San Francisco General Hospital and Trauma Center
Employee Health and Safety / Environment of Care (EOC)
Orientation Post-Test

1. The FIRST person you notify to report a safety concern or an on-the-job injury or illness is:
   a. The SFGH Safety Officer
   b. Your Supervisor
   c. The SFGH Environmental Health and Safety Officer
   d. The SFGH Occupational Health Service

2. SFGH Emergency Telephone actions do NOT include calling:
   a. 206-4911 the SFGH Sheriff's emergency phone number
   b. B-A-B-Y (206-2229) to report departmental searches after a “Code Pink” (infant/pediatric abduction)
   c. Code Blue for Medical Emergencies at 206-1122 in the SFGH Main Hospital and 911 outside of the Main Hospital (red brick buildings and Behavioral Health Center)
   d. The SF Police Bomb Squad for a bomb threat.

3. You should immediately report chemical spills of hazardous materials and utility system failures (such as floods, loss of electricity or water) to:
   a. Facilities Management / Plant Services at 206-8522
   b. The Environmental Services Department
   c. The Environmental Health and Safety Department
   d. PG&E or the San Francisco Water Department

4. R-A-C-E for immediate fire response does NOT include the following:
   a. Rescue anyone who is in immediate danger
   b. Pull the Alarm and Alert the Fire Department by calling 911
   c. Contact your supervisor
   d. Extinguish the fire or Evacuate

5. Resources for selecting, handling, storing and using hazardous materials and waste include:
   a. Contacting the Environmental Health and Safety Department
   b. Contacting your supervisor
   c. Referring to your department or unit Material Safety Data Sheet (MSDS) binder
   d. All of the above

Continued on reverse ⇒
6. Medical equipment that malfunctions should be tagged with a red equipment repair and reported to:
   a. Facilities Management / Plant Services
   b. The Environmental Services Department
   c. Biomedical Engineering
   d. The manufacturer

7. The SFGH Emergency Response Plans for fire, earthquake, bomb threat and power failure are located in the:
   a. SFGH Environment of Care Safety Manual
   b. The SFGH Policy and Procedure Manual
   c. The MSDS binder
   d. The SFGH Disaster Manual

8. Fire evacuation signs and routes are located near the:
   a. Hallways
   b. Exits and stairwells
   c. Lobby
   d. Bulletins boards

9. You are a designated disaster service worker as a Department of Public Health / SFGH and UCSF employee. If there is a level III disaster in San Francisco and you are NOT at work, you should:
   a. Call your supervisor immediately
   b. Report immediately to your hospital unit or department in person
   c. Go to the Department of Public Health at 101 Grove Street
   d. Wait for your unit or department phone tree call or if the phone lines are down, listen to radio stations KCBS (740 AM), KGO (810 AM) or KNBR (680 AM)

10. To report a piece of equipment that is NOT functioning, you must do all the following except:
    a. Pull the equipment from service
    b. Tag the equipment and provide information on what occurred
    c. Call the department that services the equipment to report the failure
    d. Deliver the equipment to the responsible department

August 2009
San Francisco General Hospital and Trauma Center
Orientation – Hunt & Find Activity

