



**Annual Review
of
CORE Competency,
Age-Specific Competency,
and
OSHA Safety &
Infection Control**

CORE AND AGE-SPECIFIC COMPETENCIES

PATIENT RIGHTS

- To be informed of their rights
- To receive a written notice of their rights
- To have the ability to exercise their rights
- To have their property treated with respect
- To voice grievances
- To have their complaints investigated
- To be informed in advance of any treatment or care to be provided, or any changes in that care
- To participate in their care
- To be informed of the disciplines providing their care.
- To refuse all or part of their care after being informed of the expected outcomes of each action
- To have the right to confidentiality of their clinical records
- To be informed of policies regarding disclosure of medical records
- To be informed in advance of care regarding payment responsibilities
- To be informed in writing of any changes in non-covered services
- To be communicated within a language or form the patient can understand
- To be informed prior to treatment of any experimental, research or investigational studies patient must give their informed consent
- To participate in all aspects of care, including the transfer/referral and/or discharge process.
- To be free from mental, physical, sexual and verbal abuse, neglect and exploitation.
- To be provided care in a manner that does not discriminate against persons on the basis of race, color, religion, sex, national origin, sexual preference, disability or age.
- To have the right to appropriate assessment and management of pain.
- To be informed about the outcomes of care, treatment, and service, including unanticipated outcomes.

ADVANCED DIRECTIVES

In compliance with the Patient Self-Determination Act of 1990, all patients, or their legal representative, will be informed of their rights to make advance directives about the medical care they receive, including life-prolonging procedures, emergency resuscitative measures, and the withholding and withdrawal of life sustaining care or service.

The patients have the following rights:

- Be given written notice regarding the right of individuals to make their own medical treatment decisions, including the right to accept or refuse treatment and the right to formulate advance directives
- Have medical record documentation that notice was given, along with whether the patient has or has not executed an advance directive
- Provided with reassurance of non-discrimination whether or not they have an advance directive
- Ensured compliance with state laws concerning advance directives
 - Ability to participate in educational programs for staff and community on issues concerning advanced directives.

In the absence of a DNR order, ACCS professional staff must institute emergency resuscitative procedures and non-professional staff not trained in CPR will seek emergency help by dialing 911. Under Virginia law, a DNR may be revoked only by the party originating the order or by the physician.

ORGAN DONATION

It is the responsibility of the transplant consortium staff to approach families of patients who meet the brain death criteria. In the event a family member approaches you regarding organ donation, assist them in contacting the nursing supervisor.

CONFIDENTIALITY POLICY

All patient information will be maintained in strict confidentiality as per HIPAA guidelines. Any discussion or divulging of patient information is a serious breach of confidentiality and is grounds for dismissal. Encourage avoidance of patient discussions in public areas at all times.

PATIENT PRIVACY, SECURITY & RESPECT

All ACCS staff will maintain patient privacy and security, along with respecting their property. Staff are encouraged to:

- Keep the patient covered at all times

- Provide a drape when working directly with the patient
- Ask visitors and others to leave while rendering care, if appropriate
- Never accept money or valuables from the patient
- Use care when handling patient property
- Obtain patient's approval before touching any personal item.

Encourage patients to:

- Keep emergency telephone numbers visible and near the telephones in their home
- Inform staff if property, money or valuables are discovered missing or damaged
- Contact supervisor with any concerns regarding their safety that involve staff or others.

ETHICAL ISSUES & CONFLICT RESOLUTION

All disciplines at ACCS will respect all rights of the patient and are obligated to report any concerns or breach of ethics that arise during the delivery of patient care. Decisions regarding care may involve conflicts between desires of the patient and proposed care or service. The following constitutes examples of ethical issues:

- Withholding or withdrawal of certain types of care or service
- Pain management
- Appropriate behavior of staff in a clinical or home health setting
- Staff acceptance of gifts from patients
- Breach of patient's rights or patient's responsibilities

The patient and his/her designated representative have the right to participate in the consideration of ethical issues that arise in his/her care. Any ethical concern or conflict should be addressed immediately with the nursing supervisor. When the situation is serious and resolution appears impossible, ACCS' Ethical Conference Group, which consists of the President/Owner of ACCS, the Chief Operations Officer, and the Chairperson of the Performance Improvement/Risk Management Committee, will request assistance from other sources (i.e. physician, lawyer or bioethicist, none of which are personally involved with the patient.) In the facility setting, the facility's ethical committee will address any ethical issues.

VIOLENCE AND ABUSE*

ACCS staff adhere to the rights of adult and pediatric patients to be free from mental, physical and sexual abuse, neglect and property exploitation.

1. The role of the medical professional in suspected violence or abuse situations include:

- observation, assessment and documentation;
- reporting of suspected abuse to authorities;
- support of the victim; and
 - maintaining the chain of evidence

2. Suspect abuse when:

- history is inconsistent with physical findings;
 - the victim or caretaker is reluctant to divulge information;
 - there is a delay in seeking treatment;
 - there is a history of prior injuries or hospitalizations;
 - explanation of how injuries were sustained changes, or is inconsistent between family members;
 - bizarre injuries i.e. bite marks, cigarette burns, abrasions around wrists & ankles;
 - clearly demarcated, characteristic 2nd or 3rd degree immersion burns.

3. Document all communications in the victim's and caretaker's own words.

4. Nurses and health care professionals are **mandated by law** to report **suspected** child abuse.

5. Adult victims need assistance with shelter from further injury and/or abuse.

6. Notify social services for suspected abuse of any person **regardless** of age.

7. In sexual assault cases, all evidence is obtained carefully and is secured in an assault kit that is provided by the local law enforcement agency. Kits have pre-labeled envelopes for specimen collection. After specimens are collected, the collecting nurse seals the containers and signs the outside of the collection box. The box is then delivered to the hospital police for safe keeping, who then sign for the box; or, it is handed directly to the law enforcement agent, who signs the box. Maintaining this chain of evidence avoids jeopardizing the legal process. The victim's clothes are also secured in a paper bag and given to law enforcement.

8. **Violence in the Workplace** is violence or the threat of violence against workers. You can protect yourself and help reduce the odds of workplace violence occurring by:

- Learn how to recognize, avoid, or diffuse potentially violent situations by attending personal safety training programs,
- Alert supervisors to any concerns about safety or security and report all incidents immediately in writing on an "Incident Report Form".
- Avoid traveling alone into unfamiliar locations or situations whenever possible.
- Carry only minimal money and required identification into community settings.

UNSAFE SITUATION POLICY

POLICY

ACCS will orient staff regarding methods for identifying, avoiding and handling unsafe situations.

PURPOSE

ACCS endeavors to provide all employees with an orientation that includes appropriate action to be taken in the event of an unsafe situation, including addressing the risks of violence in the workplace.

PROCEDURE

1. Field staff should not enter any location where they feel threatened or unsafe.
Use of Escorts: (entering or departing a potentially unsafe area)
In the event that a nurse determines he/she may be physically or verbally threatened by either entering or departing a client's home, the ACCS contracted escort service may be utilized. The nurse would be responsible for contacting the ACCS office or on-call coordinator to arrange for the escort service. ACCS administration would approve use of escort service in any given situation.
2. Driving to a client's home:
Regardless of the location of a client's home, the nurse should exercise caution when entering and leaving a residential area. The following precautions are recommended:
 - a. Keep car doors locked at all times
 - b. Notify a friend/relative of your estimated arrival and departure time to a case
 - c. Park as closely to the client's home as possible
 - d. Always be aware of your surroundings
 - e. It is advised to carry a hand - held alarm or noise device or other positive alarm device
 - f. It is recommended ACCS field staff carry a protective device such as sprays if appropriate
 - g. ACCS home health department has a cellular phone available for use in the field.
 - h. Do not travel alone in unsafe area
 - i. When staff visit patients, who live-in high-rise buildings that seem to present a security hazard, caution should be exercised in elevators, stairways, and unfamiliar residences.
 - j. Field Staff should maintain communication with a staffing coordinator at the ACCS office regarding a daily work plan and location throughout the day.
 - k. It is not advisable to take the same route to or from the client's home
 - l. Make visits during daylight hours if possible
 - m. Contact the physician if no visit is made
3. Clothing & Attire:
ACCS recommends that the nurse wear a white lab coat with proper ACCS ID when entering and departing a client's home. It is not advisable for the employee to wear jewelry or carry a purse. Employees are encouraged to carry only required identification and money.
4. Carrying articles into a home:
It is advised that any medical equipment (i.e. BP cuff) be carried into the home in a clear plastic bag. Any medications that are taken into the home should be carried in a colored bag that has a biohazard label affixed.
5. Unsafe situation in the home: (Violent patient/family member, etc.)
 - a. If confronted with an unsafe situation in a client's home, ACCS recommends the nurse should:
 - remain as calm as possible
 - do not attempt to disarm an individual who may be threatening you
 - If a phone is accessible, the nurse should try to call the ACCS office (320-1113) and ask to speak to **Dr. Atlas**.
The administration of ACCS would determine an appropriate plan of action at that time.
6. It is the responsibility of the ACCS nurse to inform ACCS administration of any potentially unsafe situation that arises in the care of a patient.
7. In the event of a car accident involving the company vehicle or the employee's vehicle while on company business, notify ACCS administration immediately if possible.
8. All incidents of threats or other acts of violence in the workplace must be reported to ACCS management and recorded on an Employee Incident Report Form that is maintained in the Human Resources Department. These records are maintained and analyzed to prevent future safety and security problems and to develop the appropriate safety training courses. ACCS management will:
 - Encourage employees to report all threats and incidences of workplace violence
 - Provide prompt medical evaluation and treatment after the incident
 - Report violent incidents to the local police promptly
 - Inform victims of their legal right to prosecute perpetrators
 - Discuss the circumstances of the incident with staff members. Encourage employees to share information about ways to avoid similar situations in the future

- Offer stress debriefing sessions and post-traumatic counseling services to help workers recover from a violent incident, when indicated
 - Investigate all violent threats and incidents, monitor trends in violent incidents by type or circumstance, and institute corrective actions through the PI/RM Committee
 - Discuss changes brought about by corrective actions during regular employee meetings.
9. Field/office staff is educated on personal safety on an annual basis.

CONSCIOUS SEDATION*

- A patient undergoing sedation analgesia will have a depressed level of consciousness but retains the ability to maintain his airway and respond to physical and/or verbal commands. The goals of sedation analgesia are to allay the individual's fear and anxiety about undergoing an elective procedure, maintain comfort, provide partial amnesia and provide a safe, rapid return to the ambulatory/pre-procedural state.
- Follow the hospital's pre-sedation admission procedure, verify and maintain intravenous access, and monitor the patient's respiratory rate, oxygen saturation, blood pressure, cardiac rate and rhythm, level of consciousness, skin condition and color, and comfort level.
- Safety is maintained by continuously monitoring the patient, having supplemental oxygen and emergency equipment in each room, a resuscitation cart with defibrillator nearby, and a telephone or call device at the bedside to summon emergency support personnel if needed.
- As with all medication administration, the nurse will know the dosage requirements, onset and duration of action of the medications as well as potential side effects. Observe and immediately report restlessness, cyanosis, pallor, flushing diaphoresis, nausea, and bradycardia/tachycardia. Other causes for concern and immediate action include nystagmus, slurred speech, unresponsiveness, hypo or hypertension, agitation, hypoventilation, respiratory depression, airway obstruction and apnea. An important point to keep in mind is that the half-life of reversal drugs is often shorter than the sedative producing agents and rebound sedation can be a significant side effect.
- The post-procedural goal is stable vital signs, baseline oxygen saturation on room air, alert level of consciousness, intact protective reflexes and an acceptable comfort level with minimal nausea prior to discharge. Post-procedural site care, pain control measures, prescriptions, home care needs, and follow-up medical care should be reviewed with the patient and a second person due to the amnesic effects of sedative drugs. The second person should provide transportation from the facility and should be identified before the procedure starts. *

PAIN MANAGEMENT*

- Pain is a sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.
- The single most reliable indicator of the existence and intensity of pain is the patient's self-report.
- Frequent pain assessment is essential.
- Around-the-clock pain control is more effective than sporadic pain relief.
- Pain control promotes wound healing, patient confidence and shortens the length of hospital stays.
- Eliminate IM route of administration whenever possible. PO and IV routes are more acceptable and less painful to the patient.
- Epidural catheters are widely used.
- Duramorph (Morphine), Bupivacaine (Marcaine), Fentanyl and Sufentanil can be given by bolus/continuous infusion via the epidural catheter.
- Side effects of epidural analgesia include respiratory depression, pruritus, nausea and vomiting, urinary retention, hypotension, decreased sensory/motor function, sedation and headache.
- Notify the physician for any of the following:
 1. Respiratory rate < 8
 2. Systolic BP < 90 mmHG
 3. Abnormal motor or sensory findings
 4. Evidence of airway obstruction
 5. Change in sedation level/altered mental status
 6. Pain unrelieved by epidural analgesia
 7. Nausea, vomiting, or pruritus unrelieved by medication
 8. Drainage from the insertion site
 9. Disconnection of catheter from the tubing
 10. Signs of infection/inflammation at the catheter insertion site
 11. Pump malfunction or alarm unresolved by nursing
 12. Severe headache or headache associated with changes in patient's position
- Patients undergoing epidural analgesia should always have an intravenous access.

SECLUSION, RESTRAINTS AND MEDICAL PROTECTIVE DEVICES*

- A **restraint** is any method of involuntarily and physically restricting a person's freedom of movement, physical activity, or normal access to his/her body.
- **Seclusion** refers to the involuntary confinement of a person alone in a room where the person is physically prevented from leaving.
- Research studies related to **falls** have demonstrated that the use of restraints may actually increase the risk of falls and contribute to injury if a fall occurs.
- **Alternatives** to restraints include companionship, changing or eliminating a treatment, environmental manipulation, reality orientation, psychosocial interventions, diversion and activity.
- Look for **physical causes** of agitated and confused behavior before restraining a patient.
- Hypoxia, fever, electrolyte imbalances hypo or hyperglycemia, acid-base imbalances, sepsis, renal failure, pain drugs, CVA, trauma, infection, and tumors are a few reasons a patient may act confused or agitated. **Treating the cause** is the best approach,
- **Alternatives** to restraints should be considered prior to their application.
- The patient should be **oriented to his environment** on admission and receive frequent reorientation throughout his hospitalization. Personal items placed where the patient expects to find them helps foster orientation and independence.
- **Companionship** decreases isolation and feelings of lack of control. Family and friends should be encouraged to visit the patient.
- **Eliminate** unneeded IV's, tubes and drains as soon as possible. If removal is not possible, camouflage them using pajamas, stockinet or stretch-flex net.
- **Light** in the room should be increased or decreased as appropriate. A night-light increases safety. A commode should be placed so the patient can easily use it.
- There are good reasons to use restraints. These include **prevention** of injury to self and others, **preservation** of life support systems or biomedical devices necessary for the patient's proper care or treatment and less restrictive techniques have proven ineffective to prevent injury or interruption of a therapy.
- Reasons **not** to use restraints include staff convenience, punishment and as a substitute for treatment programs.
- The use of restraints should be undertaken in a way that preserves **patient's rights and dignity**. **Frequent assessment** is mandatory and skin care, hydration, toileting, range of motion, hygiene and pulmonary toilet should be provided.
- A **physician's order** is required for restraints prior to their being initiated.
- **Documentation** of restraint use should include the clinical justification of use, alternatives attempted, monitoring, reassessment, and attention to patient needs.

CULTURAL AND RELIGIOUS DIVERSITY

Culture can be defined as the particular set of beliefs, practices, and values of a particular ethnic or age group. A patient's cultural background can affect his or her expectations and perspective regarding healthcare practices. A person's cultural background may also affect how he or she responds to pain, how he or she will communicate, the level of involvement of the family, practices concerning birth and death, and food preferences. Spirituality does not necessarily tie a person to a particular religion, but rather indicates issues where the individual finds hope and meaning.

American Critical Care Services values cultural diversity as directly related to our mission, values, and belief statement. ACCS values and respects the dignity of all with whom we work and serve. Mutually respecting unity and diversity fosters a community of trust and encourages a healing environment.

Culturally sensitive healthcare is critical due to the diversity of the population. To provide optimal healthcare in our home health setting, it is imperative that caregivers understand that cultural, spiritual, and religious influences play a significant role in shaping behaviors during illness, and also the treatments a patient will pursue.

