or significant adverse events to the vaccine.

~~i.~~ i. In addition, the physician, employee, family or patient may report or self-report adverse events to national early warning system for Vaccine Adverse Events Reporting System (VAERS) using the online report.

~~2.~~ 2. Staff Vaccination

~~a.~~ a. Upon hire and as needed, staff are offered COVID-19 vaccination ~~if~~for unvaccinated ~~and partially vaccinated (i.e. only received one dose from a two-dose series or require a booster dose) staff~~.

i. Staff may request through their direct supervisor or independently request COVID-19 vaccination at LHH. COVID-19 vaccination may be scheduled at a later time to cohort patient and/or staff to ensure no doses are wasted in a multi-use~~multi-use~~ vial.

i.

ii. Additionally, LHH employees are offered COVID-19 vaccination upon hire at Zuckerberg San Francisco General (ZSFG) Occupational Health Services (OHS) following their departmental protocol.

~~b.~~ b. If a staff member is not eligible for COVID-19 vaccination because of previous immunization at another location or outside of the facility, staff shall provide vaccination documentation to the LHH Medical Clinic to confirm vaccination status.

~~c.~~ c. A physician order by the Chief Medical Officer (CMO) per protocol is required for the appropriate COVID-19 vaccine dose(s) for accepting staff with no known contraindications.

~~d.~~ d. The LHH Medical Clinic provides the staff the appropriate COVID-19 vaccine handout based on the type of vaccine being administered.

~~e.~~ e. The LHH Medical Clinic documents the staff member's vaccine administration and education provided in the staff health record. If the vaccine was not given, document the reason(s) it was not administered.

~~f.~~ f. LHH Medical Clinic may report adverse event to VAERS on behalf of the staff using the online report.

ATTACHMENT:

None.

REFERENCE:

CDC (2023) Intermin Clinical Considerations for Use of COVID-19 Vaccines in the United States.
Department of Health and Human Services, Centers for Medicare & Medicaid Services, CMS-20054 Infection Prevention, Control & Immunizations.

~~CDC (2022) Stay up to date with your vaccines. All about Covid vaccines.~~

Revised: 2022/08/03, 2022/09/13, 2023/08/11 (Year/Month/Day)
Original adoption: 21/09/14

PRE-EMPLOYMENT AND ANNUAL SCREENING OF EMPLOYEES

POLICY:

1. Pre-employment and annual health assessments are required for all Laguna Honda Hospital (LHH) employees in accordance with the California Title XXII regulations.

PURPOSE:

Employees are evaluated for the presence of and immunity to communicable diseases to reduce the potential for exposing residents, staff, and visitors to communicable diseases.

PROCEDURE:

1. Prior to placement for all work assignments, Zuckerberg San Francisco General (ZSFG) Occupational Health Services (OHS) provides a physical examination and medical history and immunization status screening for all employees, which will include an assessment for the presence of active or latent infectious diseases.

2. Tuberculosis screening is performed for all employees.

3. Proof of immunity or immunizations administered for the following infectious diseases is required at ZSFG OHS. Follow up will occur at the LHH Medical Clinic as necessary:

   a. Rubella

   b. Measles

   c. Mumps

   d. Varicella

   ~~d.~~e. TDAP

4. Hepatitis B immunization is offered, and if refused, a declination must be signed and filed in the employee health record.

5. Tetanus, diphtheria, and acellular pertussis (Tdap) initial immunization and booster is offered and if refused, a declination must be signed and filed in the employee health record.

6. Influenza immunization is offered annually during the influenza season. Refer to LHHPP 72-01 C24 Employee Influenza Vaccination Policy.

7. Prospective employees determined to not have immunity to rubella, measles, or varicella must initiate the vaccine series prior to reporting to work. Continuation or hiring for employment is dependent upon completion of the vaccine series.
8. Current employees who did not complete the screening and immunization program above at the time of their original date of hire are also required to demonstrate immunity to rubella, measles, mumps, and varicella and to undergo immunization as needed to acquire immunity.

9. For employees who are unable to demonstrate immunity to rubella, measles, mumps, or varicella and who have medical contraindications(s) to immunization, employment will be considered on a case-by-case basis.

10. For employees who work in select, high-risk areas, additional immunizations may be recommended and made available.

11. Annual health assessment for all personnel working at LHH Skilled Nursing Facility (SNF) in accordance with California Title 22 regulations and includes the following:

    a. Tuberculosis screening

    b. Annual evaluation of immunization needs is assessed on a case-by-case basis and appropriate vaccines are ~~offered~~offered.

12. Documentation is maintained within LHH Medical Clinic and ZSFG OHS.

ATTACHMENT:
None.

REFERENCE:
LHHPP 72-01 C24 Employee Influenza Vaccination Policy
LHHPP 72-01 C26 Guidelines for the Prevention and Control of Tuberculosis
ZSFG Infection Control Policy 5.01 Infectious Disease Screening and Immunization Status

Revised: 16/07/12, 20/10/13, 23/09/14 (Year/Month/Day)
Original adoption: 05/11/01

EVALUATION OF COMMUNICABLE ILLNESS IN EMPLOYEES

POLICY:

1. Laguna Honda Hospital (LHH) employees with communicable or potentially communicable disease shall be evaluated for work fitness to prevent the transmission of disease to residents, staff, and visitors.

PURPOSE:

To minimize the risk for disease transmission from employees to residents, staff, and visitors.

PROCEDURE:

1. Staff shall not come to work with symptoms of a communicable disease, including any illness with a fever (until afebrile for 24 hours without the use of fever-reducing medication), uncontrolled diarrhea, vomiting, persistent cough or sputum production, contagious or suspicious rash, skin lesions or weeping dermatitis that is not easily kept covered with secretions contained, untreated conjunctivitis, or jaundice.

2. Employees who believe they have been exposed to a communicable disease at work shall report the exposure to their supervisor in accordance with the LHH Injury and Illness Prevention Program and be evaluated at Zuckerberg San Francisco General (ZSFG) Occupational Health Services (OHS).

3. Employees who experience symptoms of a communicable disease that is not related to a workplace exposure shall be evaluated by their primary care physician.

4. Employees shall report any communicable disease diagnoses to their direct supervisor and the Infection Control Nurse (ICN).

5. Employees with a communicable or potentially communicable disease must avoid resident contact. Refer to referenced ZSFG Infection Control policy for work restriction requirements. The ICN may be consulted as needed.

ATTACHMENT:

None.

REFERENCE:

LHHPP 73-01 Injury and Illness Prevention Program (IIPP)
ZSFG Infection Control Policy 5.03 Communicable Illness or Infection in Personnel: Evaluation, Exposure Determination, Management, and Work Restriction Requirements
CDC Infection Control in Healthcare Personnel available at:
https://www.cdc.gov/infectioncontrol/guidelines/healthcare-personnel/index.html

Revised: 16/01/12, 19/03/12, 20/10/13, 23/09/14 (Year/Month/Day)
Original adoption: 05/11/01

INFECTION CONTROL FOR REHABILITATION SERVICES

POLICY:

1. Members of the Laguna Honda Hospital (LHH) RehabilitationRespiratory Therapy departmentServices play an active role in preventing and controlling the spread of infection when providing therapy, and shall adhere to established infection control policies, procedures, and standards when in the facility.

2. Department managers are responsible for training their staff on department specific infection control procedures. in collaboration with the Infection Preventionist (IP), including isolation precautions that are not included in the annual hospital-wide mandatory in-services.

PURPOSE:

The purpose of this policy is to provide guidance for the RehabilitationRespiratory Therapy teamServices staff members for the prevention and transmission of infections while providing respiratory therapy to patients.

Responsibilities:

1. Occupational, Physical, and Speech Therapy Senior Therapists

   a. Assess resident care and safety within the department.

   b. Evaluate products for use with direct patient care.

   c. Ensure proper maintenance and cleaning of all equipment.

   d. Periodically review and update all procedures and equipment.

   e. Collaborate with the Infection Preventionist (IP) for infection control policy, education, and training to reduce the transmission of infectious diseases during the care of the patient with respiratory needs.

2. Staff Responsibilities

   a. Understand the general principles of Standard and Transmission-based Precaution (TBP) and be familiar with 3 types of TBP: Contact, Respiratory (droplet) and Airborne Precautions and the associated PPE and precautions for each
   b. Adhere to Standard and Transmission-based precautions as directed

   c. Collaborate and report to manager and IP, for infection control concerns

PROCEDURE:

1. Residents

a. Standard and Transmission-based Precautions

i. Rehabilitation Services staff will comply with Standard Precautions during resident encounters/therapywhen in the facility include use of required PPE

ii. Rehabilitation Services staff will follow postedcomply with Transmission-based Precautions (TBP) where appropriate, including required use of personal protective equipment (PPE), hand and respiratory hygiene, and other safety measures as required for TBP during resident therapythe infectious period.

iii. TBP's include Respiratory/Droplet Precautions, Contact Precautions and Airborne Precautions

iv. Rooms will be clearly marked with signage for TBP and Isolation (ISO) carts will be in close proximity of the room with needed PPE supplies.

a. Notify the nursing staff if these items are not present or if supplies need to be replenished

b. Strict adherence is required

v.iii. In room therapy may be provided for some residents, after an interdisciplinary consultation with Infection Control, and medical teams

- For residents on Contact precautions, if the wound can be adequately covered, the resident may attend therapy sessions on a case by case basis in consultation with the ICNInfection Control Nurse and RCT team.
- Residents with tuberculosis disease, chickenpox, measles, rubella, disseminated herpes zoster, and infectious diarrhea shall not attend therapy sessions outside of their rooms since the risk of transmitting infection to others is higher.
- Residents may have therapy sessions in their room, following appropriate infection precautions as outlined on the sign posted outside the resident's room.

b. All mat tables, plinths, wheelchairs, wheelchair cushions, tables and other therapeutic materials such as walkers, canes, tilt tables and exercise machines will be cleaned with EPA approved disinfectants daily and after each treatment when the resident is in direct contact with such equipment, or resident's body substances or fluids have come into contact with the therapeutic equipment.

c. Linen on mats will be changed by staff after each resident's use.

d. Soiled linen shall be placed in impervious plastic bags and must be securely closed during transport.

e. Floor mats will be cleaned with EPA approved disinfectants daily and after use by an incontinent resident.

f. Rehabilitation Services staff with cuts, abrasions, rashes, or minor infections on hands shall be covered with gloves or finger cot while working. Employees with draining skin lesions shall not provide resident care requiring direct resident contact and may be referred to Occupational Health or the Infection Control Nurse.

~~g. All body substances and fluids are considered to be potentially infectious.~~

~~i. Use gloves for anticipated exposure to mucous membranes and body substances from all residents.~~

~~ii. Dispose of sharps carefully in puncture-resistant containers.~~

~~h. For potential or anticipated exposure to body substances or fluids, staff must wear gloves. Hands must be washed or sanitized before and after glove use.~~

2. Visitors

a. Visitors can be permitted in the rehabilitation areas for teaching and demonstration purposes.
b. Visitors are asked to follow standard precautions including hand hygiene if participating in therapy with the resident~~hand hygiene, and cough /sneeze hygiene~~
~~c. Alcohol-based hand sanitizers and handwashing sinks with soap and papers towels will be provided and readily accessible~~

~~3. Materials~~

~~a. Sterile products~~

~~i. All instruments and materials must be packaged according to approved procedures. IP will provide oversight and collaborative assessments for maintaining sterility as needed~~

~~ii. Senior Therapists (OT, PT, and ST) must be certain that all requirements of cleaning, sterilizing, wrapping, packaging, and storage are met, and that all stored sterile supplies are routinely checked for wrapper integrity and expiration dates.~~

~~b. Disposable items~~

~~i. Must be properly stored and not reused.~~

~~ii. Must be discarded via proper procedure for type of material and hospital regulations.~~

iii. Infectious waste will be disposed of in the red waste container in the biohazardous waste storage room.

iv. Needles or sharps are single-use only items and will be properly disposed of immediately after use into the needle box

v. Needle boxes will not be overfilled but emptied at ¾ fill line; safety lid must close completely with nothing protruding outside the safe zone of the closed lid. Dispose of filled needle containers per hospital requirements.

4. Equipment

a. Senior Therapists (OT, PT, ST) are responsible for written policies on proper maintenance and cleaning of all equipment. A yearly routine preventive maintenance schedule for all equipment has been established.

b. Records of maintenance and cleaning will be kept.

5.3. Housekeeping - The Apartment

a. Kitchen counter tops shall be cleaned by a therapy aide daily and after each use of the kitchen utilizing the 3 bucket (wash, rinse, sanitize) method using the appropriate EPA approved cleaner/disinfectant

b. Oven is cleaned daily and as needed.

c. Refrigerator is cleaned weekly.

6.4. Food Preparation, Handling and Storage

a. Most food used for food preparation training is obtained from Food Service.

b. When a resident requires training with specific items not available from Food Service (e.g., boxed food; cultural food choices, etc.) items are purchased from an approved or reputable supplier (supermarket).

7.5. Storage of Food

a. Staple food is stored in dated, closed containers, in small amounts.

b. All perishable foods are date labeled and stored at proper temperatures and temperature records are kept:

i. Fruits, vegetables, dairy products, meats and poultry are stored at temperatures below 41° F. Digital temperatures are tracked centrally by Facilities Services.

ii. Frozen foods are stored at temperatures below 0° F

iii. When food or liquid is given to a resident, any unused portion is to be discarded, unless it is to be consumed by the same resident within 1-2 days in which case, it will be labeled with the current date, resident's name, and refrigerated.

iv. Separate and color-coded chopping boards are used for raw meats. These chopping boards shall be washed thoroughly using the 3-bucket method, followed by sterilization in the industrial dishwasher located in the Apartment.

v. Chopping boards used for raw meats shall not be used for other foods.

ATTACHMENT:
None.

REFERENCE:
~~LHHPP 26-05 Neighborhood Specialty Meal Program~~
LHHPP 72-01 B1 Standard Precautions
LHHPP 72-01 B2 Hand Hygiene
LHHPP 72-01 B5 Transmission-Based Precautions and Resident Room Placement

Revised: 14/01/29, 16/01/12, 20/08/25, 20/10/13, 23/01/10, 23/09/14 (Year/Month/Day)
Original adoption: 11/01/01

DEPARTMENT-SPECIFIC INFECTION CONTROL PROCEDURES

POLICY:

1. The infection prevention and control (IPC) program at Laguna Honda Hospital (LHH) provides collaboration and consultation for IPC for departments on campus.

2. Every member of staff at LHH plays an active role in preventing and controlling the spread of infection. All staff shall adhere to established infection control policies, procedures, and standards, both hospital-wide and departmental.

3. Cleaning and disinfection of resident care equipment utilized and managed by departments at LHH must comply with LHHPP 72-01 F13 Cleaning and Disinfecting Non-Critical Resident Care Equipment.

4. Department managers are responsible for training their staff on department-specific infection control procedures that are not included in the annual hospital-wide mandatory in-services. At a minimum, this training occurs:

    a. During orientation and prior to work assignment

    b. Annually

    c. When revisions are made to departmental policies

PURPOSE:

To maintain effective IPC practices that support a safe, sanitary, and comfortable environment to help prevent the development and transmission of disease and infection throughout departments at LHH.

PROCEDURE:

The following department-specific policies and procedures address infection control practices related to the job functions of the department staff:

1. Activity Therapy

    a. LHHPP 76-03 Animal Control

    ~~b. LHHPP 26-05 Neighborhood Specialty Meal Program~~

    ~~c.~~b. LHHPP 28-01 Community Outing Program

~~d.~~c. LHHPP 28-02 Farm and Therapeutic Gardens

~~e.~~d. LHHPP 28-03 Aquatic Services

~~f.~~e. LHHPP 28-04 Pool Servicing and Aquatic Area General Maintenance

~~g.~~f. Activity Therapy Policy P5.0 Animal Assisted Therapy

2. Barbers and Beauticians

   a. Barbers and beauticians shall follow the standards and regulations set by their respective professional boards, LHH Nursing department, and the Infection Control Committee.

   b. Residents must not be served in the beauty salon when the neck or scalp contains draining lesions, unless ordered by the physician.

   c. If a resident is suspected to have a lice infestation, services are to be postponed and the Nurse Manager or Charge Nurse notified immediately.

      i. The instruments used on a resident suspected with a lice infestation shall be disinfected separately from other instruments using Barbicide, which is registered by the Environmental Protection Agency (EPA) and approved for disinfecting clippers and other electrical tools per California Health and Safety Code, Article 12, Section 980.

      ii. If a resident with a lice infestation is to have their hair cut, Nursing department is responsible for cutting the hair with disposable scissors and hair clippers in the resident's room. After use, the disposable equipment is to be discarded. Refer to LHHPP 72-01 C17 Pediculosis (Lice) Management.

3. Clinical Lab

   a. A2 - Phlebotomy Procedure

   b. A3 - Identification of Patient and Collection of Blood Specimen

   c. A4 – Blood Culture Procedure

4. EKG Department

   a. Disposable electrodes are used.

b. Cable points and straps are cleaned and disinfected using isopropyl alcohol between residents.

5. Environmental Services

   a. IV Environmental Services Job Descriptions~~Job Descriptions~~

   b. XII Transmission-Based Precautions Cleaning~~Critical Areas Cleaning Procedure~~

   c. XV Pest Control and Animal Abatement

   d. XVI Ice Machine and Refrigerator Cleaning

   e. XVII Transport, Delivery Time for Biohazard, Trash and Linen

   f. XVIII Microfiber Damp Mopping Cleaning

   g. XX Privacy Curtain Replacement ~~Cubicle Curtain and Drape Cleaning~~

6. Facilities Services

   a. DP-31 Body Substance Isolation Policy

7. Nursing Services

   a. See Nursing departmental policies and procedures

8. Outpatient Clinics

   a. C1 Cleaning of Examination Rooms

   ~~a.~~b. C3 Cleaning of Medical Instruments Prior to Disinfection or Sterilization

   ~~b.~~c. C4 High-Level Chemical Disinfection

   ~~c.~~d. C6 Steam Sterilization

   ~~d. Cleaning of Examination Rooms~~

9. Nutrition Services

   a. LHHPP 26-04 Resident Dining services

~~b. LHHPP 26-05 Neighborhood Specialty Meal Program~~

~~c.~~b. LHHPP 26-06 Meal Tray Service Galley Sanitation

~~d.~~c. Food and Nutrition Services departmental policies and procedures related to food procurement, food storage, safe food handling and preparation, meal service and food distribution, machine washing and sanitizing equipment, manual washing and sanitizing equipment, and cleaning of fixed food service equipment.

10. Pharmaceutical Services

    a. 03.03.00 Infection Control

    b. 07.0~~1~~0.00 Sterile Product Preparation, Handling and Disposal

11. Radiology Services

    a. D2 Departmental Cleanliness

    b. F2 Infection Control Policy

12. Respiratory Therapy

    ~~c.~~a. ~~:~~ A4 Respiratory Services Body Substance Isolation

~~12.~~13. Volunteer Services

    a. A4.0 Infection Control

ATTACHMENT:
None.

REFERENCE:
LHHPP 72-01 C17 Pediculosis (Lice) Management
LHHPP 72-01 F13 Cleaning and Disinfecting Non-critical Resident Care Equipment

~~**SUPERCEDES:**~~
~~72-01 Infection Control Manual policies:~~
- ~~E1 Activity Therapy~~
- ~~E3 Barber and Beauticians~~
- ~~E5 Clinical Laboratories~~
- ~~E7 EKG Department~~
- ~~E8 Nutrition Services~~

- ~~E9 Environment Services~~
- ~~E10 San Francisco Sheriff's Department Personnel Communicable Disease Management Policy~~
- ~~E11 Nursing~~
- ~~E13 Pharmaceutical Services~~
- ~~E15 Facility Services~~
- ~~E16 Radiology Services~~
- ~~E17 Respiratory Therapy~~
- ~~E20 Outpatient Clinic~~
- ~~E21 Volunteer Services~~

Revised: 20/10/13, 23/10/04 (Year/Month/Day)
Original adoption: 20/08/25

RENOVATION / CONSTRUCTION INFECTION CONTROL GUIDELINES

POLICY:

1. The Centers for Disease Control and Prevention (CDC) requires healthcare facilities to perform an Infection Control Risk Assessment (ICRA) before any renovation, construction, or repair projects.

2. The completed ICRA provides for a controlled plan for the removal of building materials or construction project in healthcare facilities that does not place residents at risk for transmission of pathogens in a vulnerable population.

3. The Infection Control Nurse (ICN) shall be consulted by Facility Services or project manager during preconstruction planning for facility renovation and construction projects.

4. Construction and/or remodeling on the campus will be completed by construction teams that are skilled and trained in the standards for healthcare construction.

5. Construction teams will include the ICN during the planning, pre-construction, construction, and post construction phases at a minimum.

6. The ICN will provide regular surveillance and oversight of the project to ensure thatand the project specific recommendation are in place. This information will be shared witharea to report back to the Infection Control Committee (ICC).

PURPOSE:

1. To provide guidance to the healthcare and construction team for containing dust, fungi (including *Aspergillus*), chemicals, bacteria (including *Legionella*), and other microbial contamination that can be transmitted via the air, plumbing, or from ground disturbance during construction that is required to be minimized during the work phases of construction/renovation projects.

    a. Soil, water, dust, and decaying organic matter can provide a source of infections when introduced to a vulnerable population that can gain entrance to the facility on construction materials, tools, and the construction workers' clothes and shoes.

2. To engage best practices and healthcare construction standards are integral in the design, demolition, and construction of resident care and other areas that facilitate the desired infection control practices that is guided by completion of the ICRA.

3. To minimize infectious risks associated with internal renovation projects in resident care areas, and that the necessary controls and interventions are in place.