Use this list to learn where to find necessary equipment, supplies, and information for your job.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>✓ FOUND</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rooms, Equipment, and Supplies</td>
<td></td>
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<tr>
<td>Reception Desk</td>
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<td>Manager’s Office</td>
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<td>Lockers – Employees</td>
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<td>Conference Room</td>
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<td>Staff Lounge</td>
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<tr>
<td>Coat Rack</td>
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<tr>
<td>Emergency Stairwell</td>
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<tr>
<td>Addressograph Machine</td>
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<tr>
<td>Computer</td>
<td></td>
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<tr>
<td>Forms</td>
<td></td>
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<tr>
<td>Fire Alarm</td>
<td></td>
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<tr>
<td>Fire Extinguisher</td>
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<tr>
<td>Fire Exit</td>
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<tr>
<td>Emergency Numbers on Phone Stickers (find 3)</td>
<td></td>
<td></td>
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<tr>
<td>Fire</td>
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<td></td>
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<tr>
<td>Code Blue</td>
<td></td>
<td></td>
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<tr>
<td>Security</td>
<td></td>
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<tr>
<td>Bomb Threat Checklist (near phone)</td>
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<tr>
<td>Porter’s Closet</td>
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<tr>
<td>Toilet Paper</td>
<td></td>
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<tr>
<td>Ice</td>
<td></td>
<td></td>
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<tr>
<td>Flashlight</td>
<td></td>
<td></td>
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<tr>
<td>Identification Badge – Find 5 people wearing badges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unit-based Emergency Response Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rainbow Chart – Emergency &amp; Safety Response Resources – Call 206-5482 to obtain one.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Department Operational Manual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>On the CHN Intranet Site, find the following web pages: <a href="http://insidechnsf.chnsf.org/">http://insidechnsf.chnsf.org/</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrative Policy and Procedure Manual</td>
<td></td>
<td></td>
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<tr>
<td>Infection Control Manual</td>
<td></td>
<td></td>
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<tr>
<td>Environment of Care Manual</td>
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<tr>
<td>Employee Safety Information Form (see appendix of the Orientation Handbook)</td>
<td></td>
<td></td>
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<tr>
<td>Unusual Occurrence Reporting</td>
<td></td>
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<tr>
<td>Department of Education and Training web page Link to HealthStream Online Training</td>
<td></td>
<td></td>
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<tr>
<td>Patient Education Links Page + Krames On-Demand</td>
<td></td>
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<tr>
<td>Maps of the SFGH Campus</td>
<td></td>
<td></td>
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<tr>
<td>Other Manuals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Directory on CHN Intranet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ITEM</td>
<td>✔️ FOUND</td>
<td>COMMENTS</td>
</tr>
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<td>------</td>
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<td>----------</td>
</tr>
<tr>
<td>List below other key resources for your department.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Community Health Network of San Francisco

Record of Orientation
to Job-Specific Standards and Expectations

In order to comply with Joint Commission Standards on orientation, training and education of Staff, the employee and the manager, supervisor, or designated preceptor must review the following and sign below.

I, the EMPLOYEE, have reviewed and understood the following:

- Job Description, Performance Expectations, and Standards
- Performance Appraisal or Competency Assessment Process (Orientation Objectives or Skills Checklist)
- Department or Job-Specific Environment of Care Policies and Procedures
  - Safety
  - Security
  - Hazardous Materials and Waste
  - Fire response
- Department or Job-Specific Infection Control and the Employee’s role in the prevention of infection
- Department of Quality Management Activities and Roles

<table>
<thead>
<tr>
<th>Signature</th>
<th>Print Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Employee ________________________   __________________________
Manager or ______________________
Supervisor ______________________
Date ____________  Department and _________________________________
Work Mailing Address ______________________

The Manager or Supervisor must complete this form and retain a copy.

Revised 9/08
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WELCOME

As CEO of San Francisco General Hospital and Trauma Center, let me be the first to congratulate you on your new position and welcome you to our team.

SFGH boasts a rich history dating back to 1872 when the hospital was founded in response to an early tuberculosis epidemic. Since that time we have grown into one of the nation’s leading public hospitals and a premier tertiary academic medical center, home to many nationally renowned research programs.

As San Francisco’s only trauma center, we are truly a hospital for everyone. SFGH also operates the only psychiatric emergency department in the city, and provides 20 percent of the inpatient care. We are very proud of our long-standing relationship with the University of California, San Francisco and our role as a teaching hospital training doctors, nurses, pharmacists and other health care professionals.

General Hospital is a vibrant and busy place. Health care is an ever-changing field, and resources for public health services wax and wane. But there is one aspect of San Francisco General Hospital and Trauma Center that will not change: our commitment to the mission to provide quality health care and trauma services with compassion and respect. That dedication is why we’re all here and it’s what makes you and your co-workers so important to our organization.

There is a lot of excitement on the horizon as we set out to build a new seismically safe hospital right here on campus. A record number of San Franciscans (84%) voted in November 2008 to approve a bond allowing the city to finance our rebuild. The new facility, which is scheduled to open in 2015, will have many wonderful features for patients and staff, but getting there will be a loud and dusty process. We all will need to pull together during the construction phase.

This is the beginning of your SFGH career. I first came here in 1978, and have made a career in nursing. I am proud to lead an organization where patient care comes first. I look forward to working together to ensure that all our patients receive humanistic, cost-effective and culturally competent health services while maintaining a positive and rewarding environment for all staff.

Congratulations and welcome!

