SUBMITTAL TO THE RIVERSIDE UNIVERSITY HEALTH SYSTEM MEDICAL CENTER GOVERNING BOARD COUNTY OF RIVERSIDE, STATE OF CALIFORNIA

Riverside University HEALTH SYSTEM Medical Center

ITEM: 15.1
(ID # 26253)
MEETING DATE:
Tuesday, October 29, 2024

FROM : RUHS-MEDICAL CENTER

SUBJECT: RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER: Approve Policies, All Districts. [Total Cost $0]

RECOMMENDED MOTION: That the Board of Supervisors:

1. Review and approve the attached Medical Center and Clinics Policies.

ACTION:Consent

Jennifer Cruikshank
Jennifer Cruikshank, Chief Executive Officer – Health System 10/15/2024

MINUTES OF THE GOVERNING BOARD

On motion of Supervisor Spiegel, seconded by Supervisor Gutierrez and duly carried by unanimous vote, IT WAS ORDERED that the above matter is approved as recommended.

Ayes:	Jeffries, Spiegel, Washington, Perez and Gutierrez
Nays:	None
Absent:	None
Date:	October 29, 2024
xc:	RUHS-Medical Center, COBAB

Kimberly A. Rector
Clerk of the Board
By: _____
Deputy

SUBMITTAL TO THE RIVERSIDE UNIVERSITY HEALTH SYSTEM MEDICAL CENTER GOVERNING BOARD OF DIRECTORS COUNTY OF RIVERSIDE, STATE OF CALIFORNIA

FINANCIAL DATA	Current Fiscal Year:	Next Fiscal Year:	Total Cost:	Ongoing Cost
COST	$0	$ 0	$0	$ 0
NET COUNTY COST	$ 0	$ 0	$ 0	$ 0
SOURCE OF FUNDS: N/A			Budget Adjustment: No	
			For Fiscal Year: 24/25	

C.E.O. RECOMMENDATION: Approve

BACKGROUND:

The Riverside University Health System Medical Center (RUHS MC) is a licensed and accredited acute care hospital serving the needs of County residents since 1893. RUHS MC currently has two campuses – one in Moreno Valley and one on County Farm Road in the City of Riverside.

As an acute care hospital RUHS MC is required by the State of California to have a "governing body" separate from its administrative leaders and medical staff leadership. The "governing body" is "the person, persons, board of trustees, directors or other body in whom the final authority and responsibility is vested for conduct of the hospital." 22 CCR §70035. (See also 42 CFR 482.12 and Joint Commission Standard LD.01.03.01) The Board of Supervisors serves as the "governing body" for the hospital.

Various regulatory requirements mandate that the Governing Board participate in the leadership and decision-making of the Medical Center by reviewing and approving its policies relating to certain topics.

RUHS-MC is committed to furnishing a safe, accessible, effective and efficient environment consistent with its mission, services and applicable governmental mandates. This includes fostering the protection, safety and well-being of patients, employees, staff and visitors during natural or man-made disasters and ensuring to the greatest extent possible, adherence to our social responsibility and commitment to the community.

Impact on Residents and Businesses

The RUHS Medical Center offers a 439-bed providing adult, Pediatric and Neonatal Services, including a Level 1 Trauma Center, the county's only Pediatric Intensive Care Unit, a Stroke Center, with over 40 specialty care clinics, as well as a Medical and Surgical Center featuring state-of-the-art Outpatient Surgical, Diagnostic and Imaging Equipment, Rehabilitation Services, and an Outpatient Pharmacy. The RUHS Emergency Treatment Services/Inpatient Treatment Facility at the Arlington Campus located in Riverside is a 77-bed inpatient Psychiatric Treatment Facility. The integrated healthcare continuum is fortified with 14 RUHS-CHCs conveniently located throughout the county which work in close partnership with RUHS-BH and RUHS-PH to

offer access to comprehensive high-quality and integrated primary, Behavioral Health, Specialty Care, Dental Care and Health Promotion services.

Training future healthcare leaders is fundamental to our commitment to serving our community as well as our mission as a safety net institution. An efficient, well-functioning medical center providing care of high quality creates many positive benefits for Riverside County citizens and its businesses.

ATTACHMENTS:
Attachment A: RUHS Policy List 06.26.24 to 09.30.24
Attachment B: RUHS Policies 06.26.24 to 09.30.24

Jacqueline Ruiz, Principal Analyst 10/22/2024

Gregg Gu, Chief Deputy County Counsel 10/15/2024

RUHS Medical Center Policies Approved 6/26/2024 through 9/30/2024

#	Title	Date
1	HW 102 Escalation of Clinical Concerns.pdf	7/18/2024
2	HW 104 Policy Administration.pdf	7/18/2024
3	HW 118 Hospital Parking.pdf	8/1/2024
4	HW 137 Ice Machine Cleaning.pdf	7/19/2024
5	HW 138 RH Waiver of Life Safety Code Anesthesia Location Requirements.	7/19/2024
6	HW 141 High Level Disinfection.pdf	7/18/2024
7	HW 143 Cleaning Processing Flexible Endoscopes and Accessories.pdf	7/18/2024
8	HW 144 Oxygen Cylinder Storage and Labeling.pdf	8/26/2024
9	HW 200 Financial Assistance Programs.pdf	9/11/2024
10	HW 410 Use of Personal Cell Phones.pdf	7/18/2024
11	HW 513 Infant and Child Security HUGS.pdf	8/1/2024
12	HW 515.2 Hazardous Materials Chemical Monitoring	8/1/2024
13	HW 602 Patient Informed Consent.pdf	9/11/2024
14	HW 631 Code Green and Code BERT Guidelines.pdf	8/1/2024
15	HW 632 Patient Discharge Planning and Patient Discharge.pdf	9/11/2024
16	HW 642 Administering Seasonal Influenza Vaccine to Patients by an RN.pdf	7/18/2024
17	HW 652 Decedent Affairs.pdf	8/20/2024
18	HW 653 Autopsy Consent Documentation.pdf	7/18/2024
19	HW 654 Adverse Events.pdf	7/18/2024
20	HW 678 Blood Transfusions.pdf	7/18/2024
21	HW 688 Vascular Access Team Scope of Service.pdf	9/11/2024
22	HW 691 Sepsis Guidelines for the Management of Sepsis.pdf	7/18/2024
23	HW 1108 High Consequence Infectious Diseases.pdf	8/20/2024
24	HW 1109 Corona Virus COVID 19.pdf	8/20/2024
25	HW 1110 Portable Fans for Patient Use.pdf	8/26/2024
26	HW 1111 Aerosol Transmissible Disease Exposure Control Plan.pdf	8/26/2024

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 102	Page 1 of 4
Title: Escalation of Clinical Concerns	**Effective Date:** 7/18/2024	☐ **RUHS – Behavioral Health** ☐ **RUHS – Community Health Centers** ☐ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By: Jennifer Cruikshank CEO/Hospital Director		☐ **Policy** ☒ **Procedure** ☐ **Guideline**

1. DEFINITIONS

1.1 **Chain of Command (COC):** formal, structured communication technique used to resolve patient safety issues.

1.2 **Escalation:** the communication of problems/concerns to a higher level of authority while continuing to maintain accountability for a satisfactory resolution.

1.3 **Mutual Support:** involves team members assisting one another, providing, and receiving feedback on performance, and advocating assertively when patient safety is threatened.

2. POLICY

2.1 Riverside University Health System is committed to providing safe, quality patient care. Any employee or medical staff member who identifies a problem about patient care and is unable to resolve it should escalate the issue to successively higher levels of authority (Chain of Command) until a satisfactory resolution is achieved.

2.2 Chain of Command/Escalation ensures:

a. The appropriate people are aware of the situation.

b. Issues progress from the level closest to the event and move up as the situation warrants; and

c. Further information and guidance can be obtained which may result in resolution of the issue, thus contact information of the reporting personnel is essential.

2.3 Clinical Situations often involve judgment, which at times may differ among caregivers. However, caregivers have a duty to advocate for the patient through the organizational chain of command when they believe that a practitioner is unresponsive to concerns about the patient's condition or is making decisions that would be detrimental to the patient's well-being. Because RUHS places patient safety and well-being above all else, retaliation against anyone who invokes Chain of Command procedures is prohibited.

2.4 Hospital Chain of Communication is as follows:

a. The Charge Nurse or designated lead of the unit/department

b. The House Supervisor

c. The unit/department Manager/Director

d. The Chief Nursing Officer or designated Administrator on call

e. The Chief Executive Officer and the Chief Medical Officer

2.5 The Medical Chain of Communication is as follows;

a. Health care provider (Intern, Resident, Fellow, Physician Assistant Nurse Practitioner, or Hospitalist)

b. Attending Physician

c. Division Chief (if applicable)

d. Department Chair

e. Chief Medical Officer

2.6 The Chain of Command/Escalation procedure can vary depending on the potential or immediate possibility of patient harm. In an emergent situation (e.g. deterioration of patient clinical status), movement through the chain of command should occur more rapidly, and the person(s) contacted may vary depending on the nature of the circumstances and patient condition

2.7 Mutual Support Activities can have an impact on decreasing the need to initiate the COC. Strategies include but are not limited to:

a. Training of key personnel in conflict resolution techniques.
b. Talking directly with the member of the health care team or provider at the time of concern in a discrete area away from the patient's bedside.
c. Arranging for support during discussion with member of the healthcare team or provider.
d. Reviewing a policy or procedure with member of the healthcare team or provider.
e. Educating as appropriate.

3. PROCEDURE

3.1 Qualified personnel who encounter a patient care problem/concern, which, in their judgment, could be detrimental to the patient, MUST initiate the Chain of Command. Such issues include but are not limited to:

a. Physician orders (incomplete, conflicting)

b. Patient decline or worsening status

c. Interpersonal effectiveness of the patient care team

d. Advanced Directive Issues

e. Timeliness of response from any member of the medical team

f. Any event that places the patient at risk

3.2 If there is a significant change in patient condition based upon findings in physical assessment; the Attending and possibly, consultants must be notified immediately following identification. Such examples include but are not limited to;

a. Unanticipated decline in level of consciousness

b. Adverse outcome related to treatment

c. Signs of bleeding or infection

d. Continued decline in patient condition

e. The orders received do no resolve the patient's condition

3.3 When applicable, a code rapid response or Code Blue is called regardless of the status of the escalation process.

3.4 Communication is to be collegial and should follow the CUS model (below). The focus of the communication is to be in the best interest of the patient, fostering a conversation related to concerns.

CUS Model for Communication

C: First, state your **concern**.

U: Then, state why you are **uncomfortable**.

S: If the conflict is not resolved, state that there is a **safety** issue. Discuss in what way the concern is related to safety. If the safety issue is not acknowledged, a supervisor should be notified.

3.5 After contacting the appropriate member of the healthcare team, if the qualified personnel remain concerned that the team members response and/or orders are insufficient he/she must contact their immediate supervisor.

a. The immediate supervisor will facilitate escalation through the Chain of Command.

b. An action plan will be mutually agreed upon to address the concern and the supervisor will maintain an open line of communication with the reporting personnel.

c. An on-line incident report should be completed by the reporting personnel.

d. If an agreeable action plan is unable to be reached, the reporting personnel may escalate the problem/concern to the next administrator in the chain of command.

3.6 If the concern is directed to an intern or resident and resolution is not achieved the Attending Physician should be notified. Concerned team members are encouraged to request interns or residents to initiate Attending Consultation.

3.7 If the supervisor/manager/charge nurse pursues the issue with the involved team member and satisfaction is not obtained, they will contact the appropriate department director, or their designee, the CNO, or the Administrator on call

4. REFERENCES

4.1 The Joint Commission Leadership Standard LD.02.04.01

4.2 Senate Bill 1301 – Mandatory Reporting of Adverse Events Health & Safety Code Section 1279.1.

4.3 RUHS HW Policy 610 Reporting Never Events

4.4 RUHS Medical Staff Bylaws, Rules & Regulations

4.5 RUHS Compliance Plan and Code of Conduct

4.6 RUHS Employee Conduct Policy

4.7 National Quality Forum. List of Serious Reportable Events. Accessed via https://www.qualityforum.org/Topics/SREs/List_of_SREs.aspx

4.8 Agency for Healthcare Research and Quality (AHRQ). Overview of Mutual Support Key Concepts and Tools. Content last reviewed July 2023.

5. ATTACHMENT

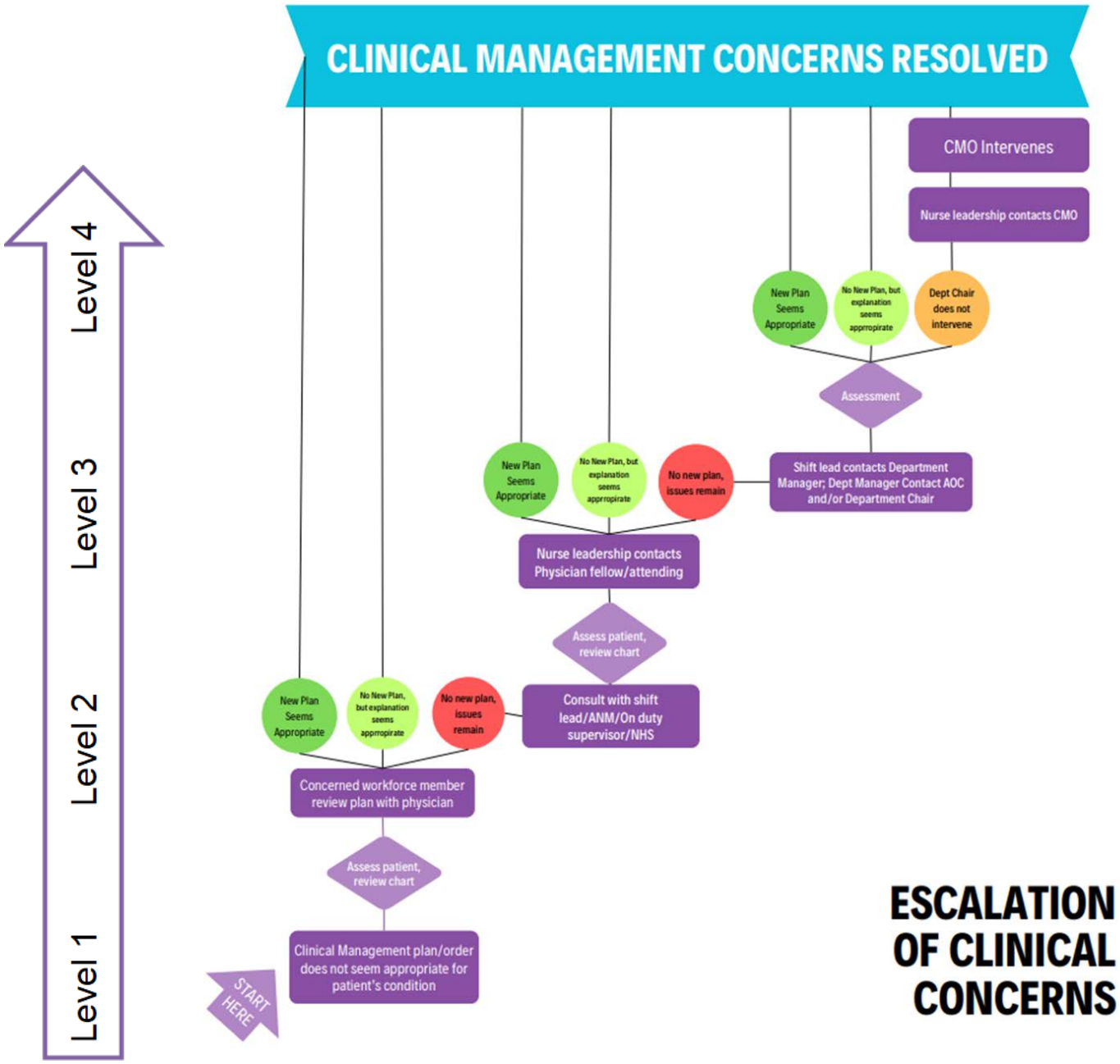
5.1 Escalation of Clinical Concerns Flowchart

Document History:

Prior Release Dates: 2/2013; 3/2018	**Retire Date:** N/A
Document Owner: Nursing Administration	**Replaces Policy:** N/A

Date Reviewed	**Reviewed By:**	**Revisions Made Y/N**	**Revision Description**
3/10/2024	Just Culture Task Force	Yes	Major revisions, add just culture framework, new flow diagram Team Stepps framework
4/22/2024	Nursing P&P	No	
5/7/2024	PAC	No	
6/13/2024	MEC	Yes	Additional physician review requested
7/11/2024	MEC	No	

ATTACHMENT #: FLOWCHART



RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER

Housewide

<table>
<tr><td></td><td>Document No: 104</td><td>Page 1 of 2</td></tr>
<tr><td>Title:

Policies and Procedures Administration</td><td>Effective Date:

7/18/2024</td><td colspan="2">☐ RUHS – Behavioral Health
☐ RUHS – Community Health Centers
☐ RUHS – Hospital Based Clinics
☒ RUHS – Medical Center
☐ RUHS – Public Health
☐ Departmental</td></tr>
<tr><td colspan="2">Approved By:
 
Jennifer Cruikshank
CEO/ Hospital Director</td><td colspan="2">☒ Policy
☐ Procedure
☐ Guideline</td></tr>
</table>

1. DEFINITIONS

1.1 Basic Service (Title 22 §70011). Basic services means those essential services required by law for licensure as a hospital including medical, nursing, surgical, anesthesia, laboratory, radiology, pharmacy and dietary services.

1.2 Governing Body. Governing body means the person, persons, board of trustees, directors or other body in whom the final authority and responsibility is vested for conduct of the hospital.

1.3 Policies. Expressions of intent, normally required by external statuses, regulations or standards. Deviation(s) from a policy are prohibited.

1.4 Procedures. Steps that must be followed to carry out a policy. Deviation(s) from a procedure are prohibited.

1.5 Special Permit (Title 22 §70061). Special permit means the document issued by the Department which constitutes the authority to perform those supplemental services which are identified as special services in Section 70351.

1.6 Supplemental Service (Title 22 §70067). Supplemental service means an organized inpatient or outpatient service which is not required to be provided by law or regulation.

2. POLICY

2.1 The policy of Riverside University Health System – Medical Center is to implement policies and procedures in compliance with legal and regulatory agency requirements.

2.2 Applicability. When policies or procedures establish conflicting expectations, the most recent articulation of such expectation shall govern.

2.3 Approval:

a. Hospital policies and procedures shall be approved by administration and, when patient care is involved, the appropriate medical staff committee.

b. Hospital policies for basic, supplemental and special permit services shall be approved by the Governing Body.

Document History:

Prior Release Dates: 11/1/86, 10/9/02, 7/20/05, 4/9/2014, 5/2017, 3/9/2021	**Retire Date:** N/A
Document Owner: Policy Approval Committee Chair	**Replaces Policy:** N/A

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
4/2024	Policy Program Administrator	N	
6/20/2024	Nursing P&P	N	
7/2/2024	PAC	N	

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER

Housewide

	Document No: 118	Page 1 of 3
Title: Hospital Parking	**Effective Date:** 8/1/2024	☐ **RUHS – Behavioral Health** ☐ **RUHS – Community Health Centers** ☒ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By:  Jennifer Cruikshank CEO/ Hospital Director		☐ **Policy** ☐ **Procedure** ☒ **Guideline**

1. DEFINITIONS

1.1 Designated Accessible Parking is defined as any parking space marked by a handicapped parking sign and blue paint on the curbing or asphalt.

1.2 Designated Patient Parking is defined as any parking space or lot designated as patient parking and is available to the patient and his/her family and/or visitors.

1.3 Employees is defined as all permanent and temporary County employees, residents, interns, students, registry, per diem, and other contracted personnel.

1.4 Employee Parking Spaces is defined as any space within designated employee parking areas.

1.5 Fire Lane is defined as any area designated as a fire lane by signage and red paint on the curbing. There is no parking in these areas at any time for any vehicle other than fire trucks or other emergency services vehicles.

1.6 Loading Zone is defined as areas designated for patient loading and unloading only. No stopping, standing, or parking at any time for any purpose other than the loading or unloading of patients or persons with disabilities.

2. PROCEDURES

2.1 Parking. To ensure that RUHS-Medical Center patients and their visitors have easy access to the facilities:

a. Designated parking lots have been established for employees, patients, and visitors.

b. Employees will park in designated employee parking areas and shall not park in areas designated for patients or visitors.

c. Employees whose work location is within the hospital will not park in the Campus Professional Center (CPC) parking lot. Unauthorized parking in this lot may be subject to a parking citation.

d. County employees from other County departments attending meetings or visiting RUHS-Medical Center shall adhere to the rules governing parking on RUHS-Medical Center property.

e. Any barrier (cones, barricades, caution tape) are considered construction zones. Parking in these areas is prohibited.

f. Parking in dirt areas is prohibited.

g. Parking in any designated 3-hour patient parking is prohibited.

h. Employees who are at the medical center for personal reasons (i.e., visiting a patient or seeking personal medical care) may park in those areas designated as patient or visitor parking.

i. Parking of any Recreational Vehicle on RUHS – Medical Center property is prohibited unless prior approval is received from RUHS administration.

2.2 Physician Parking Permits:

a. Are coordinated through the Medical Staff Services Office and issued by Human Resources.

b. Allow Attending Physicians to park in a specially designated are. (refer to attachment)

2.3 Special Permits/Dispensations. The following is a listing of special permits/designations

a. Employee Accessible Parking:

- Accessible parking is not authorized unless the vehicle's driver has been issued the State disabled person placard/license plate which is visible at all times while parked.

b. Carpool/Rideshare Parking Permits:

- Allow parking in the Carpool/Rideshare designated spaces (refer to attachment).
- Are issued by the County of Riverside Rideshare office.
- Shall hang on the rear view mirror visible through the windshield from the front of the vehicle.
- Must only be used on days where ridesharing requirements have been met.

c. Employee Recognition Permits:

- Are issued by RUHS administration.
- Shall be displayed on the front dashboard, visible through the windshield from the front of the vehicle.
- Allow the employee to park in spaces designated by RUHS administration for specific incentive programs.

2.4 Access to the Emergency Care Area.

a. These parking areas are restricted for time limited emergency vehicles only; i.e., ambulances, law enforcement vehicles and fire department vehicles**.** (refer to attachment)

2.5 Speed limit. Except as otherwise posted, the maximum vehicle speed limit anywhere on RUHS-Medical Center grounds is 15 MPH.

2.6 Enforcement.

a. The Sheriff's Department Security Staff patrol parking areas and enforce all parking regulations 24 hours day, 7 days a week.

b. All employees who observe an improper use of parking are encouraged to contact the Security Operations Center (SOC) at (951) 486 - 49714971.

c. Employees involved in an accident, find their vehicle has been vandalized, or property stolen from their vehicle while on RUHS-Medical Center property shall report it to the Security Department.

2.7 Citations

a. Violators of traffic and/or parking regulations are subject to citation by Riverside County Sheriff's Department under the provisions of County Ordinance 626, and the California Motor Vehicle Code, Section 21113 (a), (b), and (c), which states:

- In the absence of any special conditions or regulations to traffic or parking, all the provisions of the California Motor Vehicle Code relating to traffic and parking are applicable. Persons operating and/or parking vehicles on Medical Center properties are subject to the conditions and regulations established and posted by the Medical Center for those areas.

b. Any vehicle identified as an employee vehicle found parked in an unauthorized area, or identified as not having a proper parking permit for the area where the vehicle is parked, will receive a parking citation resulting in a monetary fine.

2.8 RUHS-Medical Center reserves the right to

a. Change designated parking areas as necessary

b. Close, reserve, or restrict the use of a parking space at any time.

c. Determine the hours of enforcement.

2.9 Removal of Vehicles

a. A vehicle may be removed to the nearest public storage facility under the circumstances described in Section 22658 of the Vehicle Code. In the event a vehicle is removed, the notices required by Sections 22852 and 22853 of the Vehicle Code shall be given.

3. REFERENCES

3.1 County Ordinance No. 626, County Parking Lots: Regulating Use Thereof

3.2 2010 Americans with Disabilities Act Standards for Accessible Design, 28 CFR Part 36

Document History:

Prior Release Dates: 8/28/85, 3/20/00, 02/27/07, 10/18/12, 5/15/13 and 01/06/17, 3/9/2021	**Retire Date:** N/A
Document Owner: Security	**Replaces Policy:** N/A

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
6/27/2024	Environment of Care EOC Committee	Y	Addition of 2.1 e. and g.regarding construction zones and 3 hour patient parking Minor clarifying wording Expand on removal of vehicles 2.9
7/24/2024	PAC	N	

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER

Housewide

	Document No: 137	Page 1 of 3
Title: Ice Machine Cleaning	**Effective Date:** 7/18/2024	☐ **RUHS – Behavioral Health** ☐ **RUHS – Community Health Centers** ☐ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By:  Jennifer Cruikshank CEO/ Hospital Director		☐ **Policy** ☐ **Procedure** ☒ **Guideline**

1. RESPONSIBILITIES

1.1 Plant Operations shall be responsible for:

a. Performing routine maintenance services on all ice machines located on the RUHS – Medical Center and Arlington campuses, as per manufacturers' recommendations.

b. Cleaning and sanitizing the interior of all ice machine bins and dispensers in accordance with the manufacturer recommended guidelines.

c. Maintaining ice machine equipment inventory in the Hospital Equipment Management System (HEMS).

- Preventative maintenance shall be scheduled and completed in accordance with the manufacturer recommendations.
- Records of maintenance, cleaning and sanitizing activities shall be kept on file in the department.

d. Maintaining the service manuals supplied by each manufacturer for each model of ice machine.

e. Responding to reports of ice machine failures by disconnecting the machine, labeling it, decommissioning it from service, and initiating a ticket for repair.

1.2 Environmental Services (EVS) shall be responsible for:

a. Cleaning and sanitizing the exterior surfaces of nursing units' ice machines daily.

b. Cleaning the trays, grids, and the outside of the ice dispensing chutes in nursing units as needed.

c. Maintaining the daily cleaning documentation in the EVS office.

d. Training staff responsible for cleaning ice machines upon initial department orientation, receipt of new models, employee request for re-training, and periodically thereafter.

e. Reporting worn parts or items in need of repair to the Plant Operations department.

1.3 Food and Nutrition Services shall be responsible for:

a. Cleaning and sanitizing the interior of the closed bin ice machines located in Food and Nutrition Services per manufacturers' recommendations, and as

needed, using an approved
cleaner and sanitizer in proper dilution and in accordance with the manufacturer recommended guidelines.

b. Cleaning and sanitizing the ice scoop daily and as needed.

c. Cleaning and sanitizing the exterior surfaces of ice machines in the Food and Nutrition Services department.

d. Maintaining documentation of cleanings in the Food and Nutrition Services department.

e. Reporting worn parts or items in need of repair to the Plant Operations department.

f. Contacting an authorized service technician to complete the bi-annual cleaning of the ice machines on the soda fountains in the cafeteria.

2. GUIDELINES

2.1 The machines shall be cleaned using an approved disinfectant in proper dilution and in accordance with Environmental Services Department Policy No. 452, Cleaning Ice Machines/Drinking Fountains.

2.2 Ice Machine Locations. Ice dispensing machines are located throughout the campuses including:

a. Patient care units,

b. Clinics,

c. Food and nutrition service areas,

d. Employee conference rooms.

e. Employee patio at the Arlington campus.

2.3 Staff Training

a. Environmental Services, Food and Nutrition Services, and Plant Operations supervisors shall provide training to staff, at the Moreno Valley and Arlington campuses, on the proper procedures for cleaning, sanitizing, and performing preventative maintenance on each model of ice machine.

b. Trainings shall occur upon initial orientation to the department, upon receipt of new equipment or models, when a workforce member asks for re-training, and/or when random audits indicate that workforce members may benefit from a re-training.

c. Staff shall be assessed annually for competency.

d. Supervisors shall perform periodic random audits to ensure compliance.

3. REFERENCES

3.1 The Joint Commission, Comprehensive Accreditation Manual for Hospitals (CAMH) Standard IC.02.02.01, EP 1.

3.2 RUHS Food and Nutrition Services Department policy FNS 3007 Ice Handling

3.3 RUHS Environmental Services Policy EVS 047 Dispenser Cleaning

Document History:

Prior Release Dates: 4/4/2013, 1/21/2014, 3/9/2021	**Retire Date:** N/A
Document Owner: EVS	**Replaces Policy:** N/A

Date Reviewed	**Reviewed By:**	**Revisions Made Y/N**	**Revision Description**
4/14/2024	EOC	**N**	
6/24/2024	Policy Program Admin	**Y**	**Updated Reference**
6/24/2024	Director FNS	**N**	
6/24/2024	Director Infection Prevention and Control	**Y**	**Wording for clarity**
7/2/2024	PAC	**N**	

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 138	Page 1 of 1
Title: Relative Humidity RH Waiver of Life Safety Code Anesthesia Location Requirements	**Effective Date:** 7/18/2024	☐ **RUHS – Behavioral Health** ☐ **RUHS – Community Health Centers** ☐ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By:  Jennifer Cruikshank CEO/ Hospital Director		☒ **Policy** ☐ **Procedure** ☐ **Guideline**

1. DEFINITIONS

1.1 Anesthetizing Locations is defined as any area of the hospital that has been designated to be used for the administration of nonflammable inhalation anesthetic agents in the course of examination or treatment, including the use of such agents for relative analgesia.

2. POLICY

2.1 RUHS – Medical Center elects to use the Categorical Life Safety Code (LSC) Waiver issued by the Centers for Medicare and Medicaid Services (CMS).

2.2 RUHS – Medical Center shall notify survey teams assessing LSC compliance, at the entrance conference, of RUHS – Medical Center's prior decision to use this wavier.

2.3 Plant Operations shall monitor relative humidity (RH) in anesthetizing locations and shall take corrective action when necessary in order to maintain RH levels at or above 20 percent and not exceeding 60 percent or in accordance with state and local laws and regulations when more stringent requirements exist.

3. REFERENCES

3.1 State Operations Manual under A-0726 §482.41 (4)(c), Q-0101 §482.44(a)(1), and C-0226 §485.623(b)(5)

3.2 American Society for Heating, Refrigerating, and Air conditioning Engineers (ASHRAE) Standard 170: Ventilation of Health Care Facilities.

3.3 National Fire Prevention Agency (NFPA) 99, Healthcare Facilities Code.

Document History:

Prior Release Dates: 1/28/2015, 10/10/2017, 3/9/2021		**Retire Date:** N/A	
Document Owner: Plant Operations		**Replaces Policy:** N/A	
Date Reviewed	**Reviewed By:**	**Revisions Made Y/N**	**Revision Description**
4/16/2024	Environment of Care Committee	N	

7/2/2024	PAC	N	

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER

Housewide

	Document No: 141	Page 1 of 6
Title: High Level Disinfection	**Effective Date:** 7/18/2024	☐ **RUHS – Behavioral Health** ☐ **RUHS – Community Health Centers** ☒ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By:  Jennifer Cruikshank CEO/ Hospital Director		☒ **Policy** ☐ **Procedure** ☐ **Guideline**

1. SCOPE

1.1 The policy of Riverside University Health System-Medical Center (RUHS-Medical Center) is to ensure patient safety through proper high-level disinfection of medical devices. This policy does not apply to the Arlington Campus.

2. DEFINITIONS

2.1 Cleaning. The removal of organic and inorganic material from objects and surfaces. This is normally accomplished by using detergents or enzymatic products.

2.2 Decontamination. The processes by which contaminants are removed, either by manual cleaning or mechanical means, using specific solutions capable of rendering blood and debris harmless and removing them from the surface of an object or instrument.

2.3 High-Level Disinfection (HLD). Includes pasteurization or use of chemical disinfectants to destroy all microbial life, with the exception of low numbers of bacterial spores and prions, on devices or equipment that come in contact with mucous membranes or skin that is not intact. High-level disinfectants have the capability to inactivate the hepatitis B and C viruses, Human Immunodeficiency Virus (HIV), and *Mycobacterium tuberculosis*, but do not inactivate the prion that causes Creutzfeldt-Jakob (CJD) disease.

2.4 Automatic Endoscope Reprocessor (AER). A unit for mechanical cleaning, disinfecting, and rinsing of flexible endoscopes.

2.5 Personal Protective Equipment (PPE). A variety of barriers used alone or in combination to protect mucous membranes, skin, or clothing from contact with infectious agents; includes, but is not limited to: gloves, masks, respirators, goggles, face shields, and gowns.

2.6 Prion. A small proteinaceous infectious disease-causing agent that is believed to be the smallest infectious particle. A prion is neither bacterial nor fungal nor viral and contains no genetic material. Prions have been held responsible for a number of degenerative brain diseases, including mad cow disease, Creutzfeldt-Jakob disease, fatal familial insomnia, kuru, and an unusual form of hereditary dementia known as Gertsmann-Straeussler-Scheinker disease.

2.7 Spaulding Classification. Defines the minimum level of disinfection or sterilization required based on how an item is used or the part of the body with which it makes contact. The classification system is divided into three categories:

- Critical Items. Medical devices that enter sterile tissue or the vascular system.
- Semi-Critical Items. Medical devices that come in contact with mucous membranes or skin that is not intact.
- Non-Critical Items. Medical devices that come in contact with intact skin.

3. POLICY

3.1 One of the measures for preventing infections is to provide reusable items that are free of contamination at the time of use. This can be accomplished when:

a. Medical devices to be reprocessed are categorized according to the Spaulding classification system as critical, semi-critical, and noncritical, depending on the nature of the item requiring processing and the manner in which it is to be used.

b. A US Food and Drug Administration (FDA)-cleared agent is used to achieve chemical HLD of medical devices.

c. Chemical disinfectants are used according to manufacturer's written Instructions For Use (IFU).

d. Chemical disinfectants are used and disposed of according to federal, state, and local regulations.

e. High-level disinfection (HLD) is not used for items exposed to prions at RUHS Medical Center.

3.2 Processing Medical Devices

a. Classify medical devices to be reprocessed as critical, semi-critical, or noncritical.

b. Follow manufacturers' written IFU's when:

- Preparing and using disinfectant solutions
- Calculating expiration dates
- Labeling solution soaking containers

c. Wear the following PPE during cleaning, decontamination, and when handling chemical disinfectants:

- Protective eyewear (e.g., goggles, face shields)
- Masks
- Moisture-repellant or splash-proof skin protection (e.g., gowns, aprons)
- Gloves

d. Thoroughly clean, decontaminate, dry, and visually inspect medical devices before HLD.

e. The department manager will verify that the medical device's IFU is congruent with a manual cleaning process or an automated endoscope reprocessor (AER).

- If manufacturers' written instructions for the endoscope reprocessor and the endoscope manufacturer are not congruent, department manager will:
    i. Not reprocess the device
    ii. Alert staff team members

iii. Consult and collaborate with Infection Prevention and Control to determine future actions to be taken

f. Protect HLD devices from contamination until they are delivered to the point of use.

g. Use a transport technique that does not recontaminate the device.

h. After use cover, contain, and label the soiled instruments and medical devices as biohazardous, then transport them in a secure manner to the point of decontamination and processing.

3.3 Using Chemical Disinfectants

a. Use chemical disinfectants only in well-ventilated areas.

b. Keep chemical disinfectants in covered containers with tight-fitting lids and clearly labeled with contents and expiration date.

3.4 Monitoring Temperature, Disinfectant Solution Concentration, and Exposure Time

a. HLD should occur at appropriate temperature, according to manufacturer's IFU. Record the temperature of the disinfectant solution.

b. Use a test strip, or other FDA-cleared testing device specific to the disinfectant, for detecting the MEC of the active ingredient. Monitoring solution potency should be performed before each use.

c. The test strip expiration date should be checked before use.

d. If the solution falls below its MEC, retest the solution. If the solution falls below its MEC again, discard the solution even if the designated expiration date has not been reached.

e. Completely immerse the medical devices to be disinfected in the disinfectant solution according to the device and HLD solution manufacturer's written IFU.

- To disinfect lumens and ports, flush and fill them with the disinfectant, then completely immerse the items in the disinfectant solution for the designated exposure time, according to the device's IFU.

f. After exposure to the disinfectant solutions for the required time, thoroughly rinse medical devices with water according to the IFU.

3.5 Verifying of Cleaning and Reprocessing

a. Document the following items for each medical device cleaning and reprocessing procedure:

- Date and time disinfection was performed
- Patient identifier, when applicable
- Physician
- Load content (item description or serial number if applicable)
- Name of the team member performing the HLD
- Number or identifier of the AER, if used
- Type of disinfectant used and lot number
- Test results before each load, indicating the solution used was at the proper concentration (i.e., MEC) and within the expiration date
- Temperature of the disinfectant if temperature sensitive
- Submersion time
- Disposition of defective equipment

3.6 Monitor Test Strips Used for Quality Control Procedure

a. Test strips used for monitoring MEC of the disinfectant should also be tested, based on manufacturer recommendations.

b. Three tests of positive and three tests of negative controls will be performed on each newly opened test strip bottle, unless otherwise specified by the IFU.

c. Record results of quality control strips in a logbook.

3.7 Records Maintenance

a. Records of maintenance will be completed to demonstrate compliance with local, state, and federal regulations and with accrediting agency requirements.

- High-level disinfection records will be maintained for 3 years.
- Records of routine and unscheduled maintenance and repairs and disposition of defective equipment will be maintained for 3 years.

3.8 Disposal of Chemical Disinfectants

a. Personnel should use appropriate PPE when disposing of chemicals.

b. Use a neutralizer appropriate for the chemical disinfectant if required by the IFU of the chemical.

3.9 Disinfectant spillage

a. Do not attempt large spill cleanup. For spills larger than 500 mL call Environmental Services (EVS).

b. EVS is responsible to contain the spill followed by the cleanup depending on the substance.

c. If the spill cannot be managed by EVS, EVS will initiate a Code Yellow and contact the Hazmat team of the fire department.

3.10 Competency

a. Staff members who participate in procedures that may require the reprocessing of medical devices using HLD will receive initial education and complete a competency validation.

b. Staff will receive additional training when new equipment, instruments, supplies, or procedures are introduced.

c. Competency validation will occur every year after that.

3.11 Procedures

a. Procedures for HLD should be developed using the validated instructions provided by the medical device manufacturers, reviewed at regular intervals, revised as necessary, and readily available in the practice setting.

4. REFERENCES

4.1 Guideline for high-level disinfection. In: *Guidelines for Perioperative Practices.* Denver, CO: AORN, Inc.; 2021

4.2 Petersen C, ed. *Perioperative Nursing Data Set*. 3rd ed. Denver, CO: AORN, Inc.; 2010.

4.3 Westerway SC, Basseal JM, Brockway A, Hyett JA, Carter DA. *Potential infection control risks associated with ultrasound equipment—a bacterial perspective*. *Ultrasound Med Biol*. 2017;43(2):421-426.

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3/20/2021	Infection Prevention and Control	N	Minor wording
3/2024	Manager, Infection Prevention and Control	Y	Streamlined wording
4/2024	Infection Prevention and Control Committee	N	
5/2/2024	Pre-Nursing P&P	Y	Needs a Scope
5/16/2024	Nursing P&P	N	
7/2/2024	Policy Approval Committee	Y	Check box for scope for Hospital Based Clinics

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 143	Page 1 of 4
Title: Cleaning and Processing of Flexible Endoscopes and Endoscope Accessories	**Effective Date:** 7/18/2024	☐ **RUHS – Behavioral Health** ☐ **RUHS – Community Health Centers** ☐ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By:  Jennifer Cruikshank CEO/ Hospital Director		☐ **Policy** ☒ **Procedure** ☐ **Guideline**

1. SCOPE

1.1 The policy of Riverside University Health System-Medical Center (RUHS-Medical Center) is to ensure patient safety through proper cleaning and processing of flexible endoscopes and accessories. This policy does not apply to the Arlington Campus.

2. DEFINITIONS

2.1 **Automatic Endoscope Reprocessor (AER)**: A unit for mechanical cleaning, disinfecting, and rinsing of flexible endoscopes.

2.2 **Cleaning**: A process using friction, detergent, and water to remove organic debris; the process by which any type of soil, including organic debris, is removed. Cleaning removes, rather than kills, microorganisms.

2.3 **Decontamination**: A process that removes infectious agents and renders reusable medical products safe for handling.

2.4 **Enzymatic Cleaner**: A cleaner that uses enzymes to remove protein from surgical instruments.