PROCEDURE:

1. Project Planning

The ICN and Industrial Hygienist shall be advised by the Facility Services department or project manager of plans for renovation and/or new construction. The ICRA shall be a part of integrated facility planning, design, construction, and commissioning activities; and shall be conducted during the early planning phase of a project, before construction begins; and continue through project construction and commissioning. Life Safety requirements must also be met.

a. A multidisciplinary team that includes the ICN, Industrial Hygienist, Facility Services, and clinical staff shall conduct a proactive ICRA during the design and planning phase for all demolition, renovation, and new construction projects. The scope of the project may require other subject matter experts to be involved.

b. After completing the ICRA, precautions shall be taken according to the matrix reflecting the risk level of the resident population and the hazard level of the construction work. A complete field review of infection control implications shall be conducted before any demolition or construction begins.

c. Specific areas of consideration but are not limited to:

    i. Determination of if, where, when, the duration, and how resident care area(s) closures and/or interruptions will occur

    ii. Mitigation of external air flow into the facility where there is ground disturbance or demolition of other structures external to the facility that may release air pollution that can enter windows, doors, or other ventilation mechanisms

    iii. Traffic patterns for residents, staff, and visitors to minimize contamination

    iv. Resident area risk assessment: criteria for emergency work interruptions (stop and start processes)

    v. Planning for air handling and water systems/plumbing as appropriate

    vi. Education (or whom and by whom)

    vii. Dust control expectations for subcontractors before start, as needed including workers clothing and shoes when entering the facility

    viii. Transport and approval for disposal of waste materials

d. ICRA expectations shall be incorporated into initial project agreements to ensure contractor accountability.

2. Contractor Dust Control Procedures

Contractor must provide dust control procedures for review and approval by the ICN and Industrial Hygienist.

a. Renovation areas must be isolated from resident-occupied areas using decreased air flow barriers to eliminate airflow of particles into patient areas. Critical barriers i.e. sheetrock, plywood, or plastic, to seal areas from non-work area shall be completed before beginning any construction work. Porous surfaces, including but not limited to sheetrock shall be painted on the side facing (exposed to) residents with at least one coat of a cleanable/washable no or low volatile organic compound (VOC) paint.

b. Temporary construction barriers and closures above ceilings shall be dust tight. A ceiling-to-floor sealed plastic barrier, enclosing the ladder, shall be constructed to contain the dust whenever more than one ceiling tile is to be removed within a resident care area.

c. Whenever work is performed in which dust contamination has occurred, the area is to be cleaned as soon as possible using a vacuum cleaner equipped with a High Efficiency Particulate Air (HEPA) filtration system or damp mopping procedure to prevent the “tracking” of dust throughout the facility. Sweeping and dry mopping are never appropriate in a hospital environment. Floor “tack” or “sticky” mats are to be placed in areas of construction crew egress, and replaced when they lose their ability to capture dust and debris from a user’s shoe soles.

d. If negative pressure is required (based on ICRA), negative pressure shall be established and continuously maintained to the renovation work area enclosure to contain dust generated by work activities inside the enclosure until all work is complete.

e. Negative pressure shall be monitored continuously. Recording manometers shall be used to display and record pressure differentials automatically. Pressure differential records shall be collected and reviewed by project personnel on a daily basis, as evidenced by their initials along with the date and time of the review~~,~~ and maintained available on site for review by infection control and health and safety personnel upon request.

f. Construction waste and demolition debris shall be covered and sealed during transport, and transport equipment cleaned prior to removal from the work area. Transport is to be done during the lowest activity periods. A schedule shall be drafted to inform contractor of times to avoid transport area. Elevators shall be avoided for debris transport. If an elevator is used, it shall be designated for construction use only. Appropriate signage postings are required

g. Removal of construction barriers and ceiling protection shall be done outside of normal working hours unless otherwise authorized in advance of activities. Areas will be wet mopped and/or HEPA vacuumed following barrier removal. Vacuuming outside of negative pressure areas shall be performed with a HEPA-filtered vacuum which has been aerosol challenge tested prior to initial use at the LHH site.

3. Monitoring

a. The ICN will monitor construction areas for ~~bioaerosols,~~ general particle (dust) levels, or other project specific contaminants or indicators in the vicinity of the project.

b. If monitoring results exceed background levels, or other infection control risk becomes apparent, the contractor shall be notified to correct the condition immediately to avoid fines and work stoppage as described below:

   i. All work may be stopped on a project whenever a hazardous material/waste deficiency, infection control deficiency, or dust control complaint exists.

   ii. The contractor shall take immediate action to correct the deficiencies.

4. Enforcement

a. Determination of violations shall be based on periodic rounds in collaboration with the Facility Services staff, ICN, and/or Industrial Hygienist. Findings will be reported to the ICC. Photographs may be taken to document violation(s), as feasible.

b. The contractor, project manager/coordinator, Facility Services, and others as appropriate, shall be informed in writing.

c. A record of all ICRA violations shall be maintained.

5. Documentation

a. Primary representatives shall be identified on the Infection Prevention & Control Construction Clearance Checklist (Attachment B), which contains an overview of the ICRA results and the required precautions from ICN, Industrial Hygienist, Facility Services, contractor, project manager/coordinator, and others as deemed appropriate.

b. The Clearance Checklist shall be signed by the ICN or designee and a copy shall be maintained at the work site.

ATTACHMENT:
Appendix A: Infection Control Risk Assessment (ICRA).

REFERENCE:
LHH Facility Services Policy LS-6: Life Safety Management, Building Standards
Centers for Disease Control and Prevention's *"Guidelines for Environmental Infection Control in Health-care Facilities"* (2003)
Association for Practitioners in Infection Control & Epidemiology (APIC) State-of-the-Art Report: *"The role of infection control during construction in health care facilities." (2000)*

Revised: 16/07/12, 18/11/13, 20/10/13, 23/01/10 , 23/09/18(Year/Month/Day)
Original adoption: 05/11/01

Appendix A: Infection Control Risk Assessment

Step One:
Using the following table, *identify* the Risk categories by construction type (Type A-D)

Type A	**Non-Invasive Activities and Inspection** Includes but is not limited to: • Removal of ceiling tiles for visual inspection (limit 1 tile per 50 square feet with limited exposure time) • Limited building system maintenance (e.g., pneumatic tube station, HVAC system, fire suppression system, electrical and carpentry work to include painting without sanding) that does not create dust or debris. • Clean plumbing activity limited in nature.
Type B	**Small scale, short duration activities that create minimal dust and debris** Includes but is not limited to: • Work conducted above the ceiling (e.g., prolonged inspection or repair of firewalls and barriers, installation of conduit and/or cabling, and access to mechanical and/or electrical chase spaces) • Fan shutdown/startup • Installation of electrical devices or new flooring that produces minimal dust and debris • The removal of drywall where minimal dust and debris is created • Controlled sanding activities (e.g., wet or dry sanding) that produce minimal dust and debris •
Type C	**Large-scale, longer duration activities that create a moderate amount of dust and debris.** Includes but is not limited to: • Removal of preexisting floor covering, walls, casework or other building components • New drywall placement • Renovation work in a single room • Non-existing cable pathway or invasive electrical work above ceilings • The removal of drywall where a moderate amount of dust and debris is created • Dry sanding where a moderate amount of dust and debris is created • Work creating significant vibration and/or noise • Any activity that cannot be completed within a single work shift
Type D	**Major demolition and construction projects** Includes but is not limited to: • Removal or replacement of building system component(s) • Removal/installation of drywall partitions • Invasive large-scale new building construction • Renovation work in two or more rooms •

Step Two:

Using the following table, *identify* the Risk categories by patient care areas that will be affected. If more than one risk group will be affected, select the higher risk group:

Low Risk	Medium Risk	High Risk	Highest Risk

Non-patient care areas such as:	**Patient care support areas such as:**	**Patient care areas such as:**	**Procedural, invasive, sterile support and highly compromised patient care areas such as:**
• Public hallways and gathering areas not on clinical units • Office Areas not on clinical units • Breakrooms not on clinical units • Bathrooms or locker rooms not on clinical units • Mechanical rooms not on clinical units • EVS closets not on clinical units	• Waiting areas • Clinical engineering • Materials management • Sterile processing department – dirty side • Kitchen, cafeteria, gift shop, coffee shop, and food kiosks •	• Patient care rooms and areas • All acute care units • Emergency department • Employee health • Pharmacy – general work zone • Medication rooms and clean utility rooms • Imaging suites: diagnostic imaging • Laboratory •	• All transplant and intensive care units • All oncology units • Or theaters and restricted areas • Procedural suites • Pharmacy compounding • Sterile processing department – clean side • Transfusion services • Dedicated isolation wards/units • Imaging suites: invasive imaging •

Step Three:

Match the Patient Risk Group (Low, Medium, High, Highest) from Step Two with the planned Construction Activity Project Type (A, B, C, D) from Step Two using the below table to find the Class of Precautions (I, II, III, IV or V) or level of infection control activities required. The activities are listed in Table 5 – Minimum Required Infection Control Precautions by Class.

Table 3 – Class of Precautions

Construction Project Type

Patient Risk Group	Type A	Type B	Type C	Type D
Low	I	II	II	III*
Medium	I	II	III*	IV
High	I	III	IV	V
Highest	III	IV	V	V

Infection control permit and approval will be required when Class of Precautions III (Type C) and all Class of Precautions IV or V are necessary.

Environmental conditions that could affect human health, such as sewage, mold, asbestos, gray water and black water will require Class of Precautions IV for LOW and MEDIUM Risk Groups and Class of Precautions V for HIGH and HIGHEST Risk Groups.

*Type C [Medium Risk groups] and Type D [Low Risk Groups] work areas [Class III precautions] that cannot be sealed and completely isolated from occupied patient care spaces should be elevated to include negative air exhaust requirements as listed in Class IV Precautions.

Step Four:

Assess potential risk to areas surrounding the project. Using the below table, identify the surrounding areas that will be affected and the type of impact that will occur. If more than one risk group will be affected, select the higher risk group using Table 2 - Patient Risk Group.

Table 4 – Surrounding Area Assessment

Unit Below:	Unit Above:	Unit Lateral:	Unit Behind:	Unit in Front:
Risk Group:	Risk Group:	Risk Group:	Risk Group:	Risk Group:
Contact:	Contact:	Contact:	Contact:	Contact:
Phone:	Phone:	Phone:	Phone:	Phone:
Additional Controls: ☐ Noise ☐ Vibration ☐ Dust control ☐ Ventilation ☐ Pressurization ☐ Vertical Shafts ☐ Elevators/Stairs **Systems impacted:** ☐ Data ☐ Mechanical ☐ Med Gases ☐ Hot/Cold Water	**Additional Controls**: ☐ Noise ☐ Vibration ☐ Dust control ☐ Ventilation ☐ Pressurization ☐ Vertical Shafts ☐ Elevators/Stairs **Systems impacted:** ☐ Data ☐ Mechanical ☐ Med Gases ☐ Hot/Cold Water	**Additional Controls**: ☐ Noise ☐ Vibration ☐ Dust control ☐ Ventilation ☐ Pressurization ☐ Vertical Shafts ☐ Elevators/Stairs **Systems impacted:** ☐ Data ☐ Mechanical ☐ Med Gases ☐ Hot/Cold Water	**Additional Controls**: ☐ Noise ☐ Vibration ☐ Dust control ☐ Ventilation ☐ Pressurization ☐ Vertical Shafts ☐ Elevators/Stairs **Systems impacted:** ☐ Data ☐ Mechanical ☐ Med Gases ☐ Hot/Cold Water	**Additional Controls**: ☐ Noise ☐ Vibration ☐ Dust control ☐ Ventilation ☐ Pressurization ☐ Vertical Shafts ☐ Elevators/Stairs **Systems impacted:** ☐ Data ☐ Mechanical ☐ Med Gases ☐ Hot/Cold Water
Noise & Vibration Mitigation Strategies				
☐ Use diamond drills instead of powder-actuated fasteners. ☐ Schedule noise-making periods with adjacent spaces. ☐ Use beam clamps instead of shot. ☐ Prefab where possible. ☐ Use tin snips to cut metal studs instead of using a chop saw. ☐ Install metal decking with vent tabs, then use cellular floor deck hangers. ☐ Consider compression style fittings instead of soldering, brazing or welding. ☐ Wet core drill instead of dry core or percussion. ☐ Instead of jackhammering concrete, use wet diamond saws. ☐ Use HEPA vacuums instead of standard wet/dry vacuums. ☐ Use mechanical joining system sprinkler fittings instead of threaded. ☐ Where fumes are tolerated, use chemical adhesive remover (flooring glue) instead of mechanical. ☐ To remove flooring, consider abrasive blasting instead of using a floor scraper. ☐ Use electric sheers instead of reciprocating saw for ductwork cutting. ☐ Install exterior man/material lifts.				
Ventilation & Pressurization Mitigation Strategies				
☐ HEPA to exterior. ☐ Install temporary ductwork. ☐ Utilize temporary HVAC equipment. ☐ Vacate the area. ☐ Install temporary partitions. ☐ Use carbon filtration to filter odors.				
Impact to Other Systems Mitigation Strategies				
☐ Schedule outages. ☐ Provide temporary systems. ☐ Back-feed electricity or medical gases.				

Table 5 - Minimum Required Infection Control Precautions by Class | Before and During Work Activity

Class of Precautions	Mitigation Activities (Performed Before and During Work Activity)
Class I	1. Perform noninvasive work activity as to not block or interrupt patient care. 2. Perform noninvasive work activities in areas that are not directly occupied with patients. 3. Perform noninvasive work activity in a manner that does not create dust. 4. Immediately replace any displaced ceiling tile before leaving the area and/or at end of noninvasive work activity.
Class II	1. Perform only limited dust work and/or activities designed for basic facilities and engineering work. 2. Perform limited dust and invasive work following standing precautions procedures approved by the organization. 3. This Class of Precautions must never be used for construction or renovation activities.
Class III	1. Provide active means to prevent airborne dust dispersion into the occupied areas. 2. Means for controlling minimal dust dispersion may include hand-held HEPA vacuum devices, polyethylene plastic containment, or isolation of work area by closing room door. 3. Remove or isolate return air diffusers to avoid dust from entering the HVAC system. 4. Remove or isolate the supply air diffusers to avoid positive pressurization of the space, 5. If work area is contained, then it must be neutrally to negatively pressurized at all times. 6. Seal all doors with tape that will not leave residue. 7. Contain all trash and debris in the work area. 8. Nonporous/smooth and cleanable containers (with a hard lid) must be used to transport trash and debris from the construction areas. These containers must be damp-wiped cleaned and free of visible dust/debris before leaving the contained work area. 9. Install an adhesive (dust collection) mat at entrance of contained work area based on facility policy. Adhesive mats must be changed routinely and when visibly soiled. 10. Maintain clean surroundings when area is not contained by damp mopping or HEPA vacuuming surfaces.
Class IV	1. Construct and complete critical barriers meeting NFPA 241 requirements including: Barriers must extend to the ceiling or, if ceiling tile is removed, to the deck above, and all penetrations through the barrier shall meet the appropriate fire rating requirements. 2. All (plastic or hard) barrier construction activities must be completed in a manner that prevents dust release. Plastic barriers must be effectively affixed to ground and ceiling and secure from movement or damage. Apply tape that will not leave a residue to seal gaps between barriers, ceiling or floor. 3. Seal all penetrations in containment barriers, including floors and ceiling, using approved materials (UL schedule firestop if applicable for barrier type). 4. Containment units or environmental containment units (ECUs) approved for Class IV precautions in small areas totally contained by the unit and that has HEPA-filtered exhaust air. 5. Remove or isolate return air diffusers to avoid dust entering the HVAC system. 6. Remove or isolate the supply air diffusers to avoid positive pressurization of the space. 7. Negative airflow pattern must be maintained from the entry point to the anteroom and into the construction area. The airflow must cascade from outside to inside the construction area. The entire construction area must remain negatively pressurized. 8. Maintain negative pressurization of the entire workspace by use of HEPA exhaust air systems directed outdoors. Exhaust discharged directly to the outdoors that is 25 feet or greater from entrances, air intakes and windows does not require HEPA-filtered air. 9. If exhaust is directed indoors, then the system must be HEPA filtered. Prior to start of work, HEPA filtration must be verified by particulate measurement as no less than 99.97% efficiency and must not alter or change airflow/pressure relationships in other areas. 10. Exhaust into shared or recirculating HVAC systems, or other shared exhaust systems (e.g., bathroom exhaust) is not acceptable. 11. Install device on exterior of work containment to continually monitor negative pressurization. To assure proper pressure is continuously maintained, it is recommended that the device(s) have a visual pressure indicator. 12. Contain all trash and debris in the work area.

	13. Nonporous/smooth and cleanable containers (with a hard lid) must be used to transport trash and debris from the construction areas. These containers must be damp-wiped cleaned and free of visible dust/debris before leaving the contained work area. 14. Worker clothing must be clean and free of visible dust before leaving the work area. HEPA vacuuming of clothing or use of cover suits is acceptable. 15. Workers must wear shoe covers prior to entry into the work area. Shoe covers must be changed prior to exiting the anteroom to the occupied space (non-work area). Damaged shoe covers must be immediately changed. 16. Install an adhesive (dust collection) mat at entrance of contained work area based on facility policy. Adhesive mats must be changed routinely and when visibly soiled. 17. Consider collection of particulate data during work to monitor and ensure that contaminates do not enter the occupied spaces. Routine collection of particulate samples may be used to verify HEPA filtration efficiencies.
Class V	1. Construct and complete critical barriers meeting NFPA 241 requirements including: Barriers must extend to the ceiling, or if ceiling tile is removed, to the deck above, and all penetrations through the barrier shall meet the appropriate fire rating requirements. 2. All (plastic or hard) barrier construction activities must be completed in a manner that prevents dust release. Plastic barriers must be effectively affixed to ground and ceiling and secure from movement or damage. Apply tape that will not leave a residue to seal gaps between barriers, ceiling or floor. 3. Seal all penetrations in containment barriers, anteroom barriers, including floors and ceiling using approved materials (UL schedule firestop if applicable for barrier type). 4. Construct anteroom large enough for equipment staging, cart cleaning, workers. The anteroom must be constructed adjacent to entrance of construction work area. 5. Personnel will be required to wear disposable coveralls at all times during Class V work activities. Disposable coveralls must be removed before leaving the anteroom. 6. Remove or isolate return air diffusers to avoid dust entering the HVAC system. 7. Remove or isolate the supply air diffusers to avoid positive pressurization of the space. 8. Negative airflow pattern must be maintained from the entry point to the anteroom and into the construction area. The airflow must cascade from outside to inside the construction area. The entire construction area must remain negatively pressurized. 9. Maintain negative pressurization of the entire workspace using HEPA exhaust air systems directed outdoors. Exhaust discharged directly to the outdoors that is 25 feet or greater from entrances, air intakes and windows does not require HEPA-filtered air. 10. If exhaust is directed indoors, then the system must be HEPA filtered. Prior to start of work, HEPA filtration must be verified by particulate measurement as no less than 99.97% efficiency and must not alter or change airflow/pressure relationships in other areas. 11. Exhaust into shared or recirculating HVAC systems, or other shared exhaust systems (bathroom exhaust) is not acceptable. 12. Install device on exterior of work containment to continually monitor negative pressurization. To assure proper pressure is continuously maintained, it is recommended that the device(s) have a visual pressure indicator. 13. Contain all trash and debris in the work area. 14. Nonporous/smooth and cleanable containers (with a hard lid) must be used to transport trash and debris from the construction areas. These containers must be damp-wiped cleaned and free of visible dust/debris before leaving the contained work area. 15. Worker clothing must be clean and free of visible dust before leaving the work area anteroom. 16. Workers must wear shoe covers prior to entry into the work area. Shoe covers must be changed prior to exiting the anteroom to the occupied space (non-work area). Damaged shoe covers must be immediately changed. 17. Install an adhesive (dust collection) mat at entrance of contained work area based on facility policy. Adhesive mats must be changed routinely and when visibly soiled. 18. Consider collection of particulate data during work to monitor and ensure that contaminates do not enter the occupied spaces. Routine collection of particulate samples may be used to verify HEPA filtration efficiencies.

Table 6 - Minimum Required Infection Control Precautions | Upon Completion of Work Activity

Class of Precautions	Mitigation Activities (Performed upon Completion of Work Activity)
Classes I, II and III	Cleaning: 1. Clean work areas including all environmental surfaces, high horizontal surfaces and flooring materials. 2. Check all supply and return air registers for dust accumulation on upper surfaces as well as air diffuser surfaces. HVAC Systems: 1. Remove isolation of HVAC system in areas where work is being performed. Verify that HVAC systems are clean and operational. 2. Verify the HVAC systems meet original airflow and air exchange design specifications.
Classes III, IV and V	Class III (Type C Activities only), IV, and V precautions require inspection and documentation for downgraded ICRA precautions. Construction areas must be inspected by an infection preventionist or designee and engineering representative for discontinuation or downgrading of ICRA precautions. Work Area Cleaning: 1. Clean work areas including all environmental surfaces, high horizontal surfaces and flooring materials. 2. Check all supply and return air registers for dust accumulation on upper surfaces as well as air diffuser surfaces. Removal of Critical Barriers: 1. Critical barriers must remain in place during all work involving drywall removal, creation of dust and activities beyond simple touch-up work. The barrier may NOT be removed until a work area cleaning has been performed. 2. All (plastic or hard) barrier removal activities must be completed in a manner that prevents dust release. Use the following precautions when removing hard barriers: i. Carefully remove screws and painter tape. ii. If dust will be generated during screw removal, use hand-held HEPA vacuum. iii. Drywall cutting is prohibited during removal process. iv. Clean all stud tracks with HEPA vacuum before removing outer hard barrier. v. Use a plastic barrier to enclose area if dust could be generated. Negative Air Requirements: 1. The use of negative air must be designed to remove contaminates from the work area. 2. Negative air devices must remain operational at all times and in place for a period after completion of dust creating activities to remove contaminants from the work area and before removal of critical barriers. HVAC systems: 1. Upon removal of critical barriers, remove isolation of HVAC system in areas where work is being performed. 2. Verify that HVAC systems are clean and operational. 3. Verify the HVAC systems meets original airflow and air exchange design specifications.

Other Decision-Making Considerations:

1. Identify specific site of activity e.g., resident rooms, medication room, etc.

2. Identify issues related to: ventilation, plumbing, electrical in terms of the occurrence of probable outages.

3. Identify containment measures, using prior assessment. What types of barriers? Will HEPA filtration be required?

4. Consider potential risk of water damage. Is there a risk due to compromising structural integrity?

5. Can or will the work be done during non-resident care hours?

6. Do plans allow for adequate number of isolation/negative airflow rooms?

7. Plan to discuss containment issues with the project team regarding traffic flow, housekeeping, debris removal.

DISINFECTION FOR ISOLATION ROOM

POLICY:

1. Disinfection of an isolation room shall be coordinated between staff from Laguna Honda Hospital (LHH) Nursing and Environmental Services (EVS) departments.

