

SOS

Spotlight On Safety

2019

KAISER PERMANENTE

To complete your required Annual Review you will need to:

1. Read Publication.

2. Complete Knowledge Check & Return the Original to Education & Professional Development.



Kaiser Permanente's Mission:
Kaiser Permanente exists to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve.

Kaiser Permanente, Our Values:
What guides our behavior?

How We Relate to Each Other:

Integrity: We build long term relationships by doing what's right.

Partnership: We were born of a revolutionary partnership and we live out that legacy in the way we do business every day.

Diversity: We are richly diverse and cherish what we learn from one another.

How We Work:

Accountability: We step beyond our boundaries to take responsibility for our organization's success.

Flexibility: We adapt quickly to address the changing needs of our customers.

Innovation: We find the courage to take calculated risks.

How We Define Success:

Quality: We hold quality as our highest priority.

Service: We care about everyone like family.

Results: We honor each other and our values as we produce results.

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Spotlight on Safety

All programs described here are intended for the use of Kaiser Permanente Fontana and Ontario employees and physicians. "This newsletter was produced by Education and Professional Development, content supplied by subject specialists."

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2019 National Patient Safety Goals

The Purpose of the National Patient Safety Goals is to improve patient safety. The goals focus on the problems in health care safety and how to solve them.

1. Improve the accuracy of patient identification.

1.01.01 Use at least two patient Identifiers when providing care, treatment, & services: *Patient Name, Medical Record Number & Date of Birth.*

1.03.01 Eliminate transfusion errors related to patient misidentification.

2. Improve the effectiveness of communication among caregivers.

2.03.01 Report critical results of tests and diagnostic procedures on a timely basis.

3. Improve the safety of using medications.

3.04.01 Label all medications, medication containers & other solutions on and off the sterile field in perioperative and other procedural settings.

Note: Medication containers include syringes, medicine cups, & basins.

3.05.01 Reduce the likelihood of patient harm associated with the use of anticoagulant therapy.

3.06.01 Maintain & communicate accurate patient medication information. (*Medication Reconciliation*)

6. Use alarms safely.

06.01.01 Ensure that alarms on medical

equipment are heard

& responded to on time.

7. Reduce the risk of health care-associated infections.

7.01.01 Comply with either the current Centers for Disease Control & Prevention (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines.

7.03.01 Implement evidence-based practices to prevent health care-associated infections due to multidrug-resistant organisms in acute care hospitals. **Note:** This requirement applies to, but is not limited to, epidemiologically important organisms such as methicillin-resistant staphylococcus aureus (MRSA), clostridium difficile (CDI), vancomycin-resistant enterococci (VRE), & multidrug-resistant gram-negative bacteria.

7.04.01 Implement evidence-based practices to prevent central line-associated bloodstream infections. **Note:** This requirement covers short-and long-term central venous catheters and peripherally inserted central catheter (PICC) lines.

7.05.01 Implement best practices for preventing surgical site infections.

7.06.01 Implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections (CAUTI)

Note: These 2 NPSGs are not applicable to pediatric populations.

15. The organization identifies safety risks inherent in its patient population.

risk for suicide.

Note: This requirement applies only to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.

UP Universal Protocols for Invasive Procedures

UP.01.01.01 Conduct a pre-procedure verification process.

UP.01.02.01 Mark the procedure site.

UP.01.03.01 A time-out is performed before the procedure.

Note: Gaps in the numbering indicate that the Goal is inapplicable to the program or has been "retired," usually because the requirements were integrated into the standards.

Risk Management and Patient Safety

15.01.01 Identify patients at

UOR

What is it? Unusual Occurrence Report

When is it used? Whenever there is a deviation from the quality standard of practice

When do I submit an UOR?

Appropriate Use:

- * Medication Errors
- * Falls
- * Delay in treatment
- * Pressure Ulcer ID
- * Equipment failure
- * AMA/Elopement
- * Return to surgery
- * Surgical complication

Inappropriate Use:

- * Employee Injuries
- * Personnel Issues
- * Disputes with Co-workers
- * Departmental QI measurement

How do I submit an UOR? An electronic UOR system called UOR-O (UOR-Online), aka MIDAS is in place throughout the Kaiser Permanente SCAL Region Hospitals & Medical Offices. Submit through the Hotline: Fontana 73325 & Ontario 43325.

Procedure for UOR-O:

- Go to any KP Computer & go to the UOR-O link at the bottom of the KP Fontana/Ontario Homepage (<http://fontana/>), or from the Quick Links at the top of the page.
- Click on the type of occurrence you are reporting.
- Fill out the online form with all the information you are aware of, be factual and objective in your report.
- Once you begin an UOR, the program will close in 20 minutes if no entry activity is detected.
- Review your report then click "Save" at the bottom when done to send the report.

What happens after a UOR is submitted?

- Information is electronically sent to the CD/ACD/DA/ADA for follow-up.
- Information is also electronically sent to Risk Management.

- Data is retained in the UOR Database Reviewed by Risk Management Staff to determine further follow-up as necessary.
- Information is tracked and trended at the Medical Center & at Region.

Important UOR information: UOR data is legally protected & can be submitted by any Hospital or Medical Group Employee.

Do not mention in charting that a UOR was submitted or Risk Management was contacted.

What happens to this information?

- Occurrences will be followed up in a timely manner
- Immediate involvement & resolution with other units involved in occurrence.
- Reports of accurate occurrence data will be shared with appropriate department personnel as requested or through reports to committees.

What do we learn from the UORs? Opportunities for improvement are identified through the event analysis and the Tracking and Trending of UORs.

UOR Assistance If you are unsure about the appropriateness of an issue for a Unusual Occurrence Report, submit it anyway! Too much information is better than not enough information! Please - don't stress about it!

Just Culture

Tens of thousands of individuals die each year and hundreds of thousands more are injured by preventable medical errors. An organizational culture of patient safety is imperative to improving this situation. It is the foundation of all we do in patient safety. A key component of a culture of safety is a JUST CULTURE.

Just Culture is a culture of trust where people are encouraged and even rewarded to provide essential safety-related information without fear of retaliation. It is a culture which clearly defines where the line must be drawn between acceptable & unacceptable behavior. It is a culture of accountability that:

- **Supports reporting**
- **Doesn't advocate blame, shame & train**
- **Advocates fair treatment**
- **Based on trust**
- **Has intolerance for reckless behavior**

Human error is common in our everyday life. Some literature says that we make at least 2 mistakes each hour. Generally these errors do not have a major impact. In a health care setting, errors can have a significant impact on patient safety.

At-Risk Behavior occurs when the right practice is known, but a person uses shortcuts or "drifts" into unsafe habits. Over time this drift in practice can become the norm and the risk involved is

ignored. Persons exhibiting **Reckless Behavior**:

- **Always perceive the risk he or she is taking**
- **Understand that the risk is substantial**
- **Behave intentionally**
- **Know that others are not engaging in the same behavior**
- **Make a conscious choice to disregard the substantial & unjustifiable risk.**

Working in a Just Culture means that we recognize that errors and mistakes are inevitable. Each error provides us an opportunity to learn from our mistakes. Thus, it is important to report errors and near misses. Errors & near misses can then be analyzed to determine the cause, identify things that can be fixed and implement these fixes so that the error is less likely in the future. Leadership applauds reporters and supports reporting and fixing errors.

Remember to report: errors that cause harm, errors that do not cause harm and near misses! When a patient safety issue is raised & you feel your issue is not resolved, escalate it up the appropriate chain of command. Escalation always occurs up both the administrative and medical chain of command. You are obligated to escalate the issue until the concern is resolved.

"Improving the quality of care delivered

to members & patients requires significantly increasing the reporting of actual errors and "near misses." It is recognized that the reporting of such errors can only improve if employees are assured that punitive discipline is not seen as the appropriate choice to handle most errors as an opportunity for continued, systematic improvement. The environment must encourage all employees to openly report errors or near misses & participate in analyzing the reason for the error & the determination of the resolution & corrective action needed to prevent reoccurrence." Language from National Agreement KP and CKPU, October 1, 2005

What is a Sentinel Event?

A Sentinel Event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof, or which otherwise adversely affects the quality of care & service, operations, assets or reputation of Kaiser Permanente.

Sentinel Event follow up:

Ensure stabilization of patient and report immediately to CD/ACD/DA/ADA and Risk Management (see phone number below)

Preservation of Evidence:

Whenever a piece of equipment or medical device is involved immediately remove it from service and mark it "DO NOT USE" & Notify: Clinical Technology (Bio-Med) and Risk Management

Any questions? Please feel free to contact Risk Management at:

FONTANA Ex. 7 R-I-S-K, (7475)
ONTARIO Ex. 4 R-I-S-K, (7475)

Patient Safety Officer:

Kathy Christmas, Director of Risk Management & Patient Safety.

KP FMC/OMC Safety Message

"Safety Check" – Speak Up

FMC/OMC Workplace & Patient Safety



What is a Safety Check?

It is a standardized term that will be used by all to indicate that we have a concern or need clarification!

- ☑ **SPEAKUP** – need clarification, not sure, need to communicate something important?
Say "Safety Check, please"

- ☑ **What do we do? Stop the line!**
STOP what we are doing and COMMUNICATE!
Listen to each other, seek to understand & make sure all are comfortable in proceeding.

- ☑ **WHY? – For both employee & patient safety.**
We all need to make sure and help each other to be safe for our PATIENTS

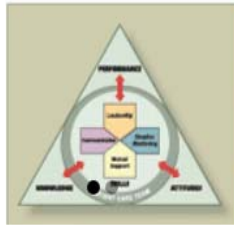
- ☑ **Not working, need help?**
Escalate by notifying your leadership



Types of events where this might be helpful?

- Need more Time Out information
- Incorrect counts, need to stop closing process
- Unable to see site mark after prep and drape
- Consent / Implant issues
- Path of Travel Safety
- Sharp Safety
- Safe patient handling situations

Team STEPPS



TeamSTEPPS[®] National Implementation



Team Communication Tools: The Joint Commission has identified team communication failures in over 60% of all patient harm events. Therefore, it is important to improve our team communication to improve patient safety! The following are team communication skills recommended by the Agency of Healthcare Research and Quality (AHRQ) and adopted by both of our medical centers:

SBAR: is a technique for communicating critical information that requires immediate attention and action concerning a patient's condition:

Situation – What is going on with the patient? Example "I am calling about Mrs. Joseph in room 251. Chief complaint is shortness of breath of new onset."

Background – What is the clinical background or context? Example "Patient is a 62 year old female post -op day one from abdominal surgery. No prior history of cardiac or lung disease."

Assessment – What do I think the problem is? Example "Breath sounds

are decreased on the right side with acknowledgment of pain. Would like to rule out pneumothorax."

Recommendation – What would I do to correct it? Example "I feel strongly the patient should be assessed now. Can you come to room 251 now?"

Call-Out: Strategy used to communicate important or critical information. It informs all team members simultaneously during emergent situations. Helps team members anticipate next steps. Important to direct responsibility to a specific individual responsible for carrying out the task. Example Incoming trauma: Leader: "Airway status?" Resident; "Airway clear."

Check-Back: Using closed-loop communication to ensure that information conveyed by the sender is understood by the receiver as intended. The steps include:

1. Sender initiates the message:
2. Receiver accepts the message and provides feedback:
3. Sender double-checks to ensure that the message was received.

Example: Doctor: "Give 25 mg Benadryl IV push", Nurse: "25 mg Benadryl IV push", Doctor: "That's correct."

Handoff: Strategy designed to enhance information exchange during transitions in care. This uses a standardized tool to assure complete, consistent transfer of information. Example: NKE +

Advance Health Care Directives

If you had a serious injury or illness, who would know what kind of treatment you would want? An Advance Health Care Directive helps assure that your wishes will be followed & allows you to name a person you trust to speak for you if you are unable to speak for yourself.

As a competent adult, you can complete an Advance Health Care Directive. You can obtain a free Advance Health Care Directive form from Membership Services, Social Services, or the Wellness Store. The wellness store also has a 14 minute video, which explains why this document is important.

There is also an excellent free workbook that is available in the Wellness Store that helps guide you through completing the form correctly. Give your self and your loved ones peace of mind by having an Advanced Health Care Directive.

Encourage your colleagues to complete the Advance Health Care Directive.
You never know when you might need it.

Advance Care Directives form can be obtained from:

1. Wellness Center (909) 427-6116 (8-250)
2. Social Services Department
(909) 427-5191(Fontana) (8-250)
(909) 724-3320 (Ontario) (8-264)
3. Member Services 1(800) 464-4000

**California Advance
Health Care Directive**

Restraints

Fontana/Ontario: Medical Center Wide Policy: Restraint DPC.SC.R.001

Types of Restraints:

Non Behavioral: Restricting a patient's movement to assist with the provision of medical or surgical care.

Behavioral: Restriction of patient movement in response to severely aggressive, destructive, violent or suicidal behaviors that place the patient or others in harm's way. Used only in the Emergency Department.

Monitoring:

Patients in restraint shall be monitored as often as necessary to assure safety and dignity and to attend to comfort needs. Items that the staff member needs to monitor include potty, positioning, circulation, nutrition/hydration, the need to continue restraint, etc. Patients shall be observed at least every 2 hours or sooner to assure that restraint remains indicated, that restraining devices remain safely applied, and to assure safety and dignity and to meet the patient's needs during use.

Documentation:

Use the Non-Behavioral Restraint Doc Flowsheet:

On each area select the appropriate option or enter comment:

Restraint Order

Assessment Justification (Must match physician order), Education,

Restraint Monitoring every 2 hours

Restraint Type: Use this section to docu-

ment the restraint(s) being used.

Patient Rights:

Patient's rights, dignity, and well-being are protected during restraint use and the following will be assured:

- ☐ Respect for the patient as an individual.
- ☐ Safety and cleanliness of the environment.
- ☐ Protection of the patient's modesty, visibility and body temperature.
- ☐ Ability of the patient and family to receive and participate in care.

Orders:

Non Behavioral: If a physician is not available, an RN may initiate restraint without the prior order of a physician. If restraint is necessary due to a *significant change*, the MD shall be notified *Immediately* for an order. Otherwise, the MD must be notified for an order as soon as possible not to exceed *12 hours from initiation*. MD will perform an in-person assessment *within 24 hours*.

PRN orders are not accepted:

If restraints are removed and the patient exhibits actions that again require restraint, a new order is **ALWAYS** required to reapply the restraints. (*This does not apply when removing restraints for patient care, such as ROM, Bath, Mobility...*)

Behavioral: Behavioral restraints may not be ordered for longer than 4 hours for adult, 2 hours for child 9-17 years old, & 1 hour for children 8 years old & younger. A RN may initiate in an emer-

gency in advance of a MD order.