2.5 **High-level disinfection (HLD)**: A process that kills all microorganisms, with the exception of small numbers of bacterial spores and prions. High-level disinfectants have the capability to inactivate the hepatitis B and C viruses, Human Immunodeficiency Virus (HIV), and *Mycobacterium tuberculosis*, but do not inactivate the virus-like prion that causes Creutzfeldt-Jakob disease (CJD). Government-registered HLD agents kill vegetative bacteria, tubercle bacilli, some spores and fungi, and lipid and nonlipid viruses, given appropriate concentration, submersion, and contact time.

3. PROCEDURES

3.1 The manufacturer's written instructions for use (IFU) for flexible endoscopes and all accessories will be followed regarding:
a. Cleaning processes
b. Selection of cleaning products
c. Selection of disinfectant/sterilization products
d. Use of alcohol
e. Compatibility with AER

3.2 Manufacturer's IFU will be followed for high-level disinfectant and chemical detergents.

3.3 Personnel will wear PPE when in contact with contaminated flexible endoscopes and endoscope accessories and wash their hands prior to donning and after removing PPE. PPE includes, but is not limited to:

a. Fluid-resistant gowns
b. Gloves
c. Masks
d. Eye protection (e.g., goggles, shields)

3.4 Precleaning

a. Pre-clean flexible endoscopes and endoscope accessories at the point of use per the manufacturer's IFU.

b. Transport the pre-cleaned flexible endoscope and endoscope accessories to the appropriate Decontamination Area using a closed container (e.g., enclosed by a plastic bag, case cart, container with a lid) that is labeled to indicate biohazardous contents.

3.5 Leak Testing

a. In the Decontamination Area, before cleaning, perform pressure (i.e., leak) tests on flexible endoscopes with leak-testing capabilities per the manufacturer's IFU:

- Manipulate the flexible endoscope control knobs in all directions during leak testing.
- If a leak is detected, keep the leak-testing device attached to the flexible endoscope and under pressure until the endoscope is removed from the water.
- When using a leak-test system that does not require water, complete the leak test before submerging the flexible endoscope in water or cleaning solution.
- Remove scope from water, turn off and depressurize the scope from the leak tester per the scope IFU. Follow department protocol for steps to be taken when leak testing fails.
- Scopes that do not pass leak test will be removed from service until repaired.

3.6 Cleaning

a. Manually clean the flexible endoscope and accessories per the manufacturer's IFU.

b. PPE required during endoscope processing includes gown, gloves, mask, and eye protection

3.7 **High-Level Disinfecting**

a. After cleaning, high-level disinfect or sterilize flexible endoscopes and endoscope accessories following the IFU.

- Rinse the flexible endoscope and flush the internal channels with water per manufacturer's IFU.
- Dry the flexible endoscope and the internal channels per the manufacturer's IFU
- Handle with clean gloves after disinfection

3.8 Storing Flexible Scopes Post HLD

a. Do not store flexible endoscopes in their original shipment cases.

b. Store clean flexible endoscopes

- In a closed cabinet with

i. Venting that allows air circulation around the flexible endoscopes
ii. Internal surfaces composed of cleanable materials
iii. Adequate height to allow flexible endoscopes to hang without touching the bottom of the cabinet
iv. Sufficient space for storage of multiple endoscopes without touching

- Hang with all removable endoscope components/accessories detached (e.g., valve mechanisms, biopsy valve covers, irrigation tubes)

c. Scope protectors may be applied if the protector does not interfere with the flexible endoscope hanging straight or restrict the air movement around channel openings.

d. Reprocess flexible endoscopes before use if:

- The endoscope has not been used for more than **seven days** or
- Evidence of improper drying exists (e.g., discoloration, wet spots, stains, soil in the storage cabinet)

3.9 Decontaminating Accessories

- Decontaminate reusable flexible endoscope accessories after each use. Sterilize reusable endoscopic accessories (e.g., biopsy forceps, cytology brushes) that enter sterile tissue or the vascular system between uses.
- Brush all surfaces of accessories using manufacturer-recommended brushes of the appropriate size and style.

3.10 Inspecting

a. Inspect flexible endoscopes, accessories, and associated equipment for integrity, function, and cleanliness:

- Before, during, and after use
- Immediately after decontamination
- Before disinfection or sterilization

3.11 Repairing

a. Remove damaged flexible endoscopes and endoscope accessories from use.

- Do not submerge a damaged flexible endoscope or any endoscope accessory unless otherwise specified in the manufacturer's instructions.
- Consult the manufacturer for directions regarding actions to be taken before shipping the flexible endoscope for repair.

3.12 **Records Maintenance** will be completed to demonstrate compliance with local, state, and federal regulations and manufacturer's written instructions.

a. Staff performing HLD will document the following items for each flexible endoscope and endoscope accessory that undergoes cleaning and processing:

- **HLD Solution**:
  - Lot number of HLD solution
  - Expiration date
  - Minimum Effective Concentration (MEC) of HLD
  - Temperature of HLD
- **Process**
  - Date
  - Time (length) of exposure to HLD

- Patient name and medical record number
- Flexible endoscope unique identification number
- Leak test
- Number or identifier of automatic endoscope reprocessor, if used
- Name of team member performing HLD
- Physician name
- Routine and unscheduled maintenance or repairs
- Disposition of defective equipment

b. Managers will maintain records of HLD as well as documentation of routine and unscheduled maintenance or repairs of scopes and disposition of defective equipment for 3 years.

4. Competency

4.1 Personnel working with flexible endoscopes will receive education and complete competency validation activities on care, cleaning, and processing of flexible endoscopes and related accessories pertinent to their role.

4.2 Staff will receive additional training when new equipment, instruments, supplies, or procedures are introduced.

4.3 Competency validation will occur annually.

5. REFERENCES

5.1 Guideline for Cleaning and Processing Flexible Endoscopes and Endoscopes Accessories. In: *Guidelines for Perioperative Practices.* Denver, CO: AORN, Inc; 2021.

5.2 *ANSI/AAMI ST58:2013 Chemical Sterilization and High-Level Disinfection in Health Care Facilities*. Arlington, VA: Association for the Advancement of Medical Instrumentation; 2013.

5.3 *Guideline for Use of High-Level Disinfectants & Sterilants in the Gastroenterology Setting.* Chicago, IL: Society of Gastroenterology Nurses and Associates, Inc; 2017:13.

5.4 RUHS-Medical Center policy HW 141 High Level Disinfection

Document History:

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3/19/2021	Director, Infection Prevention and Control	Y	Minor wording
3/2024	Infection Prevention and Control	Y	Streamlined wording
4/2024	Infection Prevention and Control Committee	N	
5/2/2024	Pre-Nursing P&P	Y	Needs a scope and Section 3 wording changes
5/16/2024	Nursing P&P	N	Consent Agenda Item

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 144	Page 1 of 2
Title: Oxygen Cylinder Storage and Labeling	**Effective Date:** 8/26/2024	☐ **RUHS – Behavioral Health** ☐ **RUHS – Community Health Centers** ☐ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By: Jennifer Cruikshank CEO/ Hospital Director		☐ **Policy** ☒ **Procedure** ☐ **Guideline**

1. DEFINITIONS:

1.1 FULL = cylinders containing ≥ 2000 psi

1.2 IN-USE = cylinders containing between 1999 psi – 501 psi

1.3 EMPTY = cylinders containing ≤ 500 psi

1.4 Walk-02-Bout (WOB) - 02 E cylinders with built-in regulator and continuous pressure reading gauge.

2. PROCEDURES:

2.1 Compressed gas cylinders are to be securely stored using a designated holder or securely chained to the wall.

2.2 Compressed gas cylinders are to be separated into one of the following three (3) categories designations “FULL”, “IN-USE”, and “EMPTY”.

a. In areas with limited space, FULL and In-USE cylinders may be stored together, provided that signage clearly indicates “FULL” & “IN-USE”. EMPTY cylinders must be stored separately marked “EMPTY”.

2.3 Compressed gas cylinders without an observable continuous gas pressure gauge reading are to have perforated tags attached separating the designations “FULL”, “IN-USE”, and “EMPTY”. The tag designations will be updated as the cylinder status changes.

2.4 WOBs do not require designation tags or removal of the regulator since the pressure gauge reading is consistently displaying the pressure level of oxygen and the regulator is built-in.

2.5 In order to safely attaching a regulator to an oxygen ‘E’ cylinder, RUHS – Medical Center staff must:

a. Remove the ‘E’ cylinders main valve stem protective plastic cover.

b. Using a tank key, carefully and slowly turn the main valve stem counter clockwise until oxygen escape is audible, then immediately close the valve. This step clears any debris.

c. Obtain an ‘E’ cylinder regulator.

d. Place a blue plastic 'O' ring on the regulator just above the two pins that insert into the cylinder main valve stem. Staff must ensure it fits properly. Some regulators have a permanent fitting and a plastic 'O' ring is not needed.

e. Securely tighten the regulator to the main valve stem using the following process:

- Using the tank key, turn the regulators T-handle clockwise until hand tight.
- If escaping gas is audible, tighten more.
- Verify that the flow valve is at zero, or gas escape will still be audible.

f. Remove "FULL" designation from attached perforated tag.

2.6 To safely remove an oxygen regulator from an oxygen 'E' cylinder, RUHS – Medical Center staff must:

a. Using a tank key, turn the main valve stem clockwise until it stops (OFF position).

b. Un-tighten the regulator and remove from main valve stem.

- Using the tank key, turn the regulator T-handle counter clockwise until it loosens enough to be removed.

c. Remove "IN-USE" designation on perforated tag leaving "EMPTY" visible.

2.7 In order to safely check the pressure reading of an oxygen 'E' cylinder, RUHS – Medical Center staff must:

a. Obtain a tank key.

b. Securely attach a regulator to the oxygen tank.

c. Using a tank key, turn the main valve stem 180 degrees counter clockwise. This step opens the tank pressure to the regulator.

- If oxygen is audibly escaping, the flow valve needs to be closed.
- If oxygen is still audibly escaping, the regulator needs tightening and/or the blue "O" ring is missing. Correct the issue before continuing.
- Observe the pressure reading.
- Ensure the appropriate designation is visible on the attached perforated tag.

2.8 To properly store the cylinder, RUHS – Medical Center staff must:

a. Locate the designated area for cylinder storage.

b. According to the amount of psi in the cylinder, place the cylinder in the approved holder in the designated area for "FULL", "IN-USE", and "EMPTY" cylinders.

3. REFERENCES:

3.1 National Fire Protection Agency (NFPA) 99: Full cylinders in racks must be segregated from those that have been opened or used. This eliminates confusion for health care personnel; if empty and full cylinders are not clearly separated, staff might accidentally retrieve a partially full or empty cylinder rather than a full one.

3.2 National Fire Protection Association. (2021). *NFPA 99: Health Care Facilities Code*. Quincy, MA: National Fire Protection Association.

3.3 Occupational Safety and Health Administration. (2023). *29 CFR 1910.101: Compressed Gases (General Requirements)*. Retrieved from https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.101

3.4 Occupational Safety and Health Administration. (2023). *29 CFR 1910.104: Oxygen*. Retrieved from https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.104

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8/23/24	Respiratory Department	Y	Added WOB language, references, full/in-use co-mingling
8/26/2024	PAC	N	

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 200	Page 1 of 11
Title: Financial Assistance for Low Income, Uninsured/Underinsured Patients	**Effective Date:** 9/11/2024	☐ **RUHS – Behavioral Health** ☐ **RUHS – Community Health Centers** ☐ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By:  Jennifer Cruikshank CEO/Hospital Director		☐ **Policy** ☒ **Procedure** ☐ **Guideline**

1. PURPOSE

1.1 The RUHS – Medical Center mission is to improve the health and well-being of our patients and communities through dedication to exceptional and compassionate care, education, and research. Our vision is to lead the transformation of healthcare and inspire wellness, in collaboration with our communities, through an integrated delivery network to bring hope and healing to those we serve. This policy demonstrates the RUHS – Medical Center commitment to our mission and vision by helping to meet the needs of the low income, uninsured patients and the underinsured patients in our community. This policy is not intended to waive or alter any contractual provisions or rates negotiated by and between RUHS – Medical Center and a third-party payer, nor is it intended to provide discounts to a non- contracted third-party payer or any other entity that is legally responsible for making payment on behalf of a beneficiary, covered person or insured.

1.2 This policy is intended to comply with California Health & Safety Code § 127400 et seq. (AB 774), Hospital Fair Pricing Policies, effective January 1, 2007, updated January 1, 2011, and January 1, 2015 (SB 1276), and United States Department of Health and Human Services (“HHS”) Office of Inspector General (“OIG”) guidance regarding financial assistance to uninsured and underinsured patients. Additionally, this policy provides guidelines for identifying and handling patients who may qualify for financial assistance. This policy also establishes the financial screening criteria to determine which patients qualify for Financial Assistance program. The financial screening criteria in this policy are based primarily on the Federal Poverty Level (“FPL”) guidelines updated periodically by HHS in the Federal Register.

2. SCOPE

2.1 This policy covers hospital inpatient and outpatient departments. An emergency physician, as defined in Section 127450, who provides emergency medical services in a hospital that provides emergency care is also required by law to provide discounts to uninsured patients or High Medical Cost patients who are at or below 400% of the FPL. Emergency Room physician fees are covered under a separate policy. All other physician fees are excluded.

3. DEFINITIONS

3.1 Bad debt: A bad debt results from services rendered to a patient who is determined by RUHS – Medical Center, following a reasonable collection effort, to be able but unwilling to pay all or part of the bill.

3.2 Financial assistance patient: A financial assistance patient is a financially eligibleSelf-Pay patient or a High Medical Cost patient.

3.3 Emergent medical condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:

a. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

i. Serious impairment to bodily functions; or

ii. Serious dysfunction of any bodily organ or part; or

b. With respect to a pregnant woman who is having contractions:

i. When there is inadequate time to effect a safe transfer to another hospital before delivery; or

ii. The transfer may pose a threat to the health or safety of the woman or the unborn child.

3.4 High medical cost patient: A financially eligible High Medical Cost patient is defined as follows:

a. Not self-pay (has third party coverage)

b. Patient's family income at or below 400% of the Federal Poverty Level (FPL)

c. Out-of-pocket medical expenses in prior twelve (12) months (whether incurred in or out of any hospital) exceeds 10% of Patient's Family income

3.5 Medically necessary service: A medically necessary service or treatment is one that is absolutely necessary to treat or diagnose a patient and could materially adversely affect the patient's condition, illness or injury if it were omitted, and is not considered an elective or cosmetic surgery or treatment.

3.6 Patient's family: For patients 18 years of age and older, patient's family is defined as their spouse, domestic partner, as defined in Section 297 of the Family Code, and dependent children under 21 years of age, whether living at home or not. For persons under 18 years of age, patient's family means a parent, caretaker relatives, and other children under 21 years of age of the parent or caretaker relative.

3.7 Reasonable payment plan: Monthly payments that are not more than 10 percent of a Patient's Family income for a month, excluding deductions for essential living expenses. "Essential living expenses" means, for purposes of this subdivision, expenses for any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

3.8 Self-pay patient: A financially eligible self-pay patient is defined as follows:

a. No third-party coverage;

b. No Medi-Cal/Medicaid coverage or patients who qualify but who do not receive coverage for all services or for the entire stay;

c. No compensable injury for purposes of government programs, workers' compensation, automobile insurance, other insurance, or third-party liability as determined and documented by the hospital;

d. Patient's Family income is at or below 400% of the Federal Poverty Level (FPL)

4. POLICY

4.1 This policy is designed to provide assistance to financially qualified patients who require medically necessary services, are uninsured, ineligible for third party assistance, or have high medical costs. Patients are granted assistance from unfunded financial assistance, State-funded California Healthcare for Indigent Program (CHIP), county programs, or grant programs for some or all their financial responsibility depending upon their specific circumstances.

4.2 Patients with demonstrated financial need may be eligible if they satisfy the definition of a financial assistance patient or high medical cost patient as defined in section 3.8 of this document.

4.3 This policy permits non-routine waivers of patients' out-of-pocket medical costs based on an individual determination of financial need in accordance with the criteria set forth below. This policy and the financial screening criteria must be consistently applied to all cases throughout RUHS – Medical Center. If application of this policy conflicts with payer contracting or coverage requirements consult with RUHS – Medical Center legal counsel.

4.4 Services that are not medically necessary services or services that are separately- billed physician services are not eligible for Financial Assistance program. Emergency department physician services are covered under a separate policy.

4.5 This policy will not apply if the patient/responsible party provides false information regarding financial eligibility or if the patient/responsible party fails to make every reasonable effort to apply for and receive government-sponsored insurance benefits for which they may be eligible.

4.6 Regardless of ability to pay, RUHS Medical Center shall accept, manage and track medically necessary referrals received from RUHS Community Health Centers for all patients. Discounted medical care made available under the RUHS-CHC Sliding Fee Discount Schedule Program will be provided to patients referred from RUHS-CHC to the Medical Center.

4.7 RUHS – Medical Center, will ensure that patients are made aware of the importance of financial screening and completion of necessary paperwork to gain appropriate healthcare coverage for costs incurred for healthcare services provided at RUHS - MEDICAL CENTER.

4.8 All patients will be provided emergency services in accordance with Emergency Medical Treatment & Active Labor Act (EMTALA) regulations. RUHS - MEDICAL CENTER staff will comply with federal and state laws regarding the conduct of county hospital financial business practices.

4.9 The Financial Assistance Program available through RUHS - MEDICAL CENTER will not substitute for personal responsibility of the patient. All patients are expected to contribute to the cost of their care based on their individual ability to pay.

4.10 Emergency Physicians, as defined in AB 1503, Stats. 2010, Ch. 445.) Section127450, who provides emergency medical services in a hospital that provides emergency care, are also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 400% of the Federal Poverty Level. This statement shall not be construed to impose any responsibilities upon the hospital.

4.11 Eligibility for the Financial Assistance Program will be considered for those individuals who are uninsured, under-insured, ineligible for any government health care benefits program and unable to pay for their care based upon a determination of financial need. Patients who are denied eligibility to government programs for failing to cooperate with the eligibility process will not be eligible for Financial Assistance.

4.12 Departmental Responsibilities

a. The RUHS - MEDICAL CENTER Financial Assistance shall be reviewed and updated to reflect the current Federal Poverty Level Guidelines (Attachment III).

b. MISP and Patient Accounts managers and staff will ensure that the policies and procedures established for the Financial Assistance Program are applied consistently. Likewise, registration shall provide to all patients the same information concerning services and charges for RUHS – Medical Center.

c. MISP eligibility staff will determine if the patient is required to apply for Federal or State sponsored programs. Patients not linked to SSI/SSDI, Medi- Cal, Medicare, or MISP will be screened for the RUHS – Medical Center Financial Assistance Program.

d. MISP eligibility staff will apply the following when determining eligibility for Financial Assistance:

i. Patient must meet the Resource limits established for the State of California's Medi-Cal program.

ii. Monetary assets will be considered

iii. The first $10,000 of monetary asset is exempt, 50% of all assets in excess of $10,000 are also exempt.

iv. All remaining assets will be compared to the Medi-Cal resource limit.

v. Individuals who exceed this limit will not qualify for assistance.

vi. Retirement accounts, deferred compensation plans qualified under Internal Revenue code, or nonqualified deferred compensation plans are not included in the determination of monetary assets.

e. RUHS - MEDICAL CENTER will post and make available income requirements, the patient may be eligible for a government- sponsored program or for the RUHS - MEDICAL CENTER Financial Assistance Program.

i. Notice (Attachment II) that provides information about the patient may be eligible for a government-sponsored program or for the RUHS – MEDICAL CENTER Financial Assistance Program. This notice will be posted in areas throughout the hospital.

4.13 Customer Service

a. Patients (or their legal representatives) seeking financial assistance will be asked to provide information quarterly concerning their health benefits coverage, financial status, and any other information that is necessary for RUHS – Medical Center to make a determination regarding the patient's need for financial assistance.

b. Financial screening provided by MISP Eligibility staff, using eligibility criteria (income, family size), will determine the amount a patient is responsible to pay.

c. All RUHS – Medical Center staff shall be informed of availability of Financial Assistance Programs.

4.14 Eligibility

a. Patients with income at or below 100% of the federal poverty level are eligible for RUHS - MEDICAL CENTER Free Care Financial Assistance Program. Patients with combined income and assets at or be 400% of federal poverty level and are uninsured or underinsured will be eligible to apply for the RUHS - MEDICAL CENTER Partial Financial Assistance Program after all other types of assistance have been exhausted.

b. Patient with high medical costs" means an insured patient with high medical costs (co-payment, coinsurance and/or reached a lifetime limit, non-covered relating to services not medically necessary), with income at or below 400% of the Federal poverty level and not already receiving a discounted rate as a result of insurance coverage, then the patient may qualify for a discount from usual charges in accordance to the following guidelines herein, including but not limited to the California Fair Pricing Law. High medical costs" means (1) annual out-of-pocket costs incurred by the individual at the hospital that exceed 10 percent of the patient's family income in the prior 12 months, or (2) annual out-of-pocket expenses that exceed 10 percent of the patient's family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months.

c. Patients who have demonstrated non-compliance with the conditions of SSI/SSDI, Medi-Cal, Medicare, MISP or any other referred assistance policy are not eligible for the RUHS - MEDICAL CENTER Financial Assistance Program.

d. Commercial Insurance deductible, Medi-Cal or Medicare beneficiaries with share of cost, deductible, and/or co- insurance do not constitute being underinsured.

e. Patients applying for the RUHS - MEDICAL CENTER Financial Assistance Program, who are denied eligibility have the right to file an appeal within 10 days. A patient has 10 days from the date that the county mailed or provided written Notice of Action (NOA). An appeal may be made by the patient contacting the RUHS - MEDICAL CENTER - MISP office to make an appointment with the appeals supervisor.

f. If determined to be eligible for the RUHS - MEDICAL CENTER Partial Financial Assistance Program by MISP eligibility staff, the patient will be referred to Patient Accounts to arrange payment of the hospital bill(s).

g. Documentation of the financial screening process will be retained by MISP according to MISP policy

4.15 Documentation Includes:

a. Date of determination of eligibility or denial for this program

b. Level of eligibility per the RUHS - MEDICAL CENTER Financial Assistance program

c. Copy of the application form

d. Copy of the approval or denial letter

4.16 Coverage Restrictions

a. Outpatient prescriptions and cosmetic surgeries are not covered under the RUHS- MEDICAL CENTER Financial Assistance Program.

4.17 Billing

a. Amounts payable to medical service providers other than RUHS - MEDICAL CENTER are excluded from this policy.

b. A Patient qualifying for assistance under the RUHS - MEDICAL CENTER Financial Assistance Policy and cooperating with Patient Accounts will not be referred to a collection agency.

c. A patient that fails to comply with requested financial updates will be responsible for payment of the original balance owned for their Hospital bill(s) in full.

d. In the event that the cost of medical care received at RUHS – MEDICAL CENTER is less than the amount the patient is responsible for, the patient will only be billed for the cost of those services. The cost of services provided will be determined using the most recently filed Medicare cost report.

e. Payment arrangements will be made for any amount owed that exceeds 10% of the monthly income of the patient. Payment plans will not exceed 12 months.

f. If a patient is cooperating and complying with the payments required according to the established responsibility for that patient, RUHS – Medical Center will not place wage garnishments or liens on primary residencies or other properties as a means of collecting the unpaid hospital UMDAP (Uniform Method of Determining Ability to Pay) bills.

g. If a patient fails to comply with their established payment plan for more than 90 days, the payment plan may be declared inoperable and the patient will be responsible for payment of the original balance owed for their Hospital bill(s) in full. Patient Accounts will attempt to contact the patient at the last known address and at the last known phone number of the patient to re-negotiate the payment plan prior to declaring any payment plan inoperable.

h. If it is determined an overpayment by the patient has occurred, RUHS – Medical

i. Center will refund any amount owed within 30 days of the determination. Interest owed on this overpayment by the hospital to the patient will be paid to the patient at the statutory rate (10% per annum) according to Civil Procedure Code 685.010 and Health and Safety Code section 127440. Interest will be accrued beginning on the date payment was received by the hospital. If the amount of interest due to the patient is less than five dollars ($5.00), the hospital is not required to pay the interest.

j. RUHS – Medical Center contracted collection agencies; billing services are required to conform to the billing/collection practices outlined in this policy.

5. **REFERENCES**

5.1 2004 CHA Voluntary Principles and Guidelines for Assisting Low Income, Uninsured Patients.

5.2 MISP policy number MISP 10

5.3 MISP policy number MISP 14

5.4 MISP policy number MISP 20

5.5 MISP policy number MISP 21

5.6 RUHS - CHC 112 Sliding Fee Discount Policy

6. ATTACHMENTS

6.1 RUHS – Medical Center Financial Assistance Statement

6.2 RUHS – Medical Center Financial Assistance Notice

6.3 Federal Poverty Guidelines

Document History:

Prior Release Dates: 11/13/2017, 5/22/2019, 4/1/2022, 1/17/2023	**Retire Date:** N/A
Document Owner: MISP	**Replaces Policy:** MISP Policies No. 204.2 and 204.3

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
8/14/2024	Policy Approval Committee	Y	Addition of one policy reference for CHC Sliding Scale policy

ATTACHMENT 6.1
RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
FINANCIAL ASSISTANCE PROGRAM

To meet the needs of the uninsured/underinsured patients who have received healthcare services at RUHS – MEDICAL CENTER and are unable to pay for these services, programs have been established to assist RUHS - MEDICAL CENTER patients to gain access to programs that may assist the patient with payment of their Hospital bill along with additional medical services that may be required.

These programs include, but are not limited to:

Medi-Cal Medicare MISP
RUHS - MEDICAL CENTER
Financial Assistance –
UMDAP

Inpatient Services – Patients expressing concern with payment for Hospital services should be referred to the Inpatient MISP Eligibility staff for assistance.

Outpatient/Emergency Room Services – Patients expressing concern with payment for outpatient or emergency room services can be referred to the MISP office to pick up an MISP/RUHS - MEDICAL CENTER Financial Assistance Program application and schedule an appointment to meet with an MISP eligibility staff.

As part of the interview/screening appointment with the MISP eligibility staff, the patient requesting assistance will be screened for eligibility for all programs named above.

Medically Indigent Services Program (MISP)
RUHS - MEDICAL CENTER Financial Assistance Program
26600 Cactus Ave Ast Floor #14
Moreno Valley CA, 92555
877-501-5085

Medi-Cal	MISP	Medicare
877-410-8827	1-877-501-5085	1-800-633-4227

ATTACHMENT 6.2
RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER FINANCIAL ASSISTANCE PROGRAM

To meet the needs of the uninsured/underinsured patients who have received healthcare services at RUHS - MEDICAL CENTER and are unable to pay for these services, programs have been established to assist RUHS - MEDICAL CENTER patients to gain access to programs that may assist the patient with payment of their Hospital bill along with additional medical services that may be required.

These programs include, but are not limited to:

Medically Indigent Services Program
(MISP) RUHS - MEDICAL CENTER Financial Assistance Program

877-501-5085

Medi-Cal	MISP	Medicare
877-410-8827	**1-877-501-5085**	**1-800-633-4227**

ATTACHMENT
6.3

Annual 24/25 Poverty Guidelines

Household/ Family Size	100%	138%	200%	322%	400%
1	$15,060	$20,783	$30,120	$48,494	$60,240
2	$20,440	$28,208	$40,880	$65,817	$81,760
3	$25,820	$35,632	$51,640	$83,141	$103,280
4	$31,200	$43,056	$62,400	$100,464	$124,800
5	$36,580	$50,481	$73,160	$117,788	$146,320
6	$41,960	$57,905	$83,920	$135,112	$167,840
7	$47,340	$65,330	$94,680	$152,435	$189,360
8	$52,720	$72,754	$105,440	$169,759	$21,0880
Each Additional Person Add	$5,380	$7425	$10,760	$17,324	$21,520

RIVERSIDE UNIVERSITY HEALTH SYSTEM –

MEDICAL CENTER, COMMUNITY HEALTH CENTERS, AND HOSPITAL BASED UNITS

Housewide

	Document No: 410	Page 1 of 2
Title: Use of Personal Cell Phones	**Effective Date:** 7/18/2024	☐ **RUHS – Behavioral Health** ☒ **RUHS – Community Health Centers** ☒ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By:  Jennifer Cruikshank CEO/ Hospital Director		☐ **Policy** ☐ **Procedure** ☒ **Guideline**

1. DEFINITIONS

1.1 Mobile device. This is a mobile phone or mobile, also called a wireless, cellular phone, cell phone, or cell speaker box is a long range, portable electronic device for mobile communication, which could include voice or text.

1.2 Cellular. This is related to a mobile telephone system that uses a number of short-range radio stations to cover the areas that it serves.

2. POLICY

2.1 This policy is intended to provide a safe patient care environment through the implementation of reasonable and appropriate safeguards to protect against the risks and vulnerabilities specific to portable data devices and cell phone use at Riverside University Health System (RUHS) – Medical Center and to provide a safe patient care environment.

2.2 Safe cell phone usage will enable staff to

a. Avoid distraction from the provision of patient care services, reducing medical care errors, and improving patient satisfaction with RUHS – Medical Center.

2.3 Use of cell phones and or accessories (e.g. ear buds, headphones, etc.) are:

a. Prohibited in front of patients or in patient care areas.

- This prohibition includes such use during transport or care of a patient in any area either inside or outside of the hospital.

b. Cell phones and or accessories may be used for personal reasons on designated break times.

c. Cell phones and or accessories may be used for personal reasons in the break room, outside or in a designated area.

2.4 Cell phone safety

a. All employees are expected to follow applicable local, state and federal laws and regulations regarding the use of cell phones while driving on duty.

Document History:

Prior Release Dates: 01/12/2009, 7/5/2017, 3/9/2021	**Retire Date:** N/A
Document Owner: Administration	**Replaces Policy:** N/A

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
4/2024	Chief Clinical Integration Officer	N	
6/3/2024	Pre-Nursing P&P	Yes	2.2b – wording, 2.3 wording. Add ear buds and headphones. Verbiage throughout.
6/20/2024	Nursing P&P	Y	Changes accepted. Need update to language for 2.4 to be decided in PAC

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
HOUSEWIDE

	Document No: 513	Page 1 of 17
Title: Infant and Child Security HUGS	**Effective Date:** 8/1/2024	☐ **RUHS – Behavioral Health** ☐ **RUHS – Community Health Centers** ☐ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By:  Jennifer Cruikshank CEO/ Hospital Director		☐ **Policy** ☒ **Procedure** ☐ **Guideline**

1. SCOPE

1.1 Infant and child security measures apply facility-wide at RUHS – Medical Center, with a special focus on departments where infants and children are receiving treatment including, but not limited to, Perinatal, Pediatric and Neonatal Units. This policy excludes Arlington Campus.

2. DEFINITIONS

2.1 **Neonatal Unit** – Neonatal Intensive Care Unit (NICU)

2.2 **Pediatric Units** – Acute Care Pediatrics and Pediatric Intensive Care Unit (PICU)

2.3 **Perinatal Units** – Labor and Delivery, Newborn Nursery and Obstetrics/Post-partum

2.4 **Electronic Infant and Child Security System**- (EICSS) is designed to assist RUHS - Medical Center staff to prevent the abduction of infant/children from Newborn Nursery, NICU and/or Pediatrics/PICU

3. PROCEDURE

3.1 Workforce Education and Training

a. All RUHS – Medical Center workforce members will receive instruction about protecting infants and children from abduction initially upon hire and at least annually. Instruction will include, but not be limited to, information about the offender profile and unusual behavior, prevention procedure (including piggybacking/tailgating into locked units), staff responsibilities and critical incident response plan.

3.2 Physical Environment Security

a. Perinatal, Neonatal and Pediatric units will secure access 24 hours a day, 7 days a week with badge or card swipe access, doors with key code access, and/or the presence of personnel assigned to screen persons seeking entry to the units for identification and business need to access the area. Doors with remote opening capabilities will have active video monitoring available so that the identity of those seeking entrance can be visualized and verified remotely prior to granting access.

i. At the time of entrance to Perinatal, Pediatric and Neonatal units, all patient visitors are to be validated with the correct visitor badge.

ii. All workforce members presenting to the Perinatal, Neonatal, and Pediatric units are required to wear their employee ID badge at all times, in compliance with RUHS policy HW 420.1 Employee Identification.

iii. External vendors and/or agency representatives who are required to interact with the infant and/or parents will present with the required vendor identification and be introduced to parents/primary caregivers by a primary care nurse. External vendors must comply with RUHS policy HW 149 Medical Supply, Device and Service Suppliers/Vendors/Manufacturer Representatives Management identification and processing requirements.

b. Only workforce members who conduct routine business within the departments will be granted badge access to locked units. All others must be screened prior to entry. Perinatal, Neonatal and Pediatric unit emergency exit doors will have a local “door ajar alarm” that will be audible to personnel within the unit whenever the door is opened.

i. Integrity of the alarms will be verified at least once a shift by the Charge Nurse or designee

c. Staff will place infant bassinets or incubators on Perinatal units on the side of mother’s bed furthest from the door. Mothers of infants on these units will be educated about the importance of keeping the infant bassinet or incubator as far from the door as possible.

d. Perinatal, Neonatal and Pediatric units will minimize the number of times the infant or child is removed from the patient’s room or a staff-supervised unit to those that are strictly medically necessary.

i. Whenever possible, medically necessary procedures performed outside of the patient’s room will be performed in a designated location that is within the perimeter of the unit.

ii. When requiring transport to an off-unit location, the infant or child will be accompanied by nurse or personnel that have been authorized by the Charge Nurse or primary care nurse with proper identification. Line-of-sight contact will be maintained at all times. A parent/guardian is encouraged to also accompany the infant or child to the off-unit location.

e. Empty or unoccupied patient rooms will be searched during a security event/Code Pink or Code Purple.

f. Doors equipped with a self-closing mechanism must not be impeded with devices such as manual hold open devices, furniture, wedges, etc.

g. Doors to rooms where staff members change, leave clothes or store unsecured scrubs including locker rooms, storage rooms, and sleep rooms, will be under strict access control at all times.

i. Scrub dispensing machines will have an access control system in place.

3.3 Electronic Infant and Child Security System (EICSS)

a. Application of the EICSS tag will be performed by the patient's RN or designee, in the unit of admission, at the earliest possible time in light of the patient's medical condition. All relevant patient information, including name and room number will be entered into the EICSS workstation by the patient's primary RN or designee as soon as ~~is~~ reasonably possible after tag activation. The EICSS tag number will be documented in the electronic health record (EHR) for each patient in the designated flowsheet location.

    i. In the perinatal units, the tag to the infant's ankle is applied within 2 hours of birth or within one hour of the time of presentation to Labor and Delivery or the Post-Partum unit if the infant is born prior to arrival at RUHS – Medical Center

    ii. In the NICU, tags will be applied to babies who are in an open crib.

    iii. In Pediatrics/PICU, patients will have a tag applied within the first hour of admission.

    iv. Infant security information/education will be given to the parent/guardian or minor children at the time of admission

b. At the beginning of each shift and with changes in tag status the primary nurse of the infant/child will:

    i. Assess that the tag is properly secured to the ankle or wrist of the infant/child

    ii. Validate that the tag number matches the tag number and patient information in the EICSS system.

c. Upon infant/child discharge, the electronic security device should be deactivated then removed immediately prior to exiting unit. Additionally, the discharge function may be required immediately prior to transport of an infant/child to surgery, MRI, or another inpatient unit that is not covered by the EICSS. Any infant/child with the security tag deactivated or not applied, for any reason, should remain in the line-of-site supervision with an approved workforce member until the infant/child has exited the facility.

d. Each unit that initiates the use of the EICSS is responsible for maintaining an inventory of tags and bands.

    i. When a tag is rendered unusable due to low battery or other malfunction, the unit Charge Nurse, or designee, will request replacement tags from the Biomedical Engineering department.

        - Biomedical Engineering is responsible for maintaining a supply or replacement tags from the vendor at all times.

    ii. Single use bands are supplied by the Storeroom.

    iii. At the beginning of each shift all EIS tags (both in use and not in use) are inventoried and admission data for the EIS tags in active use is verified by the Charge Nurse (CN) or designee.

e. Refer to Appendix A for Hugs Operational Instructions

3.4 Infant Abduction-Drills, Potential and Actual

3.5 **Drills**: The Safety Officer, or designee, will be responsible to ensure infant/child abduction drills are completed. Infant/chil abduction drills will involve the entire campus and will be conducted at a minimum of once per year. Drills are to be conducted at varying times to include all shifts and should not establish a predictable pattern. Drills are to be initiated from Perinatal, Pediatric and/or Neonatal units. A realistic scenario should be utilized with debrief and critique following the drill. Unit specific drills or tabletop exercises will be conducted three (3) times per year in the Maternal Child areas.

a. **Potential Abduction**: Staff should be alert to any unusual behavior they encounter from individuals. The alert process should include the recommendations provided by the National Center for Missing and Exploited Children and generate a communication and action plan based on observation and findings.

b. **Actual Abduction**: To assist in the timely identification of an abducted infant and/or an abductor, the facility response for infant abduction will include Activating a security alert referencing the abduction of a newborn or infant and to follow existing guidelines established.
   i. Performing a facility-wide overhead page notification, in plain language, which identifies the unit from which the infant was abducted, and includes a description of the abductor, if available.
   ii. Security responding to the location of the reported abduction to sequester the area, moving family from current location to another secure area.
   iii. Staff will immediately respond to stop vertical (floor to floor) movement, by securing interior department, stairwells and exterior doors, allowing only designated individuals to have unfettered access.
   iv. Designating specific individuals that may cancel the security alert.

c. Have designated representative responsible for communicating with Law Enforcement agencies, relaying, and updating information, as well as receiving communication from Law Enforcement for further instructions.

3.6 Parent/Guardian Education

a. Parents/Guardian/primary caregivers will be educated on security awareness and identification of hospital personnel as part of the admission process and receive on-going communication regarding unit activities and any procedures involving the infant or child from the assigned, direct patient care providers. Education to parents/guardians will include:
   i. Orientation to the use of the Security systems in place
   ii. Specific security features on staff badges to identify those who are authorized to remove an infant/child from the room
   iii. Department guidelines specifying how to prevent abduction

b. Education provided to parents/guardians on security awareness will be documented in the infant or child's medical record.

c. Based upon the home care needs of the infant or child at the time of discharge, parents/guardians will be provided identifying information about in-home care vendors and other outpatient clinical services that includes the Vendor/agency name, the purpose of any in-home visits, the anticipated time of arrival or mode

of communication. Parents/guardians with home health vendors planned will be advised to remain present with the infant/child in the home during the vendor/agency representative's visit.

3.7 Gap Assessment

a. Annually or when significant environmental changes occur to Perinatal and Neonatal units, the Perinatal/Pediatric/Neonatal nursing leadership facility Security department will lead the effort to complete a self-assessment provided by the National Center for Missing and Exploited Children and recommendations will be presented to the Perinatal Patient Safety Committee and Pediatric Department Committee.

4. REFERENCES

4.1 National Center for Missing and Exploited Children (2014). For Healthcare Professionals: *Guidelines on Prevention of and Response to Infant Abductions*
4.2 RUHS – Medical Center Housewide Policy HW 512: Code Purple – Child Abduction
4.3 RUHS – Medical Center Housewide Policy HW 511: Code Pink – Infant Abduction
4.4 RUHS – Medical Center Housewide Policy HW 420.1: Employee Identification
4.5 RUHS – Medical Center Pediatric Unit Policy 20.3: Transport of the Pediatric Patient.
4.6 RUHS – Medical Center NICU Policy: Standards of Care in the NICU
4.7 RUHS – Medical Center Housewide Policy HW 605: Patient Identification
4.8 RUHS – Medical Center Housewide Policy HW 149 Medical Supply, Device and Service Suppliers/Vendors/Manufacturer Representatives Management identification and processing requirements.

5. ATTACHMENT

5.1 Appendix A: Hugs ® Operational Instructions

Document History:

Prior Release Dates: 5/4/2023		**Retire Date:** N/A	
Document Owner: Maternal and Child Department		**Replaces Policy:** NURS 208.9 HUGS Infant Protection System	
Date Reviewed	**Reviewed By:**	**Revisions Made Y/N**	**Revision Description**
12/20/23	Maternal Child Dept, Shana Fujimoto, Lisa Patricia & Amy Pitcher	Yes	Change to Policy instead of Procedure. Minor wording and grammar changes . Updated Code Pink Drills and wording to clean Hugs tags.
6/3/2024	Pre-Nursing P&P	Yes	Major formatting corrections. Review language 3.2a
6/20/2024	Nursing P&P	N	
7/24/2024	Policy Approval Committee	Y	Add references to Employee ID policy and Vendor Management policy. Delete overlapping information.