Sue Currin
Executive Administrator
San Francisco General Hospital & Trauma Center
Orientation Agenda

7:45 – 8:00  Registration
8:00 – 8:10  Overview of the Day – Dr. Katz video
8:10 – 8:25  Welcome from the CEO
8:25 – 8:35  Trauma Overview
8:35 – 9:45  Health and Safety – Environment of Care
9:45 – 10:00 BREAK
10:00 – 10:35 Infection Control & Bloodborne Pathogens
10:35 – 10:50 Lifting, Body Mechanics & Back Safety
10:50 – 11:20 Patient Safety, Error Reporting, & Quality Improvement
11:20 – 11:45 Zero Tolerance Policy for Patient Abuse
11:35 – 12:00 HIPAA Awareness
12:00 – 1:00 LUNCH
1:00 – 1:30  Human Resources
1:30 – 2:30  Cultural Competence & Maintaining a Safe Workplace
2:30 – 3:00  Unions
3:00 – 3:10  Documentation
3:15 – 4:30  Clinical Staff: Safety Devices Skills in 4H2
Non-clinical Staff: Hunt and Find Check List
SFGH Emergency and Safety Phone Numbers – Use the prefix 206

<table>
<thead>
<tr>
<th>Phone Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4911</td>
<td>BOMB THREAT: Call SFGH Sheriff’s Office</td>
</tr>
<tr>
<td>1122</td>
<td>CODE BLUE (Medical Emergency) Main Hospital or “M” Clinic Building</td>
</tr>
<tr>
<td>911</td>
<td>CODE PINK (Infant/Pediatric Abduction)</td>
</tr>
<tr>
<td>9-911 and “0”</td>
<td>CODE RED (Fire): For SFGH, 206- prefix</td>
</tr>
<tr>
<td>9-911</td>
<td>CODE RED (Fire): For UCSF, 476- prefix</td>
</tr>
<tr>
<td>“0”</td>
<td>OPERATOR</td>
</tr>
<tr>
<td>4911</td>
<td>SECURITY EMERGENCY</td>
</tr>
<tr>
<td>8009</td>
<td>SPILL: Blood or Body Fluid</td>
</tr>
<tr>
<td>8522</td>
<td>SPILL: Chemical</td>
</tr>
<tr>
<td>8522</td>
<td>SPILL: Hazardous Material</td>
</tr>
<tr>
<td>8726</td>
<td>Biomedical Engineering, Repair and Maintain Equipment Used For Patient Care</td>
</tr>
<tr>
<td>3756 or 4049</td>
<td>Bloodborne Pathogen Safe Device Committee</td>
</tr>
<tr>
<td>3675</td>
<td>Department of Education and Training</td>
</tr>
<tr>
<td>4000</td>
<td>Disaster Information Hotline</td>
</tr>
<tr>
<td>6581</td>
<td>Employee Health Service: For SFGH City &amp; County</td>
</tr>
<tr>
<td>5482</td>
<td>Environmental Health and Safety</td>
</tr>
<tr>
<td>8009</td>
<td>Environmental Services</td>
</tr>
<tr>
<td>8522</td>
<td>Facility Services (For Utility and Building Structure Concerns)</td>
</tr>
<tr>
<td>8522</td>
<td>Fire Marshall</td>
</tr>
<tr>
<td>3756</td>
<td>Health and Safety Committee</td>
</tr>
<tr>
<td>5466 or Pager 719-1566</td>
<td>Infection Control</td>
</tr>
<tr>
<td>8684</td>
<td>Infection Control Committee</td>
</tr>
<tr>
<td>674-7000; 972-2249 or 353-6305; 600-6600</td>
<td>Injury or Illness on the Job – Kaiser; St. Francis; CPMC</td>
</tr>
<tr>
<td>650-985-6084</td>
<td>Lift Team (Pager)</td>
</tr>
<tr>
<td>469-4411</td>
<td>Needlestick Hotline (Any Blood or Body Fluid or Substance Exposure)</td>
</tr>
<tr>
<td>1-800-876-4766</td>
<td>Poison Control Center</td>
</tr>
<tr>
<td>8063</td>
<td>Sheriff’s Deputy: Employee Escort Service / Non Emergency</td>
</tr>
<tr>
<td>4911</td>
<td>Sheriff’s Deputy: Emergency</td>
</tr>
<tr>
<td>8522</td>
<td>Utility Failure (Electrical Power Outage, Flood, Water Loss): Call Facility Services</td>
</tr>
<tr>
<td>885-7580</td>
<td>Workers’ Compensation Clinic: UCSF</td>
</tr>
</tbody>
</table>
SECTION 1:
HOSPITAL OVERVIEW
SFGH Organizational Overview

San Francisco General Hospital & Trauma Center (SFGH) is an acute care teaching hospital under the jurisdiction of the City and County of San Francisco’s Department of Public Health. SFGH is affiliated with the University of California San Francisco (UCSF).

