2016 Banner Lassen Medical Center Annual Education

Infection Prevention and Control

Comply with Standard Precautions

The Centers for Disease Control and Prevention's (CDC) Standard Precautions procedures apply to all employees and clinical staff at all times at every Banner Health facility. Standard Precautions are applied to all patients regardless of their diagnosis. This evidence-based practice was designed to protect health care workers and patients from exposure to blood-borne pathogens. *See Policy #13473 "Standard and Transmission Based Precautions"* for complete precaution guidelines.

Standard Precautions includes:

- **Hand Hygiene**
  - Perform before entry into the room and upon exiting (Gel in /Gel Out)
  - Perform before and after any patient contact. (Gel in /Gel Out)
  - Perform prior to and after the use of personal protective equipment (PPE)
  - Perform after touching contaminated surfaces
  - Hand-washing with soap and water is required for
    - *Clostridium difficile (C.diff)* patients (special precautions also required)
    - Visibly soiled hands
- **Wear appropriate PPE for the task being performed**
  - PPE includes gloves, mask, eye protection, and/or gown
    - For example: wear a surgical mask when performing a lumbar puncture
- **Practice sharps safety**
  - Do not bend needles.
  - Do not recap contaminated needles.
  - Use needleless/safety devices whenever possible; activate safety device before placing in sharps container
  - Do not break off protective device on needles.
- **Cover your Cough**
  - Practice Respiratory Hygiene at all times. Cover your cough and sneezes with a tissue or the bend of your arm - never your hand.
  - If you are sick with fever and/or cough, stay home.

Comply with Transmission Based Precautions (in addition to Standard Precautions)

Transmission Based Precautions include:

- **Contact Precautions**: Spread by Direct/Indirect Contact with the patient or the patient's environment. Examples include MRSA, *C. diff* and MDRO Enterics.
  - Perform Hand Hygiene.
  - Put on gown and gloves before entering the patient room, even if you do not plan to touch the patient.
  - Dedicated equipment stays in patient's isolation room. Any item leaving an isolation room must be disinfected. *Reminder: This includes YOUR stethoscope*.
  - Contact Precautions will be automatically initiated for:
    - Patients identified with MDROs and *C.diff*.
    - Patients with a <6-month history of MRSA, a <1-year history of CRE or a <2-year history of VRE (infection or colonization).
  - Contact Precautions for patients with MDROS and/or C. diff are strictly maintained until patient meets criteria, per Policy and Procedure # 13473.
  - Contact your facility Infection Prevention Department for guidance.
- **Special Contact Precautions** (*C. difficile, Norovirus*): Includes **contact precautions** and **washing hands** with SOAP and WATER upon exiting the room. Do not use hand sanitizer. Clean equipment with bleach wipes
- **Droplet Precautions**: Spread by droplets within 3-6 feet around the patient (Influenza, Meningitis, Pertussis, etc.)
  - Perform Hand Hygiene.
  - Put on a regular surgical mask as you enter the room.
- **Airborne Precautions**: Spread in air currents (suspect/confirmed Tuberculosis, Chickenpox, Disseminated Zoster, etc.)
  - Perform Hand Hygiene.
  - Wear a fit tested N-95 respirator mask or PAPR.
  - Patients must be in a negative pressure room and door must remain closed at all times.

Comply with the Central Line-Associated Bloodstream Infection (CLABSI) Prevention Bundle

CLABSIs are associated with increased length of stay and an attributable cost of $3700 - $29,000 per episode. The CDC estimates 250,000 CLABSIs occur annually in the US at a cost of 2-8 billion dollars and approximately 31,000 deaths. Compliance with CLABSI Prevention Bundle is expected practice.

- Use Banner Health catheter insertion checklist and an all- inclusive standardized catheter cart or kit.
  - Perform Hand Hygiene.
  - Use large sterile drape to cover patient's head and body.
  - Person performing procedure wears sterile gown, sterile gloves, mask and cap.
  - All persons in the room must wear mask and cap.

Infection Prevention and Control (cont.)

- Scrub insertion site with Chlorhexidine-gluconate (CHG) based product or age appropriate product; allow to air dry.
- Perform daily assessment of necessity of the line and discontinue the central line as soon as possible.
- Avoid using the femoral site in adults.

Comply with the Prevention of Catheter-Associated Urinary Tract Infection (CAUTI) Guidelines

The CDC estimates 560,000 Catheter Associated Urinary Tract Infections per year in the US at a cost of 0.4-0.5 billion dollars and approximately 8,000 deaths.