Alternatives: (*should be done before restraints are applied*)

- Bathroom Rounds
- Wear briefs over Foley (NO diapers)
- Hide IV tubing
- Cuffed Gowns
- Diversion
- Decreased Stimuli
- Frequent Rounds
- Contracting, when Appropriate
- Consistent personnel
- Medication evaluation

Family Involvement

Non Behavioral: Monitor and Document at least every 2 hours.

Behavioral: Monitor and Document at least every 15 minutes.

Patient Wristband Identification

Does your patient have the correct wristband on?



SBAR

A structured communication technique designed to convey a great deal of information in a succinct and brief manner. This is important as we all have different styles of communicating varying by profession, culture, and gender.

Situation: A concise statement of the problem.

What is going on now?

Background: Pertinent and brief information related to the situation. *What has happened?*

Assessment: Analysis and considerations of options. *What you found/think is going on?*

Recommendation: Request/ recommend action.

What you want done?

Fall Prevention in the Hospital

Patients can fall *anytime* and *anywhere*! A myriad of factors can affect patient falls: effects of medications, unfamiliar surroundings, decreased mobility because of disease or hospital equipment (ex. IVs, SCDs, Foley Catheters).

Patient Safety is our duty. ZERO FALLS is our Goal!

Each patient will be assessed on admission and at least daily to help identify patients who are "at risk" for falls. Assessment will include all of the following: SCHMIDT FALL RISK SCORE: ABCDS Criteria (Age, Bone, Coagulation, Dementia, Surgery) Nursing Judgment. Patients "at risk" will be placed on Fall Precautions. Yellow Wristband will be placed to identify all patients that are Fall Risk. The fall risk identification signage (a large yellow dot) will be placed at the head of the bed. The patient and family will be educated on fall prevention. Environmental checks will be done by staff regularly and will include: are side rails up as appropriate? Is the call light within reach? Is the bed locked and in low position? Is the bedside

table within reach? Are bed exit alarms on? Hourly rounds should ensure the 4 Ps are being addressed (pain, potty, positioning, and personal items within reach). Nursing staff should anticipate patient needs. Bed exit alarms are used on patients identified "at risk" for falls. Bed alarms will be activated for ALL PATIENTS after 10pm. Two to four side rails may be used as appropriate for Patient Safety.

Our patients can expect to be safe while they are in our facility through our comprehensive Fall Prevention Program.

Abbreviations Official DO NOT USE

List Do Not Use	Potential Problem	Use Instead
U (unit)	Mistaken for "0" (zero), the number "4" (four) or "cc"	Write "unit"
IU (International Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write "International Unit"
Q.D., QD, q.d., qd (daily) Q.O.D., QOD, q.o.d, qod (every other day)	Mistaken for each other. Period after the Q mistaken for "I" and the "O" mistaken for "I"	Write "daily" Write "every other day"
Trailing zero (X.0 mg) Lack of leading zero (.X mg)	Decimal point is missed	Write "X mg" Write "0.X mg"
MS MSO4 and MgSO4	Can mean morphine sulfate or magnesium sulfate confused for one another	Write "morphine sulfate" Write "magnesium sulfate"

Caring For Patients In Pain

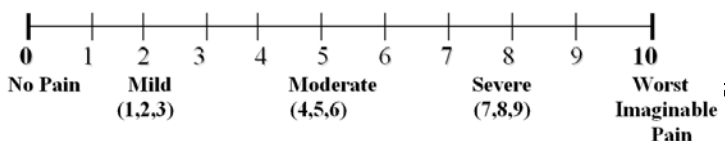
Pain is a very personal experience that exists whenever and however the patient says it does. The most reliable indicator of a patient's pain is the patient's self-report. Although healthcare providers cannot see, test, or measure a patient's source or level of pain—it does NOT make their pain experience any less real. The patient's pain experience may be affected by many things, both positive and negative. Anxiety, stress, fear, anger, temperature, poor communication, depression, and rude treatment may make the pain worse. On the other hand, good communication, a sense of trust, caring responses from caregivers, medications, massage, soothing music, and deep breathing may lessen the pain. Culture, personality, age, gender, and overall health may affect the way patients tell us about their pain. All patients admitted to the hospital must be evaluated for pain with routine vital signs using an age appropriate scale as noted below.

SPEAKING THE LANGUAGE: Pain Scales Are Important Tools of Communication:

Kaiser has adopted four, age-specific pain scales that allow us to educate our patients and "speak the same language" about pain and how it is effecting them. Although the scales are designed for certain age groups, the pain scales used should match the needs and condition of the patient.

- **N-PASS:** (Neonatal Pain, Agitation and Sedation Scale) infants ages 0 – 100 days
- **FLACC:** Ages 2 months to 7 years, may be used beyond this age group for the cognitively impaired patient
- **NUMERIC PAIN Scale:** (also known as the Visual Analog Scale or VAS) For use in adults, adolescents, and cognitively appropriate pediatric patient

- **FACES Scale:** For ages 3 years through adulthood where appropriate. If the patient is unable to understand or



rent level of pain. If medication is given, document what was given on the MAR. Reassess for effectiveness after administration – at least 15 minutes after IV, 30 minutes after IM, and 45 minutes after oral administration – and document in the pain management flow-sheet in HealthConnect.



HAZARD COMMUNICATION (HAZARDOUS MATERIALS)

Every day, we use chemical products in the course of doing our jobs (from rubbing alcohol to peroxide, from disinfectants to reagents). It is very important to know about the chemical products & hazardous substances we use, in order to make sure we USE THEM SAFELY!

You have a legal **"Right to Know"** about hazardous substances to which you may be exposed; the physicians who take care of you and the collective bargaining agent representing you should have access to the same important information. Further, you may exercise these rights without any fear of discharge or other discrimination. To that end, the California Department of Labor's Occupational Safety and Health Administration established the Hazard Communication Standard. It is designed to ensure the quality, consistency & clarity of hazard information that workers receive, making it safer for workers to do their jobs. Additionally, the Fontana and Ontario Medical Centers developed our internal Hazard Communication Program to provide the procedural framework designed to better ensure the health & safety of all employees, Physicians, and staff. Our program is intended to implement the provisions of Cal-OSHA's Haz Com Standard and to be consistent with the provisions of the United Nations Globally Harmonized System of Classification & Labeling of Chemicals (GHS).



Our written Hazard Communication Program is readily available electronically on DocuShare under section EC.Haz.001. The Hazard Communication Program addresses how you can obtain and use the appropriate hazard information. Key information sources about potential hazards and safe use of a chemical product can be found on: The **LABEL**: The container Label provides specific chemical contents and hazard warnings; **Safety Data Sheets**: An SDS is a document developed by the product manufacturer that provides important information on how to use chemical products SAFELY.

Electronic versions of the list(s) of hazardous substances and corresponding SDS's can be accessed on the **DocuShare** system, using the online MSDS Link. Hard copies of SDS's & a master list of chemical products are accessible to all employees in the Safety Office, Materials Management & the Emergency Department. For each Hazardous substance or product, the SDS provides specific information such as:

- Name, address, and emergency phone number of the manufacturer.
- The chemicals identity, common name, and chemical name.
- Health hazards, including signs and

symptoms of exposure, any medical condition that could be made worse by exposure to the substance.

- Special chemical and physical characteristics
- Protective measures, precautions for safe handling, use, & storage & recommended personal protective equipment (PPE) such as goggles & gloves, emergency & first aid procedures
- Physical hazards, such as fire, explosion, or dangerous chemical-reactions, for instance what not to mix/store it with; Health hazards
- Permissible Exposure Limits (PEL's)- PELs are regulatory limits on the amount or concentration of a substance in the air, and sometimes on the skin.

Labels & Other Forms of Warning:

All chemical containers must have legible, readily visible labels that must include the following information: Identity of the hazardous substance, which must allow for cross-referencing with the MSDS and the inventory list of the hazardous substances; Hazard Warning Statements, including **Proposition 65** warnings (California law that requires clear and reasonable warnings about chemicals known to the state to cause cancer or reproductive toxicity); Name & address of the chemical manufacturer, importer, or other responsible party. Make sure to READ the label for EACH chemical BEFORE you use it. Make sure you know the following: What is in the product? (e.g. alcohol, formaldehyde, ammonium chloride). How can it hurt you? How can you protect yourself against exposure? (e.g. safe work practices, protective equipment) How to handle spills?

Note: Containers must be relabeled whenever labels are damaged or defaced.

Identification of Hazardous Material:

Department Managers are responsible for developing and maintaining a list of hazardous materials received, handled, used or stored in their department or by their employees and SDSs related to those materials for which employees may receive an occupational exposure. The list includes hazardous materials in liquid, solid or gaseous states. Methods of disposal for hazardous wastes generated by this material or other means will also be maintained.

Chemical Spills: Act quickly—the sooner the spill is controlled the less damage it can cause. Immediate steps should be taken to control the material being spilled, regardless of the source. Contain the spill in as small an area as possible; have the proper spill kit available for the chemicals used in your area; your response to a spill

will depend on the quantity and the risk involved; chemical spills usually fall into 2 categories: small or incidental; large or emergency.

Spill Management: The best way to handle a spill is to prevent it from happening. Evaluate your methods for storing, mixing, & transporting chemicals to identify areas for additional precautions and modifications. Knowing how to handle accidental chemical spills is as important as knowing how to use the material correctly. Knowledge of a few basic guidelines involving hazardous chemical spills can go a long way towards maintaining a safe working environment. In the event of a small or large spill, please follow the following steps:

Small Spill	Large Spill
Use departmental spill kit	Evacuate the area
Follow instructions	Cordon off the area
Wear Proper PPEs	Notify your Supervisor
Notify your Supervisor	Call "33333" for the Administrative Spill Response Team
Fill out Chemical Spill Report Form, E.C.Haz.002 (Online - DocuShare)	Fill out Chemical Spill Report Form, E.C.Haz.002 (Online -DocuShare)

Note: Environmental Services (EVS) will respond and clean the area AFTER the initial spill has been managed .



Common Chemicals Used On Campus:




Chemical	How to Detect a Release	PPE's	Work Practices	Hazards	Emergency Procedures
Steris Resert™ XL HLD/ Hydrogen Peroxide	Slight odor	Safety glasses or goggles; rubber, neoprene or vinyl gloves	Use in well-ventilated area, always wear PPEs, hand hygiene	Irritant, oxidizer	Contain/Absorb
Formalin	Strong pungent odor	Nitrile gloves, safety goggles, gown	Use in well ventilated area, always wear PPEs, hand hygiene	Sensitizer, Irritant, suspected Carcinogen	Contain/Neutralize
Phenol	Aromatic, sharp, bitter, pungent odor	Nitrile gloves, safety glasses, gown	Use in well ventilated area, always wear PPEs, hand hygiene	Poison, Anesthetic, Corrosive, Irritant	Contain/Absorb. Air tight container
Silver Nitrate Applicators	Solid, odorless	Nitrile gloves, safety goggles	Use in well ventilated area, always wear PPEs, hand hygiene	Irritant	Contain/Air tight container
Chemo-therapeutic agents / hazardous drugs	Pungent odor	Nitrile gloves, safety goggles, gown	Mix under a fume hood, always wear PPEs, hand hygiene	Irritant, Carcinogen	Contain/Absorb. Air tight container
"Bravo" industrial cleanser, floor stripper Sodium hydroxide	Slight odor	Nitrile gloves, safety goggles	General ventilation, always use PPE, hand hygiene	Irritant	Contain/Absorb. Air tight container

Note: You will receive training from your department manager on any hazardous chemicals

How do you apply Age-Related Competencies in your areas?

- By considering cultural beliefs as they relate to patient age
- By utilizing interview techniques appropriate to the age of the patient and family members
- By implementing an age-appropriate care plan and by evaluating the effectiveness of the care
- By how we approach patient education and the evaluation of comprehension, concerns, and compliance
- By being aware of the resources available on age-related development specific to patient needs
- By demonstrating age-related applications in annual skills validation
- By knowing vital sign-normal value ranges appropriate to age and by interpreting these values
- By utilizing appropriate sized equipment (blood pressure cuffs, crutches) for all age groups
- By using proper positioning, proper body mechanics and obtaining assistance when needed
- By using injections-phlebotomy-appropriate needles (gauge and length) and selecting appropriate site for age
- By implementing knowledge of growth and development principles across the life span
- By providing age-appropriate coping skills to patient and family members during hospitalizations
- By providing appropriate nourishment/nutrition based on condition of patient and age.
- By providing appropriate methods of delivery of medication based on patient factors such as but not limited to weight & ability to swallow medication
- By demonstrating the ability to alter communication style based on condition of patient and age
- By demonstrating the differences of CPR-compressions, depth and rate in all population groups
- By maintaining advanced life support certification specific to the population being served
- By developing individualized educational processes based on the ability to learn, cultural & religious practices, developmental level, reading level, and barriers to learning, (emotional, language, motivation etc.),
- By implementing age-appropriate safety measures in compliance with hospital and other regulatory mandates
- By utilizing age-appropriate pain scales
- By providing education related to the continued need of immunizations, check-ups and screening across the life span
- By providing education on health, healthy lifestyles, safety behaviors and safety measures for all age groups
- By educating and monitoring age-related risk problems
- By providing age-appropriate anticipatory guidance

Trash/Paper/Chemotherapy Waste Streams

	Biohazardous Medical Waste 	PHI Waste 	Trace Chemo 
Regulatory Reference	Medical Waste Management Act (H&S Code §§117635-118360)	HIPAA Privacy Rule 45 CFR §164.53, California Civil Code §56.101	Medical Waste Management Act (H&S Code 117635-118360)
Container & labeling requirements	Initially in red biohazard bag labeled with the words "Biohazardous Waste" or with biohazard symbol and the word "BIOHAZARD." Secondly in rigid, leak resistant container with tight fitting lids of any color, labeled with "Biohazardous Waste" or biohazard symbol and the word "Biohazard" on lid and sides so as to be visible from any lateral direction. NOTE: Red Bags are to be properly tied (Single pony tail knot) Ensure segregation of red-bag waste and regular trash, red-bags are to be transported in a rigid container to the accumulation area.	Grey Paper Recycle Containers are in all departments. Paper, white and colors, newspaper, tissue paper. Discard any reports, papers or labels with protected health information (PHI) in these containers: Patient name, MR#, address, test results, orders, medications, phone number, Social Security number. Identify-hide labels are available to cover Patient information if unable to place in recycle container. Ensure confidential waste receptacles are secured or in an area where access is strictly controlled.	Yellow BD Chemo/ Sharps container marked "Chemotherapy Waste," "CHEMO," or other label approved by the DHS on the lid and sides.
What can go in the container?	Cultures and stocks of infectious agents Items soaked or caked with blood or other infectious materials: <ul style="list-style-type: none"> • Suction canisters • ET tubes • Culture plates • Bloody disposable gowns/gloves 	Confidential paper, paper containing Protected Health Information (PHI) work-related paper documents	Empty vials, empty IV tubing from chemo administration gowns and gloves contaminated from chemo administration. Trace Chemo Sharps must be segregated in separate container from non-sharps to minimize risk of needle stick
Storage requirements	May not be stored longer than 7 days	May not be stored when full longer than 7 days	May not be stored when full longer than 7 days