Appendix A

Hugs® System – User Guide

1.1 Login

a. Access to the Hugs® software, is via an individual login and password. Pediatric/PICU, NICU, Labor and Delivery and Post-partum RNs, Medical Unit Clerks and Office Assistants will be given access to log in during department orientation.

b. To access the Login pop-up box, click on the “Hello” soft button in the upper right comer of the Hugs® Computer Workstation.

c. Where prompted, enter username (employee number without any letters or other identifiers), password and click Login.

d. When a user is logged into the Hugs® software, the name of that individual will display in the upper, right-hand comer of the computer screen.

1.2 Logout

a. The Hugs® software will automatically Logout users after a minute (60 seconds) of inactivity. Staff will always manually Logout to ensure the highest level of security.

b. Click on the Logout button in the upper right comer of the Hugs® Computer Workstation.

- The Hugs® software automatically logs users after a minute (60 seconds) of inactivity.
- Staff are advised to manually Logout to ensure the highest level of security.

1.3 Tag Application

a. Gather supplies for the application: one Hugs® tag, one Hugs® strap of appropriate size, hospital-approved scissors

b. Align the band with one of the tag slots. With message "This side out" on the outside, insert the band into the back of the tag slot until resistance is felt. Move to the front of the tag and pull the band material ¼” past the "flush" mark on the band.

c. Wrap remaining end of band around the limb, above the ankle or above the wrist bone. If applied to a lower limb, align the tag with the rounded edge toward the knee.

d. While holding the tag with one hand, insert the remaining band end as instructed, above. Hugs® tag will emit a double beep indicating a functional battery and proper band application. If no double beep sounds with proper band application, remove tag from service and place tag in designated location on the unit to return to Biomedical Engineering for exchange.

e. Gently pull band ends until a secure fit is obtained. A secure fit is defined as a fit snug enough to prevent tag from slipping over the heel/hand while ensuring back of tag and band maintain light contact with the patient's skin.

f. Use hospital-approved scissors to trim the excess band material from the front side of the tag, leaving approximately ¼” tabs to allow for tightening and removal later.

g. Activation of the tag will be indicated at the Hugs® computer by appearance of an

Admit pop-up box providing details on the specific tag. The RN applying the tag is responsible for adding or designating someone with Hugs® system access to add, patient identifiers to the associated tag number. See the section “Admitting a Tag” for further instructions.

1.4 Tag Assessment

a. Each patient’s assigned RN will assess the tag and the tag site every shift for appropriate fit and the absence of any skin irritation. Assessment of band integrity, tag presence and skin integrity will be documented on the infant/patient’s electronic medical record as part of the shift assessment. If skin irritation around tag location is noted, tag site should be rotated immediately. See SUSPEND TAMPER section for instructions on removing a tag.

b. If the tag appears to be too tight, as evidenced by tag or band impressions on the patient’s skin or inability to move the tag on the skin surface, the tag will be removed, and a new strap applied to accommodate an appropriate fit. See SUSPEND TAMPER sections for instructions on removing a tag.

1.5 Tightening A Tag

a. Some patients may require periodic tightening of the tag and band to accommodate weight loss. To tighten the band:

- Grasp the cut end of the band and pull, gently, until a secure fit is obtained.
- Use hospital-approved scissors to trim the excess band material from the front of the Tag, leaving approximately ¼” tabs.

b. NOTE: Band cannot be loosened. Attempting to loosen by pulling on a band will result in damage to the band and a Tamper Alarm. If band is too tight, it must be removed. See SUSPEND TAMPER for instructions on removing a tag.

1.6 Cleaning And Storage of Hugs® Tags

a. Tags will be cleaned between patients in the designated area. Dirty tags will be stored in a separate location from clean tags.

b. Clean dirty tags as follows:

- Assemble supplies in a clean area of the workstation:
  - Gloves, gownand eye protection
  - New, soft bristle toothbrush
  - Approved Cleaning Solution by the manufacturer
  - Access to water
  - Wash cloth(s) or paper towel
- Preparation:
  - Apply eye protection
  - Don gown and gloves
  - Remove any remnants of the Hugs® band and discard

- Use a damp washcloth to remove any visible soil

- Clean tag:
  - Apply approved cleaner onto tag to cover all surfaces and scrub with a new moist toothbrush until completely clean.
  - Allow dwell time according to the manufacturer's recommendations.
  - Rinse tag under water and thoroughly remove cleaner with wet toothbrush and a wet wash cloth or paper towel.. DO NOT ALLOW CLEANER TO REMAIN ON TAG AS IT COULD BE IRRITATING TO PATIENT'S SKIN
  - Dry tag with clean towel, either paper or cloth
  - Discard toothbrush

c. Special considerations
  - Multiple tags may be cleaned at one time using the same toothbrush.
  - Do not soak the tag
  - Hugs® tags may set off alarm if both metal sides of the tag are run under water at the same time
  - Clean new tags received from the factory in the same manner prior to use.

1.7 Admitting A Tag

a. Once the band is correctly applied to the tag, as indicated by appearance of the Admit popup on the Hugs® computer(s), the Hugs® system automatically begins to monitor/protect the tag. Admit refers to assignment of patient information to an active tag. The primary nurse may delegate the admit process but will be responsible to verify proper completion of admission procedure.

b. Login to the Hugs® computer per LOGIN procedure.

c. In the appropriate Admit pop-up box enter the patient information in the Description field. If the Admit box is not present, verify that the tag number is displayed in the tag census and enter patient information as outlined in EDIT DESCRIPTION section.

d. Patient information will be as follows:
  - In the "Unit Field", select appropriate field from drop down
  - NB
  - NICU
  - Peds
  - PICU
  - For Peds/PICU area, type patient first and last name
  - In the name field, type Mom's Last name
  - Multiple births will be identified as Twin A, Twin B, etc.
  - In the Gender Field select "B" for Boy or "G" for girl.

e. Logout per LOGOUT procedure.

1.8 Editing A Tag Description

a. Login to Hugs® Computer Workstation per LOGIN procedure.

b. In the Census window of the Hugs® computer display, click on the patient's name to highlight it.

c. Click on the patient's name again to open the edit function.

d. Enter the new Patient Name information

e. Click OK to save changes.

f. Logout per LOGOUT procedure.

1.9 Suspend Tamper

a. The Suspend Tamper function will be used to temporarily remove a tag. A new strap will be required to re-apply the tag. Failure to suspend the Tamper feature before cutting the strap will result in a TAMPER ALARM.

b. The timeframe for Suspend Tamper is 5 minutes. If more time will be required, the tag will need to be discharged and a new tag applied. See DISCHARGE section for instructions.

- NOTE: The Suspend Tamper function is not required to tighten the tag.

c. Login to the Hugs® computer per LOGIN procedure. In the Census window of the Hugs® computer display, click on the patient's name to highlight it.

d. Click on SUSPEND TAMPER soft button in the toolbar.

e. Log Out per LOGOUT procedure.

- NOTE: In the Census window, the patient/tag will be highlighted in orange. The remaining time in the SUSPEND TAMPER will be displayed.

f. Remove and re-apply the tag. See TAG APPLICATION section for instructions.

1.10 Resume Tamper

a. Once the SUSPEND TAMPER time expires, the system automatically resumes monitoring the tag. If the patient/tag will not remain under the visual surveillance of a staff member until the SUSPEND TAMPER time expires, it will be necessary to Resume Tamper manually.

b. Login to the Hugs® computer per LOGIN procedure.

c. In the Census window of the Hugs® computer display, click on the patient's name to highlight it.

d. Click on Resume Tamper soft button in the toolbar.

e. Logout per LOGOUT procedure.

1.11 Transport

a. The TRANSPORT function will be used to allow a patient/tag to temporarily leave the monitored Hugs® area to move to another Hugs® monitored area, or to visit an unmonitored area such as Radiology, or Diagnostic Services. Hugs® tags for

patients traveling to Surgery or MRI will need to be discharged. See DISCHARGING A TAG section for instructions.

b. Login to the Hugs® computer per LOGIN procedure.

c. In the Census window of the Hugs® computer display, click on the patient's name to highlight it.

d. Click on the TRANSPORT soft button.

e. In the pop-up box, verify patient information, enter the amount of time, in hours and minutes, required for the TRANSPORT. If prompted, select the zones for which that tag should be signed out or All Zones.

f. Click OK.

g. Logout per LOGOUT procedure.

- NOTE: In the Census window, yellow highlight indicates a patient in TRANSPORT status. The time remaining for the TRANSPORT will be displayed.

1.12 Edit /Update Transport

a. If additional time is required to complete Transport, it will be necessary to edit/update the Transport period. If the Transport time expires and additional time is required for transport, see TRANSPORT EXPIRED for instructions.

b. Login to the computer per LOGIN procedure.

c. In the Census window of the Hugs® computer display, click on the patient's name to highlight it.

d. Click on the Transport Field.

e. In the Transport Field, enter the amount of time required for the transport.

f. Click OK.

g. Logout per LOGOUT procedure.

1.13 Transport Expired

a. When the Transport time expires and the patient/tag has not been signed back into the software, a Transport Expired pop-up box will appear. If the patient has returned to a Hugs® monitored area, click on TRANSPORT RETURN pop-up box.

b. Login to the Hugs® computer per LOGIN procedure.

c. Click TRANSPORT RETURN.

d. Logout per LOGOUT procedure

e. The software resumes monitoring the tag.

- NOTE: The system will NOT resume monitoring the patient/tag until TRANSPORT RETURN is completed even if the sign out time expires.

f. If the patient has not returned to the monitor area, it will be necessary to update the Transport.

- Verify location of patient and amount of time until patient is expected to return to

the monitored area.

- Login to the computer per LOGIN procedure.
- Click UPDATE TRANSPORT.
- In the pop-up box, verify patient information, enter the amount of time, in hours and minutes, required for the Transport.
- Click OK.
- Logout per LOGOUT procedure.

1.14 Transport Return a Tag

a. It will be necessary to TRANSPORT RETURN the patient/tag upon re-entering the Hugs® monitored area. Upon completion of the Transport return procedure, the patient/tag will no longer be highlighted in yellow in the Census window, indicating the system has resumed monitoring the tag.

b. When the tag re-enters the Hugs® monitored area, a pop-up box may appear indicating the tag has been detected by an exciter (door).

- Login to the Hugs® computer per LOGIN procedure.
- Click TRANSPORT RETURN.

c. If no pop-up box is present

- Login to the computer per LOGIN procedure.
- In the Census window of the computer display, click on the patient's name to highlight it
  - Click on the TRANSPORT Return soft button in the toolbar.

d. Logout per LOGOUT procedure.

e. NOTE: Never TRANSPORT RETURN a patient/tag that has not re-entered a Hugs® monitored area as a SUPERVISORY TIME OUT ALARM and EXIT ALARM will occur.

1.15 Babysense

a. Disable Babysense: This is to be done by a Charge Nurse or designee

- The Hugs® software will allow users who have the authority to do so to remove the skin sensing (BabySense) feature from individual Hugs® Tags. In the case of an older Pediatric patient skin sensing may not be required to ensure that the tag does not become too loose and slip off the ankle or wrist. In the case of some NICU patients, the skin sensing may be turned off due to the size of the ankle and to avoid skin irritation.
  - Login to the Hugs® computer per LOGIN procedure.
  - In the Census window of the Hugs® computer display, click on the patient's name to highlight it.
  - Click on DISABLE BABYSENSE soft button in the toolbar.

- Logout per LOGOUT procedure.
    i. NOTE: In the Census window, the patient/tag will be highlighted in blue.

b. Enable Babysense: Turns the skin sensing feature back on for a Hugs® tag that has had Baby Sense turned off.

- Login to the Hugs® computer per LOGIN procedure.
- In the Census window of the Hugs® computer display, click on the patient's name to highlight it.
- Click on ENABLE BABYSENSE soft button in the toolbar
- Logout per LOGOUT procedure.
    - NOTE: In the Census window, the patient/tag will no longer be highlighted in blue.

1.16 Locate

a. The Hugs® software can provide general (not precise) location for a Hugs® tag. To locate a Hugs® tag on a patient:

b. Login to the Hugs® computer per LOGIN procedure. In the Census window of the Hugs® computer display, click on the patient's name to highlight it.

c. Click on Locate soft button in the toolbar.

d. Logout per LOGOUT procedure. NOTE: The location is a general indicator and may only be accurate to within approximately 25 feet of actual location.

1.17 Discharging A Tag

a. The Discharge function will be used to remove a tag for discharge or transfer to another facility and transport of patients to MRI or Surgery, or instances where the timeframe for Suspend Tamper is insufficient to complete necessary procedures.

b. Removal of the tag will be the last item before the patient leaves the unit

c. Escort parent and patient

d. to the Nurse's station on the way out of the unit to have the tag discharged

e. Login to the computer per LOGIN procedure.

f. In the status window of the computer display, click on the red heart icon beside the appropriate patient/tag to access the drop-down menu.

g. Click Discharge

h. In the Discharge pop-up box, confirm patient information.

i. Click Yes to confirm discharge.

j. Logout per LOGOUT procedure.

- After discharge, tag cannot be re-used for a 10-minute period

1.18 Alarms And Events: Hugs® computer(s) of impacted zones will issue an audible notification and display the event name, patient/tag information and, when applicable

event location, in the Event window. The ALARM - EVENT box is located in the upper right-hand side of the ALARM - EVENT window on the computer screen.

a. Events

- Check Tag Tightness Event: NOTE: Failure to tighten the tag within a short period will result in a TAG LOOSE ALARM. Tightening a tag that has completely slipped off the foot may include having to Suspend Tamper and reapply with a new Hugs® Band if the Tag is too tight to slip back over the foot and ankle and secure properly
  - A Check Tag Tightness event will display when the tag has lost contact with the patient's skin for more than thirty (30) seconds.
  - Obtain patient/tag information in the Event window on the Hugs® computer(s).
  - Verify location and safety of identified patient.
  - Tighten the tag. See TIGHTENING A TAG section for instructions.
  - Event will auto clear.
- Admit Acknowledgement Event
  - A admit acknowledgement event will display when an admit pop-up box appears on the main screen unacknowledged for 60 minutes (1 Hour).
  - Obtain the Hugs® Tag ID information and address all appropriate fields on the admit pop-up box. See ADMITTING A TAG section for instructions.
  - Once the Tag has been assigned the event will auto clear.

b. Alarms: Hugs® computer(s) of impacted zones will issue an audible notification and display the alarm type, patient/tag information and, when applicable, the alarm location in the Alarm pop-up box. Once the appropriate corrective actions have been taken to verify patient's safety, the alarm can be cleared NOTE: Follow facility specific procedure for door process during alarms. Audible alarms will not have volume turned off at any time.

- Muting an Alarm: The alarm will remain muted for 5 minute(s). If the alarm has not been cleared within this time, the alarm will re-announce.
  - Login to the Hugs® computer per LOGIN procedure.
  - Click on Mute soft button, located at the bottom of the ALARM-EVENT box.
  - Logout per LOGOUT procedure.
- Clearing an Alarm: Alarms will be cleared by the Charge Nurse or designee.
  - Follow response instructions outlined for the specific alarm.
  - Login to the Hugs® computer per LOGIN procedure.
  - In the Alarm Notes field at the bottom of the Alarms-Events box, type a brief alarm explanation or click the drop-down arrow to access pre-configured list.
  - In the ALARM-EVENT box, click to highlight the alarm to be cleared.

- Click Clear soft button in the bottom right side of the ALARM-EVENT box.
- Logout per LOGOUT procedure.

- EXIT ALARM: An EXIT ALARM will occur when a patient/tag comes too close to or passes through an open monitored exit without being in TRANSPORT MODE OR DISCHARGED. An audible notification will sound, and alarm information will display in the ALARM-EVENT box on the ALARM-EVENT window at the Hugs® computer(s). In addition, an audible notification will sound at overhead speakers throughout the safe zone, identifying the location of the Exit Alarm.
  - At computer(s), obtain patient/tag information and exit/alarm location. Location will be indicated by red, flashing doors on the facility map, in the Details section of the ALARM- EVENT box. If patient is still in safe zone, the general location of the tag will be identified on the map on the upper left side of the ALARM-EVENT window.
  - When an exit alarm goes off, the charge nurse in the department will immediately have staff perform the following:
    i. Station a person at the following locations department: stairway exit and the main entrance to the department entrance.
    ii. No staff or visitors will be allowed to exit or enter until the alarm has been cleared
    iii. All nurses will perform a visual count of the newborns assigned to them and report to charge nurse.
    iv. Charge nurse will ensure that all patients have been accounted for.
  - If identified patient's location and safety cannot be immediately verified and patient count is off, activate a Code Pink or Code Purple by (refer to RUHS Policy 511 & 512) calling the Switchboard operator
  - Clear Alarm only after the identified patient's safety has been determined by the Sheriff, Charge Nurse, or Designee.
    i. See CLEARING AN ALARM section for instructions. An exit alarm at an elevator will override the elevator control for that elevator to ensure a tagged patient cannot leave without authorization. In the event of a fire alarm, this control will be disabled, and the elevators will operate as they should during a fire alarm.
- Tamper Alarm: A Tamper Alarm will display when the contact between a tag and the band is lost. This is usually due to an unauthorized removal of the tag from the patient. An audible notification will sound, and alarm information will display in the ALARM-EVENT box on the ALARM-EVENT window at the Hugs® computer(s). Possible causes for the tag and band losing contact with each other may include: 1. Attempting to loosen a band resulting in damage to the strap, 2. Failing to SUSPEND TAMPER OR DISCHARGE before cutting a strap or 3. Strap applied incorrectly
  - At Hugs® computer(s), obtain patient/tag information. Hugs® tag's general location will be identified on the map on the upper left side of the ALARM-EVENT window.

- All available staff will begin searching for identified patient.
- If identified patient's location and safety cannot be immediately verified, activate Code Pink or Code Purple by dialing 9-1-1.
- Clear Alarm only after the identified patient's safety has been determined by the Sheriff, Charge Nurse, or Designee. See CLEARING AN ALARM section for instructions.
- Clear Alarm only after the identified patient's safety has been determined by the Sheriff. See CLEARING AN ALARM section for instructions.
- Replace the band using normal procedure to avoid BAND DETACHED ALARMS.

- Improperly Applied Tag Alarm: An Improperly Applied Tag Alarm will occur, only during the initial HUGS® TAG APPLICATION process, when the Hugs® tag is applied and activated into the Hugs® software and then immediately detached or damaged within the first two (2) minutes of activation. An audible notification will sound, and alarm information will display in the ALARM-EVENT box on the ALARM-EVENT window at the Hugs® computer(s).
  - At Hugs® computer(s), obtain patient/tag information. Hugs® tag's general location will be identified on the map on the upper left side of the ALARM-EVENT window.
  - Charge Nurse or Designee will verify location and safety of identified patient.
  - If identified patient's location and safety cannot be immediately verified, activate Code Pink or Code Purple by dialing 9-1-1.
  - Clear Alarm only after the identified patient's safety has been determined by the Sheriff, Charge Nurse, or Designee. See CLEARING AN ALARM section for instructions.
  - Replace the band per normal procedure to avoid Strap Detached Alarms. Use SUSPEND TAMPER procedure if necessary.
- Band Detached Alarm: A Band Detached Alarms will occur if a Tamper Alarm or Improperly Applied Tag Alarm has been cleared, but the band has not been correctly re-applied to the tag. An audible notification will sound, and alarm information will display in the ALARM-EVENT box on the ALARM-EVENT window at the Hugs® computer(s).
  - At Hugs® computer(s), obtain patient/tag information. Hugs® tag's general location will be identified on the map on the upper left side of the ALARM-EVENT window.
  - Charge Nurse or Designee will verify location and safety of identified patient.
  - If identified patient's location and safety cannot be immediately verified, activate Code Pink or Code Purple by dialing 9-1-1.
  - Clear Alarm only after the identified patient's safety has been determined by the Sheriff, Charge Nurse, or Designee. See CLEARING AN ALARM section for instructions.

- Replace the band per normal procedure to avoid Alarm re-occurrence. Use
- SUSPEND TAMPER procedure if necessary.

- Tag Loose Alarm: A TAG LOOSE ALARM will occur when the Hugs® tag is not in contact with the patient's skin for five (5) minutes. An audible notification will sound, and alarm information will display in the ALARM-EVENT box on the ALARM- EVENT window at the Hugs® computer(s).
  - At Hugs® computer(s), obtain patient/tag information. Hugs® tag's general location will be identified on the map on the upper left side of the ALARM-EVENT window.
  - All available staff will begin searching for identified patient.
  - If identified patient's location and safety cannot be immediately verified, activate Code Pink or Code Purple by dialing 9-1-1.
  - Clear Alarm only after the identified patient's safety has been determined by the Sheriff, Charge Nurse, or Designee. See CLEARING AN ALARM section for instructions.
  - If identified patient's safety is verified, re-apply the Hugs® tag to the patient. SUSPEND TAMPER if necessary and apply a new band to re-secure on the patient.
  - Clear Alarm only after the identified patient's safety has been determined. See CLEARING AN ALARM section for instructions.
- Supervision Timeout Alarm: A Hugs® tag Supervision Timeout Alarm will occur when a Hugs® tag fails to communicate with the Hugs® system for a configured amount of time. An audible notification will sound, and alarm information will display in the ALARM-EVENT box on the ALARM-EVENT window at the Hugs® computer(s). Possible causes for loss of communication may include: 1) Patient/tag is outside of the Hugs® monitored area; 2) Tag battery expired (Tags generate an automatic Low Battery Alarm; see LOW BATTERY ALARM procedure) 3) Shielding of tag 4) Inadequate receiver (LAR) coverage
  - At Hugs® computer(s), obtain patient/tag information. Hugs® tag's general location will be identified on the map on the upper left side of the ALARM-EVENT window.
  - All available staff will begin searching for identified patient.
  - If identified patient's location and safety cannot be immediately verified, activate Code Pink or Code Purple by dialing 9-1-1.
  - Clear Alarm only after the identified patient's safety has been determined by the Sheriff, Charge Nurse, or Designee. See CLEARING AN ALARM section for instructions.
- Low Battery Alarm: A LOW BATTERY ALARM will occur when the battery of a Hugs® tag becomes low. An audible notification will sound, and alarm information will display in the ALARM-EVENT box on the ALARM-EVENT window at the Hugs® computer(s).
  - At Hugs® computer(s), obtain patient/tag information. Hugs® tag's general

location will be identified on the map on the upper left side of the ALARM-EVENT window.

- Clear alarm (See CLEARING AN ALARM section for instructions), discharge tag and apply new tag (See Discharge and Tag Application).
- Provide the low battery Hugs® tag to Nurse Manager/Assistant Nurse Manager for proper disposal and for inventory control

1.19 System downtime

a. Staff become aware Security system is down

b. Staff contact charge nurse immediately

c. Charge nurse documents the time she was notified on the "Infant/child security downtime report"

d. Charge nurse asks all nurses to make rounds on their patients and account for their babies immediately

- Nurses to physically enter each room and account for their assigned babies then notify the charge that number of babies they accounted for.
- Upon receiving report from all nurses, charge nurse tally's the list and confirms that all babies are accounted for.

e. Simultaneously:

- Charge nurse notifies House Sup and requests for ahall monitor to sit at the OB and Pediatrics entrance. The OB door monitor will monitor both the OB & L&D exits and the Pediatric door monitor will monitor the Pediatric and NICU exits. If the door monitor is not available immediately, charge nurse to assign a staff member temporarily
- House sup notifies security and AOC on call
- Charge nurse notifies Bio Med
- Charge nurse notifies Director - Director notifies Executive Director

f. Once bio med fixes the system, he tests the system to ensure it is working properly

g. Once Bio med confirms the system is functioning, he notifies House supervisor and Charge nurse

h. Charge nurse notifies the following:

- staff
- House sup notifies security

i. Charge nurse notifies Director of the time system went back up and that it has been tested.

j. Director notifies Executive Director.

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER

Housewide

	Document No: 515.2	Page 1 of 4
Title: Hazardous Chemical Materials Monitoring	**Effective Date:** 8/1/2024	☐ **RUHS – Behavioral Health** ☐ **RUHS – Community Health Centers** ☐ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By:  Jennifer Cruikshank CEO/ Hospital Director		☐ **Policy** ☒ **Procedure** ☐ **Guideline**

1. DEFINITIONS

1.1 Cal-OSHA**:** A state government agency established by the California Occupational Safety & Health Act of 1973. Administered by the California Department of Industrial Relations, Cal-OSHA's mission is to protect public health and safety through research and regulation related to hazards on the job in California workplaces and related to the use of pressure vessels such as boilers and tanks.

1.2 Cal-OSHA Threshold Limits Cal-OSHA Permissible Exposure Limits (PEL) are restrictions established by Cal-OSHA and defined as the maximum permitted 8-hour time-weighted average concentration of an airborne contaminant. PEL exposures are usually measured over a Time Weighted Average (TWA).

1.3 Ceiling Limit is the maximum concentration of an airborne contaminant to which an employee may be exposed to at any time.

1.4 Hazardous chemicals are defined by Cal-OSHA as chemical for which there is statistically significant evidence based on at least one study conducted in accordance with established scientific principles that acute or chronic health effects may occur in exposed employees.

1.5 Hazardous Vapors: A vapor refers to a gas-phase material that normally exists as a liquid or solid under a given set of conditions. They are formed by evaporation from a liquid or solid. When vapors originate from hazardous chemicals, they represent a risk to exposed employees. Hazardous vapors are created from chemicals most frequently used to sterilize equipment and preserve specimens. The list of hazardous chemicals present at the hospital changes as new chemicals, equipment, and/or processes are introduced into the work area. They presently include:

- Ethylene Oxide (EtO)
- Nitrous Oxide
- Formaldehyde (formalin)
- Xylene

1.6 Personal Monitoring Badges (Passive Monitoring) are defined as the badges used to measure personal exposure to specific hazardous vapor concentrations. The badges shall be used within the criteria as specified by the manufacturer's instructions included in the packaging.

1.7 Sampling Period is defined as the period during which a monitoring badge is worn to measure vapor exposure.

1.8 Short Term Exposure Limit (STEL) is defined as an employee's exposure to an airborne contaminant measured as a 15-minute time weight average (TWA) that shall not surpass the STEL value specified for the substance in CCR 5155 table AC-1 at any time during the workday. If an alternative averaging period is specified in the footnotes to Table AC-1, the TWA exposure over that period should also not exceed the designated STEL at any time during the workday.

2. PROCEDURES

2.1 **Monitoring**: Hazardous vapor monitoring shall be conducted, recorded, and retained in accordance with Cal-OSHA regulations as follows:

a. Consistent monitoring for exposure to vapors produced by hazardous chemicals shall occur in the Accredited Laboratory Department and the Operating Room.

b. Continuous monitoring shall occur outside of the morgue

c. Upon reasonable suspicion that employees may be exposed to excess concentration levels of airborne contaminants in accordance with CCR 5155(c).

i. When a substance has additive health effects and the value of the fraction of the allowable daily exposure is more than the unity (refer to section (B) of the Appendix to CCR 5155).

ii. Employee exposure to concentrations above the PEL can also result in monitoring for substances without a ceiling limit. Additionally, that substance shall be controlled through engineering and/or administrative controls, exposure monitoring, medical surveillance, etc.) to prevent harmful health effects to employees, patients & etc.

iii. Monitoring could be feasible if employee exposure to an airborne contaminant/ hazardous vapor/substance exceeds the STEL specified for that substance in Table AC-1 at any point during their workday.

iv. TWA exposure over the averaging period (refer to footnotes for Table AC-1) exceeds the STEL specified for that substance at any point during the workday.

d. The department is responsible for contacting the Safety Division Certified Industrial Hygienist (CIH) to schedule monitoring to be as responsive as possible. Instances where exposure concentrations can be increased include, but are not limited to:

i. Malfunction of ventilation systems in the work area.

ii. Increase in specimens being processed.

iii. Increase in the time spent in the affected areas.

e. Department Managers shall request additional monitoring at any other time when they reasonably feel there may be a change in exposure, including but not limited to patient or employee requests.

2.2 **Monitoring Badges:** Badges must be worn by employees who work in these Departments during the designated sampling period.

a. Monitoring badges and a badge kit shall be provided by an approved contracted vendor established by the Clinical Laboratory Department designee. The badges

b. must be worn properly during the entire work shift, including during break and/or mealtimes. Badges shall be:
    i. Attached to the workforce member's collar or lapel (breathing zone) for a personal sample.
    ii. Placed on a stationary object in the chemical use zone at the approximate height of 4.5 to 5.5 feet to be considered an area sample.

c. Workforce members shall seal and secure their badges at the end of the work shift in the foil pouch included in the badge kit. The designated approved contractor vendor shall collect the badge at the end of the workday or within a week of the sampling period.

d. Damaged Badges worn by employees during a work sample will be reported to the department manager and or designated approved contractor vendor to replace the badge and begin a new sampling period.

2.3 Monitoring Protocols: The measurements used shall be representative of the workforce members' full shift or short-term exposure to the chemical in question.

a. Monitoring shall consist of recording the start and stop times of the monitoring period on the collection badge. All pertinent information should be placed on the accredited laboratory analysis data information card.
    i. Samples collected shall be sealed utilizing the protocols and materials inside the lab sample badge kit accompanied with the lab data card.
    ii. The Department manager and/or designee will mail the data card to the designated accredited laboratory in a timely manner for analysis.

2.4 Employee Notification

a. All results from monitoring shall be reported by the Department Managers and/or designee to the Safety Division. Department Managers shall review the results with the affected employees.

b. Employees should follow the Workers' Compensation procedures if the results exceed the Cal-OSHA threshold limits.

2.5 Results Exceeding the Cal-OSHA PEL

a. Employees should never be purposefully exposed above the Permissible Exposure Limit (PEL) under the Cal-OSHA mandate. However, it is the Action Level (AL) (half the PEL) that triggers the implementation of precautionary measures (e.g., engineering and/or administrative controls, exposure monitoring, medical surveillance, etc.) to protect employee exposure.

b. Verification re-sampling shall be promptly scheduled after the following notifications have been made if the vapor monitoring results exceed the allowable Cal-OSHA limit for a specific chemical:
    i. Notify Hospital Administration, County Safety Certified Industrial Hygienist (CIH), Department Managers, affected workforce member(s), and the Environment of Care Committee.

c. Take action based on County Safety Certified Industrial Hygienist (CIH) and Administration recommendations.

2.6 Hazardous Vapor Emergencies

a. A Code Orange shall be implemented whenever a **hazardous vapor** is **released outside the designated areas of use**, a **Code Orange** shall be , and all relevant **Code Orange protocols** from the **Hazardous Materials Spill or Release procedure/guidelines** should be **followed**

b. The Department manager shall consult with Safety Division and Certified Industrial Hygienist to determine the necessity to perform vapor monitoring in and around the areas of the release.

2.7 Data Documentation

a. All monitoring results shall be recorded and retained by the Department/Nurse Manager, the designated approved contracted vendor, and the Hospital Safety Division.

2.8 New Chemical Protocol. Unit managers and/or supervisors should review Safety Data Sheets (SDS) if a new chemical or procedure is introduced to the following:

a. **Employer** shall offer **appropriate training** in accordance with **Title 8 CCR 5194** for the **Hazard Communication program** and the **Injury Illness Prevention Program**.

b. Employees using or exposed to the new chemical or procedure.

c. Department Manager in collaboration with County Safety Certified Industrial Hygienist (CIH) to determine if it is necessary to monitor for vapors the new chemical produces.

i. If the County Safety Certified Industrial Hygienist (CIH) is not available, Department Managers shall contact the Safety Division On-Call personnel at (951) 955-3520 (micro-53520) for assistance.

3. REFERENCES:

3.1 RUHS - Medical Center Emergency Operations Plan #EM1022, Hazardous Spill Procedures (Code Orange)

3.2 California Occupational Safety and Health Administration (Cal-OSHA), Title 8, Section 5141, and Control of Harmful Exposure to Employees and Section 5155, Airborne Contaminants

3.3 RUHS Policy HW 865 – Hazardous Drug Spill Deactivation and Waste Management for additional detailed information regarding the process and response procedures involving a Hazardous Material Spill/ Release.

Document History:

Prior Release Dates: 3/2000, 3/2003, 9/17/2013, 3/9/2021	**Retire Date:** N/A
Document Owner: County Safety, Environment of Care	**Replaces Policy:** HW 515.2 Hazardous Vapor Monitoring

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
6/27/2024	Safety Loss Control	Yes	Change title. Revise compliance-related and adherence to regulations wording, and ensure that the instructions reflect current protocols

7/24/2024	PAC	Y	Insert former policy name in 'replaces policy' field

RIVERSIDE UNIVERSITY HEALTH SYSTEM

Housewide

	Document No: 602	Page 1 of 5
Title: Patient Informed Consent	**Effective Date:** 9/11/2024	☐ **RUHS – Behavioral Health** ☒ **RUHS – Community Health Centers** ☒ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By:  Jennifer Cruikshank CEO/ Hospital Director		☒ **Policy** ☐ **Procedure** ☐ **Guideline**

1. DEFINITIONS

1.1 **Informed Consent -** A process of obtaining and documenting permission before conducting a healthcare intervention on a person. It involves discussion between a practitioner and the patient or patient's legal representative about the nature of the procedure, the potential risks, benefits and alternatives to the treatment.

1.2 **Medical Emergency -** A medical emergency exists when:

a. Immediate services are required for the alleviation of severe pain

OR

b. The procedure is required for immediate diagnosis and treatment of unforeseeable medical conditions, which, if not immediately diagnosed and treated, would lead to serious disability or death.

AND EITHER

a. The patient is unconscious or incapable of giving consent and there is insufficient time to obtain informed consent from the patient's legal representative

OR

b. The procedure must be undertaken immediately and there is insufficient time to fully inform the patient or a legal representative of possible consequences.

2. POLICY

2.1 RUHS honors each patient's right to give or withhold consent for medical treatment.

2.2 No treatments, other than treatments needed to address a medical emergency, will be permitted unless the patient, or a person legally authorized to consent on the patient's behalf, has consented to treatment.

2.3 **Emergencies -** In the case of a medical emergency:

a. Only the emergency condition may be treated.

b. The medical determination that an emergency exists must be documented by a licensed physician and placed in the medical record.

c. Treatment that exceeds what is necessary for the emergency condition may not be rendered without consent from someone authorized to consent to treatment on a nonemergency basis.

d. The medical emergency treatment exception is not applicable when a patient has validly refused medical treatment, and the emergency arises from the fact that treatment was not given.

e. If evidence exists to indicate that the patient (or the patient's legal representative) would refuse the treatment, legal counsel shall be consulted.

2.4 **Rescue / "Code" Teams -** The designated Medical Center Rescue / "Code" teams may attempt to resuscitate a person who is in immediate danger of loss of life without first seeking consent or a formal determination by a physician that an emergency exists. All care provided by those teams will be documented according to the team protocol.

2.5 The following types of procedures will require documentation of informed consent before they are performed on a non-emergency basis:

a. Operative procedures

b. Invasive procedures that have the potential for serious risks and / or adverse reactions

c. Blood transfusions or other use of blood products

d. Planned use of all forms of general anesthesia and moderate sedation

e. Electroconvulsive therapy

2.6 It is the treating practitioner's responsibility to ensure informed consent is obtained and documented prior to beginning non-emergency medical treatment.

a. The practitioner who performs or orders a treatment is responsible for ensuring the patient's consent is obtained. This responsibility may not be delegated to a non-physician provider or an advanced practice provider without practice privileges to perform the treatment independently, without supervision.

b. The treating practitioner may assign a licensed resident physician from the treatment team to obtain the informed consent with a patient or patient's representative about a procedure or medical treatment; however, the treating physician is still responsible for ensuring that the nature of the procedure, the potential risks, benefits and alternatives of the treatment are discussed directly with the patient or patient's representative, and all questions are answered.

c. If general anesthesia is required, the anesthesia practitioner must discuss associated risks, benefits and alternatives with the patient or patient's representative prior to treatment and document in the patient's medical record.

d. If Dialysis or Chemotherapy is required

- Initiation of these services at RUHS (first time) require written informed consent.
- Pre-established ongoing treatment will be discussed by the treating practitioner and documented in the medical record via progress note to include associated risks, benefits and alternatives with the patient or patient's representative; and patient agreement to continue pre-established treatment.

e. If a non-physician practitioner, such as a Physician's Assistant (PA), Nurse Practitioner (NP) or Certified Registered Nurse Anesthetist (CRNA), has been granted practice privileges to perform a procedure independently, they are responsible for obtaining the patient's consent prior to beginning the procedure.

f. If a non-physician other than a practitioner with practice privileges will perform the procedure, then the ordering practitioner is responsible for securing the consent. For example, when submitting orders for the administration of blood products or for placement of peripherally inserted central catheter (PICC) lines by nursing staff the ordering practitioner must ensure informed consent is obtained before those orders can be acted upon.

g. If more than one practitioner is providing the treatment, they can determine together which practitioner will obtain consent.

2.7 Physicians in training, who have verifiable competency in a particular procedure, as documented within the Graduate Medical Education (GME) Credentialing lists, are responsible for ensuring informed consent is obtained when supervising other physicians in training performing that particular procedure.

2.8 The patient or patient's representative must also sign and date the informed consent form, unless the consent is obtained by telephone (see section 2.9 below). If requested, a reasonable attempt will be made to provide the patient or patient's representative with a copy of the signed informed consent form and the original will be stored in the patient's medical record. Patients may also visit their My Chart portal for a copy of the consent form at https://myruhealth.org.

2.9 An Informed Consent discussion must include:

a. Assessment of the patient's capacity to understand the discussion or location of an appropriate substitute decision maker if the patient is incapable by age, mental state or medical condition of understanding the decision under discussion.

b. A discussion about the patient's proposed care, treatment, and services.

c. Potential risks, benefits, and alternatives to the proposed care, treatment, and services.

d. Any potentially conflicting interests the practitioner may have such as research or financial interests.

2.10 **Consent by telephone -** Consent for medical or surgical procedures should be obtained by telephone only if the person having the legal authority to consent for the patient is not otherwise available. The telephone discussion between the practitioner and the patient's legal representative and a responsible RUHS employee should be confirmed by either (a) the practitioner and one RUHS employee or (b) by two RUHS employees and documented in the telephone consent section of the informed consent with name, signature, title, date and time.

2.11 **Interpreters -** If a patient or his/her legal representative cannot communicate with the practitioner due to a language or other communication barrier, the practitioner will arrange for an interpreter according to the instruction in RUHS policy *HW 142 Access to Language Services for Non or Limited English Proficient, Deaf, and Hearing-Impaired Persons.* If an interpreter is used in person, the interpreter will sign, date, and time on the informed consent form. If an interpreter is used online or on phone, the required information will be documented along with the Interpreter's telephone ID on the informed consent form.

2.12 **Nursing role -** The nurse will ensure that the appropriate informed consent form has been signed and is in the medical record prior to the procedure being done.

2.13 **Abbreviations -** Abbreviations should not be used in the informed consent form.

2.14 **Corrections** – If an error is identified in the informed consent form, the treating provider must either prepare a new electronic consent form, or when using a paper consent form, use a single line through the material to be deleted. The physician and patient must initial, date, and time each correction made to paper consent forms.

2.15 **Names of practitioners -** The names of the practitioner(s) performing the procedure(s) should be identified in the consent form. Use of medical group practice name or use of a surgeon's name followed by "and associates" is not acceptable. Also, the name(s) of other practitioners who will conduct specific, significant surgical tasks not being done by the primary surgeon/practitioner, should be included on the informed consent form.

a. If the listed performing practitioner(s) is unable to perform or complete the procedure, a qualified substitute practitioner(s) will be selected, together with associates and assistants (including anesthesia practitioners, pathologists, and radiologists) from the medical staff to whom the practitioner may assign designated responsibilities.

b. If circumstances require a change in the treating practitioner after a consent form has been signed by the patient, the new treating practitioner is responsible for discussing that change with the patient or patient representative, answering any questions and documenting that the discussion took place either by executing a new consent form or in a separate note in the medical record prior to the start of the treatment.

2.16 **Refusal to Consent -** Patient and those giving consent on their behalf are entitled to refuse any and all recommended care and treatments. The practitioner's duty is to make every effort to explain the risks, benefits, and likely consequences of refusing the recommended treatment so that such refusals are informed by that information.

a. Refusals of recommended care or treatments should be documented in the patient's chart.

b. Consultation by Psychiatry or with the RUHS Bioethics Committee may be indicated if there are questions about the patient's capacity to appreciate the consequences of such a refusal, or whether refusal by a substitute decision-maker is in the patient's best interest or the refusal could have consequences for another individual, such as a fetus in utero.