Providing Culturally Competent Care:

1. Stereotyping factors such as age, climate, war, gender, sexual orientation, socioeconomic status, and physical or mental disabilities will create differences and possibly conflict between members of a group.
2. Virginia offers many opportunities to learn about other cultures, religions and ethnicities. Becoming more familiar with cultures and religions other than our own allows us to better understand those who come from different backgrounds.
3. The patient's privacy must be taken into consideration. Is the patient uncomfortable being touched or unclothed? Does the patient have particular personal space boundaries? Does the patient require time for prayer, meditation, or another spiritual practice?
4. Learning how the patient regards his or her cultural and spiritual boundaries shows respect. How does the patient wish to be addressed? Ask the patient before touching, removing clothes, etc.
5. To further educate yourself or others, go to: ccnm.thinkculturalhealth.hhs.gov

INCIDENT REPORTS

All events or occurrences which may be deemed as harmful or detrimental to the patient must be reported to the nursing supervisor whether or not the incident resulted in a bad outcome for the patient. The following is a list of reportable events and occurrences that could take place in the clinical and/or home health setting:

- falls: attended or unattended;
- car accidents, with or without injury;
- bone breaks, sprains, torn ligaments
- burns;
- medication errors;
- patient refusing treatment
- caregiver barred from home;
- unplanned absence of caregiver;
- failure of family member to perform procedure as taught;
- mishaps due to misuse of equipment;
- patient complaints of alleged theft;
- home care staff/patient disagreements;
- failure of patient/family to use on-call emergency plan;
- failure of home care staff to report accident-causing hazard in the home;
- unplanned return to an in-patient setting;
- breakage or damage to personal property of patient or family;
- adverse or allergic drug reactions;
- abuse of patients;
- child abuse;
- failure to respond to patient or family request for assistance, information or treatment;
- loss or breakage;
- non-compliance;
- procedure resulting in trauma and/or injury;

IV incidences such as:

- phlebitis, pre or post infusion;
 - extravasation;
 - infiltration;
 - suspected IV related infection;
 - defective equipment;
 - expired equipment in use;
 - expired medications;
 - improper use of equipment; and
 - Threats or other aggressive behavior, including violence in the workplace, must be reported and logged in to help prevent future security and safety problems.
- Safety Hazards to be reported whether or not the incident resulted in a bad outcome for the patient include:
 1. frayed cords
 2. lack of ground wire
 3. improper use of extension cord(s)
 4. smoking around/near oxygen supply
 5. improper use of equipment
 6. lack of battery back-up when equipment demands requires it
 7. all hazardous materials or waste spills, exposures, or other incidents
 8. utility systems management problems, failures, or user errors
 9. use of equipment that has not been properly tested and maintained per manufacturers' guidelines

ADVERSE MEDICATION REACTIONS

Any patient demonstrating adverse effects of current medication administration will be cared for as per ACCS policy. **Adverse medication reactions are specific signs and symptoms of a reaction not directly associated with that medication. Significant adverse drug reactions are unintended undesirable, and unexpected effects of prescribed medications that:**

- **require discontinuing a medication or modifying the dose**
- **require hospitalization**
- **result in disability**
- **require treatment with a prescription medication**
- **result in cognitive deterioration or impairment**

- **are life threatening**
- **result in death or**
- **result in congenital anomalies**

Adverse drug reactions may be unpredictable and are unexpected biological responses to medications.

- A drug profile record will be maintained on all ACCS clients (to include common side effects that may be observed).
- If a patient exhibits possible adverse reactions to a medication such as nerve, tissue and/or vascular damage; toxic reactions or anaphylaxis, a physician and pharmacist will be notified immediately. The Home Health Nursing Supervisor should be notified after the patient is stable or before then if needed.
- Consider an adverse reaction when a patient exhibits the following signs and symptoms unrelated to patient diagnosis:
 - Central nervous system: headache, tremors, dizziness, muscle spasm, confusion
 - Gastrointestinal: nausea, vomiting, diarrhea, cramps, abdominal pain
 - Skin: rash, flushing
 - Cardiovascular: dizziness, hypertension, arrhythmia, tachycardia, bradycardia
 - Respiratory: shortness of breath, dyspnea on exertion, respiratory depression
- The physician will decide if any further action needs to be implemented by the nursing staff or client.
- If patient appears to be in immediate danger, appropriate emergency response will be initiated. An anaphylaxis kit will be provided when the following IV medications are being administered: a) first time IV antibiotic/IV medication therapy, b) blood/blood products administration, c) and PRN upon request. A CPR mask with anti-reflex valve is available for all professional staff in the event CPR is required from an adverse reaction.
- An incident report should be completed by RN/LPN observing each occurrence of adverse reaction and should be submitted to Chief Operations Officer and pharmacist. The pharmacist is responsible for completing the appropriate forms for the FDA. Physician's orders are required for the administration of medications and/or treatments in response to adverse reactions.
- ACCS professional staff is responsible for patient instruction related to any adverse drug reaction. Any related patient instruction will be completed and documented.
- The Performance Improvement process (see Performance Improvement/Risk Management Plan) identifies and reviews significant adverse medication reactions, based on an approved definition, as stated above. This mechanism prompts improvements to prevent or reduce the likelihood of such reactions in the future. The PI/RM activities should assess the effectiveness of the improvements; assess the usefulness of ACCS' definition; assess the mechanism's effectiveness to detect all such reactions. A summary of adverse reactions (including anaphylaxis) will be included in the Improving Organizational Performance activities of the agency.
- Significant adverse medication reactions are reported promptly to appropriate agencies consistent with applicable law and regulation and organization policies and procedures.

SENTINEL EVENTS

- I. **A sentinel event is an unexpected occurrence or variation involving death or serious physical or psychological injury or the risk thereof. Serious injury specifically includes loss of limb or function not related to the natural course of the patient's illness or underlying condition, or any of the following events: suicide, infant abduction or discharge to the wrong family, rape, hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities, surgery on the wrong patient or wrong body part.**
An event is sentinel because it sends a warning signal that requires immediate attention.
 - Following a sentinel event, ACCS administration will take a number of actions including those that are immediate. They include:
 1. Immediately, prompt and appropriate care will be provided to the patient. The patient's physician will be notified. This will involve stabilizing the patient, performing necessary procedures, providing medications, taking actions to prevent further harm and/or reversing the harm that has occurred, if possible.
 2. Actions will be taken that will contain the risk of the event occurring again immediately.
 3. Evidence will be preserved if at all possible so that ACCS can learn from an error and understand why it occurred.
- II. **When a sentinel event occurs, ACCS personnel involved will notify the Chief Operations Officer. The Chief Operations Officer will discuss the event with ACCS administration to determine further communication and disclosure with relevant parties, including patients and their families affected by the event, colleagues who could provide support and the opportunity to learn from the error, liability insurers, appropriate organizational staff, including the President, Vice President of Operations and the Director of Performance Improvement/Risk Management, other people who could provide emotional support or problem solving help for the individual who made the error.**
- III. Reportable sentinel events will be reported to JCAHO within 5 business days of the occurrence or the organization's awareness of the event. ACCS will complete the self-reporting form to provide this information to JCAHO.

- IV. A root cause analysis will be conducted within 45 days. ACCS will either submit the report directly to JCAHO or provide for JCAHO to evaluate ACCS' response to the event under an approved protocol.

EMPLOYEE INJURY/INCIDENT REPORTING

To properly administer and comply with the State Workmen’s Compensation Laws and with the Federal Occupational and Safety Health Act, it is essential that employees who become ill or who are injured on the job be referred to a physician. An incident report must be completed by the ACCS employee as soon as possible after an injury occurs. ACCS initiates the employee’s first report of injury. The physician is solely responsible for determining which cases should be reported and initiates Workmen’s Compensation and/or OSHA forms for processing. Examples of incidents to be reported are: needle sticks, injuries experienced during patient care that require treatment, lost work days or hospitalization, motor vehicle accidents involving the company vehicle or the employee vehicle while on company business. A urine drug and alcohol screening is required of the employee after an injury/incident occurs unless waived by ACCS administration.

IDENTIFICATION OF HIGH RISK, PROBLEM-PRONE ACTIVITIES WITHIN ACCS
ACCS identify the following activities as high risk, problem-prone for injuries and exposure to staff:

- Needle stick injuries
- Back and/or other muscle/joint sprains or injuries
- TB exposure

A. IMPLEMENTATION ACTIVITIES TO REDUCE THE RISK OF STAFF INJURIES:

- Education to be completed upon orientation to ACCS and annually thereafter:
 1. Sharps Management and Needle-Stick Policy
 2. Back Care for the Healthcare Professional
 3. HIV and Healthcare Personnel
 4. OSHA, Safety and Infection Control Review, include employee health issues, including TB exposure.
- FIT mask fitting for employees. Effective 01.01.03, all facility-staffing employees are fit tested prior to the hiring process. ACCS will accept documentation of appropriate fit testing completed through another facility, agency or the military. All Home Health staffing employees are fit-tested if a patient’s diagnosis warrants it being done prior to being assigned to that patient.

REPORTING INFECTIONS

- Organization/Community acquired infections appearing during home health care will be recorded by ACCS. Surveillance and recording of home health associated infections provides the agency and the infection control community information to comply with state law, follow trends and detect problems.
- Any infection detected in home health patient within 48 hours after hospital discharge should be considered organization-acquired or community-acquired. Any infection detected in the home health patient within 48 hours of hospital discharge will be considered a facility-acquired infection.

HHS RECOMMENDED IMMUNIZATION SCHEDULE
FOR HEALTH CARE PROVIDERS*

Influenza	Yearly vaccination
Hepatitis B	Series of three initial doses. Titer and/or booster after exposure incident. Titer and/or booster may be required after seven years.
Measles, Mumps, Rubella	If born before 1956, natural immunization confirmed titer. If born after 1957, Proof of two doses of MMR or proof of one MMR confirmed titer. (MMR is a requirement for employment at many health care facilities.)
Tetanus and Diphtheria	Series of initial doses in childhood. Booster every <u>ten years</u> . Booster after an exposure incident.
Poliomyelitis	Primary series in childhood. In an outbreak, oral polio vaccine (OPV) should be provided to any health care provider whose immunization status is unknown or incomplete.
Pneumococcal	Initial immunization for health care providers over 65 years of age, or any health care provider with chronic illness such as diabetes, cardiac heart and lung disease. Booster as necessary in consultation with your physician.

- Your continued good health is very important to us. To help keep you up to date on workplace pathogens and protecting yourself from infection, we have included information on hepatitis.

HEPATITIS A-E VIRUS*

- **Hepatitis A Virus** is transmitted by the fecal-oral route and can be prevented by good personal hygiene and thorough hand-washing.
- **Hepatitis B Virus** is transmitted by needle-stick or mucous membrane exposure to blood containing the Hepatitis B virus. All patients should be handled with Standard Precautions. **Hepatitis B vaccine** is available.
- **Hepatitis C Virus** has no vaccine at this time. It is the most common blood-borne infection in the United States, affecting at least 4 million people. The Hepatitis C virus spreads through contact with blood. Recent studies show that a new form of interferon, called peginterferon, combined with ribavirin stops the virus more effectively than standard interferon and ribavirin. If liver failure or cancer develops, liver transplantation usually is the only way to prolong life. Hepatitis C infection is the most common reason for liver transplantation in the United States.
- **Hepatitis D Virus** is an RNA virus that is dependent on Hepatitis B for survival. Only those individuals who have Hepatitis B can also have Hepatitis D. There is no specific treatment for Hepatitis D.
- **Hepatitis E Virus** is spread by contaminated food or water through a fecal-oral route of transmission. Rarely found in the USA, it should be considered in any person who has traveled to Asia, Africa, and the republics of the former Soviet Union who has symptoms of viral hepatitis and yet has negative serology for the other hepatitis viruses.

WORKER EXPOSURE TO HEPATITIS AND HIV*

- In the unfortunate event of an exposure or contact with blood or a potentially infectious body fluid, washing the affected area **immediately** is important.
- If the area is skin, **wash** the wound vigorously with soap and water.
- If the area is a mucous membrane, **flush** the area with water.
- **Notify** the supervisor of the facility/home health where the exposure occurred and ACCS. You will then be given instructions about where to receive post-exposure medical evaluation and treatment.
- In addition to using Standard Precautions on all patients continuously, **never** recap, bend or break needles and always place needles, scalpels and other sharp instruments in a sharps container.

GENERAL SAFETY GUIDELINES FOR ALL PATIENTS*

- Always familiarize yourself with the location and contents of the **code cart** and/or **emergency supplies** and the code procedure at the client's facility or the patient's home. Assure that you can identify the members of the code team and your role during a code.
- Assure that **side rails** are up on occupied beds and that the bed height is in the lowest position.
- Assure that the patient's **call bell** is within easy reach and that he or she has been instructed in its use.
- Assure presence and/or assistance of **back-up personnel** prior to giving treatment to restless, agitated, or emotionally disturbed patients.
- Assure that each hospital patient has an **identification band** on and checks the name badge before administering treatment.
- Remember the **5 R's of drug administration:** right drug, right patient, right dose, right route and right time.
- Assure that all **safety hazards** have been removed from the patient's environment as determined by his age, diagnosis and disability.
- Assure that any patient that is acutely ill or is a danger to himself or others is under **direct and constant observation** by nursing personnel.
- Assure that any **physical restraints** are padded and that the patient's extremities are periodically checked for impairment.
- Assure that all **patient records** are properly identified with an Addressograph stamp or their name and medical record number for home health patients.
- Assure that the patient's **allergies** are clearly indicated on the patient's kardex and chart and have been verified prior to drug administration.
- Assure that **spills** are promptly and properly cleaned up.
- Assure that **wheels are locked** on all occupied beds, wheelchairs, and stretchers when a patient is left unattended.
- Before administration of any **blood products, insulin or heparin**, or a drug ordered in an unusual dosage, route, or frequency, double check the order and your calculations with another R.N.
- Remember that all patient information, including that found on the computer management system is **confidential**. The management of the information contained in the computer is protected by the Federal Privacy Act of 1974 (PL93-579). Unauthorized access or use of this system is a violation of federal law and violators can be punished.

BLOOD GLUCOSE MONITORING*

Calibrate the blood glucose monitoring equipment according to manufacturer's directions before use. This practice will increase the **accuracy** of the value.

BACK CARE

Occupational back injury is the second leading occupational illness/injury problem in the United States, with the rate reported to be 21.7 cases per 100 employees. At least 1 in every 15 nurses will experience back injury serious enough to interfere with their professional careers.

The nature of **bedside nursing** is such that nurses are highly susceptible to back injuries: heavy and/or multiple lifts of moving and unstable objects (such as patients) are frequent. **Some general do's and don'ts:**

- Weight control and general physical fitness
- Maintain good posture
 1. Don't slump-sit, support your lower back
 2. Don't stand in one position for too long.
 3. Change positions frequently
 4. Don't twist, pivot to face your work
- When lifting:
 5. Avoid lifting with your back flexed. Use your knees to spare your back.
 6. Know your limits. Get help whenever possible or use lifting aids, such as a Hoyer lift.
 7. Keep your head high and chin tucked when lifting.
 8. Keep the weight as close to your body as possible.

EMERGENCY PREPAREDNESS PLAN

Policy: In the event of either a man made, natural disaster, or inclement weather, ACCS will endeavor to provide care to its patients with minimum disruption. All ACCS staff is advised to keep this document in an easily accessible place

Procedure: A. Inclement Weather Plan (i.e. snowstorm) - Based on weather reports indicating inclement weather (i.e. snowstorm), the following plan will be activated:

- a) Staffing Coordinators/On-Call Coordinators will contact field staff assigned during the period of potential inclement weather and assess whether staff need transportation to homes/hospitals.
- b) Administration will arrange for four-wheel drive transportation to be available if necessary.
- c) Staffing Coordinators/On-Call Coordinators will contact home health clients to inform them of any changes in staff schedules due to the inclement weather.
- d) Administration/Back-up RN's for on - call will assist staff/on-call personnel in identifying patients who must receive care based on their acuity level and family's ability to provide care.
- e) All possible attempts will be made to provide staffing coverage by utilizing alternate transportation methods, switching staff and/or utilization of RN Supervisors if needed for cases that require care due to acuity level.

B. Man Made/Natural Disaster Plan

Purpose: To assure consistency in the delivery of home care during a natural/man made disaster.

- Procedure:**
1. Office staff will be contacted as soon as possible by telephone to receive assignments. (see phone tree). If neither regular nor cellular telephone service is operating, and roads are impassable for travel, staff should stay home or in a shelter until communications are restored. If phone lines are not operating and roads are passable for travel, office staff are requested to meet at the office or at the President's home if office is damaged.
 2. The President of ACCS, Chief Operations Officer, and Office Manager will coordinate scheduling staff, using the telephone tree (see attached) and confirmation of designated patient categories will be undertaken.