Pathology/Controlled Substances/Pharmaceutical/Hazardous/Universal Waste Streams

Pathology Waste	Controlled Substances	Sharps - Pharmaceutical Waste	Hazardous Waste	Universal Waste
				
Medical Waste Management Act (H&S Code § 117635-118360)	DEA, RCRA & California Medical Waste Mgt. Act	Medical Waste Management Act (H&S Code 118275(c) & (h) – Assembly Bill 762	Title 22, California Code of Regulations § 66262	California Health & Safety Code 25150.6 22 CCR §66273.1
Rigid, leak resistant container with tight fitting lids of any color. Labeled with the words "Pathology Waste," "PATH" or other label approved by the DHS on lid and sides so as to be visible from any lateral direction.	Depends on classification of controlled substances. For the majority that are California only hazardous pharmaceutical wastes, "Incineration Only" or other label approved by the DHS on lid & sides so as to be visible from any lateral direction. <i>NOTE – Pharmacy Container not approved for sharp's waste.</i>	Rigid puncture-resistant container that, when sealed, is leak resistant & cannot be opened without great difficulty. Containers should be labeled with the words "sharps waste" or with the biohazard symbol and the word "BIOHAZARD" <i>NOTE – For consolidation of regular sharps and pharmacy waste (per AB 762), the container MUST be labeled with the legend "Incineration" or "High Heat Only."</i>	Vary by waste type and volume but must be leak proof & compatible with the waste. "Hazardous Waste" labels stating chemical hazard, "Accumulation Start Date" & Facility/Department generating waste.	Rigid container that is labeled and dated.
Surgery specimens or tissues which have been fixed in formalin or other fixatives. Fixatives must be decanted off prior to disposal. Fetal remains cannot go in these containers. They must be placed in Ziploc or sealable plastic containers for disposal to crematorium.	DEA Schedule 2-5 narcotics. Most diluted injectables classified as pharmacy waste must be sent for incineration. Some solids are P&U listed and must be sent as Resource Conservation & Recover Act (RCRA) wastes. Some very dilute are non-hazardous & can be wasted to sewer if Publicly Owned Treatment Works (POTW) approves after witnessing.	All pharmaceuticals & Sharps waste: partial vials and IV bags containing medications. Sharps go in red sharp's container. Live & attenuated vaccines. Diluted chemo agents. Devices and implements that could potentially puncture or cut the skin, and/or otherwise cause percutaneous injury, e.g. Sharps with or without engineered injury protection All disposable needles & syringes with needles, scalpels/ blades	All chemical wastes that are deemed "hazardous" due to their chemical characteristic(s) or are specifically listed as hazardous waste in applicable government regulations characteristically hazardous or listed All federally Listed (RCRA) Bulk Chemotherapy drugs all Pharmaceutical wastes that are specifically regulated under federal HW laws	Batteries; thermostats, thermometers, switches, gauges & regulators that contain Mercury; lamps, such as fluorescent, sodium, & metal halide; and "E-Waste"- consumer electronic devices such as CRTs, TVs, printers, phones, and computers.
May not be stored when full longer than 7 days	On-site for no longer than 90 days. If <10 lbs./yr., can store for 1 year	On-site for no longer than 90 days. If <10 lbs./yr., can store for 1 year	Storage time limits vary with generator status and TSDF distance.	1 year maximum storage time limit.

RADIATION SAFETY REVIEW

We are exposed to radiation/cosmic rays on a daily basis from the earth, buildings, and the food we eat. Radiation exposures such as these do not normally give us cause for alarm. As a Kaiser employee, it is important that you are aware of potential sources of radiation exposure in the medical center and the basic safety procedures to protect yourself.

Sources of Radiation:

• **X-Ray producing equipment:** usually found in the radiology department, and in surgery, ED, and patient care areas, as well as specialty areas such as the cardiac cath lab.

• **Diagnostic radionuclides:** usually found in the nuclear medicine department & in-patient care areas. They include technetium-99m, gallium-67, thallium-201 and present a minimal risk to healthcare workers.

• **Therapeutic radionuclides:** usually found in the nuclear medicine department & patient care areas where therapeutic nuclear medicine patients are cared for. Radioiodine (I-131) is an example and is used to treat hyperthyroidism & thyroid cancer. Therapeutic radionuclides present a potential radiation hazard but if proper safety precautions are followed there is minimal risk for the healthcare worker.

• **Radiation therapy equipment:** usually found in the radiation therapy department.

• **Radionuclides:** used in laboratory activities.

Occupationally Exposed Staff:

Those who routinely and regularly work with and around radiation and radioactive materials (Radiological technologists and Nuclear Medicine technologists). These staff are given special training in dealing with radioactive materials & are monitored.

Those staff members that have occasional contact with radiation sources, such as nurses, are not considered Occupationally Exposed. Basic radiation precautions are to be followed by all staff.

Potential Radiation Hazards:

When you are near an X-ray machine that is actually making an exposure: In this situation, you may be exposed to the x-ray beam or scattered x-rays unless you leave the immediate area while the x-ray machine is on or are properly shielded (Increase your distance).

When you are near or in contact with radionuclides: In these situations, radiation is emitted from radioactive material & from objects that have been contaminated by the radioactive material. When you or your clothing have been contaminated by radioactive material.

Radioactive Contamination: Is the presence of radioactive materials anywhere they don't belong or not appropriately identified, contained, or controlled.

May be external or internal (ingested, absorbed, or inhaled). Can produce significant levels of exposure. May be present without YOUR knowledge.

Non-Radiation Producing Equipment (Do not cause radiation exposure):

X-ray machines not actively making an exposure; patients who have had x-rays or external beam radiation therapy treatments; nuclear medicine imaging equipment; iodine contrast material; ultrasound equipment; radiation detecting laboratory equipment; microwave ovens.

Radioiodine (I-131) Thyroid Cancer and Hyperthyroid Conditions Safety Procedures Access to the patient: Private room, radioactive material sign posted on door, all visitors and ancillary personnel must be cleared by nursing; patient may not leave the room.

Visitors: None for first 24 hours, no pregnant or children visitors, patient must stay in the bed throughout the visit, visitors must remain at least six feet away from the patient; visits must end with the "limits of stay" time posted on the patient door and/or in the patient chart.

Patient Care: No pregnant nurses, plan your activities to reduce time in room, wear your film badge at waist level, wear latex gloves, shoe covers, gowns & remove before leaving the room, wash your hands with gloves ON then dispose of the gloves and then wash your hands again.

State and Kaiser Permanente Standard 5,000 mrem per year is the maximum dose permitted by state regulations for workers considered to be "occupationally exposed."

Kaiser Permanente standards are more conservative than the state's. We set our standards to achieve radiation exposure levels **As Low As Reasonably Achievable= ALARA**. Our maximum permissible exposure per year is 1,000 mrem for occupationally exposed workers.

What does this mean for you?

If you do not routinely work with or near radiation sources or you work with low activity sources, you will probably receive no measurable radiation exposure. If you routinely work with radioactive material or radiation sources, you may be exposed to low levels of radiation.

RADIATION SAFETY PRECAUTIONS

RECOGNITION- Radiation sources are marked by the International Radiation Hazard Symbol;

a purple trefoil on a bright yellow background. Be aware of the source.

TIME - Reduce your exposure time to radiation by making sure you plan in advance to complete all procedures near a radiation source as quickly as possible.

DISTANCE - Stay at least six (6) feet away from any radiation source, or leave the room briefly during X-ray exposures

SHIELDING - Do not remain in or enter a room during X-ray exposures unless you

are wearing a lead apron or are standing behind a lead shield.

AVOIDING RADIOACTIVE CONTAMINATION:

- Avoid contact with objects or areas that may be contaminated.
- Don't eat, drink, or smoke in areas where radioactive materials are in use.
- Wear gloves, a gown, and shoe covers if indicated
- Don't apply cosmetics or groom your hair while in the area.
- Wash your hands when leaving the area.
- Don't handle radioactive materials unless you are trained and authorize to do so!



- Read and follow all signs & instructions.

Caution
X-Ray

Sign posted on all
doors leading to an
X-ray room

MORE INFORMATION: The Regional Radiation Safety Manual is the authoritative reference for radiation safety policies & procedures.

Contact your manager or the Medical Center Area Radiation Safety Officer (ARSO). **Regional Radiation Safety Officer (RRSO), Robert McDermott, 8-336-5180.** Further information on radiation safety may be accessed at the KP website at <http://medphys.kp.org/dirs/rsm/rsmcont.html>

WorkPlace Safety System

Kaiser Permanente's Goal is an injury-free workplace. There can be no acceptable number of injuries, & we must continually strive to improve our work practices and environment. Our vision is to create a culture of safety; this means a workplace where:

- Observing people at work & providing them feedback is routine & done by everyone
- Injuries and incidents are investigated through a formal process & result in positive changes to prevent recurrence
- Everyone accepts accountability for their own personal safety
- Everyone works to improve work practices and tasks are reviewed, re-engineered & standardized to increase safety & reduce injury risks
- *Management provides, maintains, & ensures a safe work environment*

Link with Other Kaiser Permanente Goals

Adoption of a culture of safety is a core objective of both Patient Safety & WorkPlace Safety. A safer workplace environment is a safer patient care environment.

- Injury-free employees stay on the job & provide **consistent staffing**.
- Pain-free staff and physicians provide **superior service and care**.
- A safety climate is correlated with better **compliance** with standard precautions against Bloodborne pathogens.
- Staff, physicians and managers working in a culture of safety demonstrate increased **productivity, loyalty, and harmony**.
- The lack of employee **engagement** & satisfaction can be directly correlated with lost workday/time incidents or percentage of lost workdays.
- Management attention to health & safety was found to be associated with improved staff **satisfaction** with the hospital.
- The reduction in workplace injuries results in **healthier staff** and real **cost savings** for the organization.
- *Our efforts to improve workplace safety directly support & reinforce our strategic LMP goals around **attendance & workforce development**.*
- **Incident Investigation:** Identify the cause(s) of injuries and prevent incident recurrence
- **Performance Management:** Drive Accountability

The cycle of safety is as follows:

1. The Safety Conversations/Safety Hazard is reported;
2. Unsafe act is corrected immediately; a work order is placed to address a hazardous environmental condition and/or observation/hazard is reported to DA, EH&S, or Administration;
3. Applicable P&P's checked for update/

- revision by employee input;
4. Observation/hazard discussed at Environment of Care Committee;
5. P&P update/revision sent to Medical Executive Committee for final approval; *The Safety Observation/Safety Hazard is corrected.*

The Top 5 Workplace Safety Injuries

Infectious Exposure: Punctures (Sharps), Bodily Fluids (Splashes)

Patient Handling: Patient Repositioning/Transfers, Combative Patients

Equipment Handling: Doors/Chairs/Beds/Gurneys/Tables

Path of Travel: Slips/Trips/Falls, Walking

Body Mechanics: Repetitive Motions, Awkward Postures

- directly to the DA & Labor leadership.
- Working closely with UBT leads on WPS initiatives.
- Emphasizing the benefits of working safely.
- Assisting in reducing barriers to WPS.

Contact EH&S for more information or to become involved Safety is everyone's responsibility. Think Safe, Work Safe, Bee Safe, and Thrive! Safety Protects Health, Your Greatest Wealth.



S.A.F.E. Hotline

FMC: ext. 7-7233 OMC: ext. 4-7233
In addition to reporting safety concerns, the S.A.F.E. Hotline has information available on:
Chemical Spills; Glutaraldehyde; SDS's; Emergency Preparedness; Formaldehyde, and Ergonomics.

Every Employee is Responsible for the Safety Program.

Lockout/Tagout

What Employees Need to Know

Introduction:

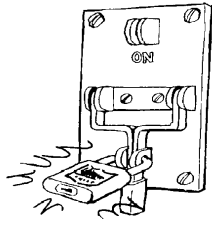
There are machines and equipment in our workplace which require periodic servicing and maintenance. The unexpected start-up of these machines/equipment or uncontrolled release of energy from them could cause injury to employees (e.g., electrocution).

What is "Lockout/Tagout"? Lockout and Tagouts are the ways maintenance personnel control hazardous energy from being released when they are working on a piece of equipment.

Hazardous Energy includes things like electricity, steam, & compressed gas.

Lockout: A physical lock that holds a switch in the off position or holds shut a valve so hazardous energy cannot be released while the maintenance is occurring.

ring.



tion (OSHA) requires a program to control hazardous energy during the servicing and maintenance of machines and equipment. The regulation requires that everyone who may come across a lockout or a tagout is aware of what it is and what it means.

How this applies to YOU:

Lockouts and Tagouts protect lives and ensure human safety. You may be working in or walking through an area where a Lockout or Tagout is being used.

Tagout: A paper or plastic tag that is placed on a breaker/switch, or valve that warns other people not to operate it. Tagouts are used when a Lockout cannot be used.

OSHA Requirements: The Occupational Safety and Health Administration

If you see one, DO NOT TOUCH IT!!!
Someone's life may be at stake!



Code Gray Stat Calls – Security Assistance

When confronted with a hostile or aggressive person & you need to summon Security assistance discretely & STAT, politely let the person know you are contacting someone who can assist. Contact security & call Code Grey & security will respond immediately to the area. Your immediate supervisor should be contacted immediately following as soon as it is safe to do so.



Code Silver - Active Shooter

Any person witnessing someone brandishing a weapon with intent to cause harm, or hear shots fired should immediately call 911 or security, who will in turn notify Local Law Enforcement & the Telecommunications Department. If 911 is called first, security must be alerted directly after. You will be asked to provide as much information as possible to include but not limited to; description of suspect(s), last known location, how many weapons or other items carried by suspect, and do you recognize suspect.

If you hear an overhead page stating "Code Silver," "Gunfire," or a "Suspect is in your Location," below are some recommendations:

At Location Away From The Active Shooter:

- It is recommended to seek shelter behind a closed and secured office door within your department and remain in the location unless you feel it is safe or instructed by Police to evacuate.
- Remain calm assist other staff, visitors, and patients to take immediate shelter
- Turn off lights, close blinds, block windows
- Turn off radios, silence cell phones or other devices that emit sound
- Do not open secured door if someone knocks on the door unless you are certain you know who it is.