2.17 **Special Consent Requirements -** The following procedures have specialized consent requirements under California land or Federal law:

a. **Blood transfusions -** Patients must be given (1) "A Patient's Guide to Blood Transfusion" whenever there is a reasonable possibility that an autologous transfusion may be needed and (2) allowed adequate time for pre-donation unless there are medical contraindications to pre-donation or the patient waives that right.

b. **HIV testing -** If a patient does not independently request an HIV test, prior to ordering one a medical care provider must make certain disclosures to the patient. The provider also must provide certain information and counseling when the test result is released to the patient. If a patient declines an HIV test that fact must be documented in the patient's medical record.

c. **Sterilization -** The Obstetric Gynecology Department, Family Medicine Department, and the Urology Division each have a policy regarding sterilization that includes appropriate informed consent in compliance with state and federal laws.

d. Silicone Implants and Collagen Injections - State law requires provision of specified information to patients prior to undergoing procedures that include the use of these materials.

e. Vaccines - Federal law requires the furnishing of written information before the administration of most vaccines. These statements can be found at www.immunize.org/vis

f. Procedures related to research - All research at RUHS is governed by the RUHS Institutional Review Board which may require completion of a specific informed consent form before a procedure relating to research is performed.

3. REFERENCES

3.1 The Joint Commission Comprehensive Accreditation Manual for Hospitals Standard RI.01.03.01.

3.2 California Hospital Association Consent Manual “Role of the Physician Obtaining Consent” 2.7

3.3 Medical Informed Consent: General Considerations for Physicians, Paterick et al., Mayo Clin Proc. 2008;83(3):313-319

3.4 42 CFR Sec. 482.51(b)(2); Interpretive Guideline A-0392

Prior Release Dates: 7/1986, 10/2008, 7/2009, 8/2014, 9/13/2018, 12/9/2020	**Retire Date:** N/A
Document Owner: Regulatory Compliance	**Replaces Policy:** N/A

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
3/13/2024	Compliance	Y	Added anesthesia documentation Language
5/20/2024	Compliance/Regulatory/Dr. Garrison, Dr. Clark, Dr. Kumar, Dr. Thompson, Gregg Gu	Y	Added Anesthesia and Dialysis clarification 2.6
8/1/2024	Pre-Nursing P&P	Y	Follow up on comments and changes requests
8/15/2024	Nursing P&P	Y	Clarification language
8/22/2024	Nursing P&P	N	
8/26/2024	PAC	Y	Adding ‘written’ consent, and ‘via progress note” to 2.6 d. on dialysis and chemo consent to meet regulatory requirements and to aid in the ability to locate of these consent.
9/10/2024	MEC via evote	Y	Change “anesthesiologist” to “anesthesia practitioner.” Change ‘anesthesia’ to ‘general anesthesia’

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 631	Page 1 of 4
Title: Code Bert/Code Green	**Effective Date:** 8/31/2024	☐ **RUHS – Behavioral Health** ☐ **RUHS – Community Health Centers** ☐ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By: Jennifer Cruikshank CEO/ Hospital Director		☐ **Policy** ☐ **Procedure** ☒ **Guideline**

1. SCOPE

1.1 This policy applies to Riverside University Health System (RUHS) – Medical Center, except for Arlington campus, which maintains a separate policy.

2. DEFINITIONS

2.1 Agitated / Disruptive Behavior: Behavior exhibited by a patient or other individual that is demonstrating increasingly escalating behavior by: pacing, yelling, arguing and name calling.

2.2 Code Green: is a code phrase established to alert staff and Code Green responders of a patient or other individual(s) within the hospital environment who is believed to be combative or exhibiting behaviors which pose an imminent threat to themselves or others, or a patient on a legal hold attempting to leave.

2.3 Code Behavioral Emergency Response Team (BERT): A code word established to alert staff and Code BERT responders or other individual(s) within the hospital environment who is exhibiting early escalation behaviors (i.e., raised voice, uncooperative, refusing to follow directions).

2.4 Dangerous / lethal behavior: Behavior exhibited by a patient or other individual that suggests a threat against other (hit / kick / bite) or that can potentially escalate to harm to self of others.

2.5 Decisional capacity is defined as an individual's ability to (1) understand the nature and consequences of a decision and (2) to make and (3) communicate a decision. Decisional capacity can vary over time and patients that cannot make a decision about one aspect of their care may still retain that capacity with regard to other decisions. Patients are presumed to have full decisional capacity until a physician determines that a patient lacks capacity to make informed decisions. This determination will be documented in the patient's medical record.

2.6 Emergency Responders: Behavioral Emergency Response Team (BERT) registered nurse (s), Security Officer(s), Riverside Sheriff Officers (RSO), and other trained RUHS staff.

2.7 Medical Incapacity Hold (MIH) is an order which allows for involuntary detainment of a patient in Riverside University Health System – Medical Center who meets all of the following criteria: a. The patient lacks decisional capacity but is expressing an

intention to leave the Medical Center b. The patient's intention to leave poses a serious threat to their own safety or the safety of others c. The patient does not meet criteria for a psychiatric hold based on California State mental health care law d. A substitute decision-maker is not immediately available, or a substitute decision maker has consented to the MIH.

2.8 Mobile Crisis Response Team: RUHS – Behavioral Health (BH) Crisis Support System of Care Program. The Team is field based and assist 24/7.

3. CODE BERT Guideline / Procedure

3.1 Activating a Code Behavioral Emergency Response Team (BERT)

a. A Code BERT should be activated for any patient, staff or visitor who requires early intervention and de-escalation of agitated / disruptive behavior. A Code BERT may be called on a patient on a medical incapacity hold (MIH) or decisional capacity.

b. A Code BERT is a non-emergency page to BERT team responder and not activated overhead.

c. Any staff member may activate a Code BERT by:

i. At the RUHS – Medical Center: Dialing "9-1-1" on any hospital telephone and providing the location of the Code BERT. The caller remains on the telephone while the hospital operator connects the caller to the BERT team nurse.

ii. At the RUHS – Education Building: Dialing "0-1" on any hospital telephone and providing the location of the Code BERT. The caller remains on the telephone while the hospital operator connects the caller to the BERT team nurse.

iii. At the RUHS - Medical Surgical Center (MSC): Dialing (888) 374-1113 to activate the RUHS Mobile Crisis Response Team. The Mobile Crisis Response Team will arrive and determine the need of the individual.

iv. Surrounding parking lots and exterior locations within 250 yards of the RUHS – Medical Center. The caller may activate the closest 'blue emergency phone' located in parking lots.

3.2 Code BERT Procedure

a. The BERT team RN / Responders are trained to communicate and safely intervene in crisis situations and assist and verbally de-escalate situations involving patients', family members and visitors.

b. RUHS provide a de-escalation crisis intervention training program for staff.

i. Department management will assign appropriate staff members to attend or complete training.

c. Responding to all Code BERT within 15 minutes or sooner following hospital operator transfer of caller. Depending on call volume calls may be triaged for severity.

d. Responders: BERT team RN (s), Security Guard (s), primary nurse, Department Managers and other trained responders.

e. BERT team RN functions in a lead capacity and may delegate other responsibilities to other responding staff.

f. Post Code BERT debriefing is completed with all participants and identify areas of improvement.

3.3 Code BERT documentation

a. Every Code BERT must be documented in the electronic health record, or downtime forms when appropriate.

4. Code GREEN Guideline / Procedure

4.1 Activating a Code Green

a. A Code Green should be activated for any patient, staff or visitor who is demonstrating behavior that is dangerous or lethal.

i. Suggests a threat against staff, patient, or a visitor.

ii. Violence or harm to self or others seems imminent.

iii. Patient on a legal hold (5150/5250) is attempting to leave.

iv. Patient on a medical incapacity hold (MIH) or decisional capacity is attempting to leave.

b. A Code Green is an emergency page and will be announced overhead by the hospital operator.

c. Any staff may activate a Code Green by:

i. At the RUHS – Medical Center: Dialing “9-1-1” on any hospital telephone and providing the location of the Code Green. If the patient is attempting to leave, provide physical and clothing description and have primary sitter follow at safe distance.

ii. At the RUHS – Education Building, and MSC: Dialing “0-1” on any hospital telephone and providing the location of the Code Green.

iii. At the RUHS – Campus Professional Center (CPC) : Dialing “9-1-1” on an outside line for Riverside Sheriff Dispatch Communication.

iv. Surrounding parking lots and exterior locations within 250 yards of the RUHS – Medical Center. The caller may activate the closest ‘blue emergency phone’ located in the parking lots.

4.2 Code Green Procedure

a. The Code Green team RN(s) / Responders are trained to communicate and safely intervene in crisis situations.

b. RUHS provide a de-escalation crisis intervention training program for staff.

i. Department management will assign appropriate staff members to attend or complete training.

c. A Code Green is an immediate response time once paged and announced overhead by hospital operator.

d. Responders: Code Green team RN (s), Security Guard (s), Riverside Sheriff Officer RSO (s), House Supervisor, primary nurse, Department Managers, Attending / Resident Physician and other trained responders.

e. BERT team RN functions in a lead capacity and may delegate other responsibilities to other responding staff.

f. Post Code Green debriefing is completed with all participants and identify areas of improvement.

4.3 Code Green documentation

a. Every Code Green must be documented in the electronic health record, or downtime forms when appropriate.

5. REFERENCES

5.1 RUHS – Medical Center House-wide policy 694: Guidelines for addressing Non-psychiatric Patients who lack Decisional Capacity and Who ARE a Threat to Themselves or Others.

Document History:

Release Dates: 9/17/1997, 3/25/2003, 12/15/2010, 8/24/16, 9/12/2019, 10/26/2022	**Retire Date:** N/A
Document Owner: BERT ANM Coordinator	**Replaces Policy:** HW 631 Code Green

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
5/29/2024	BERT Team	Yes	Activation clarification
6/3/2024	Pre-Nursing P&P	Yes	Corrections to formatting. 3.2a and b removed and added to scope of service
6/13/2024	Nursing P&P	No	Consent agenda
7/24/2024	PAC	Y	Add previous release dates and previous name in document history table. Correct formatting.

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 632	Page 1 of 6
Title: Patient Discharge Planning and Patient Discharge	**Effective Date:** 9/11/2024	☐ **RUHS – Behavioral Health** ☐ **RUHS – Community Health Centers** ☐ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By:  Jennifer Cruikshank CEO/Hospital Director		☐ **Policy** ☐ **Procedure** ☒ **Guideline**

1. PURPOSE

1.1 To provide a policy for the management of the discharge planning process from point of entry into the facility through discharge.

2. DEFINITIONS

2.1 Health Care Decision Maker: Examples of a health care decision maker include but are not limited to Legal Guardian, Power of Attorney (POA), Health Care Proxy Patient Representative, Surrogate Decision Maker

2.2 A patient representative could be a family member, friend, or other individual who supports the patient during the hospital stay.

2.3 "Family caregiver" means a relative, friend, or neighbor who provides assistance related to an underlying physical or mental disability but who is unpaid for those services.

3. GUIDELINES

3.1 Discharge Planning

a. The hospital must discharge, transfer, or refer the patient where applicable, along with all necessary medical information pertaining to the patient's current course of illness, treatment, post-discharge goals of care, and treatment preferences, at the time of discharge, to the appropriate post-acute care service providers and suppliers, facilities, agencies, and other outpatient service providers and practitioners responsible for the patient's follow-up or ancillary care.

b. RUHS designated personnel will make appropriate arrangements for posthospital care, including, but not limited to, care at home, in a skilled nursing or intermediate care facility, or from a hospice, are made prior to discharge for those patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning. If the hospital determines that the patient and family members or interested persons need to be counseled to prepare them for posthospital care, the hospital shall provide for that counseling.

c. The discharge planning process shall focus on the patient's goals and treatment preferences and includes the patient and the patient's authorized representative in the discharge planning for post-discharge care. There must be documentation in the patient's medical record of the patient's goals and treatment preferences. The documentation must include that the patient and the patient's authorized representative were included in the development of the goals, as reflected in the

notes by the physician, nurses,
social worker, case management and/or discharge planners, as applicable.

d. As part of the discharge planning process, RUHS shall provide each patient who has been admitted to the hospital as an inpatient with an opportunity to identify one family caregiver who may assist in posthospital care and shall record this information in the patient's medical chart.

    i. If the patient is unconscious or otherwise incapacitated upon admittance to the hospital, RUHS staff will make every effort to identify patients next of kin or legal guardian, within a specified time period, at the discretion of the attending physician or following the patient's recovery of consciousness or capacity. Should the patient not become conscious RUHS staff shall follow the direction of HW 601.5 Healthcare Decision for Unrepresented Patients.

    ii. If the patient or legal guardian declines to designate a caregiver pursuant to this section, RUHS shall promptly document this declination in the patient's medical record and follow the policy outlined in HW 601.5 when appropriate.

e. The discharge planning process and the discharge plan shall be consistent with:

    i. the patient's goals for care and their treatment preferences

    ii. ensuring an effective patient transition from hospital to post-discharge care, and

    iii. reduction in the factors that lead to preventable hospital readmission.

f. RUHS medical staff will identify, at an early stage of hospitalization, those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning and will also provide a discharge planning evaluation for those patients upon the request of the patient, patient's representative, or patient's physician. Patients will be identified by the criteria listed below:

    i. Physician order or request

    ii. Multi-Disciplinary Team consults and referrals.

    iii. Request by the patient, family, support person or Health Care Decision Maker / patient representative

    iv. Discharge planning assessment

g. A discharge planning evaluation shall include an evaluation of a patient's need for appropriate post-hospital services and must also include a determination of the availability of the appropriate services as well as of the patient's access to those services. Services may include but not limited to:

    i. Hospice care services

    ii. Post-hospital extended care services (SNF (Skilled Nursing Facility), LTACH (Long Term Acute Care Hospital), IRF (Inpatient Rehab Facility), etc.)

    iii. Home health services

    iv. Non-healthcare services and community-based care providers

h. The discharge planning evaluation shall be included in the patient's medical record for use in establishing an appropriate discharge plan. The results of the

evaluation must be discussed with the patient or the patient's Health Care Decision Maker/patient representative.

i. The patient's designated family caregiver will be notified of the patient's discharge or transfer to another facility as soon as possible and, in any event, upon issuance of a discharge order by the patient's attending physician. If the hospital is unable to contact the designated caregiver, the lack of contact shall not interfere with, delay, or otherwise affect the medical care provided to the patient or an appropriate discharge of the patient. The hospital shall promptly document the attempted notification in the patient's medical record.

ii. The patient and family caregiver are informed of the continuing health care requirements following discharge from the hospital. The right to information regarding continuing health care requirements following discharge shall also apply to the person who has legal responsibility to make decisions regarding medical care on behalf of the patient if the patient is unable to make those decisions for himself or herself. The hospital shall provide an opportunity for the patient and his or her designated family caregiver to engage in the discharge planning process, which shall include providing information and, when appropriate, instruction regarding the posthospital care needs of the patient. This information shall include, but is not limited to, education and counseling about the patient's medications, including dosing and proper use of medication delivery devices, when applicable. The information shall be provided in a culturally competent manner and in a language that is comprehensible to the patient and caregiver, consistent with the requirements of state and federal law, and shall include an opportunity for the caregiver to ask questions about the posthospital care needs of the patient.

iii. Any discharge planning evaluation or plan shall be developed by or under the supervision of registered nurses, social workers, or other appropriately qualified personnel as determined by RUHS.

3.2 Requirements related to post-acute care services.

a. In discharge planning, the RUHS discharge planner shall provide list of home health agencies (HHAs), skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs) or long-term care hospitals (LTCHs) that are available to the patient, that are participating in the Medicare program, and that serve the geographic area or in the case of a SNF, IRF, or LTCH, in the geographic area requested by the patient. HHA (Home Health Agency) must request to be listed by the hospital as available.

i. The list must only be presented to patients for whom home health care post hospital extended care services, SNF, IRF, or LTCH services are indicated and appropriate as determined by the discharge planning evaluation.

ii. For patients enrolled in managed care organizations, the hospital shall make the patient aware of the need to verify with their managed care organization which practitioners, providers or certified suppliers are in the network of the patient's managed care organization.

iii. There must be documentation in the patient's medical record that the list was presented to the patient or to the patient's authorized representative.

iv. The patient or the patient's Health Care Decision Maker/patient representative shall be informed of their freedom to choose among participating Medicare providers and suppliers of the post-discharge services.

v. When possible, RUHS treatment team shall respect the patient's or the patient's Health Care Decision Maker/patient representative goals of care and treatment preferences, as well as other preferences they express. RUHS will not specify or limit the qualified providers or suppliers available to the patients.

vi. The RUHS Case Management and Social Work department will assist patients, their families, and/or the patient's representative in selecting a post-acute care provider by using and sharing data that includes, but is not limited to HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures.

vii. The RUHS Case Management and Social Work department will ensure that the post-acute care data on quality measures and data on resource measures is relevant and applicable to the patient's goals of care and treatment preferences.

viii. RUHS shall identify any HHA or SNF to which the patient is referred in which there is a disclosable financial interest, and any HHA or SNF that has disclosable financial interest.

b. The discharge planning evaluation must also include a determination of the availability of the appropriate services as well as of the patient's access to those services.

c. The patient's condition must be re-evaluated and documented every 3 working days at a minimum, or more frequently as changes are identified that impact post-discharge needs and/or the discharge plan.

3.3 Discharge information

a. A transfer summary shall accompany the patient upon transfer to a skilled nursing or intermediate care facility. The transfer summary shall include essential information relative to the patient's diagnosis, hospital course, pain treatment and management, medications, treatments, dietary requirement, rehabilitation potential, known allergies, and treatment plan, and shall be signed by the physician.

b. A copy of the discharge summary shall be given to the patient and the patient's legal representative, if any, prior to transfer to a skilled nursing or intermediate care facility.

c. RUHS shall establish and implement a written policy to ensure that each patient receives, at the time of discharge, information regarding each medication dispensed, pursuant to Section 4074 of the Business and Professions Code.

d. RUHS shall provide every patient anticipated to need long-term care at the time of discharge with contact information for at least one public or nonprofit agency or organization dedicated to providing information or referral services relating to community-based long-term care options in the patient's county of residence and

appropriate to the needs and characteristics of the patient. At a minimum, this information shall include contact information for the area agency on aging serving the patient's county of residence, local independent living centers, or other information appropriate to the needs and characteristics of the patient.

e. A contract between a general acute care hospital and a health care service plan that is issued, amended, renewed, or delivered on or after January 1, 2002, may not contain a provision that prohibits or restricts any health care facility's compliance with the requirements of this section.

f. Discharge planning policies adopted by RUHS in accordance with this section shall ensure that planning is appropriate to the condition of the patient being discharged from the hospital and to the discharge destination and meets the needs and acuity of patients.

g. RUHS is not required to do either of the following:

   i. Adopt a policy that would delay discharge or transfer of a patient.

   ii. Disclose information if the patient has not provided consent that meets the standards required by state and federal laws governing the privacy and security of protected health information.

h. This section does not supersede or modify any privacy and information security requirements and protections in federal and state law regarding protected health information or personally identifiable information, including, but not limited to, the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Sec. 300gg).

i. For discharge planning for individuals experiencing homelessness – refer to Medical Center policy HW 632.1 Discharge Planning – Homeless Patients

3.4 DOCUMENTATION

a. Electronic Medical Record

4. REFERENCES

4.1 eCFR :: 42 CFR 482.43 -- Condition of participation: Discharge planning.

4.2 Centers for Medicare and Medicaid Services [CMS]. (2020). §482.43 Condition of Participation: Discharge planning.

4.3 California Code of Regulations, Title 22, General Hospital, Article 7 Administration (HSC 1262.5 pages 196-198)

4.4 California Department of Public Health, AFL 15-25 Senate Bill (SB) 675: Hospital Discharge Planning and Family Caregivers, December 7, 2015.

4.5 California Health and Safety Code Section 1262.5 Bill Text - SB-675 Hospitals: family caregivers.

4.6 RUHS – Medical Center policy HW 601.5 Healthcare Decision for Unrepresented Patients

4.7 RUHS – Medical Center policy HW 632.1 Discharge Planning – Homeless Patients

4.8 RUHS – Medical Center policy HW 648 Referrals to Other Facilities

4.9 RUHS – Medical Center policy HW 656 EMTALA Screening Stabilizing and Transfer of Patients with Emergency Medical Conditions

Document History:

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Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
1/2024	Integrated Care Management	Y	Updated policy to meet California Health and Safety Code Section 1262.5 amendments (SB No. 675)
8/1/2024	Pre-Nursing P&P	N	Consent Agenda
8/15/2024	Nursing P&P	N	
9/6/2024	PAC	Y	Suggest additional reference

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER

Housewide

	Document No: 642	Page 1 of 3
Title: Administering Seasonal Influenza Vaccine to Patients by Licensed Nurse	**Effective Date:** 7/18/2024	☐ **RUHS – Behavioral Health** ☐ **RUHS – Community Health Centers** ☐ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By:  Jennifer Cruikshank CEO/ Hospital Director		☐ **Policy** ☒ **Procedure** ☐ **Guideline**

1. SCOPE

1.1 This policy and procedure applies to admitted patients at Riverside University Heath Systems – Medical Center. It does not apply to clinics within the Medical Center (refer to clinic-specific policy).

2. POLICY

2.1 A Licensed Nurse may administer the Inactivated Influenza Vaccine as follows:

a. Influenza vaccine season is October 1st through March 31st. If vaccine is available, patient screening and administering may begin in September, and continue beyond March 31st if the virus is circulating, the vaccine is available, and has not expired.

b. Screen all patients to see if they qualify for the influenza vaccine upon admission or prior to discharge during influenza vaccine season.

c. When indicated and appropriate, the influenza vaccine may be given any time prior to discharge

d. Inpatients may only receive inactivated or recombinant seasonal influenza vaccine. Live attenuated influenza vaccine is not administered to inpatients.

e. Age-appropriate seasonal influenza vaccine will be available. Product specific guidelines will be followed per the manufacturer label.

f. Influenza vaccine may be administered concurrently or sequentially with other inactivated vaccines or with live vaccines.

2.2 IF UNSURE whether to administer the influenza vaccine, contact the Licensed Practitioner for clarification and document the Licensed Practitioner's instructions.

3. PROCEDURE

3.1 Assess for vaccination need

a. INCLUSION criteria, as follows when there is an absence of any contraindication:

- Patients aged greater than or equal to 6 months of age
- Women who are pregnant or who might be pregnant in the influenza season are recommended to receive influenza vaccine. Influenza vaccine can be administered at any time during pregnancy.

- People who do not recall whether they received influenza vaccine this year

3.2 Screen patient for potential contraindications. If unsure about whether a condition is a contraindication to receiving the vaccine, discuss with primary medical team and clarify. If the patient refuses vaccination, document “Refused” in the electronic health record.

a. Potential EXCLUSION criteria**:**

- Patient already immunized this flu season
- Severe allergy to eggs (CDC no longer views this as an absolute contraindication), may contact Licensed Practitioner
- Previous severe allergic reaction to influenza vaccine
- History of Guillian-Barre Syndrome
- Patient refusal/declination

3.3 PRECAUTIONS:

a. The Licensed Nurse will consult with the Licensed Practitioner prior to administering the vaccine to persons with moderate-to-severe acute febrile illness as they usually should not be vaccinated until their symptoms have abated. However, minor illnesses with or without fever do not contraindicate use of influenza vaccine.

3.4 Provide all patients with a copy of the most current federal Vaccine Information Statement (VIS). You must document in the patient’s medical record the publication date of the VIS and the date it was given to the patient.

a. Provide non-English speaking patients with a copy of the VIS in their native language, if available. These can be found at www.immunize.org/vis or at www.cdc.gov

3.5 Prepare to administer vaccine.

a. Place order in electronic health record for age-appropriate influenza vaccine. To complete the order, accept and sign “per protocol”.

3.6 Administer the vaccine

a. Age greater than or equal to 36 months. Administer injectable seasonal influenza vaccine intramuscularly in the deltoid muscle.

b. Age greater than or equal to 6 months up to 35 months. Administer injectable seasonal influenza vaccine intramuscularly in the anterior thigh muscle.

3.7 Document each vaccine administration in the designated location in the medical record.

3.8 Adverse Event Reporting

a. Report all adverse reactions to influenza vaccine via hospital incident report system

3.9 Refer to Hospital Wide Policy on Medication Errors and Adverse Drug Reactions 805.

4. REFERENCES

4.1 Grohskopf LA, Blanton LH, Ferdinands JM, Chung JR, Broder KR, Talbot HK. Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices — United States, 2023–24 Influenza Season. MMWR Recomm Rep 2023;72(No. RR-2):1–25. DOI:

http://dx.doi.org/10.15585/mmwr.rr7202a1.

4.2 CMS Conditions of Participation §482.23 ((04/02/24)

4.3 RUHS Medical Center: Housewide Policy 805: Medication Errors and Adverse Drug Reactions

4.4 https:www.immunize.org .Standing orders for Administering Influenza Vaccine to Adults (2023) www.immunize.org/catg.d/p3066.pdf

4.5 Influenza. cdc.gov/flu/index.htm

Document History:

Prior Release Dates: 2/2007, 9/2014, 5/2/2018, 5/11/2021	**Retire Date:** N/A
Document Owner: Nursing House Supervisor	**Replaces Policy:** Nursing Standardized Procedure 431

Date Reviewed	**Reviewed By:**	**Revisions Made Y/N**	Revision Description
2/29/2024	Pre-Nursing P&P	Y	Recommendations to 1.1, 3.2. specified scope to apply to inpatients. Update to new CDC best practice on egg allergy procedure.
4/22/2024	Nursing P&P	N	
5/6/2024	P&T	N	
7/2/2024	PAC	N	
7/11/2024	MEC	N	

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 652	Page 1 of 4
Title: Decedent Affairs	**Effective Date:** . 8/20/2024	☐ **RUHS – Behavioral Health** ☐ **RUHS – Community Health Centers** ☐ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By:  Jennifer Cruikshank CEO/ Hospital Director		☐ **Policy** ☐ **Procedure** ☒ **Guideline**

1. DEFINITIONS

1.1 Decedent: Deceased Patient

1.2 Fetal Death: "intrauterine fetal demise" means a death prior to the complete expulsion or extraction from its mother of a product of conception (irrespective of the duration of pregnancy); the death is indicated by the fact that after such separation, the fetus does not breathe or show any other evidence of life such a beating heat, pulsation of the umbilical cord, or definite movement of voluntary muscles.

2. GUIDELINE

2.1 Purpose

a. Establish a guideline to maintain decedent affairs management for deceased patient remains, including legal documents, and defines responsibilities.

3. Patient Death Notifications to Next of Kin

a. Notification of a patient's death will be provided to the decedent's family/next of kin by the physician responsible for the patient's care at the time of death.
b. Social workers from the Department of Patient and Family Services will be available to provide support to the grieving family.

4. Notification and Documentation of Patient Death

a. The nursing unit staff will notify the Nursing House Supervisor (NHS)/Admissions Nurse (AN) of a patient death by telephone within 1 hour and will follow-up with documentation as detailed in a. through f. below. The patient's remains will be transported to the hospital morgue after postmortem care is completed.
b. Unit notification to the NHS will include the following:
   - Name of patient.
   - Medical Record Number (MR#) of patient (in cases of stillbirth, use the mother's MR#).
   - Date and Time of death.
   - Name of pronouncing physician.
   - Nursing Unit.
   - The decedent's medical records.

c. Nursing will complete the post-mortem flowsheet documentation fields and print Deceased patient record report (deliver to Nursing House Supervisor)
d. The NHS will review the Deceased patient record to ensure that the form is completed accurately and matches the death note.
e. The nursing unit will discharge the deceased patient from the computer system.
f. The NHS will contact the nursing unit for any questions/clarification.
g. If there is no mortuary listed, the NHS will verify with the nursing unit that the family has been notified of the need to make mortuary arrangements within 48 hours.
h. The NHS will record the information onto the Mortuary Log.

5. Fetal Death

5.1 Parental and/or legal guardian decision regarding burial or cremation is required, for fetal death.

5.2 The family always has the option of burial, cremation, or sending the fetus to the lab for proper handling.

6. Autopsy

6.1 If a properly completed written consent for autopsy has been obtained from the legal next of kin, the Authorization for Autopsy form #231 (a double-sided form, including the completed physician worksheet), will be copied and filed in the decedent affairs binder in the Nurse Staffing Office with the Death Notification Form #144.

- The original autopsy authorization will be delivered promptly to the Pathology Department, Monday through Friday, during normal business hours.
- If an autopsy will be postponed, Pathology will notify the NHS/AN of the rescheduled date and time.
- If the legal next of kin requests a private autopsy, refer them to the Coroner's Office at (951) 443-2300 for assistance.

7. Organ Procurement

7.1 In the event of organ procurement, the NHS will be notified by the nursing unit of the patient's death and donor status.

7.2 The Nursing Unit will initiate the **post-mortem flowsheet** at the time the patient is declared brain dead.

7.3 The Nursing Unit/Operating Room will submit the Deceased patient record report to the NHS following delivery of the patient's remains for organ or tissue procurement.

8. Additional Administrative Management Procedures

8.1 Daily the NHS will review the Mortuary Log and follow up on any pending autopsy or mortuary arrangement issues.

8.2 Laboratory will send a copy of the Morgue Log (Pathology Department) to the Nurse Staffing Office weekly.

8.3 The day shift NHS will review and reconcile the Morgue Log and the Death Record with the Nurse Staffing Office Mortuary Log and resolve any pending matters. All

open cases on the Nurse Staffing
Office Mortuary Log will be carried over each day onto a new log sheet until the remains are removed from the morgue.

8.4 For decedents in 2-point soft restraints within 24 hours of death the NHS will reference in the Daily Mortuary Log and document in the medical record the information was placed in the Daily Mortuary Log.

8.5 Medical Records will reconcile, on a daily basis, the Death Record Log with the NHS Mortuary Log.

9. Release of Patient Remains to Mortuary Staff

9.1 All patient remains will be identified by:

- Patient name
- Date of Birth
- MR#

9.2 Mortuary personnel will be referred to the Nurse Staffing Office.

9.3 The NHS will confirm that the patient remains are in the morgue by reviewing the mortuary log and the Deceased patient record report.

9.4 The NHS will verify that there are no pending issues regarding the decedent.

9.5 Patient remains scheduled for autopsy and/or pick-up by the Coroner's Office are not to be released to the mortuary.

9.6 The NHS must have written or verbal authorization from the legal next of kin stating the mortuary selected to handle the arrangements.

9.7 The mortuary will date, time, and sign, for the patient's remains on the Deceased patient record report

9.8 A copy of the Deceased patient record report will be provided to the mortuary staff for claiming the remains from the morgue.

9.9 The Pathology/Laboratory staff will be notified (micro 65295; after 1500 – micro 65300) that the mortuary staff is en route to pick up the patient remains.

9.10 The morgue attendant will complete the documentation on the Mortuary Log as follows:

- Name of mortuary.
- Pick-up date, time, and signature of mortuary staff.
- Any special comments.

10. Referrals to the Public Administrator's Office

10.1 The following circumstances will be cause for automatic referrals to the Public Administrator's Office:

- Patients who cannot be identified; i.e. John/Jane Doe
- Patients who have no identified next of kin.
- Fetal demise or stillborn for which burial is required when the family has declined or failed to make funeral arrangements.

11. Review of Unclaimed Remains

11.1 The Department of Patient and Family Services staff will review the Decedent Affairs Binder in the Nurse Staffing Office daily for unclaimed remains and will contact the family as appropriate to ensure timely removal of remains.

11.2 The Social Worker will:

- Send a letter via post to the next of kin within 4 days of patient expiring if unsuccessful in contacting the family by telephone.
- Forward a copy of the letter to Nurse Staffing Office and Medical Records Department.

11.3 Document in the Decedent Affairs Log all activities attempted, and the results of the efforts made to contact the family/next of kin.

11.4 If there is no response from the patient's family within 10 days of sending the letter, the Patient and Family Services staff will continue attempts to contact the family again by telephone or letter.

11.5 If there continues to be no response from the family after 14 days, the Patient and Family Services staff will contact the Riverside Public Administrator at (951) 443-2300. The Public Administrator's office will require the following information from the patient's medical record:

- Full name
- Date of Birth
- Social Security Number
- Marital status
- Address and phone number
- Name of documented next of kin
- Date and time of death
- Documented efforts to contact the family or next of kin
- Payor status
- Admission information
- Diagnosis
-

12. Downtime Procedure

12.1 **During an EPIC downtime Form #144 "Deceased Patient Record" shall be used in accordance with the procedures listed above.**

Document History:

Release Dates: 3/2/2016	**Retire Date:** N/A
Document Owner: Decedent Affairs Committee	**Replaces Policy:** N/A

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
8/9/2023	Kim Hoyer	Y	Updated language to support digital documentation workflow
11/1/2018	Decedent Affairs Committee	Y	4a. notification to NHS within 1hr 4d. NHS ensures #144 matches death note. (currently not our practice to view medical record to confirm date/time of death) 9.6 include verbal authorization

8/21/2019	Nursing P&P	Y	Minor wording
9/3/2019	Policy Approval Committee	N	

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 653	Page 1 of 3
Title: Autopsy Consent Documentation	**Effective Date:** 7/18/2024	☐ **RUHS – Behavioral Health** ☐ **RUHS – Community Health Centers** ☐ **RUHS – Hospital Based Clinics** ☐ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By:  Jennifer Cruikshank CEO/ Hospital Director		☐ **Policy** ☐ **Procedure** ☐ **Guideline**

1. DEFINITIONS

1.1 **Autopsy** is defined as a medical procedure and service performed by physicians specializing in pathology that examines a body after death to confirm the cause of death or the extent of changes produced by a disease.

1.2 **Protected Health Information (PHI):** Protected Health Information (PHI) is defined as verbal, written, or electronic information which is created or maintained by RUHS – Medical Center and identifies the individual patient. Patient PHI includes, but is not limited to:

a. The patient's presence or location in the hospital.

b. Demographic information, such as name, age, date of birth, address, telephone and/or fax number, email, income; Social Security Number, account number, driver's license number, health plan, and/or medical record number.

c. Information about the patient's medical condition, diagnostics/testing, treatment, and prognosis.

d. Photographs/images of a patient, fingerprints, and/or unique identifying characteristics.

2. RESPONSIBILITIES

2.1 The Attending Physicians are responsible for:

a. Attempting to secure autopsies in cases of unusual deaths and of medical-legal and educational interest.

b. Obtaining and ensuring the proper documentation of consent authorization for a patient autopsy.

2.2 The Pathologists are responsible for:

a. Performing all in-hospital autopsies for which proper authorization has been obtained.

3. PROCEDURES

3.1 Any of the following persons, in no specific order of priority, may authorize and consent to a postmortem examination and autopsy on a decedent's body:

a. An individual who has been appointed an agent in the decedent's power of attorney for health care;
b. The surviving spouse or registered domestic partner;
c. A surviving child or parent;
d. A surviving sibling;
e. Any other kin or person who has acquired the right to control the disposition of the remains;
f. A public administrator;
g. A coroner or any other duly authorized public officer.

3.2 Autopsy Requests from Family

b. The family must speak to the attending physician.
c. Staff shall provide the family with the Coroner's Office phone number (951) 443-2300 for assistance.

3.3 Documenting Authorization/Permission

a. All autopsies require a completed *Authorization for Autopsy* form before the procedure may be performed.
   - Upon receiving the *Authorization for Autopsy*, the Attending Physician shall notify the Pathologist that permission has been obtained and the completed authorization form shall be delivered to the Chief of Pathology during business hours.
   - A copy of the authorization form shall be filed in the Nurse Staffing Office.
   - A copy of the authorization form shall be given to the authorizing party, if requested.
   - A copy of the authorization form shall be filed in the patient's medical record.

b. Verbal authorization from the responsible relative or legally authorized agent may be obtained by telephone by the attending physician and documented in the patient's medical record.
   - A verbal/written authorization is invalid if it is made known that the deceased was, at the time of his or her death, a member of a religion, church, or denomination which relies solely upon prayer for the healing of disease.

c. Efforts to obtain an authorization for an autopsy shall be documented in the patient's medical record

4. REFERENCES:

4.1 42 CFR §482.22, Conditions of Participation: Medical Staff.
4.2 45 CFR §164.512, Privacy of Individually Identifiable Health Information
4.3 The Joint Commission, Comprehensive Accreditation Manual for Hospitals, Update 2, September 2011, MS.05.01.0, PI.03.01.01.
4.4 CA Health and Safety Code. Article 3. Responsibility of Coroner [102850 - 102870]
4.5 RUHS – Medical Center Policy HW 652 Decedent Affairs
4.6 RUHS –Medical Center Department of Clinical Laboratory and Pathology Policy No. 3.1
4.7 California Government Code Title 3 Government of Counties. Article 2. Inquests [27490 - 27512]

Document History:

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Document Owner: Pathology	**Replaces Policy:** N/A

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
01/31/24	Decedent Affairs Committee	No	
4/22/2024	Nursing P&P	No	
7/2/2024	PAC	No	

RIVERSIDE UNIVERSITY HEALTH SYSTEM
Housewide

	Document No: 654	Page 1 of 3
Title: Adverse Events	**Effective Date:** 7/18/2024	☐ **RUHS – Behavioral Health** ☒ **RUHS – Community Health Centers** ☒ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By:  Jennifer Cruikshank CEO/ Hospital Director		☐ **Policy** ☒ **Procedure** ☐ **Guideline**

1. DEFINITIONS

1.1 Adverse Event: unintended physical injury resulting from or contributed to by medical care that requires additional monitoring, treatment or hospitalization, or that results in death.

1.2 Action Hierarchy: a tool to assist teams in identifying which actions will have the strongest effect for successful and sustained system improvement.

1.3 Root-Cause Analysis (RCA) is a process for identifying the basic or contributing causal factor(s) that underlies variation in performance associated with adverse events or close calls.

1.4 Contributing Factor: Contributing factors are additional reasons, not necessarily the most basic reason that an event has occurred.

1.5 Corrective Action Plan (CAP): the end product of the comprehensive systematic analysis. The CAP identifies the strategies that RUHS intends to implement to reduce the risk of similar events occurring in the future.

1.6 Just Culture: Applies the principles of shared accountability to drive continuous learning and improvement through:

a. Organizational accountability for systems designs and how the system processes response to errors in way that is fair, predictable, and replicable.

b. An organizational culture that holds individuals accountable for the quality of their choices.

1.7 Never Event: A Never Event is defined as one of the “Adverse Event” occurrences as listed by California Health and Safety Code Section 1279.1 and one of the 29 “Serious Reportable Events in Healthcare” as listed by the National Quality Forum’s (NQF) that could negatively impact patient care and safety.

1.8 Sentinel Event. A patient safety event (not primarily related to the natural course of a patient’s illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of duration of harm) or permanent harm (regardless of severity of harm)

2. POLICY

2.1 Riverside University Health System (RUHS) is committed to enhancing organizational learning by designing a system’s process for careful identification, investigation, and analysis

of patient safety events to understand the root cause(s) associated with an event/error, and to incorporate Human Factors Analysis (HFAC) methodology to inform the development of an effective and sustainable corrective action

3. PROCEDURES

3.1 Response to an adverse event shall include the following:

a. Immediately:

- The relevant care team provides a response that stabilizes the patients, discloses the event to the patient and family, and provides support for the family as well as staff involved in the event.
- Immediate Notification of organization leadership
- Adverse Event Checklist (Attachment 1)

b. Follow mandatory requirements for reporting:

- The Chief Clinical Integration Officer and/or the Compliance Officer will coordinate with the Chief Operating Officer (COO), Chief Nursing Officer (CNO), Chief Medical Officer (CMO), and Chief Executive Officer (CEO) to ensure that the California Department of Public Health (CDPH) receives the report within:
    - Twenty-four (24) hours of detection if the Never Event IS an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors.
    - Five (5) days of the detection of the Never Event if the event is NOT an ongoing threat to the welfare, health or safety of other patients, personnel, or visitors.

c. Within 45 days of an event that is substantiated and meets the definition of a sentinel event in section 4.2 above will require completion of a comprehensive systematic analysis. If the event does not meet the definition of a sentinel event, the event shall nevertheless be considered a patient safety event. The following actions are taken for sentinel events:

- Completion of a comprehensive systematic analysis for identifying the causal and contributory factors such as a root cause analysis (RCA).Strong corrective actions derived from the identified causal and contributing factors that eliminate or control system hazards or vulnerabilities and result in sustainable improvements over time.
- Timeline for implementation of corrective actions
- Determine systemic improvement with measurable outcomes.