Home Health Patient Categories:

- a. **Acute:** Patient that requires services today as scheduled; for example, sterile wound dressing with drainage; ventilator-dependent; new insulin dependent diabetic, living alone, who is unable to self-administer insulin.
 - b. **Borderline:** Could be postponed 24-48 hours; for example, a patient with a sterile wound dressing without drainage, cardiovascular assessment; respiratory assessment; medication teaching, new insulin dependent diabetic, living alone who is able to self-administer insulin.
 - c. **Stabilizing:** Could be postponed for up to four days; for example, a patient who is anticipating discharge in 1-2 visits, a diabetic post-surgical without open wound and post-MI.
3. Each staff member at the top of each column of the phone tree will be responsible for calling those office staff members listed under their prospective names.
 4. The office staff are responsible for the following as needed:
 - RN, LPN's: triage clients, home visits, and communications by phone with patients.
 - Administration: triage patients, set up communications, assign tasks, assessment of damage.
 - Support Staff: phone calls to field staff clients, phone receptionist.
 5. If a home visit is impossible to an acute patient, the staff member will contact the Chief Operations Officer. The Chief Operations Officer will ensure contact of the Emergency Services Department and/or hospital as predetermined and agreed upon by the patient and physician during the admission procedure to arrange care.
 6. Staff and patients are instructed to utilize back up battery systems in the home in event of an electrical failure. The DME company will be contacted to replace any malfunctioning equipment as soon as possible.
 7. In the event of an industrial disaster resulting in evacuation of all persons in the area, clients will be advised to call 911 for healthcare service.
 8. Announcements may be broadcast via several radio stations in Richmond in the event that the corporate office delays opening or closes for the day. The leadership team (President, Chief

Operations Officer, and Office Manager) are authorized to call in announcements to AM/FM Inc at 804-330-5700. The announcements may be heard on 4 stations. (95.3, 96.5, 103.7, 106.5)

9. If the emergency preparedness plan is put into effect, administration will evaluate the effectiveness of the plan. A report will be submitted to the PI/RM Committee. At least annually a mock emergency preparedness drill must be evaluated if the plan has not actually been in effect within the year.

BOMB THREAT*

- Remain calm; note the date and time, and any background noises.
- If it is a telephone threat, keep the caller on the phone as long as possible.
- A nearby co-worker should call security.
- If the threat is made in person, attempt to engage the person in a conversation and memorize the individual's appearance, gender and age.
- Ask the following questions:
 1. Where is the bomb?
 2. When will it explode?
 3. What does it look like?
 4. How do you deactivate it?

NON-DISCRIMINATION POLICY

American Critical Care Services agrees to comply with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 and the Age of Discrimination Act of 1975, and all requirements imposed pursuant thereto, to the end that no person shall on the grounds of race, creed, color, religion, sex, national origin, sexual preference, disability or age, be excluded from participation in, be denied benefits of, or otherwise be subjected to discrimination in the provision of any care of services. Specifically, the above includes (but not is limited to) the following characteristics:

PROCEDURE

1. Inpatient and outpatient care will be provided in a manner that does not discriminate against persons on the basis of race, creed, color, religion, sex, national origin, sexual preference, disability or age.
2. Employees will be assigned to patient services without regard to the race, creed, color, religion, sex, national origin, sexual preference, disability or age of either the patient or employee.
3. Staff privileges will not be denied professionally qualified personnel on the basis of race, creed, color, religion, sex, national origin, sexual preference, disability or age.

DRUG-FREE POLICY

- American Critical Care Services supports a drug-free work environment. To that end, our policy requires that all applicants for employment submit to a pre-employment drug screen at the applicant's expense. This must be a drug screen specifically designed for medical professionals.
- American Critical Care Services is pleased to collect a fee of \$38.00 from applicants desiring to have this test performed at any Lab Corp location in Richmond, Northern VA or Maryland. ACCS staff will provide directions to Lab Corp locations for the applicant's convenience. Otherwise, applicants may elect to have an equivalent drug screen conducted elsewhere possibly at a higher cost. Once an employee has worked a minimum of 40 hours for American Critical Care Services, the drug screen fee will be reimbursed to this employee. If the applicant elects to utilize a lab other than Lab Corp, a receipt for the cost of the drug screen must be presented for reimbursement.
- Pre-employment drug screens must be performed within 10 (ten) working days prior to start to work date.
- Further American Critical Care Services conducts random drug screens to which employees agree to submit at any time given a 4-hour notice. Lab costs for random screens are the responsibility of ACCS.
- Employees understand that positive readings on drug screens could result in immediate termination of employment with ACCS.

POLICY FOR FACILITY HIRING OF ACCS STAFF

Facilities choosing to offer employment to ACCS employers are requested to honor the following guidelines:

1. Having identified that facility wishes to offer employment to an ACCS employee, facility:
 - a. Notifies ACCS administrator
 - b. May not hire employee for a period of 90 days from notification date. Employee may continue to staff at facility during this period.
 - c. May hire employee after 90-day notification

Should facility wish to hire and work ACCS employee immediately:

1. Having identified that facility wishes to offer employment to ACCS employee, facility:
 - a. Notifies ACCS administrator
 - b. May hire ACCS employee immediately
 - c. Accepts invoicing of recruitment fee from ACCS

AGE-SPECIFIC COMPETENCIES FOR ELDERLY CARE*

Age-specific considerations to remember when caring for the older adult are system specific. Decreased cardiac reserve can result in low blood pressure. Decreased PaO₂ predisposes the person to hypoxia. CNS sensitivity can result in a lower dosage requirement. Renal clearance and liver detoxification can be slowed as well.

Elderly Care Guidelines:

- Normal changes that occur with aging predispose the older patients to skin breakdown, bone fractures, hearing loss, vision loss, memory impairment and slow metabolism of drugs.
- Good skin care and frequent; gentle position changes prevent skin breakdown.
- Appropriate footwear, good lighting, removal of obstacles, and supervision while walking decrease falls.
- Speaking slowly and clearly while facing the patient enhances communication.
- Properly fitted hearing aids with fresh batteries improve hearing; glasses improve vision.
- Night lights and reorientation aid recall.
- Drugs are metabolized more slowly. Be alert for signs of toxicity when an elderly patient is receiving a normal dosage of medication.
- Bladder capacity decreases from 600 ml in a young adult to 250 ml in the elderly.
- Frequent need to urinate at night while coupled with impaired vision and memory increase the risk for falls.
- Call lights within reach, beds in low position, bathroom lights on; all help the elderly patient maintain comfort, confidence, and dignity at night.

Each stage of growth and development throughout the life span has its own unique characteristics. An Age-Specific Quick Reference has been provided for your review. Please consult the quick reference guide for insights into growth and development issues pertinent to your plan of care.

*Used with permission from Mills & Mehlman, Inc., April 2000

OSHA, SAFETY, AND INFECTION CONTROL REVIEW

Policy:

ACCS staff members receive a copy of the Annual Safety Review Policy and OSHA Standards Review during orientation and then annually.

Purpose:

To provide an environment which is safe for patients, employees and the community.

Procedure:

All ACCS staff members will review the following policies during ACCS orientation, then an annual safety review will be sent to all ACCS employees:

1. OSHA Blood borne Pathogen Exposure Control Plan
2. Safety/Infection Programs
 - a. Hand-Hygiene Recommendation
 - b. Standard and Transmission-based precautions
 - c. Equipment disinfection
 - d. Transport of specimens
 - e. Sharps management policy
 - f. Infectious waste
 - g. Communicable disease reporting policy
 - h. Protocol on infectious waste management/infection control and patient safety in the home
 - i. Medication Safety
 - j. Office/Home fire safety plans
 - k. Office electrical safety
3. Tuberculosis Review
4. Hazard Communication Programs
5. Medical Device Reporting Policy

A. OSHA Blood-borne Pathogen Exposure Control Plan

- The OSHA Blood-borne Pathogens Standard was issued to reduce the occupational transmission of infections caused by microorganisms sometimes found in human blood and other potentially infectious materials.
- Hepatitis B Virus (HBV) and Human Immunodeficiency Virus (HIV) have been shown to be responsible for infecting workers who were exposed to human blood and certain other body fluids containing these viruses. Workers can be injected by needle-stick injuries, direct contact of mucous membranes, and non-intact skin with contaminated blood/materials. Occupational transmission of HBV occurs much more often than transmission of HIV. There is a 40% chance of becoming injected with

Hepatitis B by needle prick while the threat of HIV from needle prick is 0.5%. There is also a threat of transmission of Hepatitis C, Delta Hepatitis, Syphilis, Malaria, Babesiosis, and Creutzfeldt-Jakob disease (human mad cow disease) and others.

B. Epidemiology, Modes of Transmission and Symptoms of Blood borne Diseases

- Certain pathogenic microorganisms found in the blood of infected individuals can be transmitted to other individuals by blood or other body fluids. Health care workers, whose occupational duties expose them to blood and other potentially infectious materials, are at risk of contacting any one of these blood-borne pathogens.
- Blood-borne pathogens are spread via several routes: parenterally, through contact with mucous membranes and non-intact skin, sexually, and perinatally, with sexual transmission (both homosexual and heterosexual) being by far the most prevalent means of transmission. In health care settings, the most commonly reported methods of transmission are cuts or sticks from contaminated sharps and needles, contacts between blood and pre-existing skin lesions, and infectious body fluid contamination of the eyes, nose and mouth.
- Hepatitis B is an inflammation of the liver and is a serious liver infection caused by a virus.
- Hepatitis B is the major infectious occupational health hazard in the health care industry. It is the most common infectious blood-borne hazard transmitted on the job. The CDC believes that as many as 18,000 health care workers may be infected by HBV each year. Nearly 10% of these become long term carriers of the virus and may have to give up their profession. Several hundred health care workers will become actively ill or jaundiced from Hepatitis B. Approximately 300 workers may die annually as a result (directly or indirectly) of Hepatitis B.
- Health care workers are at a much higher risk for HBV infection than the general public due to their frequent occupational exposure to blood and other body fluids. Studies have shown that approximately 30% of health care workers show evidence of past or present HBV infection. Strong concentrations of HBV in body fluids and feces make it highly contagious and easily spread. Thus, unsanitary water supplies can easily allow the spread of HBV. HBV is spread from person to person mainly by blood, semen and vaginal fluids. HBV is usually passed by having sex or sharing needles with an infected person. HBV has an incubation period of 6 weeks to 6 months. Carriers still have hepatitis B in their blood even after all symptoms subside. Infected persons should be isolated or follow careful infection prevention procedures, especially during home care. Infected individuals should use disposable eating utensils and should not share food or drink with family members. These precautionary measures should be followed until the person tests negative for HbsAg and shows the appearance of anti-HBs.
- Some HBV infections are asymptomatic, especially in children. More than 2/3 of all cases have no symptoms but are still carriers. Symptoms of HBV may include jaundice, anorexia, nausea, arthritis, rash and fever. Chronic carriers of HBV, who may be asymptomatic but still infectious to others, are at risk of chronic liver disease and liver cancer later in life. Patients may have no symptoms; have flu-like symptoms; or experience a more severe course with classic symptoms. Classic symptoms include flu-like, mild fever, extreme fatigue, joint and muscle aches, nausea, vomiting, extreme fatigue, and diarrhea and especially jaundice, loss of weight/appetite, yellow colored skin or eyes, dark colored urine, light colored bowel movements.
- Hepatitis C has similar etiology and symptoms, with a higher chance of developing chronic disease. It is more prevalent in the US than hepatitis B. There is no immunization or cure. The only currently available treatment is interferon, with an effectiveness rate of 15-50%. Low effectiveness may be related to low patient compliance due to unpleasant side effects of the medication. Patients may remain asymptomatic for up to twenty years.

C. Modes of transmission

- Parenteral—through the skin, through open wounds or punctures; transplant, transfusion, accidental puncture wounds with contaminated instruments, sharing dirty needles, acupuncture, tattoos, body piercing.
- Mucous membrane contamination—eyes or mouth
- Sexual—sexual intercourse (homosexual and heterosexual)
- Prenatal—mother to child via placenta.
- Mother to child through breast milk.

Human Immuno-deficiency Virus (HIV)

- Infection with HIV in the workplace represents a small, but real hazard to healthcare workers. With almost a million AIDS cases reported in the general population there is an ever-increasing potential for exposure to health care workers. Although there is currently no vaccine which is effective against HIV, the barrier techniques which help prevent HBV will also be effective against HIV.
- HIV attacks the CD4 (T4) lymphocytes of an individual's immune system. T4 cells are vital to the body's ability to recognize and defend itself from infection and disease. Although HIV is a fragile virus that has difficulty surviving outside the human body, it causes progressive damage to the human immune system over a variable period of time making the individual vulnerable to a host of infections or malignancies. The condition known as AIDS represents the end stage of HIV infection.
- Due to the long incubation period of HIV 2-10 years, the vast majority of HIV infected individuals have no symptoms and may not know that they are infected. These individuals can transmit the virus to others via direct contact with blood or other body fluids and through sexual intercourse regardless of whether or not they have developed the symptoms of AIDS. Only blood and blood products, semen and vaginal secretions have been directly linked to the transmission of HIV.
- 50% of HIV infected individuals will exhibit one or more of the following symptoms within 2-4 weeks of initial infection: febrile illness with night sweats resembling mononucleosis or influenza which resolves spontaneously; malaise, body aches,

maculopapular rash (similar to measles; lymphadenopathy; headache, diarrhea, decreased appetite, white spots in the mouth. Presently, it is not understood why some people develop symptoms faster than others. It is thought that certain co-factors such as stress, poor nutrition, alcohol or drug abuse, and certain sexually transmitted diseases (syphilis), may trigger the virus to begin replication.

- Because of job related risks and their profound negative impact on health care workers, considerable interest has focused on the possible prevention of HIV infection after an exposure accident. The only potentially effective agent at this time is Zidovudine (AZT), but the data concerning its effectiveness is inconclusive. There is not enough information for a scientific recommendation, but despite this, many hospitals have instituted AZT prophylaxis protocols. Clearly any person would like to avoid the risk of HIV infection, with its attendant social, economic, and emotional costs and its virtual certainty of death. The importance of participating in an organized program with immediate counseling available cannot be overemphasized. The decisions involved are extremely complex and health care workers who have suffered an exposure often need emotional support as well as medical advice.

D. Identification of Procedures which may expose employees to blood or other potentially infective material and those employees whom may be exposed performing duties that are part of there job description.

RN, LPN, CNA ALL MAY POTENTIALLY EXPOSED TO BLOOD OR BODY FLUIDS WHILE PERFORMING THEIR JOB REQUIREMENTS.

Oral/nasal suctioning	Mouth to mouth resuscitation
Wound care	GI flushes and feedings
Phlebotomy	Hemodialysis/peritoneal dialysis
Bladder catheterizations	Obtaining urine specimens
Emptying Foley cath. bags	Enemas
Bleeding during surgery or labor/delivery	IV therapy

E. Methods of Compliance

1. Universal Precautions/Standard Precautions

- A blood borne pathogen is defined as a pathogenic microorganism that is carried, replicated, or transmitted in blood or blood products and is capable of causing disease.
- Universal Precautions/Standard Precautions is an approach to infection control. It is meant to reduce the risks associated with exposure to blood-borne pathogens but cannot entirely eliminate the risks.
- All blood and other potentially infectious body fluids will be treated as though known to be infectious for HBV or HIV or other blood-borne pathogens.
- Universal precautions apply to blood, all body fluids containing visible blood and certain other body fluids including cerebrospinal fluid, synovial fluid, pleural fluid, peritoneal and pericardial fluid and amniotic fluid. Standard precautions apply to those and all body fluids, secretions, and excretions (except sweat) regardless of whether they contain visible blood, including feces, nasal secretions, sputum, tears, urine, saliva, breast milk and emesis.
- OSHA, EPA and others have variously defined the amount of blood required to constitute an infectious risk as “substantial”, “dripping” and “significant”. The EPA has offered an objective definition that 15 milliliters of blood (about the size of three teaspoons) must be present to be of sufficient dose to be infections. This definition of quantity does not preclude the use of protective clothing; it only helps to define what constitutes infectious waste when disposing of blood-soaked materials.

2. Work Practice Control methods

To avoid needle-sticks:

- Do not bend, hand recap, shear or break contaminated needles or sharps
- Place contaminated sharps in an appropriate puncture resistant leak-proof container immediately after use.
- Ensure that sharps containers are not placed too high and are easily accessible
- Ensure sharps containers are not over filled
-

The use of safer sharps is an integral part of our exposure control plan,

We will evaluate our past history of exposures to determine the highest risk procedures. **High risk functions include:**

- Administering injections/IV therapy
- Collecting blood
- Disposing of sharps used for patient care
- Housekeeping tasks, especially handling trash and dirty linens.