At Location of Active Shooter:

If the suspect enters your work area and there is no indication that you can evacuate or escape, recommended best option is to remain in a secure-for-now location. In worse case scenario if secured location becomes non-secured law enforcement professionals recommend as a last resort disrupting or incapacitating the shooter if you have no other choice, or if in a group make plan to overcome the suspect. If your decision is to run it is recommended to do so in a zigzag pattern to make yourself a difficult target. If the active shooter(s) leaves the area, barricade the room or go to a safer location.

Code Red - Fire

If you discover a fire, remember the following procedures:

Rescue – remove those in immediate danger from the fire area

Alarm! Sound the alarm by pulling the nearest pull station, and call **33333 (Fontana and Ontario campus, all areas)**. All Fontana Off sites, including Palm Court I & II call 9-911 and 8-250-5500. All Ontario Off sites call 9-911 and 8-264-5500.

Contain the fire by closing all doors.

Extinguish the fire-only if it is safe to do so, and you have been trained, or

Evacuate the area- if the situation warrants and the authority coordinating the response deems it necessary.

Evacuation The decision to evacuate may be made following an earthquake or emergency event such as a fire. When/if it is determined that some or all of the facility may not be suitable for continued safe occupancy, a partial or total evacuation may be warranted. The decision to evacuate is the responsibility of the Hospital Command Center (HCC) staff, led by the Incident Commander in consultation with the Policy Group (MCAT) or the emergency response agency on scene (Fire Department).

Types of Evacuation

- Partial evacuation is defined as the movement from one area to another location within the Medical Center.
- Total evacuation is defined as the movement from one area to outside of the Medical Center.

Partial vs. Total Evacuation

- Evacuations are dangerous & disrupt patient care & should be undertaken **ONLY** for the gravest situations.
- Partial evacuation or re-location of staff, patients and visitors is preferable. This is accomplished by:
 - ◇ Choosing to re-locate to the closest, safe, "life safety compartment." Modern buildings, especially hospitals, are built to be compartmentalized into life safety units to reduce the need for total evacuation of facilities.
 - ◇ Choose destination horizontally **FIRST** and then vertically (up or down) depending upon safety factors and the nature of the emergency.
 - ◇ The **LAST** option to be considered is total evacuation and providing needed medical care outside the building until an alternative care site can be found.

Evacuation Summary The fire and life safety systems installed today, including our automatic fire sprinkler systems, are designed to control a fire and therefore lessen the need to evacuate all occupants. However, in the event of a FIRE, evacuations should occur with occupants of the fire floor, the floors immediately above and below, as well as departments on either side of the fire. Horizontal evacuation is **ALWAYS** preferred over vertical evacuation. The Medical Center's structural fire protection features include "Fire Separation" on all floors, basement through the top floor. Additionally, each floor is subdivided into compartments by rated walls and barriers designed to forestall the movement of smoke. Whenever evacuation is needed, move patients from the area of danger to the adjacent "smoke compartment," typically beyond the nearest set of rated fire doors. If further evacuation becomes necessary, patients, visitors and employees should then be evacuated vertically using the stairs. Because of potential power failure, the elevator should NOT be used for patient evacuation during a fire.

KNOW THE FOLLOWING DEPARTMENT SPECIFIC INFORMATION:

Emergency Operations Plan (EOP) (DocuShare); Fire Evacuation Route(s); Location of exit stairwells; Location of Fire Extinguisher(s); Pull Station Alarm; Evacuation Equipment; Evacuation Staging location.



SMOKE FREE CAMPUS

In the interest of the health and comfort of all patients, visitors, and occupants, this is a tobacco free campus. This effort is to promote a healthier work environment for all. All forms of tobacco use, including electronic cigarettes, are prohibited at the Fontana and Ontario Medical Centers and Medical Offices. Personnel who violate this policy will be subject to corrective action up to & including termination. (Medical Center Wide Policy EC.FE.24)



Code Stroke

Act F.A.S.T. Every Minute Counts.

Face- Does one side of face droop? Ask patient to smile.

Arm- Is one arm weak or numb? Ask patient to raise both arms. Does one arm drift downward?

Speech- Is speech slurred? Ask the patient to repeat a simple sentence.

Time- If patient shows any of these symptoms.

Act immediately-The faster the response, the better the chances of survival

ED patient will be triaged first by the RN then, expedited to the ED Physician who evaluates the patient and determines to initiate the Code Stroke system at "33333"

Inpatients with new onset Stroke symptoms call Rapid Response Team at "22222" and add 411 for the Manager on Duty (MOD) response.

MOD will evaluate the patient. After evaluation by MOD a Code Stroke will be called if needed throughout the Medical Center.

Call Code Stroke at "33333".

CODE TRIAGE— DISASTER

Personal Disaster Preparedness: Disasters can occur in just a few seconds. Personal preparedness lessens the impact on families, on workplaces and on communities. Since our hospital plays a particularly important role during community disasters, it is imperative that we understand the importance of personal preparedness. Preparedness of our hospital staff will have a significant impact on Kaiser's ability to provide uninterrupted service to the community. Every hospital employee has an important role in hospital operations and in our ability to provide care to the community regardless of circumstance. Personal preparedness has a direct impact on the effectiveness of the hospital during critical times. Hospital staff will feel more inclined to focus on their jobs if they are prepared at home and have planned for the safety and well-being of their family during a disaster.

Code Triage is announced in response to an internal or external disaster. When Code Triage is paged over the PA system, the Labor Pool of the entire Medical Center may be activated if needed. If you are instructed to report to the Medical Center for reassignment, please report to the Labor Pool.

Emergency Operations Plan Manual with Department specific roles, policies, & procedures is located on DocuShare under Environmental, Health & Safety

CODE PURPLE—Child CODE PINK—Infant

Action during a **Code Purple or Code Pink** (infant abduction) is everyone's responsibility. When a code Purple or Pink is announced through the overhead PA system, remember the following:

Go to your nearest exit and/or stairwell & monitor for anyone trying to exit with an infant or something that could conceal an infant (i.e. duffle bag).

Do not attempt to stop the abductor as they may try to harm you or the child.

Notify Security immediately by dialing:

Fontana ext.75500 Ontario ext. 45500

Give the officer as much information regarding the incident as possible, including the description of the person(s) involved and direction of travel.

Notify your supervisor - Do this only after you have notified the Security Department's Command Center.

A Purple wristband will be placed on patients that are confused, delirious or comatose.

A Purple sticker will be placed on the fall precaution sign.

If a confused patient leaves the unit and cannot be found, call ext. 33333, the gender of the patient (**male or female**), and the unit they are missing from.

Notify the following individuals:

- Director of the Unit
- Patient's Physician
- Director of Risk Management
- Unit Secretary (shall notify Hospital Administration/Administrator-On-Call).

If the patient **is not found within 15-30 minutes**, the following individuals must be notified:

- Patient's next of kin
- Fontana or Ontario Police Department
- Administration or Risk Management will notify Public Affairs
- Once the patient **is located**, the following must be done:
- Notify the Unit the patient is assigned
- Escort the patient to the Unit he/she is assigned
- Notify operator/security
- Patient should be re-evaluated for alternative measures

CARDIAC OR RESPIRATORY ARREST

Code white—Pediatrics

Code white—Neonatal

CARDIAC OR RESPIRATORY ARREST CODE BLUE- 18 years and older

EMERGENCY PHONE NUMBERS

Security : Fontana ext. 75500 Ontario ext. 45500

SAFETY Hotline: Fontana ext. 77233 Ontario ext. 47233

Fire: Fontana ext. 33333 Ontario ext. 33333

Risk: Fontana ext. 77475 (7-R-I-S-K) Ontario ext. 47475 (4-R-I-S-K)

2019 Infection Control Update

The Infection Control Manual is available on-line. Hard copies will only be available: Fontana: Bed Coordinator's office, Infection Control Department. Ontario: Ontario Vineyard Ambulatory Surgical Center, Assistant Clinical Director's Office on the 4th floor of the hospital & the Infection Control Department.

Hand Hygiene: The most effective way to prevent the spread of infection is through effective hand hygiene. Effective hand hygiene can be achieved by: Washing your Hands with Soap & Water for at least 15 seconds.

Rubbing your hands with the waterless alcohol based hand rub until dry. The waterless alcohol based hand rub is more effective against microorganisms than soap and water.

Always wash with soap and water if your hands are visibly soiled, you are caring for a patient with *Clostridium difficile* (C. difficile), after using the restroom or you feel an accumulation of the waterless product on your hands.

"Red Rule" At the Kaiser Permanente Fontana and Ontario Medical Centers, a culture of safety has involved incorporation of safety practices such as Rapid Response Teams, Condition Help, Daily Safety Briefings and Patient Safety Executive Walkarounds. These strategies have been adopted to help us reduce the risk of patient harm from preventable adverse events. Another safety practice used by highly reliable industries—**Red Rule**—was first adopted in the KP Southern California Region by Fontana Medical Center. This practice has since served as a model for other Kaiser Permanente Southern California centers. **The Fontana and Ontario Medical Centers Red Rule: Everyone MUST perform hand hygiene before and after every patient interaction**

What is a Red Rule?

- Rules that cannot be broken
- Few in number, easy to remember
- Associated only with processes that can cause serious harm
- Any staff member is empowered to speak up when the rule is not being followed
- Every healthcare worker, regardless of rank or experience is expected to stop the work if the red rule is violated

What do Red Rules require?

- Leadership support
- Must be followed all the time
- Managed through a *Just Culture* approach

What does that mean?

- Means that everyone, including our frontline workers are empowered to use the **Red Rule** that we have adopted
- Means that it becomes ingrained into our culture.

Make a difference, when you see someone not washing their hands; remind them by saying "Red Rule."

HAND LOTION:

Use only the lotion provided by the Medical Center to prevent drying or cracking of skin. Do not use other lotions as they may contain interfere with the integrity of gloves.

ARTIFICIAL NAILS:

The use of artificial nails (extensions, wraps, etc.) and nail gels is prohibited for all healthcare workers with direct hands-on patient care. This is a condition of employment.

RESPIRATORY

HYGIENE

COUGH ETIQUETTE

To Prevent the

Transmissions of All Respiratory Infections:

- Offer tissue or a surgical mask to members to cover their nose/mouth when coughing or sneezing



World Health Organization "5 Moments for Hand Hygiene."
This approach recommends health-care workers to clean their hands:

1. Before touching a patient.
2. Before clean/aseptic procedures.
3. After body fluid exposure/risk.
4. After touching a patient.
5. After touching patient surroundings.

Fontana Medical Center Precautions Program:



Standard Precautions are the first line of infection control precautions & are applied for the care of ALL PATIENTS, AT ALL TIMES regardless of their diagnosis or presumed infection status.

- Offer alcohol based degermer after contact with respiratory secretions and contaminated environment

- During flu season, post the "Cover Your Cough" signs to alert members

DO IT IN YOUR SLEEVE to prevent the spread of viruses when coughing & sneezing.

DON'T!!! Coughing/sneezing in the air disperses particles at least 3 feet which can be easily inhaled by those near you.

Most people who cough/sneeze **in their hands** generally don't wash before handling charts, keyboards, telephones, elevator buttons, door knobs... & visitors.

DO!!! Coughing/sneezing into a tissue or handkerchief still requires proper hand washing before resuming work. **Coughing in your sleeve** decreases the spread of germs.

PERSONAL PROTECTIVE EQUIPMENT (PPE) PPE is

only effective if it does not permit blood or body fluids to soak through to reach the healthcare worker's skin. **Wear a appropriate personal protective equipment (PPE) when contact** with the patient's blood and body substances, non-intact skin such as rashes and mucous membranes (eyes, nose, and mouth) is anticipated.

Help keep yourself and others healthy

Cover your cough



Selection of PPE is based on the type and degree of risk associated with the task being performed. PPE selection is also indicated on the isolation sign. Any concerns about PPE should be discussed with your supervisor or Infection Control.

PPE is provided in designated locations through out the Medical Center where these neon green/yellow signs are located.

WHEN TO WEAR PPE:



Gloves for any anticipated contact with blood, body fluids, mucous membranes, non-intact skin or rashes. Gloves must be changed after contact with each patient, moving from dirty to clean body areas, when contaminated, and when torn or punctured. Perform

hand hygiene after removal of gloves.

Mask and Eye Protection for any anticipated splash or spray of blood or body fluids to prevent exposure of mucous membranes of the mouth, nose and eyes. Protective eyewear includes goggles and masks with shields.

Long sleeve impervious gowns for any anticipated contact of clothing with blood or body fluids. Most PPE are disposable.

Disposal of PPE: Dispose of PPE in regular trash. If contaminated with biohazardous fluid, place in red bag & dispose in biohazardous bin. Goggles should be decontaminated between patients with hospital approved disinfectant.

ALL PPE MUST BE:

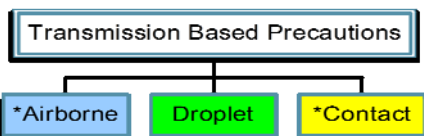
- Removed when contaminated and placed in an appropriate container for disposal.
- Dispose of PPE when saturated with blood or any potentially infectious material in a biohazard container. Dispose of PPE in a chemo container if PPE contaminated by chemotherapeutic agents.

Linen Handling and Storage

- All used or soiled linen is handled using Standard Precautions.
- Employee must wear gloves when handling soiled linen.
- Handle as little as possible with minimal motion.
- Hold linen away from the body.
- Do not store extra linen in patient's room.
- Store clean linen in a covered cart/cabinet.

TRANSMISSION BASED PRECAUTIONS

These are additional precautions for patients known or suspected to be infected by certain infectious organisms.



Additional precautions required for:

CJD Alert: for Creutzfeldt-Jakob disease

Special Precautions: SARS, Avian Influenza,

Strict Precautions: Smallpox, Viral Hemorrhagic Fevers



Mumps, Meningococcal disease and Plague. A **surgical mask is worn when within 3 feet** from the patient to prevent exposure.

Contact Precautions reduce transmission by direct or indirect contact. Direct contact transmission involves skin to skin contact.

Indirect transmission is contact by a contaminated item in the patient's environment. **Gowns and gloves are worn upon entering the room.** MRSA, VRE, Scabies, Lice, skin Anthrax and Neonatal Herpes Simplex are included in this category.

Contact Plus Precautions (with gown and gloves required upon entering room) will be applied while patient with diarrhea is suspected of C. difficile.