3.2 RUHS medical center will hold billing during the investigation period.

3.3 A copy of this policy will be made available to patients, patients' family members, and payers upon request.

3.4 Oversight of events:

a. Performance Improvement Patient Safety Committee (PIPSC)

b. Medical Executive Committee (MEC)

c. Executive Leadership Safety Event Committee

3.5 All documentation of findings, records, and proceedings, including the RCA and any action plans developed as part of performance improvement activities, will be confidential and protected under California Evidence Code Section 1157.

4. REFERENCES

4.1 The Joint Commission, Comprehensive Accreditation Manual for Hospitals (CAMH), Sentinel Event Policy. 2022. Accessed via https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/sentinel-event-policy/camh_24_se_all_current.pdf

4.2 USDepartmentofVeteransAffairsNationalCenterforPatientSafety.2021GuidetoPerforminga RootCauseAnalysis.

4.3 Wood LJ, Wiegmann DA. Beyond the corrective action hierarchy: A systems approach to organizational change. Int J Qual Health Care. 2020 Sep 23;32(7):438-444. doi: 10.1093/intqhc/mzaa068. PMID: 32578858; PMCID: PMC7654382.

4.4 RUHS policy HW 610 Reporting Never Events.

5. ATTACHMENTS

5.1 ADVERSE EVENTS CHECKLIST

5.2 LIST OF NEVER EVENTS (PSNet)

5.3 ACTION HEIARCHY

Document History:

Prior Release Dates: 5/1997, 3/2007, 10/2008, 6/1/16, 7/10/2019, 2/10/2023	**Retire Date:** N/A
Document Owner: Regulatory	**Replaces Policy:** Replaces 610 Reporting Never Events

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
03/21/2024	RUHS Cares Committee, Director Regulatory, Director Quality, Patient Safety Officer	Y	Combine elements of HW 610 and HW654. Update Event checklist, reformat never 29 list, add oversight committee, specify billing procedures for hold, incorporate just culture and early resolution principals.
5/2/2024	Pre-Nursing P&P	Y	Minor formatting and add revision date to adverse event checklist
5/16/2024	Nursing P&P	N	Consent Agenda Item
7/2/2024	PAC	N	

Riverside University HEALTH SYSTEM

Adverse Event Checklist

Pt Initials & MRN: _____

Date/Time of Incident: _____ Type of Incident: _____

Location of Incident: _____ Completed by: _____

Adverse Event: unintended physical injury resulting from or contributed to by medical care that requires additional monitoring, treatment, or hospitalization, or that results in death.

ACTIONS TAKEN

☐ Provide immediate intervention to patient to minimize harm. **TIP**: Immediate actions may include assigning a sitter for the patient, moving the patient's room, getting a CT scan ordered stat, etc.

☐ Ensure the immediate needs of caregivers are met.

☐ Assess the environmental context, noting all people present, IV medication lines, and equipment. **TIP:** Observe the built environment, including lines-of-sight, visual clutter, and the distances between workers and equipment, supplies, and information. Note ambient noise, lighting, and temperature. How busy is the area in which the event occurred? (patient census/volume and acuity, co-occurrence of other distracting events)

☐ Physical Evidence: Save any consumable (disposable) items such as IV tubing, blood transfusion bags, and medication containers. Sequester/confiscate any biomedical device involved in the event, preserving all settings and taking it out of service until it is interrogated, and its safe operation verified by Biomedical Engineering. Collect rhythm strips, paper lab reports, or other paper documents that may be lost or destroyed.

☐ Workforce: Note the names of potential witnesses, including ancillary staff who might have participated in the initial response and since left. Obtain written statements from all involved immediately after the event.

☐ **Immediately** initiate chain of command to notify of the event *notification date/time:*_____

☐ Director/ANM/House Supervisor will notify the Executive Director/Administrator on Call (AOC).

☐ Director/ANM/Charge nurse to notify physician and document the notification in the EMR.

☐ Physician should document via a progress note in the EMR, including family notification. (Refer to RUHS Policy# 601.6)

☐ Director/ANM/Charge Nurse to review EMR to ensure all documentation is complete (i.e. code sheets, flow sheets, assessments, and applicable narrative notes).

☐ Director/ANM/Charge Nurse will start preparing a timeline of events up to the event, and post event actions.

☐ Director/ANM/Charge Nurse to complete a RUHS incident report (IR) as soon as possible after the event.

☐ Director/ANM/Charge Nurse debrief with staff involved.

☐ Director/ANM/Charge Nurse notify Hospital Patient Advocate.

☐ Director/ANM/Charge Nurse notify Risk Management (Quality Management)

☐ Investigate and prepare timeline (Regulatory & Quality)

☐ If appropriate, notify Life Safety and/or Emergency Management

ATTACHMENT 2: REPORTABLE ADVERSE EVENTS
Health and Safety Code, Section 1279.1 (b) (1) – (7)

Surgical events, including the following:

A. Surgery performed on a wrong body part that is inconsistent with the documented informed consent for that patient. A reportable event under this subparagraph does not include a situation requiring prompt action that occurs in the course of surgery or a situation that is so urgent as to preclude obtaining informed consent.

B. Surgery performed on the wrong patient.

C. The wrong surgical procedure performed on a patient, which is a surgical procedure performed on a patient that is inconsistent with the documented informed consent for that patient. A reportable event under this subparagraph does not include a situation requiring prompt action that occurs in the course of surgery, or a situation that is so urgent as to preclude the obtaining of informed consent.

D. Retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained.

E. Death during or up to 24 hours after induction of anesthesia after surgery of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.

Product or device events, including the following:

A. Patient death or serious disability associated with the use of a contaminated drug, device, or biologic provided by the health facility when the contamination is the result of generally detectable contaminants in the drug, device, or biologic, regardless of the source of the contamination or the product.

B. Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. For purposes of this subparagraph, "device" includes, but is not limited to, a catheter, drain, or other specialized tube, infusion pump, or ventilator.

C. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.

Patient protection events, including the following:

A. An infant discharged to the wrong person.

B. Patient death or serious disability associated with patient disappearance for more than four hours, excluding events involving adults who have competency or decision making capacity.

C. A patient suicide or attempted suicide resulting in serious disability while being cared for in a health facility due to patient actions after admission to the health facility, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the health facility.

Care management events, including the following:

A. A patient death or serious disability associated with a medication error, including, but not limited to, an error involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose.

B. A patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products.

C. Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a facility, including events that occur within 42 days postdelivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy.

D. Patient death or serious disability directly related to hypoglycemia, the onset of which occurs while the patient is being cared for in a health facility.

E. Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life. For purposes of this subparagraph, "hyperbilirubinemia" means bilirubin levels greater than 30 milligrams per deciliter.

F. A Stage 3 or 4 ulcer, acquired after admission to a health facility, excluding progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admission.

G. A patient death or serious disability due to spinal manipulative therapy performed at the health facility.

Environmental events, including the following:

A. A patient death or serious disability associated with an electric shock while being cared for in a health facility, excluding events involving planned treatments, such as electric countershock.

B. Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by a toxic substance.

C. A patient death or serious disability associated with a burn incurred from any source while being cared for in a health facility.

D. A patient death associated with a fall while being cared for in a health facility.

E. A patient death or serious disability associated with the use of restraints or bedrails while being cared for in a health facility.

Criminal events, including the following:

A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider.

B. The abduction of a patient of any age.

C. The sexual assault on a patient within or on the grounds of a health facility.

D. The death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility.

An adverse event or series of adverse events that cause the death or serious disability of a patient, personnel, or visitor.

ATTACHMENT III: ACTION HEIARCHY

	ACTION CATEGORY	EXAMPLE
Stronger actions (these tasks require less reliance on humans to remember to perform the task correctly)	Architectural/physical plant changes	Replace revolving doors at the main patient entrance into the building wit powered or swinging doors to reduce patient falls.
	New devices with usability testing	Perform heuristic tests of outpatient blood glucose meters and test strips and select the most appropriate for the patient population being served
	Engineering control (forcing function)	Eliminate use of universal adaptors and peripheral devices for medical equipment and use tubings/fitting that can only be connected the correct way (eg. IV tubing and connectors that cannot physically be connected to sequential compression devices or SCDs).
	Simplify process	Remove unnecessary steps in a process
	Standardize on equipment or process	Standardize on the make and model of medication pumps used throughout the institution. Use bar coding for medication administration.
	Tangible involvement by leadership	Participate in unit patient safety evaluations and interact with staff; support the RCA2 process; purchase needed equipment; ensure staffing and workload are balanced.
Intermediate actions	Redundancy	Use two RNs to independently calculate high-risk medication dosages
	Increase in staffing/decrease in workload	Make float staff available to assist when workloads peak during the day
	Software enhancements, modifications	Use computer alerts for drug-drug interactions.
	Eliminate/reduce distractions	Provide quiet rooms for programming PCA pumps; remove distractions for nurses when programming medication pumps.
	Education using simulation-based training, with periodic refresher sessions and observations	Conduct patient hand-offs in a simulation lab/ environment, with after action critiques and debriefing.
	Checklist/cognitive aids	Use pre-induction and pre-incision checklists in operation rooms. use a checklist when reprocessing flexible fiber optic endoscopes.
	Eliminate look- and sound-alikes	Do not store look-alikes next to one another in the unit medication room.
	Standardized communication tools	Use read-back for all critical lab values. Use red-back or repeat-back for all verbal medication orders. Use a standardized patient hand-off format.
	Enhanced documentation, communication	Highlight medication name and does on IV bags.

Weaker actions (these tasks require more reliance on humans to remember to perform the task correctly)	Double checks	One person calculates dosage, another person reviews their calculation.
	Warnings	Add audible alarms or caution labels.
	New Procedure/ memorandum/ policy	Remember to check IV sites every 2 hours.
	Training	Demonstrate correct usage of hard-to-use medical equipment.

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER
Housewide

	Document No: 678	Page 1 of 18
Title: Blood Transfusions	**Effective Date:** 7/18/2024	☐ **RUHS – Behavioral Health** ☐ **RUHS – Community Health Centers** ☐ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By:  Jennifer Cruikshank CEO/Hospital Director		☐ **Policy** ☐ **Procedure** ☒ **Guideline**

1. SCOPE

1.1 The scope of this guideline is to outline within Riverside University Health System (RUHS) practice standards for processing and safe administration of blood transfusion in accordance with current practice guidelines for all clinical staff who perform blood transfusions and/or blood component transfusions.

1.2 For Pediatrics and Neonates, where the term patient or authorized surrogate is used it is understood that a parent or legal guardian applies.

2. DEFINITIONS

2.1 **Blood Volume** - Is defined as approximately 60ml/kg to 80ml/kg in adult patients, 70ml/kg to 90ml/kg in pediatric patients, and 90ml/kg to 100ml/kg in neonatal patients.

2.2 **Emergency Release** – is a process of dispensing un-crossmatched blood at the physician's request due to a life-threatening emergency or major traumatic injury.

2.3 **Informed consent** – Agreement or permission accompanied by full notice about the care, treatment, or service that is the subject of the consent. A patient must be apprised of the nature, risks, and alternatives of a medical procedure or treatment before the physician or other health care professional begins any such course. After receiving this information, the patient/authorized surrogate then either consents to or refuses such a procedure or treatment.

2.4 **Licensed Practitioner (LP)** – An individual as permitted by law and regulation and also by the organization, to provide care and services without direction or supervision within the scope of the individual's license and consistent with the privileges granted by the organization.

2.5 **Massive Blood Transfusion Protocol (MTP)** – Is defined as the replacement of a patient's (Adult, Pediatric) total blood volume within the first 12 hours of transfusion (Referenced per RUHS – MC policy HW 604.2 Massive Transfusion).

2.6 **Patient Identifiers** – Information directly associated with an individual that reliably identifies the individual as the person for whom the service or treatment is intended. Acceptable identifiers may be the individual's name, an assigned

identification number (Medical Record Number), date of birth, or other person-specific identifier.

2.7 **Obstetrics/Post-Partum (OB/PP) Blood Response –** Is defined as a blood transfusion for any obstetric patient with continued bleeding after initial measures have failed to stop the bleeding.

3. PROCEDURE

3.1 All blood and blood component requests must be legible, accurate and complete with two independent identifiers for correct recipient identification.

3.2 Pre-Procedure:

a. Compliance with the Gann Act (California Health and Safety Code 1645) mandates that every physician who determines that there is reasonable possibility that his/her patient may require a blood transfusion must provide the patient with the legal document "A Patient's Guide To Blood Transfusion" Found here: https://www.mbc.ca.gov/Resources/brochures/blood-transfusions.aspx

b. Transfusionists shall ask about previous transfusions and reactions and notify the Physician and Blood Bank if previous transfusions or reactions have occurred.

c. Provide education to the patient or authorized surrogate decision maker. If the patient will not be monitored in a clinical setting post transfusion, provide written instructions for transfusion reaction monitoring.

d. Baseline Assessment: includes measurement of vital signs (blood pressure, heart rate, temperature, respiratory rate, oxygen saturation). Assessment should include symptoms of transfusion reaction such as urticaria, pruritus, edema, chest pain, dyspnea, wheezing and chills.

3.3 Compatibility Testing:

a. RN to obtain Specimen for compatibility testing and place in the appropriate specimen collection tube. Specimens must be collected three days prior to initiating the transfusion.

b. Patient Verification is acceptable by either;

i. Independent dual verification by two staff members of patient identification and specimen labeling. Staff shall initial label to indicate. This should be performed in the presence of the patient.

ii. Blood Bank approved electronic identification system (bar code scanning) of patient and specimen label in the presence of the patient.

c. Cross Match Band: Place Blood Bank armband with the corresponding crossmatch numbers. If the wrist is not available, may be attached to the patient's ankle. Date and time can serve as an indicator of expiration for subsequent care teams

d. Second determination of compatibility testing (second collection)

i. Blood bank will notify nursing units when a second draw is required. A

retype order will be entered. (AABB Standard 5.14.5).

ii. During blood bank system down time all patients will require second determination of compatibility

3.4 Dispensing of Blood/Blood Components

a. For routine/crossmatched products: The RN/transfusionist will release the order from the blood administration module in EPIC, print the release form and write the crossmatch number (obtained from the patient's crossmatch armband.)

b. For emergent/non crossmatched products: see attached workflow, bring patient labels to blood bank and affix to Form #665

c. Only 1 blood product unit may be retrieved at a time (Exception: Operating Room (OR), Post Anesthesia Care Unit (PACU), Emergency Department (ED), Labor and Delivery (L&D), and Adult Critical Care Unit (ACCU).

i. Blood products (excluding Platelets and Cryoprecipitate) may be released in blood bank issued cooler. The cooler is a holding and transportation unit designed to maintain and monitor blood products within a 1 to 6°C temperature range for 24+ hours.

d. Transfusion service staff (lab) and RN/designee will verify:

i. Forms, tags, and label identification must have identical information.
- Patients Full Name
- Medical Record Number
- Date of Birth
- Patients Blood Type or confirmation type is unknown
- Donor Blood Type
- Donor Unit Number
- Expiration date of donor unit

Recipient ABO type	ABO Compatible RBC Units	ABO Compatible Plasma or Platelet Units
O	O	A, B, O, AB
A	A, O	A, AB
B	B, O	B, AB
AB	A, B, O, AB	AB

e. If the blood or blood product is NOT going to be transfused, it must be returned to the Blood Bank within the first thirty (30) minutes from the time that it was released from Blood Bank for the purpose of maintaining an appropriate temperature to allow re-issue.

i. Exception: if the blood products are released in a blood cooler.

3.5 Administration of Blood

a. Refer to Elsevier Blood Product Administration for clinical skill detail.

b. Administer prophylactic medication if applicable.

   i. Oral premedication should be administered 30 minutes before transfusion start

   ii. IV premedication should be administered within 10 minutes of transfusion start

c. Prepare equipment: blood warmer (if applicable), infusion system, syringe infusion pump, IV access, infusion set with compatible IV solution (0.9% Normal Saline).

d. Verification at the time of Administration: Two licensed staff (e.g.: two RNs; one RN and an LVN; one RN and a physician; or two physicians) shall verify <u>in the presence of the</u> <u>patient, the following:</u>

   i. Physician order for transfusion and consent to transfuse.

   ii. Intended recipient/Patient's name, DOB, MRN, Cross match number, ABO group and Rh type.

   iii. Donation identification number, Donor ABO group and if required donor, Rh type.

   iv. Special transfusion or blood component processing requirements.

   v. Components expiration date and if applicable, time.

   vi. The date and time of issue. (infusion must begin within 30 minutes of issue time)

   vii. Final visual inspection of the product.

e. Upon verification the transfusionist and independent verifier shall complete the Transfusion Record Form #625 or #665 Emergency Release Form.

f. Starting the Transfusion: Transfusion should be started slowly for first 15 minutes (1-2mL/min; not faster than 120 mL/hr) and then rate can be increased to as fast as tolerated and routine transfusion should not exceed 300mL/h. Slower rates recommended for patients at risk for circulatory overload. Faster rates of infusion, applicable to hemorrhagic shock are at the discretion of the treatment team and not within the scope of this guideline.

g. Observe for a transfusion reaction and measure vital signs within 15 minutes

h. After the first 15 minutes if no adverse events are suspected the rate of transfusion should be increased and must be completed within 4 hours of the start of the transfusion. However, the patients size, blood volume and hemodynamic condition should be taken into consideration in determining flow rate.

i. Monitoring during the transfusion: periodically monitor the patient throughout the infusion including IV site

j. Vitals signs should be taken before, 15 minutes after initiation and after transfusion. Vital signs should be taken immediately if there is a suspected transfusion reaction or change in the clinical condition of the patient

k. Suspected Transfusion Reactions:

i. Transfusion reactions symptoms may include;

- Fever ≥1 C rise in temperature to ≥38 C,
- Chills with or without rigors
- Respiratory distress, including wheezing, coughing, hypoxia, dyspnea
- Hyper or hypotension
- Abdominal, chest, flank, or back pain
- Pain at the infusion site
- Skin manifestations: rash, flushing, urticaria, pruritus, and localized edema
- Nausea/Vomiting

ii. Patient Focused Steps;

- Stop transfusion immediately, keep line open
- Perform clerical recheck between patient and the components.
- Consult with clinical team for a plan of care
- Identify and complete additional diagnostic steps to investigate in collaboration with blood bank.

iii. Component focused Steps;

- Contract blood bank for directions on investigating potential causes of the reaction
- Obtain instructions for returning any remaining component, associated intravenous fluid bags and tubing
- If transfusion reaction is confirmed, order a Transfusion Reaction Investigation (LAB4734), draw one pink top tube of blood and send to the Blood Bank.

3.6 Special Considerations when administer blood products via syringe (neonates, infants, and small pediatrics. Patients receiving less than a full unit):

a. Connect Y tubing to the appropriate syringe on “Y” and to extension

tubing on bottom end.

b. Spike blood component: ensure extension tubing remains closed

c. Aspirate full volume of bag into syringe

d. Clamp tubing to bag and open clamp for extension tubing

e. Prime tubing with blood product

f. Turn off and disconnect IV fluids if infusing in IV line to be used for blood component administration.

g. Flush line with 0.9% sodium chloride solution

h. Connect syringe to IV pump designated for blood transfusion

i. Connect IV tubing to child's IV line

j. Open clamp to blood component

k. Start pump. Unless otherwise specifically indicated by the child's clinical condition.

l. Observe patients closely for the first 15 minutes and take vital signs

3.7 Completing the Transfusion

a. Assess vital signs in addition to the stop date/time and volume received.

b. Discard the empty blood container and tubing in a biohazard container

3.8 Document all required information on:

a. EPIC activity for blood administration

b. Forms issued with product Transfusion Record Form #625 or #665 Emergency Release Form.

c. Documenting "See EHR" is acceptable when elements of the transfusion are imbedded in the electronic health record workflow.

d. In case of Electronic Health Record downtime, the downtime process is as follows:

i. LP to write transfusion order on downtime order form

ii. Nurse to complete downtime form #630 and send with blood sample to blood bank for compatibility testing.

iii. When blood is ready to transfuse, Nurse to complete form #8 and send to blood bank. The specific unit is released with a copy of form #630 to be completed during transfusion process.

4. REFERENCES

4.1 AABB Standards for Blood Banks and Transfusion Services, 33rd Edition, 2022.

4.2 Elsevier, Clinical Nursing Skills, Blood Product Administration

4.3 Elsevier, Clinical Nursing Skills, Blood Product Administration (Pediatrics)

4.4 The Joint Commission**,** clabsi_toolkit_tool_3-22_cvc_maintenance_bundles.pdf (jointcommission.org), February 2023.

4.5 RUHS Housewide Policy 604.2, Massive Transfusion

4.6 RUHS Housewide Policy 606.1 Consent for Blood Transfusion Paul Gann Act

4.7 RUHS Nursing Policy 610, Specimen Labeling Policy

5. ATTACHMENTS

5.1 Transfusion Record Form 625

5.2 Emergency Release Blood Product Workflow

5.3 Authorization to Release Blood Products, Form 8, (Downtime Form)

5.4 Crossmatch Administration Request, Form 630 (Downtime form)

5.5 Emergency Release of Blood, Form 665

5.6 Emergency Release of Blood, Form 665 (Downtime Form)

Document History:

Prior Release Dates: 8/17/16, 5/10/2018, 8/26/2019, 7/20/2023	**Retire Date:** N/A
Document Owner: Nursing Director Trauma Services	**Replaces Policy:** N/A

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
3/15/2024	Nursing	Y	Major changes, revise section order, update create emergency workflow attachment, add nursing assessment frequency during transfusion, add electronic verification
4/22/2024	Blood and Tissue Committee	N	
6/4/2024	Policy Approval Committee	N	
7/11/2024	MEC	N	

Transfusion Record Form # 625

TEST, RUHOTX
MR No: **20023931** Acct #: 108834
LOC: RANA-A1301 ABO/Rh: **O Pos** DOB: 04/10/1985
Specimen Draw Date/Time: 07/21/2022, 13:09
Special Needs: KNEG
Patient Antibodies: C, WRM

Unit No: **W126622027986** O
Product ABO/Rh: **O Pos**
Product: E2720V00 - FFP CP2D
570

Expiration Date/Time: 07/26/2022, 23:59
Blood Unit Antigens: CMV -

Crossmatch #: E264499
Crossmatch Interpretation: Not Required
Tech Id: E264499 Product Selection: 07/21/2022 14:44
Product Issued Date/Time:
Comments:
PTAG180

TRANSFUSION RECORD

State Law requires that the women tested be informed as to the rhesus (Rh) typing test results.

BLOOD/COMPONENTS MUST BE RETURNED TO BLOOD BANK WITHIN 30 MINUTES IF NOT TRANSFUSED OR STORED IN A COOLER.

BLOOK

VERIFICATION OF:
- ☐ Patient's Name, DOB, and M.R. No. against Patient's wristband
- ☐ Patient and Donor ABO/Rh
- ☐ Donor No. and Expiration Date on all Forms and Labels
- ☐ Paul Gann consent on file (Form 163)
- ☐ Crossmatch Number: _____ PT. UNIT_____

_____
Signature of person starting transfusion (Print name, date, and time)

_____
Signature of person verifying transfusion (Print name, date, and time)

_____
Signature of person completing/stopping transfusion (Print name, date, and time)

Date/Time Started:			Date/Time Stopped:
AMT Given:	ALL	3/4	1/2	1/4

VITAL SIGNS	Temp.	Pulse	B/P
Pre-Txn			
15 min. vitals			
Post-Txn within 1 hour			

Transfusion Reaction: ☐ Yes ☐ No (If YES, check all symptoms that are present)

☐ Chills	☐ Hypotension/Shock	☐ Hemoglobinuria
☐ Nausea/Vomiting	☐ Hypertension	☐ Abnormal Bleeding
☐ Pain (chest/back/arm)	☐ Hematuria	☐ Oliguria/Anuria
☐ Dyspnea	☐ Jaundice	☐ Heat at Infusion Site
☐ Elevated Temperature	☐ Facial Flushing	☐ Edema Pulmonary/Peripheral
☐ Other:		

Department of Clinical Laboratory & Anatomic Pathology • Bing Wang, M.D., Pre-Transfusion Medical Director
Riverside University Health System Medical Center • 26520 Cactus Ave., Moreno Valley, Ca 92555

SEE REVERSE FOR INSTRUCTIONS IF PATIENT REACTS ADVERSELY TO TRANSFUSION

Form # 625 Rev. 06/19 Original – Medical Record • 2nd – Blood Bank

AT THE FIRST SIGN OF AN ADVERSE REACTION:

1. **STOP TRANSFUSION IMMEDIATELY!**
2. Keep IV open with slow saline drip, but use a new administration set to avoid infusing the blood remaining in the original set.
3. Check for agreement of all identifying names and numbers on donor unit, transfusion record and patient wristband.
4. Notify the attending physician and the Blood Bank at once and describe symptoms.
5. Send the following to the Blood Bank STAT:
   - Pink top tube drawn atraumatically to avoid hemolysis
   - An order for a Transfusion Reaction Workup.
   - Remainder of the unit with attached IV set tied off and needles removed. (Avoid contaminating the unit as it may need to be cultured).
   - "Blood Bank" copy of the completed Transfusion Record.
   - At Blood Bank's request, first voided urine marked "Post Transfusion".

NOTE: "Signs and symptoms suggestive of mild allergic reactions (eg. urticaria) need NOT be reported to the blood bank or transfusion service." (Section 7.4.1.2 25th ed. AABB Standards, 2008)

Emergency Release Blood Product Workflow

Emergency Release Process

Step	Action
1.	Call Blood Bank x65266
2.	Time required for blood
3.	Provide the patient's name and MRN *Exception: Inbound Trauma Activation*
4.	Indicate the blood component and amount required or indicate Trauma Cooler
5.	Provide patient's age and sex
6.	Provide the number and name of the ordering physician
7.	Indicate the location of the patient
8.	Verify or correct when orders are read back to assure accuracy
9.	Send staff to collect blood with sheet of patient labels
10.	Collect pre-transfusion specimen (if not already in blood bank)

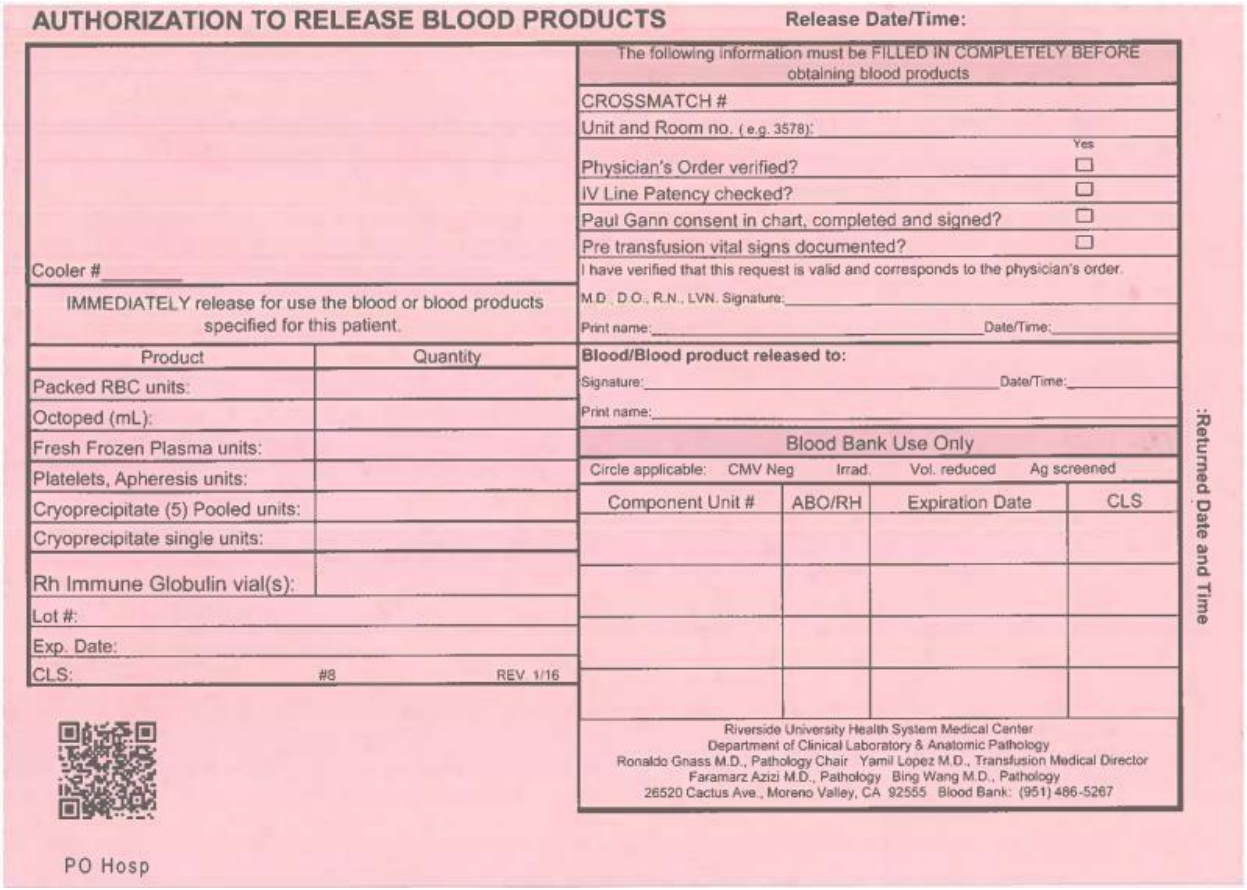
Blood Availability:

Immediate	10-30 minutes from receipt of sample in Lab	>30 minutes from receipt of sample in Lab
O Type (+ or -) blood	Group Specific uncross matched Blood	Crossmatched Blood

Emergency Release Documentation

- The Transfusion Record Form #655, emergency released units will contain the caution that the blood is being released on an emergency basis.
- The physician authorizing the emergency release must sign the Emergency Request section of the Blood Bank Requisition Form and return it to the Blood Bank.
- Blood specimens and requisitions must be appropriately labeled. Many hemolytic transfusion reactions have occurred under emergency conditions when routine patient identification procedures are ignored or circumvented.
- The Blood Bank will complete testing and notify the physician of the results of testing.

Authorization to Release Blood Form # 8 (Downtime form)



AUTHORIZATION TO RELEASE BLOOD PRODUCTS **Release Date/Time:**

Cooler #_____

IMMEDIATELY release for use the blood or blood products specified for this patient.

Product	Quantity
Packed RBC units:	
Octoped (mL):	
Fresh Frozen Plasma units:	
Platelets, Apheresis units:	
Cryoprecipitate (5) Pooled units:	
Cryoprecipitate single units:	
Rh Immune Globulin vial(s):	
Lot #:	
Exp. Date:	
CLS:	

#8 REV. 1/16

PO Hosp

The following information must be FILLED IN COMPLETELY BEFORE obtaining blood products

CROSSMATCH #

Unit and Room no. (e.g. 3578):

	Yes
Physician's Order verified?	☐
IV Line Patency checked?	☐
Paul Gann consent in chart, completed and signed?	☐
Pre transfusion vital signs documented?	☐

I have verified that this request is valid and corresponds to the physician's order.

M.D., D.O., R.N., LVN. Signature:_____

Print name:_____ Date/Time:_____

Blood/Blood product released to:

Signature:_____ Date/Time:_____

Print name:_____

Blood Bank Use Only

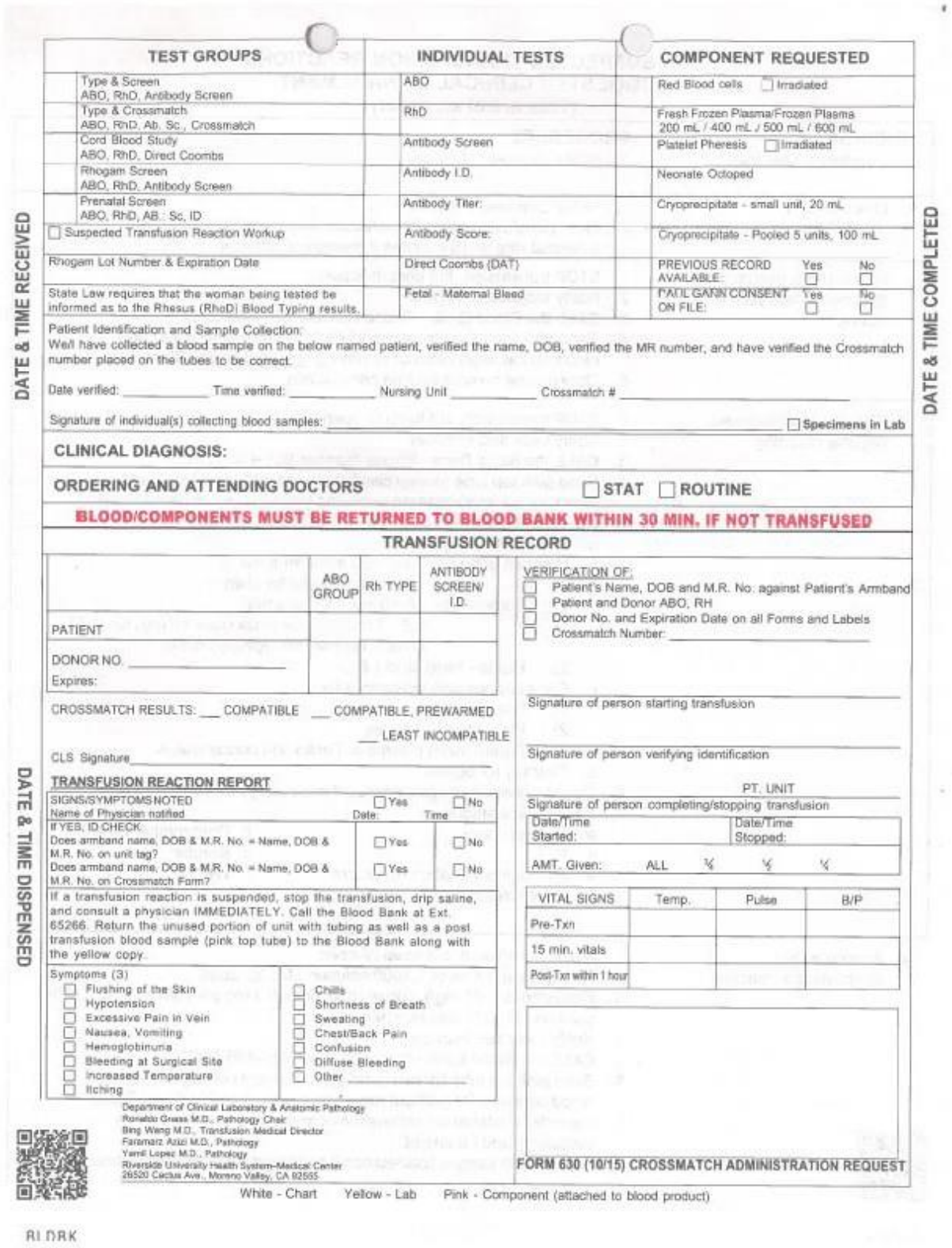
Circle applicable: CMV Neg Irrad. Vol. reduced Ag screened

Component Unit #	ABO/RH	Expiration Date	CLS

Riverside University Health System Medical Center
Department of Clinical Laboratory & Anatomic Pathology
Ronaldo Gnass M.D., Pathology Chair Yamil Lopez M.D., Transfusion Medical Director
Faramarz Azizi M.D., Pathology Bing Wang M.D., Pathology
26520 Cactus Ave., Moreno Valley, CA 92555 Blood Bank: (951) 486-5267

:Returned Date and Time

Crossmatch Administration Request Form # 630 (Downtime Form)



DATE & TIME RECEIVED

DATE & TIME COMPLETED

DATE & TIME DISPENSED

TEST GROUPS	INDIVIDUAL TESTS	COMPONENT REQUESTED
Type & Screen ABO, RhD, Antibody Screen	ABO	Red Blood cells ☐ Irradiated
Type & Crossmatch ABO, RhD, Ab. Sc., Crossmatch	RhD	Fresh Frozen Plasma/Frozen Plasma 200 mL / 400 mL / 500 mL / 600 mL
Cord Blood Study ABO, RhD, Direct Coombs	Antibody Screen	Platelet Pheresis ☐ Irradiated
Rhogam Screen ABO, RhD, Antibody Screen	Antibody I.D.	Neonate Octoped
Prenatal Screen ABO, RhD, AB.: Sc, ID	Antibody Titer:	Cryoprecipitate - small unit, 20 mL
☐ Suspected Transfusion Reaction Workup	Antibody Score:	Cryoprecipitate - Pooled 5 units, 100 mL
Rhogam Lot Number & Expiration Date	Direct Coombs (DAT)	PREVIOUS RECORD AVAILABLE: Yes ☐ No ☐
State Law requires that the woman being tested be informed as to the Rhesus (RhoD) Blood Typing results.	Fetal - Maternal Bleed	PATIL GATIN CONSENT ON FILE: Yes ☐ No ☐

Patient Identification and Sample Collection:
Well have collected a blood sample on the below named patient, verified the name, DOB, verified the MR number, and have verified the Crossmatch number placed on the tubes to be correct.

Date verified: _____ Time verified: _____ Nursing Unit _____ Crossmatch # _____

Signature of individual(s) collecting blood samples: _____ ☐ Specimens in Lab

CLINICAL DIAGNOSIS:

ORDERING AND ATTENDING DOCTORS ☐ STAT ☐ ROUTINE

BLOOD/COMPONENTS MUST BE RETURNED TO BLOOD BANK WITHIN 30 MIN. IF NOT TRANSFUSED

TRANSFUSION RECORD

	ABO GROUP	Rh TYPE	ANTIBODY SCREEN/ I.D.
PATIENT			
DONOR NO. _____ Expires:			

CROSSMATCH RESULTS: ___ COMPATIBLE ___ COMPATIBLE, PREWARMED ___ LEAST INCOMPATIBLE

CLS Signature _____

VERIFICATION OF:
- ☐ Patient's Name, DOB and M.R. No. against Patient's Armband
- ☐ Patient and Donor ABO, RH
- ☐ Donor No. and Expiration Date on all Forms and Labels
- ☐ Crossmatch Number: _____

Signature of person starting transfusion

Signature of person verifying identification

PT. UNIT

Signature of person completing/stopping transfusion

Date/Time Started:	Date/Time Stopped:
AMT. Given: ALL ¾ ½ ¼	

TRANSFUSION REACTION REPORT

SIGNS/SYMPTOMS NOTED Name of Physician notified	☐ Yes Date:	☐ No Time
If YES, ID CHECK: Does armband name, DOB & M.R. No. = Name, DOB & M.R. No. on unit tag?	☐ Yes	☐ No
Does armband name, DOB & M.R. No. = Name, DOB & M.R. No. on Crossmatch Form?	☐ Yes	☐ No

If a transfusion reaction is suspended, stop the transfusion, drip saline, and consult a physician IMMEDIATELY. Call the Blood Bank at Ext. 65266. Return the unused portion of unit with tubing as well as a post transfusion blood sample (pink top tube) to the Blood Bank along with the yellow copy.

VITAL SIGNS	Temp.	Pulse	B/P
Pre-Txn			
15 min. vitals			
Post-Txn within 1 hour			

Symptoms (3)
- ☐ Flushing of the Skin
- ☐ Hypotension
- ☐ Excessive Pain in Vein
- ☐ Nausea, Vomiting
- ☐ Hemoglobinuria
- ☐ Bleeding at Surgical Site
- ☐ Increased Temperature
- ☐ Itching
- ☐ Chills
- ☐ Shortness of Breath
- ☐ Sweating
- ☐ Chest/Back Pain
- ☐ Confusion
- ☐ Diffuse Bleeding
- ☐ Other _____

Department of Clinical Laboratory & Anatomic Pathology
Ronaldo Grass M.D., Pathology Chair
Bing Wang M.D., Transfusion Medical Director
Fatimarz Azizi M.D., Pathology
Yamil Lopez M.D., Pathology
Riverside University Health System-Medical Center
26520 Cactus Ave., Moreno Valley, CA 92555

FORM 630 (10/15) CROSSMATCH ADMINISTRATION REQUEST

White - Chart Yellow - Lab Pink - Component (attached to blood product)

RLDRK

Crossmatch Administration Request Form # 630 (Downtime Form) (Cont.)