- We will choose safety devices that meet our needs and conform to OSHA’s criteria
 - They must provide a barrier between the sharp and the employee’s hands
 - They must allow or require the employee’s hands to remain behind the needle after use.
- The safety feature must be a part of the device prior to contamination and must remain in place throughout the waste stream.
- They must be easily used with little training or education

- They must not interfere with patient care
 - We will attempt to use automatically retracting capillary puncture devices, plastic or coated capillary tubes, and selected safer needle devices.
- Where recapping or contaminated needles is medically necessary, a one-handed technique or a mechanical device will be used.

3. Disposable Sharps

- Sharps containers are available for use. The containers are labeled, color-coded, and are puncture resistant and leak-proof. They are kept upright at all times and the lid will be tightly sealed prior to removal of the container. If the outside of the container becomes contaminated it shall be placed into another leak-proof container prior to disposal.
- Any contaminated object that can puncture the skin is considered a contaminated sharp. This includes needles, scalpels, broken glass, and any other objects capable of penetrating the skin. These must be placed immediately into the sharps container. These containers will never be overfilled but will be replaced when objects can no longer be dropped easily into them.
- Recapping of contaminated needles is strictly forbidden in this facility except under rare circumstances where no alternative is feasible. In these situations, recapping will only be performed by the use of a mechanical device or by a one-handed scoop method. In addition, no one is permitted to bend, shear, or break a contaminated needle or scalpel.

4. General Policies

- Avoid splashing, spraying or splattering of blood when performing procedures
- Do not eat, drink, smoke, apply cosmetics or lip balms or handle contact lenses when you may be exposed to blood or infectious material.
- Petroleum based lubricants may eat through latex gloves
- Never mouth pipette or suction blood or potentially infectious material.
- Don't store food, drinks in refrigerators, shelves, counter tops where blood or infectious material may be present.
- Blood or other potentially infectious materials are to be placed in a biohazard container that prevents leakage during collection, handling, processing, storage, transportation or shipping. If the primary container could be punctured, then it must be placed in another container that is puncture resistant and labeled with the biohazard symbol.

5. Good Housekeeping

- Good housekeeping is every health care worker's responsibility
- Clean and decontaminate with disinfectant solution at end of each shift. Clean equipment and working surfaces.
- Do not pick up broken glass with bare or gloved hands. Use tongs, forceps, brush and dust pan
- Handle soiled laundry as little as possible and place in labeled, leak proof bags.
- In certain situations, 10:1 bleach solution may be used.

6. Personal Protective Equipment

- Personal Protective Equipment (PPE) will be used to prevent blood or other potentially infectious material from passing through to, or contacting the employees work or street clothes, undergarments, skin, eye, mouth or other mucous membranes, unless engineering controls and work practices have eliminated occupational exposure.
- ACCS maintains an inventory of personal protective equipment, including protection for the eyes, hands, face, head, extremities, air passages and clothing. Although this equipment is meant to reduce the risks of exposure, it may not eliminate it. Risks are reduced only when the equipment is used properly and is in good repair. During invasive procedures on a patient, this equipment must be used to avoid exposure. All protective equipment must be removed prior to leaving the work area.
- All employees who have potential occupational exposure to blood borne pathogens receive training conducted materials received at the time of orientation. These employees also receive training on the epidemiology, symptoms, and transmission of blood borne pathogen diseases. In addition, the training program covers, at a minimum, the following elements:
 - a copy and explanation of the standard
 - an explanation of methods to recognize tasks and other activities that may involve exposure to blood and OPIM, including what constitutes an exposure incident.
 - An explanation of the use and limitations of engineering controls, work practices, and PPE
 - An explanation of the types, uses, location, removal, handling, decontamination, and disposal of PPE
 - An explanation of the basis for PPE selection
 - Information on the hepatitis B vaccine, including information on its efficacy, safety, method of administration, the benefits of being vaccinated, and the vaccine will be offered free of charge.
 - Information on the appropriate actions to take and persons to contact in an emergency involving blood or OPIM.
 - An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident and the medical follow-up that will be made available.
 - Information on the post-exposure evaluation and follow-up that the employer is required to provide for the employee following signs of exposure incident.
 - An explanation of the signs and labels and/or color coding required by the standard and used at the facility.
 - An opportunity for interactive questions and answers with the person conducting the training session.

RECORDKEEPING

Training records are completed for each employee upon completion of training. These documents will be kept for at least three years at the ACCS corporate office. Employee training records are provided upon request to the employee or the employee's authorized representative within 15 working days. Such requests should be addressed to the Human Resources Department.

MEDICAL RECORDS

Medical records are maintained for each employee with occupational exposure in accordance with the 29 CFR 1910.20."Access to Employee Exposure and Medical Records"

The Human Resources Dept is responsible for maintenance of the required medical records. These confidential records are kept at the corporate office for at least the duration of employment plus 30 years.

Employee records are provided upon request of the employee or to anyone having written consent of the employee within 15 working days. Such requests should be sent to the Human Resources Department, at the ACCS corporate office.

OSHA RECORDKEEPING

An exposure incident is evaluated to determine if the case meets OSHA's Recordkeeping requirements (29 CFR 1904). This determination and the recording activities are done by the Human Resources Department.

Gloves: Disposable latex or vinyl gloves for use by this agency.

- Employees need to be aware that gloves are not puncture resistant.
- Gloves must be replaced as soon as practical when contaminated (at a minimum, after each patient).
- Make sure the gloves are the right size and are intact without flaws.
- Disposable gloves may not be washed for reuse.
- Gloves are not required for IM and SQ injections as long as blood contact with the hands is not anticipated.
- When removing protective equipment, place it in designated container.
- When equipment is penetrated by infectious material or blood, remove immediately.
- Gloves will be removed prior to writing in a patient's chart or prior to answering the telephone.
- Contaminated gloves will be disposed of by placing them in the biohazardous waste container, unless they have not been contaminated with body fluids, in which case they may go into the regular trash.
- Heavy-duty utility gloves (nitrile or neoprene type) used for cleanup may be decontaminated for reuse if glove integrity is not compromised.
- Employees shall wash their hands with soap and running water immediately after removing their gloves.
- Sterile gloves will be used for procedures involving contact with normally sterile areas of the body.
- Use examination (non-sterile) gloves for procedures involving contact with mucous membranes, unless otherwise indicated, and for other patient care or diagnostic procedures that do not require the use of sterile gloves.
- Change gloves between patients
- Gloves must be used for the following:
 - If the skin of the healthcare worker is cut, abraded or chapped.
 - When examining abraded or non-intact skin or patients with active bleeding
 - During invasive procedures and cleaning involving body fluids and decontaminating procedures
 - When performing phlebotomy procedures.
- To avoid soiling your hands, gloves must be removed in the following manner:
 - Peel one glove off from the top to bottom and hold it in gloved hand.
 - With exposed hand, peel second glove from inside, tucking first glove inside second.
 - Dispose of gloves and wash hands.

Eyewear: Protective eyewear is used by this agency when indicated (goggles, face shields, glasses with solid side-shields).

- Protective eyewear, better known as goggles, protects the eyes from splashing and aerosolization of body fluids and harmful chemicals.
- If a procedure presents a danger of splashing or if a manufacturer recommends that goggles be worn when using their product, the employee must wear goggles.
- Protective eyewear, other than prescription glasses, shall be removed prior to exiting a treatment area or patient's home.
- Goggles and face shields will be cleaned and decontaminated after each use

Masks: Masks are used by this agency when indicated

- Contaminated masks will be replaced immediately or as soon as is feasible.
- Contaminated masks will be replaced in the biohazardous waste container located in each treatment area.

Gowns, Aprons, Lab Coats:

- Gowns are worn to protect street clothing and the arm and neck areas from contamination. Gowns may be changed daily unless they become soiled or wet, at which time they must immediately be removed and replaced.
- Protective laboratory coats, gowns, and aprons will be removed and replaced as soon as they become visibly contaminated. Disposable gowns should be properly disposed by placing them into the appropriate container based on whether or not they are contaminated. If coats, gowns are reusable, they will be laundered as appropriate.

Resuscitation Equipment

- Pocket masks, resuscitation bags and/or other ventilation devices are used by this agency. This will minimize the exposure during emergency resuscitation.

Selection of Appropriate PPE

- Determination of appropriate personal protective equipment (PPE) is based on the anticipated exposure to blood or other potentially infectious body fluids during a given procedure. The type of exposure, amount of blood or fluids, and likelihood of splattering are taken into account when making these determinations. Following is a general outline which employees are to follow regarding PPE. It is the obligation of every employee performing these procedures to wear the designated PPE. On rare occasions, there is the possibility of greater than normal exposure to blood and body fluids for a particular treatment procedure. On these occasions, the employee should upgrade the PPE to an appropriate level of protection.
- Minimal exposure potential: vascular access, suture removal, bandage change. Appropriate PPE: Latex gloves
- Moderate potential for exposure: arterial punctures, abscess care: Appropriate PPE: gloves, long sleeve lab coat
- High potential for exposure: aerosolized treatments, induced sputum collection. PPE: gloves, long sleeve lab coat, face protection mask and eyewear.

7. Latex Allergy

- Latex Allergy is a significant occupational hazard for healthcare workers. While this allergy was first recognized in the 70's, it became more prevalent in the 80's, with increased awareness of the transmission of blood borne pathogens and has become particularly prominent since 1992, when OSHA's Blood Borne Pathogen Standard was implemented.
- Recent literature suggests that approximately 14% of healthcare workers experience some degree of latex allergy. Employees in other industries and patients also develop latex sensitivity.
- ACCS will inform employees about this potential hazard and will respond as necessary to any possible latex allergy.
- The source of the allergy is believed to be proteins from the milky fluid harvested from the rubber tree and used to produce latex. The proteins attach to the powder used in some gloves. The powder carries the proteins to the skin of the wearer and even into the air when they may be inhaled and come into contact with body membranes. While direct skin contact is the most common means of developing the allergy, inhalation is also a significant factor.

- Latex is contained in many products other than gloves

Balloons	condoms	erasers	elastic
Band-Aids	catheters	diaphragms	stethoscope
Adhesive tape	handlebars	raincoats	sneakers
Ambu bags	tourniquet	IV tubing	Multi-dose vials
Masks paint	electrode pads	goggles	blood pressure cuffs

I. Types of Reactions

- Irritation: dry, itchy, irritated areas on the skin, usually on the hands due to contact with the gloves. This is the most common reaction and is not a true allergy. The symptoms usually resolve when the contact ceases.
- Allergy contact dermatitis: skin rash, blisters and sores developing 6-48 hours after the contact; repeated contact may cause the symptoms to spread beyond the area of contact. Symptoms usually resolve when it is discontinued.
- Latex Allergy: immediate hypersensitivity presenting as hives, itching eyes, swelling of the lips or tongue, asthma, dizziness, abdominal pain, nausea, hypotension, shock and possible death.

II. Diagnosis:

- Latex allergies can be diagnosed through a medical history, physical examination and tests. While there are currently no FDA approved materials for skin testing for latex allergies, several alternatives are available. Standard glove use tests or skin tests involving pricking or scratching the skin through a drop of liquid containing latex particles may also be used. Itching swelling, redness or blistering at the test site indicates a positive test. These tests must be performed only in facilities experienced with the tests and equipped to handle severe reactions. Exposure even to a small amount of allergen used in the skin test can evoke a life-threatening reaction
- There are FDA approved blood tests to detect latex antibodies. These tests are much safer, eliminating the need to expose the patient to the allergen, but may be somewhat less sensitive.
- Cross sensitivity with certain fruits, such as banana, avocado and kiwi, may interfere with test interpretation and may result in some false positives.

III. Treatment:

- Some meds may help alleviate symptoms, but the best treatment is avoidance. Some facilities have latex free areas for affected workers as well as affected patients. This includes latex free surgical suites and latex free hospital rooms

PROGRAM ADMINISTRATION:

- The Home Health Dept is responsible for the implementation of the ECP. Home Health will maintain, review, and update the ECP at least annually, and whenever necessary to include new or modified tasks or procedures. The Home Health Dept can be contacted at the corporate office. Home Health will maintain and provide all necessary PPE, engineering controls (e.g., sharps containers), labels, and red bags as required by the standard. All nurses working in the hospitals should obtain PPE from the facility in which they are staffing and follow the policies of the facility. Home health will ensure that adequate supplies of the aforementioned equipment are available in the appropriate sizes. The Home Health Dept will be responsible for training, documentation of training, and making the written ECP available to employees, OSHA, NIOSH representatives.

- Human Resources will be responsible for ensuring that all medical actions required are performed and that appropriate employee health and OSHA records are maintained. Human Resources can be contacted at the corporate office.

Prevention: Guidelines issued by National Institute for Occupational Safety and Health (NIOSH)

- Use latex gloves only when absolutely necessary. Use non-latex gloves when possible.
- Use reduced powder gloves when latex gloves must be used.
- Always wash hands as soon as gloves are removed
- Do not use oil-based creams or lotions, which can cause glove deterioration, unless they have been shown to reduce latex related problems and maintain effective barrier protection of the glove.
- Tell employers and your healthcare providers about your allergy.
- Wear a medical alert bracelet.
- Frequently clean all areas where latex containing articles are used, including upholstery and ventilation ducts.
- Frequently change ventilation filters and vacuum bags used in high latex areas.
- Educate employees about the potential for latex allergies as well as the symptoms.
- Be prepared to accommodate employees who have or who develop latex allergies.
- If several employees have recently developed latex allergy, consider having the environment tested

8. Hepatitis Vaccination

- ACCS will offer Hepatitis B vaccination to all employees who have occupational exposure to blood borne pathogens. This will be offered at no cost to the employee.
- The vaccine is 85-97% effective at protecting you from getting the disease. HBV is given in 3 separate shots. All 3 are required to be protected. The second injection is given one month from initial injection and the final dose is given 6 months from the initial date.
- An employee has the right to refuse the Hepatitis vaccination. It is mandatory that the employee sign the declination form. The employee may then request the vaccination at any time during employment.
- There is currently no recommendation or requirement for a titer or booster at any routine interval.
- If the employee has had the series but can offer no written documentation to this effect, they must sign the Lack of Documentation form.

9. Exposure Determination

- ACCS follows OSHA’s occupational exposure definition to make exposure determinations for each job classification. An occupational exposure is any reasonable anticipated skin, eye, mucous membrane or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee’s duties. High risk employees must be offered the Hepatitis B vaccine and receive complete training program prior to commencement of their duties.

High risk employees –routine duties involve potential for exposure to blood borne pathogens.

Low risk employees—routine duties do not have any potential for exposure

High risk of exposure: RN, LPN, CNA, NA, PT, OT, ST, office staff nurses

Low risk of exposure: All other non-clinical clerical office staff positions.

10. Biohazardous Waste

See protocol for Infectious Waste Management/Infection Control and Patient Safety in the home

11. OSHA Biohazardous Labeling Requirements

1. Warning labels must be affixed to containers of:
 - Contaminated Waste
 - Containers used to store, transport, or ship blood or other potentially infectious materials.
 - Refrigerators, freezers and other containers used to store, transport, or ship blood and/or other potentially infectious materials.
 - Sharps containers
2. Label must include the Universal Biohazard symbol
 - The biohazard symbol should be colored fluorescent orange or orange red and the word “BIOHAZARD” printed in a contrasting color.
 - Labels must be affixed to the container in such a manner that they will be readily visible and cannot be accidentally removed.
3. Red containers or bags may be substituted for labels.
4. Signs identical to the biohazard symbol are located at the entrance to label areas and storage areas where exposure to blood-borne pathogens is likely.

12. Handling Emergencies involving Occupational Exposure

1. Accidents/spills
 - Blood and other potentially infectious materials
 - Isolate area where spill occurs.
 - Put on gloves, mask, eyewear, and fluid proof gown prior to cleaning up spill
 - Use the absorbent material in the spill kit (provided by the pharmacy provider). Use a scoop from the kit to place the absorbed materials in the biohazard bag also contained in the kit.
 - Clean area where spill occurred with both: soap and water and disinfectant.