CLOSTRIDIUM DIFFICILE (C. difficile)

C. difficile is shed in feces. Watery diarrhea I s always present with/without probable a bdominal pain, loss of appetite and/or fever. Contamination on hands, gloves, equipment and environment can provide the route of transfer from the spore to the patient.

- Early testing and prompt isolation is essential to prevent cross transmission of C. diff spores.
- There is a conditional order for C. diff PCR in all admitting order sets. This order is released when a sample is collected.
- For the specimen to be acceptable for testing, stool sample must be loose/watery and conforms to the shape of the specimen cup.

Hand Hygiene Must Be Performed With Soap and Water Only. Alcohol based degermer is ineffective against spores.

EVS must clean room with a bleach product.

Discontinuation of Contact Plus Precautions-The patient must meet the following criteria: A negative C-difficile PCR test or, diarrhea ceases for 48 hours or, there is an alternative diagnosis such as Inflammatory Bowel Disease or medication induced diarrhea. A new clean room must be provided if patient qualifies for removal from isolation.

MRSA Methicillin Resistant Staphylococcus Aureus is a bacteria that is resistant to certain antibiotics. Contact Precautions are used for patients with active Infections. These include bloodstream, respiratory, wound and urine infections. Patients with MRSA colonization will not be isolated. This includes patients with positive nasal cultures.

MRSA nasal cultures must be performed on certain groups of patients upon admission unless they have previously tested positive. These groups include patients:

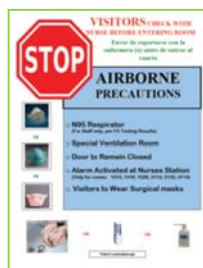
- Re-admitted within 30 days of discharge from an acute care hospital.
- Receiving dialysis (peritoneal or hemodialysis).
- From skilled nursing facilities.
- Admitted to Critical Care including NICU.



Precautions Signs: They are color coded by type of precautions. The back of each sign lists the disease(s) for which the sign applies. Nursing staff will place at the entrance of the room after the patient is discharged, EVS will clean the sign and return to the Nursing staff.

Airborne Precautions include diseases such as Tuberculosis, Chickenpox & Measles. The **N95 respirator** is used for Tuberculosis, Avian Influenza, SARS and the Bioterrorism agents Smallpox and Viral Hemorrhagic fevers. Use airborne Isolation rooms. A powered air purifying Respirators (PAPR) cart is ordered when precautions are initiated.

Droplet Precautions include diseases transmitted via large particles which require close contact usually 3 feet or less. These diseases include Influenza, Pertussis,



MRSA nasal surveillance culture must be done within 24 hours of admission. The only exception is for patients who may have nasal packs due to certain surgical procedures or when the patient refuses. This exception must be documented in the medical record. Once a patient has tested **positive for MRSA, no further MRSA nasal surveillance tests will be needed.**

All Chronic Hemodialysis patients with an ICU stay whose admission nasal MRSA test is negative will be re-tested prior to discharge. These patients will be identified with a blue wrist band.

• **VRE** Vancomycin-Resistant Enterococci are bacteria that can cause infection.

Contact Precautions are used for patients with active VRE infections. These include wounds, bloodstream or urinary tract infections. Patients with VRE colonization will not be isolated.

SPECIAL PRECAUTIONS: Are used for **SARS (Severe Acute Respiratory Syndrome) and AVIAN INFLUENZA.** **Special Precautions** require full head, neck and eye protection, in addition to wearing an N95 respirator, gown and gloves. The **Special Precautions** sign, information packet and supplies are available from Sterile Processing and Nursing Administration. There is a specific order for donning (applying) and doffing (removing) PPE to avoid contamination of mucous membranes, skin and clothing.

STRICT PRECAUTIONS: Precautions that apply to bioterrorism related conditions such as Smallpox & Viral Hemorrhagic Fevers. In addition to the personal protective equipment listed above, incineration of trash and linen is required.

See **Bioterrorism Exposure Control Plan** below for more detail.

Creutzfeldt-Jakob Disease (CJD) Precautions

CJD is a neurological disease similar to Mad Cow Disease.

Standard Precautions applies for the routine care of the patient with suspected or confirmed CJD. Nursing Administration to activate CJD Response Team specialhandling of items contaminated with **high risk tissues:** brain, spinal cord, spinal fluid, duramater, pituitary gland, eye tissue (including optic nerve) Special handling of contaminated trash, instruments (disposable, or special disinfection/sterilization parameters for suspected cases with high risk tissues) Informational packet & sign is available from Sterile Processing and Nursing Administration. The packet contains the IC Alert Sign which is placed on the door.

EXPOSURE CONTROL PLANS

There are 3 Exposure Control Plans in the Infection Control Manual

PLAN 1: BLOODBORNE PATHOGEN EXPOSURE CONTROL PLAN

Our medical center's written Exposure Control Plan (ECP) is designed to prevent or minimize occupational exposure to Blood and **other potentially infectious materials (OPIM)** which includes fluids from around the heart, lungs, abdomen, joints, spine, semen, vaginal fluid and amniotic fluid. The ECP contains at least the following information: Kaiser Permanente's role in protecting employees and healthcare workers obligation to use protective measures. Procedures and conditions that can place the healthcare workers at risk and the protective measures to be taken Procedure for reporting bloodborne exposure and post exposure prophylaxis and follow up. A copy of our written ECP is available on the DocuShare electronic document site.

BLOODBORNE PATHOGENS (BBP):

OSHA defines "Bloodborne Pathogens" as microorganisms that are present in human blood & are capable of causing disease (s) in humans. These pathogens include, but are not limited to, Hepatitis B virus (HBV) Hepatitis C virus, & human immunodeficiency virus (HIV). At the Fontana and Ontario medical centers, we are committed to providing a safe and healthful workplace, & our organization's policy is to establish & maintain an effective bloodborne pathogen exposure control plan in accordance with the Cal-OSHA BBP Standard Title 8, section 5193.

The contents of the Cal-OSHA Standard include methods of compliance; Hepatitis B Vaccination; communication of hazards to employees; exposure incidents & post exposure management; exposure control methods; sharps injury documentation; recordkeeping. A copy of the Cal -OSHA Bloodborne Pathogen Standard is available in the Infection Control Manual and electronically on *DocuShare*.

Modes of BBP Transmission: The three modes of BBP transmission to healthcare workers are:

- Needle sticks/punctures
- Splash to the eyes or mucous membranes
- Open cuts or skin abrasions

Symptoms and Basic Epidemiology of Bloodborne Diseases:

Hepatitis B and Hepatitis C: Hepatitis is a viral disease that attacks the liver. May produce no symptoms, or may cause fatigue, loss of appetite, nausea and vomiting, jaundice, liver damage, cirrhosis, cancer of the liver and death.

Hepatitis B is a vaccine preventable disease. The **Hepatitis B vaccine** is available at no cost to employees and is strongly recommended. The vaccine is 96% effective in preventing disease. Contact Employee Health to obtain the vaccine.

Hepatitis C does not currently have a vaccine available.

Human Immunodeficiency Virus (HIV) ultimately destroy the immune system, leading to fatigue, weight loss, wasting, and additional symptoms of AIDS. There is currently no vaccine available.

Risk Identification:

It is imperative that appropriate methods are used to recognize tasks, activities and conditions that may involve blood or OPIM. These tasks and activities may expose the employee to an increased risk of blood or OPIMs. BBP exposure to the skin, eye, mucous membrane, or parenteral contact can occur with the following:

- Blood drawing – arterial, venous fingerstick or needlestick.
- Suctioning – nasotracheal, endotracheal, oral.
- Cleaning up blood or potentially infectious material spills.

Methods to Prevent or Reduce Exposure

WORK PRACTICE CONTROLS:

These are controls that reduce the likelihood of exposure by altering the manner in which a task is performed. Examples of *work practice controls* include:

- Hand Hygiene
- Use of Personal Protective Equipment while cleaning instruments

- Wearing gloves when emptying a indwelling catheter
- No recapping of needles by a two-handed technique
- Activating sharp safety devices
- Using resuscitation bags (i.e. Ambu bags), mouthpieces, and other ventilation devices

NO Eating or Drinking in Work Area:

To protect the employee and avoid cross-contamination in the work area, **CAL-OSHA** regulations do not allow eating, drinking, application of cosmetics, lip balm or handling contact lenses in **patient care areas**.

ENGINEERING CONTROLS:

Engineering Controls are tools that are used to isolate or remove bloodborne pathogen hazard from the workplace. Examples include:

- Sharps disposal containers
- Self-sheathing needles & other sharp-safety devices (Engineered Sharps Injury Protection features)
- Hand washing sinks
- Personal protective equipment.

PREVENTION OF SHARPS INJURIES:

Wherever feasible, use a "Needleless System" for the withdrawal of body fluids and/or the administration of medication or fluids.

Always fully activate and properly engage the **Engineered Sharps Injury Protection** feature of the syringe (safety device) immediately after use. Do not recap needles. In unique situations where recapping of a contaminated needle is necessary (e.g. inoculation of blood cultures, administration of incremental doses of medication), use a mechanical device or a **one-handed technique**. Discard disposable sharps in the closest designated sharps/pharmaceutical containers located **immediately after use**. Pick up potentially contaminated broken glassware or sharp items using mechanical means (e.g. dust pan and brush, tongs, forceps, etc.)

NEVER overfill sharps containers. Overfilled sharp containers pose a risk of needle sticks. Close tightly and **Replace when 3/4 full** or contact EVS for replacement. **Remember** when drawing blood or starting an I.V., the major risk is a needlestick injury. **Signs and Labels** Warning labels are

affixed to containers of regulated waste, refrigerators and freezers containing blood or OPIM; and other containers used to store, transport or ship blood or OPIM. These labels will include the universal symbol: Regulated waste containers will be labeled with the words "BIOHAZARDOUS WASTE" "MEDICAL WASTE". Sharps

containers will be marked "SHARPS WASTE" or "INCINERATE

ONLY" – (See Biohazard Waste section) Biohazard specimen

bags must only be used to store or transport biohazardous specimens and must be disposed of as biohazardous (medical waste).

Personal Protective Equipment (PPE):

Selection of appropriate PPE is based upon the type and risk of BBP exposure, for example, face shields, impermeable gloves, goggles if blood or body fluid splash can be reasonably expected during routine procedures, operations or foreseeable emergencies. **ALWAYS** wear the appropriate PPE.

EMERGENCIES – MANAGING A BLOOD OR BODYFLUIDS SPILL. In the event of a spill of blood or OPIM, use the **Kwik-Chlor Kit** (a chlorine based blood spill management solution) to

include the use of gloves and other appropriate PPE, during cleaning and decontamination procedures. Notify your manager & EVS without delay.

RESUSCITATION EQUIPMENT:

To minimize occupational exposure during resuscitation, use Ambu bags, mouthpieces and other ventilation devices.

BBP EXPOSURE/POST EXPOSURE FOLLOW-UP IN CASE OF AN EXPOSURE:

Wash or rinse the affected area immediately and report to you supervisor. Your supervisor will direct you to the appropriate area for a medical evaluation. You must see a physician within 2 hours of the exposure to start appropriate treatment. Healthcare worker: Complete the BBP exposure report form bring packet to provider.

Managers: The packet is located online in the Docushare.

Prompt reporting of an exposure is necessary because the anti-retroviral medications are more effective if started within 2 hours after the exposure.

Medical follow up may involve: laboratory testing; preventive therapy: medications or vaccinations; other procedures if indicated Employee Health will record information related to sharps injuries on the "Needle stick and Sharp Object Injury Data Report" and the OSHA 300 log. This is the designated Sharps Injury Log required by Cal OSHA.

BIOHAZARDOUS (Medical) WASTE: Defined as items visibly **saturated** with blood or other potentially infectious body fluids (OPIM) including: sharps (e.g. empty syringes, needles), laboratory cultures, pathology specimens and recognizable anatomical remains.

Note: Pharmaceutical containers are used to discard sharps & medications including vaccine & medication vials (e.g., ampoules)

Place items designated as "Biohazardous Waste" in a **RED BAG at the point of origin**. Biohazard waste must be carried from the point of origin to the soiled utility room in a puncture proof container with a lid locked in place. All sharps (including empty syringes) must be placed in sharps containers. Discard bulk blood, suctioned fluids, secretions not contained within a disposable unit (such as a suction canister) by carefully pouring down a drain connected to the sewer system using Personal Protective Equipment. If contained in suction canister, lock lid tight and place canister in a red bag and dispose in the Biohazardous Waste container in the soiled utility room. Biohazard waste bin lids must be closed tightly. No storage on top of sharps containers and biohazard bins. Biohazard waste bins must be labeled on all sides with universal bio-hazard symbol.

Hepatitis B Vaccination: The HBV Vaccine is available free of charge to all employees who may have potential occupational exposure to BBP. The Employee Health department or your manager can provide detailed information regarding the efficacy and safety of this vaccine, as well as the benefits of being vaccinated.

EMPLOYEE INPUT FOR THE REVIEW & UPDATING OF THE BLOODBORNE PATHOGEN EXPOSURE CONTROL PLAN.



Healthcare workers are encouraged to provide feedback in updating this Plan through the Unit Based Teams or by calling the Safety Hotline: SAFE- (7233). Following the completion of this module; you are encouraged to take the opportunity for interactive questions and answers, and to discuss this material further with your manager as you turn in the post test; or simply call the SAFE Hotline.

PLAN 2: AEROSOL TRANSMISSIBLE DISEASE (ATD) EXPOSURE CONTROL PLAN (FORMERLY THE TUBERCULOSIS EXPOSURE CONTROL PLAN)

A copy of the ATD Standard is available in the Infection Control Manual. An aerosol transmissible disease (ATD) is a disease or pathogen that requires droplets or airborne precautions to prevent exposure.

"Airborne" refers to relatively small particles which can remain suspended in the air and can travel great distances.

"Droplets" are relatively large in size and can result from coughing, sneezing or talking and are generally deposited on the ground within 3 feet from the point of expulsion.

Signs and symptoms for ATDs that requires further medical evaluation include:

fever with rash, fever with cough, headache or neck stiffness or sensitivity to light

The ATD Exposure Control Plan contains:

- Identification of job classifications at risk of exposure to ATDs
- Descriptions of interventions for an ATD exposure.
- Description of specific methods the facility uses to control ATD exposures
- Procedures for training on ATDs

Work practice controls: to prevent exposures include the use of airborne infection isolation rooms for airborne transmissible diseases, N95 respirators, Powered Air Purifying Respirators (PAPRS) during high hazard procedures and aeration of rooms for one hour after a patient is discharged

The ADT Exposure Control Plan: identifies HCWs at risk for occupational exposure to airborne and droplet transmitted diseases such as tuberculosis, chickenpox, measles, pertussis, RSV, H1N1, influenza and the procedures that put them at risk.