FOR SUSPECTED TRANSFUSION REACTIONS
SUGGESTED CLINICAL MANAGEMENT
(This is not an order)

FINDINGS	PROCEDURE
I. Circulatory Overload	1. Notify Licensed Provider
II. Urticaria only	1. Notify Licensed Provider 2. Slow transfusion, give IM antihistaminics, resume transfusion at a normal rate in 15 minutes if therapy is effective.
III. Fever, chills, lumbar pain dyspnea, chest pain or oozing	1. **STOP** transfusion, but keep IV open 2. Notify Licensed Provider 3. **CALL** the Blood Bank - Phone Number 951-486-5267 4. Send pink top tube (drawn carefully to prevent hemolysis) and blood container(s) (without removing recipient set) to Blood Bank. 5. Obtain urine sample for free hemoglobin
IV. Shock, Hemoglobinuria, oliguria, bleeding	1. **STOP** transfusion, but keep IV open 2. Notify Licensed Provider 3. **CALL** the Blood Bank - Phone Number 951-486-5267 4. Send pink top tube (drawn carefully to prevent hemolysis) and blood container(s) (without removing recipient set) to Blood Bank. 5. **INSTITUTE PROPHYLACTIC TREATMENT IMMEDIATELY** a. Maintain blood pressure b. Maintain urine flow over 100 ml/hr for adult over 1-2 ml/kg/hr for child 1) Furosemide, 40-80 mg. I.V. for adult 0.5 - 1 mg/kg/dose (max dose 40 mg) for child (This dose may be repeated once) 2) Fluids - keep strict I & O c. Consider possible indications for: 1) Heparin 2) Platelet concentrates 3) Fresh frozen plasma or Factor VIII concentrates d. Therapy for sepsis 6. Obtain urine sample (catheterize if necessary) for free hemoglobin. 7. Get baseline studies: a. Platelet count b. Prothrombin Time c. PTT d. Bilirubin e. Hemoglobin and/or Hematocrit f. WBC g. BUN, Creatinine and Electrolytes
V. Anaphylaxis or anaphylactoid reaction	1. **STOP** transfusion, but keep IV open 2. Epinephrine 0.4 ml of 1:1000 solution I.M., for **adult** 3. Epinephrine 0.01 mg/kg/dose (max dose 0.3 mg per injection) of 1:1000 solution I.M. Q15 min for **child** 4. Notify Licensed Provider 5. **CALL** the Blood Bank - Phone Number 951-486-5267 6. Send pink top tube (drawn carefully to prevent hemolysis) and blood container(s) (without removing recipient set) to Blood Bank. 7. Consider bacterial contamination or antibodies to IgA in further evaluation and treatment 8. Obtain urine sample (catheterize if necessary) for free hemoglobin.

BLDBK

Emergency Release of Blood Form # 665

EMERGENCY BLOOD RELEASE FORM
CROSSMATCH NOT PERFORMED

Riverside University HEALTH SYSTEM

NAME:
DOE112, DOE112

Pt. Blood Type

STX Order ID: 154

MR:
DOB: 01/01/2000

Male
19 years old

Product	Unit Number	Prod. code	Unit Blood Type	Exp Date	Loc	Issued D/T	Issued to:	Transfused	Returned
RBC	W125619000100	E0382V00	O Pos	5/30/19	EMG	5/8/19 14:11	Mountain, Dew by Ellsworth-Lara, Oralia	☐	☐
RBC	W125619000101	E0382V00	O Pos	5/30/19	EMG	5/8/19 14:11	Mountain, Dew by Ellsworth-Lara, Oralia	☐	☐
RBC	W125619000102	E0382V00	O Pos	5/30/19	EMG	5/8/19 14:11	Mountain, Dew by Ellsworth-Lara, Oralia	☐	☐
RBC	W125619000103	E0382V00	O Pos	5/30/19	EMG	5/8/19 14:11	Mountain, Dew by Ellsworth-Lara, Oralia	☐	☐
RBC	W125619000109	E0382V00	O Pos	5/30/19	EMG	5/8/19 14:11	Mountain, Dew by Ellsworth-Lara, Oralia	☐	☐
RBC	W125619000110	E0382V00	O Pos	5/30/19	EMG	5/8/19 14:11	Mountain, Dew by Ellsworth-Lara, Oralia	☐	☐
FFP	W125619000105	E5548V00	A Pos	5/11/19	EMG	5/8/19 14:11	Mountain, Dew by Ellsworth-Lara, Oralia	☐	☐
FFP	W125619000106	E5548V00	A Pos	5/11/19	EMG	5/8/19 14:11	Mountain, Dew by Ellsworth-Lara, Oralia	☐	☐
FFP	W125619000107	E5548V00	A Pos	5/11/19	EMG	5/8/19 14:11	Mountain, Dew by Ellsworth-Lara, Oralia	☐	☐
FFP	W125619000108	E5548V00	A Pos	5/11/19	EMG	5/8/19 14:11	Mountain, Dew by Ellsworth-Lara, Oralia	☐	☐
FFP	W125619000112	E5548V00	A Pos	5/12/19	EMG	5/8/19 14:11	Mountain, Dew by Ellsworth-Lara, Oralia	☐	☐
FFP	W125619000113	E5548V00	A Pos	5/12/19	EMG	5/8/19 14:11	Mountain, Dew by Ellsworth-Lara, Oralia	☐	☐
PLT	W125619000116	E3077V00	A Pos	5/10/19	EMG	5/8/19 14:11	Mountain, Dew by Ellsworth-Lara, Oralia	☐	☐ Room temp
PCRY	W125619000118	E3591V00	AB Pos	5/8/19	EMG	5/8/19 14:11	Mountain, Dew by Ellsworth-Lara, Oralia	☐	☐ Room temp

Cooler # _____

Department of Clinical Laboratory & Anatomic Pathology
Yamil Lopez M.D., Pre Transfusion Medical Director
Ronaldo O. Gnass M.D., Pathology Chair
Bing Wang M.D., Pathology
Faramarz Azizi M.D., Pathology
Riverside University Health System
26520 Cactus Ave., Moreno Valley, CA 92555

CLINICAL DIAGNOSIS

I, _____
SIGNATURE/PRINT NAME OF PHYSICIAN DATE/TIME

accept the responsibility for the transfusion of the blood listed above without waiting for completion of the compatibility tests.

BLOOD RELEASED TO (SIGNATURE/PRINT REQUIRED) DATE/TIME

SIGNATURE/PRINT NAME OF CLINICAL LAB SCIENTIST RELEASING BLOOD DATE/TIME

Riverside University Health System
Medical Center & Community Health Centers

EMERGENCY BLOOD RELEASE FORM

Form #665 5/2019

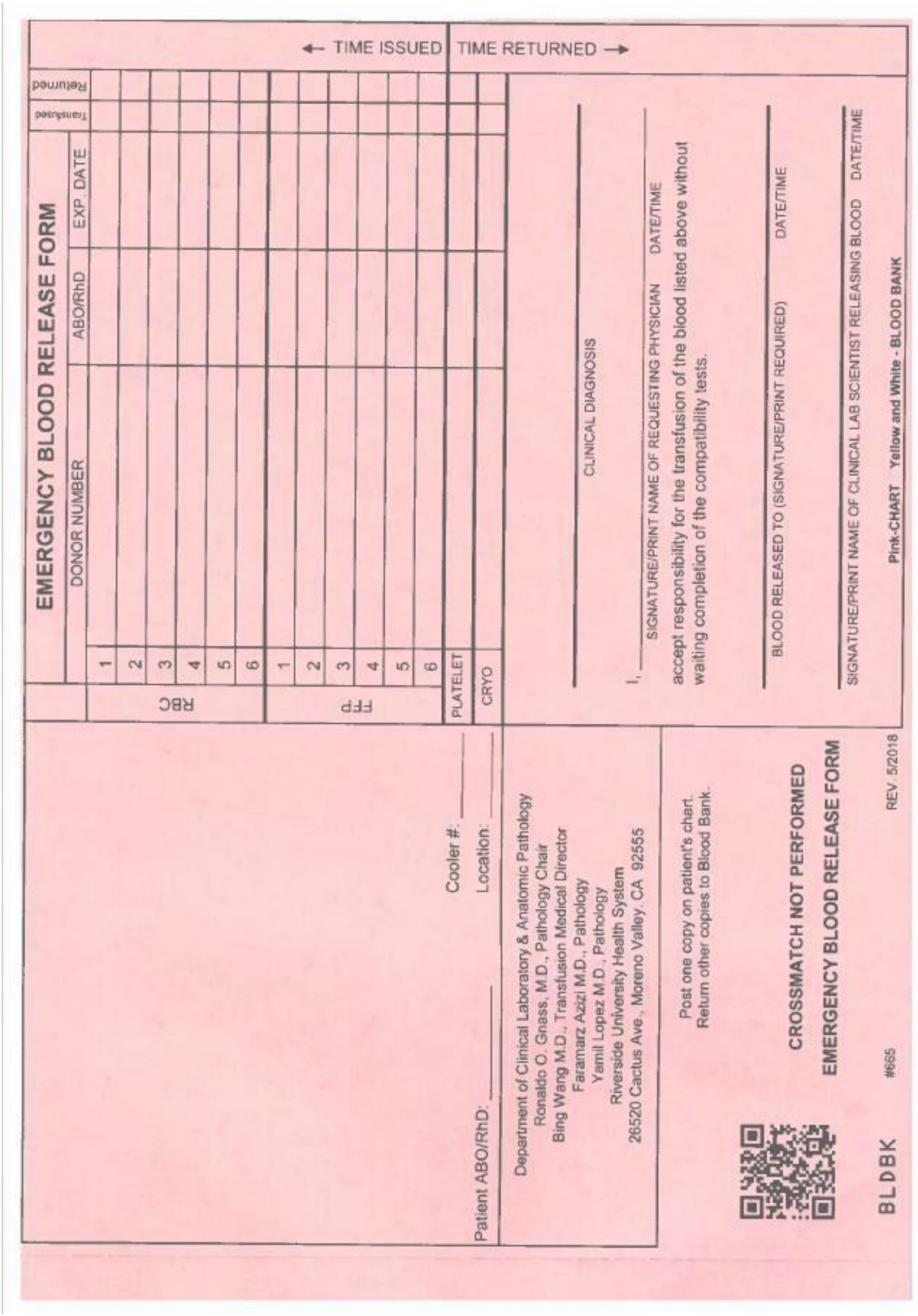
BLDBK

Distribution: White – Chart / Yellow & Pink – Blood Bank

Place pt. label here

DATE/TIME RETURNED:
CLS Initials:

Emergency Release of Blood Form # 665
(Downtime Form)



EMERGENCY BLOOD RELEASE FORM

← TIME ISSUED | TIME RETURNED →

		DONOR NUMBER	ABO/RhD	EXP. DATE	Transfused	Returned
RBC	1					
	2					
	3					
	4					
	5					
	6					
FFP	1					
	2					
	3					
	4					
	5					
	6					
PLATELET						
CRYO						

CLINICAL DIAGNOSIS _____

I, _____ SIGNATURE/PRINT NAME OF REQUESTING PHYSICIAN DATE/TIME

accept responsibility for the transfusion of the blood listed above without waiting completion of the compatibility tests.

_____ BLOOD RELEASED TO (SIGNATURE/PRINT REQUIRED) DATE/TIME

_____ SIGNATURE/PRINT NAME OF CLINICAL LAB SCIENTIST RELEASING BLOOD DATE/TIME

Pink-CHART Yellow and White - BLOOD BANK

Cooler #: _____

Location: _____

Patient ABO/RhD: _____

Department of Clinical Laboratory & Anatomic Pathology
Ronaldo O. Gnass, M.D., Pathology Chair
Bing Wang M.D., Transfusion Medical Director
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Yamil Lopez M.D., Pathology
Riverside University Health System
26520 Cactus Ave., Moreno Valley, CA 92555

Post one copy on patient's chart.
Return other copies to Blood Bank.

CROSSMATCH NOT PERFORMED

EMERGENCY BLOOD RELEASE FORM

BLDBK #665 REV: 5/2018

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER AND HOSPITAL BASED CLINICS

Housewide

	Document No: 688	Page 1 of 5
Title: Scope of Service for the Vascular Access Team	**Effective Date:** 9/11/2024	☐ **RUHS – Behavioral Health** ☐ **RUHS – Community Health Centers** ☒ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By: Jennifer Cruikshank CEO/Hospital Director		☒ **Policy** ☐ **Procedure** ☐ **Guideline**

1. SCOPE:

1.1 All patients greater than or equal to 28 days within Riverside University Health System-Medical Center and Hospital Based Clinics, excluding Arlington campus and Neonatal Intensive Care Unit (NICU).

2. DEFINITIONS:

2.1 Central Vascular Access Device (CVAD): a single or multi-lumen vascular access catheter inserted via a peripheral vein of the upper or lower limbs or large vein of the chest or groin with the tip advanced to a central position, either the superior vena cava (upper body insertion), or inferior vena cava (lower body insertion), preferably at the cavoatrial junction. Such devices include tunneled and non-tunneled catheters via the internal jugular, subclavian, or femoral veins which includes hemodialysis catheters and implanted ports.

2.2 Enhanced Adult-Difficult Intravenous Access (EA-DIVA): A clinical predictive scale used to identify difficult venous cannulation in adult patients.

2.3 Midline Catheter: a single or multi-lumen catheter inserted into a peripheral vein of the upper arm via the basilic, cephalic, or brachial vein with the terminal tip located at the level of the axilla in children and adults.

2.4 Peripherally Inserted Central Catheter (PICC): a single or multi-lumen vascular access catheter inserted through veins of the upper extremities in adults and children; for infants, may be inserted through veins of the scalp or lower extremity. The catheter tip is advanced to the superior vena cava, preferably at the cavoatrial junction (upper limb insertion), or inferior vena cava, above the diaphragm (lower limb insertion).

2.5 Vascular Access Device (VAD): Catheter, tube, or device inserted into the vascular system, including veins, arteries, and bone marrow.

2.6 Vascular Access Team Registered Nurse (VAT RN): The VAT RN has advanced skills, knowledge, and demonstrates competence in evaluation and inserting PICC and Midline catheters, and management for VADs.

2.7 Vascular Access Team Licensed Vocational Nurse (VAT LVN): The VAT LVN is specially trained and demonstrates competence in dressing changes for all VADs and provides support with the insertion of VADs.

3 GUIDELINES:

3.1 Location, hours of service:

a. VAT RN, 24 hours per day, 7 days a week.

b. VAT LVN, 0700-1730 hours, 7 days a week.

3.2 Vascular Access Team consultation criteria:

a. Request for assistance for VAD after two (2) failed traditional attempts.

b. Provider order for PICC or Midline evaluation and placement.

c. Existing patients who have an active CVAD that have concerns needing troubleshooting.

d. A patient with an EA-DIVA of ≥ 8 (Attachment 5.1)

3.3 Scope of service:

a. PICC or Midline evaluation and placement per provider's order.

b. Provide routine CVAD dressing changes.

c. Provide recommendations as to the necessity of an existing CVAD or the removal of such.

d. Provide troubleshooting support for a malfunctioning CVAD, offering recommendations for appropriate interventions, including but not limited to catheter replacement or de-clotting procedures.

e. Assist in the verification of CVAD tip placement and functionality with patients who have pre-existing line.

f. Collaborate with the Nephrology provider in determining the appropriateness of vascular access devices for patients who are on active renal replacement therapy such as hemodialysis or peritoneal dialysis or kidney transplant recipients.

g. Assist in establishing peripheral vascular access on patients after attempts have been made but failed to establish vascular access.

h. Assist in accessing and de-accessing implanted ports per provider's order.

i. Assist the RUHS Infection Control Department in its adherence monitoring and implementation activities regarding the use of central line insertion practices (CLIP).

j. Support training and development of nursing workflow.

3.4 Exclusion criteria for PICC or Midline insertion:

a. Assessment of a catheter to vein ratio of greater than 45 percent.

4 COMPETENCY:

4.1 Training and competency:

a. VAT RN and LVN competency assessment occurs during initial orientation, annually with performance appraisals, changes in service, and new technology.

b. VAT RN Specific Training or Competency:

i. Initial Orientation Training

ii. PICC and Midline Insertion Competency

iii. Implanted Port Access and De-access Competency

iv. CVAD Dressing Change Competency

v. PICC Removal Competency

vi. Ultrasound Guided Peripheral Intravenous Catheter Insertion Competency

vii. Restoring patency and function of Central Venous Access Device (CVAD) Competency

c. VAT LVN Specific Training or Competency:

i. Initial Orientation Training

i. CVAD Dressing Change Competency

ii. Ultrasound Guided Peripheral Intravenous Catheter Insertion Competency

5 DATA COLLECTION AND REPORTING:

5.1 Data Collection:

a. The following will be collected within internal database for volume metrics including, but not limited to:

i. PICC evaluation

ii. PICC placement

iii. UGPIV placement

iv. Line removal

v. Troubleshoot

vi. Chest x-ray

vii. Routine dressing changes

viii. Line labeling

5.2 Data Reporting:

a. Monthly reporting to Director of Nursing and Clinical Support Teams and Disease Specific Programs.

b. Real-time interactive dashboard available to RUHS – Medical Center Leadership.

6 ATTACHMENTS:

6.1 Enhanced Adult – Difficult IV Access Score

7 REFERENCES:

7.1 Infusion Nurses Society (INS). (2021). Infusion therapy standards of practice. Standard 34: Vascular access device placement. Journal of Infusion Nursing, 44(Suppl. 1), S97-S101. (Level A)

7.2 Infusion Nurses Society (INS). (2021). Infusion therapy standards of practice. Standard 26: Vascular access device planning. Journal of Infusion Nursing, 44(Suppl. 1), S74-S81. (Level A).

7.3 Infusion Nurses Society (INS). (2021). Infusion therapy standards of practice. Standard 42: Vascular access device assessment, care, and dressing changes. Journal of Infusion Nursing, 44(Suppl. 1), S119-S123. (Level A).

7.4 Infusion Nurses Society (INS). (2021). Infusion therapy standards of practice. Standard 45: Vascular access device removal. Journal of Infusion Nursing, 44(Suppl. 1), S133-S137. (Level A).

7.5 Alexandrou, E. (2019). Chapter 2: Right assessment and vein selection. In N.L. Moureau (Ed.), Vessel health and preservation: The right approach for vascular access (pp. 9-22). Cham, Switzerland: Springer Nature. Retrieved March 20, 2024, from **https://link.springer.com/book/10.1007/978-3-030-03149-7.**

Document History:

Prior Release Dates: N/A	**Retire Date:** N/A
Document Owner: VAT ANM – Coordinator	**Replaces Policy:** N/A

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
06/3/2024	Pre-Nursing P&P	Yes	Corrections to 5.1a with verbiage
06/13/2024	Nursing P&P	No	Consent Agenda
8/6/2024	Policy Approval Committee	Yes	

Attachment 6.1: Enhanced Adult- Difficult IV Access Score

EA-DIVA	SCORE
Past history of difficult peripheral venous cannulation	
Present = 3	
Absent = 0	
Vascular depletion	
Previous use of chemotherapeutic agents or intravenous drug abuse, previous venipunctures = 2	
Absent = 0	
Coagulative disorder and/or intake of anticoagulant or antiplatelet drugs	
Present = 1	
Absent = 0	
Neurovascular disease	
Peripheral neuropathy and/or vasculopathy = 1	
Absent = 0	
Clinical examination of skin	
Dark, thick, or fragile skin = 1	
Absent = 0	
Overweight (BMI > 25)	
Present = 1	
Absent = 0	
Vein evaluation	
Not visible, not palpable, rolling, or winding vein = 2	
Absent = 0	
One-side only availability	
One side = 1	
Two sides = 0	
Total	
Sum all scores	
IF TOTAL > 8, PLEASE USE ADVANCED TECHNIQUES OR REFER TO SPECIALISTIC EVALUATION	

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER

Housewide

	Document No: 691	Page 1 of 10
Title: Sepsis Guidelines for the Management of Sepsis, Severe Sepsis, and Septic Shock in Adults	**Effective Date:** 7/18/2024	☐ **RUHS – Behavioral Health** ☐ **RUHS – Community Health Centers** ☐ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By:  Jennifer Cruikshank CEO/Hospital Director		☐ **Policy** ☐ **Procedure** ☒ **Guideline**

1. SCOPE

1.1 To provide a guideline for identifying and treating patients ≥ 15 years of age and in-patient adults ≥ 18 years of age who have been identified and activated with Severe Sepsis or Septic Shock.

1.2 To provide a guideline for identification and management of sepsis during pregnancy and postpartum by utilizing a 2-step approach as recommended by the California Maternal Quality Care Collaborative (CMQCC) to reduce both false-positive and false negative cases (see section 4 below).

2. DEFINITIONS

2.1 **B-Lines:** is a seen artifact relevant in lung ultrasonography.

2.2 **Fluid Resuscitation Algorithm:** An algorithm that assess the patient's tolerance, responsiveness, and need for crystalloid fluids utilizing a POCUS exam and invasive and/or noninvasive hemodynamic monitoring (See Attachment 1).

2.3 **Maternal Sepsis:** a life-threatening condition with organ dysfunction resulting from infection during pregnancy, childbirth, post-abortion, or the postpartum period (up to 42 days).

2.4 **Point of Care Ultrasound (POCUS) Exam:** an ultrasonography exam performed at the bedside to evaluate the collapsibility of the inferior vena cava (IVC), dynamic ability of the heart, and the presence of B-Lines in the lungs.

2.5 **Systemic Inflammatory response Syndrome (SIRS) Criteria**: Systemic inflammatory response syndrome (SIRS) is an exaggerated defense response of the body to a noxious stressor (infection, trauma, surgery, acute inflammation, ischemia or reperfusion, or malignancy) to localize and then eliminate the endogenous or exogenous source of the insult.

a. Heart Rate > 90 mmHg beats/minute (expect in patients with a known physiologic condition preventing tachycardia or beta blocker use).

b. Respiratory Rate > 20 breaths/minute.

c. Temperature < 36°C or > 38°C.

d. WBC < 4,000 cells/mm³ or > 12,000 cells/mm³ or > Bands > 10%.

2.6 **Sepsis**. A known or suspected infection accompanied by 2 or more SIRS criteria.

2.7 **Severe Sepsis**: Sepsis associated with signs or symptoms of at least one organ dysfunction as evidenced by:

a. Intubation

b. BVM assisted

c. Non-invasive Inspiratory Positive Pressure Ventilation (NIPPV) (Acutely)

d. Requiring ≥ 8L of O_2 to maintain oxygen saturation > 93%

e. Urine output < 0.5 mL/kg or < 30 mL/kg/hr for at least 2 hours

f. New Altered Mental Status

g. Hypotensive with systolic blood pressure (SBP) < 90 mmHg, or Mean Arterial Pressure (MAP) < 65 mmHg

h. Creatine > 2 mg/dL (acute)

i. Platelets < 100,000 mcL (acute)

j. T-Billi > 2 mg/dL (acute)

k. INR > 1.5 (acute)

l. Lactate > 2 mmol/L

m. Maintained $EtCO_2$ ≤ 34 mmHg or ≥ 46 mmHg

2.8 **Septic Shock:** Severe Sepsis associated with either:

a. Hypotension (SBP < 90 mmHg or MAP < 65 mmHg), or

b. Lactate > 4 mmol/L despite adequate fluid resuscitation based off provider discretion or completion off the Fluid Resuscitation Assessment Algorithm.

2.9 **Time Zero:** Earliest time when patient met criteria to initiate activation of sepsis protocol based on suspected or known source of infection, SIRS criteria, and evidence of end organ dysfunction.

3. GUIDELINES

3.1 Resuscitation Bundle Goals: Hours one (time zero) begins at time of presentation to ED (triage time), time of recognition (if a patient does not meet criteria at triage but later develops SIRS/sepsis), or time of Sepsis Rapid Response Activation

a. Therapeutic Management within **Hour One** consider:

i. Use of elements within Sepsis bundle

ii. Draw POC Lactate.

iii. Draw POC Glucose

iv. Draw two sets of blood cultures following the Guidelines for Blood Culture Collection.

v. Initiate cardiac monitoring, including $EtCO_2$

vi. If applicable, draw a venous Blood Gas (VBG) from a central line to evaluate the $ScVO_2$.

vii. Administer Broad-Spectrum antibiotic and/or narrow-specific antibiotics if organism is known.

viii. Perform a Fluid Resuscitation Assessment

ix. Consider vasopressor therapy if non-responsive to fluid and MAP < 65 mmHg.

b. Therapeutic Management within **Hour Three** consider:

i. Repeat Serum Lactate (POC or Lab Sent).

ii. Repeat Glucose draw (POC or Lab Sent).

iii. If applicable, repeat VBG for $ScVO_2$.

iv. Consider vasopressor therapy if non-responsive to fluid and MAP < 65 mmHg.

c. Therapeutic Management after **Hour Three** consider:

i. Repeat Glucose draw (POC or Lab Sent).

ii. If applicable, repeat VBG for $ScVO_2$.

iii. Consider documenting median plateau pressure for intubated patients.

d. Therapeutic Management within **24 hours**:

i. Repeat Glucose draw (POC or Lab Sent).

e. Tissue Perfusion Management during Three-Hour Bundle:

i. Adequate tissue perfusion can be measured with any of the follow:

- Cap refill < 3 sec
- Decreasing Serial Lactate (Less than 2 or 60% reduction)
- SVcO2 optimized (60%-80%) from central line

f. Fluid Volume Status Management Bundle:

i. Any Fluid Resuscitation Assessment that indicates fluid should be given (See Attachment 5.1), should consider giving crystalloid bolus. Amount of bolus will be determined by treating Physician.

ii. Once the fluid bolus is complete, and a total of 1500mls or more has been given an additional Fluid Resuscitation algorithm assessment will be completed prior to subsequent boluses. If the Fluid Resuscitation Assessment indicates the patient is fluid responsive and fluid tolerant, the process will be repeated until the Physician determines the patient has received adequate fluid resuscitation, or it is considered harmful to the patient to administer fluids.

iii. If the Fluid Resuscitation Assessment no longer indicates fluids will be beneficial, but Tissue Perfusion has not been optimized, vasopressor and/or inotropic support should be considered to maintain MAP > 65 mmHg.

g. Per the treating provider's discretion, deviations from the algorithm may occur.

3.2 Activate Rapid Response (RRT) per protocol when patient meets severe sepsis/septic shock activation criteria.

a. Ensure sepsis documentation in the patient's medical record is complete and consider elements of either invasive or non-invasive hemodynamic monitoring measurements (See Attachment 5.3).

b. Evaluate patient status and need to switch from non-invasive to invasive therapy and need for central and arterial line placement.
   i. It is recommended to switch to invasive therapy when clinically indicated by treatment team.

c. Consider Initiate Monitoring:
   i. Continuous cardiac monitoring.
   ii. Glucose checks q3 hours
   iii. Lactate checks q3 hours
   iv. Continuous pulse oximetry
   v. Consider vital signs q1 hour.

d. Notify provider and rapid response team when fluid boluses are complete during Six-Hour resuscitation.

e. Discuss abnormal lab values with the primary physician and update plan of care as needed.

f. Note if blood glucose readings is ≥ 180 mg/dL on two or more readings, consider diabetic consult. Discuss abnormal values with primary physician.

g. Note if median plateau pressure is < 30 cm H_2O. Discuss abnormal values with the primary physician.

4. GUIDELINES: MATERNAL SEPSIS EVALUATION

4.1 Step One: screen is positive if any 2 or more of the following 4 criteria are met:
   a. Oral temp <36°C (96.8°F) or ≥38°C (100.4°F)
   b. Heart rate >110 beats per minute
   c. Respiratory rate >24 breaths per minute
   d. WBCs >15,000/mm^3 or <4,000 or > 10% bands

4.2 If suspected infection, start source directed antibiotics (obtain aerobic & anaerobic blood cultures before administration) and 1-2L of fluids

4.3 Step Two: Confirmation of Sepsis if 1 or more criteria met (see attachment 5.2) – Evaluation for end organ injury including lab studies listed below and prompt bedside evaluation by a physician or other clinician. While waiting for lab results, therapy should be initiated for infection within 1 hr with administration of antibiotics targeted for the presumed site and bolus of 1-2L IV fluid.
   a. Laboratory values
      i. CBC (including % immature neutrophils [bands], platelets)
      ii. Coagulation status (prothrombin time/international normalized ratio/partial thromboplastin time)
      iii. Comprehensive metabolic panel (specifically include bilirubin, creatinine [≥ 1.2 mg/dl or doubling])
      iv. Lactic Acid: >2 mmol/L in absence of labor
   b. Bedside Assessment
      i. Urine output (place Foley catheter with urometer; urine output < 0.5 ml/kg/hr x 2 hours)
      ii. Cardiovascular: SBP < 85 mm Hg *or* MAP < 65 mm Hg *or* > 40 mm Hg decrease in SBP (after fluids)
      iii. Mental status assessment (agitated, confused or unresponsive)
      iv. Respiratory: New need for mechanical ventilation or PaO_2/FiO_2 <300

4.4 If all criteria negative patient remains at high risk for sepsis and requires close supervision and evaluation.

4.5 If elevated lactate only and patient in labor, maintain close surveillance; consider additional fluids, repeat lactate.

4.6 MAP < 65 mm Hg patient in Septic Shock, admit to ICU If hypotension persists after 30ml/kg fluid load, asses hemodynamic status and consider vasopressor use.
4.7 Evaluate wound for source organism.
4.8 Maternal Fetal Medicine will be consulted on all obstetric sepsis cases and will determine appropriate timing of delivery.
4.9 Anesthesia will be consulted for maternal patients with clinical sings of sepsis or septic shock to determine appropriateness for neuraxial procedures.
4.10 Sepsis related discharge education to be given upon discharge to patient and/or caregiver.

5. ATTACHMENTS

5.1 Fluid Resuscitation Assessment Algorithm

5.2 Maternal Sepsis Evaluation Flow Chart

5.3 Invasive and Noninvasive Hemodynamic Monitoring Elements

6. REFERENCES

6.1 Bonet M, Nogueira Pileggi V, Rijken MJ, et al. Towards a consensus definition of maternal sepsis: Results of a systematic review and expert consultation. Reprod Health 2017 May 30; 14(1):67. doi: 10.1186/s12978-017-0321-6.

6.2 Dellinger, R.P., Levy, M.M., Rhodes, A., Annane, D., Gerlach, H., Opal, S.M., & Moreno, R., (2021) Surviving Sepsis Campaign: International Guidelines for Management of Severe Sepsis and Septic Shock: 2021. *Journal of Critical Care Medicine*. 2021, 41(2), 580-637.

6.3 Gibbs R, Bauer M, Olvera L, Sakowski C, Cape V, Main E. Improving Diagnosis and Treatment of Maternal Sepsis: A Quality Improvement Toolkit. Stanford, CA: California Maternal Quality Care Collaborative.

6.4 Levy MM, Evans LE, Rhodes A et al: Surviving Sepsis Campaign Bundle: 2018 update. Journal of Intensive Care Medicine, 2018: 44:925-928 hyyps://doi.org/10.1007/s00134-018-5085-0

6.5 Specifications Manual for National Hospital Inpatient Quality Measures Discharges. SEP-1. 01-01-18 (1Q18) through 06-30-18 (2Q18)

6.6 Mervyn, S., Deutschman, C.S., Seymour, C.W. (2016) The Third International Consensus Definitions of Sepsis and Septic Shock (Sepsis-3). JAMA. 2016;315(8):801-810. doi:10.1001/jama.2016.0287

6.7 HW 604: Nurse Performed Point of Care Ultrasound

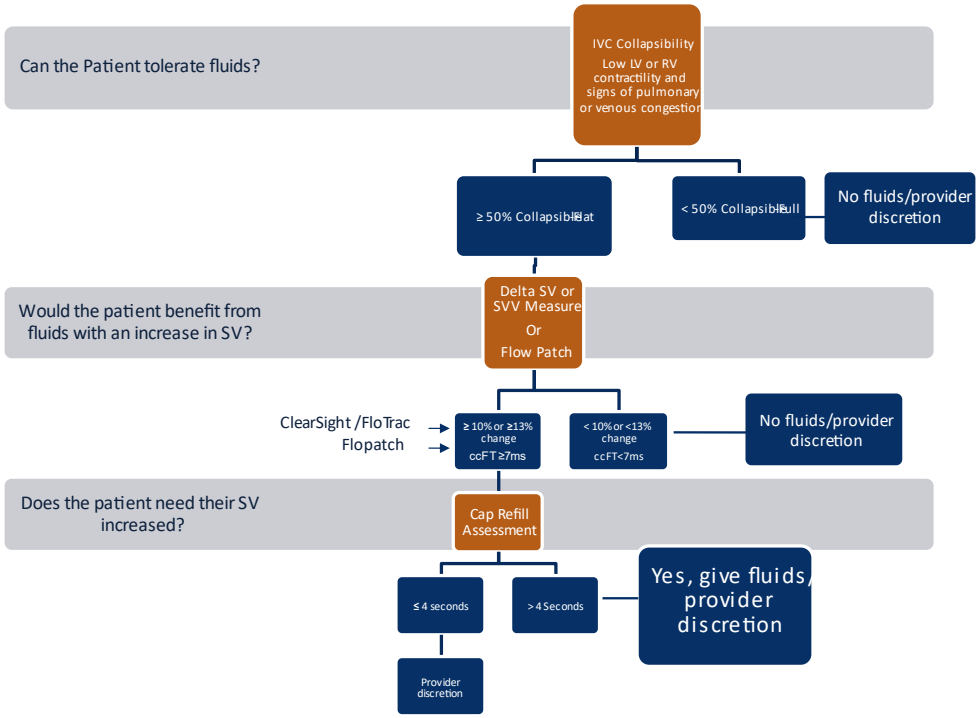
Document History:

Prior Release Dates: 12/2015, 7/2019. 5/4/2023	**Retire Date:** N/A
Document Owner: Nursing: Sepsis Nurse Coordinator	**Replaces Policy:** N/A

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
7/8/2023	Perinatal Nursing Leadership	Yes	Reflect all changes here Scope 1.2 Maternal sepsis 2.8 Maternal sepsis definition 4. Maternal sepsis evaluation guideline; 5.2 Maternal Sepsis Evaluation Flow Chart Attachment
9/13/2023	OB/GYN Department	No	
9/27/2023	Nursing P&P	Yes	Definitions Alphabetized 2.8- Alphabetized and defined SIRS 3.2a-minor change to Language 5.3-Added Attachment 6.7-Added
6/3/2024	Pre-Nursing P&P	Yes	Correct order of definitions.
6/13/2024	Nursing P&P	No	Consent agenda
7/11/2024	PAC	No	

ATTACHMENT 5.1: Fluid Resuscitation Assessment Algorithm

Fluid Resuscitation Algorithm Assessment



When RRT activation begins:
Fluid Resuscitation Algorithm Assessment should be used upon activation as baseline assessment. The Fluid Resuscitation Algorithm Assessment should be followed after every 1500mls fluid bolus or more to guide Resuscitation until fluid goal is met.

Document Fluid Resuscitation elements at initial activation and after each 1500ml fluid bolus or more, and at 3 -hour mark while patient is under RRT activation until fluid goal is met. (.EMSEPSIS)

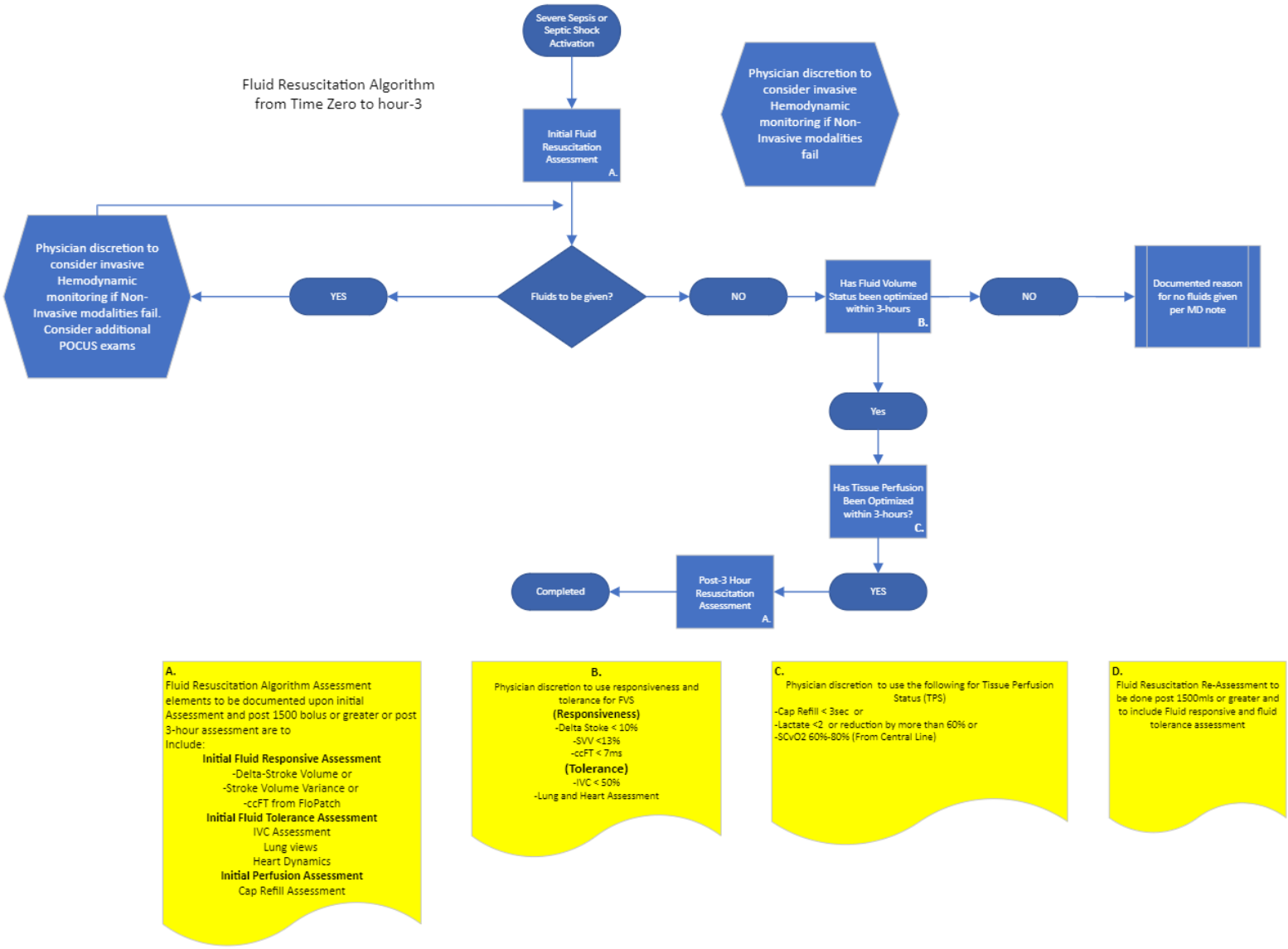
Fluid Resuscitation Algorithm Assessment elements to be documented upon initial Assessment and post 2000ml bolus are to Include:

Fluid Responsive Assessment
-Delta-Stroke Volume or
-Stroke Volume Variance or
-ccFT from FloPatch

Fluid Tolerance Assessment
IVC Assessment
Lung views
Heart Dynamics

Perfusion Assessment
Cap Refill Assessment

Riverside University HEALTH SYSTEM



A.
Fluid Resuscitation Algorithm Assessment elements to be documented upon initial Assessment and post 1500 bolus or greater or post 3-hour assessment are to Include:

Initial Fluid Responsive Assessment
-Delta-Stroke Volume or
-Stroke Volume Variance or
-ccFT from FloPatch
Initial Fluid Tolerance Assessment
IVC Assessment
Lung views
Heart Dynamics
Initial Perfusion Assessment
Cap Refill Assessment

B.
Physician discretion to use responsiveness and tolerance for FVS
(Responsiveness)
-Delta Stoke < 10%
-SVV <13%
-ccFT < 7ms
(Tolerance)
-IVC < 50%
-Lung and Heart Assessment

C.
Physician discretion to use the following for Tissue Perfusion Status (TPS)
-Cap Refill < 3sec or
-Lactate <2 or reduction by more than 60% or
-SCvO2 60%-80% (From Central Line)

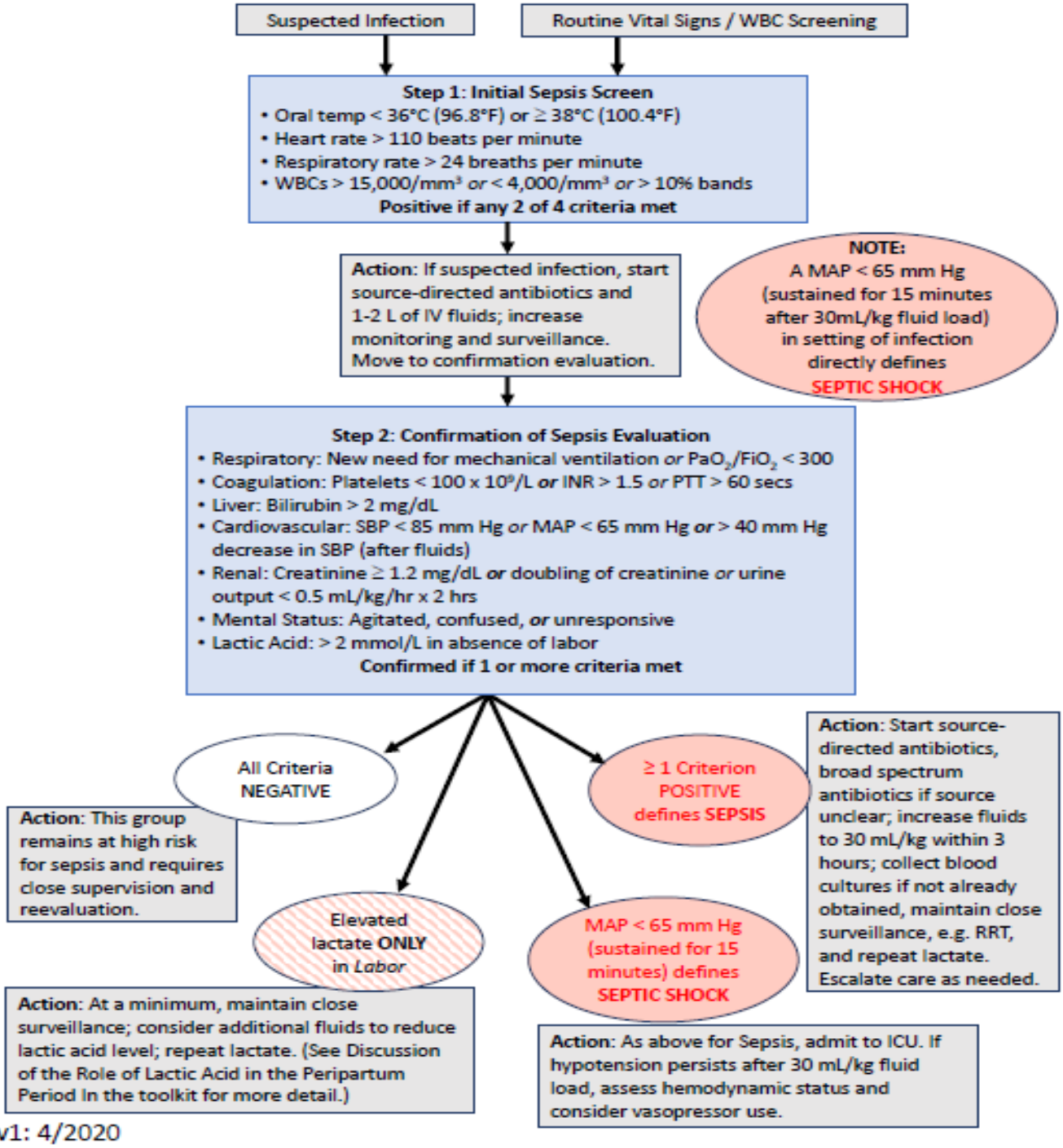
D.
Fluid Resuscitation Re-Assessment to be done post 1500mls or greater and to include Fluid responsive and fluid tolerance assessment

ATTACHMENT 5.2: Maternal Sepsis Evaluation Flow Chart

CMQCC
California Maternal Quality Care Collaborative

Appendix D

Maternal Sepsis Evaluation Flow Chart



Rev1: 4/2020

Appendix D: Maternal Sepsis Evaluation Flow Chart. Taken from CMQCC *Improving Diagnosis and Treatment of Maternal Sepsis Toolkit Errata 7/1/2022*

ATTACHMENT 5.3: Invasive and Noninvasive Hemodynamic Monitoring Elements

- IVC collapsibility
- Dynamic ability of the heart
- Delta stroke volume
- Stroke volume variation
- Stroke volume
- Systemic vascular resistance
- ccFT (Corrected Carotid Flow Time)
- Venous Tracing Assessment (FloPatch)

RIVERSIDE UNIVERSITY HEALTH SYSTEM - MEDICAL CENTER

Infection Prevention and Control

	Document No: 1108	Page 1 of 14
Title: High Consequence Infectious Diseases	**Effective Date:** 8/20/2024	☐ **RUHS – Behavioral Health** ☐ **RUHS – Community Health Centers** ☐ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By:  Jennifer Cruikshank CEO/Hospital Director		☒ **Policy** ☐ **Procedure** ☐ **Guideline**

1. SCOPE

1.1 The policy of Riverside University Health System - Medical Center (RUHS – Medical Center) is to ensure preparedness in the event of a suspected or confirmed case of a high consequence infectious disease or novel pathogen in a Medical Center or Arlington Campus patient.