- Remove and dispose of disposable personal protective equipment.
 - Wash hands with soap and running water.
2. Sharps and contaminated broken glass or materials from biohazard container.
 - These items are never picked up by hand even when wearing nitrile gloves. Always use forceps or scoop and brush.
 - Isolate area
 - Get nitrile gloves from spill kit
 - Pick up items with scoop and brush or forceps
 - Place into a sharps container.
 - Remove and clean nitrile gloves
 - Wash hands with soap and water
 3. Emergencies involving patient care:
CPR—Always use CPR device-
Unexpected bleeding; airway obstruction, etc
 - The patient must be cared for immediately in these events
 - If treatment results in blood or other body fluids contaminating any area of employee’s skin or eyes or mucous membranes, these are to be washed with soap and running water as soon as possible. Mucous membrane contact with a patient’s body fluids is an exposure incident and the employee may request a post exposure evaluation.
 - If blood or other body fluids soak through clothing, then this clothing must be removed, and skin underneath cleaned with soap and running water
 - The contaminated item of clothing is to be placed in an appropriate container to be laundered.
 - If at any time during this emergency, it becomes possible, with no increased risk to the patient, to interrupt treatment and put on proper personal protective equipment, then the employee is to do so.
 4. Reporting of Accidents and Emergencies
 - Employee should report any and all such emergencies to the employer as soon as feasible
 - All incidents that involve having to treat a patient without appropriate personal protective equipment must be documented (see Report of emergency involving patient treatment where employee was unable to use appropriate PPE)
 - Employer will investigate these incidents to determine whether changes can be instituted to prevent such occurrences in the future. The PI/RM committee will track above referenced reports for improvement activities.
 5. While recognizing the probability of occupational exposure is low in the branch offices, branch directors are instructed to call ACCS corporate office in the event of a hazardous waste spill. The employee is not to come in contact with the waste or attempt to clean it without permission from the corporate office. In the event that it is not safe for the employee to clean up the waste, the corporate office will arrange clean-up by a biohazard agency.

13. Post Exposure Evaluation and Follow up

- An exposure incident is a specific occupational incident involving eye, mouth, other mucous membranes, non-intact skin, or parenteral contact with blood or other potentially infectious materials, including saliva.
- Employee will immediately inform ACCS administration. After office hours, they will inform the back up RN on call. Following this report of an exposure, the employer will immediately make available, at no cost to the employee, a confidential medical evaluation and follow up that includes:
 - Completion of an incident report within 12 hours and documentation of the routes of exposure and the circumstances under which the exposure incident occurred. This should include routes of exposure and how the exposure occurred.
 - Identification and documentation of the source individual, unless the employer can establish that identification is infeasible or prohibited by state or local confidentiality laws.
 - Testing of the source individual’s blood, as soon as feasible and after consent is obtained, in order to determine HBV and HIV infectivity. If consent is not obtained, the employer shall establish that legally required consent cannot be obtained. When law does not require the source individual’s consent, the source individual’s blood, if available, shall be tested and the results documented. If the source individual’s blood status is already known, testing need not be repeated. Document that the source individual's test results were conveyed to the employee's health care provider.
 - INFORMATION CONCERNING THE SOURCE INDIVIDUAL’S HIV OR HBV STATUS MUST BE TREATED AS CONFIDENTIAL. THIS OBLIGATION EXTENDS TO ANY EMPLOYEE TO WHOM THE INFORMATION IS DISCLOSED.
 - Following an exposure, immediate collection and testing of the exposed employee’s blood will be done, after consent is obtained. The employee may refuse this service or may have the blood collected and preserved for 90 days, during which time the employee may choose whether or not to have the testing done.
 - Copies of all documentation, a copy of the blood borne pathogen standard and the results of the HIV and HBV testing (source and employee) will be given to the healthcare professional chosen to provide post exposure care. Employee and patient confidentiality will be maintained at all times.
 - Post exposure prophylaxis as recommended by the US public health service
 - Counseling as determined by the designated healthcare provider

- Evaluation of reported illnesses.

Follow up

The Human Resources Dept at ACCS will ensure that the health care professional responsible for the employee's hepatitis B vaccination and post- exposure follow- up are given a copy of OSHA's blood borne pathogens standard. The Human Resources Dept also ensures that the health care professional evaluating an employee after an exposure incident receives the following:

- Description of the employee's duties
- Documentation of the routes of exposure and circumstances under which exposure occurred
- Results of source individual's blood test, if available.
- All medical records relevant to the treatment including vaccination status and exposure report (incident) form
- If the employee refuses the post exposure follow up, they will be required to complete and sign the confidential employee informed refusal of post exposure medical evaluation.
- The employer shall obtain and provide to the employee a copy of the evaluating health care professional's written opinion within 15 days of the completion of the evaluation.

Post Exposure Prophylaxis

- ACCS employees may review the Public Health Service Guidelines for the Management of health Care Worker Exposures to HIV and Recommendations for Post-exposure Prophylaxis.
-

PROCEDURES FOR EVALUATING THE CIRCUMSTANCES SURROUNDING AN EXPOSURE INCIDENT

The Performance Improvement committee will review the circumstances of all exposure incidents to determine:

- Engineering controls in use at the time
- Work practices followed
- A description of the device being used
- Protective equipment or clothing was used at the time of the exposure
- Location of the incident
- Procedure being performed when the incident occurred
- Employee's training

If it is determined that revisions need to be made, the Policy and Procedure committee will ensure that appropriate changes are made to this ECP. (Changes may include and evaluation of safer devices, or other changes to the ECP)

Administrative Maintenance and Update of Exposure Control Plan

- The exposure control plan will be reviewed on an annual basis or more frequently if changes are needed by the policy and procedure committee. The policy and procedure committee will solicit the input from non-managerial employees responsible for direct patient care who are potentially exposed to injuries from contaminated sharps in the identification, evaluation and selection of effective engineering and work practice controls.

SAFETY PROGRAM

POLICY

ACCS has a plan to maintain safety of the environment and equipment management that support patient care, and of the environment in which care or services are provided to the patient. ACCS will minimize avoidable risks and injuries through sound planning, resource allocation, effective training, implementation, and ongoing monitoring and improvement of risk-reduction activities. These activities can be accomplished through management process, staff activities and/or technology.

Patient environment refers to the residential setting in which the patient receives care or services.

***Organization environment* refers to ACCS' office(s) and corporate vehicles.**

ACCS manages the physical and personal security of patients, staff, (including addressing the risks of violence in the workplace), and individuals coming to the organization's facilities. In addition, security of the established environment, equipment, supplies and information is also important.

- ACCS conducts proactive risk assessments that evaluate the potential adverse impact of the external environment and the services provided on the security of patients, staff, and other people coming to the organization's facilities.
- The potential for workplace violence is considered during the risk assessment.

ACCS uses the risks identified to select and implement procedures and controls to achieve the lowest potential for adverse impact on security. ACCS controls access to and egress from security-sensitive areas: ACCS' office(s) and vehicle(s).

PURPOSE

1. To provide and maintain a safe environment for ACCS employees.
2. To promote and maintain a safe environment for care to be provided to patients.
3. To promote safe work practices.
4. To identify and implement activities to reduce the risks of staff work-related injuries.
5. To prevent or minimize the incidence of patient related accidents and to decrease the potential for harm or injury.
6. To reduce and control environmental hazards or risks associated with the care or services provided to the patient.
7. To maintain equipment in good working order.

8. To appropriately store equipment, medications, nutrition therapy solutions, and supplies.

PROCEDURE

1. The following policies are part of the organizational environmental safety plan for ACCS:

- Office Fire Safety Plan
- Incident Reports
- Client Incident Reports
- Employee Incident Reports
- Employer First Report of Injury
- Office Personal Safety Policy
- Office Electrical Safety Policy
- Back Support Policy
- Unsafe Situation Policy
- Emergency Preparedness Plan
- Vehicle Use Policy
- Hazardous Communication Program/MSDS
- Environmental Services Survey
- See also Infection Control Program

2. The following policies are part of the patient environment safety plan for ACCS:

- Home Fire Safety Policy
- Home Electrical Safety Policy
- Home Bathroom Safety Policy
- Medication Safety Policy
- Environmental and Mobility Safety Policy
- Protocol on Infectious Waste Management / Infection Control and Patient Safety in the home.
- Medical Device Reporting Policy
- Initial Patient Assessment Policy and Forms
- See Also Infection Control Program

3. This plan is shared with employees during initial orientation and annually during the safety review.

Hand Hygiene Recommendations

POLICY

ACCS will adopt the categories and recommendations of the Centers for Disease Control (CDC) for hand hygiene for personnel in healthcare settings.

PURPOSE

To improve hand-hygiene practices of healthcare workers and to reduce transmission of pathogenic microorganisms to patients and personnel in the healthcare settings.

CATEGORIES

As in previous CDC guidelines, each recommendation is categorized on the basis of existing scientific data, theoretical rationale, applicability, and economic impact. The system for categorizing recommendations by the CDC is as follows:

- **Category IA.** *Strongly recommended for implementation and supported by well-designed experimental, clinical, or epidemiologic studies.*
- **Category IB.** *Strongly recommended for implementation and supported by certain experimental, clinical, or epidemiologic studies and a strong theoretical rationale.*
- **Category IC.** *Required for implementation, as mandated by federal or state regulation or standard.*
- **Category II.** *Suggested for implementation and supported by suggestive clinical and epidemiologic studies or a theoretical rationale.*
- **No recommendation.** *Unresolved issue. Practices for which insufficient evidence or no consensus regarding efficacy exist.*
-

RECOMMENDATIONS

1. Indications for handwashing and hand antisepsis
 - A. When hands are visibly dirty or contaminated with proteinaceous material or are visibly soiled with blood or other body fluids, wash hands with either a non-antimicrobial soap and water or an antimicrobial soap and water. (**Category IA**)
 - B. If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands or wash hands with an antimicrobial soap and water. (**Category IB**)
 - C. Decontaminate hands before having direct patient contact (**Category IB**)
 - D. Decontaminate hands before donning sterile gloves when inserting a central intravascular device (**Category IB**)
 - E. Decontaminate hands before inserting indwelling urinary catheters, peripheral vascular catheters, or other invasive devices that do not require a surgical procedure. (**Category IB**)

- F. Decontaminate hands after contact with a patient’s intact skin (e.g. Taking a pulse or blood pressure, and lifting a patient) **(Category 1B)**
 - G. Decontaminate hands after contact with body fluids or excretions, mucous membranes, non-intact skin, and wound dressings if hands are not visibly soiled. **(Category 1A)**
 - H. Decontaminate hands if moving from a contaminated-body site to a clean-body site during patient care. **(Category II)**
 - I. Decontaminate hands after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. **(Category II)**
 - J. Decontaminate hands after removing gloves. **(Category 1B)**
 - K. Before eating and after using the restroom, wash hands with a non-antimicrobial soap and water or with an antimicrobial soap and water. **(Category 1B)**
 - L. Antimicrobial-impregnated wipes (i.e. towelettes) may be considered as an alternative to washing hands with non-antimicrobial soap and water. Because they are not as effective as alcohol-based hand rubs or washing hands with antimicrobial soap and water for reducing bacterial counts on the hands of health care workers (HCWs), they are not a substitute for using an alcohol-based hand rub or antimicrobial soap. **(Category 1B)**
 - M. Wash hands with non-antimicrobial soap and water or antimicrobial soap and water if exposure to *Bacillus anthracis* is suspected or proven. The physical action of washing and rinsing hands under such circumstances is recommended because alcohols, chlorhexidine, iodophors, and other antiseptic agents have poor activity against spores **(Category II)**
 - N. No recommendations can be made regarding the routine use of nonalcohol-based hand rubs for hand hygiene in health care settings. **(Unresolved issue)**
2. Hand-Hygiene Techniques
- A. When decontaminating hands with an alcohol-based hand rub, apply product to palm of one hand and rub hands together, covering all surfaces of hands and fingers, until hands are dry. **(Category 1B)** Follow the manufacturer’s directions regarding the volume of product to use.
 - B. When washing hands with soap and water, wet hands first with water, apply an amount of product recommended by the manufacturer to hands, rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse hands with water and dry thoroughly with a disposable towel. Use towel to turn off the faucet. **(Category 1B)** Avoid using hot water, because repeated exposures to hot water may increase risk of dermatitis.
 - C. Liquid, bar, leaflet or powdered forms of plain soap are acceptable when washing hands with a non-antimicrobial soap and water. When bar soap is used, bar racks that facilitate drainage and small bars of soap should be used. **(Category II)**
 - D. Multiple-use cloth towels of the hanging or roll type are not recommended for use in health care settings. **(Category II)**
3. Surgical Hand Antisepsis
- A. Remove rings, watches and bracelets before beginning the surgical hand scrub. **(Category II)**
 - B. Remove debris from underneath fingernails using a nail cleaner under running water. **(Category II)**
 - C. Surgical hand antisepsis using either an antimicrobial soap or an alcohol-based hand rub with persistent activity is recommended before donning sterile gloves when performing surgical procedures. **(Category 1B)**
 - D. When performing surgical hand antisepsis using an antimicrobial soap, scrub hands and forearms for the length of time recommended by the manufacturer, usually 2-6 minutes. Long scrub times, i.e. for 10 minutes, is not necessary. **(Category 1B)**
 - E. When using an alcohol-based surgical hand-scrub product with persistent activity, follow the manufacturer’s instructions. Before applying the alcohol solution, pre-wash hands and forearms completely. After application of the alcohol-based product as recommended, allow hands and forearms to dry thoroughly before donning sterile gloves. **(Category 1B)**
4. Selection of Hand-Hygiene Agents
- A. When selecting non-antimicrobial soaps, antimicrobial soaps, or alcohol-based hand rubs, solicit information from manufacturers regarding any known interactions between products used to clean hands, skin care products, and the types of gloves used in the institution. **(Category II)**
 - B. Before making purchasing decisions, evaluate the dispenser systems of various product manufacturers or distributors to ensure that dispensers function adequately and deliver an appropriate volume of product. **(Category II)**
 - C. Do not add soap to a partially empty soap dispenser. This practice of topping off dispensers can lead to bacterial contamination of soap. **(Category 1A)**
5. Skin Care
- A. Encourage HCWs to use hand lotions or creams to minimize the occurrence of irritant contact dermatitis associated with hand antisepsis or handwashing. **(Category 1A)**
6. Other Aspects of Hand-Hygiene
- A. Do not wear artificial fingernails or extenders when having direct contacts with patients at high-risk. **(Category 1A)**
 - B. Keep natural nail tips less than ¼ inch long. **(Category II)**

- C. Wear gloves when contact with blood or other potentially infectious materials, mucous membranes, and non-intact skin could occur. (*Category 1C*)
 - D. Remove gloves after caring for a patient. Do not wear the same pair of gloves for the care of more than one patient, and do not wash gloves between uses with different patients. (*Category 1B*)
 - E. Change gloves during patient care if moving from a contaminated body site to a clean body site. (*Category 2*)
 - F. No recommendation can be made regarding rings in health care settings. *Unresolved issue*)
7. Health Care Worker Educational and Motivational Programs
- A. As part of an over-all program to improve hand-hygiene practices of HCWs, educate personnel regarding the types of patient care activities that can result in hand contamination and the advantages and disadvantages of various methods used to clean their hands. (*Category 2*)
 - B. Monitor HCWs adherence with recommended hand-hygiene practices and provide personnel with information regarding their performance. (*Category 1A*)
 - C. Encourage patients and their families to remind HCWs to decontaminate their hands. (*Category 2*)
8. Administrative Measures
- A. Make improved hand-hygiene adherence an institutional priority and provide appropriate administrative support and financial resources. (*Category 1B*)
 - B. Implement a multidisciplinary program designed to improve adherence of health personnel to recommended hand-hygiene practices. (*Category 1B*)
 - C. Store supplies of alcohol-based hand rubs in cabinets or areas approved for flammable materials. (*Category 1C*)

Standard Precautions

Policy

Precautions to be taken with all clients shall include the use of Standard Precautions which apply to:

- a. blood
- b. all body fluids, secretions, and excretions (except sweat)
- c. non-intact skin
- d. mucous membranes

Purpose

Standard Precautions are used to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection. Standard Precautions applies to all patients regardless of their diagnosis or presumed infection status.

Procedure

Handwashing

1. Wash hands after touching blood, body fluids, secretions, excretions, and contaminated items, whether or not gloves are worn. Wash hands immediately after gloves are removed, between patient contacts, and when otherwise indicated to avoid the transfer of microorganisms to other patients or environments. It may be necessary to wash hands between tasks and procedures on the same patient to prevent cross-contamination of different body sites.
2. Use plain (non-antimicrobial) soap for routine handwashing.
3. Use an antimicrobial soap or a waterless antiseptic agent for specific circumstances (e.g., control of outbreaks to hyper-endemic infections), as defined by the infection control program.

Gloves

1. Wear gloves (clean, non-sterile gloves are adequate) when touching blood, body fluids, secretions, excretions, and contaminated items.
2. Put on clean gloves between tasks and procedures on the same patients after contact with materials that may contain a high concentration of microorganisms.
3. Remove gloves promptly after use, before touching contaminated items and environmental surfaces, and before going to another patient, and wash hands immediately to avoid transfer of microorganisms to other patient environments.