- Physicians must document an order and indication for placement of an indwelling urinary catheter**.**
- Limit the use and duration of catheters to situations necessary for patient care.
- The use of indwelling urinary catheters should be limited to the following indications:
  - Urinary retention, acute or chronic, where clean intermittent catheterization is not feasible.
  - Close monitoring of urine output in critically ill, incontinent, or uncooperative patients.
  - Fluid challenge in patients with acute renal insufficiency.
  - Perioperative use for patients having gynecological, urological or perineal procedures.
  - Urinary incontinence posing a risk to patient, including sacral or perineal pressure ulcer, or contamination of recent surgical site.
  - Patient requires prolonged immobilization, comfort care in terminally ill patients.
- Perform daily assessment for urinary catheter necessity.

Infection Prevention and Control (cont.)

Prevent Surgical Site Infection (SSI)

- Administer prophylactic antibiotics within 1 hour prior to incision (2 hours for vancomycin and fluoroquinolones).
- Select the antibiotic based on the surgical procedure, the most common pathogens for a procedure, and published recommendations.
- Discontinue prophylactic antibiotics within 24 hours after surgery (48 hours for cardiac surgery).
- Do not remove hair at the operative site, unless it will interfere with the procedure. If necessary, hair should be removed prior to entering surgical area by method of clipping. Do not use razor.
- Control blood glucose levels during the perioperative period...
- Perform optimal preparation and disinfection of the operative site and hands of surgical team members.
- Adhere to standard principles of operating room asepsis, including minimizing operating room traffic.
- Sterilize all surgical equipment according to published guidelines; minimize the use of immediate use (flash) sterilization.
- Pre-Op CHG bathing for all appropriate surgical patients.

Protect Yourself and Protect Your Patients

- Make sure your immunizations are up-to-date: Influenza, Hepatitis B, MMR, Tdap, Varicella
- Report exposures to blood and body fluids or infectious disease to the department supervisor or charge person as soon as the exposure happens
- Stay home if you are ill and/or contagious

Know your Resources

- You can reach the Infection Prevention team at BLMC by calling 530-252-2276 or 970-231-6850 (enter area code and #).
- Look for the Infection Prevention and Control page on the Banner Intranet: System wide Links→Infection Prevention and Control

Infection Prevention and Control (cont.)

Review all Infection Prevention Policies and Procedures on the Employee Intranet, under Policies and Procedures

Restraint and Seclusion

- Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely, including Personal Restraint.
- Restraint of seclusion of any kind is an intervention of last resort to secure the physical safety of the patient, a staff member, or others. Restraints are used in the least restrictive manner possible and are discontinued as soon as possible.
- 2 categories of restraint: 1) to protect the physical safety of the non-violent or non-self-destructive patient, and 2) to manage violent self-destructive behavior.
- Medical Staff must have a working knowledge of the restraint and seclusion policy.
- Medical Staff may not be involved with applying restraints or seclusion without proper training.
- Restraint requirements for **non-violent or non-self-destructive patient:**
  - Obtain an order for restraint prior to application of restraints or immediately after application of restraint.
  - Obtain an order with each new episode of restraint and daily if patient restrained greater than 24 hours.
  - Re-assess the patient every 2 hours or more frequently based on the individual needs of the patient.
  - Inform patient, patient's family or authorized representative about reasons for restraint use.
  - Provide an educational handout entitled "Understanding Restraints:, as appropriate
  - Update the patient's Problem List.

Restraint and Seclusion (cont.)

- Update restraint log.
- Discontinue restraints when the condition requiring the restraint no longer exists.

- Restraint requirements for **violent or self-destructive behavior:**
  - Obtain a written or documented verbal order prior to initiation of restraint or seclusion.
  - Notify the attending physician as soon as possible if the attending physician did not order the restraint.
  - Perform a face-to-face evaluation of the patient as soon as possible, but no later than 1 hour after the initiation of violent restraint or seclusion.
  - Monitor the patient for: appropriateness and necessity of restraints or seclusion, restraint safely applied, risks associated with the intervention, level of distress or agitation, cognitive status and, vital signs if able to obtain.
  - Each order for restraint or seclusion in violent situations must state the maximum duration of the restrain or seclusion according to the following limits:
    - Age related time limitations for orders:
      - Every four hours for patients age 18 and older
      - Every two hours for patients ages 9 through 17
      - Every one hour for patients less than age 9

Restraint and Seclusion (cont.)

- Orders may be renewed if necessary up to a total of 24 hours in increments stated above.
- Notify family regarding initiation of restraint or seclusion if release obtained from patient
- Provide education materials from Krames to patient and/or family
- Discontinue restraint or seclusion at the earliest possible time, regardless of the length of time specified in the order.