2. BACKGROUND

2.1 Infectious disease emergencies are circumstances caused by biological agents, including organisms such as bacteria, viruses, or toxins, with the potential for significant illness or death in the population. Infectious disease emergencies may include naturally occurring outbreaks or emerging infectious diseases. High consequence infectious diseases (HCID) have epidemic or pandemic potential, significant severity or mortality, and limited vaccine and treatment modalities. They are an ongoing public health concern. Over the last two decades, the world has faced many HCID outbreaks that have traveled from country to country.

2.2 Currently known examples of HCIDs that can generate substantial public health and economic concerns are:

a. Severe Acute Respiratory Syndrome (SARS Cov-1)

b. Middle East Respiratory Syndrome (MERS)

c. A H5N1 (Avian Flu)

d. Measles

e. Smallpox

f. Ebola Virus Disease (EVD)

2.3 With today's volume and speed of travel, increased interactions with animal populations, and changes in the environment and human behaviors, HCIDs may spread rapidly from anywhere in the world. Therefore, hospitals must be prepared to respond to such threats.

3. POLICY

3.1 Patient Screening

a. Individuals presenting to the Medical Center Emergency Department (ED) shall be screened for potential HCIDs. Screening questions may include inquiries

regarding recent domestic and international travel, exposure to others who are sick, or experiencing recent new or worsening symptoms.

3.2 Patients that are identified through screening to have potential HCIDs will be triaged as soon as possible. The patient will:

a. Have a mask placed immediately (unless medically contraindicated)

b. Be placed in a single occupancy airborne infectious isolation room (AIIR). If AIIRs are not available, the patient may be placed in a single occupancy room with the door closed. A portable HEPA filtration machine may be placed in the room.

c. Have a medical evaluation as soon as possible

- If after medical assessment it has been determined that the patient is not suspected of an HCID, Standard and/or Transmission-based Precautions according to suspected condition will be followed.
- If after medical assessment it has been determined that the patient is suspected of an HCID, Transmission-based Precautions will be instituted according to the current Centers for Disease Control and Prevention (CDC) recommendations for the condition suspected. Staff will wear appropriate Personal Protective Equipment (PPE).

3.3 Arlington Campus Considerations

a. Patients shall be screened upon presentation to Arlington Campus.

b. If a patient is suspected to have an HCID

- Place a mask on the patient (unless medically contraindicated)
- Place the patient in a single occupancy room (if available)
- Notify the Attending Psychiatric Physician and/or the consulting Internal Medicine physician for immediate transfer to the Medical Center.

3.4 Environmental Services (EVS)

a. Hospital approved cleaners and disinfectants will be used, following the Manufacturer's Instructions For Use (IFU).

b. Standard Precautions and appropriate PPE will be utilized at all times.

c. EVS staff entering the room of a suspected or confirmed HCID patient will follow appropriate Transmission-based Precautions, including appropriate delay of terminal cleaning after transfer or discharge of the patient, as required.

3.5 Linen and Waste Management

a. Follow current EVS policies and procedures and California Department of Public Health (CDPH) guidelines.

3.6 Specimen Transport

a. Specimens should be delivered to the Laboratory, avoid using the pneumatic tube system.

3.7 Disease Notification

a. For all conditions listed in section 2.2, ED staff must immediately notify the Attending physician and House Supervisor (64204).

- If the patient was brought in by Emergency Medical Services (EMS), law enforcement, or transferred from another facility, ED staff must notify the corresponding agency immediately.

b. The House Supervisor shall immediately notify by phone:

- The Public Health Department
  - Normal working hours: 951-358-5107
  - After hours: 951-782-2974
- Administrator on Call (AOC)
- Infection Prevention and Control (64690)
- Environmental Services (65480)
- Laboratory (65300)
- Pharmacy (64502)
- Plant Operations (as needed for HVAC system inquiries) (64075)

3.8 Viral Hemorrhagic Fevers (e.g., Ebola) Considerations

Component	Recommendation	Comments
Patient Placement	• Single patient room (containing a private bathroom or commode) with the **door closed** • RUHS-Medical Center should maintain a log of all persons entering the patient's room	• RUHS-Medical Center will consider posting personnel at the patient's door to ensure appropriate and consistent use of PPE by all persons entering the patient room
Personal Protective Equipment (PPE)	• All persons entering the patient room should wear at least: ○ **Double gloves** ○ **Boot covers** that are waterproof or **leg covers** ○ **Single use fluid resistant or impermeable gown** that extends to at least mid-calf ○ **Respirators,** including **N-95** respirators or **powered air purifying respirators** (PAPR) ○ **Single use full-face shield** that is disposable ○ **Single use surgical hoods** to ensure complete coverage of the head and neck	• Recommended PPE should be worn by Healthcare Personnel (HCP) upon entry into patient rooms or care areas. Upon exit from the patient room or care area, PPE should be **carefully removed** without contaminating one's eyes, mucous membranes, or clothing with potentially infectious materials, and ○ Discarded, or ○ For re-useable PPE, cleaned and disinfected

Component	Recommendation	Comments
	○ **Apron that is waterproof and covers the torso** to the level of the mid-calf should be used if Ebola patients have vomiting or diarrhea ○ **Goggles are no longer recommended.**	according to the manufacturer's reprocessing instructions and hospital policies. • See Attachment I for instructions for donning and removing PPE. A dedicated observer must be present for both donning and doffing of PPE. • Hand hygiene should be performed immediately after removal of PPE
Patient Care Equipment	• **Dedicated** medical equipment (preferably disposable, when possible) should be used for the provision of patient care • All non-dedicated, non-disposable medical equipment used for patient care should be cleaned and disinfected according to manufacturer's IFU, preferably with **bleach 1:10.**	
Patient Care Considerations	• Limit the use of needles and other sharps as much as possible • Phlebotomy, procedures, and laboratory testing should be limited to the minimum necessary for essential diagnostic evaluation and medical care • All needles and sharps should be handled with extreme care and disposed in puncture-proof, sealed containers	
Aerosol Generating Procedures (AGPs)	• Avoid AGPs for Ebola (EVD) patients. • If performing AGPs, use a combination of measures to reduce exposures from aerosol-generating procedures when performed on Ebola VD patients. • Visitors should not be present during aerosol-generating procedures.	• Although there is limited data available to definitively define a list of AGPs, procedures that are usually included are Bilevel Positive Airway Pressure (BiPAP), bronchoscopy, sputum induction, intubation and

Component	Recommendation	Comments
	• Limiting the number of HCP present during the procedure to only those essential for patient care and support. • Conduct the procedures in a private room and ideally in an **Airborne Infection Isolation Room (AIIR)** when feasible. Room doors should be kept closed during the procedure except when entering or leaving the room, and entry and exit should be minimized during and shortly after the procedure. • HCP should wear **gloves**, a **gown**, **disposable shoe covers**, and a **face shield** that fully covers the front and sides of the face, and respiratory protection that is at least as protective as a NIOSH certified fit-tested **N95 filtering facepiece respirator** or higher (e.g., powered air purifying respiratory or elastomeric respirator) during aerosol generating procedures. • Conduct environmental surface cleaning following procedures (see section below on environmental infection control). • If reusable equipment or PPE (e.g. Powered air purifying respirator, elastomeric respirator, etc.) are used, they should be cleaned and disinfected according to manufacturer instructions, preferably with bleach 1:10. • Collection and handling of soiled re-usable respirators must be done by trained individuals using PPE	extubation, and open suctioning of airways. • Because of the potential risk to individuals reprocessing reusable respirators, disposable filtering face piece respirators are preferred.
Hand Hygiene	• HCP should perform hand hygiene frequently, including before and after all patient contact, contact with potentially infectious material, and before putting on and upon removal of PPE, including gloves. • RUHS-Medical Center should ensure that supplies for performing hand hygiene are available.	• Hand hygiene can be performed by washing with soap and water or using alcohol-based hand rubs. If hands are visibly soiled, use soap and water, not alcohol-based hand rubs.
Environmental	• Alert EVS immediately to ensure	• Use Environmental

Component	Recommendation	Comments
Infection Control	proper protocol for environmental cleaning and disinfection and waste and linen management. Diligent environmental cleaning and disinfection and safe handling of potentially contaminated materials is paramount, as blood, sweat, emesis, feces and other body secretions represent potentially infectious materials • HCP performing environmental cleaning and disinfection should wear recommended PPE (described above) and consider use of additional barriers (shoe and leg coverings, etc.) if needed. • Face protection (face shield) should be worn when performing tasks such as liquid waste disposal that can generate splashes. • Follow standard procedures, per hospital policy and manufacturers' instructions, for cleaning and/or disinfection of environmental surfaces and equipment • Textiles and laundry should be disposed of in a red biohazardous bag • Food utensils and dishware should be disposable • Red biohazard bags are collected by EVS and autoclaved	Protection Agency (EPA)-registered bleach 1:10, to disinfect hard non-porous surfaces. o Follow label instructions for use
Safe Injection practices	• RUHS-Medical Center should follow safe injection practices as specified under Standard Precautions.	• Any injection equipment or parenteral medication container that enters the patient treatment area should be dedicated to that patient and disposed of at the point of use.
Duration of Infection Control Precautions	• Duration of precautions should be determined on a case-by-case basis, in conjunction with local, state, and federal health authorities.	• Factors that should be considered include, but are not limited to: presence of symptoms related to Ebola VD, date symptoms resolved, other conditions that

Component	Recommendation	Comments
		would require specific precautions (e.g., tuberculosis, *Clostridium difficile*) and available laboratory information

Monitoring and Management of Potentially Exposed Personnel	• RUHS-Medical Center will monitor all potentially exposed HCP
	• Persons with percutaneous or mucocutaneous exposures to blood, body fluids, secretions, or excretions from a patient with suspected Ebola VD should
	  ○ Stop working and immediately wash the affected skin surfaces with soap and water. Mucous membranes (e.g., conjunctiva) should be irrigated with copious amounts of water or eyewash solution
	  ○ Immediately contact emergency department/supervisor for assessment and access to postexposure management services for all appropriate pathogens (e.g., Human Immunodeficiency Virus, Hepatitis C, etc.)
	• HCP who develops sudden onset of fever, intense weakness or muscle pains, vomiting, diarrhea, or any signs of hemorrhage after an **unprotected exposure** (e.g., not wearing recommended PPE at the time of patient contact or through direct contact to blood or body fluids) to a patient with Ebola VD should
	  ○ Not report to work or should immediately stop working
	  ○ Notify their supervisor
	  ○ Seek prompt medical evaluation and testing in the ED
	  ○ Notify local and state health departments
	  ○ Comply with work exclusion until they are deemed no longer	

Component	Recommendation	Comments

	infectious to others
	• For asymptomatic HCP who had an **unprotected exposure** (e.g., not wearing recommended PPE at the time of patient contact or through direct contact to blood or body fluids) to a patient with Ebola VD
	  ○ Should receive medical evaluation and follow-up care including fever monitoring twice daily for 21 days after the last known exposure.
	  ○ The exposed personnel should be contacted twice daily by their supervisor to discuss potential symptoms and document fever checks
	  ○ May continue to work while receiving twice daily fever checks, based upon hospital policy and discussion with local, state, and federal public health authorities.	

Monitoring, Management, and Training of Visitors	• Avoid entry of visitors into the patient's room
	  ○ Exceptions may be considered on a case-by-case basis for those who are essential for the patient's wellbeing.
	• Establish procedures for monitoring, managing, and training visitors.
	• Visits should be scheduled and controlled to allow for:
	  ○ Screening for Ebola VD (e.g., fever and other symptoms) before entering or upon arrival to the hospital
	  ○ Evaluating risk to the health of the visitor and ability to comply with precautions
	  ○ Providing instruction, before entry into the patient care area on hand hygiene, limiting surfaces touched, and use of PPE according to the current
		• Visitors who have been in contact with the Ebola VD patient before and during hospitalization are a possible source of Ebola hemorrhagic fever (EHF) for other patients, visitors, and staff.

Component	Recommendation	Comments
	policy while in the patient's room o Visitor movement within the facility should be restricted to the patient care area and an adjacent waiting area.	

4. REFERENCES

4.1 California Department of Public health. All Facilities Letter, AFL 22-24, November 2022

4.2 California Department of Public Health. Ebola Virus Disease (EVD) Medical Waste Management, October 2022

4.3 Centers for Disease Control and Prevention. Interim Guidance for Preparing Frontline Healthcare Facilities for Patients Suspected to Have Ebola Virus Disease (EVD), May 2024

4.4 Centers for Disease Control and Prevention
National Center for Emerging and Zoonotic Infectious Diseases (NCEZID)
Division of High-Consequence Pathogens and Pathology (DHCPP)

4.5 McQuiston JH, Montgomery JM, Hutson CL. Ten Years of High-Consequence Pathogens—Research Gains, Readiness Gaps, and Future Goals. Emerging Infectious Diseases. 2024;30(4):800-802. doi:10.3201/eid3004.240160.

4.6 RUHS-Medical Center Housewide Policy 1102 Influx of People with Infectious Diseases

5. ATTACHMENTS

5.1 Donning and doffing PPE for Ebola

Document History:

Prior Release Dates: New	**Retire Date:** **N/A**
Document Owner: **Infection Prevention and Control Manager**	**Replaces Policy:** IC 7-21 Prevention Ebola Virus,IC 7-22 Checklist for PPE Ebola Virus

Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
07-2024	Infection Prevention and Control Committee		New policy
7/24/2024	Nursing Policies and Procedures	N	
8/6/2024	Policy Approval Committee	N	

Attachment I: Donning and doffing PPE for Ebola

Healthcare workers must understand the following basic principles to ensure safe and effective PPE use, which include that no skin may be exposed while working in PPE.

Donning

PPE must be donned correctly in proper order before entry into the patient care area and not be later modified while in the patient care area. **The donning activities must be directly observed by a trained observer.**

During Patient Care

PPE must remain in place and be worn correctly for the duration of exposure to potentially contaminated areas.

Healthcare workers should perform frequent disinfection of gloved hands using an ABHR, particularly after handling body fluids.

If during patient care a partial or total breach in PPE (e.g., gloves separate from sleeves leaving exposed skin, a tear develops in an outer glove, a needlestick) occurs, the healthcare worker must move immediately to the doffing area to assess the exposure.

Doffing

The removal of used PPE is a **high-risk process** that requires a structured procedure, a trained observer, and a designated area for removal to ensure protection.

PPE must be removed slowly and deliberately in the correct sequence to reduce the possibility of self-contamination or other exposure to Ebola virus. **The doffing activities must be directly observed by a trained observer.**

Donning PPE Checklist

Donning PPE	Protocol	Check
1. Engage Trained Observer	The donning process is conducted under the guidance and supervision of a trained observer who confirms visually that all PPE is serviceable and has been donned successfully. The trained observer will use this checklist to confirm each step in donning PPE and can assist with ensuring and verifying the integrity of the ensemble. **No exposed skin or hair of the healthcare worker should be visible at the conclusion of the donning process.**	

Donning PPE	Protocol	Check
2. Remove Personal Clothing and Items	Change into surgical scrubs (or disposable garments) and dedicated washable (plastic or rubber) footwear in a suitable, clean area. No personal items (e.g., jewelry, watches, cell phones, pagers, pens) should be brought into the patient's room.	
3. Inspect PPE Prior to Donning	Visually inspect the PPE ensemble to be worn to ensure it is in serviceable condition, all required PPE and supplies are available, and that the sizes selected are correct for the healthcare worker. The trained observer reviews the donning sequence with the healthcare worker before the healthcare worker begins and reads it to the healthcare worker in a step-by-step fashion.	
4. Perform Hand Hygiene	Perform hand hygiene with ABHR. When using ABHR, allow hands to dry before moving to the next step.	
5. Put on Inner Gloves	Put on the first pair of gloves.	
6. Put on Boots		
7. Put on Gown or Coverall	Put on gown or coverall. Ensure the gown or coverall is large enough to allow unrestricted freedom of movement. Ensure cuffs of inner gloves are tucked under the sleeve of the gown or coverall.	
8. Put on N-95 Respirator	Put on N95 respirator. Complete a user seal check.	
9. Put on Surgical Hood	Over the N95 respirator, place a surgical hood that covers all of the hair and the ears, and ensure that it extends past the neck to the shoulders. Be certain that the hood completely covers the ears and neck.	
10. Put on Outer Apron (if used)	Put on a full-body apron to provide additional protection to the front of the body against exposure to body fluids or excrement from the patient.	
11. Put on Outer Gloves	Put on the second pair of gloves (with extended cuffs). Ensure the cuffs are pulled over the sleeves of the gown or coverall.	
12. Put on Face shield	Put on full-face shield (if the hood does not have one) over the N95 respirator and surgical hood to provide additional protection to the front and sides of the face, including skin and eyes.	
13. Verify	After completing the donning process, the integrity of the ensemble is verified by the trained observer. The healthcare worker should be comfortable and able to extend the arms, bend at the waist and go through a range of motions to ensure there is sufficient range of movement while all areas of the body remain covered. A mirror in the room will be useful for the healthcare worker while donning PPE.	
14. Disinfect Outer Gloves	Disinfect outer-gloved hands with alcohol-based hand rub (ABHR). Allow to dry prior to patient contact.	

Doffing PPE Checklist

PPE doffing is performed in the designated PPE removal area. **Place all PPE waste in a leak-proof infectious waste container.**

Doffing PPE	Protocol	Check
1. Engage Trained Observer	The doffing process is conducted under the supervision of a trained observer, who **reads aloud each step** of the procedure and confirms visually that the PPE has been removed properly. Prior to doffing PPE, the trained observer must remind healthcare workers to avoid reflexive actions that may put them at risk, such as touching their face. **Post this instruction** and **repeat it verbally during doffing**. Although the trained observer should minimize touching healthcare workers or their PPE during the doffing process, the trained observer may assist with removal of specific components of PPE as outlined below. **The trained observer disinfects the outer-gloved hands immediately after handling any healthcare worker PPE.**	
2. Inspect	Inspect the PPE to assess for **visible contamination, cuts, or tears** before starting to remove. Disinfect PPE using bleach **1:10 wipes**. If the facility conditions permit **bleach 1:10 spray** can be used.	
3. Disinfect Outer Gloves	Disinfect outer-gloved hands with **bleach 1:10 wipes**.	
4. Remove Apron (if used)	Remove and discard apron taking care to avoid contaminating gloves by rolling the apron from inside to outside.	
5. Inspect	Following apron removal, inspect the PPE ensemble to assess for visible contamination or cuts or tears. If visibly contaminated, then disinfect affected PPE using bleach 1:10 wipes.	
6. Disinfect Outer Gloves	Disinfect outer-gloved hands with **bleach 1:10 wipes**.	
7. Remove Boot or Shoe covers	While sitting down, remove and discard boot or shoe covers.	
8. Disinfect and Remove Outer Gloves	Disinfect outer-gloved hands with **bleach 1:10 wipes**. Remove and discard outer gloves taking care not to contaminate inner gloves during removal process.	
9. Inspect and Disinfect Inner Gloves	Inspect the inner gloves' outer surfaces for visible contamination, cuts, or tears. **If an inner glove is visibly soiled, cut, or torn**, disinfect the gloves with **bleach 1:10 wipes**. Then remove the inner gloves, perform hand hygiene with ABHR on bare hands, and don a clean pair of gloves.	

Doffing PPE	Protocol	Check
10. Remove Face Shield	Remove the full-face shield by tilting the head slightly forward, grabbing the rear strap and pulling it over the head, gently allowing the face shield to fall forward and discard. Avoid touching the front surface of the face shield.	
11. Disinfect Inner Gloves	Disinfect gloves with **bleach 1:10 wipes**.	
12. Remove Surgical Hood	Unfasten (if applicable) surgical hood, gently remove, and discard. The trained observer may assist with unfastening hood.	
13. Disinfect Inner Gloves	Disinfect gloves with **bleach 1:10 wipes**.	
14. Remove Gown or Coverall	Remove and discard a) Depending on gown design and location of fasteners, the healthcare worker can either untie fasteners, receive assistance by the trained observer to unfasten the gown, or gently break fasteners. Avoid contact with scrubs or disposable garments with the outer surface of gown during removal. Pull gown away from body, rolling inside out and touching only the inside of the gown. b) To remove coverall, tilt head back to reach zipper or fasteners. Unzip or unfasten coverall completely before rolling down and turning inside out. Avoid contact of scrubs with outer surface of coverall during removal, touching only the inside of the coverall.	
15. Disinfect and Change Inner Gloves	Disinfect inner gloves with either **bleach 1:10 wipes** or **ABHR**. Remove and discard gloves taking care not to contaminate bare hands during removal process. **Perform hand hygiene with ABHR**. Don a new pair of inner gloves.	
16. Remove N-95 Respirator	Remove the N95 respirator by tilting the head slightly forward, grasping first the bottom tie or elastic strap, then the top tie or elastic strap, and remove without touching the front of the N95 respirator. Discard N95 respirator.	
17. Disinfect Inner Gloves	Disinfect inner gloves with either with **bleach 1:10 wipes** or **ABHR**	
18. Disinfect Washable Shoes	Sitting on a new clean surface (e.g., second clean chair, clean side of a bench) use **bleach 1:10 wipes** to wipe down every external surface of the washable shoes.	
19. Disinfect and Remove Inner Gloves	Disinfect inner-gloved hands with **bleach 1:10 wipes**. Remove and discard gloves taking care not to contaminate bare hands during removal process.	
20. Perform Hand Hygiene	Perform hand hygiene with ABHR.	
21. Inspect	Perform a final inspection of healthcare worker for any indication of contamination of the surgical scrubs or disposable garments.	

Doffing PPE	Protocol	Check
	If contamination is identified, immediately inform infection preventionist or their designee before exiting PPE removal area.	
22. Scrubs	Healthcare worker can leave PPE removal area wearing dedicated washable footwear and surgical scrubs or disposable garments.	
23. Shower	Showers are recommended at each shift's end for healthcare workers performing high risk patient care (e.g., exposed to large quantities of blood, body fluids, or excreta). Showers are also suggested for healthcare workers spending extended periods of time in the Ebola patient room.	
24. Protocol Evaluation/ Medical Assessment	The infection preventionist or their designee on the unit at the time should meet with the healthcare worker to review the patient care activities performed to identify any concerns about care protocols and to record healthcare worker's level of fatigue.	

RIVERSIDE UNIVERSITY HEALTH SYSTEM-MEDICAL CENTER
Infection Prevention and Control

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Title: Corona Virus (COVID-19)	**Effective Date:** 8/20/2024	☐ **RUHS – Behavioral Health** ☐ **RUHS – Community Health Centers** ☐ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By:  Jennifer Cruikshank CEO/Hospital Director		☒ **Policy** ☐ **Procedure** ☐ **Guideline**

1. SCOPE

1.1 Riverside University Health System-Medical Center (RUHS-Medical Center) utilizes infection prevention measures to prevent the transmission of COVID-19 among patients and staff.

2. POLICY

2.1 Source Control

a. Visual alerts may be displayed at entrances. Alerts should request patients to inform staff if they have the following symptoms: fever, respiratory symptoms, loss of sense of taste or smell, nausea, vomiting, or diarrhea.

b. Masks will be available for patients at all points of entry. Patients should be educated on hand hygiene and respiratory/cough etiquette. For patients who cannot wear a mask, tissues should be provided.

c. Symptomatic patients will be given a mask (if medically appropriate) and placed in appropriate designated areas. The designation of areas shall comply with all patient privacy requirements as per RUHS policy HW 700 Patient Privacy HIPAA.

2.2 Infection Prevention and Control for the Hospitalized Patient

a. Hand hygiene, Standard Precautions, and Transmission-based Precautions (Airborne, Contact, and Eye protection) are to be followed by all Medical Center personnel when caring for suspected or confirmed COVID-19 patients.

b. Required personal protective equipment (PPE) include:

i. Gown
ii. Gloves
iii. Fit tested N-95 or powered air purifying respirator (PAPR)
iv. Eye protection (face shield or goggles)

c. Patients should be placed in Airborne Infection Isolation Rooms (AIIR). If AIIRs are not available, patients will be placed in regular rooms and the door will remain closed at all times.

2.3 Testing and Sample Collection

a. Specimens shall be collected and sent to the lab without delay, avoiding use of the pneumatic tube system.

b. For Arlington Campus: Roommates of the positive COVID-19 patient will be tested.

2.4 Laundry and Food Services

a. Management of laundry and food service utensils is in accordance with routine procedures and will follow RUHS-Medical Center policies.

2.5 Waste

a. Management of waste (regular and biohazard) is in accordance with routine procedures and will follow RUHS-Medical Center policies.

2.6 Patient Cohorting

a. Cohorting of patients in isolation units and the use of alternative sites such as surge tents may be necessary. In times of surge, laboratory testing may be limited or delayed, therefore patients may be cohorted based upon clinical symptoms.

b. Consideration should be taken when cohorting patients that may be coinfected with other pathogenic organisms (e.g., methicillin-resistant *Staphylococcus aureus*). These may require additional Isolation Precautions.

2.7 Patient Transport

a. Patients must be masked when being transported to other areas of the facility, unless medically contraindicated. Efforts should be made to keep the patient within the room, when possible.

2.8 Medical Evaluation and Empiric Treatment

a. All patients with suspected COVID-19 infection may also be tested for common causes of respiratory infection and pneumonia as clinically indicated. Testing for other respiratory pathogens should not delay specimen collection for COVID-19 testing.

2.9 De-isolation of Hospitalized Patients

a. An order for an Infectious Disease consultation must be placed by the care team prior to deisolating a patient at the Medical Center.

b. For Arlington Campus: Patients may be deisolated by a physician when meeting current deisolation criteria.

2.10 Patient Education

a. Education regarding COVID-19 will be provided to suspected or confirmed COVID-19 patients upon discharge.

2.11 Infection Prevention and Control of COVID-19 in Peri- and Postpartum Settings

a. After the infant is born, the suspected or confirmed COVID-19 mother should put on a surgical mask and then perform hand hygiene before handling the baby.

b. Rooming-in with mother: Newborn infants of COVID-19 infected mothers that are in the same room as the mother should be housed in an isolette. The isolette should be placed at least 3-6 feet from the mother when she is not interacting with the baby. The mother should wear a new surgical mask and a clean gown when coming in contact with the baby and perform hand hygiene before handling the baby.

c. Neonatal Intensive Care Unit (NICU): If a newborn infant of a COVID-19 infected mother is housed in the NICU instead of the mother's room, the infant should be monitored for symptoms and placed on Airborne and Contact Precautions with eye protection. All efforts should be made to isolate the infant in a NICU Isolation room. The infant should be tested at 24 and 48 hours of life. If both tests are negative and the infant does not have any symptoms, isolation may be discontinued.

d. Follow current NICU visitation protocols for admitted and non-admitted mothers with confirmed COVID-19.

e. Exceptions may be made by the unit director for extenuating circumstances.

2.12 Cleaning of Rooms and Equipment

a. Terminal cleaning will be performed on all rooms occupied by suspected or confirmed COVID-19 patients.

b. Cleaning and disinfection of patient equipment and environmental surfaces will be performed in accordance with routine procedures and will follow RUHS-Medical Center policies.

c. Ultraviolet lights (UV) are located in most patient rooms and are operational at all times to help eliminate virus particles.

2.13 Visitors

a. Refer to the most current RUHS-Medical Center visitation guidelines.

b. All visitors of suspected or confirmed COVID-19 patients will be instructed on proper PPE and hand hygiene.

2.14 Staff Resources

a. Vaccination

i. Personnel are strongly encouraged to obtain all recommended COVID-19 vaccinations.

ii. Tracking and reporting of employee vaccinations or declination will be done in accordance with state and federal requirements.

2.15 Employee Exposure Response

a. Staff that have had close contact exposure (member of their household tests positive) should test only if symptomatic. The staff member must adhere to the following:

i. If the COVID-19 positive household member can self-isolate: The asymptomatic staff member will continue to work while wearing a mask and should monitor themselves for any symptoms for 10 days.

ii. If the COVID-19 positive household member cannot self-isolate: The asymptomatic staff member will continue to work while wearing a mask and should monitor themselves for any symptom for 10

days after the positive household member tests negative by antigen test.

2.16 Return to work Criteria

a. Refer to the most current RUHS-Medical Center protocol.

2.17 Reporting

a. The Infection Prevention and Control Department will report positive results and deaths due to COVID-19 to the local public health department as required.

2.18 Surge

a. In the event of a surge in COVID-19 patients, RUHS-Medical Center will follow established emergency response and surge activity policies and procedures.

2.19 Guidelines are subject to change at any time based on California Department of Public Health (CDPH) and Centers for Disease Control and Prevention (CDC) recommendations.

3. REFERENCES

3.1 California Department of Public Health (CDPH), All Facilities Letters

3.2 Centers for Disease Control and Prevention (CDC). (2023). Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic. Retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/index.html

3.3 RUHS-Medical Center Housewide Policy 607 Inpatient Overflow and Surge Areas for External Disasters and Pandemics

3.4 RUHS-Medical Center Housewide Policy 1102 Influx of People with Infectious Diseases

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Date Reviewed	**Reviewed By:**	**Revisions Made Y/N**	**Revision Description**
12-2023	Infection Prevention and Control Committee	Yes	Streamlined wording, updated current practices, changed document name, removed pandemic references
2/1/2024	Pre-Nursing P&P	Yes	2.9, 2.11d needs modifications
7/24/2024	Nursing P&P Evote	No	
8/6/2024	Policy Approval Committee	Y	Add language about patient privacy in 2.1 c, strengthen language from 'should' to 'shall' in 2.3 a.

RIVERSIDE UNIVERSITY HEALTH SYSTEM – MEDICAL CENTER

	Document No: 1110	Page 1 of 2
Title: Portable Fans for Patient Use	**Effective Date:** 8/26/2024	☐ **RUHS – Behavioral Health** ☐ **RUHS – Community Health Centers** ☒ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By: Jennifer Cruikshank CEO/Hospital Director		☒ **Policy** ☐ **Procedure** ☐ **Guideline**

1. SCOPE

1.1 To ensure the safe and appropriate use of portable fans in clinical areas, minimizing the risk of cross-contamination and maintaining a safe environment for patients and staff.

2. POLICY

2.1 Portable fans are linked to cross-contamination in healthcare settings and should not be routinely used in clinical areas**.**

2.2 Risk assessment must be conducted prior to the use of fans to ensure that:

a. All other alternative methods of cooling have been considered.

b. The use of the fan is determined to be beneficial for the patient to assist in patient comfort, chronic breathlessness in Chronic Obstructive Pulmonary Disease (COPD) patients, or to regulate a patient's body temperature.

3. GUIDELINES

3.1 Patient Use

a. Fans are to be utilized by patients only, they are not for staff use.

3.2 Request and Approval

a. Fans will only be provided upon request by the patient or family member.

b. Fans are provided by RUHS-Medical Center Plant Operations, outside fans are prohibited.

3.3 Positioning and Safety

a. Fans and cords must be positioned to avoid safety/trip hazards.

b. Do not use fans with damaged electrical cords or near wet surfaces.

c. Fans must not interfere with other equipment or tasks (e.g., clip-on fans must not obstruct personal protective equipment (PPE) usage).

3.4 Procedures

a. Fans should be turned off during:

- Wound care
- Sterile or aseptic procedures

- Procedures that may result in splashes of bodily fluids
- Aerosol-generating procedures

3.5 Operation

a. Do not use the oscillating function. This helps to limit the direction of airflow.

b. Fans should be set to the lowest speed that achieves the intended cooling effect.

c. Airflow must be directed at the patient and not towards the door.

d. The fan should be placed at bed level or higher.

e. Proper hand hygiene and use of PPE should always be followed.

3.6 Restrictions

a. Fans are prohibited in the following areas:

- Rooms with multiple patients
- Rooms with patient on Transmission-Based Precautions. Exceptions may be made for extenuating circumstances. If a fan is used in an isolation room, the door must remain closed.
- Operating rooms
- Procedure/examination rooms

3.7 Single Patient Use

a. Fans are intended for single patient use only and should be discarded upon discharge.

4. REFERENCES

4.1 The Joint Commission. (n.d.) Fans - Patient Care Areas. Retrieved from https://www.jointcommission.org/standards/standard-faqs/hospital-and-hospital-clinics/environment-of-care-ec/000001276/

Document History:

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Date Reviewed	Reviewed By:	Revisions Made Y/N	Revision Description
08-2024	Infection Prevention and Control Committee		New policy
8/26/2024	PAC	N	

RIVERSIDE UNIVERSITY HEALTH SYSTEM-MEDICAL CENTER

Housewide

	Document No: 1111	Page 1 of 22
Title: Aerosol Transmissible Disease Exposure Control Plan	**Effective Date:** 8/26/2024	☐ **RUHS – Behavioral Health** ☐ **RUHS – Community Health Centers** ☒ **RUHS – Hospital Based Clinics** ☒ **RUHS – Medical Center** ☐ **RUHS – Public Health** ☐ **Departmental**
Approved By: Jennifer Cruikshank CEO/Hospital Director		☐ **Policy** ☐ **Procedure** ☒ **Guideline**

1. SCOPE

1.1 The policy of Riverside University Health System-Medical Center (RUHS-Medical Center) is to employ effective measures to monitor and minimize the transmission of aerosol transmissible diseases (ATDs) among health care workers, visitors, and patients.

1.2 See APPENDIX I. This appendix contains a list of diseases and pathogens which are to be considered aerosol transmissible pathogens for the purpose of Cal/OSHA Section 5199. RUHS-Medical Center provides the protections required by Section 5199 for those pathogens and diseases listed under “Airborne Infectious Diseases/Pathogens.”

2. DEFINITIONS

2.1 See APPENDIX II.

3. REVIEW OF ATD PLAN

3.1 This Plan will be reviewed annually, or sooner if changes occur.

4. Job Classifications Having Occupational Exposure To ATDs

4.1 The following clinical and non-clinical job classifications have occupational exposure to ATDs:

- Clinical nursing personnel
- Physicians (attendings, fellows, residents, interns)
- Nursing Assistants & Technicians
- Clinical Laboratory personnel
- Respiratory Care personnel
- Environmental Service personnel
- Radiology/Nuclear Medicine personnel
- Physical Therapy personnel
- Occupational & Speech Therapy personnel
- Licensed Independent Practitioners
- Facilities personnel
- Transport personnel
- Security personnel
- Admitting personnel with clinical exposure

- Pastoral Services personnel
- Rehabilitation Services personnel
- Social Services personnel
- Case Management personnel
- Perioperative personnel
- Lift team
- Plant Operation personnel
- Other personnel with potential exposure not listed above

5. Aerosol generating procedures (AGPs)

5.1 The following is a list of AGPs performed at RUHS-Medical Center. **These procedures are considered high hazard procedures if performed on a patient who is suspected or confirmed to have an aerosol transmissible disease or Influenza.** (alphabetical order, not in order of importance)

- Aerosolized medication administration (including Nebulizer administration)
- Autopsy procedures that may aerosolize pathogens
- Chest physiotherapy (e.g., vest, IPV, high-frequency oscillatory ventilation)
- Diagnostic procedures (e.g., bronchoscopy, pulmonary function testing, gastric aspirates, EGD)
- Endotracheal intubation and extubation
- High flow O2 delivery with active manipulation
- Laboratory procedures that may aerosolize pathogens
- Lung Biopsy
- Manual ventilation (e.g., BVM)
- Non-invasive ventilation (e.g., BiPAP, CPAP) with active manipulation
- Open suctioning of airways
- Operative procedures involving the airway
- Repairing, replacing, or maintaining air systems or equipment that are anticipated to contain aerosolized M. tuberculosis or other aerosol transmissible diseases
- Respiratory care procedures (e.g., bronchoscopy, tracheostomy, endotracheal tube care)
- Resuscitative procedures
- Sputum induction
- Thoracotomy

6. ENGINEERING CONTROLS, WORK PRACTICE CONTROLS & PERSONAL PROTECTIVE EQUIPMENT

6.1 RUHS-Medical Center will use feasible engineering and work practice controls to minimize employee exposures to ATDs.

6.2 Containment

a. Early identification, triage, and isolation of symptomatic patients by a licensed healthcare provider.

b. Provide masks to symptomatic patients for source control unless medically contraindicated. Patients may also be provided a tissue to cover their nose and mouth if unable to wear a mask.

c. Prompt medical evaluation of persons with symptoms suggestive of Tuberculosis (TB), COVID-19, or other ATDs.