2. Only Environmental Protection Agency (EPA) disinfectants and cleaners on the EPA list for specific microbes will be utilized

3. Standard Precautions and any transmission-based precautions that were in effect shall be maintained during terminal cleaning of an isolation room including hand hygiene and use of personal protective equipment (PPE).

4. Cleaning must be accomplished before disinfection can be accomplished.

5. Clean from “clean to dirty” as possible.

PURPOSE:

To promote infection prevention and control standards and prevent cross-contamination of organisms.

PROCEDURE:

1. Terminal cleaning of the isolation room is to be carried out when a resident is relocated, discharged, or expired. The Nurse Manager or Charge Nurse shall assign a CNA/PCA or HHA to initiate the terminal cleaning process.

2. Terminal cleaning is a shared process between Nursing and EVS staff. Coordination of services is needed by the Nurse Manager or designee for timely and appropriate cleaning and disinfection. ~~If concerns, contact the Infection Control Nurse (ICN) for guidance.~~

3. Nursing and EVS will utilize Standard Precautions and any transmission-based precautions that were in effect at the time the room was vacated.

    a. This includes the appropriate PPE required for the type of isolation case (i.e. Contact, Contact Enhanced, Droplet, and/or Airborne Precautions)

    b. Keep room door closed to reduce air contamination with dust, chemicals, and pathogens while cleaning and disinfecting.

    c. Change gloves during the cleaning procedure when they become visibly soiled or when moving from dirty to clean tasks, such as from cleaning the bed to gathering clean linens.

d. Hand hygiene is performed~~removed~~ before donning and after removing gloves.

4. Nursing staff will remove the bed linens from the bed and place in the dirty linen hamper. Nursing staff will also clean and remove items from the previous occupant. Nursing will notify EVS once this is completed.

5. EVS cleans and disinfects room with appropriate disinfectant(s) according to EVS Policy XII Critical Areas Cleaning Procedure. This includes the remaining furniture, floor, walls (including the TV on the wall), and bathroom, including high touch areas such as light switches, nurse call button, and door handles/knobs.

6. EVS shall notify the Nurse Manager or Charge Nurse when terminal cleaning is completed.

ATTACHMENT:
None.

REFERENCE:
LHHPP 72-01 B1 Standard Precautions
LHHPP 72-01 B5 Transmission-Based Precautions and Resident Room Placement
Nursing Policy and Procedure D9 3.0 Bed Stripping and Terminal Cleaning~~Bed Stripping and Bedside Cleaning~~
Environmental Services Policy XII Critical Areas Cleaning Procedure
CDC. Centers for Disease Control and Prevention. (2020, April). Environmental Cleaning Procedures. Best practices for environmental cleaning in healthcare facilities. Retrieved from website September 1, 2020. https://www.cdc.gov/hai/prevent/resource-limited/cleaning-procedures.html

Revised: 14/05/27, 20/10/13, 23/03/14 2023/09/18 (Year/Month/Date)
Original Adoption: 05/11/01

MANAGEMENT OF RESIDENT'S PERSONAL CLOTHING

POLICY:

1. Clean and contaminated resident's personal clothing shall be managed in accordance with Laguna Honda Hospital's (LHH's) infection control and laundry practices to prevent or reduce the transmission of pathogens to others.

2. Residents clothing will be clean, not torn or ragged, in good working condition, and appropriate for the season and weather.

3. LHH has a process for identifying and managing lost and/or damaged personal clothing during the laundry process.

PURPOSE:

The purpose of this policy is to provide guidance to staff to provide clean and sanitized laundering management services for resident's personal clothing, reduce loss and damage to resident's personal clothing, and to reduce or prevent exposure to potentially infectious materials by following best practices that have been shown to prevent transmission of microorganism and reduce infections for disease prevention.

DEFINITIONS:

- **Personal laundry/clothing/personal clothing (clean):** Clothing belonging to the resident including but not limited to shirts, blouses, pants, shorts, skirts, socks, outerwear, gloves, undergarments, or other clothing items. Hospital provided linens refer to bed and bathing items that do not belong to the resident and are not covered in this policy.

- **Contaminated personal clothing (dirty):** Clothing that has been worn by the resident and has become overtly soiled, wet, obvious body odors, or contaminated with blood or body fluids.

PROCEDURE:

Resident's personal clothing is labeled for identification with permanent ink or tags and is identified as either the facility to launder or resident's responsible party to launder. The facility will have a separate area for dirty and clean laundry.

Clean resident's personal clothing is stored in resident's designated clean clothing areas, such as individual resident wardrobes and drawers. Clean clothing is transported through the facility in carts designated for clean clothing only and kept covered during transportation.

Resident's personal clothing is not to be shared with other residents or worn by staff. Notify the resident and/or responsible party of lost or damaged items during laundering.

Contaminated clothing is bagged and contained at the point of collection and not carried to another area for containment. Do not sort or rinse contaminated at the point of collection.

No additional precautions (~~i.e.~~i.e., double bagged) or categorizing/sorting of clothing originating from transmission-based precautions room is necessary. Double bagging is recommended only if the outside bag is visibly contaminated, is observed to be wet through to the outside of the bag, of if the resident is suspected or confirmed with a pediculosis (lice) infestation.

Wear gloves when handling soiled or contaminated clothing. If wet or grossly contaminated, wear a fluid resistant apron or gown. Do not agitate or shake ~~clothing;~~clothing, place immediately in dirty hamper.

Contaminated clothing shall be placed in a covered dirty hamper. The dirty hamper should not be stored inside a resident's room. Do not overfill the hamper exposing contaminated personal clothing.

Contaminated clothing is washed, dried, folded, and placed in the resident's clothing storage area using the proper washing and drying temperatures and using appropriate facility laundry detergent following manufacturer's recommendations.

ATTACHMENT:
None.

REFERENCE:
LHHPP 72-01 B1 Standard Precautions
LHHPP 72-01 B2 Hand Hygiene
LHHPP 72-01 C17 Pediculosis (Lice) Management
LHHPP 72-01 F4 Management of Hospital-Provided Linen
LHHPP 73-06 Bloodborne Pathogen Exposure Control Plan
CMS State Operations Manual (November 2017). *Appendix PP-Guidance to Surveyors for Long Term Care Facilities*. §483.80(e) Linens.

Revised: 14/05/27, 20/10/13 (Year/Month/Date)
Original adoption: 05/11/01

MANAGEMENT OF HOSPITAL-PROVIDED LINEN

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) hospital-provided linen and laundry management practices as it pertains to infection control and prevention precautions, will be consistent with Centers for Disease Control and Prevention (CDC) guidelines.
2. LHH contracts with a commercial linen laundry facility that meets the requirements for hospital laundry prescribed temperatures, detergents, and other disinfection agents.

PURPOSE:

To manage hospital-provided linen in a manner to minimize the risk of contamination with soiled linens or other contaminated items during sorting, packaging, transporting, and storing.

Please refer to the Standard Work on Resident Laundry for additional details regarding the handling of resident clothing/laundry.

DEFINITIONS:

Hospital-provided linen: Hospital-provided items such as towels, washcloths, bed linens, patient gowns, pants, and tops. Resident's personal clothing is not addressed in this policy.

PROCEDURE:

1. Clean Linen

a. Clean linen is delivered to the neighborhood by Environmental Services (EVS) staff in an appropriate cart and kept covered to prevent dust and debris contamination and placed into the neighborhood clean linen room/area.

b. Each neighborhood has dedicated clean linen areas used for sorting and storing clean linen.

c. Clean linen is not for staff personal use.

d. Perform hand hygiene before handling clean linen.

e. Clean linen must be covered when transporting or storing.

f. Do not take more clean linen than what is needed into the resident's room.

i. Do not store clean linen in resident rooms, drawers, or closets inside resident rooms.
ii. Linens inside a resident room are considered contaminated and should not be used for others; if this occurs, place even unused linens in dirty hamper for laundering.

2. Contaminated Linen/Laundry

a. Observe Standard Precautions when handling used linen including but not limited to gloves or a fluid resistant gown for overly wet items.

b. When removing linen, have a hamper just outside the resident room in the hallway to dispose of soiled linens. Linen cart should not be taken into resident rooms. If this is unavoidable, the cart will need to be wiped down with a hospital grade disinfectant prior to being returned to service.

c. Do not allow contaminated linen to come into contact with staff clothing as microorganisms can be spread by this method:

i. Hold linen away from the body.

ii. Do not agitate or shake contaminated linen.

iii. Gently remove linen and roll contaminated or wet areas inward.

iv. Place soiled linen immediately in hamper lined with a linen bag.

- Do not place soiled linen on the floor or other non-hamper area including furniture, or over-bed tables.

- Do not carry soiled linen in the hallway or other common areas nor drag bags on floor.

v. Contaminated linen shall be placed inside a covered hamper.

vi. The dirty hamper should not be stored inside a resident's room. Do not overfill the hamper exposing contaminated linen.

vii. Dirty linen bags are removed from the hamper frame, secured, and placed in the designated dirty linen area to be picked up by EVS for removal.

viii. Access to the dirty linen area must be secured from accidental entrance by unauthorized personnel.

ATTACHMENT:
None.

REFERENCE:
EVS Policy II Scope of Services
EVS Policy IX Waste Management Policy
EVS Policy XVII Transport, Delivery, Time for Biohazard, Trash and Linen
EVS Policy IX Reject Linen Procedures
~~EVS Policy II Housekeeping Services~~
~~EVS Policy IX Collection, Handling, Storage, and Disposal of Biohazardous Waste~~
LHHPP 72-01 B1 Standard Precautions
LHHPP 72-01 B2 Hand Hygiene
LHHPP 72-01 C17 Pediculosis (Lice) Management
LHHPP 72-01 F3 Management of Resident's Personal Clothing
LHHPP 73-06 Bloodborne Pathogen Exposure Control Plan
Resident Laundry Standard Work
CDC website (updated 2020, March). Appendix D-Linen and laundry management. Retrieved August 26, 2020, from website https://www.cdc.gov/hai/prevent/resource-limited/laundry.html#anchor_1585334108204
California Department of Public Health Website (Updated 2023, August). Laundry Service California Code Regulations Title 22. Retrieved September 5, 2023

Revised: 14/05/27, 20/10/13, 23/01/10 2023/09/05 (Year/Month/Date)
Original adoption: 05/11/01

BLOOD/BODY FLUID SPILL CLEAN-UP

POLICY:

1. Blood and/or body fluid (e.g. vomitus, urine) spill clean-up requires a 2-step process of cleaning followed by disinfection that is completed immediately after the spill utilizing the appropriate personal protective equipment (PPE).

Definitions:

Clean/Cleaning: Cleaning is the first step to be performed for a spill that contains blood/body fluids which may potentially transmit infectious disease. Cleaning involves removing the material that has been spilled (blood, body fluid, vomitus, urine etc.) using the process outlined below

Disinfect/Disinfection: Disinfection of the area is the second step to be performed for a spill that contains blood/body fluids which may potentially transmit infectious disease. Disinfection involves using an EPA- approved disinfectant for such materials, applying after cleaning, and allowing for the appropriate wet contact time in order for deactivation of the organism to occur. This step may also include a clean water rinse.

EPA: Environmental Protection Agency – federal agency responsible for the protection of people and the environment from significant health risks including chemicals.

PURPOSE:

To provide guidance that minimizes the potential for exposure to pathogens that may be transmitted in blood or body fluids when spills occur. Safety of the immediate area must be secured prior to cleaning and disinfection.

PROCEDURE:

1. **General Cleaning Procedures: (all may not apply to every type of spill)**
    a. Clean in a manner “from cleaner to dirtier”
    b. Clean in a manner “from highest to lowest” or “top to bottom” to prevent dripping or falling of spillage that may contaminate (ex: clean bed rails before cleaning floors)
    c. Clean floors last
    d. Blood and body fluid spills must be immediately confined using absorbent paper towels or absorbent granules (if available)
    e. Safety of others
    f. Environmental Services (EVS) is responsible for the clean-up and disinfection of the blood/body fluid spill.
    g. Nursing staff may need to provide appropriate barriers and signage to prevent others from entering the contaminated area until EVS arrives.

h. Nursing staff may clean up smaller spills (not including blood and body fluids which require both cleaning and disinfecting and waste removal) when there is no broken glass or debris in which both cleaning and disinfection with the standard hospital-wide approved disinfectant can be accomplished.

2. Blood spill kits are available on each unit.from Central Processing Department (CPD) maintains additional kits for replenishment or for spills where more kits are required for containment. Each kit containsand contain absorbent powder and PPE. (These should be on each floor for immediate use)

3. **Safety :**
   a. A visual inspection / assessment of the spill will be made prior to cleaning up a body fluid spill in order to determine:
      i. Patient or others safety including self, during cleaning process
      ii. The spill is addressed and confined immediately, without delay
   b. Don appropriate PPE which may include utility gloves for broken glass, fluid resistant gowns for splashing or potential contamination of clothing
   c. Standard Precautions will be observed for clean-up and disinfection

4. **Blood and/or body fluids must be immediately contained**
   a. Confine or contain the spill using absorbent paper towels or absorbent granules if immediately available
   b. Dispose of towels or granules as infectious waste
   c. Disinfect the same area using a facility approved EPA intermediate-level disinfectant which may include a chlorine-based disinfectant following the manufacturer's instructions
   d. Do NOT use a chlorine-based disinfectant on a urine spill which can release chlorine gas when mixed with urine. Chlorine gas is an immediate irritant to eyes, causing watering eyes, and cough
   e. Allow disinfectant to remain in wet contact with the surface(s) for the allotted time and rinse area with clean water, if indicated
   f. Immediately send all reusable items for reprocessing (mop heads, cloths)

ATTACHMENT:
None.

REFERENCE:
Environmental Services Policy and Procedure XVIII. Transport, Delivery, Time for Biohazard, Trash and LinenCollection, Handling, Storage and Disposal of Bio-hazardous Waste
LHHPP 72-01 B1 Standard Precautions
LHHPP 72-01 F13 Cleaning and Disinfecting Non-Critical Resident Care Equipment
LHHPP 73-06 Bloodborne Pathogen Exposure Control Plan
OSHA Bloodborne Pathogen Standard, 2015

Revised: 16/01/12, 20/10/13, 23/01/10, 23/09/14 (Year/Month/Day)

Original adoption: 05/11/01

CLASSIFICATION OF REUSABLE MEDICAL DEVICES AND PROCESSING REQUIREMENTS

POLICY:

1. Laguna Honda Hospital (LHH) utilizes the Spaulding Classification System of medical devices for cleaning, disinfection, and/or sterilization according to standards of practice as a best practice.

PURPOSE:

To provide guidance for the cleaning and reprocessing of reusable resident medical devices in an effort to prevent transmission of microorganism to other residents.

PROCEDURE:

1. Classification categories for the cleaning and reprocessing of reusable resident medical devices are based on:

    a. Type of resident contact (e.g. invasive vs. non-invasive)

    b. Likelihood of contamination with pathogenic organisms

    c. Expected level of contamination (e.g. bioburden)

    All reusable medical devices will be classified and processed according to the following standards of practice.

2. Prior to final processing, all medical devices are to be thoroughly cleaned to remove organic material and decrease the bioburden.

3. Reusable medical devices are classified and processed as follows:

    a. **Critical Devices:**

        i. Refer to LHHPP Outpatient Clinic policies in references.

    b. **Semi-Critical Devices:**

        i. Are devices that touch mucous membranes or non-intact skin and should be free of all microorganisms with the exception that some bacterial spores are acceptable.

        ii. Examples of semi-critical devices include: flexible endoscopes, thermometer, laryngoscope blades, endotracheal tubes, respiratory therapy and anesthesia equipment, diaphragm fitting rings, and other similar devices. Devices must be processed between resident contacts. If item is being used

for use on one resident, devices should be processed on intervals recommended by the manufacturer or according to current standards and when visibly soiled.

iii. Semi-critical devices require high-level disinfection using chemical disinfectants according to manufacturer's recommendation. Specific items may require specific procedures including sterile water rinses and air drying

c. **Non-Critical Devices:**

i. Refer to LHHPP 72-01 F13 Cleaning and Disinfecting Non-Critical Resident Care Equipment.

ATTACHMENT:
None.

REFERENCE:
LHHPP 72-01 F13 Cleaning and Disinfecting Non-Critical Resident Care Equipment
Outpatient Clinic Policy C3 Cleaning of Medical Instruments Prior to Disinfection or Sterilization
~~Outpatient Clinic Policy C4 High-Level Chemical Disinfection~~
~~Outpatient Clinic Policy C5 Flexible Nasopharyngeal Laryngoscope~~
~~Outpatient Clinic Policy C6 Steal Sterilization~~
Nursing Policy D9 7.0 Wheelchair and Geriatric Chair Cleaning
CDC. (2016). Infection control; disinfection and sterilization. A Rational Approach to Disinfection and Sterilization. Retrieved from website September 2, 2020. https://www.cdc.gov/infectioncontrol/guidelines/disinfection/rational-approach.html

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Original adoption: 05/11/01

CLEANING AND DISINFECTING NON-CRITICAL RESIDENT CARE EQUIPMENT

POLICY

Non-critical patient care equipment (touch intact skin) must receive low-level disinfection with a hospital grade disinfectant after use on each patient. Surfaces must be pre-cleaned when visibly soiled before being disinfected. Disinfection is performed following the manufacturer's instruction for use (IFU) using EPA registered disinfectant.

PURPOSE

To minimize the risk of transmitting infections, between patients or employees, via contact with equipment that may be contaminated.

DEFINITION

1. **Non-critical** is the classification level given to resident care equipment that does not come into contact with any sterile body cavity or mucous membrane. Non-critical resident care equipment requires low level disinfection procedures between resident use. Such items may include but are not limited to blood pressure cuffs or pulse oximeters in which the intact skin serves as an effective barrier to pathogens.

1. **Dedicated equipment:** Any medical equipment that will be used by a single resident and is not shared with other residents for the duration of the prescribed treatment.

1. **Multi-resident use equipment:** Shared equipment used for multiple residents for care when intact skin will provide a sufficient barrier. Shared equipment is cleaned and/or disinfected after each resident use.

1. **Minimum contact time:** Time required to effectively render the pathogen inactive and not capable of being transmitted to others. Contact time is determined and listed on the product label.

2. **Terminal Cleaning:** A cleaning procedure that is performed when a resident is discharged or transferred from a previously occupied resident room.

PROCEDURE

The following grid outlines the procedure to be utilized for cleaning some of the most commonly used patient care equipment:

1. **Shared Equipment All In-patient Care Units**

This list is not all inclusive.

Equipment	User	Timing

Automated Vital Sign machine	Nursing	After use on each resident
BP cuffs	Nursing	After use on each resident
Geri chairs/recliners	EVS	Daily & Terminal clean
Commode	EVS	Daily & Terminal clean
Glucose monitors	Nursing	After use on each resident
IV poles	EVS	Daily & Terminal clean
Bedside tables	Nursing/EVS	Daily & Terminal clean
Thermometers	Nursing	After use on each resident
Walkers	Nursing/PT/OT	After use on each resident
Wheelchairs	Nursing/PT/OT	After use on each resident
Feeding pumps	Nursing	After use on each resident
IV pumps	EVS	Daily & Terminal clean
Medication carts	Nursing	After use on each resident
Wound Care carts	Nursing	After use on each resident
Scale	Nursing	After use on each resident
WOWs	Nursing	After use on each resident

Use bleach wipes for patients on Enhanced Contact Isolation for C. difficile.

2. **Discharge Room Cleaning**

All reusable patient care equipment in the room when the patient is discharged will be cleaned by the EVS using a hospital grade disinfectant solution following the manufacturer's IFU. Items to be cleaned and disinfected include but are not limited to the bed, bedside table and stand, chairs and recliners, IV poles, and commode. After cleaning some items maybe be placed in a clean storage area.

1. ATTACHMENTS
None

REFERENCE:
None

Revised: 2011/2005, 2012/05/22, 2016/01/12, 2020/06/23, 2023/03/14 (Year/Month/Day)

Original adoption: Est. 2005/11/01

INSTRUMENT RECALL

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) will provide a policy and process for the recall of medical instruments according to standards of practice to remove products from human use that may have become potentially contaminated from failed biological testing for sterility, manufacturers' notification of instrument integrity or other compromised breaches once LHH is aware of the recall.

PURPOSE:

To provide guidance to staff for the process for recalling and immediate removal of instruments out of circulation in the event of a breach when known.

PROCEDURE:

1. A recall of supplies either commercially prepared or in-house prepared, shall be initiated when it is determined and confirmed that a product might pose a hazard to the patient and/or employee when used. This hazard may result from a sterilizer failure, packaging defect, product defect, or other source.

2. Once known, a recall to the affected department(s) is initiated by Central Processing Department (CPD).

3. Recall of commercially prepared products:

    a. Commercial vendors are required to notify the Food and Drug Administration (FDA) of known defects/violation in their product(s) as a voluntary action to safeguard public health and to take appropriate action.

    b. A recall notice shall be received from the vendor, confirmed by CPD, outlining the nature and scope of the problem, and lot numbers involved. CPD will identify any departments who use the affected product.

    c. If a recall is issued, a notice will be distributed to all areas affected, note the nature of the problem, with additional identifying information, such as lot numbers

    d. Physically remove all defective items from stock. Inform CPD of the inventory removed.

    e. Assemble material in one location, tag to ensure items are not used, and handle according to instructions from Purchasing.

4. Recall of Local CPD Sterilized Products (non-commercial):

a. Upon notice of a biological monitor failure ~~from the microbiology lab~~, all material sterilized on and/or after the day of the biological failed test shall be recalled.

~~b. Sterilization labs will perform their own monitoring for breaches prior to distribution and reprocess those items per lab standards~~

~~c.~~b. If indicated, CPD staff will physically remove all affected material from stock and other CPD locations (e.g., exchange carts, shelves, storage, emergency carts, etc.) or department specific locations.

i. Failed sterilization re-usable packets are torn down and re-processed.

ii. Single-use items are returned to CPD for proper return processing or disposal.

~~d.~~c. The equipment will be taken out of service until appropriate repairs and validation processes have been successfully completed.

~~e.~~d. Reprocess all recalled items.