Mask, Eye Protection, Face Shield

1. Wear a mask and eye protection or face shield to protect mucous membranes of the eyes, nose, and mouth during procedures and patient-care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, or excretions.

Gown

1. Wear a gown (a clean, non-sterile gown is adequate) to protect skin and to prevent soiling of clothing during procedures and patient care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, or excretions.
2. Select a gown that is appropriate for the activity and amount of fluid likely to be encountered.
3. Remove a soiled gown as promptly as possible, and wash hands to avoid transfer of microorganisms to other patients or environments.

Patient – Care Equipment

1. Handle used patient – care equipment soiled with blood, body fluids, secretions, and excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and transfer of microorganisms to other patients and environments.
2. Ensure that reusable equipment is not used for the care of another patient until it has been cleaned and reprocessed appropriately.
3. Ensure that single use items are discarded properly.

Environmental Controls

1. Ensure that the agency has adequate procedures for the routine care, cleaning, and disinfection of environmental surfaces (i.e.: beds, equipment, other frequently touched surfaces) and ensure that these procedures are being followed.

Linen

1. Handle, transport, and process linen soiled with blood, body fluids, secretions, and excretions in a manner that prevents skin and mucous membrane exposure and contamination of clothing, and that avoids transfer of microorganisms to other patients and environments.

Occupational Health and Blood Borne Pathogens

1. Take care to prevent injuries when using needles, scalpels, and other sharp instruments or devices; when handling sharp instruments after procedures; when cleaning used instruments; and when disposing of used needles.
2. Never recap used needles, or otherwise manipulate them using both hands, or use any other technique that involves directing the point of a needle toward any part of the body.
3. Use either a one-handed “scoop” technique or a mechanical device designed for holding the needle sheath.
4. Do not remove used needles from disposable syringes by hand, and do not bend, break, or otherwise manipulate needles by hand.
5. Place used disposable syringes and needles, scalpel blades, and other sharp items in appropriate puncture resistant containers, which are located as close as practical to the area in which the items were used, and place reusable syringes and needles in a puncture resistant container for transport to the reprocessing area.
6. Use mouthpieces, resuscitation bags, or other ventilation devices as an alternative to mouth-to-mouth resuscitation methods in areas where the need for resuscitation is predictable.

Patient Placement

1. In a facility, place a patient who contaminates the environment or who does not (or cannot be expected to) assist in maintaining appropriate hygiene or environmental control in a private room. If a private room is not available, consult with infection control professionals or pursue other alternatives.

Transmission Based Precautions

POLICY

American Critical Care Services will use Transmission Based Precautions in addition to Standard Precautions for all patients when appropriate.

PURPOSE

Precautions to be taken for patients documented or suspected to be infected with highly transmissible or epidemiologically important pathogens for which additional precautions beyond Standard Precautions are needed to interrupt transmission.

PROCEDURE

The following are three types of Transmission Based Precautions which may be combined for diseases that have multiple routes of transmission.

Airborne Precautions

1. In addition to Standard Precautions, use Airborne Precautions, or the equivalent, for patients known or suspected to be infected with microorganisms transmitted by airborne droplet nuclei (small particle residue [5 um or smaller in size] of evaporated droplets containing microorganisms that remain suspended in the air and that can be dispersed widely by air currents within a room or over a long distance).
2. **Patient Placement** – Placement in a private room is needed in hospitals with monitored negative pressure.
3. **Respiratory Protection** – Wear respiratory protection when entering the room of a patient with known or suspected infectious pulmonary tuberculosis. Susceptible persons should not enter the room of patients known or suspected to have measles (rubeola) or varicella (chickenpox) if other immune caregivers are available. If susceptible persons must enter the room of a patient known or suspected to have measles or varicella, they should wear a mask. Persons immune to measles or varicella need not wear respiratory protection.
4. Place surgical mask on patient if transport or movement of patient is necessary to minimize patient dispersal of droplet nuclei.

Droplet Precautions

1. In addition to Standard Precautions, use Droplet Precautions, or the equivalent, for a patient known or suspected to be infected with microorganisms transmitted by droplets (large particle droplets [larger than 5 mm in size] that can be generated by the patient during coughing, sneezing, talking, or the performance of procedures).

2. Private room is needed for a patient in the facility or if not available assign to room with patient who has the same active microorganism but with no other infection. When w\either option is not available, maintain spatial separation of at least 3 feet between the infected patient and other patients and visitors.
3. **Mask** – In addition to standard precautions, wear a mask when working within 3 feet of the patient.
4. **Patient Transport** – Limit movement and transport of the patient from the room to essential purposes only. Minimize patient dispersal of droplets by masking the patient when transporting or moving if possible.

Contact Precautions

1. In addition to the Standard Precautions, use Contact Precautions, or the equivalent, for specified patients known or suspected to be infected colonized with epidemiologically important microorganisms that can be transmitted by direct contact with the patient (hand or skin-to-skin contact that occurs when performing patient care activities that require touching the patient’s dry skin) or indirect contact (touching) with environmental surfaces or patient care items in the patient’s environment.
2. **Patient Placement** – Private room is needed for the patient in the facility. If private room is not available, place patient in the room with a patient who has active infection with the same microorganism but with no other infection.
3. **Gloves and Handwashing** – In addition to wearing gloves as outlined under Standard Precautions, wear gloves (clean, non-sterile gloves are adequate) when entering the room. During the course of providing care for the patient, change gloves after having contact with infective material that may contain high concentrations of microorganisms (fecal material and wound drainage). Remove gloves after caring for the patient and wash hands immediately with an antimicrobial agent or a wireless antiseptic agent. After glove removal and handwashing, ensure that hands do not touch potentially contaminated environmental surfaces or items in the patient’s room to avoid transfer of microorganisms to other individuals.
4. **Gown** – In addition to wearing a gown as outlined under Standard Precautions, wear a gown (a clean, non-sterile gown is adequate) when caring for the patient if you anticipate that your clothing will have substantial contact with the patient, environmental surfaces, or item’s in the patients room, or if the patient is incontinent or has diarrhea, an ileostomy, a colostomy, or wound drainage not contained by a dressing. Remove the gown after caring for the patient and ensure that clothing does not contact potentially contaminated environmental surfaces to avoid transfer of microorganisms to others.
5. **Patient Transport** – Limit the movement and transport of the patient from their room to essential purposes. Patients transported out of their environments should ensure precautions are maintained to minimize the risk of transmission.
6. **Patient Care Equipment** – Dedicate the use of noncritical patient care equipment to a single patient. If use of common equipment or items is unavoidable, then adequately clean and disinfect them before use for another patient.

Equipment Disinfection

POLICY

Disinfection in the home and/or equipment will be performed to provide a safe environment for care

PURPOSE

To prevent the transmission and/or spread of infectious pathogens in the home setting.

PROCEDURE

1. Non-critical items include crutches, bed board, blood pressure cuffs, back supports and a variety of medical accessories. Once non-critical items are thoroughly cleaned, they may be reused. Cleaning is usually done with a detergent and running water (tap water is acceptable). Non-critical items (those that do not ordinarily touch the patient or touch only intact skin) can be cleaned with detergent.
2. Semi-critical items require a higher level of disinfection. Semi-critical items are those that come in contact with intact mucous membranes and are reused only on the same patient. Examples of such items used in the home care setting include tracheostomy tubes and reusable thermometers. The following disinfectants are recommended for use in the home: bleach, white vinegar, hydrogen peroxide, boiling water, phenolics, and isopropyl alcohol. The type of disinfection method to be used will depend on a number of factors, but particularly on the item to be disinfected. Bleach can corrode metal objects and boiling may damage some objects that are not thermostable. Bleach, 70% alcohol and 3% hydrogen peroxide are excellent disinfection methods.
3. Outdated supplies must be discarded - it is the nurse’s responsibilities to check expiration date prior to using supplies.
4. Cleanliness and/or sterility of supplies must be maintained during storage and delivery of supplies.
5. Disinfection
 - a. All objects to be disinfected should first be thoroughly cleaned to remove all soil and organic material.
 - b. Reusable objects that touch mucous membranes, for example, tracheostomy tubes, suction catheters and glass thermometers should be limited to use on one patient.
 - c. When disinfection of reusable objects is indicated, one of the following methods can be used: bleach (a 1:10 dilution of bleach solution, boiling water, ethyl or isopropyl alcohol (70%) or hydrogen peroxide (3%). The object should be disinfected for at least three minutes.
 - d. A 1:10 bleach solution will be maintained in all homes of known HIV infected clients.

Transport of Specimens

POLICY

Specimens of blood or other potentially infectious materials shall be placed in a container which prevents leakage during collection, handling, processing, storage, transport, or shipping. The container must be closed before being stored, transported, or shipped.

PURPOSE

Specimens are properly contained and labeled in order to eliminate or minimize the possibility or inadvertent employee contact with blood or other potentially infectious materials.

PROCEDURE

1. The container for storage, transport, or shipping shall be affixed with a biohazard label or red-bagged, then closed prior to being stored, transported or shipped.
2. If outside contamination of the primary container occurs, or if the specimen could puncture the primary container, the primary container shall be placed within a secondary container which prevents leakage and/or resist puncture during handling, processing, storage, transport, or shipping.
3. The container will be utilized from the point of collection until the specimen is delivered to the laboratory.

Protective Equipment Policy

POLICY

Protective equipment will be utilized by health care professionals or patients as necessary based on their potential risk to infection.

PROCEDURE

1. Goggles and masks, or surgical mask with face shield, will be worn by employees to protect eye/nose/mouth mucosa during procedures/activities likely to generate splashes/sprays of blood, body fluids, secretions and excretions.
2. Gloves shall be worn when touching blood, body fluids, secretions, excretions, contaminated items, mucous membranes and non-intact skin.
3. Gowns shall be worn to protect skin and clothing during procedures/activities likely to generate splashes/sprays of blood, body fluids, secretions and excretions.
4. Clients with compromised immunity may require masks, gloves, and/or gowns if potential exposure to infection is anticipated. (AIDS patients, leukemia patients, etc.)
5. Employees/patient caretakers involved in care of patient shall be advised of any precautions to be taken in preventing infection transmission.

Sharps Management Policy

PURPOSE

To outline the procedure for the management of sharps and the protocol to be followed when a needle stick occurs.

SUPPORTIVE DATA

1. Nurses will understand sharps management and the protocol to be followed when a needle stick occurs.
2. Recapping a needle greatly increases the chance of a needle stick.
3. The use of an easily accessible, impermeable container for immediate needle disposal decreased the incidence of needle stick.

PROCEDURE

1. A sharps container is to be carried by all nurses who draw blood in the home.
2. A sharps container must be issued upon the first visit to all patients in the home health setting. Sharp containers will be located at the patient bedside in each client's home.
3. The sharps container must be closable, puncture resistant, labeled with biohazard label and leak-proof on the sides and bottom, and maintained in an upright position throughout use. Containers that are full must be promptly disposed of (or emptied and decontaminated in the case of reusable sharps) and replaced.
4. Contaminated disposable sharps shall be discarded as soon as possible after use, in the disposable sharps containers. As soon as possible after use, reusable contaminated sharps are to be placed in a reusable sharps container until properly processed.
5. The home health nurse will teach the patient/family the proper use of the sharps container:
 - a. Contaminated needles and other sharps shall not be bent, recapped or removed. Shearing or breaking of contaminated needles is prohibited. No one-hand technique will be permitted.
 - b. The sharps container must remain in the home until it is full.
 - c. The sharps container is to be used for needles only, not trash.
 - d. The lid on the sharps container is to be kept closed (not locked) and out of children's reach when not being used.
 - e. The nurse will remove the sharps container from the home after it is full or when therapy is completed, and it will be placed in a red bag.
6. The nurse will return the used sharps container to the agency office and place it in a specified trash container specifically designated for items requiring disposal (incineration). The waste management company will remove the sharps container from the premises.
7. The nurse will follow the guidelines entitled: Post-exposure: Evaluation and follow up.

CLINICAL EXPECTATIONS

1. Follow the guidelines for post exposure follow up. This guideline is found in the ACCS Blood Borne Pathogen Exposure control Plan/
2. Complete an incident report/investigation within 12 hours of the occurrence and deliver it to the Director of Human Resources.
3. It is to include:
Whether or not employee has been vaccinated with Hepatitis B vaccine, HBsAg (surface Antigen) and HIV screen should be done on the patient.
Details of the incident
Information about the patient including name, telephone, number, physician and HbsAg and HIV status if known

Infectious Waste

POLICY

Infectious waste will be disposed of in a manner that is in accordance with OSHA requirements.

PURPOSE

To prevent the transmission and/or spread of infectious pathogens.

PROCEDURE

1. Definition:
Infectious waste is waste that may cause disease or can be suspected of harboring pathogenic organisms including, but not limited to: contaminated bandages, pathological specimens, syringes and needles, contaminated clothing, surgical gloves and biological waste which includes disposable medical supplies.
2. The nurses employed by American Critical Care Services should instruct the family in the proper method of disposal of infectious waste:
 - a. Infectious waste must be separated from other waste material.
 - b. Infectious waste should be placed in bags that are water-resistant and strong enough to resist tearing, ripping, or bursting under normal handling conditions.
 - c. The infectious waste bags must be secured to prevent leakage during storage, handling or transport. They must not be overfilled, (Double-bagging is recommended).
 - d. Sharps and syringes must be placed directly into puncture-resistant and leak-proof containers. When the sharps container is filled, lids and openings must be secured.
 - e. "Biohazard" labels must be affixed to containers/bags unless bags are red.
 - f. Arrangements will be made with durable medical equipment company (DME), IV Therapy or private waste management firm to pick up used supplies as the patients need dictates.
 - g. Liquid waste can be poured down the drain or commode into the public sewage system with the exception of chemotherapy drugs.
 - h. Supervisors will review infectious waste protocol with clients when opening case and document on initial client assessment form.
 - I. Infectious waste transported from the client home and brought to the ACCS office for removal by a waste management firm, on an as needed basis, will be maintained in a locked closet (key maintained by ACCS management) appropriately labeled as a biohazard. This area is inaccessible to the general public

Protocol on Infectious Waste Management/Infection Control and Patient Safety in the Home

American Critical Care Services endeavors to protect all of its patients, caregivers and others from pathogenic organisms generated by infectious waste and from potential safety hazards encountered in the home. Therefore, the following Protocol for Waste Management/Infection Control and Patient Safety in the Home should be followed:

- A. Infectious Waste is any waste capable of causing disease. Infectious waste includes contaminated bandages, pathological specimens, syringes and needles, contaminated clothing, surgical gloves and biological waste that includes disposable medical supplies.
 1. Infectious waste should be separated from other waste.
 2. Infectious waste should be contained in bags that are water resistant and have strength sufficient to resist ripping, tearing, or bursting when handled under normal conditions. (Double bagging is recommended).
 3. The bags must be secured to prevent leakage during storage, handling and transport.
 4. Sharps and syringes should be placed directly into closed, puncture resistant and leak-proof containers. When filled, lids and openings must be secured, then placed in double bags with other biohazards materials.
 5. Biohazard labels must be affixed to containers/bags unless the containers and/or bags are red.
 6. The Durable Medical Equipment Company or a private waste company should be utilized to pick up used supplies on a regular basis.
 7. Liquid wastes can be poured down the drain or commode to the public sewage system with the exception of chemotherapy drugs.

8. If patient has been diagnosed with AIDS, it is recommended that a private waste company be utilized for disposal of wastes.
9. If a patient is receiving chemotherapy at home, a spill kit will be obtained from the pharmacy providing medications to be used in the event of a chemical spill.

B. Infection Control Measures:

1. The use of standard precautions for the handling of blood, all body fluids, secretions and excretions (except sweat), whether or not they contain visible blood, non-intact skin; and mucous membranes should be used to reduce the risk of exposure. Compliance with standard precautions includes:

- a. **Gloves:** Use when coming in contact with blood, body fluids, secretions, excretions, contaminated items, mucous membranes, and non-intact skin. Wash hands well after removing your gloves.
- b. **Masks and protective eyewear:** To protect eye/nose/mouth mucosa during procedures/activities likely to generate splashes/sprays of blood, body fluids, secretions and excretions.
- c. **Gowns:** To protect skin and clothing during procedures/activities likely to generate splashes/sprays of blood, body fluids, secretions and excretions.

2. Handwashing decreases the number of infectious pathogens which will decrease the spread of disease. Family/caregivers should wash hands before patient contact, when touching blood, body fluids, secretions, excretions, contaminated items, immediately after glove removal and between patients. Antibacterial soap with water and paper towels should be used when washing your hands. If running water is not available hands can be washed with an antiseptic foam and rinse. If this type of alternative is used, family/caregivers should wash their hands with soap and running water as soon as feasible thereafter.