San Francisco Health Commission

As the SFGH Governing Body, the San Francisco Health Commission is ultimately responsible for maintaining the quality of patient care. This responsibility is executed through the SFGH Joint Conference Committee, Director of Public Health (who also serves as Executive Director of the Health Commission), and is delegated to the SFGH Executive Administrator. The SFGH Executive Administrator is responsible for the hospital operations, provision of services, and all of its related facilities and programs.

Executive Committee

The SFGH Executive Committee is responsible for the ongoing operation of the hospital campus. Campus operations include the acute care, emergency, psychiatry, skilled nursing, ambulatory care, ancillary services, nursing, finance, and physician services. The Executive Administrator chairs the SFGH Executive Committee.

Medical Executive Committee

The Medical Executive Committee provides oversight for the provision of quality patient care services. The Performance Improvement and Patient Safety Committee (PIPS), which is a sub-committee of the Medical Executive Committee, is composed of senior management staff, medical staff leadership and other hospital personnel involved in quality of care activities. The PIPS Committee oversees SFGH performance improvement and patient safety activities. The Medical Executive Committee is chaired by the Chief of Staff.

Nursing Executive Committee

The Nursing Executive Committee (NEC) provides oversight for the provision of quality nursing care services. The NEC is responsible for ensuring that patients with the same nursing needs receive comparable levels of nursing care throughout the hospital. Nursing care guidelines and related policies and procedures define the practice of nursing throughout the hospital. The NEC membership is composed of nursing leadership from areas where nursing care is provided on the SFGH campus. The Chief Nursing Officer co-chairs the NEC with an elected Nurse Manager.
San Francisco Department of Public Health Mission

The mission of the San Francisco Department of Public Health is to protect and promote the health of all San Franciscans. The San Francisco Department of Public Health shall:

- Assess and research the health of the community
- Develop and enforce health policy
- Prevent disease and injury
- Educate the public and train health care providers
- Provide quality, comprehensive, culturally-proficient health services
- Ensure equal access to all.

San Francisco General Hospital & Trauma Center
Mission, Vision, Values and Goals

MISSION: To provide quality healthcare and trauma services with compassion and respect.

VISION: Rebuild sfgh so we can continue to provide healthcare and trauma services for people in need.

VALUES:

- Patient and staff safety
- Quality healthcare
- Disease prevention
- Staff retention and recruitment
- Culturally responsive care
- Efficient resource management
- Academic excellence in training and research

GOALS:

1. Promote patient safety
2. Enhance clinical care
3. Promote staff retention and recruitment
4. Maintain hospital infrastructure
5. Comply with all regulatory standards and attain specialty certifications
6. Maintain services during hospital rebuild
Organizational Ethics

SFGH will meet the health care needs of patients and their families by:

- Being sensitive to and respectful of the ethnic, cultural, and the lifestyle diversity of patients and families while planning care and services;
- Attempting to ascertain and honor the choices, priorities, and values of patients and families;
- Acknowledging and attempting to minimize the disruption of privacy necessitated by care;
- Respecting patient confidentiality;
- Providing quality health care services in a timely manner to all who qualify, regardless of payer coverage or ability to pay; and
- Responsibly managing the resources of SFGH. eSFGH and its staff will act honestly, truthfully, and fairly to all concerned by:
  - Fully disclosing to patients and others information regarding rights and responsibilities, costs, discharge and complaint practices;
  - Informing clients and others of the organizational mechanisms for resolution of conflict in decision-making;
  - Making and accepting referrals in the best interest of the patient;
  - Regularly reviewing marketing and public information dissemination to assure accuracy; and
  - Assuring that services are not significantly compromised for financial reasons.