CHICKENPOX (Varicella)

- Viral disease with sudden onset of fever, skin eruptions that are vesicular (contain fluid) for 4-5 days and leaves a granular scab. Lesions commonly occur in successive crops and are more abundant on the trunk of the body.
- Varicella vaccine is mandatory for all non-immune HCWs as a condition of employment.
- Transmitted by airborne spread of secretions of the respiratory tract

HERPES ZOSTER (shingles): A local reactivation of infection with the virus that caused chickenpox (varicella). HZV usually occurs in older adults. However, people with HIV infection and other immunocompromised conditions are at increased risk for HZV zoster. ***Patients with shingles that are immunosuppressed or have disseminated disease will be placed in an airborne infection isolation room.***

MEASLES:

- Viral disease that appears as a red blotchy rash on the third to seventh day of infection, beginning on the face, becoming generalized and lasting 4-7 days.
- Preventable by two doses of MMR vaccine. Immunity to measles is a condition of employment. Vaccine is mandatory for all non-immune HCW as a condition of employment.
- Transmitted by airborne and direct contact with nasal or throat secretions of the infected person.

TUBERCULOSIS (TB): Tuberculosis is a disease caused by *Mycobacterium tuberculosis* (MTB). The lungs are the most common site for symptomatic tuberculosis (85%). We commonly think of TB as a respiratory illness, but it can involve any body organ or tissue.

TB Infection vs. TB Disease:

TB Infection: means that the person was exposed to a person with TB. There are no signs or symptoms present in TB infection. TB infection is usually detected by a positive PPD skin test.

TB Disease: means that the bacteria has become active and is producing signs and symptoms of TB such as:

- Cough with blood tinged sputum
- Fever
- Unexplained weight loss
- Night sweats
- Loss of appetite
- Chest x-ray may present with cavitary lesions, consolidation or an upper lobe infiltrates.

Populations at High Risk for infection include the following:

- close contact with TB patients
- residents of skilled nursing facilities
- prisoners
- homeless
- people with HIV/AIDS
- immigrants from high prevalence areas
- children under the age of 5 and the elderly

Transmission:

Persons with active disease of the lungs and upper airway may be infectious and may spread TB germs when they cough, talk, sneeze, or sing.

The infectivity of a person is defined by Acid Fast Bacilli sputum smear and culture results.

TB PPD SCREENING TEST:

- PPD skin tests are read in millimeter (mm) of induration after 48-72 hours. Yearly PPD testing is adequate to monitor HCW. If a HCW is exposed to TB, additional testing/screening will be performed.
- PPD skin test may not be accurate in immunosuppressed individuals.
- Health care workers with a positive PPD will fill out a periodic questionnaire.

Multiple-Drug Resistant MTB: (MDR-TB) occurs when the bacterium causing the disease is resistant to antibiotics usually used to treat TB. This resistance can occur through inadequate or incomplete treatment. Although this makes the disease harder to treat, it does not make it more infectious

Care of Patients with Known or Suspected TB, Measles, chickenpox or Shingles in immunosuppressed or disseminated patients:

- Patients admitted to the hospital are placed in an airborne infection isolation room. The door is kept closed.
- Healthcare workers must wear the N95 respirator when entering a precaution room.

- HCWs must wear N95 respirators they were fit tested with to achieve maximum protection from infectious microorganisms.
- N95 respirators are single use.
- Dispose of N95 respirators in regular trash unless contaminated with biohazardous fluids.
- HCWs must wear a **powered air purifying respirator (PAPR)** when performing high hazard procedures.
- Call Employee Health to be fit-tested or to verify the appropriate respirator you were fitted with.
- Fit Checking is performed upon donning the N95 respirator to verify that an acceptable face seal is achieved.

Employees shall wear a minimum of a PAPR when performing or assisting in a high-hazard procedure on suspected or confirmed patients or cadavers potentially infected with ATD

When a patient with an airborne or droplet transmissible disease must leave their room for treatments or procedures, provide a surgical mask for the patient, with instructions to wear it over the nose & mouth.

If you are assigned to wear a PAPR you must complete initial and annual respiratory protection training.

Annual training will be required & will be provided by Employee Health or designated trainer in conjunction with N95 Fit Testing.

High-Hazard Procedures are Defined as:

- Administration of nebulizer or aerosolized medication, including Pentamidine
- Autopsy • Bronchoscopy
- Centrifugation • CPR
- Intubation • Laboratory testing of viral cultures
- Lancing TB lymph nodes • Nasal/endotracheal suctioning
- Pentamidine administration (aerosolized)
- Pulmonary function testing • Sputum induction
- Ventilator disconnecting

AMBULATORY SETTING:

For a patient with a suspect or confirmed Aerosol Transmissible Disease (ATD), patients must wear a surgical mask when:

- In the waiting room
- Ambulating in the hallway
- In the exam room (patient should be placed in an exam room as soon as possible)

DEFINITION OF AN ATD EXPOSURE INCIDENT:

An Airborne ATD Exposure May Occur When a Healthcare Worker:

Has contact with a person who has ATD that generate small-particles without the use of exposure prevention measures. Enters a patient room without the use of exposure prevention-measure (e.g. airborne infection isolation room, N-95 mask or PAPR during high-risk procedures.)

A Droplet ATD Exposure May Occur When a Healthcare Worker: Has contact with a person who has a ATD disease without the use of exposure prevention measures. Enters a patient room without the use of exposure prevention measure (e.g. a surgical mask within 3 feet of the patient.)

In Case of an ATD Exposure: Immediately report to your supervisor who will direct you to the appropriate area for a medical evaluation. Medical follow up may involve: Preventive therapy: medications or vaccinations, other procedures if indicated (e.g. Chest x-ray) Employee Health & Infection Control will determine if an exposure has occurred & will monitor for infection as a result of a work related exposure. Infected HCWs are treated at no expense, using the Department of Public Health Services guidelines. Other diseases included under the ATD Exposure Control Plan are Pertussis, Influenza and Respiratory Syncytial Virus (RSV).



EMPLOYEE INPUT IN REVIEWING AND UPDATING THE ATD EXPOSURE CONTROL PLAN.

Healthcare workers are able to provide feedback in updating this Plan through the Unit Based Teams or by calling the Safety Hotline: SAFE- Fontana (77233) Ontario (47233).

PLAN 3: BIOTERRORISM EXPOSURE CONTROL PLAN

This plan covers screening of patients for biologic agents, room placement, cleaning/disinfection of equipment and linen, patient education, discharge management and homecare.

The Federal Centers for Disease Control and Prevention (CDC) has identified seven (7) disease agents/conditions that may represent a possible bioterrorist attack. These diseases require intensive surveillance and rapid reporting. The seven agents are Anthrax, Botulism, Brucellosis, Plague, Smallpox, Tularemia and Viral Hemorrhagic Fevers. The San Bernardino Public Health Department must be notified within 1 hour of suspected diagnosis & the Infectious Disease Physician & Nursing Administration must be notified immediately.

The "Bioterrorism Exposure Control Plan for Patient Management" includes screening forms, patient room placement, cleaning/disinfection of equipment & linen, discharge management, home care & patient education materials.

Kaiser Permanente Bioterrorism Preparedness & Response information for employees and clinicians can be found at:

<http://insidekp.kp.org/insidekp/communicate/readiness/index.html>

Event Related Shelf Life:

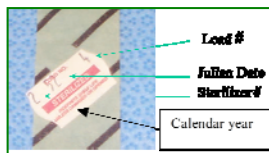
Medical Center sterilized supplies and equipment as well as some commercially sterilized supplies **will use event-related shelf life. No expiration date will be used for these packages.** Package integrity is to be checked per policy. Proper conditions must be maintained to provide sterility of products.

Conditions that Compromise Sterile Packages Include:

Visible droplets or moisture in the interior or exterior of package, punctured, torn, dust, broken or damaged heat seal, no change in chemical indicator to indicate sterility. Supplies from manufacturers may have an expiration date. Discard expired items:

INFECTION PREVENTION BUNDLES

CENTRAL LINE BLOODSTREAM INFECTION PREVENTION BUNDLE



The **Central Line Bloodstream Infection** prevention bundle (CLBSI) includes the following elements for all central line & PICC insertions.

CENTRAL LINE INSERTION BUNDLE:

- Hand Hygiene Maximal Barrier
- Chlorhexidine Skin Antisepsis & Dry Time
- Optimal Catheter Site Selection - subclavian site preferred

Maximal Barrier Kit Contents:

- * Sterile Gloves
- * Long-Sleeved Sterile Gown
- * Mask
- * Large Sterile Sheet Drape
- * Protective Eyewear
- * Cap

CENTRAL LINE MAINTENANCE BUNDLE:

- Hand Hygiene prior to accessing lines
- Change transparent dressings with Biopatch every 7 days and prn with documentation.
- If gauze is used, it must be changed three times per week (eg. Monday, Wednesday and Friday).
- Two person dressing change to include a PICC Nurse.
- Disinfect hubs, connectors and ports by scrubbing with alcohol for 15 seconds or using an alcohol impregnated hub protector cap.
- Chlorhexidine daily bath for adult patients with central lines.
- Daily review of line necessity with prompt removal of unnecessary lines.

VENTILATOR - ASSOCIATED PNEUMONIA (VAP) PREVENTION BUNDLE: A VAP is the development of pneumonia after a patient has been intubated with an endotracheal tube.

VAP BUNDLE ELEMENTS:

- Head of bed elevated to 30°
- Daily "sedation vacation"
- Ventilator weaning – daily assessment of readiness to extubate.
- Peptic ulcer disease prophylaxis
- DVT prophylaxis.
- Oral care every 4 hours and every 12 hours with CHG impregnated brush.

SURGICAL SITE INFECTION PREVENTION

What is a Surgical Site Infection (SSI)?

A surgical site infection is an infection of the incision and/or other part of the body involved in a surgery. The SSI can develop within 30 days of the surgery or **within 90 days** of the surgery if an implant was used. For the prevention of SSI, the hospital monitors the following Surgical Care Improvement Project (SCIP) (SCIP is a national quality partnership committed to improving patient safety by decreasing surgical complications) measures:

1. The right antibiotic at the right time
2. Tighter glucose control
3. Changing practice for preoperative hair removal (no shaving)
4. Keeping OR patients warm







CATHETER URINARY TRACT INFECTION (CAUTI) PREVENTION BUNDLE:

The following evidence based prevention bundle elements have been implemented and are being monitored: **Criteria for necessity of indwelling catheter needs to be reviewed daily. Approved Regional criteria for insertion and continued use of indwelling catheters for males and females.**

Frequent urine output monitoring for critically-ill patients

(i.e. CHF, shock, sepsis, 24-hour urine collection)
Chemically-paralyzed, sedated, or comatose patient
Stage 3 or 4 pressure ulcer or excoriation in incontinent patient
Acute urinary retention/obstruction (post-void residual on scanning > 150 ml)
Peri-operative use for selected surgical procedures (renal/urology surgery, colorectal surgery, abdominal/pelvic surgery, major orthopedic surgery)
Trauma: spinal injury or pelvic fracture (if urethral disruption is suspected, patient must first see a Urologist)
End of life care or comfort measures per patient and/or family's request
Continuous bladder irrigation

Prevention of CAUTI

Catheter/Meatal Junction	Catheter/Tubing Junction
	
Prevention: Aseptic Technique During insertion, includes: 1. Hand hygiene 2. Catheter securement to prevent tugging and urethral trauma	Prevention: Limit use of leg bags Specimen collection from sampling port without breaking seal
Outlet Tube	Backflow
	
Prevention: Single patient container to measure urine No touching of spigot when emptying container	Prevention: Maintain unobstructed urine flow Collection bag below level of the bladder

Tips for cleaning keyboards in patient care areas

Do your part to keep keyboards clean: remove gloves & degerm prior to touching the keyboard unless patient is in contact precautions EVS will Perform routine daily wiping of the keyboards in the patient's rooms and nursing stations. If the keyboard is visibly contaminated, users are responsible for wiping down with a medical center approved disinfectant wipe such as the Sani-Cloth.



EMPLOYEE HEALTH UPDATE

ANNUAL/PERIODIC HEALTH EVALUATION

- Annual Screening is necessary to determine the healthcare worker is currently free of infection and able to perform his/her assigned duties.
 - Annual TB Questionnaire/PPD skin test must be completed if previously negative. PPD Skin Test must be read 48-72 hours after placement.
 - If you have a Positive PPD history, complete the Annual Questionnaire only. Do not repeat a PPD Skin Test.
- A Chest X-ray (CXR) is not required annually. A CXR is only ordered if a new conversion, no CXR performed at time of hire.

or if needed for evaluation related to questions answered on the Annual Health Screening questionnaire.

Respiratory Protection

If your duties bring you into contact with Airborne isolation you must be provided protection from aerosol transmissible diseases such as Tuberculosis. You will be Fit Tested and may require training for the Powered Air Purified Respirator.

- N95 respirator Fit Test must be performed annually to assure you are wearing the mask that is appropriate and there are no facial changes.
- If previously PAPR trained, re-training is an annual requirement. Your department may have selected Core Groups as the PAPR users.
- The Annual TB Screening and FIT Test should be completed at the same time. This will assure you have met both requirements. It will also reduce the number of visits to Employee Health
- When your annual screening is completed and entered into EHS1 data base, the forms are placed in the Employee Health file.

If your Annual Screening is not completed in the time designated, the employee's name is placed on the "Delinquent List" & sent to their Manager, Human Resources & the Hospital or Medical Group Administrator.

INFLUENZA VACCINE Is offered annually during the Flu Season. The Influenza vaccine will be offered to all employees/ volunteers and physicians starting the fall season. Help protect your patients, yourself & your family-get immunized! You are required to participate in the Influenza program by receiving a flu vaccine or signing a declination.

EXPLORING MYTHS

MYTH "I never get the Flu."

FACT: Influenza (flu) is a serious disease of the nose, throat, and lungs, and it can lead to pneumonia. The flu is worse than the common cold. Influenza causes an average of 3,000-49,000 deaths and 55,000-431,000 hospitalizations in the U.S. each year. Even healthy people, not just babies or elders, can die from influenza.

MYTH "The flu shot can cause the flu."

FACT: Inactivated Flu vaccine does not give people the flu. The flu contains only certain strains of inactivated ("dead") virus. People may still catch a cold or other viruses that the vaccine is not designed to match. It takes 10-14 days before you build antibodies to protect you from the flu virus, so if you are exposed during that period you may experience mild like symptoms. Some people get a little soreness or redness where they get the shot. It goes away in a day or two. Serious problems from the flu shot are very rare.

MYTH "The Flu Shot does not work."