3. Certain clinical procedures require the nurse to use sterile techniques (i.e. sterile dry dressing changes, wound care). This prevents and controls the spread of infection. When appropriate, your nurse will teach you and your caregivers how to correctly use sterile technique when carrying out certain procedures (i.e. wound care, sterile dry dressing changes).

4. Potential signs and symptoms of infection that you should report to your nurse include the following:

- a. **Changes in the skin:**
 - redness or rash,
 - heat,
 - swelling,
 - weeping or drainage
- b. Green or yellow drainage from a wound
- c. Increased temperature
- d. Sore throat
- e. Cough or change in sputum amount or color
- f. Fever, chills, or sweating
- g. Nausea, vomiting, diarrhea
- h. Burning or painful urination
- i. Tenderness or pain to a body part
- j. Stiff neck or headache
- k. Rapid pulse

5. An environment that is safe for everyone requires utilizing good housekeeping practices. Some housekeeping guidelines include the following:

- a. Use a diluted bleach solution (1 tablespoon of bleach to each cup of water) to clean floors, sinks, commodes, etc. Pour the dirty mop water in the toilet.
- b. Clean and remove soil on a routine basis. Keep patient areas free of clutter and used supplies.
- c. Use disposable gloves when handling soiled linen. Machine wash linens and other patient laundry in hot, soapy water, and if appropriate add a cup of household bleach.
- d. Dispose of all used patient supplies according to the guidelines your nurse has reviewed with you.

C. Accidents occur in people of all ages and are especially more common and serious for the older adult. Preventive measures may help protect the patient and his family from accidental injury.

1. **Fire Response**

- a. Identify a fire escape plan for your family. Review with all members of the family and practice drills. Make sure fire exits are free of clutter.
- b. Install smoke detectors (including a battery-operated smoke detector) and check them on a regular basis.
- c. Keep a multi-purpose fire extinguisher handy. Ensure the extinguisher stays charged.
- d. Keep all emergency numbers (i.e. fire department, 911, rescue squad) in a central location to provide for easy access.
- e. To prevent fires and burns:
 - Don't smoke in bed or when sleepy
 - Don't smoke around any oxygen sources
 - Keep the hot water heater set at 120 F or lower

Have your home checked when there are signs of wiring problems. Limit use of electrical extensions

- When cooking, keep pot handles turned away from front of stove, use back burners if possible.

2. Electrical Safety
 - a. Have your home checked when there are any signs of wiring problems.
 - b. Use space heaters according to the manufacturer's instructions.
 - c. Use extension cords and octopus plugs according to manufacturer's instructions. Do not overload.
 - d. Avoid liquid exposure to any medical equipment being used for patient care.
 - e. You will be instructed by the DME company and your ACCS nurse on how to utilize back-up battery systems in the home for equipment (i.e. ventilators), in the event of an electrical failure. The DME company will be contacted to replace any malfunctioning equipment as soon as possible.
3. Environmental and Mobility Safety
 - a. Remove throw rugs for patient using such devices as walker or cane.
 - b. Tack down carpet edges.
 - c. Use non-skid tape on backing of throw rugs.
 - d. When climbing stairs make sure the handrail is easy to grasp and solid.
 - e. Have proper lighting around all stairways especially for the top and bottom stairs.
 - f. Make sure there is a clear walkway through every room.
 - g. Keep all loose objects picked up and out of the way.
 - h. Wipe up any spills immediately.
 - i. Do not walk on a freshly washed or waxed floor. Wait until it is dry.
 - j. When carrying objects make sure your view is not blocked.
 - k. Avoid wearing socks, slippers or smooth solid shoes on an uncarpeted floor.
 - l. Seek help when lifting heavy objects. Always use good body mechanics when lifting objects. Bend with your knees and not with your back. Ask your nurse for any instruction you may need for performing safe transfers.
4. Bathroom Safety
 - a. Use non-skid mats in the bathroom.
 - b. Use treads or slip resistant mat in the tub or shower to prevent slipping when wet.
 - c. Use grab bars while taking a tub bath or shower to prevent falls.
 - c. Do not use electrical equipment around water or while bathing to prevent electrical shock.
5. Medication Safety
 - a. Talk with your physician, pharmacist and nurse about any questions you may have about the medications that have been prescribed for you. Keep a current list of all your medications to show your pharmacist or physician to prevent any harmful combination of drugs.
 - b. Do not mix medications with alcohol. Drinking alcohol with medications is dangerous.
 - c. Always keep medications in their original containers. Read the label and follow your physician's orders regarding any medicine you take. Always take your medication at the time indicated. Your nurse will review with you actions to take when doses are missed, prescription refill information, disposal of unused or expired medications and storage of medicines.
 - d. Always turn on a light when taking any drug so that you can read the label.
 - e. Keep all medicines away from children, out of sight and out of reach.
 - The ACCS nurse will assess the patient's knowledge of medications that have been prescribed.
 - The ACCS staff member will make the following recommendations regarding medication safety:
 - a. Talk with your physician, pharmacist and nurse re: any questions you have regarding medications you are taking.
 - b. Keep a current list of medications to show your physician or pharmacist to prevent any harmful combination of drugs.
 - c. Do not mix alcohol with medication.
 - d. Always keep medications in their original containers.
 - e. Read the label and follow your physician's orders regarding any medication.
 - f. Always take medications at the time indicated. Do not skip doses.
 - g. Medication will not be stored with any hazardous chemicals (i.e. household cleaning liquids or equipment sterilization chemicals)
3. ACCS nurse will review with the patient/caregiver actions to take when doses are missed, prescription refill information, properly dispose of unused or expired medications and storage of medications.
4. ACCS nurse will instruct patient to keep all medications away from children, out of sight and out of reach.

Communicable Diseases Reporting Policy

POLICY

Any known or suspected case of a reportable disease in an ACCS caregiver, client, and/or a client's family member is reported to the appropriate public health official as mandated by Virginia State Law. The Home Health Division of American Critical Care Services will initiate an Infection Report/Pathogen Identification at the time of exposure and will maintain an Infection Control Log.

PURPOSE

To comply with state regulations for reporting communicable diseases, maintain accurate infectious disease records and follow up reports that would reduce the potential spread of infection.

PROCEDURE

1. When the caregiver, client and/or a client's family member is diagnosed with a reportable infection, a verbal report is made to the appropriate health care official. If requested by public health officials, written report will follow.
2. American Critical Care Services requires that an Infection Report/Pathogen Identification be completed and returned to the Director of Home Health.
3. All reportable infectious diseases according to the Virginia Department of Health: (786-6261)
Acquired Immuneodeficiency Syndrome (AIDS) Malaria
Amebiasis MEASLES, RUBEOLA
ANTHRAX MENINGOCOCCAL INFECTION
Arboviral infection Mumps
Aseptic meningitis Nosocomial outbreak
Bacterial meningitis Occupational illness
BOTULISM Ophthalmia neonatorum
Brucellosis Pertussis (Whooping Cough)
Campylobacter infection Phenylketonuria (PKU)
Chancroid PLAGUE
Chickenpox POLIOMYELITIS
Chlamydia trachomatis infection PSITTACOSIS
Congenital rubella syndrome Q fever
DIPHTHERIA Rabies in animals ¹
Encephalitis - primary and post-infections RABIES IN MAN
FOODBORNE OUTBREAK Rabies treatment post exposure
Giardiasis Reye syndrome
Gonorrhea Rocky Mountain spotted fever
Granuloma inguinale Rubella (German measles)
Haemophilus influenza infection, invasive Salmonellosis
Hepatitis A Shigellosis
 B SMALLPOX
 Non-A, Non-B Syphilis, all stages PRIMARY AND SECONDARY
 Unspecified Tetanus
Histoplasmosis Toxic shock syndrome
Human immunodeficiency virus (HIV) infection Toxic substance related illness
Influenza Trichinosis
Kawasaki syndrome TUBERCULOSIS
Lead-elevate levels in children (1993) Tularemia
Legionellosis Typhoid fever
Leprosy (Hansen's disease) Typhus, flea borne
Leptospirosis Vibrio infection, including cholera
Listeriosis WATER BORNE OUTBREAK
Lyme disease YELLOW FEVER
Lymphogranuloma veneteum

HOME FIRE SAFETY PLAN

POLICY

ACCS staff will discuss fire response and fire hazards in the home with the client and/or caregivers.

PURPOSE

To decrease/minimize the presence of fire hazards in the home.

To assist clients/caregivers in effectively responding to fire emergencies.

PROCEDURE

1. During the initial visit to patient home, ACCS staff will identify potential fire hazards in the home.
2. The ACCS staff member will:
 - a. Identify and review with the patient an escape plan to be implemented in the event of a fire.
 - b. Identify smoke detectors present in the home. If there are none, he/she will recommend that the client install them and check them on a regular basis.
 - c. Identify fire extinguishers in the home. If none are present, recommend that the family get a multi-purpose fire extinguisher.
 - d. Recommend that the patient keep all emergency numbers (i.e. fire department, 911, rescue squad) in a central location to provide for easy access.
 - e. Notify the fire department of disabled persons in the environment.
3. The ACCS staff member will review the following recommendations with the client/caregiver to prevent fires and burns:
 - a. Do not smoke in bed
 - b. Do not smoke near any oxygen sources
 - c. Keep the hot water heater set at 120 F or below
 - d. Have your home checked when there are signs of wiring problems
 - e. Limit the use of extension cords
 - f. When cooking, keep pot handles away from the front of the stove

Office Fire Safety Plan

Policy: ACCS maintains a fire safety plan which fosters the safety and well-being of office staff in the event of a fire.

Purpose: The safety and well-being of ACCS office staff is a major concern of management.

Procedure:

1. In the event of a fire, employees are to exit the building via the nearest exit and meet at the dumpster in the parking lot.
2. Before exiting the office, the Director of Human Resources will check the Education room for evacuation of applicants and/or orientees.
3. Call 911.
4. Take a head count.
5. Report any information about the fire to the first emergency vehicle responding.
6. Fire extinguisher is located in the kitchen.
7. All new office staff are to be oriented to the physical layout of the office and shown all exits and location of the fire extinguisher.
8. Hallways and exit routes are clearly marked and free of clutter.
9. Employees with keys to the office:
 - A. Employee opening the office in the morning is responsible for removing the dead bolt locks from all exit doors and assuring that exits are unobstructed.
10. The ACCS Ruthers Road office has three smoke detectors on contract with ADT (security alarm) which will activate and dispatch fire personnel in the event of a fire when the office is closed. ADT inspects the alarm systems annually with contract renewal.
11. ACCS management will conduct periodic impromptu fire drills to assure staff's knowledge of this policy and fire safety.
12. Fire extinguishers will be inspected and tested as recommended by the manufacturer.
13. This plan will be posted in ACCS Ruthers Road office.
14. Annually, ACCS will review fire safety plan with office and field staff.
15. Fire safety plan will be shared with new staff during orientation.
16. Keep all outside exits free of obstruction.
17. Walking paths are uncluttered.

OFFICE ELECTRICAL SAFETY POLICY

POLICY

ACCS maintains an electrical safety plan which fosters the safety and well-being of office staff.

PURPOSE

To prevent injuries to office employees related to electrical hazards.

PROCEDURE

1. All office electrical equipment will be used according to the manufacturer's recommendations.
2. Extension cords will not be used.
3. All electrical office equipment will be turned off when the office is closed (i.e. typewriters, coffee pot, copy machines, radios, lamps, lights).
4. The main hallway lights will remain on when the office is closed to allow for adequate lighting upon entering the office.

5. Light bulbs in overhead lights that have burned out or are not working properly will be reported to management immediately for replacement or repair.
6. Any equipment with frayed cords will be turned off and unplugged. Management will be notified immediately, and equipment will not be used until repairs are made.
7. Octopus plugs and adapters will not be used.
8. In the event of a power failure, Dominion Virginia Power will be contacted to report the failure and assess the amount of time required for power to be restored.
9. The phone system is equipped with a battery backup that is estimated to last approximately 2 hours. In the event that telephone service is interrupted, Comcast will be contacted for repair.
10. Power surge bars will be used for computer equipment to prevent equipment damage from power surge.
11. The computer server is backed up daily on tape. The previous day's tape is stored offsite by the systems administrator. Old tapes are stored in the office in a fire- proof box.
12. The computer server is equipped with battery power backup in the event of a power failure. Battery power is estimated to last 2-3 hours. After this time, the server will shut down. The server is also equipped with its' own surge protector.
13. The copy machine and fax machines have individual surge protectors.

TB Review

Since 1985, the Centers for Disease Control (CDC) have reported a resurgence of Myco- bacterium tuberculosis (TB). TB is transmitted through the air, and spreads easily in overcrowded and poorly ventilated places such as homeless shelters and correctional facilities. Outbreaks of TB have become a serious concern. For years TB has been cured with anti-tubercular drugs but new strains of drug resistant TB appearing. One strain is Multiple Drug Resistant TB (MDR-TB). MDR-TB has been diagnosed in more than 40 states including Virginia.

Mycobacterium tuberculosis spreads through the air in droplets generated when a person with active TB coughs, sneezes, speaks, spits or sings. These droplet nuclei are so small that regular air currents within a building keep them airborne for hours. You become infected with TB if you inhale droplet nuclei which may establish itself in the lungs and spread throughout the body. One of the simplest ways to control the spread of the droplets is for the patients and staff to cover all coughs and sneezes with a tissue. Most people's immune systems will fight off TB after initial exposure. Immuno-suppression and frequent exposure to active TB are two factors that increases a person's chance of contracting TB.

Tuberculosis infection is not the same as active TB. Only 10 percent of those infected with TB will progress into a contagious case of active TB.

➤ **If you are infected but have not progressed to active TB:**

1. You will have no symptoms.
2. You will not be contagious.
3. You will not know you are infected unless you have a positive Mantoux skin test (PPD).
4. It may take months or years before you progress into active TB.
5. You may never develop active TB at all.
6. Chest X-Ray is normal.

➤ **If you progress into active pulmonary or laryngeal TB:**

1. Your symptoms can include a deep hacking cough for two weeks or more, fever, night sweats, weight loss, loss of appetite, anorexia, lethargy, weakness and possible chest pain.
2. You will be contagious.
3. You will have a positive PPD test.
4. Your Chest X-Ray is usually abnormal.
5. You will need to take medication.

➤ **The groups with the highest incidence of TB are the following:**

1. HIV – positive patients
2. Other immunosuppressed patients such as patients receiving chemotherapy.
3. Economically and socially depressed individuals such as the homeless, alcoholics, and drug users.
4. Foreign – born people from regions where TB is widespread.

Drug – resistant tuberculosis does not respond to the usual anti-tubercular drug therapies. MDR-TB develops when individuals stop taking their medication before the treatment is completed. This could be a result of the strict medication schedule, the outward symptoms clearing up after taking the medication for a few weeks or poor access to healthcare. Partial treatment is worse than none because the bacteria is still active and can become immune or resistant to the anti-tubular drugs. At least ten percent of new TB cases are multi-drug resistant.

Identification of Persons with TB Infection and Disease

A person exposed to an individual with infectious TB should be given a tuberculin skin test. If the skin test is positive or if symptoms suggest TB infection, a chest radiograph should be obtained to rule out active TB or to detect the presence of fibrotic lesions suggestive of old healed TB lesions.

The Mantoux tuberculin skin test is the preferred method of skin testing. The Mantoux tuberculin skin test is the intradermal injection of purified protein derivative (PPD) of killed tubercle bacilli, usually on the inner forearm. The site is examined 48 to 72 hours later for induration. The diameter if the induration is measured; erythema or bruising is disregarded.

- a. 5 or more millimeters is considered positive for the highest risk groups including persons with HIV Infections (HIV Infection is one of the strongest known risk factors associated with the progression from TB infection to active TB disease); persons who have recently had close contact with a person with infectious TB; persons who have chest radiographs consistent with old, healed TB; and injecting drug users whose HIV status is unknown.
- b. 10 or more millimeters induration is considered positive for other high risk groups including foreign born persons from high prevalence areas; low income population; residents of long term institutional settings (nursing homes, correctional facilities); persons with medical conditions that have been reported to increase the risk of TB (chronic renal failure, diabetes, leukemia, HIV); children who are in one of the high risk groups listed above or health care worker who serve any of the high risk groups.
- c. 15 or more millimeters induration is considered positive for persons with no risk factors for TB.

A negative TB skin test does not absolutely rule out TB infection for high risk groups, especially in persons with TB – like symptoms, HIV infection or AIDS. It takes (2) to (10) weeks from the time of infection for an exposed person to react to tuberculin.