SFGH will maintain the highest level of expertise in the delivery of care by:

- Recruiting and selecting staff who are reflective of the ethnic, cultural, and life style diversity of the SFGH patient population;
- Orienting, training, and evaluating each staff person to ensure competency based on identified job descriptions;
- Respecting the diversity of staff and patients by establishing a procedure to review and accommodate, as appropriate, requests from staff not to participate in an aspect of patient care where it conflicts with their religious beliefs, cultural values or ethics; and
- Providing a mechanism for the management and resolution of actual and potential conflicts of interest between staff and their SFGH obligations and outside interests.

To reach the SFGH Ethic’s Committee call the Medical Staff Office at 206-2342.
**SFGH Code of Conduct**

San Francisco General Hospital is committed to providing health care services in compliance with all federal and state laws and regulations.

All employees are expected to abide by a high standard of ethical behavior, integrity, and to exercise good judgment when conducting business on the hospital’s behalf. In this regard, the following represents an overview of this compliance program.

1. **Obey the Law**: All employees must strictly observe all federal and state laws and regulations. Examples include MediCal regulations, CAL-OSHA regulations and infection control policies. Each employee is expected to be familiar with the basic legal standards relevant to his/her duties. Employees can learn the laws and regulations with which they are not familiar through training by supervisors, or by contracting department heads or the Compliance Officers. Employees are obligated to ask for assistance when they do not understand the legal obligations of their job.

2. **Quality Health Care**: All employees must show respect, compassion, truth and integrity in working to achieve excellence in patient care. The hospital is dedicated to providing the highest quality of care to all members of the community in an appropriate and efficient manner.

3. **Ethical Conduct**: Employees are expected to demonstrate integrity when acting on behalf of the medical center. Every employee is required to demonstrate loyalty, to avoid using his or her position for personal gain, and to avoid conflicts of interest. All ethical standards must be upheld.

4. **Confidentiality**: Employees are expected to follow all polices regarding privacy, including the policy on Patient Confidentially. By signing the Department of Public Health’s Confidentiality Agreement, an employee acknowledges his or her understanding and agrees to abide by these policies.

5. **Billing/Coding Practices**: As recipients of Medicare and Medi-Cal funds, the hospital has an obligation to comply with all anti-fraud and abuse requirements. Failure to adhere to these regulations can result in criminal charges or civil liability for both the hospital and the individual participants. Employees must be sure to follow all billing and coding procedures carefully.

6. **Report Possible Violations**: All employees are obligated to report any activity he or she reasonably believes is in violation of the law, ethical standards of conduct or hospital policies to their supervisor, department head or the Compliance Officer. The employee does not need to be certain that the violation has occurred in order to report it. Reporting enables the medical center to investigate potential problems quickly and to take action when necessary.

Employees may report violations without fear of retribution, harassment or discrimination. Reports can be made in person, by fax or by phone.

**Lines of Reporting:**

- Your Supervisor
- If you are not comfortable going to your supervisor, you may contact your department head
- Compliance Officer: (415) 206-4104
- Compliance Hotline: (415) 642-5790
- Human Resources
Employee Assistance Program

The Employee Assistance Program (EAP) is a voluntary, completely confidential, free service available to City & County employees, their family members and significant others. The EAP offers professional services that include:

- Assessment and referral
- Groups and workshops
- Organizational development
- Management consultation
- Resource library
- Brief counseling

For more information contact:

**Employee Assistance Program**
(415) 554-9580
1360 Mission Street
San Francisco, CA  94103

Equal Employment Opportunity and Affirmative Action Office

The Equal Employment Opportunity and Affirmative Action (EEO/AA) Office offers a wide variety of services to assist in the recruitment, training and retention of city/county personnel. Some services provided through the EEO/AA office include:

- Labor Force Analysis
- Affirmative Action Monitoring
- EEO Investigation and Monitoring
  - Discrimination Complaints
  - Americans with Disabilities Act
- Disputes Resolution
  - Communications
  - Conflict Resolution
- Cultural Competency Services
  - Bilingual Services: Proficiency Testing
- Retreat/Meeting Facilitation
- EEO Training
  - Americans with Disabilities Act
  - EEO Issues and Policies
  - Managing Diversity in the Workplace
  - Sexual Harassment Prevention
- Cross Cultural Development
  - Environmental Assessment and Intervention
  - Conflict Mediation
  - Leadership Style Feedback
  - Tailored Training
  - The Enneagram as a Management tool

For more information contact:
San Francisco Department of Public Health
Equal Opportunities/Affirmative Action Office
101 Grove Street, Room 241, San Francisco, CA  94102
(415) 554-2595
SECTION 2:
KEY POLICIES AND PROCEDURES
**Key Policies and Procedures**

In this section you will find policies and procedures designed to assure the highest quality care and the safety of our patients. You may find updates to these policies on the CHN intranet site at http://insidechnsf.chnsf.org/. Click on the SFGH link in the left-hand column and then on “SFGH Policies & Procedures.” http://in-sfghweb01.in.sfdph.net/CHNpolicies/production/search/policies.htm See also Appendix I for more online resources.