FACT: Most of the time the flu shot will prevent the flu. In scientific studies, the effectiveness of the flu shot has ranged from 70% to 90% when there is a good match between circulating viruses and those in the vaccine. Getting the vaccine is your best protection against this disease.

MYTH "The side effects are worse than the flu."

FACT: The worst side effect you're likely to get from a flu shot is a sore arm. The nasal mist flu vaccine might cause nasal congestion, runny nose, sore throat and cough. The intradermal vaccine may cause redness, mild itching and local swelling at the site. The risk of a severe allergic reaction is less than 1 in 4 million.

MYTH "Only older people need a flu vaccine."

FACT: Everyone at least 6 months of age or older should get a flu vaccine. People who are at high risk for complications, this includes; people with certain medical conditions such as; asthma, diabetes, heart disease, and kidney disease. Women who are pregnant, and people 65 years and older are also high risk.

MYTH "You must get the flu vaccine before December."

FACT: Flu vaccine can be given before or during the flu season. The best time to get vaccinated is September or October. Flu vaccines will be offered continuously through flu season.

Off Work Orders for Communicable Illnesses

Policy: In order to provide a non-contagious health care environment free of communicable illnesses (as required by California Administrative Code, Title 22, Section 70723)

"personnel evidencing signs or symptoms indicating the presence of infectious disease shall be medically screened prior to having patient contact."

Responsibilities:

Each person employed in the medical centers and outlying medical offices shares responsibility for the effective implementation of this procedure. The reporting & management procedure is set forth below.

Health Care Workers/Non-Health Care Worker's Responsibility

1. When a personal, significant, communicable illness (see list below) is suspected, report to Department Administrator/ Manager or staffing person before or at time of reporting to work/unit.
2. Inform the medical provider at the time of examination that you are a HCW/Non-HCW and answer any questions about your work environment. This will enable the examiner to take appropriate action to minimize the spread of communicable disease.
3. Submit any off work orders and/or restrictions to DA/ Manager.
4. Follow instructions given to you by the medical provider.

Latex Allergies

Employees that are sensitive to latex products are offered a latex safe environment.

- Latex free supply carts are available.
- Employee Health nurse will provide screening tools for healthcare workers who state they have latex allergy.
- RAST test will be ordered to determine level of sensitivity to latex.
- Employee Health Physician will perform a consult with all identified employees
- Your department manager will be notified & informed to have latex free glove available for you at all times

Please let your Manager and Employee Health Department know about any symptoms of sensitivity you may develop.

List of communicable illnesses:

Chickenpox (Varicella)	Conjunctivitis (Pink Eye)
Herpes simplex, whitlow	Mumps
Scabies or Lice	Shingles
Suspected infectious diarrhea	Skin abscess
Draining skin lesions	Severe Hepatitis
Measles	Pulmonary Tuberculosis
Respiratory infections	Strep Throat
Skin rash (undetermined origin)	Unknown illness with fever

Privacy & Security HIPPA

In recent years, a great deal of work to reform & improve healthcare delivery in the United States began, particularly focused on providing greater access to care & simpler more flexible administrative activities. As our country moved toward a more standardized information framework, & greater use of electronic health records, protecting confidentiality & patient information became more critical. To this end, we are required to comply with the **Privacy and Security Rules** under the Health Insurance Portability & Accountability Act of 1996 (HIPAA).

- Privacy Rules apply to all forms of Protected Health Information (PHI), whether electronic, written or oral.
 - Security Rules cover PHI in electronic form
- In California we are also subject to the state's Confidentiality of Medical Information Act (CMIA). California law requires us to report incidents of unauthorized access to health information to the California Department of Public Health (CDPH), & also created various fines for the intentional or negligent misuse of health information. Federal law requires us to report incidents of unauthorized access to the U.S. Department of Health and Human Services. KP is required to safeguard all Protected Health Information (PHI), electronic or otherwise. This includes the prevention of impermissible uses & disclosures of protected health information. Find out more information at http://kpnet.kp.org/national/compliance/regional/scal/privacy_security/index.html

Quick Tips for Managing Personal Health Information

- Prevent "Distribution Errors". Make sure you are giving (or sending) the right material to the right person. Ask for ID when appropriate
- Double-check contents of mailing before sealing envelope and make sure the

address is correct

- Make sure that the mail merge is working correctly before printing all letters/materials
- Spot check several of the letters/materials once printing is complete
- Ask a co-worker to help double-check your work (but remember to only ask co-workers who would have a business reason to see any Personally Identifiable Information)
- Do not use, access, or disclose more information than is necessary to do your job.
- Do not post passwords or keypad access codes near doors, offices, or workstations.
- Never share your passwords.
- Avoid discussing PHI in public areas where others may overhear.
- Never remove medical records from your facility without express approval from your supervisor.
- Never access the medical record of a friend, family member, or celebrity because you are curious about his/her health status.
- Do not use a trash can to dispose of PHI, use a confidential destruction bin or shredder.
- Do not step away from your computer without first locking the workstation.
- Never check your laptop or PDA as baggage or leave it unattended or unsecured at home, in your car, work, or in transit.

The consequences of these errors can be serious: Federal & State laws require that all breaches (unauthorized access to or potential disclosure of health information) must be reported. When breaches affect more than 500 individuals, we must immediately report the breach to the

Department of Health and Human Services (HHS), & HHS will publish the violation on their public Web site. Criminal & monetary penalties (fines & jail time) for errors can now extend to *individuals* even if the error is accidental. Kaiser employees who disregard or violate any privacy or confidentiality requirements are subject to disciplinary actions up to & including termination. In accordance with the Principles of Responsibility (POR) and HIPAA regulations, it is your responsibility to report privacy & security errors. When an error is reported, the appropriate Compliance Office will investigate, determine if it is substantiated and if substantiated, verify affected parties. The information is then shared with Human Resources for appropriate action. Kaiser Permanente will, as appropriate, notify regulatory agencies and affected individuals and prepare for potential media and external interest.

Medical Center Compliance Officer for Fontana & Ontario:
Martha Lewis (Sikkins) (909) 427-7736
(tie line: 8-250-7736)
Compliance Hotline 1(888) 774-9100
Anonymous 24/7

The **Principles of Responsibility** cover a wide range of topics including:

- Conflicts of interest
 - Ethics in business practices
 - Protecting Kaiser Permanente assets
 - Accurate & honest recording & reporting
 - Making safety & environmental awareness a priority
 - Confidentiality, privacy, and information security
 - Federal and state whistleblower laws
 - Preventing fraud, waste, and abuse
- Examples of Compliance Issues:**

- Theft, fraud, waste, and abuse
- Violating health, safety, and environmental regulations
- Conflicts of interest
- Accepting inappropriate gifts & gratuities
- Discrimination & harassment
- Improper use of Kaiser Permanente property & systems
- Falsifying documents
- Inaccurate or incomplete documentation & coding
- Not following regulatory requirements,

for example: Medicare

- Illegal use or disclosure of confidential information
- Not following job requirements or limitations

If you suspect a potential compliance, ethics or integrity violation, or have questions about specific actions or practices, you can get help by:

- Talking to your supervisor, manager or chief
- Talking to your union representative
- Talking to your Human Resources representative
- Talking to your facility or regional compliance officer
- Talking to your controller (for finance-related concerns)
- Visiting the Compliance Web site at: <http://kpnet.kp.org/national/compliance/regional/scal/index.html>

Calling the KP Compliance Hotline at: 1 (888) 774-9100

We all have a responsibility to maintain an environment in which we can speak candidly about our concerns and report suspected noncompliance. Managers and

supervisors have additional responsibilities to promote this kind of environment. Kaiser Permanente does not tolerate retaliation against individuals who: report illegal, unethical, or otherwise inappropriate acts, refuse to participate in wrongdoing, or cooperate with government investigations. Anyone who retaliates against individuals who report or refuse to participate in violations of law, regulations, policies, or the Principles of Responsibility is subject to disciplinary action up to & including termination.

Culturally Responsive Care

"We Value a Multicultural Work Force and the Cultural Diversity of Our Communities..."

Culturally Responsive Care (CRC) & Diversity ties into our KP vision & promise. It reinforces the organization's commitment to provide outstanding care and service to the diverse populations we serve.

California State Law-SB853, The Department of Managed Health Care (DMHC) requires health plans to provide members with Limited English Proficiency (LEP) access to language assistance (interpretation and translation) resources when obtaining health care services. Further, DMHC regulations require KP to:

- Capture and track the language preferences of our members
- Ensure 24/7 access to language assistance services
- Translate vital documents into certain threshold languages
- Train Health Plan employees who have contact with members on language assistance
- Define administrative and clinical points where language assistance services will be available
- Ensure the KP contracted providers are compliant with DMHC Language Assistance Regulations

Monitor and regularly report compliance Kaiser Permanente is responsible to uphold its contractual requirement in its Medi-Cal and State Sponsored Program contracts. Participation in is an integral part of our social mission and helps to fulfill our community service obligation as a non-for-profit organization.

"Is the ability to work with a variety of people & acquire the skill to understand certain cultures as well as being sensitive to their cultural differences."

As KP employees and service to our members, we are to:

- Demonstrate cultural competence.
- Respect and demonstrate consideration for other points of view.
- Explore differences by making sure that everyone has an opportunity to be heard.

Regulatory Requirements: CLAS Standards Federal Mandates Culturally & Linguistically Appropriate Services (CLAS) in Health Care: Promotes access to health care for limited-English proficient (LEP) individuals through the elimination of language and cultural barriers (*December 2000*).

Enforcing Agencies:

Department of Health & Human Services (HHS)

Office of Civil Rights

Office of Minority Health

Centers for Medicaid & Medicare Services (CMS)

There are 14 Federal Cultural & Linguistic Appropriate Service (CLAS) Standards. Below are the four federally mandated CLAS Standards and the 10 recommended

standards, which along with the mandated requirements have been adopted into California Law, Accreditation Standards and KP contractual requirements.

FEDERALLY MANDATED CLAS:

Standards – KP Employees must adhere to the following:

Standard 1 Culturally Competent Care

Standard 2 Staff Diversity

Standard 3 Staff Education & Training

Standard 8 Organizational Framework for Cultural Competence

Standard 9 Organizational Self-Assessment

Standard 10 Collection of Data About Individual Patients

Standard 11 Collection of Data About Communities

Standard 12 Community Partnerships for CLAS

Standard 13 Complaint & Grievance Resolution

Standard 14 Information to the Public

Standard 4

INTERPRETATION – SPOKEN LANGUAGE Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Qualified Bilingual Staff (QBS) are KP employees qualified, through testing and training, to provide language assistance.

QBS Level 1 - use language skills in non-clinical situations that require only conversational language.

QBS Level 2 - speak well enough to function in most business and/or clinical settings that require a greater level of fluency including medical terminology.

Non-QBS staff - All KP employees may greet and assist members/patients with getting to their destination in the member's target language (e.g., Spanish), even if the employee does not have a QBS designation. If the conversation goes into the scope of a QBS Level 1 or Level 2, then the non-QBS employee is asked to transition the patient/member to a QBS employee to further assist in the patient's target language.

QBS badge - QBS staff must wear appropriate QBS badge identifying their level of qualification.

INTERPRETATION: FACE-TO-FACE SERVICES:

Qualified Bilingual Staff (QBS) – Always try to obtain QBS as the first choice for interpretation.

QBS Listing - For a current list of QBS employees, locations and levels: Go to My HR > KP & ME tab, select "Diversity" go to "Qualified Bilingual Staff Listings" link under Diversity Resources, where you will find the QBS IDENTIFIER WEBSITE.

Approved Interpretation Vendors:

When requesting services, please provide:

- Cost Center (GL string/NCOA): Business Unit (Region/Entity), Location, and Department codes
- Interpreter Expense Code = 78615
- FDA Approver's Name and NUID

• Patient's Information, such as MRN
CTS LANGUAGELINK (800) 535-7993
Face to Face in all languages no American Sign Language (ASL)

INTERPRETERS UNLIMITED

(844) 855-0249

Face to Face in all languages including

American Sign Language (ASL)

ACCOMODATING IDEAS (800) 257-1783

American Sign Language (ASL) only

LIFESIGNS (888) 930-7776; After-Hours

(800) 633-8883 American Sign Language

(ASL) only

For Additional Information:

Go to My HR > KP & ME tab, select "Diversity" go to "Language Services" select link under Interpreter Services, to find additional resources.

OVER-THE-PHONE INTERPRETATION SERVICES

LANGUAGE LINE (800) 523-1786

When requesting services, please provide your Medical Center's Client ID: 201247

Visual Impaired

Scanner equipment zooms to large print. Located in Fontana Medical Center Health Store MOB 1 & 2.

The Language Concordance Program promotes language alliance between patients and physicians. Members can be linked to Physicians who speak their language.

Standard 5

Health care organizations must provide to patients/ consumers in their preferred language both verbal offers and written notices **informing them of their right to receive language assistance services.**

TRANSLATION SERVICES – WRITTEN LANGUAGE

Translation is the conversion of written text of one language into another language. All English translations into another language must be translated by an approved KP vendor. A member has a right to request a document to be translated into their primary language. The translated document must be received by the member within 21 days of the request. Refer to your manager for additional details.

Qualified Bilingual Staff are Not Qualified to Perform Written Translations.

Documents not immediately available in a target language can be sight translated by a QBS employee. When requesting translation services, notify your manager immediately. Your manager will provide to the vendor:

- Business Unit (Region/Entity)
- Location Code
- Department Code
- Translation Expense Code
- FDA Approver's NUID
- Requester's (KP EE) Name and Number/NUID
- Language Needed

APPROVED TRANSLATION VENDORS are: Global Language Solutions & Avantpage:

Standard 6 Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. *Family and friends should not be used* to provide interpretation services (Except on request by the patient/consumer).

Standard 7 Health care organizations must *make available* easily understood *patient-related materials* and *post signage in the languages* of the commonly encountered groups and/or groups represented in the service area.

For Our Members

- Increased loyalty & trust in clinicians skills
- Increased satisfaction with their care
- Compliance with treatment plan, appointments, and lifestyle change recommendations
- Better control of chronic disease symptoms Improved health status and quality of life – *Thrive*

For Clinicians:

- Better communication with patients
- Better compliance to treatment plan
- Fewer return visits
- Improved health outcomes (decreased ER visits, hospitalization, etc.)
- Resource savings on cost & time
- Increased professional satisfaction – *Thrive*

Alternative Format Solutions:

The Hearing Impaired

Pocket Talkers – A device for the hearing impaired that amplifies sound, i.e. a person's voice.

Ubi-Duo – Through instantaneous typing one can start a conversation right away instead using paper and a pen, or waiting for an interpreter to arrive.