Environmental Controls

Measures to reduce the recirculation of TB droplet nuclei may include:

1. Quickly isolating anyone suspected of having TB.
2. Having negative pressure isolation rooms available in the facility with exhaust vents to the outside of the facility.
 - a. Ventilation in this room must be designed to contain and filter contaminated air.
 - b. Isolation rooms must be kept under negative pressure so that air does not seep out of the room into the hallways but flows from adjacent areas into the ventilated room.
 - c. Doors should be kept closed and fit the door frame closely.
 - d. Respiratory isolation signs should be posted outside the door.
3. Ventilating general use areas (i.e.: waiting rooms, emergency rooms, radiology suites).
 - a. Air should flow from clean to less clean areas.
 - b. Air flow should be monitored regularly.
4. Procedures that induce coughing and generate airborne secretions pose a health risk and proper ventilation during the procedures is necessary.
 - a. Patients being tested for active TB with the cough inducing test should be in a treatment room under negative pressure. They should not return to the waiting rooms until the coughing subsides.
 - b. Before undergoing such procedures as bronchoscopes, all patients suspected of having TB should be screened. These procedures done on active TB patients should be performed in isolation rooms.
5. Respiratory Protection – Disposable High Efficiency Particulate Air respirators (HEPA) are recommended for use when you are in active TB patient isolation rooms, during procedures that generate airborne secretions, when caring for undiagnosed patients suspected of having active TB and during vehicle transport of contagious TB patients. Patients should wear a surgical mask during transport. Wearing a respirator will maximize your protection. If properly worn these masks are designed to filter out 1 to 5-micron sized TB droplets. Before using a respirator, training should be provided to you on how to properly fit, use and maintain your respirator.

PREVENTION OF TUBERCULOSIS

The main purpose of preventive therapy is to prevent latent infection from progressing to clinically active TB. Therefore, persons with positive tuberculin skin tests who do not have the clinically active disease should be evaluated for preventive therapy. Preventive therapy is recommended for the following persons with a positive tuberculin test regardless of age:

- a. Persons with known or suspected HIV.
- b. Close contacts of persons with infectious and active TB.
- c. Persons whose tuberculin skin test results recently converted to positive.
- d. Persons with medical conditions that have been reported to increase the risk of TB.

Preventive therapy is recommended for the following persons in high incidence groups who have a positive tuberculin test result:

- a. Foreign born person from high prevalence areas (i.e. Asia, Africa)
- b. Medically undeserved, low income populations.
- c. Residents of long-term institutions.

Preventive therapy is recommended for persons in low incidence groups who have a positive tuberculin test result, are younger than 35 years of age, and do not have any known risk factors for TB.

The usual preventive therapy regimen is isoniazid (INH) for a minimum of six continuous months for adults and 9 continuous months for children. Twelve months is recommended for HIV infection or other forms of immunosuppression. Persons with preventive therapy should be monitored monthly for drug side effects, especially signs and symptoms of hepatitis.

INFECTION CONTROL MEASURES

- The early identification of disease in a person with infectious TB is essential. TB should be suspected in all persons who have symptoms (cough, fever, night sweats, chills, fatigue, weight loss, loss of appetite), especially those with confirmed or suspected HIV and undiagnosed pulmonary disease. Precautions should be taken to prevent the airborne transmission of infection until TB is diagnosed and treated or ruled out. Effective isolation should be initiated for persons with confirmed or suspected TB to reduce

the risk that they will pose to others. Antituberculosis drug treatment should be promptly initiated for persons with active disease to render them noninfectious. Persons at high risk for TB infection should be screened and if infected, evaluated for preventive therapy.

- On going TB screening should be provided to health care workers. At the time of hire you should receive the Mantoux Skin Test (PPD) to serve as a baseline comparison. If you have previously tested positive, have had adequate treatment for the disease, or have previously recovered from TB, you are exempt from the skin test. You should still have a chest radiograph or sputum smear if symptoms appear. As long as you are PPD negative you should be tested annually. If you have an unprotected exposure, you should have a skin test done immediately. If you experience any symptoms of active TB, you should immediately report your symptoms and be promptly tested for active TB. If you are diagnosed with pulmonary or laryngeal TB, you should be restricted from work until you get treatment, your cough is resolved, and a physician certifies that you are no longer contagious.

References

1. **TB Facts for Health Care Workers, U.S. Department of Health and Human Services, 1993.**
2. **Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health Care Facilities, U.S. Department of Health and Human Services, 1994.**

Hazard Communication Program

Policy

ACCS manages its hazardous materials and wastes risks by identifying materials used that need special handling and implement processes to minimize the risks of their unsafe use and improper disposal.

ACCS' Hazardous Communication Program incorporates the following procedures to ensure compliance with applicable law and regulation from the EPA and OSHA:

- ACCS creates and maintains an inventory list that identifies hazardous materials and waste used, stored, or generated.
- ACCS establishes and implements processes for selecting, handling, storing, transporting, using and disposing of hazardous materials and waste from receipt or generation through use and/or final disposal. Please refer to the following policies:
Hazardous Chemicals and Materials Policy
Regulated Infectious Waste Policy
Chemotherapy Protocol
Sharps Management and Needle Stick Policy
- ACCS provides adequate and appropriate space and equipment for safely handling and storing hazardous materials and waste.
- ACCS identifies and implements emergency procedures that include specific precautions, procedures, and protective equipment used during hazardous materials and waste spills or exposures.
- ACCS maintains documentation, including required permits, licenses, and adherence to other regulations.
- ACCS properly labels hazardous materials and waste.
- ACCS effectively separates hazardous materials and waste storage and processing areas from other areas of the facility.
- ACCS stores and handles medical gases in the home setting consistent with applicable FDA, Department of Transportation, and OSHA laws and regulations.

I. Introduction

The OSHA Hazard Communication Standard was promulgated to ensure that all chemicals would be evaluated and test information regarding the hazards would be communicated to employers and employees. The goal of the standard is to reduce the number of chemically related occupational illnesses and injuries.

In order to comply with the Hazard Communication Standard this written program has been established for American Critical Care Services. All divisions and sections of the company are included within this program will be available (for review by an employee) in the following location(s):

- a. Chief Operations Officer's Office

Basic components of the program include:

- Hazardous Chemical Inventory List
- Material Safety Data Sheets
- Labels and Other Forms of Warning
- **Employee Information and Training**
- Non-routine Tasks
- Unlabeled Pipes (Non-applicable to ACCS)
- On-Site Contractors
- Program Review

II. Hazardous Chemical Inventory List

Definition: Hazardous materials and waste are any chemicals, materials or waste that provide hazard to your health. The intent of Hazard Communication Program is to define a process to identify and handle materials/wastes that could be potential hazard to health.

A list of all known hazardous chemicals (products) used at American Critical Care Services is contained in Appendix A of this written program.

A list of hazardous chemicals used by each department is kept with material safety data sheets (MSDS) Appendix B, in the respective departments.

III. **Hazard Determination**

All hazardous chemicals in this facility are purchased materials, there are no manufactured or intermediate hazardous chemicals. Therefore, American Critical Care Services shall rely on the hazard determination made by the chemical manufacturer as indicated on the MSDS.

IV. **Material Safety Data Sheets (MSDS)**

- Material Safety Data Sheets (MSDS) are developed by the manufacturer and include the following information:
 - a) specific chemical identity of hazardous chemical involved
 - b) physical/chemical characteristics of hazardous chemical
 - c) known acute and chronic effects and related health information
 - d) exposure limits
 - e) whether chemical is carcinogenic
 - f) precautionary measures
 - g) emergency and first aid procedures
 - h) identification of organization preparing MSDS
- When chemicals are ordered, the education/supply coordinator and receptionist shall specify on the order that chemicals are not to be shipped without corresponding material safety data sheets.
- When MSDS's arrive, they will be reviewed for completeness by the education coordinator and the individual (i.e. receptionist, personnel manager) who ordered the item. Should any MSDS be incomplete, a letter will be sent immediately to the manufacturer requesting the additional information.
- A copy file of MSDS's for all hazardous chemicals to which employees of this company may be exposed will be kept in labeled binders in the Chief Operations Officer's office.
MSDS's for hazardous chemicals used by departments will be kept in labeled binders in the office of the respective departments. MSDS's will be available for employees during each work shift. Should MSDS's be unavailable, please contact:

- Office Manager at (804) 320-1113 immediately

MSDS's will be reviewed annually by the Chief Operations Officer and Office Manager. Should there be any MSDS that has not been updated within the past year, a new MSDS will be requested.

After three documented requests for an MSDS have been unsuccessful, the problem will be reported to the nearest Virginia Occupational Safety and Health (VOHS) office.

V. **Labels and Other Forms of Warning**

- The Hazard Communication Standard requires that hazardous chemicals be labeled by manufacturers. The label must contain the following:

Chemical identity

Appropriate hazard warnings

Name and Address of the chemical manufacturer, importer, or other responsible party

- When chemicals are ordered by the ACCS corporate staff, the purchase order will indicate the need for the above stated information to be included on the labels or ACCS will refuse acceptance of the shipment.
- Upon delivery of chemicals, the Office Manager or the C.O.O. or his/her designated representative (i.e. receptionist) will ensure that chemicals are labeled properly. Any chemicals without proper labeling will not be accepted.
- When chemicals are transferred from the manufacturer's containers to secondary containers, the supervisor of each area will ensure that the containers are labeled with the identity of the chemicals and appropriate hazard warnings.

See Appendix C for an example of in-house labeling.

The entire labeling procedure will be reviewed annually by the C.O.O. and the Office Manager and changed as necessary.

VI. **Employee Information and Training**

Prior to starting work, new employees of ACCS will attend the health and safety orientation program during the initial orientation program. Either the personnel manager or education coordinator is responsible for organizing and conducting initial training.

Training will consist of one session during initial ACCS employee orientation and will be reviewed annually in conjunction with the ACCS Safety and Infection Review.

The format for the training program will consist of verbal instruction accompanied by handouts. The following topics will be covered:

An overview of the requirements of the Hazard Communication Standard

The Labeling system and how to use it

How to review MSDS's and where they are kept

Chemicals present in work operations

Physical and health effects of hazardous chemicals

Methods and observation techniques used to determine the presence or release of hazardous chemicals in the area.

Personal protective equipment and work practice to lessen or prevent exposure to chemicals

Steps the company has taken to lessen or prevent exposure to chemicals

Safety/emergency procedures to follow if exposure occurs

Location and availability of the written program

Following each annual training session, the employee is required to sign and date the training record verifying attendance.

ACCS uses the signature page from the OSHA Safety and Infection Control in-service package as verification. See Appendix D for a sample training record.

Before any new employees can begin work each requires the use of or potential exposure to hazardous chemicals, training as indicated above must be completed!

Additional training will be provided when necessary with the introduction of each new hazard. Records of this additional training will be maintained. Any reporting by employees of hazardous waste/materials will be done utilizing the incident reporting policy/procedure.

VII. Non-Routine Tasks

Hazardous non-routine tasks at ACCS have been identified as follows:

<u>Task</u>	<u>Hazardous Chemicals</u>
None	None

Prior to any employee beginning a hazardous non-routine task, he/she must report to ACCS nursing supervisor or education coordinator to determine the hazard involved and the protective equipment required.

VIII. Unlabeled Pipes *N/A for ACCS

Work activities are often performed in areas where chemicals are transferred through pipes. These pipes are not required to be labeled; however, the employee needs to be aware of potential hazards. Prior to starting work in areas having unlabeled pipes, the employee shall contact the education coordinator to determine:

- identity of the chemical in the pipes
- potential hazards
- safety precautions

* **Note:** No work activities have been identified as being performed at ACCS in which chemicals are transferred through pipes.

IX. Multi-Employer Workplaces

Often one or more ACCS employee works at a site (i.e. client home, hospitals, nursing homes, physician offices, etc.) with employees of these facilities or with employees of other employers (i.e. DME, pharmacy, etc.) When ACCS employees working at these locations are exposed to chemicals used or stored by these facilities or employers, then it is that facility's or employer's responsibility to provide ACCS employee with:

A copy of the MSDS

Information on any precautionary measures that need to be taken to protect employees; and

The chemical labeling system used.

X. Hazardous Material Incident Reporting

An incident report will be completed documenting any hazardous material spills, and/or employee injury/exposure related to hazardous material.

The OSHA 200 log listing employee injuries will be updated and forwarded to OSHA annually in March.

XI. Program Review

This written Hazard Communication Program for ACCS will be reviewed by the Chief Operations Officer and Office Manager annually and updated as necessary. Appendix E contains the review and signature form

MEDICAL DEVICE REPORTING POLICY

POLICY: American Critical Care Services will report all illnesses, adverse events, serious injuries, and deaths that may have been caused by or contributed to by a medical device according to the Food and Drug Administration's MDR regulation.

PURPOSE:

To comply with FDA's regulations for uniform reporting of adverse events related to medical devices. To assist the FDA with collecting appropriate information to protect the public from hazardous medical devices.

PROCEDURE

1. ACCS will report deaths and serious injuries to the FDA and to manufacturers under a uniform reporting system. This report will be filed whenever ACCS receives or otherwise becomes aware of information that reasonable suggests that a device "has or may have caused or contributed" to the death, serious illness, or serious injury of a patient or employee of ACCS. The definition of types of injuries to be reported includes illnesses or injuries that are life threatening, or results in permanent impairment of a body function or permanent damage to a body structure; or necessitates medical or surgical intervention to preclude permanent impairment of a body function or permanent damage to a body structure.

- Deaths will be reported within 10 working days to the FDA and the manufacturer.

- Serious injuries will be reported to the manufacturer only within 10 working days. If the manufacturer is unknown, then report injuries to the FDA.
 - Summary of deaths and injuries must be submitted to the FDA semiannually on January 1 and July 1
2. Device malfunction is not reportable under this regulation. However, the FDA recommends the user facilities report malfunctions to the manufacturer using form 3500A. (SEE MDR MANUAL)
 3. Individual reports will be submitted to FDA and manufacturers using MANDATORY MEDWATCH FORM 3500A.
 - From 3500A must include the following: patient information, description of adverse event or product problem, suspect medical device information, user facility information, and initial reporter information.
 4. Semiannual reports will be submitted using FDA FORM 3419. If no MDR reports are submitted during the reporting period, this form is not required.
 - FDA Form 3419 must contain the following:
 - HCFA provider number or number assigned by the FDA
 - Reporting year and period (Jan. - June)
 - Facility's name and complete address
 - Total number of reports attached or summarized
 - Date of the semiannual report and the lowest and highest report numbers submitted during the report period.
 - Name, position title and complete address of the individual designated as the ACCS contact person responsible for reporting to FDA and whether that person is a new contact person.
 - Information for each reportable event that occurred during the semiannual reporting period including
 - * user facility report number
 - * name and address of device manufacturer
 - * device brand name and common name
 - * product model, catalog, serial and lot number
 - * brief description of the event reported to the manufacturer and/or FDA
 - * where the report was submitted i.e. to FDA, manufacturer, distributor

In lieu of submitting a summary of each reported event, ACCS may complete part 1 of the Form 3419 and attach a copy of each mandatory report FDA Form 3500A. The copies and envelope must be clearly marked SEMIANNUAL REPORT.

5. ACCS may be contacted by phone or in writing by the FDA if additional information is required concerning the adverse events. FDA will indicate a specified time limit and will require prompt attention.
6. ACCS will designate the Director of Education to serve as the contact person and maintain all related MDR information to include copies of every report and all information sent to FDA. Additionally, ACCS will record adverse events that were evaluated but not reported to the FDA. ACCS will document the reasons why certain events were not reported.
7. All MDR information will be maintained by ACCS for 2 years.
8. Definitions included in the MDR manual: A DEVICE is defined as an instrument, apparatus, implement, machine, contrivance, implant, invitro reagent, or other similar or related article including component, part or accessory which is recognized in the official National Formulary or the US Pharmacopoeia, or any supplement to them. intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease in man or other animals, or intended to affect the structure or any function of the body of man or other animals, and which is not a drug, i.e., the product does not achieve its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of its primary intended purposes. * Examples of medical devices are hospital beds, heart valves, ventilators, bandages. GENERALLY, IF IT IS USED IN MEDICAL PRACTICE AND IT IS USED IN MEDICAL PRACTICE AND IT IS NOT A DRUG OR BIOLOGIC, IT IS A DEVICE.
9. TEMPORARY DAMAGE is reportable if it is life threatening.
10. User/Operator error should be reported--because all instances that reasonably suggest a device has or may have caused or contributed to a device related death, serious injury, or serious illness. FDA needs to be aware of events that are related to user error any time such an error has or may have caused or contributed to a reportable event.

Last Revised: 05/2004, 10/2008