~~f.~~e. The resident's attending physician will be notified, to the extent possible, if a recalled product has been identified as being used during a specific treatment.

5. Develop and submit a written final recall report to include:

a. Type and total implicated items,

b. Type and total items recalled, and

c. Percent of total implicated items recalled.

ATTACHMENT:
None.

REFERENCE:
LHHPP 72-01 E4 Central Processing Department
APIC Infection Control and Applied Epidemiology, Principles and Practice ~~@~~ ~~http://apic.org/Resource_/TinyMceFileManager/Education/Preventing-Inf-in-Amb-Care-Winter2012-FINAL.PDF~~
Association for the Advancement of Medical Instrumentation Standards @ http://www.aami.org/index.aspx

Revised: 16/03/08, 20/10/13, 23/09/14 (Year/Month/Day)
Original adoption: 05/11/01

STORAGE OF STERILE MEDICAL SUPPLIES

POLICY:

1. Handling, transportation, and storage of medical supplies shall be done according to the accepted standards of practice for infection prevention and control to reduce contamination of products which compromise sterility.

2. Packages that have been compromised (damaged, wet, torn etc.) will be removed from circulation and not used.

3. A central processing location will be maintained for large bulk storage.

4. Each neighborhood will have smaller designated storage rooms for frequently used items utilizing the same storage standards that must adhere to standard storage requirements.

PURPOSE:

Laguna Honda Hospital (LHH) utilizes event-related sterility for packaging materials dependent upon package material, storage conditions, ~~transport~~transport, and handling. An event must occur to compromise package content sterility which may include seal breakage or loss of package integrity (holes, tears, punctures), moisture penetration, or exposure to airborne contaminants. Event-related sterility is not dependent on dates of expiration but a “first in/first out” rotation should be utilized with older packages used first.

PROCEDURE:

1. Items that have a time-limited shelf life shall have a label attached which states, "Sterile Until (manufacturer’s recommended date shall be written in here)."

2. Staff are responsible to visually inspect any sterile package prior to use to check for time-limited shelf life label and conditions which would constitute a presumptive break in package integrity. Items shall not be used past the labeled date if present or, if there is any evidence that the package integrity has been compromised. Situations that would indicate this include a broken seal, tears or holes in packaging material, evidence of water damage, etc.

3. All items are to be transported to neighborhoods will be in covered tote bins, carts, or shelves.

4. Storage of sterilized items shall be as follows:

    a. All items are to be stored in a segregated, designated storage area or room. Storage area shall not be in a high traffic area or in an area where there is a likelihood of damage or contamination.

b. Open shelving is acceptable if items are being stored in a segregated room designated only for the storage of sterile items. Closed shelving should be used any time there may be potential for contamination or, when items are stored in a non-dedicated room.

c. Shelving must have a solid bottom shelf to protect from dust / debris. Storage requirements include the bottom shelf being at least 10 inches above the floor, at least 2 inches from the walls and at least 18 inches from the ceiling.

d. Efforts to reduce contamination must include regular environmental cleaning, keeping door closed in the designed room, and avoiding direct sunlight on the supplies for temperature and humidity control.

e. Do not store items near water sources

f. Outside shipping cartons including cardboard boxes are considered contaminated and shall not be used as dispenser boxes or shelf storage . Remove outside carton before transport to clean storage area

5. Inventory control

a. Inventory (shelf) counts shall be determined and utilized to avoid long shelf lives.

b. Inventory counts shall be evaluated periodically (a minimum of annually).

c. Items shall be stocked and rotated on the principle of “first in, first out.”

ATTACHMENT:
None.

REFERENCE:
APIC (2018) APIC Implementation guide: Infection Preventionist’s guide to the OR
Central Processing Department Policies and Procedures

Revised: 16/03/08, 20/10/13, 23/01/10, 23/09/14 (Year/Month/Day)
Original adoption: 05/11/01

CONFINED SPACE PROGRAM

POLICY:

Laguna Honda Hospital and Rehabilitation Center (LHH~~aguna Honda~~) is committed to preventing workplace injury and illness due to hazardous environments.

PURPOSE:

To implement and maintain an effective Confined Space Entry Program, pursuant to Title 8, Sections 5157 and 5158 for a Permit Required Confined Space Program and consistent with the City and County of San Francisco Department of Public Health Occupational Safety and Health Policies.

DEFINITIONS:

1. Confined Space

a. A space that is each of the following:

i. Is large enough and so configured that an employee can bodily enter and perform assigned work;

ii. Has limited or restricted means for entry or exit;

iii. Is not designed for continuous employee occupancy.

2. Permit Required Confined Space

a. A confined space that:

i. Contains or has a potential to contain a hazardous atmosphere; or

ii. Contains a material that has the potential for engulfing an entrant; or

iii. Has an internal configuration such that an entrant could be trapped or asphyxiated by inwardly converging walls or by a floor which slopes downward and tapers to a smaller cross section; ~~-~~or

iv. Contains any other recognized serious safety or health hazard.

PROCEDURE:

1. Confined Space Identification and Characterization

Confined spaces that either LHHaguna Honda employees or contractors may enter have been identified in Appendix A and the flow chart in Appendix B. is used to determine whether or not an entry permit is required.

For the permit required confined spaces in Appendix A, LHH will alert exposed employees and other employees performing work in the area, by posting danger signs or by any other equally effective means, of the existence, location of and the danger posed by the permit spaces.
Using a sign reading “DANGER -- PERMIT-REQUIRED CONFINED SPACE, DO NOT ENTER”

2. General Procedures for Work in Confined Spaces

a. Any LHHaguna Honda employee planning to enter a confined space must complete the pre-entry safety checklist (Appendix C).

b. Any employee planning to enter a confined space must notify a Facility Services Supervisor prior to entry. If a Supervisor is not available, entry is not permitted.

c. Neither LHHaguna Honda employees nor contractors may enter any permit required confined space before either Workplace Safety & Emergency Management (WSEM) staff, the Chief Engineer, or designee has signed an entry permit.

d. If the hazards, potential hazards, or hazards introduced by a work procedure can be effectively removed, the space may be classified back to non-permit confined space. Only WSEMorkplace Safety staff, the Chief Engineer, or designee may make this determination.

e. Entry into non-permit confined spaces outside of normal business hours (prior to 7am and after 5pm) is not permitted except in an emergency. If deemed absolutely necessary by the Watch Engineer, entry can be made after notifying SFSD at 4-2319. SFSD must also be contacted every 30 minutes and upon exiting the space.

f. Entry into a permit-required confined space outside normal business hours is prohibited.

3. Non-Permit Entry Procedures

The employee requiring access to the space will:

a. Perform a visual inspection of the confined space without crossing the barrier of the entry access point.

b. Complete the ENTRANT section of the pre-entry safety checklist (Appendix C).

c. If all questions on the ENTRANT section pre-entry safety checklist are answered NO:

   i. Review pre-entry safety checklist with a Supervisor.

   ii. Notify designated Supervisor of entry time.

   iii. Establish contact with designated Supervisor at each 30 minute interval of occupancy and upon exiting space.

d. If any question on the ENTRANT section of the pre-entry safety checklist is answered yes, the space is re-classified as a permit--required confined space.

   i. DO NOT ENTER space.

   ii. Secure entry access point.

   iii. Provide the pre-entry safety checklist to a Supervisor and follow the procedures for entry into a permit required confined space.

4. Permit Entry Procedures

~~Permit-required confined space program (permit space program). Under the permit required confined space program required by subsection (e)(4), the employer shall:~~

~~(1) Implement the measures necessary to prevent unauthorized entry;~~

~~(2) Identify and evaluate the hazards of permit spaces before employees enter them;~~

~~(3) Develop and implement the means, procedures, and practices necessary for safe permit space entry operations, including, but not limited to, the following:~~

~~(A) Specifying acceptable entry conditions;~~

~~(B) Isolating the permit space;~~

~~(C) Purging, inerting, flushing, or ventilating the permit space as necessary to eliminate or control atmospheric hazards;~~

~~(D) Providing pedestrian, vehicle, or other barriers as necessary to protect entrants from external hazards; and~~

~~(E) Verifying that conditions in the permit space are acceptable for entry throughout the duration of an authorized entry.~~

~~(4) Provide the following equipment (specified in subsections (A) through (I), below) at no cost to employees, maintain that equipment properly, and ensure that employees use that equipment properly:~~

~~(A) Testing and monitoring equipment needed to comply with subsection (d)(5);~~

~~(B) Ventilating equipment needed to obtain acceptable entry conditions;~~

~~(C) Communications equipment necessary for compliance with subsections (h)(3) and (i)(5);~~

~~(D) Personal protective equipment insofar as feasible engineering and work practice controls do not adequately protect employees;~~

~~(E) Lighting equipment needed to enable employees to see well enough to work safely and to exit the space quickly in an emergency;~~

~~(F) Barriers and shields as required by subsection (d)(3)(D);~~

~~(G) Equipment, such as ladders, needed for safe ingress and egress by authorized entrants;~~

~~(H) Rescue and emergency equipment needed to comply with subsection (d)(9), except to the extent that the equipment is provided by rescue services; and~~

~~(I) Any other equipment necessary for safe entry into and rescue from permit spaces.~~

~~(5) Evaluate permit space conditions as follows when entry operations are conducted:~~

~~(A) Test conditions in the permit space to determine if acceptable entry conditions exist before entry is authorized to begin, except that, if isolation of the space is infeasible because the space is large or is part of a continuous system (such as a sewer), pre-entry testing shall be performed to the extent feasible before entry is authorized and, if entry is authorized, entry conditions shall be continuously monitored in the areas where authorized entrants are working;~~

~~(B) Test or monitor the permit space as necessary to determine if acceptable entry conditions are being maintained during the course of entry operations, and~~

~~(C) When testing for atmospheric hazards, test first for oxygen, then for combustible gases and vapors, and then for toxic gases and vapors.~~

~~(D) Provide each authorized entrant or that employee's authorized representative an opportunity to observe the pre-entry and any subsequent testing or monitoring of permit spaces;~~

(E) Reevaluate the permit space in the presence of any authorized entrant or that employee's authorized representative who requests that the employer conduct such reevaluation because the entrant or representative has reason to believe that the evaluation of that space may not have been adequate;

(F) Immediately provide each authorized entrant or that employee's authorized representative with the results of any testing conducted in accord with subsection (d).

NOTE: Atmospheric testing conducted in accordance with Appendix B would be considered as satisfying the requirements of this subsection. For permit space operations in sewers, atmospheric testing conducted in accordance with Appendix B, as supplemented by Appendix E, would be considered as satisfying the requirements of this subsection.

(6) Provide at least one attendant outside the permit space into which entry is authorized for the duration of entry operations;

NOTE: Attendants may be assigned to monitor more than one permit space provided the duties described in subsection (i) can be effectively performed for each permit space that is monitored. Likewise, attendants may be stationed at any location outside the permit space to be monitored as long as the duties described in subsection (i) can be effectively performed for each permit space that is monitored.

(7) If multiple spaces are to be monitored by a single attendant, include in the permit program the means and procedures to enable the attendant to respond to an emergency affecting one or more of the permit spaces being monitored without distraction from the attendant's responsibilities under subsection (i);

(8) Designate the persons who are to have active roles (as, for example, authorized entrants, attendants, entry supervisors, or persons who test or monitor the atmosphere in a permit space) in entry operations, identify the duties of each such employee, and provide each such employee with the training required by subsection (g);

(9) Develop and implement procedures for rescuing entrants from permit spaces, for providing necessary emergency services to rescued employees, for summoning additional rescue and emergency services, and for preventing unauthorized personnel from attempting a rescue;

(10) Develop and implement a system for the preparation, issuance, use, and cancellation of entry permits as required by this section;

(11) Develop and implement procedures to coordinate entry operations when employees of more than one employer are working simultaneously as authorized entrants in a permit space, so that employees of one employer do not endanger the employees of any other employer. If the requirements of sections 5158 or 8355 apply to one or more of the other employers, then the procedures shall also ensure coordination with those employers, so as not to endanger any exposed employees;

(12) Develop and implement procedures (such as closing off a permit space and canceling the permit) necessary for concluding the entry after entry operations have been completed;

(13) Review entry operations when the employer has reason to believe that the measures taken under the permit space program may not protect employees and revise the program to correct deficiencies found to exist before subsequent entries are authorized; and

NOTE: Examples of circumstances requiring the review of the permit space program are: any unauthorized entry of a permit space, the detection of a permit space hazard not covered by the permit, the detection of a condition prohibited by the permit, the occurrence of an injury or near-miss during entry, a change in the use or configuration of a permit space, and employee complaints about the effectiveness of the program.

(14) Review the permit space program, using the canceled permits retained under subsection (e)(6) within 1 year after each entry and revise the program as necessary, to ensure that employees participating in entry operations are protected from permit space hazards.

NOTE: Employers may perform a single annual review covering all entries performed during a 12-month period. If no entry is performed during a 12-month period, no review is necessary.

Appendix C presents examples of permit space programs that are considered to comply with the requirements of subsection (d).

(e) Permit system.

(1) Before entry is authorized, the employer shall document the completion of measures required by subsection (d)(3) by preparing an entry permit.

NOTE: Appendix D presents examples of permits whose elements are considered to comply with the requirements of this section.

(2) Before entry begins, the entry supervisor identified on the permit shall sign the entry permit to authorize entry.

(3) The completed permit shall be made available at the time of entry to all authorized entrants or their authorized representatives, by posting it at the entry portal or by any other equally effective means, so that the entrants can confirm that pre-entry preparations have been completed.

(4) The duration of the permit may not exceed the time required to complete the assigned task of job identified on the permit in accordance with subsection (f)(2).

(5) The entry supervisor shall terminate entry and cancel the entry permit when:

~~(A) The entry operations covered by the entry permit have been completed; or~~

~~(B) A condition that is not allowed under the entry permit arises in or near the permit space.~~

~~(6) The employer shall retain each canceled entry permit for at least 1 year to facilitate the review of the permit space program required by subsection (d)(14). Any problems encountered during an entry operation shall be noted on the pertinent permit so that appropriate revisions to the permit space program can be made.~~

~~(f) Entry permit. The entry permit that documents compliance with this section and authorizes entry to a permit space shall identify:~~

~~(1) The permit space to be entered;~~

~~(2) The purpose of the entry;~~

~~(3) The date and the authorized duration of the entry permit;~~

~~(4) The authorized entrants within the permit space, by name or by such other means (for example, through the use of rosters or tracking systems) as will enable the attendant to determine quickly and accurately, for the duration of the permit, which authorized entrants are inside the permit space;~~

~~NOTE: This requirement may be met by inserting a reference on the entry permit as to the means used, such as roster or tracking systems, to keep track of the authorized entrants within the permit space.~~

~~(5) The personnel, by name, currently serving as attendants;~~

~~(6) The individual, by name, currently serving as entry supervisor, with a space for the signature or initials of the entry supervisor who originally authorized entry;~~

~~(7) The hazards of the permit space to be entered;~~

~~(8) The measures used to isolate the permit space and to eliminate or control permit space hazards before entry;~~

~~NOTE: Those measures can include the lockout or tagging of equipment and procedures for purging, inerting, ventilating, and flushing permit spaces.~~

~~(9) The acceptable entry conditions;~~

~~(10) The results of initial and periodic tests performed under subsection (d)(5) accompanied by the names or initials of the testers and by an indication of when the tests were performed;~~

~~(11) The rescue and emergency services that can be provided on-site and additional service that can be summoned and the means such as the equipment to use and the numbers to call) for summoning those services;~~

~~(12) The communication procedures used by authorized entrants and attendants to maintain contact during the entry;~~

~~(13) Equipment, such as personal protective equipment, testing equipment, communications equipment, alarm systems, and rescue equipment, to be provided for compliance with this section;~~

~~(14) Any other information whose inclusion is necessary, given the circumstances of the particular confined space, in order to ensure employee safety, and~~

~~(15) Any additional permits, such as for hot work, that have been issued to authorize work in the permit space.~~

~~(g) Training.~~

~~(1) The employer shall provide training so that all employees whose work is regulated by this section acquire the understanding, knowledge, and skills necessary for the safe performance of the duties assigned under this section.~~

~~(2) Training shall be provided to each affected employee:~~

~~(A) Before the employee is first assigned duties under this section;~~

~~(B) Before there is a change in assigned duties;~~

~~(C) Whenever there is a change in permit space operations that presents a hazard about which an employee has not previously been trained;~~

~~(D) Whenever the employer has reason to believe either that there are deviations from the permit space entry procedures required by subsection (d)(3) or that there are inadequacies in the employee's knowledge or use of these procedures.~~

~~(3) The training shall establish employee proficiency in the duties required by this section and shall introduce new or revised procedures, as necessary, for compliance with this section.~~

~~(4) The employer shall certify that the training required by subsections (g)(1) through (g)(3) has been accomplished. The certification shall contain each employee's name, the signatures or initials of the trainers, and the dates of training. The certification shall be available for inspection by employees and their authorized representatives.~~

~~(h) Duties of authorized entrants. The employer shall ensure that all authorized entrants:~~

~~(1) Know the hazards that may be faced during entry, including information on the mode, signs or symptoms, and consequences of the exposure;~~

~~(2) Properly use equipment as required by subsection (d)(4);~~

~~(3) Communicate with the attendant as necessary to enable the attendant to monitor entrant status and to enable the attendant to alert entrants of the need to evacuate the space as required by subsection (i)(6);~~

~~(4) Alert the attendant whenever:~~

~~(A) The entrant recognizes any warning sign or symptom of exposure to a dangerous situation, or~~

~~(B) The entrant detects a prohibited condition; and~~

~~(5) Exit from the permit space as quickly as possible whenever:~~

~~(A) An order to evacuate is given by the attendant or the entry supervisor,~~

~~(B) The entrant recognizes any warning sign or symptom of exposure to a dangerous situation,~~

~~(C) The entrant detects a prohibited condition, or~~

~~(D) An evacuation alarm is activated.~~

~~(i) Duties of attendants. The employer shall ensure that each attendant:~~

~~(1) Knows the hazards that may be faced during entry, including information on the mode, signs or symptoms, and consequences of the exposure;~~

~~(2) Is aware of possible behavioral effects of hazard exposure in authorized entrants;~~

~~(3) Continuously maintains an accurate count of authorized entrants in the permit space and ensures that the means used to identify authorized entrants under subsection (f)(4) accurately identifies who is in the permit space;~~

~~(4) Remains outside the permit space during entry operations until relieved by another attendant;~~

~~NOTE: When the employer's permit entry program allows attendant entry for rescue, attendants may enter a permit space to attempt a rescue if they have been trained and equipped for rescue operations as required by subsection (k)(1) and if they have been relieved as required by subsection (i)(4).~~

~~(5) Communicates with authorized entrants as necessary to monitor entrant status and to alert entrants of the need to evacuate the space under subsection (i)(6);~~

~~(6) Monitors activities inside and outside the space to determine if it is safe for entrants to remain in the space and orders the authorized entrants to evacuate the permit space immediately under any of the following conditions;~~

~~(A) If the attendant detects a prohibited condition;~~

~~(B) If the attendant detects the behavioral effects of hazards exposure in an authorized entrant;~~

~~(C) If the attendant detects a situation outside the space that could endanger the authorized entrants; or~~

~~(D) If the attendant cannot effectively and safely perform all the duties required under subsection (i);~~

~~(7) Initiate on-site rescue procedures and, if necessary, summon additional rescue and other emergency services as soon as the attendant determines that authorized entrants may need assistance to escape from permit space hazards;~~

~~(8) Takes the following actions when unauthorized persons approach or enter a permit space while entry is underway:~~

~~(A) Warn the unauthorized persons that they must stay away from the permit space;~~

~~(B) Advise the unauthorized persons that they must exit immediately if they have entered the permit space; and~~

~~(C) Inform the authorized entrants and the entry supervisor if unauthorized persons have entered the permit space;~~

~~(9) Performs non-entry rescues or other rescue services as part of the employer's on-site rescue procedure; and~~

~~(10) Performs no duties that might interfere with the attendant's primary duty to monitor and protect the authorized entrants.~~

~~(j) Duties of entry supervisors. The employer shall ensure that each entry supervisor:~~

~~(1) Knows the hazards that may be faced during entry, including information on the mode, signs or symptoms, and consequences of the exposure;~~

~~(2) Verifies, by checking that the appropriate entries have been made on the permit, that all tests specified by the permit have been conducted and that all procedures and~~

~~equipment specified by the permit are in place before endorsing the permit and allowing entry to begin;~~

~~(3) Terminates the entry and cancels the permit as required by subsection (e)(5);~~

~~(4) Verifies that rescue services are available and that the means for summoning additional services are operable;~~

~~(5) Removes unauthorized individuals who enter or who attempt to enter the permit space during entry operations; and~~

~~(6) Determines, whenever responsibility for a permit space entry operation is transferred and at intervals dictated by the hazards and operations performed within the space, that entry operations remain consistent with terms of the entry permit and that acceptable entry conditions are maintained.~~

~~4.~~

a. A Facility Services Supervisor will review the pre-entry checklist and the following information to draft a confined space entry permit (Appendix D):

   i. Uses of confined space, which may adversely affect the atmosphere.

   ii. Physical characteristics, configuration and location of the confined space.

   iii. Existing or potential hazards.

   iv. Safety Data Sheets (SDS's) for any product to be used in the operation.

   v. Lockout requirements.

   vi. Processes to be used in the confined space such as cutting or welding.

   vii. Emergency Response capabilities.

b. The Supervisor will provide the draft entry permit to Workplace Safety staff or the Chief Engineer, who will develop a strategy for mitigating the unsafe condition or the hazard introduced by a work procedure (chemicals, or hot work) and complete the Entry Permit, and if applicable, the Hot Work Permit. The control strategy may include one or more of the following methods

   i. Pre-entry atmospheric testing;

   ii. Continuous atmospheric testing (personal and/or area);

   iii. Use of an entry attendant;

iv. Natural ventilation;

v. Mechanical ventilation;

vi. Lockout/Tagout procedures;

~~vi.~~

vii. Use of respirators or other personal protective equipment;

viii. Use of safety equipment (fire extinguishers, barricades, etc.).

c. The LHH Industrial Hygienist (IH) or Chief Engineer will sign the entry permit, make it available to entrants and post it at the entry site.

d. Prior to entry the LHH IH or Facilities Services Safety Engineer or designee will conduct a safety tailgate meeting with the entrants and attendants to address all aspects of the entry permit and an emergency response plan.

e. Whenever anyone enters a permit-required confined space, an attendant is required to:

i. Be present at all times when employees are in the permit required confined space and shall limit activities to assisting in confined space operations.

ii. Maintain continuous communications with entrants by radio or voice.

iii. Restrict entry in the confined space to those specified on the permit.

iv. Monitor activities of the confined space.

v. Order an evacuation and summon/initiate rescue from outside the confined space.

vi. Remain stationed outside the confined space unless replaced by another trained attendant

f. All atmospheric testing will be completed by an authorized employee trained in gas detector use, and using a gas detector with ~~according to~~ the following protocol:

i. Check the condition of the detector, including current calibration, battery charge, and proper working order. Do not use a meter that is not calibrated or not functioning properly.

ii. The detector should be used in a clean environment for several minutes before testing the atmosphere in the confined space.

iii. The confined space atmosphere will be tested in the following order:

- Oxygen content;
- Flammable gases and vapors;
- Toxic air contaminants;

iv. Testing will be performed to attain reading from the top, middle and bottom of the confined space.

v. The space will be monitored as necessary to determine if acceptable entry conditions are being maintained during the course of entry operations. This may include having entrants wear monitors.

vi. If a hazardous atmosphere is detected during entry, all employees will be evacuated from the space and the entry permit will be canceled and the space re-evaluated. There may be no hazardous atmosphere within the space whenever any employee is inside the space.

vii. LHH shall verify that the space is safe for entry and that the pre-entry measures required have been taken, through a written certification that contains the date, the location of the space, and the signature of the person providing the certification. The certification shall be made before entry and shall be made available to each employee entering the space or to that employee's authorized representative.

viii. Any employee who enters the space, or that employee's authorized representative, shall be provided an opportunity to observe the pre-entry testing required.