Restraints should be discontinued when the patient meets the criteria outlined in the order. The RN will terminate the restraint or seclusion and document the rationale in the medical record.

Reference: Policy 12414 Restraint Use in Non Violent Situations; 12415 Restraint Use in Violent Situations

Pain Management

1. Pain management is a priority for BLMC. Clinicians:
   - Perform pain assessments on patients
   - Use standardized validated rating scales and/or behavioral tools.
   - Document the efficacy of pain relief at appropriate intervals after starting or changing treatment.
2. Clinicians provide information about pain management to patients and families
3. When changes in patient patters or new pain develop, it will be reported to the LIP for further evaluation and consideration for modification of the treatment plan.

Clinicians ask about pain and use the patient's self-report as the primary source of the assessment. Self-report may include:

- Description of pain
- Location
- Intensity/severity:

Pain Management (Cont.)

- Numeric Rating Scale (NRS)
- FACES – used for children and adult patients

For patients who are unable to self-report

- Clinicians assess pain using the Hierarchy of Pain Assessment Techniques (Appendix A of policy)
- The clinician assumes pain is present when painful pathologic conditions are present or a procedure is performed (Appendix B of policy)

Reference: Policy 9171 Pain Management

Environment of Care

"CODE" Calls:

All Code calls can be announced overhead by dialing 6202 from an internal phone line.

Code Red**:** Fire, Smoke, or Excessive Heat –

- "RACE" (Rescue, Alarm, Contain, and Extinguish) – Rescue persons, pull Alarm & call ext. 6202 for overhead page, Contain fire; Extinguish if possible and Evacuate if necessary.
- "PASS" (Pull, Aim, Squeeze and Sweep) – Pull the pin, Aim at base of fire, Squeeze the handle, Sweep to extinguish fire.
- Policy: Fire Alarm Pull Stations and Fire Extinguisher Location/Use identifies the location of all fire alarm pull stations and the fire extinguishers in the event of a fire.

Code Blue: Cardiopulmonary Arrest

Code Pink: Infant/ Child Abduction

Code Grey: Combative Person/ Security Alert

- **Level I**: Combative Person
- **Level II**: Combative Person with Deadly Weapon.
- **Lock Down**: Lock down for any reason ex: External Threat

Code Orange: Chemical Spill

Code Triage: Internal/External Disaster

Code Yellow: Bomb Threat

- Phase 1: A facility search will be conducted expeditiously with minimal disruption to the normal routine

Environment of Care (cont.)

- Phase 2: If a suspicious object is located, a complete or partial evacuation of a building or buildings may be necessary.

Code Purple: Over Capacity

- Phase I: Over Capacity (facility over capacity)
- Phase II: Surge Capacity (On-site alternate holding areas for patients have been initiated)
- Phase III: Disaster Capacity (holding areas on-site exhausted and more patients holding)

Medical Equipment Management Plan

The purpose of the Medical Equipment Management Plan is to support a safe patient care and treatment environment by managing risks associated with the use of clinical equipment technology.

The Medical Equipment Management Plan is designed to define the processes necessary to provide for proper purchase, maintenance and safe use of medical equipment throughout all of Banner Health. The plan is designed to establish organizational protocol for administering clinical technologies that ensure continual availability of safe, effective equipment via a capital management assessment and procurement program, life-cycle support program which includes scheduled maintenance, timely repair and evaluation of events that could have an adverse impact on the safety of patients or staff.

The scope of the Medical Equipment plan includes all departments utilizing medical equipment. Departments where specialized equipment is utilized are responsible for participating in the use of the Medical Equipment plan and for coordinating their departmental efforts with Clinical Engineering.

Personal Protective Equipment (PPE)

The purpose of the Personal Protective Equipment policy is to protect the employees of Banner Lassen Medical Center from exposure to work place hazards and reduce the risk of injury through the use of personal protective equipment (PPE). PPE is not a substitute for more effective control methods and its use will be considered only when other means of Law

Environment of Care (cont.)

protection against hazards are not adequate or feasible. It will be used in conjunction with other controls unless no other means of hazard control exist.

This policy applies to all employees who by nature of their job function have the potential to be exposed or come in contact with chemical, physical, radiological or biological hazards which by this exposure can cause illness, injury or impairment in the function of any part of the body.

Personal protective equipment including those for eyes, face, head, and extremities, protective clothing, respiratory devices, protective shields and barriers shall be provided, utilized and maintained in a sanitary and reliable condition whenever deemed necessary by reason of hazards, processes or environment.