TTY/TDD – A Teletypewriter (TTY), also known as a Telecommunications Device for the Deaf (TDD), is an electronic device for text communication via a telephone line, used when one or more of the parties have hearing or speech impairment.

CA Relay Service – From your standard telephone dial 9-711 to reach specially-trained Communication Assistants to relay conversations between deaf, hard of hearing, or speech-loss individuals.

The Visually Impaired

Large Print – improves communication with members who have low vision.

Audio Solutions – Text-to-Audio creates audio information from electronic text.

Braille – Documents in Braille are available upon member's request.

Note: Every staff member is responsible to know how to locate/obtain and use the above devices - see your Manager.

HealthConnect Documentation:

Documenting in HealthConnect all language assistance encounters, which includes:

- Preferred written and spoken language
- If patient needs an interpreter
- Need for alternative ways to communicate
- Date of the encounter
- NUID or EEID of QBS staff, or interpreter identification number of outside contractor's (vendor) interpreter, (either over the phone or face to face)
- Language provided (Spanish, Mandarin, etc.)
- Manner in which language service was provided (face-to-face, telephone, etc. or reason it was refused Note: If a physician is language concordant with the patient, the physician is not providing interpretation but communicating directly with the patient and this must also be documented in the appropriate HealthConnect reportable field.

Please contact your local CRC designee to learn where to properly document language services in the medical record. Standard documents (contain no member-specific information) must be provided to members in their preferred written language proactively. This applies to the following documents:

- Applications
- Consent form, including any form by which a member authorizes or consents to any action by the Health Plan
- Letters containing important information regarding eligibility and participation criteria
- Notices provided to members advising

of the availability of free language assistance and other outreach materials

- The Health Plan's explanation of benefits or similar claim processing information that requires a response from a member

Resources/Referrals

Community based referrals should be culturally and linguistically appropriate.

Please refer to your *Social Services Department* for additional information at Fontana (909) 427-5191; Ontario MC (909) 724-3330

Policies located on Document Management System (DMS):

Quality Translation Process for Member Informing Materials

Qualified Interpreter Services for Limited English Proficient Persons.

Web-based training available on KP Learn at <http://learn.kp.org>



Americans with Disabilities Act

What is a Disability? A physical or mental impairment that substantially limits one or more of the major life activities (mobility, emotional, cognitive, thinking, learning ability, vision, speech, or hearing)

How common is it? 1 out of 5 people have a disability (approximately 20% of the US population)

Common Disabilities:

People who use Wheelchairs

People who are Blind or Visually Impaired

People who are Deaf or Hard of Hearing

The Basics:

Interacting with People with Disabilities

Ask before you help Be polite and wait until your offer is accepted

Don't make assumptions Don't assume their visit is due to their disability

Speak directly to a person with a disability Not to his/her companion or sign language interpreter

Listen They know what they need better than anyone

Use normal tone of voice Do not raise your voice unless requested

People who use Wheelchairs

- Wheelchair users are people, not equipment
- Don't push or touch someone's wheelchair
- Keep ramps and wheelchair-accessible doors unlocked and unblocked
- Be sure there is a clear path of travel
- Know where accessible bathrooms are located
- Keep lowered counter tops uncluttered

Helpful Resources: High-Low Exam Tables & Wheelchair Scales.

People who are Blind or Visually Impaired:

- Identify yourself before you make physical contact
- If a person needs guidance, offer your arm or shoulder
- Verbally communicate your intention to offer assistance
- Make contact with the person's hand with the back of your hand
- The person being guided will take hold of your arm, elbow or shoulder
- Describe settings, obstacles, or possible hazards in the path of travel
- Offer to read written information
- In a waiting room, offer assistance guiding him/her into the exam room
- In the Pharmacy, read out the name for a person who is blind

Helpful Resources:

Large Print Scanner, Audio CDs: Text to Audio (Health Store MOB 1 & 2) Braille vendors available

People who are Deaf or Hard of Hearing:

When using an American Sign Language (ASL) interpreter, speak to the person:

- Maintain eye contact
- Do not cover your mouth
- Speak clearly
- Most watch people's lips to help them understand
- There is no need to shout

Service Animal Remember: Service Animals are working animals, not pets

- Service Animals also assist people with invisible disabilities
- Don't touch a person's cane or guide dog
- Walk on the opposite side of the guide dog
- To avoid a distraction, do not make noises at the Service Animal
- Do not feed the Service Animal; it may disrupt his/her schedule
- Members with Service Animals are not required to show documentation
- Service animals may or may not be wearing identifying markers

When appropriate, you may ask:

- What service does your animal provide?
- Is this animal required for a disability?

Employee Diversity Associations

KP African-American Professionals Association (KP-AAPA):
Lynn Summers (909) 427-7470
(tie line: 8-250)

KP Asian Pacific American Network (KP-APAN):
Mariko Kobata (562) 986-2419
(tie line: 8-339)

KP Latino Association (KPLA)
Jesus Lopez (909) 427-6096
(tie line: 8-250)

KP Veterans
Christioun Outen (909) 724-7426
(tie line: 8-264)

KP Pride
Voicemail Number (626) 405-5035

- ♦ **Golden Rule: Treat others the way you want to be treated**
- ♦ **Platinum Rule: Treat others the way they want to be treated**

Emergency Medical Treatment and Active Labor Act (EMTALA)

Congress enacted the **Emergency Medical Treatment and Active Labor Act** ("anti-dumping law") in 1986 as part of COBRA. It is administered and enforced through the Centers for Medicare and Medicaid Services (CMS)

Why? This legislation came about following highly publicized incidents where hospital emergency rooms allegedly refused to accept or treat patients with emergency conditions if the patient does not have medical insurance. The Act was designed to better insure that all people have access to emergency medical treatment regardless of their ability to pay.

To whom does this apply? Any person employed at our Hospitals.

What does this mean? If a person comes to the emergency department with an Emergency Medical Condition, the hospital must: Provide a medical screening examination. Stabilize the emergency medical condition, discharge the patient, admit the patient, or transfer patient to a higher level of care.

When/Where does this obligation apply?

Whenever the patient presents to the Emergency Department

At all locations on the hospital campus and within a 250-yard radius if:

1. A request for emergency services is made, or if
2. A reasonably prudent layperson would conclude that a person is in need of emergency treatment, based on the person's appearance or behavior.

How does this affect you? When asked, give accurate way-finding information, based on where the patient states he/she needs to go.

Anyone who thinks he/she is having an emergency or in active labor must be directed to the Emergency Department.

SOCIAL SERVICES DEPARTMENT

HIGH RISK SCREENING AND REPORTING GUIDE

CHILD ABUSE REPORTING

If there is reasonable suspicion of child abuse, then Children & Family Services, (CFS) aka Child Protective Services, (CPS) must be called to report the case and discuss the disposition of the patient.

If there are significant physical findings:

- The treating physician must document the findings on Form **CalEMA 2-900**
- Photograph all suspicious physical findings
- If there are no physical findings, document on form SS 8572 (Suspected Child Abuse Report Form)
- If child needs protection, call Security (ext. 5500) and POLICE for immediate response.
- In progress note/smart set/order set, indicate that the report was made and include case number given by the agent.

Scanning any Abuse Reporting Form to HealthConnect is prohibited.

Children & Family Services Hotline:

San Bernardino County (909) 384-9233

FAX (909) 891-3545 or (909) 891-3560

Riverside County 1(800) 442-4918

FAX (951) 413-5122

Whenever a Child Abuse Report Form is completed, send a copy to Kaiser's Social Services Department

You may Consult Medical Social Work at:

Fontana Medical Center (909) 427-5191 (tie line: 8-250)

Ontario Medical Center (909) 724-3320 (tie line: 8-264)

CHILD SEXUAL ABUSE

If Abuse occurred more than 96 hours ago:

- Call Police and/or CPS Hotline. If calling Police, call the office that has jurisdiction where the assault took place.
- Complete Form SS8572 (Suspected Child Abuse Report Form)
- Call Social Services Department for assistance in scheduling a "Code 900" sexual exam with the child's Primary physician.

If the child does not have a Pediatric Primary physician, or is followed by a Family Medicine Physician, those cases shall be scheduled with a "SCAN Champion" physician. Physician SCAN champions are;

- **Dr. Alison Nguyen - Fontana**
- **Dr. Eva Feliciano - Chino Grand**
- **Dr. Olga Acosta - Redlands**
- **Dr. Marian Lee - Chino**
- **Dr. James Killeen - Victorville**

If Abuse Occurred Less Than 96 Hours Ago:

Call Police and/or Child Abuse Hotline. Child must be seen in the Emergency Department where exam will be completed by LEM-SART (Law Enforcement Medical Sexual Assault Response Team).

- San Bernardino County Sheriff: (909) 829-7311
- San Bernardino City Sheriff: (909) 387-8313
- Fontana Police (909) 350-7700
- Ontario Police (909) 395-2001
- Law enforcement/CPS will schedule Evidentiary Exam.
- LEMSART phone number: (909) 427-9227

LEM-SART will complete form **CalEMA 2-923** & gather evidence. **If the alleged abuse occurred more than 96 hours ago: The evaluating provider can use form "CalEMA" 2-925, to document their findings.**

Possible Sexual Abuse to Adolescent, between 14 and 18 years old: If possible Stranger or Date Rape: Call Fontana Police at (909) 350-7700, Ontario Police (909) 395-2001 or Sheriff (909) 387-8313, then ask and encourage patient to give consent for exam. If abuse may be by a Family Member (Incest): Call the Police and Children & Family Services (If family refuses an examination, Children & Family Services can give permission, even if the family refuses consent) For Exam: If less than 96 hours, CFS will schedule Evidentiary Exam by "Law Enforcement Medical Services Sexual Assault Response Team" (LEMSART) : **(909) 428-9227.**

Consensual sexual activity must be reported as abuse if one party is 13 years old or younger. Also, if the younger party is 14 to 17 years old and the other older party is over 21 it must be reported.

ELDER DEPENDENT ABUSE

The MD Champion is Dr. Adetunji Adegboyega, of the Fontana Medical Center—Upland Clinic (909) 367-7120

Screen/Identify:

- Physical abuse, (bruises, poor medical care)
- Physical neglect, (unkempt appearance, poor hygiene)
- Emotional abuse, (complains of name-calling, fearful)
- Material/financial abuse, (complains of others withholding funds for care, missing personal funds)

Report:

Fontana Police Department (909) 350-7700, Ontario Police Department (909) 395-2001 or San Bernardino County Sheriff (909) 387-8313 and Medical Center Security (ext. 5500),

Adult Protective Services Hotline for San Bernardino County : 1-877-565-2020

Adult Protective Services Hotline for Riverside County: 1-800-491-7123



If abuse occurred in long-term care facility or adult day care center call the Long-Term Care Ombudsman Program 909-686-4402. After hours call APS Hotline.

Document:

Complete **Form #SOC341**, Fax APS Reporting Form to the county where patient resides:
San Bernardino County APS Fax Number: (909) 891-3545
Riverside County APS Fax Number: (951) 413-5815

Send a copy of report to Kaiser's Social Services Department thru inter-office mail or by faxing it.
Fontana Medical Center—Social Services – Bldg 7 Fax Number: 909-427-5192, tie line: 8-250
Ontario Medical Center – Social Services– Bldg D, Suite 230. Fax Number: 909-724-3321, tie line: 8-264

DOMESTIC VIOLENCE

The MD Champion is Dr. Jasvir A. Uppal
Screen/Identify:

Sample Opening Question: *"Because abuse and violence are so common, I've started asking about it routinely."*

Treat Injury Document in Medical Record:

Use patient's own words, Obtain consent to photograph, Include history of abuse.

Complete CALEMA 2-920, The Suspicious Injury Report Form.

Describe visible injuries specifically
Notify law enforcement agency where the incident occurred.
Fontana Police Department (909) 350-7700
Ontario Police Department (909) 395-2001
San Bernardino County Sheriff (909) 387-8313
Notify Kaiser Permanente Social Services Department at:
Fontana Medical Center (909) 427-5191 (tie line: 8-250)
Ontario Medical Center (909) 724-3320 (tie line: 8-264)

Assess Risk:

- Gun or other weapon involved?
- Does he/she think it's safe to go home?

Offer Support, State "There is help available." Ask About Other Victims:

Are there any children or elders in the home? Are they ever affected by this behavior? A report to CFS or APS may be warranted.

Referral/Follow-up:

Refer to shelter/community agency. List of resources can be downloaded from the physician's portal – Abuse Reporting and Prevention. Provide Social Services phone number should patient wish to have further support. (It is often safer for a victim to call us than for us to phone them).

- **All Forms are available on the Physicians Portal, in the "Abuse Reporting and Prevention" tab:**
- **Click on Fontana Medical Center**
- **All reporting forms should not be filed in the patient's medical record.**

Send or fax your original report to the reporting agency contacted.

Mail or fax a copy of your report to Kaiser's Social Services Department at:

Fontana: 909-427-5192, tie line: 8-250 Bldg. 4
Ontario: 909-724-3321, tie line: 8-264 Bldg. D, Ste 230



What do you do when there is a patient complaint?

We do our best to resolve concerns real time. If this is not possible, the manager is contacted to assist in resolution. If it is still unresolved to the patient's satisfaction it should be forwarded to Member Services for action (Any complaint in writing must be forwarded to manager/member services) 1(800)464-4000. Everyone is encouraged to report concerns through the escalation process, however, anyone may report concerns to The Joint Commission. There will be no retaliatory action or disciplinary action for reporting.

Community Resource Referrals

The referral to culturally and linguistically appropriate Community Resources is another element of the comprehensive health plan offered at Kaiser Permanente.

Did you know that the Kaiser Permanente makes culturally and linguistically appropriate referrals to Community Resources?

Most referrals to Community Resources are made through the Social Services departments within Kaiser Permanente. When available, the person making the referral will always attempt to make sure the referral is culturally and linguistically appropriate for the member, taking into account language preferences, religious needs, and cultural beliefs among other considerations.

Below are samples of the various types of Community Resources:

- Child Care Programs
- Assisted Living
- Nursing/Convalescent Care
- WIC (Women, Infants, Mothers) Program
- Sober Living Facilities
- Homeless Shelters
- Alcoholics/Narcotics Anonymous Groups
- Domestic Abuse Support Group, etc.

References for Community Resources:

Dial 211 from an outside line or:
Kern County: 1(661) 321-4261 or www.capk.org
LA County: 1(800) 339-6993 or www.211la.org or www.lacare.org/providers/resources/crd
Orange County: 1(888) 600-4357 or www.211oc.org
San Bernardino County: 1(888) 435-7565 or www.211sb.com
San Diego County: 1(800) 227-0997 or www.211sandiego.org