~~LHH shall verify that the space is safe for entry and that the pre-entry measures required have been taken, through a written certification that contains the date, the location of the space, and the signature of the person providing the certification. The certification shall be made before entry and shall be made available to each employee entering the space or to that employee's authorized representative.~~

~~vi. Any employee who enters the space, or that employee's authorized representative, shall be provided an opportunity to observe the pre-entry testing required.~~

g. Where ventilation is used to control the atmosphere in a confined space:

i. Ventilation equipment shall be directed at the immediate areas where employees will be present in the confined space.

ii. Source air shall be clean.

iii. Only electric fans shall be used and if the confined space has the potential for an explosive atmosphere, explosion proof ventilation shall be used.

iv. Fans shall be located outside of the confined space when feasible.

v. Egress shall not be impeded by ventilation equipment.

vi. Ventilate the space for at least 15 minutes prior to testing the atmosphere.

vii. Ventilation shall continue until the employee leaves the confined space.

h. Lockout/Tagout requirements will be implemented as indicated by the LHH Lockout/Tackout Program.

i. When WSEM~~orkplace Safety~~ staff or the Chief Engineer determine that PPE is required:

- Equipment shall be provided at no cost to the employee.
- Respirators will be used as indicated by LHH Respiratory Protection Program.
- Other personal protective equipment will be used as indicated by LHH Injury Illness Prevention Program or Personal Protective Equipment Program.

5. Emergency Response

a. Emergency entry rescue service will be established for permit entry, with at least one person trained and immediately available to perform rescue and emergency services. ~~The local Fire Department is the designated emergency entry rescue service.~~

~~b. LHH employees are not authorized and shall not perform entry rescue if hazards cannot be controlled or eliminated prior to entry.~~

~~c.~~b. Emergency rescue procedures shall be reviewed prior to each PERMIT REQUIRED entry.

~~d.~~c. The attendant shall establish communication with the Facility Services Supervisor prior to entry ~~in case the emergency entry rescue service (Fire Department) must be summoned~~.

~~e.~~d. Attendant will be present and responsible for maintaining communication with entrants, monitoring conditions in and out of confined space, preventing unauthorized entry, ordering an evacuation, and initiating emergency procedures.

~~f.~~e. Entrants will initiate self-rescue if conditions change, such as the gas monitor alarm has been activated.

f. The attendant will initiate non-entry rescue and contact the Facility Services Supervisor if entrants are unable to perform self-rescue.

g. To facilitate non-entry rescue, retrieval systems or methods shall be used whenever an authorized entrant enters a permit space, unless the retrieval equipment would increase the overall risk of entry or would not contribute to the rescue of the entrant. Retrieval systems shall meet the following requirements.

h. Each authorized entrant shall use a chest or full body harness, with a retrieval line attached at a suitable point so that when rescued, the entrant presents the smallest possible profile (for example at the center of the entrant's back near shoulder level, or above the entrant's head). Wristlets may be used in lieu of the chest of full body harness if the employer can demonstrate that the use of a chest or full body harness is infeasible or creates a greater hazard and that the use of wristlets is the safest and most effective alternative.

a. The other end of the retrieval line shall be attached to a mechanical device or fixed point outside the permit space in such a manner that rescue can begin as soon as the rescuer becomes aware that rescue is necessary. A mechanical device shall be available to retrieve personnel from vertical type permit spaces more than 5 feet deep.

~~g.~~b. If an injured entrant is exposed to a substance for which a Safety Data Sheet (SDS) or other similar written information is required to be kept at the worksite, that SDS or written information shall be made available to the medical facility treating the exposed entrant.

~~h. If non-entry rescue does not work, the Facility Services Supervisor will inform the Fire Department of the hazards they may confront so they can equip and conduct themselves appropriately and assist where needed.~~

~~To facilitate non-entry rescue, retrieval systems or methods shall be used whenever an authorized entrant enters a permit space, unless the retrieval equipment would increase the overall risk of entry or would not contribute to the rescue of the entrant. Retrieval systems shall meet the following requirements.~~

~~Each authorized entrant shall use a chest or full body harness, with a retrieval line attached at a suitable point so that when rescued, the entrant presents the smallest possible profile (for example at the center of the entrant's back near shoulder level, or above the entrant's head). Wristlets may be used in lieu of the chest of full body harness if the employer can demonstrate that the use of a chest or full body harness is infeasible or creates a greater hazard and that the use of wristlets is the safest and most effective alternative.~~

~~(B) The other end of the retrieval line shall be attached to a mechanical device or fixed point outside the permit space in such a manner that rescue can begin as soon as the rescuer becomes aware that rescue is necessary. A mechanical device shall be available to retrieve personnel from vertical type permit spaces more than 5 feet deep.~~

~~(4) If an injured entrant is exposed to a substance for which a Safety Data Sheet (SDS) or other similar written information is required to be kept at the worksite, that SDS or written information shall be made available to the medical facility treating the exposed entrant.~~

6. Hot Work Permit

A hot work permit (Appendix E) must be completed by the Safety Engineer or the Senior Safety Engineer, ~~Workplace Safety staff, the Chief Engineer,~~ or designee before any of the following work procedures are to be performed in any confined space:

a. Welding

b. Cutting

c. Heating

d. Any other procedure that may produce a source of ignition

REFERENCE:
73-01 Laguna Honda Injury and Illness Prevention Program

ATTACHMENT:

Appendix A: List of Confined Spaces
Appendix B: Confined Space Classification Flow Chart
Appendix C: Laguna Honda Confined Space Pre–Entry Safety Checklist
Appendix D: Laguna Honda Confined Space Entry Permit
Appendix E: Hot Work Permit

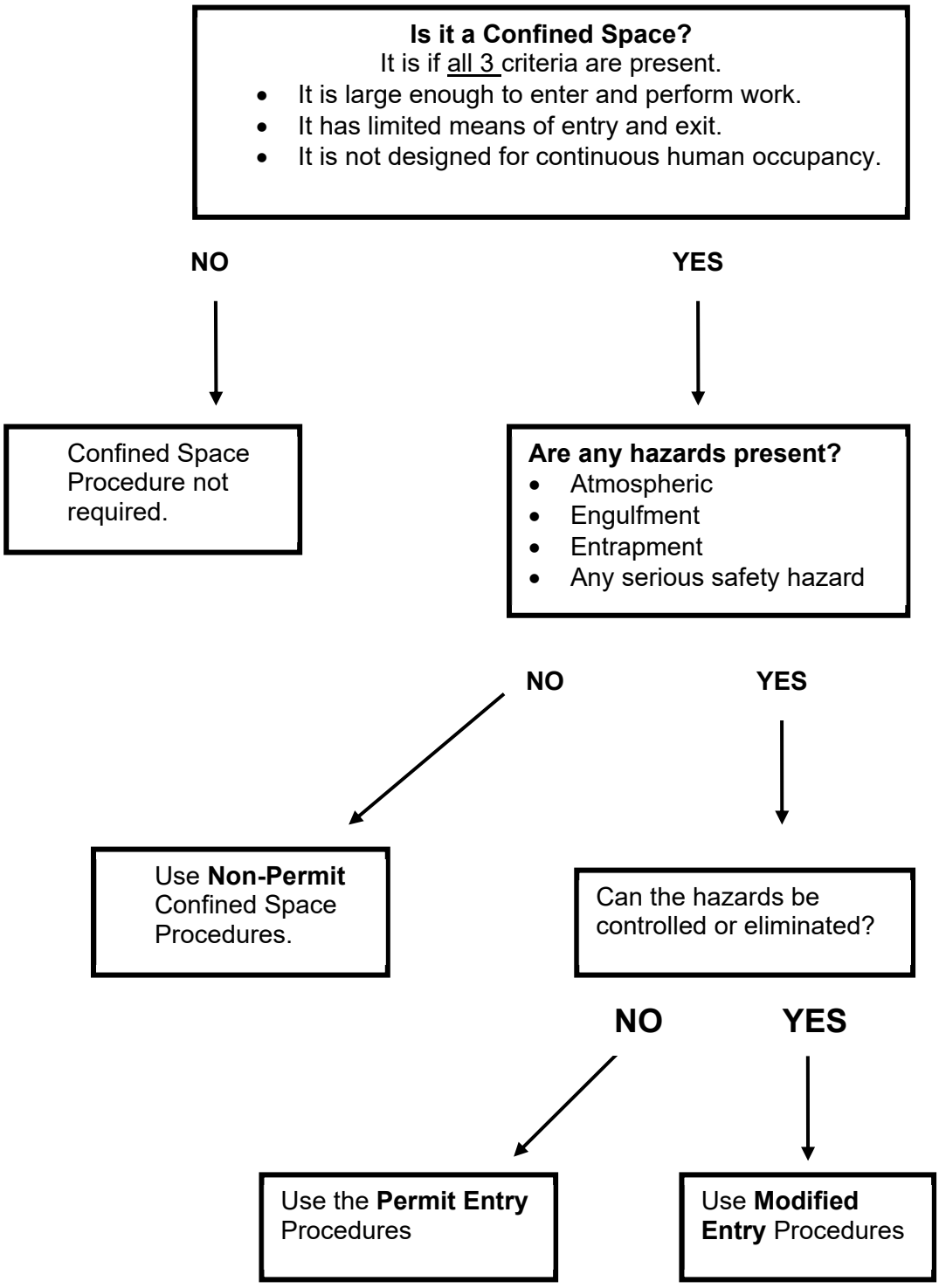
Original adoption: 17/01/10 (Year/Month/Day)

Appendix A: List of Confined Space Access Points at Laguna Honda

Building	Access point Number	Description of Space	Access Point Location(s)
Admin	A1	A wing basement crawlspace	End of A Wing inside exit stairwell
Admin	A2	Mechanical room under stage	Under stage in Simon theater
Admin	A3	A wing crawlspace	Hatch @ bottom of stairs to SFSD office
Admin	A4	Simon Theater crawlspace	Wall Hatch @ bottom of stair 1
Admin	A5	Main tunnel	1st Floor through boiler room
Admin	A6	Simon Theater crawlspace	5 Screens on exterior of H wing
Admin	A7	Main tunnel	Floor Hatch outside -D2
Admin	A8	Main tunnel	Wall Hatch outside D2
Admin	A9	Main tunnel	Hatch on Exterior by G wing
Admin	A10	C wing crawlspace	C wing-Eastside Exterior door in sump pit
Admin	A11	C wing crawlspace	Wall hatch inside storage space at end of C wing
Admin	A12	B wing crawlspace	B Wing Eastside – Exterior Space door in sump pit
Admin	A13	B wing crawlspace	Wall Hatch inside COPC clinic shop
Admin	A14	D wing crawlspace	D Wing - -Exterior Space door in sump pit
Admin	A15	E wing crawlspace	Exterior Hatch Westside E wing towards main spine
Admin	A16	E wing crawlspace	Wall Hatch at the bottom of E Wing
Admin	A17	E wing crawlspace	E Wing - Exterior Space door in sump pit
Admin	A18	K wing crawlspace	Access grate in ground
Admin	A19	K wing crawlspace	Access grate in ground
Admin	A20	K wing crawlspace	K wing- Eastside
Admin	A21	M wing crawlspace	Exterior hatch at end of M Wing
Admin	A22	M wing crawlspace	Wall hatch to hot H20 tank
Admin	A23	Main tunnel	Floor hatch inside M3 mechanical room
Admin	A24	Main tunnel	Wall hatch at end of corridor 3rd floor
Admin	A25	Boneyard crawl space	Door in rear of boneyard
Admin	A26	Boneyard	4th floor end of corridor between M&O wings
Admin	A27	Load center C	Vault in O3 mechanical space
Admin	A28	O wing crawlspace	Wall hatch to hot h20 tank
Admin	A29	Main water supply valve pit	Valve pit in O4 East side patio area
Admin	A30	O wing crawlspace	Exterior Hatch at end of O wing
Admin	A31	L wing crawlspace	Access grate in ground
Admin	A32	L wing crawlspace	Access gate in ground
Admin	A33	Main tunnel	Steam tunnel access at bottom Stairwell
Admin	A34	F wing crawlspace	F wing exterior door in sump pit
Admin	A35	F wing crawlspace	Exterior hatch west side F wing

H Bld	H1	12 AHUs and exhaust fans	Roof of H building through PFS break room
Link Building	L1	Kitchen AHU	Roof of link building
Link Building	L2	Café AHU	Roof of link building
Link Building	L3	Pharmacy AHU	Roof of link building
Link Building	L4	Gaylord hood system	Roof of link building
Link Building		Loading dock lifts	kitchen loading dock
Pavilion	P1	P1 crawl space	back of clinic
Pavilion	P2	PM crawl space	behind PMA Nurses' station
Pavilion	P3	2 AHUs and IDECS	Pavilion roof
Pavilion	P4	Kitchen dumbwaiter	kitchen and cafeteria
Pavilion	P5	Mezzanine mechanical room	
Pavilion	P6	Pool AHU #6	
South Tower	S1	2 AHUs and IDECS	South tower roof
South Tower	S2	2 boilers	South tower boiler room
South Tower	S3	Hot water storage tank	
South Tower	S4	Heating hot water tank	
South Tower	S5	Linen chute	soiled linen room on each floor
North Tower	N1	2 AHUs	North tower roof
North Tower	N2	2 loading dock lifts	North loading dock
North Tower	N3	Linen chute	soiled linen room on each floor
Grounds	G1	Vaults	
Grounds	G2	Cistern	horseshoe parking area
Grounds	G3	Grease trap tank	
Grounds	G4	4 USTs	
Grounds	G5	1 Above ground fuel tank	
Grounds	G6	Old generator	
Grounds	G7	2 Water tanks	Hill behind east parking lot

Appendix B:
Confined Space Classification Flow Chart



Appendix C:
Laguna Honda Confined Space Pre–Entry Safety Checklist

Instructions: THIS FORM MUST BE COMPLETED BEFORE EVERY ENTRY INTO A NON PERMIT CONFINED SPACE. Complete the form and notify a Facility Services Supervisor before prior to entry. Maintain this record in LHH CONFINED SPACE LOG binder in the Facility Services Office.

ENTRANT SECTION

DATE _____

Name of Entrant(s) _____

Description of intended work tasks _____

Area to be entered _____

Entry Access Point _____

	Circle One	
Will chemicals such as glues or paints be used inside the space?	**Y**	**N**
Will "hot work" (welding, cutting etc.) be performed, or the use of any equipment that may introduce a source of ignition inside the space?	**Y**	**N**
Is heavy equipment such as generators, tractors, backhoes, forklifts, trucks or cars operating near the space -- that may create an oxygen–deficient environment?	**Y**	**N**
Is there evidence of engulfment hazards such as water, soil, or sewage inside the space?	**Y**	**N**
Is there plant debris or decaying animal matter inside the space that can create a hydrogen sulfide exposure hazard?	**Y**	**N**
Is there evidence of toxic air contaminants inside the space?	**Y**	**N**
Is any other hazardous condition present or probable to develop while inside the space?	**Y**	**N**

If you answered YES to any of the above questions:
Do not enter the space and report to a supervisor for further instruction.
If you answered NO to all of the above questions, ask your Supervisor to complete the sections below.

SUPERVISOR SECTION

Facilities Services Supervisor _____
PRINT NAME SIGN NAME /DATE/TIME

Will the entrant be working alone? YES NO

What is the estimated length of entry _____ mins

Do any systems require lockout? YES NO Specify:

Recommended Personal Protective Equipment	Respirator (consult Industrial Hygienist) Fire Extinguisher First Aid Kit Barricades, Signs, Cones Hearing Protection Gloves Coveralls	Access Ladder Safety Glasses Face Shield & Goggles Hardhat Safety Shoes/Boots Other_____

SAFETY SECTION

Inspection Findings:

Status of Space:
(Circle One) Non-Permit Permit Required

Appendix D:

Laguna Honda Confined Space Entry Permit

Permit valid for one entry and one work shift only.
Start Date & Time:_____ End Date & Time:_____
Location and ID of Permit Space:_____
Reason for Entry (Description of Work):_____

List of Materials/Chemicals in or brought into space: (attach all SDSs)_____

List of equipment in or brought into space:_____

Entry Supervisor:_____
Entry Personnel:_____

Attendant(s):_____

Pre-Entry Atmospheric Testing:
Date: _____ Time: _____
Oxygen: _____% Other Toxic Gas/Vapor: _____ _____ ppm
LEL: _____% Other Toxic Gas/Vapor: _____ _____ ppm

Acceptable Entry Conditions:
% O2: 19.5-23.5%
% LEL: <10%
Other toxic gases/vapors: consult IH

Signature of person completing testing: _____

Hazards Identified Initials _____

Oxygen deficiency (less than 19.5 %)	Mechanical
Oxygen over 23.5 %	Slippery Surface
Flammable gases/vapors (at or above 10% of the lower explosive limit (LEL))	Vertical Drop/Falls
	Low or High Temperature
Toxic gases/vapors (from materials in space or chemicals to be used in space)	Interior Slope
	Low Overhead
HOT WORK (requires additional precautions)	Engulfment
Electrical	Other (specify):_____

Isolation/Lockout-Tagout/Controls Initials _____

Cleaned, drained, washed & purged
Electrical Lock-out/Tag-out Completed LIST ___
_____
Mechanical LOTO Completed LIST
_____
Pneumatic LOTO Completed LIST _____
_____
Ventilation (specify method) – Natural or Mechanical (electric powered or gasoline powered)
_____
Coordination with Contractor Completed

Equipment Required Initials _____

Personal Protective Equipment	Safety Equipment
Safety Glasses	Gas Meter
Goggles	Full Body Harness and Lifeline
Face Shield & Goggles	Personal Distress Device (each person)
Coverall	Tripod w/ Mechanical Retrieval Device
Hardhat	Two way Radio
Gloves	Fire Extinguisher
Safety Shoes/Boots	First Aid Kit
Respirator _____	Barricades, Signs, Cones
10 minute Escape Pack	Ground Fault Circuit Interrupters
Hearing Protection	Lighting/Explosion Proof Flashlight
Other_____	Access Ladder

Emergency/Rescue Procedures

a. Do not enter the confined space to rescue entrants.
b. Contact Supervisor, dial 911 if no response.
c. Keep one employee present outside the space to monitor the rescue effort, and direct the Fire Department to the victim(s).
d. If the victim(s) can be removed by the hoisting device, provide CPR and First Aid as necessary until emergency response personnel arrive.

Pre-Entry Safety Briefing Held (List all Entrants, Standby, Supervisors, etc)

Name	Signature

Periodic Atmospheric Testing: Initials _____

Detector	Time	Location	% Oxygen	%LEL	Potential Toxic Gases/Vapors	Conc. (ppm)	Initial

Acceptable Entry Conditions:

% O2: 19.5-23.5%
% LEL: <10%
Other toxic gases/vapors: consult IH

Workplace Safety /Chief Engineer or Designee Authorization:
I certify that required precautions have been taken & necessary equipment is provided for confined space entry.

_____ _____ _____
Print Name Signature Date & Time

Appendix E: Hot Work Permit

36RE98

HOT WORK PERMIT

The supervisor, in issuing this permit, certifies that all safety factors have been considered and cared for satisfactorily. Return this permit upon completion of the job which it is to cover to the authorizing supervisor. The supervisor will write "complete", date and initial across the face of the permit.

AREA OF HOT WORK:

WORK TO BE DONE:

OTHER SIDE MUST BE FILLED OUT!

APPROVAL

I have personally checked the conditions necessary and as specified. I authorize this "Hot" work to begin.

APPROVED BY:

DATE: TIME:

HOT WORK PERMIT IS GOOD FOR HOURS ONLY.

THIS PERMIT CAN BE ISSUED FOR ONLY ONE SHIFT.
IT BECOMES VOID AT THE END OF WORK SHIFT DAY.

	YES	NO	N/A
1. Read the Hot Work Permit Procedure.			
2. Work area and equipment has been made free of flammable, combustible, and hazardous materials.			
3. Gas test taken.			
4. Is a fire extinguisher on the job?			
5. Smoke alarms covered?			
6. Lines disconnected and/or blanked?			
7. Is fire watch provided?			
8. Adjoining equipment and operations considered ok from standpoint of possible effect on the job.			
9. Other necessary precautions. SPECIFY:			

SEE OTHER SIDE!

THIS PERMIT CAN BE ISSUED FOR ONLY ONE SHIFT.
IT BECOMES VOID AT THE END OF WORK SHIFT DAY.

THEFT AND LOST PROPERTY

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (LHH) shall provide a means to help facilitate the return of personal belongings lost on the LHH campus.