Management of Patient Owned Equipment and Supplies:

Medical equipment items used in conjunction with medical management of patients. A physician order is required for use of the equipment.

Security and Care of Prisoners

Guidelines for forensic and clinical staff in the care of prisoners and to establish a procedure in the event of a security incident involving State Prison or County jail inmates.

- Appropriate law enforcement agency will be responsible for providing security and monitoring of the prisoner in their custody at all times
- Law enforcement officials will give reasonable notice whenever a person in custody is to be brought into or taken out of the hospital.
- Law enforcement or approved designee will stay with the prisoner in view and in view of the prisoner at all times, 24 hours a day, regardless of the prisoner's status or security level.

Environment of Care (cont.)

enforcement officer or designee must accompany the prisoner to all procedures and treatment areas.

- All prisoners will be listed as "confidential" patients.
- Law enforcement will determine and maintain limitations on visitors, phone calls, etc.
- Law enforcement officers will be oriented to hospital policies and expectations.
- Law enforcement is responsible for application and monitoring of shackles/handcuffs unless they interfere with patient care of is unsafe.

Tobacco Free Campus

Banner prohibits the use of tobacco products on all Banner campuses, including; cigarettes, cigars, pipes tobacco or chew tobacco, herbs and tobacco-less cigarettes or like products.

Safety Management Plan

Medical Staff thorough the Quality Council or facility equivalent; 1) participates in the identification of potential risks within the clinical aspects of patient care, general safety and employee well-being. 2) Assist with the development and implementation of corrective actions designed to reduce organizational risk.

Material Safety Data Sheets (MSDS) Be familiar with the hazards posed by chemicals used in your workplace. MSDS information is available 24/7 by calling (800) 451-8346

Safety Concerns: Report all Safety Concerns to the Western Region Risk Management Office at (970) 392-2469 or administration on-call (AOD) at (530) 249-1322.

Reference: Policies: Code Gray – Combative person/Security Alert; Code Pink – Infant/Child Abduction; Code Red Fire; Fire Alarm Pull Stations and Fire Extinguisher Location/Use; Medical Equipment Management Plan; Personal protective Equipment (PPE); Policy 6132 - Hazard Communication Program; Policy 6017 Bomb Threat Procedure – Code Yellow; Management of Patient Owned Equipment and Supplies; Policy 12682 Fire Safety Management Plan; Policy 6128 Hazardous Materials & Waste Management Plan; Security and Care of Prisoners; Security Management Plan 02.01.02; Policy 10635 Surge Management Policy; Policy 11878 Tobacco Free Campus; Utilities System Management Plan; Policy 7618 Safety Management Plan

Impaired Practitioner

The term **impaired** is used to describe a practitioner who is prevented by reason of illness or other health problems from performing his professional duties at the expected level of skill and competency. Impairment also implies a decreased ability or willingness to acknowledge the problem or to seek help to recover. It places the practitioner at risk and creates a risk to public health and safety. Some signs of impairment are deterioration of hygiene or appearance, personality or behavior changes, unpredictable behavior, unreliability or neglecting commitments, excessive ordering of drugs, lack of or inappropriate response to pages or calls, decreasing quality of performance or patient care.

BLMC will assist the entry of a suspected or confirmed impaired practitioner into evaluation, appropriate treatment, and/or rehabilitation.

Reference: BLMC Bylaws Well-Being Committee

Disruptive Behavior

Disruptive conduct by a member of the medical staff is behavior which adversely impacts on the quality of patient care, and includes verbal or physical abuse, sexual harassment, and/or threatening or intimidating behavior toward colleagues, team members, or patients/ visitors. This conduct will not be tolerated. Any medical/ AHP staff member, team member, or agent of the hospital, volunteer, patient/visitor may file a complaint about a practitioner for disruptive behavior. No retaliation will be taken for reporting a concern in good faith. Complaints may be referred to the Medical Staff Office at (530) 252-2225 or to the Chief Medical Officer (CMO) at (530) 252-2224. Complaints should be in writing and will be maintained by the Medical Staff Office.

Reference: Professional Conduct Policy 13636

Rapid Response Team

The Rapid Response Team is a patient safety strategy that can "rescue" patients when their conditions deteriorate and reduce the number of Code Blues and the inpatient mortality rate. The Rapid Response Team is a team of clinicians who come to the bedside to assist with assessment and treatment of an inpatient that has had an acute change in condition. The Rapid Response Team can be called at **any time**.