6.3 Airborne Infection Isolation Rooms (AIIRs)

a. Any patient with suspected or confirmed airborne infectious disease (AirID) will be cared for in an AIIR to the extent feasible, until medically determined to be non-infectious. Transfer within the facility to an AIIR will occur within 5 hours of identification.

b. Any patient with suspected or confirmed AirID who cannot be placed in an AIIR will be transferred to another facility with an AIIR within 5 hours unless it is documented that, at the end of the 5 hours period, and at least every 24 hours thereafter:

- The local health officer has been contacted.
- There are no AIIRs or areas available within that jurisdiction.
- Reasonable efforts have been made to contact establishments outside of that jurisdiction.
- All applicable measures recommended by Infection Prevention and Control have been implemented, and all employees who enter the room or area housing the individual are provided with, and use, respiratory protection.
- Exceptions: Where the treating physician determines that transfer would be detrimental to a patient's condition, the patient need not be transferred. In that case the facility shall ensure that employees use respiratory protection when entering the room or area housing the individual. The patient's condition shall be reviewed at least every 24 hours to determine if transfer is safe, and the determination shall be recorded. Once the transfer is determined to be safe, the transfer must be made within 5 hours.
- Where it is not feasible to provide AIIRs or areas to individuals suspected or confirmed to be infected with or carriers of novel or unknown aerosol transmissible pathogens (ATPs), the employer shall provide other effective control measures to reduce the risk of transmission to employees, which shall include the use of respiratory protection.

c. For suspected or confirmed AirID patients, AGPs are performed either in a negative pressure room or using a portable HEPA filtered enclosed module.

- Exception: Where no such room or area is available and the treating physician determines that it would be detrimental to the patient's condition to delay performing the procedure, high hazard procedures may be conducted in other areas.

d. Negative pressure shall be maintained in AIIRs or areas. The required ventilation rate may be achieved in part by using in-room high efficiency particulate air (HEPA) filtration or other air cleaning technologies, but in no case shall the outdoor air supply ventilation rate be less than 6 (six) air changes per hour (ACH).

e. Doors and windows of AIIRs shall be kept closed while in use for AII.

f. AIIRs at RUHS-Medical Center are on a continuous electronic monitor for negative air pressurization.

g. If the AIIR is in use for an AirID case and not maintaining negative pressure, the patient will be moved to another AIIR as soon as possible.

h. If the problem(s) prevent the room from providing effective AII, then the room shall not be used for that purpose until the condition is corrected.

i. When a suspected or confirmed case vacates an AIIR or area, the room or area shall be ventilated according to the guidelines for preventing the transmission of TB in healthcare settings for a removal efficiency of 99.9% before permitting employees to enter without respiratory protection. For recently vacant AIIRs at RUHS-Medical Center, rooms should be allowed to ventilate a minimum of 35 minutes prior to entry without respiratory protection.

j. Contaminated Air: To the extent feasible, all air from exhaust systems used for AIIRs shall be directly exhausted to the outside of the building, while maintaining negative pressure relative to all areas inside the building. Exhaust-air outlets shall be positioned so that air does not re-enter the building.

k. Engineering controls shall be maintained, inspected and performance monitored for filter loading and leakage at least annually, whenever filters are changed and more often if necessary to maintain effectiveness.

l. Filter Disposal: Filters from exhaust systems or machines used to clean air contaminated with TB bacteria shall be containerized and treated as medical waste in accordance with Health and Safety Code sections 25080, 25081 and 25090 of the Health and Safety Code.

6.4 Patient Placement

a. Single patient rooms should be used for suspected or confirmed droplet or airborne transmitted diseases.

b. All respiratory precaution areas must be identified when in use.

- Signs will be posted at entry to AIIR when in use for a patient with suspected or confirmed AirID.

6.5 Personal Protective Equipment (PPE)

a. Appropriate protective equipment will be provided to RUHS-Medical Center employees at no cost. Healthcare providers may always choose to add a higher level of respiratory protection or PPE than required.

b. Powered Air Purifying Respirators (PAPRS) are the preferred respiratory protection when aerosol generating procedures are performed on patients with suspected or confirmed airborne infectious diseases (high hazard procedures).

6.6 **Healthcare providers <u>with direct participation in</u> high hazard procedures** (cases with confirmed or suspected airborne infectious diseases or Influenza) must:

- Wear a fit tested N-95 respirator or PAPR
- Follow Standard Precautions which includes wearing appropriate PPE according to the anticipated risk of exposure

b. **Healthcare providers <u>observing</u> high hazard procedures** (cases with confirmed or suspected airborne infectious diseases or Influenza) must:

- Wear a fit tested N-95 respirator or PAPR

- Follow Standard Precautions which includes wearing appropriate PPE according to the anticipated risk of exposure
- Remain an adequate distance from the patient's head and neck so as to avoid the risk of exposure to blood and body fluids

c. PPE required for AGPs (on patients that are NOT suspected or confirmed to have an airborne infectious disease or Influenza).

- Standard Precautions which include wearing appropriate PPE according to the anticipated risk of exposure.

d. Exception: Bronchoscopy

- N95 respirator is required for all bronchoscopy procedures (whether or not it is considered a high hazard procedure). Exceptions for emergent cases would be based on the providers clinical judgement.

- Gloves, gown, and eye protection are required for all bronchoscopy procedures (whether or not it is considered a high hazard procedure). Exceptions for emergent cases would be based on the providers clinical judgement.

7. RESPIRATORY PROTECTION PROGRAM

7.1 Respirator assignments by task/location

Task/Location	Potential Exposure	Respirator Type	Employees Included
Performing high hazard procedures (AGPs on cases with confirmed or suspected airborne infectious disease (AirID)) or present when such procedures are performed (see above 5.1 for list of high hazard procedures)	Infectious aerosols	PAPR or N-95	All Clinical Personnel
Performing high hazard procedures on cadavers potentially infected with aerosol transmissible pathogens or present while such procedures are performed	Infectious aerosols	PAPR or N-95	All Clinical Personnel
Performing high hazard procedures on confirmed or suspected influenza cases or present during such procedures	Infectious aerosols	N95	All Clinical Personnel
Entry into airborne infection isolation room or other area occupied by confirmed or suspected case of AirID	Infectious aerosols	N95	All Clinical and Non-clinical Personnel
Performing patient care or present during performance of procedures on an AirID confirmed or suspected case	Infectious aerosols	N95	All Clinical and Non-clinical Personnel
Cleaning/decontaminating area occupied by AirID confirmed or suspected case	Infectious aerosols	N95	Environmental Services

Repair/maintenance of air systems or equipment that may contain or generate aerosolized infectious agents	Infectious aerosols	N95	Plant Operations Facilities Environmental Services
Transport of an AirID confirmed or suspected case when the patient is not masked	Infectious aerosols	N95	All Clinical and Non-clinical Personnel
Laboratory operations involving aerosol transmissible pathogens	Infectious aerosols	Refer to Laboratory policies and procedures	Clinical Laboratory Personnel

7.2 Employees at RUHS-Medical Center will be provided with a NIOSH approved respirator that is at least as effective as an N-95 unless Centers for Disease Control and Prevention (CDC) or California Department of Public Health (CDPH) specifies a more protective level.

7.3 Employees who perform high hazard procedures (APGs on suspected or confirmed ATD cases or cadavers) will be provided with an equivalent or greater protection of a PAPR, such as N-100 mask, unless RUHS-Medical Center determines that this use would interfere with the successful performance of the required task.

7.4 RUHS-Medical Center will provide a respirator when the employee:

a. Enters an AIIR or area in use for AII

b. Is present during the performance of procedures or services for an AirID case or suspected case

c. Repairs, replaces, or maintains air systems or equipment that may contain or generate aerosolized pathogens

d. Is working in an area occupied by an AirID case or suspected case. All room decontamination will be performed after appropriate ventilation of the room.

e. Is present during the performance of aerosol generating procedures on cadavers that are suspected of, or confirmed as being infected with airborne infectious pathogens

f. Is performing a task for which the Exposure Control Plan requires the use of respirators

g. Transports an AirID case or suspected case in an enclosed vehicle (e.g., van, car, ambulance, or helicopter)

7.5 Fit testing

a. All employees assigned to use a respirator must pass a fit test.

b. Medical evaluation will be provided to determine the employee's ability to use a respirator before the employee is fit tested or required to use the respirator

c. The Occupational Health Department manages the Respirator Fit-Testing Program for the N-95 respirator for health care workers.

d. Either qualitative or quantitative methods of fit testing may be used.

e. Employees will be fit tested:

- At the time of initial fitting
- When a different size, make, model, or style of respirator is used
- At least every year

f. Fit testing will be completed on all individuals as defined above. Additional follow-up testing may be needed for persons whose test fails or who have changes or any other circumstance which may significantly alter the size or shape of the face.

g. Respirators will not be worn when conditions prevent a good face seal. Such conditions may include the following: growth of facial hair, absence of one or both sets of dentures, facial deformity, weight change of >15% of total body weight.

h. Individuals who do not pass fit testing with the initial respirator will be fit tested for alternative brands to achieve a passing fit test. As a final alternative, a PAPR may be offered.

7.6 For Droplet Precautions regular isolation masks or surgical masks will be worn. Fit testing is not required for these masks.

7.7 Materials Management maintains necessary quantities of PPE, specifically respirators & masks, based on usage that keeps a perpetual inventory. During times of increased need, these parameters will be increased to allow for stockpiling of additional masks & respirators.

8. MEDICAL SURVEILLANCE, VACCINATIONS, & EXPOSURE INCIDENTS

8.1 The Occupational Health Department provides medical surveillance for Tuberculosis (TB) in staff.

8.2 Medical surveillance provisions, including vaccinations, examinations, evaluations, determinations, procedures, medical management, and follow-up, shall be:

a. Performed by or under the supervision of an Occupational Health Nurse or Physician

b. Provided according to any Centers for Disease Control and Prevention (CDC) and California Department of Public Health (CDPH) recommendations that are current at the time these evaluations and procedures take place.

c. Provided in a manner that ensures the confidentiality of employees and patients. Test results and other information regarding exposure incidents and TB conversions shall be provided without providing the name of the source individual.

8.3 Test for Tuberculosis infection

a. New Hires

- A health examination, including TB screening, is a requisite for employment at RUHS-Medical Center, and must be performed prior to start of duty. Such screening will include a two-step tuberculin skin test (TST) or QuantiFERON upon hire for those who have:

- Not previously had a test or
- Whose previous test was negative or

- Whose previous test results are unknown

b. A history of previous non-recent BCG vaccination is not a contraindication for testing

c. New hires providing documentation of prior positive test may be excluded as long as they are asymptomatic and document a negative (or stable) chest x-ray within the past one year.

d. Students must receive TB screening by their primary institution or agency prior to assignment to the Medical Center.

e. Interns and volunteers must be evaluated and screened for TB by Occupational Health prior to the start of their duty unless evidence of screening is provided by the worker.

8.4 Annual Testing

a. Every 12 months, all health care workers who have direct or close indirect patient contact at any location where patient care is provided will receive and complete a health-screening questionnaire. This information will be assessed by Occupational Health.

b. For RUHS-Medical Center healthcare workers in high-risk areas such as Emergency Department, Respiratory Therapy, or Pulmonary Clinic, the frequency of testing may be increased.

c. Health care workers who have direct or close indirect patient contact and who have exhibited negative results on their previous test will receive a test annually.

d. If there is documentation of a previously positive test for the healthcare worker, an additional test need not be done.

8.5 Reporting

a. Occupational Health will report conversion rates to the Infection Prevention and Control Committee quarterly.

8.6 Administration Of Test

a. Occupational Health care professionals who are trained in application/interpretation are used to perform this procedure. All skin testing is recorded in millimeters of induration; standard interpretation of Tuberculin Skin Tests (TST) is used.

b. Positive test results are reviewed with health care workers by Occupational Health.

8.7 Chest Radiography (CXR)

a. All new hires with a history of positive skin tests must provide documentation of a CXR performed within the past one year or a CXR will be ordered by Occupational Health.

b. RUHS-Medical Center healthcare workers with a known positive test will have an annual health assessment. Chest X-Ray is performed if indicated by symptomatology.

8.8 Employee Medical Evaluation and Latent Tuberculosis Therapy

a. Testing and medical evaluation are available in the Occupational Health office, Monday through Friday during clinic hours and at no cost to the employee.

b. Treatment for latent TB is now recommended for all persons with positive TST or QuantiFERON, regardless of age. Latent disease therapy is especially indicated for anyone with any CXR abnormalities consistent with old TB disease. Such individuals will be referred to their private medical care system for latent TB therapy.

8.9 Conversions

a. Anyone exhibiting a positive test when previously negative ("conversion") will receive a CXR. If the CXR is within normal limits, the employee is referred to their private care physician and/or the Department of Public Health for evaluation for any further diagnostic testing and for possible latent TB therapy. If the CXR is abnormal, the employee is referred to the Department of Public Health for diagnostic evaluation, including induced sputum tests and drug therapy. The employee may return to work when cleared by the Department of Public Health. TB conversions will be recorded in accordance with California Code of Regulations, Title 8, Section 14300 et seq.

b. RUHS-Medical Center shall investigate the circumstances of the conversion and determine whether the conversion is likely occupational or not occupational. In making the determination Occupational Health may interact with Infectious Diseases Consulting Team in evaluating the possible role of any recent exposures, and correct any deficiencies found during the investigation.

8.10 Vaccines

a. Occupational Health makes available to all susceptible health care workers with occupational exposure all vaccine doses listed in Appendix III.

b. Seasonal influenza vaccine shall be provided during the period designated by the CDC for administration and need not be provided outside of those periods.

c. Immunity to measles, mumps, rubella, and varicella (through vaccination or titer checks) is mandatory for new employees unless there is a medical contra-indication.

d. Recommended vaccinations are made available to all employees who have occupational exposure after the employee has received the training required in this Plan and within 10 working days of initial assignment unless:

- The employee has previously received the recommended vaccination(s) and is not due to receive another vaccination dose; or
- Occupational Health has determined that the employee is immune in accordance with current CDC and CDPH guidelines; or
- The vaccine(s) is contraindicated for medical reasons.

e. Occupational Health will make additional vaccination(s) available to employees within 120 days of the issuance of new CDC or CDPH recommendations.

f. Occupational Health will not make participation in a prescreening program a prerequisite for receiving a vaccine unless CDC or CDPH guidelines recommend prescreening prior to administration of the vaccine.

g. If the employee initially declines a vaccination but at a later date while still covered under the standard, decides to accept the vaccination, Occupational Health will make the vaccination available within 10 working days of that request.

h. Employees who decline to accept a recommended and offered vaccinations will sign a declination.

Exception:

Where Occupational Health cannot implement these procedures because of the lack of availability of vaccine, Occupational Health will document efforts made to obtain the vaccine in a timely manner and inform employees of the status of the vaccine availability. Occupational Health will check on the availability of the vaccine at least every 10 working days and inform employees when the vaccine becomes available.

8.11 Exposure Incidents

a. Tuberculosis Reporting:

- The Infection Prevention and Control Department reports known or suspected cases of tuberculosis in patients to the local department of public health.
- The Case Manager coordinates the discharge approval plan with the local department of public health.
- The Microbiology Laboratory submits all Acid-Fast Bacillus (AFB) smear samples to the public health laboratory.

b. Determine whether employees may have had contact with the case or suspected case. Exposures are defined in consultation with the local department of public health.

c. Infection Prevention and Control will notify other employer(s) within 24 hours of notification of the diagnosis. These other employers may include, but are not limited to, paramedics, emergency medical technicians, emergency responders, personnel at referring health care facilities or agencies, homeless shelters, and corrections personnel.

d. Within 24 hours of becoming aware of the potential exposures, Infection Prevention and Control will notify the manager within the work area who will, in turn, identify those with likely exposure that should report to Occupational Health. Workers may be contacted in person, by phone, or e-mail.

e. A post-exposure evaluation will be provided as soon as feasible.

f. Where the physician recommends precautionary removal, RUHS-Medical Center will maintain until the employee is determined to be noninfectious, the employee’s earnings, seniority, and all other employee rights and benefits, including the employee's right to his or her former job status, as if the employee had not been removed from his or her job or otherwise medically limited. Exception: Precautionary removal provisions do not extend to any period of time

during which the employee is unable to work for reasons other than precautionary removal.

g. If processes are identified that could prevent future exposures, performance improvement will be implemented as soon as possible. If needed, policies will be amended, and workers will be updated on revised practices.

h. TB Exposures

- When an exposure incident occurs, the healthcare worker with unprotected exposure will be identified and referred to Occupational Health for follow-up and medical evaluation.
- Infection Prevention and Control, Unit Manager/Supervisor or designee, Occupational Health, and Nursing administration will assist in identifying all exposed employees and refer them promptly to Occupational Health for testing. If the employee converts to positive, a CXR will be done.
- Occupational Health will coordinate the exposure follow-up.
- Any employee suspecting he/she has been involved in unprotected exposure must report to his/her supervisor and to Occupational Health. Occupational Health will collaborate with Infection Prevention and Control to evaluate the incident.

i. RUHS-Medical Center workers with Active Tuberculosis

- RUHS-Medical Center workers identified as having active tuberculosis will be referred to their primary care physician.
- If testing was completed with the Occupational Health Department, the Occupational Health Department will notify the local department of public health of this reportable case.
- The local department of public health will approve the healthcare worker's return to work clearance.

9. TRAINING

9.1 Training will be provided as follows:

a. At the time of initial assignment to tasks where occupational exposure may take place.

b. At least annually thereafter.

c. With changes, such as introduction of new engineering or work practice controls, modification of tasks or procedures or institution of new tasks or procedures which affect the employee's occupational exposure or control measures. The additional training may be limited to addressing the new exposures or control measures.

9.2 The training program contains at a minimum the following elements:

a. An accessible copy of the regulatory text of this standard and an explanation of its contents.

b. A general explanation of ATDs including the signs and symptoms of ATDs that require further medical evaluation.

c. An explanation of the modes of transmission of ATPs or ATPs-L and applicable source control procedures.

d. An explanation of this ATD Exposure Control Plan and the means by which the employee can obtain a copy of the written plan and how they can provide input as to its effectiveness.

e. An explanation of the appropriate methods for recognizing tasks and other activities that may expose the employee to ATPs or ATPs-L.

f. An explanation of the use and limitations of methods that will prevent or reduce exposure to ATPs or ATPs-L including appropriate engineering and work practice controls, decontamination and disinfection procedures, and personal and respiratory protective equipment.

g. An explanation of the basis for selection of personal protective equipment, its uses and limitations, and the types, proper use, location, removal, handling, cleaning, decontamination, and disposal of the items of personal protective equipment employees will use.

h. A description of the employer's TB surveillance procedures, including the information that persons who are immune compromised may have a false negative test for LTBI.

i. Training meeting the requirements of Section 5144(k) of these orders for employees whose assignment includes the use of a respirator.

j. Information on the vaccines made available by the employer, including information on their efficacy, safety, method of administration, the benefits of being vaccinated, and that the vaccine and vaccination will be offered free of charge.

k. An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident, the medical follow-up that will be made available, and post-exposure evaluation.

l. Information on the employer's surge plan as it pertains to the duties that employees will perform. As applicable, this training shall cover the plan for surge receiving and treatment of patients, patient isolation procedures, surge procedures for handling of specimens, including specimens from persons who may have been contaminated as the result of a release of a biological agent, how to access supplies needed for the response including personal protective equipment and respirators, decontamination facilities and procedures, and how to coordinate with emergency response personnel from other agencies.

m. An opportunity for interactive questions and answers with the person conducting the training session.

- The person conducting the training shall be knowledgeable in the subject matter covered by the training program as it relates to the workplace that the training will address.

- Training material appropriate in content and vocabulary to the educational level, literacy, and language of employees shall be used.

9.3 TB training shall address the following subjects:

a. Identification of individuals at increased risk for TB, especially those with Human Immunodeficiency Virus (HIV) infection.

b. Modes of TB transmission and the differences between TB infection and disease.

c. Symptoms and consequences of TB.

d. The responsibilities RUHS-Medical Center and the employee to prevent TB exposure, including an explanation of requirements within this plan.

e. Use and limitations of all methods required by this plan and all methods utilized by the employer to prevent TB exposure.

f. TB surveillance, including the criteria used to determine whether a TST result is positive, and the effect of HIV infection and other medical conditions on the interpretation of the result.

g. Preventive therapy, medical treatment, the difficulty of treating drug-resistant TB, and the role of incomplete medical treatment in the development of drug-resistant TB.

h. Specific instructions on proper application and use of the appropriate respiratory protection.

i. The importance of therapy for latent disease (positive test but not active disease).

9.4 Training on this plan will include evaluation of the learner on the content of the training material.

10. RECORDKEEPING

10.1 Medical records

a. Occupational Health will establish and maintain an accurate medical record for each employee with occupational exposure, in accordance with Cal/OSHA Section 3204, Access to Employee Exposure and Medical Records, of these orders.

NOTE: This record may be combined with the medical record required by Cal/OSHA Section 5193, Bloodborne Pathogens, but may not be combined with non-medical personnel records.

10.2 This record includes:

a. The employee’s name and employee identification number

b. The employee's vaccination status for all vaccines required by this standard, including the dates of all vaccinations, any medical records relevant to the employee's ability to receive vaccination, any determinations of immunity, and any signed declination forms; Exception: As to influenza vaccine, the medical record need only contain a declination form for the most recent influenza vaccine.

c. A copy of all results of examinations, medical testing, and follow-up procedures as required by this section

d. The employer's copy of the physician written opinion as required; and

e. A copy of the information regarding an exposure incident that was provided to the physician as required.

10.3 For TB, Occupational Health will document all employee test results, including the name of the person tested, the date of the test, and the result.

a. TB test conversions from known negative to positive and diagnosed cases of TB shall be recorded on the log of occupational injuries and illnesses (Cal/OSHA 200 Log) maintained pursuant to Cal/OSHA section 14301 unless it can be demonstrated that the conversion or TB case was not work related.

10.4 Confidentiality. RUHS-Medical Center will ensure that all employee medical records required by this section are:

a. Kept confidential; and

b. Not disclosed or reported without the employee's express written consent to any person within or outside the workplace except as permitted by this section or as may be required by law.

c. These provisions do not apply to records that do not contain individually identifiable medical information, or from which individually identifiable medical information has been removed.

d. RUHS-Medical Center will maintain the medical records required by this section for at least the duration of employment plus 30 years in accordance with Section 3204, Access to Employee Exposure and Medical Records, of these orders.

10.5 Training records.

a. Training records include the following information:

- The date(s) of the training session(s);
- The contents or a summary of the training session(s);
- The names and qualifications of persons conducting the training; and
- The names and job titles of all persons attending the training sessions.

b. Training records are maintained for 3 years from the date on which the training occurred.

10.6 Records of implementation of ATD Plan.

a. Records of annual review of the ATD Plan are retained for three years.

b. Records of the unavailability of vaccine shall include the name of the person who determined that the vaccine was not available, the name and affiliation of the person providing the vaccine availability information, and the date of the contact. This record is retained for three years.

c. Records of the unavailability of AIIRs or areas include the name of the person who determined that an AIIRs or area was not available, the names and the affiliation of persons contacted for transfer possibilities, and the date of the contact, the name and contact information for the local health officer aiding, and the times and dates of these contacts. This record is retained for three years.

d. Records of decisions not to transfer a patient to another facility for AII for medical reasons is documented in the patient’s chart, and a summary is provided to the Plan administrator providing only the name of the physician determining that the patient was not able to be transferred, the date and time of the initial decision

and the date, time, and identity of the person(s) who performed each daily review. This record is retained for three years.

e. Records of inspection, testing and maintenance of non-disposable engineering controls including ventilation and other air handling systems, air filtration systems, containment equipment, biological safety cabinets, and waste treatment systems are maintained for a minimum of five years and include the name(s) and affiliation(s) of the person(s) performing the test, inspection or maintenance, the date, and any significant findings and actions that were taken.

f. Records of the respiratory protection program are established and maintained in accordance with Section 5144, Respiratory Protection, of these orders.

10.7 Availability

a. RUHS-Medical Center ensures that all records, other than the employee medical records, required to be maintained by this section are made available upon request to the Chief and the National Institute of Occupational Safety and Health (NIOSH) for examination and copying.

b. Employee training records required by this subsection is provided upon request to employees, employee representatives, the Chief and NIOSH for examination and copying.

c. Employee medical records required by this subsection is provided upon request to the subject employee, anyone having the written consent of the subject employee, the Chief and NIOSH in accordance with Section 3204, Access to Employee Exposure and Medical Records, of these orders for examination and copying.

10.8 Transfer of Records

a. RUHS-Medical Center is compliant with the requirements involving the transfer of employee medical and exposure records that are set forth in Section 3204, Access to Employee Exposure and Medical Records, of these orders.

b. If RUHS-Medical Center ceases to do business and there is no successor employer to receive and retain the records for the prescribed period, RUHS-Medical Center shall notify the Department of Safety and Health (DOSH) and NIOSH, at least three months prior to the disposal of the records and shall transmit them to NIOSH, if required by NIOSH to do so, within that three-month period. NOTE: Authority cited: Section 142.3, Section 6308; Labor Code. Reference: Section 142.3, Labor Code, Section 6308, 8 CCR 332.3.

11. SOURCE CONTROL MEASURES

11.1 RUHS-Medical Center may utilize multiple measures for source control, including:

a. Respiratory hygiene stations located in visible areas for patient & visitor use, with signage to indicate preventive measures and provision of masks, tissues, and hand gel.

b. Masking of coughing patients during transport or in ambulatory waiting areas.

c. Prompt placement of patients with respiratory symptoms into exam rooms.

11.2 Early Identification and Precautions for Patients with suspected or confirmed ATD

a. A patient admitted with suspected or confirmed AirID will be placed into Airborne Precautions utilizing an AIIR.

b. A patient admitted with suspected or confirmed droplet transmissible disease will be placed into Droplet Precautions utilizing a standard, single room.

c. Signage: Any AIIR in which a patient with known/suspected AirID is placed shall be posted with an Airborne Precautions sign so that employees and other persons can easily identify the protective measures they are required to take. Likewise, a Droplet Precautions sign will be posted outside rooms in use for droplet precautions.

d. Waste from rooms of patients with known/suspected ATD is handled the same as waste from all other patients:

- Routine waste such as magazines, cups, papers require no additional precautions.
- Biohazardous waste such as liquid blood or sharps are handled per the Biohazardous Waste Policy.

11.3 Discontinuation of Airborne Precautions for Tuberculosis

a. The following guidelines are utilized for determining when a patient with pulmonary TB has become noninfectious. The patient should meet all three of the following criteria:

- Patient has received at least 2 weeks of accepted multidrug anti-TB therapy
- Patient has demonstrated clinical improvement
- Patient has had three consecutive AFB-negative smear results of sputum specimens collected 8-24 hours apart, with at least one being an early morning specimen OR a single bronchoscopy specimen that is AFB-negative

b. For a patient placed in an AIIR because of suspected infectious TB disease of the lungs, airway, or larynx, Airborne Precautions may be discontinued when:

- Pulmonary TB disease is considered unlikely
- The patient has three consecutive negative AFB sputum smear results. (Each of the three sputum specimens should be collected in 8–24-hour intervals, and at least one specimen should be an early morning specimen) OR a single bronchoscopy specimen that is AFB-negative.
- Alternatively, release from airborne precautions can occur if the treating physician documents that TB is no longer in the differential diagnosis.

12. AMBULATORY CARE SETTINGS

12.1 To prevent the spread of aerosol transmissible diseases in ambulatory care settings, source control measures will be implemented. Patient screening, prompt isolation, respiratory hygiene and cough etiquette enforcement should be performed.

12.2 Patients identified as suspected or confirmed ATD should be given a mask and placed in a private room as soon as possible, limiting time spent in waiting areas.

12.3 Cleaning of rooms occupied by suspected or confirmed ATD should be delayed for one hour if the patient was placed in an AIIR, or two hours if a regular exam room was used.

13. ARLINGTON CAMPUS

13.1 Patients identified at the Arlington Campus as suspected or confirmed ATD will be given a mask and placed in a private room if available.

13.2 Prompt transfer to the Medical Center campus should be ordered.

14. REFERENCES

14.1 California Code of Regulations, Title 8, Section 5144, 5199 Title 17 and Title 22.

14.2 Department of Health and Human Services, Centers for Disease Control and Prevention. Controlling Tuberculosis in the United States. Recommendations from the American Thoracic Society CDC, and the Infectious Diseases Society of America, 2005.

14.3 Department of Health and Human Services, Centers for Disease Control and Prevention. Guideline for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005.

14.4 Siegal JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, June 2007.

14.5 Respiratory Hygiene/Cough Etiquette in Health Care Settings, CDC, August 1, 2009

14.6 Guidelines for Tuberculosis (TB) Screening and Treatment of Patients with Chronic Kidney Disease (CKD), Patients Receiving Hemodialysis (HD), Patients Receiving Peritoneal Dialysis (PD), Patients Undergoing Renal Transplantation and Employees of Dialysis Facilities, May 18, 2007.

14.7 California Tuberculosis Controllers Association Position Statement: The Utilization of QuantiFERON TB Gold in California, May 18, 2007.

14.8 CDC. Guideline for Infection Prevention in Hospital Personnel. Atlanta, GA, April 12, 2024

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Date Reviewed	**Reviewed By:**	**Revisions Made?**	**Revision Description**
12-2020	Infection Prevention and Control Committee	Yes	Minor wording changes throughout document.
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8/26/2024	PAC	No	

APPENDIX I: AEROSOL TRANSMISSIBLE DISEASES/PATHOGENS

The following is a list of diseases and pathogens which are to be considered aerosol transmissible pathogens for the purpose of Section 5199. RUHS-Medical Center provides the protections required by Section 5199 for those pathogens and diseases listed below under "Airborne Infectious Diseases/Pathogens."

Airborne Infectious Diseases/Pathogens

- Aerosolizable spore-containing powder or other substance that is capable of causing serious human disease, e.g., Anthrax/*Bacillus anthracis*
- Avian influenza/Avian influenza A viruses (strains capable of causing serious disease in humans)
- Varicella disease (chickenpox, shingles)/Varicella zoster and Herpes zoster viruses, disseminated disease in any patient. Localized disease in immunocompromised patient until disseminated infection ruled out
- Measles (rubeola)/Measles virus
- Monkeypox/Monkeypox virus
- Novel or unknown pathogens
- Severe acute respiratory syndrome (SARS)/SARS-associated coronavirus (SARS-CoV-1)
- Smallpox (variola)/Variola virus
- Tuberculosis (TB)/*Mycobacterium tuberculosis*: extrapulmonary, draining lesion; pulmonary or laryngeal disease
- COVID-19 (SARS-CoV-2): Confirmed or suspected.
- Any other disease for which the CDC or CDPH recommends airborne infection isolation

Droplet Precautions

- Diphtheria/*Corynebacterium diphtheriae* – pharyngeal
- Epiglottitis, due to *Haemophilus influenzae* type b
- Group A Streptococcal (GAS) disease (strep throat, necrotizing fasciitis, impetigo)/Group A *Streptococcus*
- *Haemophilus influenzae* Serotype b (Hib) disease/*Haemophilus influenzae* serotype b - Infants and children
- Influenza, human (typical seasonal variations)/influenza viruses
- Meningitis
  - *Haemophilus influenzae*, type b known or suspected
  - *Neisseria meningitidis* (meningococcal) known or suspected
- Meningococcal disease/*Neisseria meningitidis*: sepsis, pneumonia (see also meningitis)
- Mumps (infectious parotitis)/Mumps virus
- Mycoplasmal pneumonia/*Mycoplasma pneumoniae*
- Parvovirus B19 infection (erythema infectiosum, fifth disease)/Parvovirus B19
- Pertussis (whooping cough)/*Bordetella pertussis*

- Pharyngitis in infants and young children/Adenovirus, Orthomyxoviridae, Epstein-Barr virus, Herpes simplex virus,
- Pneumonia
  - *Adenovirus*
  - *Chlamydia pneumoniae*
  - *Mycoplasma pneumoniae*
  - *Neisseria meningitidis*
  - *Streptococcus pneumoniae*
- Pneumonic plague/*Yersinia pestis*
- Rubella virus infection (German measles) (also see congenital rubella)/Rubella virus
- Scarlet fever in infants and young children/Group A streptococcus, serious invasive disease
- Viral hemorrhagic fevers due to Lassa, Ebola, Marburg, Crimean-Congo fever viruses, and Hantaviruses
- Any other disease for which the CDC or CDPH recommends droplet precautions

APPENDIX II. DEFINITIONS

Aerosol transmissible disease (ATD) or aerosol transmissible pathogen (ATP). A disease or pathogen for which droplet or airborne precautions are recommended, as listed in Appendix I.

Aerosol transmissible pathogen-laboratory (ATP-L). A pathogen that meets one of the following criteria: (1) the pathogen appears on the list in Appendix I, (2) the Biosafety in Microbiological and Biomedical Laboratories (BMBL) recommends biosafety level 3 or above for the pathogen, (3) the biological safety officer recommends biosafety level 3 or above for the pathogen, or (4) the pathogen is a novel or unknown pathogen.

Airborne infection isolation (AII). Infection control procedures as described in Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings. These procedures are designed to reduce the risk of transmission of airborne infectious pathogens and apply to patients known or suspected to be infected with epidemiologically important pathogens that can be transmitted by the airborne route.

Airborne infectious disease (AirID). Either: (1) an aerosol transmissible disease transmitted through dissemination of airborne droplet nuclei, small particle aerosols, or dust particles containing the disease agent for which AII is recommended by the CDC or CDPH, as listed in Appendix I, or (2) the disease process caused by a novel or unknown pathogen for which there is no evidence to rule out with reasonable certainty the possibility that the pathogen is transmissible through dissemination of airborne droplet nuclei, small particle aerosols, or dust particles containing the novel or unknown pathogen.

Airborne Infection Isolation (AII) precaution. The isolation of patients infected with organisms spread through airborne droplet nuclei 1–5 µm in diameter. This isolation area receives substantial air changes per hour (ACH) (>12 ACH for new construction since 2001 and >6 ACH for construction before 2001) and is under negative pressure (the direction of the air flow is from the outside adjacent space [e.g., the corridor] into the room). The air in an AII room is preferably exhausted to the outside but can be recirculated if the return air is filtered through a high efficiency particulate air (HEPA) filter.

Airborne Infection Isolation Room (AIIR) A room designed to maintain AII. Formerly called negative pressure isolation room, an AII room is a single-occupancy patient-care room used to isolate persons with suspected or confirmed AirID. Environmental factors are controlled in AII rooms to minimize the transmission of infectious agents that are usually spread from person to person by droplet nuclei associated with coughing or aerosolization of contaminated fluids. AII rooms should provide negative pressure in the room (so that air flows under the door gap into the room), an air flow rate of 6–12 ACH, and direct exhaust of air from the room to the outside of the building or recirculation of air through a HEPA filter.

Airborne Infectious Pathogen (AirIP). Either: (1) an aerosol transmissible pathogen transmitted through dissemination of airborne droplet nuclei, small particle aerosols, or dust particles containing the infectious agent, and for which the CDC or CDPH recommends AII, as listed in Appendix I, or (2) a novel or unknown pathogen for which there is no evidence to rule out with reasonable certainty the possibility that it is transmissible through dissemination of airborne droplet nuclei, small particle aerosols, or dust particles containing the novel or unknown pathogen.

Air change. Replacement of the quantity of air contained by a room or enclosure with an equal quantity of fresh air or HEPA filtered air.

Droplet precautions. Infection control procedures as described in the CDC Guideline for Isolation Precautions designed to reduce the risk of transmission of infectious agents through contact of the conjunctivae or the mucous membranes of the nose or mouth of a susceptible person with large-particle droplets (larger than 5 µm in size) containing microorganisms generated from a person who has a clinical disease or who is a carrier of the microorganism.

High hazard procedures. Procedures performed on a person who is a case or suspected case of an aerosol transmissible disease or on a specimen suspected of containing an ATP-L, in which the potential for being exposed to aerosol transmissible pathogens is increased due to the reasonably anticipated generation of aerosolized pathogens. Such procedures include, but are not limited to, sputum induction, bronchoscopy, aerosolized administration of pentamidine or other medications, and pulmonary function testing. High Hazard Procedures also include, but are not limited to, autopsy, clinical, surgical and laboratory procedures that may aerosolize pathogens.

Isolation room. A room which is used to provide negative air pressure in accordance with the standards.

Isolation unit. A commercially available apparatus which is used to provide negative air pressure.

Latent TB infection (LTBI). Infection with *M. tuberculosis* in which bacteria are present in the body but are inactive. Persons who have LTBI but who do not have TB disease are asymptomatic, do not feel sick and cannot spread TB to other people. They typically react positively to TB tests.

Negative pressure. The relative air pressure difference between two areas. The pressure in a containment room or area that is under negative pressure is lower than adjacent areas, which keeps air from flowing out of the containment facility and into adjacent rooms or areas.

NIOSH. The National Institute for Occupational Safety and Health.

Novel or unknown ATP. A pathogen capable of causing serious human disease meeting the following criteria:

(1) There is credible evidence that the pathogen is transmissible to humans by aerosols; and

(2) The disease agent is:

(a) A newly recognized pathogen, or

(b) A newly recognized variant of a known pathogen and there is reason to believe that the variant differs significantly from the known pathogen in virulence or transmissibility, or

(c) A recognized pathogen that has been recently introduced into the human population, or

(d) A not yet identified pathogen.

NOTE: Variants of the human influenza virus that typically occur from season to season are not considered novel or unknown ATPs if they do not differ significantly in virulence or transmissibility from existing seasonal variants. Pandemic influenza strains that have not been fully characterized are novel pathogens.

Occupational exposure. Exposure from work activity or working conditions that is reasonably anticipated to create an elevated risk of contracting any disease caused by ATPs or ATP-Ls if protective measures are not in place. In this context, "elevated" means higher than what is considered ordinary for employees having direct contact with the general public outside of the facilities, service categories and operations listed in subsection (a)(1) of the Standard. Occupational exposure is presumed to exist to some extent in each of the facilities, services and operations listed in subsection (a)(1)(A) through (a)(1)(H). Whether a particular employee has occupational exposure depends on the tasks, activities, and environment of the employee, and therefore, some employees of a covered employer may have no occupational exposure. For example, occupational exposure typically does not exist where a hospital employee works only in an office environment separated from patient care facilities or works only in other areas separate from those where the risk of ATD transmission, whether from patients or contaminated items, would be elevated without protective measures. It is the task of employers covered by this standard to identify those employees who have occupational exposure so that appropriate protective measures can be implemented to protect them as required. Employee activities that involve having contact with or being within exposure range of cases or suspected cases of ATD, are always considered to cause occupational exposure. Similarly, employee activities that involve contact with, or routinely being within exposure range of, at-risk populations are considered to cause occupational exposure. Employees working in laboratory areas in which ATP-L are handled or reasonably anticipated to be present are also considered to have occupational exposure.

Respirator. A device which has met the requirements of 42 CFR Part 84, has been designed to protect the wearer from inhalation of harmful atmospheres, and has been approved by NIOSH for the purpose for which it is used.

Source control measures. The use of procedures, engineering controls, and other devices or materials to minimize the spread of airborne particles and droplets from an individual who has or exhibits signs or symptoms of having an ATD, such as persistent coughing.

Standard. For the purposes of this document, the "standard" refers to the CalOSHA ATD Standard Title 8, Section 5199.

TB conversion. A change from negative to positive as indicated by TB test results, based upon current CDC or CDPH guidelines for interpretation of the TB test.

APPENDIX III: AEROSOL TRANSMISSIBLE DISEASE VACCINATION

RECOMMENDATIONS FOR SUSCEPTIBLE HEALTH CARE WORKERS

Vaccine	Schedule
Influenza	One dose annually
Measles	Two doses
Mumps	Two doses

Rubella	One dose
Tetanus, Diptheria, and Acellular Pertussis (Tdap)	One dose, booster as recommended
Varicella-zoster (VZV)	Two doses

Source: *California Department of Public Health, Immunization Branch*

Immunity should be determined in consultation with *Prevention of Vaccine-Preventable Diseases.*