2. San Francisco Sheriff's Office (SFSO) shall be notified to report missing property due to theft.

3. LHH is not responsible for lost items of staff, volunteers, visitors, and/or contractors.

4. Personal belongings found that are unclaimed for 30 days shall be discarded or donated to the Volunteer Services department for processing.

5. For lost or stolen property belonging to residents or patients, a grievance must be filed in addition to pursuing the claims process.

PURPOSE:

To facilitate the return of property to the rightful owner and dispose unclaimed items. To promote property loss control, minimize theft through intervention, and provide a process to report resident loss of property.

PROCEDURE:

1. Lost and Found Items

a. Any person who loses personal belongings or finds property shall:

   i. Place items in the receptacles labeled "lost and found" located in the hospital lobby and atrium or bring items to the Administration office.

   ii. The person(s) who located an item(s) shall provide as much information as possible to Administration staff.

b. Administration staff shall record items brought to their attention or deposited in the bins on the Lost and Found log stored in the Administration Office.

c. Items found will be stored for 30 days in the Administration Office.

d. Administration staff shall contact the owner if sufficient identification is indicated on the item and check the lost items list to see if the item has been reported lost.

e. Lost items may be claimed from the Administration Office after a description of the lost item and identification of the person claiming the item is provided.

f. Persons who are unable to locate their lost items in the Administration Office may be referred to SFSO to file a report, if appropriate.

g. Disposition of items found:

i. Soiled items will be discarded immediately.

ii. Property not claimed after 30 days from date of log in shall be donated to the LHH Volunteer Services department.

2. Theft of Property

a. LHH staff shall report theft of property to SFSO.

b. SFSO shall follow their internal processes in responding to the report of theft that may include preparing a Police Incident Report that is processed through the criminal justice system or providing a liaison with the San Francisco Police Department to assist with further investigation.

c. SFSO shall maintain theft reports and statistical data.

d. LHH Administration and SFSO shall meet twice a year to review statistical data to improve prevention of theft.

3. Claims and Liability

a. The resident may file a claim for loss of property, by completing a claim form entitled "Claim Against the City and County of San Francisco". The filing of a claim form does not guarantee reimbursement for the lost or stolen property. ~~Social Worker or any member of Resident Care Team may assist resident in completing claims form.~~

b. The Medical Social Worker (MSW) or any member of Resident Care Team (RCT) may assist resident in completing claims form.

c. The MSW or any member of the RCT shall assist the resident with or complete a grievance on behalf of the resident/patient that has a loss of property.

~~b.~~d. LHH is liable for damage or loss of the personal property of a resident, but only if negligence or willful wrongdoing on the part of LHH or its employee is shown. LHH may also deny liability when reasonable efforts to safeguard the resident's personal property has been provided and the resident chooses to take other actions, or the property is not listed on the resident's IRP. Liability is subject to the

amounts provided by law, including Civil Code sections 1840, 1859.
~~Refer to LHHPP 22-05 Handling Resident's Property and Prevention of Theft and Loss for more detail.~~

ATTACHMENT:
None.

REFERENCE:
LHHPP 22-05 Handling Resident's Property and Prevention of Theft and Loss
LHHPP 24-06 Resident/Patient Visitor Complaints and Grievances

Revised: 94/08/15, 12/09/25, 19/09/10~~, 23/08/08~~ (Year/Month/Day)
Original adoption: 93/05/20

Revised Clinical Nutrition Policies and Procedures

1.16 Nutrition Screening and Documentation Process

Revised: ~~8/23~~11/23

Policy: All residents admitted shall receive a nutrition and hydration screening. A complete comprehensive assessment, quarterly review and reassessment shall be documented in the EHR according to the guidelines mandated by California Code of Regulations- Title 22, Center for Medicare and Medicaid Services (CMS) guidelines, and the OBRA Federal Statute.

Purpose: To provide medical nutrition therapy for our residents and communicate the nutrition plan of care to the Resident Care Team (RCT) and comply with the State and Federal guidelines.

Procedure:

1. The dietetic technician (DTR) or Registered Dietitian (RD) shall complete the initial screening for nutrition risk within 48 hours for newly admitted/readmitted residents to identify immediate nutrition needs and documented in the EHR. A baseline care plan must be developed by the RD within 48 hours of a resident's admission.

2. Within 7 days of admission, the K section of the MDS is completed by the DTR/RD and any other associated CAA section that is identified that needs to be filled out by the RD/DTR. The CAA summary is formulated by the RD.

3. Newly admitted or readmitted residents shall have a comprehensive assessment written by an RD within 14 days of admission. Residents admitted to the medical or rehabilitation acute unit shall be assessed, and a nutritional assessment completed within 3 working days (day of admission day zero) or as needed by nursing risk assessment/MD consult.

4. The Nutrition Care Process (NCP) is used to provide a standardized language through the use of terminology organized by each NCP step, which include Assessment, Diagnosis, Intervention, Monitoring & Evaluation. This is intended to guide the RD and DTR, in providing individualized high-quality nutrition care. The RD or DTR documents subjective and objective data gleaned from the EHR, the resident and/or resident family, meal observations, nursing staff, medical staff and ancillary departments. The ADIME guidelines are below:
    i. ADIME:
        a. ASSESSMENT Nutrition assessment is a systematic method for obtaining, verifying and interpreting data needed to identify nutrition-related problems, their causes and their significance. Data is obtained in the review of clinical history, laboratory indices, discussions with the resident and the health care team. Current food intake from daily meals and supplemental foods are determined through meal observations, contacts with nursing staff and review of the chart notes. When the primary source of nutrition is from enteral feedings, a nutrition professional evaluates the adequacy and suitability of the formula for the resident. It consists of the following elements:
            i. Food/Nutrition related history
            ii. Anthropometric measurements

iii. Biochemical data, medical tests, and procedures
iv. Nutrition-focused physical findings
v. Client history

b. DIAGNOSIS: The purpose of a nutrition diagnosis language is to describe nutrition problems consistently so that they are clear within and outside profession. Nutrition diagnoses typically fall within the following 3 domains:
   i. Intake
   ii. Clinical
   iii. Behavioral-Environment
c. INTERVENTION: Nutrition interventions are specific actions used to remedy a nutrition diagnosis/problem. The RD calculates the resident's individual nutrient needs for calories, protein, fluid and other nutrients. Therapeutic restrictions in the diet, the president's personal food and ethnic preferences and other meal requests are used to develop the meal pattern and immediate goals of nutrition therapy. The RD considers the expected degree of dietary compliance for the resident. Diets are liberalized when appropriate.
d. Four domains of nutrition intervention have been identified:
   i. Food and/or Nutrition Delivery
   ii. Nutrition Education
   iii. Nutrition Counseling
   iv. Coordination of Nutrition Care
e. MONITORING/EVALUATION: The purpose of nutrition monitoring and evaluation is to quantify progress made by the patient/client in meeting nutrition care goals. Nutrition monitoring and evaluation terms are combined with nutrition assessment terms and organized in four domains:
   i. Food/Nutrition-Related History
   ii. Anthropometric Measurements
   iii. Biochemical Data, Medical Tests, and Procedures
   iv. Nutrition-Focused Physical Findings

~~5.~~ Clinical nutrition protocol and guidelines as outlined in Standards of Practice for Clinical Nutrition: Laguna Honda Hospital are used by the RD to assess the resident's current nutritional status. The RD shall complete a review of the resident's nutritional status and the care plan at least quarterly in the EHR, or more frequently as nutritional risk warrants. A comprehensive annual assessment shall be completed based on the MDS schedule.~~in the fourth quarter of each year.~~

5.

6. The RD is a member of the RCT and attends weekly or as scheduled RCT meetings to discuss nutritional status. The plan for the resident's nutritional care is based on goals and interventions discussed in the resident care conference.

7. The care plan for nutrition is coordinated with the resident/caregiver, the core RCT and other ancillary team members, such as speech therapy and occupational therapy. The RD provides expertise in nutritional interventions in acute and chronic diseases, resident nutrition needs, techniques for maximizing independent feeding, food and eating safety, socialization at meals, dietary restrictions in nutrition therapy, individualized meal patterns, food preferences and available menu substitutions. The care plan for nutritional care is documented in the Care Plan section of the EHR along with the initial assessment & the associated CAA. In cooperation with the RCT, the nutrition goals and interventions are developed for nutrition problems triggered in the assessment.

Attachments: Standards of Practice for Clinical Nutrition: Laguna Honda Hospital

References:

Nutrition Care Process Terminology (eNCPT) – Academy of Nutrition and Dietetics
https://www.ncpro.org/nutrition-care-process

CMS guidelines

F692 §483.25 (g)(1)(2)(3)
F693 §483.25 (g)(4)-(5)
F636 §483.20 (b)
F655, F656, F657§483.21 (a)

1.19 Acute Medical/Rehab Admissions/Transfers

Revised: ~~8/23~~11/23

Policy: When Residents are diagnosed with an acute medical problem requiring a transfer to an acute nursing unit, diet orders for meals and supplements will be cancelled. Meals and other scheduled food orders will be held until a new diet order is received from the attending physician.

Purpose: To assure that residents receive the appropriate diet for their current medical condition.

Procedure:

1. Communications: The Diet Clerks run the daily admission/discharge/transfer report prior to each meal. The diet clerk communicates via EPIC secure chat to the assigned Registered Dietitian (RD) and Dietetic Technician (DTR) and informs them of the admission, discharge, or transfer to an acute unit.

2. Once the resident is transferred, the receiving acute unit orders the new diet order via EPIC and diet order interfaces with the CBORD system to update the individual residents card file. The same process of notification occurs when the resident leaves the acute unit to return to SNF unit.

3. All foods are discontinued for the resident if on an NPO order. No meals, ~~or~~ supplements or other foods will be sent to the resident until a diet is ~~unless~~ ordered by the Physician ~~and checked by the RD~~. -All nourishment bag meals shall be removed from the tray line set up and nourishment delivery cart.

1.20 Nutrition Screening and Assessment Documentation for Acute Hospital Admissions

Revised:~~8/23~~ 11/23

Policy: All residents admitted to the medical or rehabilitation hospital acute unit shall receive a Nursing nutrition screen within 24 hours of admission. A complete comprehensive assessment and follow up shall be documented by the RD in the EHR according to the guidelines established and outlined for determination of priority level.
Purpose: To provide medical nutrition therapy for our residents and communicate the nutrition plan of care to the Resident Care Team (RCT).
Procedure:
Residents admitted to the medical or rehabilitation hospital acute unit shall have a nutritional assessment completed within the guidelines established for low, medium, and high risk.

1. Newly admitted residents shall have a Nursing Nutrition Screen completed in the EHR to identify nutrition needs. The RD follows the established guidelines (see table below) for identifying risk level and completes the nutrition assessment.

2. The Nutrition Care Process (NCP) is used to provide a standardized language using terminology organized by each NCP step, which include Assessment, Diagnosis, Intervention, Monitoring & Evaluation. This is intended to guide the RD in providing individualized high-quality nutrition care. The RD documents subjective and objective data gleaned from the EHR, the resident and/or resident family, meal observations, nursing staff, medical staff, and ancillary departments. The ADIME guidelines are below:
    i. ADIME:
        a. ASSESSMENT: Nutrition assessment is a systematic method for obtaining, verifying, and interpreting data needed to identify nutrition-related problems, their causes and their significance. It consists of the following elements:
            i. Food/Nutrition related history
            ii. Anthropometric measurements
            iii. Biochemical data, medical tests, and procedures
            iv. Nutrition-focused physical findings
            v. Client history
        b. DIAGNOSIS: The purpose of a nutrition diagnosis language is to describe nutrition problems consistently so that they are clear within and outside profession. Nutrition diagnoses typically fall within the following 3 domains:
            i. Intake
            ii. Clinical
            iii. Behavioral-Environment
        c. INTERVENTION: Nutrition interventions are specific actions used to remedy a nutrition diagnosis/problem. Four domains of nutrition intervention have been identified:
            i. Food and/or Nutrition Delivery
            ii. Nutrition Education

iii. Nutrition Counseling
iv. Coordination of Nutrition Care

d. MONITORING/EVALUATION: The purpose of nutrition monitoring and evaluation is to quantify progress made by the patient/client in meeting nutrition care goals. Nutrition monitoring and evaluation terms are combined with nutrition assessment terms and organized in four domains:
   i. Food/Nutrition-Related History
   ii. Anthropometric Measurements
   iii. Biochemical Data, Medical Tests, and Procedures
   iv. Nutrition-Focused Physical Findings

3. Clinical nutrition protocol and guidelines are used by the RD to determine level of nutrition risk for each resident. RD shall document any nutritional recommendations and notify provider through the EHR.

4. The nutrition follow-up schedule is determined by the RD using the Clinical Nutrition guidelines below or shall be adjusted on an individual basis when:
   a. Resident is stable on current nutrition regimen.
   b. Nutrition problems have resolved.
   c. Resident transfers to a higher or lower level of care

Nutrition Risk Level Guidelines for Clinical Nutrition: LHH Food and Nutrition Services

Admission Day = Day Zero*

Category*	High (1 or more from below) (within 24hours)	Moderate (within 72 hours)	Low (within 72 hours)
Nutrition History	• < 50% of goal nutrition intake ≥ 5 days	• <50-75% of goal nutrition intake > 7 days • Food Allergies/intolerances • Food insecurity not addressed. Complicated food preferences	• No significant change in recent intake • >50-75% goal nutrition intake • Food insecurity addressed. Routine food preferences
Diet Order	New TPN: Assess **within 24 hours.** New Tube Feed: Assess **within 24 hours.**	NPO/Liquid diet All other diet orders not listed as high/low (ex. GI related diet, Aspiration risk diet, Liquid diets) Evolving TF/TPN +/-PO plan Stable TF/TPN plan	Regular Mechanical Soft Consistent CHO Renal Cardiac or Low Sodium Fluid Restricted Vegetarian/Vegan
Weight History and Nutrition Focused Physical Exam	• Weight loss (unintentional) ○ > 2% one week ○ > 5% one month ○ > 7.5% 3 months • >10% 6 months	• Weight loss (unintentional) ○ ≤ 1-2% one week ○ ≤ 5% one month ○ ≤ 7.5% 3 months ○ ≤ 10% 6 months	• No weight change or otherwise planned intentional weight loss

Nutrition Diagnosis	• -Inadequate enteral/parenteral infusion • -Malnutrition (acute) •	• -Non healing wound • -Altered labs r/t nutrition • - No prior knowledge of therapeutic diet, drug-nutrient interaction or reinforce new diet education	• -Stable or healing wound • -Reinforce existing therapeutic diet or drug-nutrient interaction
Other Clinical Indicator	• -Medical dx: malnutrition, failure to thrive, refeeding syndrome, burn, SBO or GI injury • -Unstable outputs (ostomy, emesis, large GI drain output)	• -Medical dx: new nutrition related disease or condition (i.e. renal disease, GI condition, or dysphagia) • pressure ulcers all stages • Change in acuity increasing AMS) • -Need to monitor output management (emesis, -ostomy, GI drain) • - Unstable labs warrants nutrition change (i.e. lytes, glucose, triglycerides, renal)	• -Medical dx: stable nutrition related disease or condition (i.e. renal disease, GI condition, or dysphagia) • -Stable clinical course • -No persistent GI complaints • -Labs stable or addressed with medication or diet prescription
Reassessment/ Follow Up	• Within 3 days	• Within 5 days	• Within 7 days
Responsible Party	RD	RD	RD

*Per RD clinical judgement to assign nutrition risk w/ categories and examples to provide general framework.

References:

Nutrition Care Process Terminology (eNCPT) – Academy of Nutrition and Dietetics https://www.ncpro.org/nutrition-care-process

CALIFORNIA CODE OF REGULATIONS, TITLE 22, DIVISION 5 CHAPTER 1, ACUTE HOSPITAL - 70273 Dietetic Service General Requirements

1.23 Discharge Diet Instruction

Revised: ~~8/23~~11/23

Policy: Residents on therapeutic dietary restrictions requiring discharge diet instruction ~~will~~ shall receive instruction from a Registered D~~d~~ietitian prior to discharge.

Purpose: To assure that ~~patients~~ residents leaving the hospital on therapeutic diets receive education on the essentials of that diet.

Procedure:

1. The Registered Dietitian ~~will~~ shall provide nutritional counseling ~~on those~~for residents being discharged on a therapeutic diet restriction at least 24 hours prior to discharge.

2. The Dietitian ~~will~~ shall gather the necessary materials and information for the resident's diet.

3. The dietitian ~~will~~ shall instruct resident and family members on the essentials of the diet.

~~4. The dietitian will provide a phone number for follow up calls.~~

~~5.~~4. The dietitian ~~will~~ shall document that a diet instruction was given and an assessment of the ability of the resident to understand and comply with the diet in the integrated charting notes.

1.25 NPO or Clear Liquid Diet Orders

Revised: 11/238/23

Policy: A Clinical Dietitian is notified when a resident's diet order changes to NPO or clear liquid diet All patients/residents who are NPO (nothing per oral or nothing by mouth) or on a clear liquid diet without supplements formulated for clear liquids for longer than three (3) days will be evaluated for nutrition risk by the registered dietitian nutritionist (RDN) or designee

Purpose: To assure adequate nutrition intervention.

Procedure:

1. Residents who receive a diet order for NPO or clear liquid are noted by the diet clerk and communicated to the unit Dietitian and Dietetic Technician via secure message communication in the EPIC chart. The Diet Clerk runs the admission/discharge/transfer report daily and prior to each meal that includes any change in diet.

2. The regular diet order for the resident is discontinued in EPIC and CBORD. The new order for NPO is made in EPIC. Nursing shall monitor patients/residents on NPO or on a clear liquid diet without supplements formulated for clear liquids daily and refer to the RDN or designee as needed.

2.

3. If the order for NPO or clear liquid diet continues for three days, the Dietitian confers with the nursing staff and the physician. The Dietitian documents in a nutrition note to assess the nutritional adequacy of the diet. The RDN or designee shall review the medical record of each individual who is NPO or on a clear liquid diet without a supplement formulated for clear liquids for longer than three (3) days and assess their nutritional status.

4. The RDN or designee shall document assessment of nutrition status in the medical record including recommendations for addressing nutrition status. Recommendations may include:
    a. An alternate feeding route (e.g., enteral or parenteral nutrition)
    b. Progression of diet
    c. Addition of nutrition supplements specifically for clear liquid diets
    d. Referral to RDN or designee

3.

Deletion Clinical Nutrition Policies and Procedures

1.11 Nutritionally Adequate Menus

Revised: 8/23

Policy: All menus are assessed for nutritional composition.

Purpose: To assure that menus meet the nutritional requirements set forth in the Recommended Daily Dietary Allowances and the RDIs established by the National Academy of Sciences.

Procedure:

- Menus are submitted to the Clinical Dietetic Staff for review and approval.

  Approved menus are assessed for nutritional adequacy using the CBORD system.
- Any menus which do not meet current standards are revised to provide appropriate nutrients.

- Nutritional composition of menus is assessed as menus are revised.

- When a modified diet does not meet the standards, it is noted in the diet manual.

1.8 Menu Program ***FOR DELETION***

Established and Revised: 03/81, 05/85, 2/88, 2/89, 5/97, 9/06, 7/09, 8/18
Reviewed: 8/13, 8/14. 8/18

Policy: The menu is written and approved by a qualified Dietitian.

Purpose: To provide meals acceptable to the residents, to ensure that the menu meets the Recommended Daily Allowances established by the National Research Council, and to meet the therapeutic needs of the residents.

Procedure:

- The facility's diet manual is used as a reference in developing the menu.
- The regular menu is written first, following guidelines of menu development including color, texture, shapes, etc. and the established meal pattern.
- A four week cycle menu is used, adjusted seasonally and rotated to avoid repetition. The menu is reviewed and revised as necessary.
- The modified consistency and therapeutic diets are extended using the regular menu as a base. The menu is extended for the following diets: Low Sodium, Diabetic, Mechanical Soft and Puree, recognizing the many other diet choices available, including dysphasia consistency foods.
- Portion sizes are listed on the master menus for all diets.
- Menu suggestions and results of comment card surveys are considered in the planning of the menu. Menus are reviewed by the Menu Committee.
- All menu changes are approved by the Chief Dietitian/Dietitian.
- A copy of each day's menu as served is kept on file for one year

Revised Nursing Policies and Procedures

ASSESSMENT, PREVENTION, AND MANAGEMENT OF PRESSURE INJURY

POLICY:

1. The Registered Nurse (RN) is responsible for assessing each resident for presence and risk of pressure injury (PI) on admission navigator and/or flowsheet section in EHR and/or following any significant/clinical change in condition that may increase the resident's risk of developing a pressure injury.

2. Upon resident's intra-facility (within Laguna Honda) relocation, including Pavilion Acute, and/or vice-versa, the sending licensed nurse is responsible for conducting skin checks and completing skin section in the electronic health record (EHR) for any presence of pressure injury/complex wound.

3. The sending RN from SNF and/or Pavilion Acute and the receiving RN from SNF and/or Pavilion Acute will perform skin assessment of the resident.

4. Upon resident's discharge to acute hospital, the licensed nurse is responsible for conducting skin checks and complete skin section of the EHR.

5. Wound, Ostomy, and Continence RNs (WOCNs), trained wound care champion RNs, or physicians can identify and stage pressure injuries.

6. The RNs, Licensed Vocational Nurses (LVN), Certified Nursing Assistants (CNA), within his/her scope of practice, for observing and reporting changes in the resident's skin status

PURPOSE:

To provide guidelines to nursing in prevention and management of pressure injury.