**National Patient Safety Goals**

The Joint Commission requires accredited hospitals to implement the National Patient Safety Goals (NPSGs) with the purpose of improving patient safety. The goals promote specific improvements in patient safety by providing health care organizations with proven solutions to persistent patient safety problems. SFGH values quality and patient safety. Meeting the Patient Safety Goals assists us in our efforts to be the best public hospital in the United States. Following are the goals that were active for 2009. The most current goals can be reviewed on the CHN Intranet Joint Commission link.

<table>
<thead>
<tr>
<th></th>
<th>Patient Identification</th>
<th>NPSG.01.01</th>
</tr>
</thead>
</table>
| 1 | Improve the accuracy of patient identification. | Use at least two patient identifiers when providing care, treatment and services. At SFGH we use first and last name and date of birth when:  
- Administering blood  
- Administering Medications  
- Collecting blood samples or other specimens  
- Providing other treatments or procedures  
- Containers used for collecting blood or specimens are labeled in the presence of the patient. |

<table>
<thead>
<tr>
<th></th>
<th>Communication Among Caregivers</th>
<th>NPSG.01.03.01</th>
</tr>
</thead>
</table>
| 2 | Improve the effectiveness of communication among caregivers. | Eliminate transfusion errors related to patient misidentification.  
- Two person verification process at patient’s bedside  
- One of two must be a qualified transfusionist  
- The second individual must be qualified to participate in the process. |

<table>
<thead>
<tr>
<th></th>
<th>Communication Among Caregivers</th>
<th>NPSG.02.01.01:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>For verbal or telephone orders or for telephone reporting of critical test results the individual giving the order verifies the complete order or test result by having the person receiving the information record and “read-back” the complete order or test result.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Communication Among Caregivers</th>
<th>NPSG.02.02.01:</th>
</tr>
</thead>
</table>
|   | There is a standardized list of abbreviations, acronyms, symbols and dose designations that are not to be used throughout the organization. This applies to all orders and medication related documentation that is handwritten or entered as free text into a computer.  
See CHN Intranet Approved Abbreviations site for the current “Do Not Use Abbreviations” list. |