A Rapid Response can be initiated by calling ext. 6202 for an overhead page and requesting the Rapid Response Team.

- Anytime a clinician is concerned about a sudden or ongoing worsening of a patient's condition.

Reference: Policy 13220 Rapid Response Team and Standing Orders

Abuse and Neglect

All in- and out-patients should be informally screened at admission for signs of abuse and neglect.

- Possible indicators of abuse/neglect may include:
  - Patient states that abuse/neglect occurred
  - Repeated and/or unexplained traumatic injuries
  - Explanation of injuries is vague or refuses to explain
  - Patient exhibits fear, withdrawal or unnatural compliance in presence of caregiver
  - Suspicious injuries, "doctor hopping," etc.
  - Unusual delay in obtaining treatment for injuries.
- If abuse and/or neglect is suspected you should:
  - Report this immediately to CPS or APS
  - Document findings, observations and statements made by the patient or family/caregiver(s) which support the suspected abuse/neglect
  - Photograph injuries, if appropriate.

Falls

A. The scope of this policy is Adult Inpatients.
B. Fall Risk Determination is performed by RN.
C. Fall Prevention is performed by hospital staff.
D. All patients are scored to determine a fall risk using the Morse Fall Scale. Initial score is performed on admission with rescoring performed:

1. With change in RN primary caregiver.
2. When patient is transferred to another level of care.
3. With a change in physical or mental status.
4. After an actual fall.
5. Exceptions: The Adult Mobility and Fall Risk assessment from Cerner may not be performed in these areas, per facility guidelines:
   a. WIS patients are assessed (see PeriBirth) – patents are not banded.
   b. Periop, endoscopy, emergency department, and other procedure and outpatient areas are currently excluded.

E. The RN may reassign the fall risk category based on clinical judgment.
F. The Fall Precaution Program will be evaluated at least annually, or more often as indicated, for changes in process or procedure that will reduce risk of falls based on data analysis and review.

Reporting and documentation of any patient fall via BLMC VEvent Incident Reporting System is essential.

Reference: Fall Precaution Program Policy 8204

Reporting Concerns

Healthcare workers may anonymously report, without fear of disciplinary action, any urgent patient safety or quality concern, as well as any improvement idea through the BLMC Reporting System.

Concerns may also be reported to:
Risk Management at: (970) 392-2469
Administration on-Call (AOD) at: (530) 249-1322
California State Department of Health
(916) 558-1784

The Joint Commission
Division of Accreditation Operations
Office of Quality Monitoring
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
800-994-6610 or compliant@tjc.org

Compliance: Issue Reporting

Banner Health fosters an environment where employees, medical staff members, patients, vendors, and others affiliated with Banner feel free to bring forward any good faith question or concern and they feel free to report suspected policy violations, illegal or unethical conduct without fear of retaliation. Employees should also feel free to report any questionable business practices that may or may not be a violation of law or policy. The procedure below is primarily applicable to Banner employees. There are other procedures and avenues for medical staff members, patients, and vendors to raise their compliance-related questions and concerns, although all should feel free to use the Banner Comply Line.

Banner Comply Line: 888-747-7989

Reference: Compliance: Issue Reporting Policy 6013

Culture of Safety

Leaders create and maintain a culture of safety and quality throughout the hospital. Safety and quality thrive in an environment that supports teamwork and respect for other people, regardless of their position in the hospital. Behavior that intimidates others and affects morale or staff turnover undermines a culture of safety and can be harmful to patient care. All medical staff signs and agrees to abide by the Banner Medical Staff Code of Conduct at all times. Any deviation from that code will be addressed by the MEC.

Reference: Professional Conduct Policy 13636

Fire Safety

The hospital minimizes the potential for harm from fire, smoke, and other combustibles. BLMC is NON Smoking throughout the campus. Physicians and other providers should follow the acronym RACE for fire response: Remove people from immediate danger, Activate the fire alarm and call ext. 6202, Contain the fire by closing doors, Extinguish the fire if practical and Evacuate if necessary. Fires are announced as Code Red.

Policy 12682 Fire Safety Management Plan

Organ Donation

BLMC works with the California Organ Procurement Organization as well as tissue and eye banks to maintain potential donors while the necessary testing and placement of potential organs takes place in order to maximize the viability of donor.

Reference: Anatomical Donations: Organ, Tissue, and Eye Procurement Policy 13777

Alternate Procedure During Downtime for EHR

BLMC will maintain a procedure for downtime that will ensure patient care, discharge, and documentation procedures in the event of computer downtime.

Reference: Electronic Medical Record Downtime Guidelines Policy 6139