PROCEDURE:

1. Prevention of Pressure Injury for Resident at Risk

a. Skin care: nursing assistants should keep the resident clean and dry and minimize exposure to moisture and associated irritants from incontinence, perspiration, or wound. Handle skin gently and minimize friction (refer to Appendix B for LHH Skin Care products).

b. Skin check: nursing assistants are to thoroughly check the resident's skin at least once daily, paying particular attention to bony prominences and report changes to the primary nurse (team leader) and charge nurse This may be incorporated into the resident's daily hygiene care.

c. .

d. Repositioning: reposition residents who are immobile, at least every 2 hours or per care plan. Draw sheets should be used for repositioning. Avoid positioning directly on trochanter or existing ulcer.

e. Use caution when moving a resident. Avoid shearing/friction by using lifting devices or bed linen to position residents who cannot assist during transfers and position changes.

f. Positioning devices: use wedges, and/or pillows to keep bony prominences from direct contact with

one another.

g. Support surfaces: nursing staff will apply a pressure-relieving support surface (bed/wheelchair) and/or specialized mattress when needed after evaluation from the physician and RCT. If re-evaluation is needed notify the physician for evaluation and/or consult with the wound specialist or to the Plastics clinic (Refer to LHPP 24-03 Support Surfaces).

h. Protective devices:

   i. Protectors for ankle and elbow to minimize friction.
   ii. Heel protectors/devices or pillows under the length of the lower legs to suspend the heels. Do not put the pillow directly under the knees.
   iii. Footboards or bed cradles can be used to keep the pressure of bed linens off the feet.
   iv. Foam arm rest covers (available from central supply under “arm desk stabilizer lateral”) for wheelchair arms can be used.

i. Careful placement in chairs: position chair-bound resident with good postural alignment, and distribution of weight, balance and pressure relief.

   i. Refer to occupational therapy for evaluation of appropriate seating device.
   ii. Avoid sitting directly on the pressure injury.
   iii. Keep top of thighs horizontal and ankles in a comfortable, neutral position on floor or footrest.
   iv. Rest elbows, forearms and wrists on arm supports. Use foam armrest supports on wheelchair.
   v. Instruct or assist residents to relieve pressure by redistributing weight off buttocks at least hourly. Have residents shift their weight every 15 minutes if they are able.
   vi. Document the use of positioning devices and repositioning schedule (as tolerated) in the resident care plan.

2. Assessment of Pressure Injury

The licensed nurse shall complete the Braden scale to identify residents at risk of developing PI. The Braden scale shall be completed on admission, weekly thereafter for 3 consecutive weeks; then quarterly and annually following the Minimum Data Set (MDS) schedule; and when there is a significant decline or change of condition.

a. The charge nurse or licensed nurse will inform the Resident Care Team (RCT) of any resident identified at risk utilizing the Braden score for pressure injuries and develop an initial care plan. The RCT will review and contribute to the care plan as needed.

b. The charge nurse or licensed nurse will ensure that the plan of care is reviewed with nursing staff and ensure through direct supervision that the plan of care is being implemented.

c. TheWound, Ostomy, and Continence RNs (WOCNs) trained wound care champion RNs, or physicians will assess pressure injuries when present. The LVN may assist in data collection under supervision of RN:

   i. location
   ii. size (length, width, depth in cm)
   iii. stage of injury
   iv. wound bed, color and type of tissue, including evidence of healing (granulation tissue)
   v. whether the wound edge around the ulcer is hard, thick, rolled or white-gray tissue, macerated edge, or open edge (healthy edge)

vi. presence of pain, nature, frequency
vii. exudate, slough, eschar, necrotic tissue and odor
viii. sinus tracts, tunneling, undermining
ix. periwound for erythema, warmth, maceration, or induration
x. signs of wound infection, such as tenderness of surrounding tissue, edema or swelling, purulent drainage or foul odor

Indicators of a deteriorating pressure injury include increase in injury size, increase in exudate, loss of granulation tissue, purulent drainage and development of slough, necrosis, eschar or odor.

d. The RN will reassess pressure injuries, at least weekly, to determine whether the prescribed treatment is working and document on the electronic health record (EHR) until healed. A clean pressure injury should show evidence of some healing within two weeks.

e. The RN will reevaluate the treatment plan weekly, or as soon as there is any evidence of deterioration in the condition of the resident or the wound. If the injury fails to respond to treatment, notify the physician to evaluate and/or refer the resident to the Plastics clinic.

3. Management of /Pressure Injury

a. Following detection of a pressure injury, the charge nurse or designee will:

i. notify the neighborhood provider (or if immediate treatment is needed, on-call physician) and a treatment plan shall be implemented within eight (8) hours;
ii. notify the dietitian within 24 hours (call Dietary office)
iii. notify the resident and / or Surrogate Decision Maker (SDM) within twenty four hours
iv. complete a wound assessment and progress note in the electronic health record (EHR)
v. develop a plan of care for prevention and treatment for the injury(ies) with interdisciplinary team input
vi. submit an Unusual Occurrence
vii. Schedule a Resident Care Conference (RCC) within a week. The RCT shall conduct a meeting to review the plan of care of resident with newly identified PI.

b. The Wound, Ostomy and Continence (WOCN) RNs, trained wound care champion RNs, ann/or physicians will assess pressure injury(ies) weekly. The LVN may assist in gathering data under the supervision of the RN.

c. The RCT will reevaluate the treatment plan if the injury(ies) fails to show evidence of healing within two weeks, or when the injury(ies) shows signs of deterioration.

The Attending Physician in conjunction with the RCT will evaluate non-healing and worsening pressure injuries. The Physician will refer to the Plastics Clinic when it is needed.

4. Documentation of Pressure Injury

a. Admission: Complete the Braden Scale and a skin assessment in the EHR.
b. Document condition of skin as part of Minimum Data Set (MDS quarterly, annually including significant change of condition assessmentsand complete the Braden scale.

c. Intra-facility relocation: the sending licensed nurse is responsible for conducting skin checks and completing the skin assessment in the EHR for any presence of pressure injury/complex wound.

d. Discharge to acute:

   i. Upon resident's discharge to acute hospital, the licensed nurse is responsible for conducting skin checks and completing the skin assessment in the EHR.
   ii. LHH Acute: The sending RN from SNF and the receiving RN from Pavilion Acute will perform skin assessments of the resident.

e. Complete the Braden scale on admission, every weekly thereafter for 3 consecutive weeks, then quarterly and annually following the Minimum Data Set (MDS), and for any decline or signification change in condition.

f. Resident Assessment Instrument (RAI): When a pressure ulcer/pressure injury is triggered as a Care Area Assessments (CAA) Problem Area, the MDS Coordinator will:

   i. Utilize the CAA guidelines to identify additional areas needing assessment.
   ii. Document the assessment in the CAA notes, including the decision to care plan or not.
   iii. Review the RAI policy and consult with the physician and RCT to determine if a significant change in condition MDS assessment must be completed when a resident develops a stage 2 or higher pressure ulcer/pressure injury.

g. Resident Care Plan: If the resident is identified as being at risk for pressure injuries as determined through the Braden scale or has a pressure injury, a comprehensive, interdisciplinary care plan is developed that:

   i. identifies problems (i.e., PI risk factors and/or presence of injury),
   ii. develops individualized goal(s),
   iii. develops interventions to address prevention or treatment
   iv. develops interventions for wound and wound treatment pain if assessed as problem

h. SNF and Acute care units: Wound assessment is done weekly and/or when there is a decline in the condition of the wound. These assessments are documented in the EHR.

i. Nursing Assistants are to document any changes in skin condition they observed in the EHR, including the name of the licensed nurse notified.

j. Daily documentation: Evaluation of status of dressing if present (whether intact or with presence of drainage; the status of area surrouinding PI (that can be observed without removing the dressing); the presence of possible complications, such as signs of increasing area of ulceration or soft tissue infection; whether pain, if present, is being adequately controlled.

k. Weekly nursing summaries: Summaries include assessment of any new risk factors for developing a pressure injury as well as an evaluation of the effectiveness of implemented treatment/interventions and revision of care plan as needed.

l. Notification: Document all notifications to the physician, dietitian and family or SDM when a pressure injury is detected and when the ulcer shows no evidence of healing.

m. Resident education/counseling: Resident teaching or counseling related to prevention/management of pressure injuries is to be documented in the EHR and/or resident care plan.

APPENDICES:

Appendix 1: Definition of Pressure Ulcer and Intervention
Appendix 2: LHH Skin Care Formulary
Appendix 3: LHH Wound Care Formulary
Appendix 4: Waffle Overlay

REFERENCES:

Acute & Chronic Wounds: Current Management Concepts, Elsevier, 4th edition, 2012

Evidence-Based Pressure Ulcer Prevention: A Study Guide for Nurses, HC Pro, 2008 Sizewise

European Pressure Ulcer Advisory Panel (EPUAP), National Pressure Injury Advisory Panel (NPIAP), Pan Pacific Pressure Injury Alliance (PIPPIA). (2019). In *Prevention and treatment of pressure ulcers/injuries: Clinical practice guidelines. The international guideline* (3rd ed.).

Wound, Ostomy and Continence Nurses Society-Wound Guidelines Task Force WOCN 2016 Guideline for Prevention and Management of Pressure Injuries (Ulcers), Journal of Wound, Ostomy and Continence Nursing: May/June 2017 - Volume 44 - Issue 3 - p 241-246

CROSS-REFERENCES:

Hospitalwide Policy and Procedure
- 24-15 Prevention and Management of Pressure Ulcer

Nursing Policy and Procedure
- C 1.0 Admission and Readmission Procedures
- C 1.2 Nursing Guidelines for Relocation between Laguna Honda SNF Neighborhoods
- C 3.0 Documentation of Resident Care/Status by the Licensed Nurse
- C 4.0 Notification and Documentation of Change in Resident's Status

Document originated: 2001/11

Revised: 2005/02; 2008/03; 2015/12/04; 2017/11/04; 2018/03/06; 2019/03/12; 2022/10/11; 2023/05/09

Reviewed: 2023/05/09

Approved: 2023/05/09

WOUND ASSESSMENT AND MANAGEMENT

POLICY:

1. The Registered Nurse (RN) is responsible for performing wound assessment, dressing application, and notifying the physician for presence of wound infection, wound deterioration, and non-healing wound.

2. The Licensed Vocational Nurse (LVN) under the supervision of the RN may collect wound assessment data and perform dressing application as ordered by the physician.

PURPOSE:

1. To provide a guideline in wound assessment and appropriate wound management.

BACKGROUND:

A. Definitions:

1. Arterial - wounds caused by ischemia, which is related to the presence of arterial occlusive disease.

2. Diabetic or Neuropathic - Neuropathy is often associated with diabetes. Wounds results from damage to the autonomic, sensory, or motor nerves and have an arterial perfusion deficit.

3. Pressure – wounds due to the damage to the skin or underlying structures as a result of tissue compression and inadequate perfusion.

4. Venous – wounds caused by failure of the venous valve function to return blood from the lower extremities to the heart. This causes venous congestion and leads to venous hypertension.

Types of Wound	Arterial	Diabetic/Neuropathic	Pressure	Venous
Location	The distal aspect of arterial circulation can be anywhere on the leg, including the toes and feet	Can be anywhere on the lower extremity, usually located on the foot	Usually over a bony prominence	Located in the gaiter area (ankle to mid-calf), it is often medial malleolus and maybe circumferential
Wound Margin	“Punched out,” well-defined borders	Usually with a calloused edge	Usually circular	Irregular shaped
Wound Size	Can be small, but often increases due to lack of arterial perfusion	Often small	Can be very large or very small	Usually large
Wound Bed	Pale wound bed, little or no granulation, necrotic tissue is common	Similar to arterial wounds, usually with a calloused edge	Can have viable or necrotic tissue	Usually shallow, can have viable or necrotic tissue
Exudate	Minimal to no exudate	Minimal to no exudate	Can vary from none to heavy	Can vary from none to heavy to

				generalized weeping
Types of Wound	**Arterial**	**Diabetic/Neuropathic**	**Pressure**	**Venous**
Edema	If present, localized	If present, localized	Can be localized, usually not seen	Generalized edema to lower extremity
Pain	Occurs at rest, at night, or when the extremity is elevated	Due to neuropathy, the pain maybe absent or severe	Usually present, but often undertreated	Often occurs in a dependent position along with edema
Best Practice	1. If perfusion is not adequate, consider vascular consult 2. If perfusion is adequate, follow protocol based on wound assessment and characteristics 3. If dry and stable, leave eschar intact	1. Maintain optimal moisture 2. Control diabetes, if appropriate 3. Repetitive removal of callous 4. Bioburden control and prevention of systemic infection 5. Remove pressure with appropriate off-loading shoe or other appliance	1. Remove necrotic tissue 2. Maintain optimal moisture 3. Protect periwound skin 4. Control bioburden 5. Remove pressure	1. Compression 2. Remove necrotic tissue 3. Maintain optimal moisture 4. Protect periwound skin 5. Control bioburden 6. Ensure lower extremity moisturization

PROCEDURE:

A. Management of Pressure Ulcer – refer to LHHPP 24-15 Management of Pressure Ulcers.

B. For management of arterial, diabetic/neuropathic, or venous wounds, refer to table under Background section.

Note: For wounds that would require compression dressing, refer to Attachment 1: Two Layer Compression Bandage System

C. Use of Advanced Wound Products Specific to Skin Substitutes and Extracellular Matrix (ECM)

1. Special dressing specifically the skin substitutes and ECM are only applied in the Outpatient clinic. Refer to Attachment 2: Use of Advanced Wound Products Specific to Skin Substitutes and ECM.
2. To prevent damage of the newly applied product, the primary dressing is left in place up to 7 days.
3. Secondary dressing is changed when soiled or dislodged.

D. Documentation and Reporting on the Electronic Health Record (EHR)

1. Document initial application of treatment ordered
2. Document a complete wound assessment (e.g. location, description of wound, including size, quantity and quality of drainage if present, including wound edges and wound bed, condition of surrounding tissues, progress towards healing and when deterioration of the wound is observed or suspected,) weekly.
3. Report any undue bleeding, untoward reactions to the physician; and document.
4. Document progress towards healing, resident's reaction to dressing change and response to pain, if necessary.
5. RCT will conduct a meeting for new onset or worsening of wound.

ATTACHMENTS:

Attachment 1: Two Layer Compression Bandage System
Attachment 2: Use of Advanced Wound Products Specific to Skin Substitutes and ECM
Attachment 3: Wound Assessment Record

REFERENCES:

The Wound Care Handbook from Medline Industries (2007)
Bryant, R. A.., & Nix, D. P. (2012). Acute and Chronic Wounds: Current Management Concepts (4th Ed.). St. Louis Missouri, Elsevier, Mosby

CROSS-REFERENCES:

Hospitalwide Policy and Procedure
24-15 Management of Pressure Ulcers

Nursing Policy and Procedure
C 4.0 Notification and Documentation of Change in Resident Status
K 1.0 Assessment, Prevention & Management of Pressure Ulcer/Pressure Injury

Revised: 2000/08, 2008/03; 2015/05/12; 2019/03/12

Reviewed: 2023/03/09

Approved: 2023/03/09

OXYGEN ADMINISTRATION

POLICY:

1. A licensed nurse may administer oxygen during an urgent situation pending the physician's evaluation.

2. The physician's order for oxygen therapy must include the method of administration, the liter flow rate, and/or the percentage and duration. PRN orders must include the reason for administration.

3. Residents requiring continuous oxygen shall be placed in a room that has wall oxygen.

4. Oxygen tanks shall be secured at all times in an approved oxygen carrying device unless stored inside the oxygen storage cabinet.

5. Disposable oxygen tubing administration devices shall be labelled with the date and initials according to the following schedule: ~~every 7 days and PRN~~. Routine weekly changes shall be documented by the AM shift nursing staff.

    a. Daily and PRN: sterile water for humidifier, tracheostomy collar, tracheostomy tubing and tracheostomy mask.
    ~~5.~~b. Weekly and PRN: Nasal cannula oxygen tubing, suction tubing, suction cannister, Yankauer, nebulizer set (mask and tubing) and reusable humidifier bottles.

PURPOSE:

To safely administer oxygen therapy and compressed air.

BACKGROUND:

Disposable oxygen devices may include but are not limited to: humidifiers, nebulizers, connecting tubing, nasal cannula, mask or tracheostomy mask.

PROCEDURE:

A. Equipment:

1. Obtain oxygen delivery system supplies from neighborhood storage room or central supply.

2. Obtain from Central Supply, as needed:
    a. For rooms without oxygen:
        i. Small “E” tank oxygen cylinder with valve protection device attached. (Each Neighborhood will have an emergency cylinder of Oxygen on the crash cart. Additional are stored on selected neighborhoods.)
        ii. Compressed Air Connector if no humidification required (only available in PMA, PMS and south tower.)
        ~~i.~~ Oxygen Concentrators are an option for oxygen flow rates up to 5 lpm.
    b. For room swith wall oxygen
        i. Flow meter for oxygen or compressed air based on physician order.

- "NO SMOKING" sign(s)

- ~~Small "E" tank oxygen cylinder with valve protection device attached. (Each Neighborhood will have an emergency cylinder of Oxygen on the crash cart. Additional are stored on selected neighborhoods.)~~
- ~~Appropriate regulator~~
- ~~Compressed Air Connector if no humidification required~~
- ~~Oxygen Concentrators are an option for oxygen flow rates up to 5 lpm.~~

B. Safety measures for oxygen are to be followed.

1. Residents and visitors are to be informed of the risks of smoking when oxygen in use, as needed.

2. "OXYGEN IN USE" signs are to be clearly visible:

   a. around the neck of the wall mounted oxygen flow regulators
   b. on oxygen or compressed air tanks in carriers or on wheelchairs
   c. outside the door of resident's room when oxygen or compressed air is in use in the room

3. "OXYGEN STORAGE. NO SMOKING. NO OPEN FLAME" signs visible where oxygen is stored

4. **No alcohol or tincture, oil, glycerin, Vaseline or petroleum** product is to be used on or near residents receiving oxygen.

5. When oxygen tubing is not in use, make sure oxygen is turned off and tubing is stored in bags by the resident's bedside

6. Do not connect or disconnect electrical devices such as suction machines, electric razors and cell phones or any heat producing device during oxygen treatment,

7. Oil or grease is not to come in contact with the oxygen or compressed air cylinder regulator, valve gauge or fittings.

8. If fire breaks out on the neighborhood, turn off all oxygen sources. If a resident cannot survive without oxygen therapy, move resident/bed to a safe area before resuming oxygen.

9. If oxygen cylinders are required:

   a. Never drop cylinders, permit them to strike each other, tamper with safety devices or attempt to repair cylinders or valves.
   b. Always look at the cylinder gauge to determine contents before administering any.
   c. Oxygen cylinders in storage shall be equipped with valve protection devices and stored in oxygen cabinet.
   d. Oxygen tanks shall be placed on an oxygen carriage when transported within the facility with valve protector devices on.
   e. Cylinder valves shall be closed before moving cylinder on all tanks including empty cylinders.

C. Setting up and monitoring oxygen cylinders:

1. Remove cap and plastic cover.
2. Open and close valve quickly to remove dust from valve.
3. Place proper diameter-indexed regulator, with adapter attached, on the tank and position so that regulator is perpendicular to tank for easy reading.

4. Open valve to assure there is no leakage of oxygen. Close valve and open liter flow to remove oxygen from the regulator.
5. No smoking sign will be posted on front of tank. Also a no smoking tag, plastic bag with oxygen tubing, cannula, mask and compressed air connector will be hung on tank.
6. Always check the amount of oxygen in cylinder before dispensing.
7. Unless in use, the oxygen regulator is closed.
8. Cylinders are to be stored on unit in appropriate cylinder holder. Cylinders stored in the open are protected from weather.
9. Empty cylinders are segregated from full cylinders.
10. Check level of oxygen shown by cylinder gauge. When cylinder gauge nears empty, obtain a new tank from Central Supply

D. ~~**Breaking down**~~**When oxygen cylinders are no longer needed, or are empty**.

~~1. Remove regulators from cylinders.~~

~~2. Place valve covers on cylinders.~~

~~3.~~1. Nursing will disinfect the oxygen cylinder (avoiding valve stem) with the facility-approved disinfectant.

~~4.~~2. Nursing will put "empty tag" on the oxygen cylinder and place the disinfected cylinder in the oxygen storage cabinet in the clean utility room in the designated location for empty cylinders.

~~5.~~3. Central Supply will pick up used/empty cylinders.

E. Procedure

1. Refer to Elsevier Clinical Skills titled "Oxygen Therapy: Nasal Cannula or Oxygen Mask."

F. Documentation in EHR

1. Physician will order the individualized oxygen therapy needed for the resident
2. Licensed nurses will document:
   a. Every shift for continuous order or during the shift when administered intermittently and PRN
   b. Delivery method (e.g., nasal cannula, etc)
   c. Oxygen Flow Rate
   c. Other information based on each individualized order and/or care provided (e.g., if tubing changed, with humidifier)

REFERENCES:

Elsevier Clinical Skills: Oxygen Therapy: Nasal Cannula or Oxygen Mask, Adapted from Perry, A.G. and others (Eds.). (2022). *Clinical nursing skills & techniques* (10th ed.). St. Louis: Elsevier. Published: September 2021

https://point-of-care.elsevierperformancemanager.com/skills/380/quick-sheet?skillId=GN_22_1&virtualname=sanfrangeneralhospital-casanfrancisco

CROSS REFERENCES:

Respiratory Services Policies & Procedures:
- A 2. Safety Regulations for Oxygen Therapy
- A 6. Oxygen Administration: Nasal Cannula
- A 7. Oxygen Administration: Simple- Oxygen Mask
- A 8. Oxygen Administration: Non-Rebreather Mask
- A 9. Oxygen Administration: Venturi Mask

Revised: 2006/03, 2006/04, 2009/08, 2017/01/10; 2019/03/12; 2022/01/11; 2022/07/12; 2022/12/13; 2023/03/14

Reviewed: 2023/03/14

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Deletion Outpatient Clinic Policies and Procedures

HIGH-LEVEL CHEMICAL DISINFECTION

POLICY:

High-level chemical disinfection is performed by trained and qualified Clinic Staff according to accepted standards of practice and LHH Infection Control Policy G7, "High-Level Chemical Disinfection".

PURPOSE:

High-level chemical disinfection is a process used for the disinfection of semi-critical resident care devices (devices that touch mucous membranes or non-intact skin). This level of disinfection is effective in destroying most types of harmful microorganisms, but not necessarily bacterial spores

PROCEDURE:

1. Prior to the disinfection process, all devices are cleaned according to LHH Infection Control Policy G4, "Cleaning of Reusable Medical Instruments" and to LHH Outpatient Clinic Policy C3 "Cleaning of Medical Instruments Prior to Disinfection and Sterilization".

2. Fluid resistant gowns, gloves, face masks, and eye protection are worn during the cleaning and disinfection procedures.

3. Hospital approved high-level disinfectants must be used.

   Chemicals are mixed, stored and used in accordance with manufacturer's recommendations and LHH Infection Control Policy G7, "High-Level Chemical Disinfection".

4. Refer to Appendix A for Specific instructions on the use of Cidexplus® OPA Solution (*ortho*-Phthalaldehyde 0.55%) for high-level disinfection.

5. After removing devices from the disinfectant solution, rinse devices thoroughly with sterile water. Sterile water is used to prevent contamination with organisms that may be present in tap water, such as non-tuberculous mycobacteria and *Legionella*.

Reference:
LHH Infection Control Policy G7, "High-Level Chemical Disinfection"
CDC Guideline for Disinfection and Sterilzation in Healthcare Facilities, 2008

Revised: 12/05/15

Appenidix A: Use of Cidexplus® OPA Solution (*ortho*-Phthalaldehyde 0.55%) for High-Level Chemical Disinfection

For Complete information on use refer to Cidexplus®OPA Product information

1. Material Compatibility

For compatibility of device materials with Cidexplus® OPA refer to device manufacturer's recommendations and Cidexplus® OPA Product information.

2. Cleaning Agent Compatibility

Detergents that are either highly acidic or alkaline are contraindicated as cleaning agents since improper rinsing could affect the efficacy of the Cidexplus® OPA Solution by altering its pH. Rinse devices completely prior to immersion in Cidexplus® OPA Solution.

3. Safety

Caution: Contains *Ortho*-Phthalaldehyde

- Harmful by inhalation and if swallowed
- Irritating to respiratory system and skin
- Risk of serious damage to eyes
- May cause sensitization by inhalation and skin contact

Precautions

- Wear suitable protective clothing, gloves and eye/face protection
- Use only in well-ventilated areas
- Avoid contamination of food
- Avoid release to the environment

First-Aid Measures

- Refer to Cidexplus® OPA Product Information

4. Directions for Use

Activation

a. Does not require activation before use.

b. Test the activated solution with compatible test strips prior to each use. The minimum effective concentration (MEC) of *ortho*-Phthalaldehyde is 0.3%.

5. Cleaning

Feces, mucous, tissues, blood and other body fluids must be thoroughly cleansed from surfaces and lumens of devices before processing in Cidexplus® OPA Solution.

Thoroughly clean, rinse and rough dry devices before immersing in Cidexplus® OPA Solution.

Clean and rinse lumens of hollow instruments before filling with Cidexplus® OPA Solution.

6. **Usage**
   a. **Test the solution with Solution Test Strips prior to each use.**
   b. Immerse cleaned and rough dried medical devices completely in the Cidexplus® OPA Solution, filling all lumens.
   c. Leave medical devices completely **immersed for at least 12 minutes at room temperature** for High-Level Disinfection.
   d. Rinse with sterile water
   e. Used *ortho*-Phthalaldehyde solution is neutralized as per Product Information and is placed in a sealed container provided by Industrial Hygienist and will be picked up by Facility Services for disposal

Revised: 12/05/15

FLEXIBLE NASOPHARYNGEAL LARYNGOSCOPE

POLICY:
Flexible nasopharyngeal laryngoscopes are cleaned and disinfected consistent with LHH Infection Control Policies G4 “Cleaning of Reusable Medical Instruments”, G7 “High-Level Chemical Disinfection” and F9 "Chemical Sterilization Standards".

PURPOSE:
To destroy microorganisms both cleaning and high-level disinfection are necessary to prevent disease transmission.

PROCEDURE:

1. Classification and processing requirements

A flexible nasopharyngeal laryngoscope is classified as a semi-critical medical device because during use the device makes contact with mucous membranes but does not usually penetrate normally sterile areas of the body. Refer to Infection Control Policy G2, “Classification of Reusable Medical Devices and Processing Requirements.”

High-Level Disinfection is acceptable for processing semi-critical medical devices.

2. High-level disinfection on the day of use

a. Perform leakage test to ensure scope seal has not been compromised (refer to leakage tester instruction manual for proper procedures).

b. Select a high-level disinfectant consistent with device and disinfectant compatibility and LHH Infection Control Policy G7, “High-Level Chemical Disinfection.”

c. Prepare the high-level disinfectant as recommended by the disinfectant manufacturer.

d. Prepare the proper container for the high-level disinfectant and pour the solution into it.

e. Immerse the scope for the scope and disinfectant manufacturers’ recommended time and temperature conditions for high-level disinfection.

f. If using Cidex as disinfectant, immerse for 12 minutes at room temperature.

NOTE: These conditions should be strictly followed since over immersion may damage the scope.

g. Using sterile gloves:

- Remove the scope from chemical solution.
- Rinse the scope thoroughly using sterile water.
- Dry the scope thoroughly using sterile gauze.

3. Cleaning after procedure and use of the laryngoscope

Immediately after removing the laryngoscope from the patient:

A. Gently wipe all debris off insertion tube with gauze soaked in freshly prepared enzymatic detergent solution.

B. Ensure all debris has been removed from the insertion tube, deflection section, and illumination/observation windows.

C. Transfer the laryngoscope from the procedure room to the reprocessing room in a leak proof enclosed container. .

D. In the reprocessing room thoroughly but gently wash the entire outer surface of the scope with a mild pH enzymatic detergent following the manufacturer's instructions.

E. Thoroughly rinse the scope with potable water and gently dry or allow to air dry.

4. High-level disinfection after initial cleaning procedure

A. Perform leakage test to ensure scope seal has not been compromised (refer to leakage tester instruction manual for proper procedures).

B. Select a high-level disinfectant consistent with device and disinfectant compatibility and LHH Infection Control Policy G7, "High-Level Chemical Disinfection."

C. Prepare the high-level disinfectant as recommended by the disinfectant manufacturer.

D. Prepare the proper container for the high-level disinfectant and pour the solution into it.

E. Immerse the scope for the scope and disinfectant manufacturers' recommended time and temperature conditions for high-level disinfection.

F. If using Cidex as disinfectant, immerse for 12 minutes at room temperature.

NOTE: These conditions should be strictly followed since over immersion may damage the scope.

G. Using sterile gloves:

- Remove the scope from chemical solution.
- Rinse the scope thoroughly using sterile water.
- Dry the scope thoroughly using sterile gauze.

5. Storage

Store the laryngoscope in a clean, dry, dust-free locked storage cart. The storage area will be cleaned with a hospital approved disinfectant each time the laryngoscope is used. The laryngoscope will be placed in a cleaned tray lined with a new chuck and locked until the next time it is used.

6. DISPOSAL OF *Ortho*-PHTHALALDEHYDE SOLUTION

Used *ortho*-Phthalaldehyde solution is neutralized as per Product Information and placed in a sealed container provided by the Industrial Hygienist and will be picked up by Facility Services for disposal.

References:
LHH Infection Control Policy G2, "Classification of Reusable Medical Devices and Processing"
LHH Infection Control Policy G4, "Cleaning of Reusable Medical Instruments"
LHH Infection Control Policy G7, "High-Level Chemical Disinfection"
LHH Infection Control Policy F9, "Chemical Sterilization Standards"

Revised: 12/05/15

STEAM STERILIZATION

POLICY:

1. Reusable medical instruments and other items are steam sterilized whenever possible. Moist heat in the form of saturated steam under pressure is the most widely used and the most dependable method of sterilization.
2. Steam sterilization is conducted in accordance with LHH Infection Control Policy G9, "Steam Sterilization Standards".

PURPOSE:

Steam sterilization is a process for the sterilization of critical patient care devices (devices that enter sterile tissue or access the vascular system).

DEFINITIONS:

Steam sterilization is a sterilization process that uses saturated steam under pressure for a specified exposure time and at a specified temperature, as the sterilizing agent to eliminate all forms of viable microorganisms including spores.

PROCEDURE
Pre-sterilization

- Item(s) are taken to the Soiled Utility Room
- They are cleaned of any type of soil, including organic debris
- After cleaning, the item(s) are transported to the Wrapping Room, and wrapped and ready to be placed in the steam sterilizer

Sterilization using a Pre-Vacuum Steam Sterilizer

The minimum exposure period for steam sterilization of wrapped supplies is at 270° F (132° C) with 4 minutes exposure time and 20 minutes for drying time.

1. Wrapping and packaging
   The following types of sterile packaging are currently approved:
   - Rigid sterilization containers
   - Paper-plastic peel pouches
   - Non-woven wrappers (polypropylene). Two layers of wrap (double wrap) are used

2. Loading the sterilizer

   a. Label each package with:
   - Load identifier
   - Sterilization date
   - Staff's initials

b. Load all items in a way that allows steam to circulate freely around each item and does not allow moisture to collect. Peel pouches face the same direction. Instrument sets are on the bottom shelves

- Instrument sets cannot be stacked; steam must be able to circulate freely around each item.
- Items capable of holding water (i.e. basins) should be positioned in a fashion that would allow water to drain out of them.
- Metal items cannot be placed above textile items.

c. Loading racks or baskets are used for peel pouches so that they can be placed on edge and properly spaced.

3. Sterilization

a. Record the unique load identifiers used for the sterilization.

b. Visually verify that all settings are correct.

c. Initiate sterilization cycle following specific instructions that are provided in Appendices to this document.

d. Include a *Challenge Pack* in each load.

4. Unloading the sterilizer

a. Visually inspect the *Indicator Tape* on all packages for black bars indicating that sterilization conditions have been achieved. Record results in *Sterilization Log*, which is kept adjacent to the steam sterilizer.

b. Visually inspect the *Chemical Strip* in the *Challenge Pack* for color change indicating that sterilization has been achieved., Record results in *Sterilization Log*, which is kept adjacent to the steam sterilizer.

c. If printout/graph is used, visually inspect the printout/graph and verify that the sterilization parameters of 270° F (132° C) of 4 minutes of exposure time and drying time of 20 minutes have been met. Initial and date the printout/graph and retain in *Sterilization Load Records*.

d. The sterilized items must remain on the sterilization carriage until they have cooled to room temperature. Do not place the carriage under cool-air vents and if possible, place it in a low traffic area and label it with a "Caution Hot" sign.

e. Use gloves to unload items. Set aside items to be dust covered. Inspect packages and trays for damage and moisture.

5. Release of sterilization load for use

a. The Clinic Nurse is responsible for:

- Assembling all testing information in the *Sterilization Load Record*
- Verifying completeness of the *Sterilization Load Record* detailed below

- Reviewing all test results for each load
- Releasing the load for use based on acceptable test results (see Appendix B: Release of Sterilized Load)
- Notifying Clinic Nursing Director if testing results are not acceptable for release of the load

6. Sterilization load records

Sterilization Load Record for each steam sterilized load includes:

a*. Steam Sterilization Log* in which are recorded:
- Unique identifier for each load. If only one load is run per day, this identifier can be the sterilization date
- Date and time cycle was run
- Printed name and initials of operator
- Identification of sterilizer
- Chemical Tape results
- Chemical Strip (from *Challenge Pack*) results

b. Temperature and time of exposure. This can be either the temperature printout/graph or manual documentation of time and temperature demonstrating sterilization at 270° F (132° C) for 4 minutes of exposure time and a drying time of 20 minutes.

c. Biological monitor results including:
- Date of testing
- Lot number of Biological indicator
- Test Biological indicator results
- Control Biological indicator results

d. Signed *Release of Sterilization Load* including printed name and signature of Clinic Nurse releasing the load for use.

e*. Sterilization Load Records* are maintained on-site for a period of three years.

7. Sterilization monitors
The steam cycle is monitored by Mechanical, Chemical and Biological Monitors.

a. Physical Monitors of chamber temperature and time are verified by monitoring the gauges and printout/graph.

At the end of the cycle/day the temperature printout/graph is removed, dated and retained in *Sterilization Load Records.*

Alternatively chamber temperature and time are monitored visually, recorded manually and retained in the *Steam Sterilization Log*, which is kept adjacent to the sterilizer.

b**.** Chemical Monitors do not verify sterility but verify that the conditions required for the process have been met. Chemical indicators are affixed to outside and incorporated into the pack to monitor temperature or time and temperature exposure

- Indicator Tape is used to secure packages. Black bars appear on the surface of the Indicator Tape when it is exposed to sterilization conditions
- Chemical Strips are placed inside each sterilization package. The Chemical Strip changes color from rose to brown and validates that the inside of each sterilization package has been exposed to sterilization conditions
- At the end of the sterilization cycle, when the steam sterilizer is being unloaded, the Indicator Tape securing wrapped packages is interpreted and the results are recorded in the *Steam Sterilization Log*, which is kept adjacent to the steam sterilizer.
- **NEVER USE AN ITEM IF THE INDICATOR TAPE OR CHEMICAL STRIPS HAVE NOT CHANGED COLOR**

c**.** Biological Monitors validate the effectiveness of the steam sterilization cycle. Spores of *Geobacillus stearothermophilus,* (formerly known as *Bacillus stearothermolious*) are used as the *Biological Indicator*. On incubation, viable spores in the *Biological indicator* will germinate and produce acidic metabolic products that cause the media to change color from purple to yellow. A successful sterilization process will kill all spores and the media color will remain purple on incubation.

A *Challenge Pack* is included in every sterilization load. The *Challenge Pack* contains a Chemical Strip and a Biological Indicator sealed in a paper plastic peel pouch. The *Challenge Pack* is placed in the most challenging area for the steam sterilizer. This is typically on the bottom shelf, near the door and over the drain.

At the end of the cycle, the Biological Indicator is labeled "test" and dated. A control Biological Indicator from the same lot is labeled "control" and dated.

Both test and control Biological Indicator are placed in the Attest Auto-Reader which will provide an alert when the incubation is completed.

- After completion of the steam sterilization cycle, fully open the sterilizer door for a minimum of 5 minutes to achieve adequate cooling of the biological indicator prior to removal from the sterilizer.

  If the biological indicator **is not contained** in a test pack or any other heat absorbing packaging material, remove the biological indicator from the sterilizer and allow to cool for an additional 10 minutes prior to crushing OR,

  It the biological indicator **is contained** in a test pack or any other heat absorbing packaging material, the test pack or packaging material should be removed from the sterilizer and opened up for 5 minutes to dissipate heat prior to removing the biological indicator. Then allow the biological indicator to cool outside the test pack for an additional 10 minutes prior to crushing.

Results are interpreted according to the manufacturer's instructions and records are retained in the *Sterilization Load Records* along with the testing date and name of technician performing the test and interpreting the results.

Reference:
LHH Infection Control Policy G9 :Steam Sterilzation Standards"
CDC Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008
Appendix A: Operation of the Pre-Vacuum (Pre-Vac) Steam Sterilizer

Appendix B: Release of Sterilization Load
Appendix C: Procedure for Performing the Bowie-Dick Test on the Steam Sterilizer
Appendix D: Procedure to Perform a Leak Test on Steris Sterilizer
Appendix E**:** Procedure for the use of Chemical Intergrator Strip for Steam Sterilizer

Most recent review: 10/10
Revised:14/01/28

APPENDIX A: OPERATION OF THE PRE-VACUUM (PRE-VAC) STEAM STERILIZER

OPERATION:

1. Load sterilizer cart. Place items on the cart ensuring:

a. proper packing
b. proper labeling
c. correct expiration date on Instrument containers only
d. Biological Spore Test package

2. Put a sterilizer label which includes the date.

3. Load all items in such a way that moisture will not collect. Peel pouches face in the same direction. Instruments sets should be placed on the bottom shelves.

4. Load sterilizer and close the door.

5. Hi-vacuum sterilizer in SPD screen should say **"PREVAC PREVAC"**. Press #4 on the touch screen pad to start cycle.

6. After cycle starts, record the cycle # in the monitoring log.

7. At the end of the cycle, the machine will intermittently buzz, and the screen will display **"COMPLETE"** cycle. Printout the monitoring record automatically.

8. Review the print out and check for the correct date, time and temperature including 4 minute exposure time and 20 minutes drying time and initial it.

9. Unload the sterilizer after 30 minutes, and cool for 1 hour.

10. Remove items from cart with gloved hands, and cool or dispense as appropriate.

APPENDIX B: RELEASE OF STERILIZATION LOAD

PRIOR TO STERILIZATION TESTS

Cycle Number: _____

Sterilization Date: _____

Sterilization Operator: _____

LEAK TEST _____PASS _____FAIL

Cycle Number: _____

Sterilization Date: _____

Sterilization Operator: _____

AIR REMOVAL TEST (BOWIE DICK)
Color change from Yellow to Dark Blue _____PASS _____FAIL

STERILIZATION MONITORING RESULTS

Physical Monitoring:
_____ 270 degrees F for 4 minutes and 20 minutes drying time

Chemical Monitoring:

_____ Indicator Tape outside of all packages has developed black bars
_____ Chemical Strip in Challenge Pack has changed color from yellow to black

Biological Monitoring:

Lot number of Biological indicators: _____

_____Test Biological Indicator remains purple (negative) on incubation

Lot number of Biological indicators for "Control": _____

_____ Control Biological Indicator turns yellow (positive) on incubation

PACKAGING INTEGRITY:

Cycle Number: _____

Sterilization Date: _____

Sterilization Operator: _____

_____ All packages are intact
_____ All packages are dry
_____ All packages are without stains or water marks

Load #_____ Date:_____

RECALL NOTES:

LOAD RELEASED FOR USE BY:

_____ _____
CRSCT/Printed Name Date

_____
Signature

_____ _____
Clinic Nurse/Printed Name Date

_____
Clinic Nurse/Signature

APPENDIX C

PROCEDURE FOR PERFORMING THE BOWIE-DICK TEST ON THE STEAM STERILIZER

To test for air leaks in the vacuum system of a vacuum type sterilizer once a week. The test should be done at the same time each day, and when possible the test should be the first run of the day.

PROCEDURE:

This cycle is used to conduct a Bowie-Dick test on the sterilizer. Tests such as DART (Daily Airway Removal Test) or Bowie-Dick are designed to document the removal of residual air from a sample challenge load. A DART (Bowie-Dick test) cycle should be done daily before processing any loads. The chamber must be at operating temperature when DART (Bowie-Dick test) cycle is performed. The DART Warm-up cycle should be completed prior to performing DART (Bowie-Dick test) cycle.

1. Press **MORE CYCLES** touch screen pad at the cycle selection menu to access the second screen of cycles. Press **DART TEST** touch screen pad.

2. A second menu then appears on the screen. A DART test should only be run in a machine that is at operating temperature (that is, has run one or more cycles). If the sterilizer has not run any cycles prior to the DART test, run the DART WARM-UP cycle.

a. The operator is prompted to close the chamber door, if it is open. Once closed, the door seals automatically.
b. The sterilizer automatically runs a cycle with three minute sterilize and one minute dry values.
c. Once the Warm-up cycle is complete, the display returns to cycle select menus.

3. Open the chamber door (if it is not already open). Load the DART indicator and close the door.

4. Start the DART cycle. The cycle runs automatically, as follows:

ACTIVATE SEAL- Steam enters the door seal, pressing seal against inside surface of door.
PURGE- Chamber is purged with steam. Start of condition is printed.
PULSE #1 through **PULSE #2**- Vacuum point is printed and pressure/vacuum pulse is repeated.
CHARGE- Chamber is charged with steam. Start of steam charge is printed.
STERILIZE- Start of sterilization exposure is printed when the chamber reaches set temperature. Chamber temperature is printed every minute. Chamber is controlled at set point plus overdrive.
FAST EXHAUST- Start of exhaust is printed and chamber is exhausted to 4.0 psig.
DRY- Start of dry is printed and display counts down dry time remaining.
AIR BREAK- Chamber is returned to atmospheric pressure.
RETRACT SEAL- A vacuum is drawn on the seal, retracting it from inner surface door.
COMPLETE- Complete tone sounds. Cycle summary and end of cycle messages are printed.

Review and verify critical cycle parameters were achieved during processing, then sign printout to indicate verification.

5. Once the cycle is complete:

a. Open the chamber door by pressing on the food pedal.
b. Unload the DART test pack.

Refer to instructions packaged with DART indicator. Forward the exposed test strip to the appropriate personnel for examination.

APPENDIX D

PROCEDURE TO PERFORM A LEAK TEST ON STERIS STERILIZER

This procedure is used to confirm that the sterilizer vacuum is intact in the piping and door. This cycle automatically checks for leaks in the piping and door seal, it is NOT a substitute for the BOWIE-DICK Test. Test should be done a minimum of once a week and documented in the monitoring record.

PROCEDURE:
This cycle is used for testing vacuum integrity of the sterilizer's piping.
A Vacuum Leak Test cycle should be run on the sterilizer at least once each week. In this cycle, the sterilizer automatically checks for vacuum leaks in the piping and door

seal. If the sterilizer fails that leak test, it must be inspected by a service technician. This test is not a substitute for a Bowie-Dick test. The leak test can be used to confirm that the sterilizer piping is intact after performing repairs.
NOTE: The measured leak rate (mm Hg per minute) is calculated by the control over a timed 10 minute period and is included in the cycle printout. A leak rate of 1.0 mmHg/minute or less is considered acceptable.
1. Press **MORE CYCLES**. The leak test cycle touch screen pad appears on the display.
2. To start the leak test press the **LEAK TEST** touch screen pad. Printer records cycle start. Cycle runs automatically as follows:
ACTIVATE SEAL- Steam enters the door seal, pressing seal against inside surface of door.
PURGE- Chamber is purged; printer records end of purge.
PULSE #1 (and **PULSE#2**)- Two vacuum and pressure pulses then occur and the printer records each.
CHARGE- After the pressure pulses, temperature rises to 270 F (132 C), unit begins to draw a vacuum for 10 minutes. (Printer records temperature at beginning of 10 minute vacuum time.)
LEAK TEST/EVACUATING- Printer records temperature and vacuum at end of evacuation time.

APPENDIX E

PROCEDURE FOR THE USE OF CHEMICAL INTEGRATOR STRIP FOR STEAM STERILIZER

Provide an indication that the sterilization process was performed.

SUPPLIES AND EQUIPMENT NEEDED:
Chemical Steam Integrator strip

PROCEDURE:
Place an integrator strip inside every package sterilized. There are no exceptions. The integrator strip is a chemical indicator that monitors time and temperature conditions. Chemical indicators do not guarantee

sterility, but help demonstrate if certain parameters have been met and can be used to troubleshoot or to validate cycle parameters.

An integrator monitor strip will be placed in each package containing an implantable item (i.e. bone screws and plates, Tevdek suture.)