<table>
<thead>
<tr>
<th></th>
<th>Communication Among Caregivers</th>
<th>NPSG.02.03.01:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SFGH measures, assesses and, if needed, takes action to improve the timeliness of reporting, and the timeliness of receipt of critical tests and critical results and values by the responsible</td>
<td></td>
</tr>
<tr>
<td>Section</td>
<td>Topic</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------</td>
<td>-------------</td>
</tr>
<tr>
<td>3</td>
<td>Medication Safety</td>
<td>Improve the safety of using medications.</td>
</tr>
<tr>
<td></td>
<td>NPSG.03.03.01:</td>
<td>SFGH identifies and, at a minimum, annually reviews a list of look alike/sound alike medications used by the organization and takes action to prevent errors involving the interchanges of these medications. See CHN Intranet Joint Commission link for the complete list.</td>
</tr>
<tr>
<td></td>
<td>NPSG.03.04.01:</td>
<td>Label all medications, medication containers (for example syringes, medicine cups, basins), or other solutions on and off of the sterile field.</td>
</tr>
<tr>
<td></td>
<td>NPSG.03.05.01:</td>
<td>Reduce the likelihood of patient harm associated with the use of anticoagulation therapy. See the SFGH Anticoagulation Treatment Guidelines.</td>
</tr>
<tr>
<td>7</td>
<td>Infections</td>
<td>Reduce the risk of health care associated infections.</td>
</tr>
<tr>
<td></td>
<td>NPSG.07.01.01:</td>
<td>Comply with current World Health Organization (WHO) hand hygiene guidelines or Centers for Disease Control and Prevention (CDC) hand hygiene guidelines. At SFGH we use Purell™ alcohol-based sanitizer and soap &amp; water.</td>
</tr>
<tr>
<td></td>
<td>NPSG.07.02.01:</td>
<td>Manage as sentinel events all identified cases of unanticipated death or major permanent loss of function related to a health care associated infection.</td>
</tr>
<tr>
<td></td>
<td>NPSG.07.03.01:</td>
<td>Implement evidence-based practices to prevent health care associated infections due to multiple drug-resistant organisms in acute care hospitals.</td>
</tr>
<tr>
<td></td>
<td>NPSG.07.04.01:</td>
<td>Implement best practices or evidence-based guidelines to prevent central line-associated bloodstream infections.</td>
</tr>
<tr>
<td></td>
<td>NPSG.07.05.01:</td>
<td>Implement best practices for preventing surgical site infections.</td>
</tr>
<tr>
<td>8</td>
<td>Medication Reconciliation</td>
<td>Accurately and completely reconcile medications across the care continuum.</td>
</tr>
<tr>
<td></td>
<td>NPSG.08.01.01:</td>
<td>A process exists for comparing the patient’s current medications with those ordered for the patient while under the care of the organization.</td>
</tr>
<tr>
<td></td>
<td>NPSG.08.02.01:</td>
<td>When a patient is referred or transferred from one organization to another the complete and reconciled list of medications is communicated to the next provider of service and the communication is documented. Alternatively, when a patient leaves the organization’s care directly to his or her home, the complete and reconciled list of medications is provided to the patient’s known primary care provider, or the original referring provider, or a known, next provider of service.</td>
</tr>
<tr>
<td></td>
<td>NPSG.08.03.01:</td>
<td>When a patient leaves the organization’s care, a complete and reconciled list of the patient’s medications is provided directly to the patient, to the patient’s family as needed and the list explained</td>
</tr>
<tr>
<td></td>
<td></td>
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<tr>
<td>---</td>
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</tr>
<tr>
<td><strong>SFGH Orientation Handbook</strong></td>
<td>to the patient and/or family, with a reminder to discard any old medication lists. The discussion with patient or family is documented. <strong>NPSG.08.04.01:</strong> In settings where medications are used minimally, or prescribed for a short duration, modified medication reconciliation processes are performed. This applies when only short-term medications are used and there are no changes to long-term medications.</td>
<td><strong>9</strong></td>
</tr>
<tr>
<td><strong>10</strong></td>
<td>Vaccinations</td>
<td>Reduce the Risk of Influenza and Pneumococcal Disease in Institutionalized Older Adults.</td>
</tr>
<tr>
<td><strong>13</strong></td>
<td>Patient Involvement in their Care</td>
<td>Encourage the ways in which the patient and his or her family can report concerns about safety and encourage them to do so.</td>
</tr>
<tr>
<td><strong>14</strong></td>
<td>Prevent Health Care Associated Pressure Ulcers</td>
<td>Prevent Health Care Associated Pressure Ulcers.</td>
</tr>
<tr>
<td><strong>15</strong></td>
<td>Safety Risks Inherent in patient population</td>
<td>The organization identifies safety risks in its patient population.</td>
</tr>
<tr>
<td><strong>16</strong></td>
<td>Response to Changes in Patient’s Condition</td>
<td>Improve recognition and response to changes in a patient’s condition.</td>
</tr>
</tbody>
</table>
DO NOT USE ABBREVIATIONS

Since 2004, the Joint Commission and SFGH has indicated that the following abbreviations **MAY NOT BE USED IN ANY HAND-WRITTEN, PATIENT-SPECIFIC COMMUNICATION**, including and not limited to: medication and treatment orders, medication and treatment administration records, laboratory and radiology orders, progress notes, etc.

<table>
<thead>
<tr>
<th>Item</th>
<th>Do NOT use Abbreviation</th>
<th>USE</th>
<th>Potential Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>U (for unit)</td>
<td>Write “unit”</td>
<td>Mistaken as zero, four, or cc.</td>
</tr>
<tr>
<td>2</td>
<td>IU (for international unit)</td>
<td>Write “international unit”</td>
<td>Mistaken as IV (intravenous) or 10 (ten).</td>
</tr>
<tr>
<td>3</td>
<td>QD</td>
<td>Write “daily” or “once daily” and</td>
<td>Mistaken for each other and for “QID”. The period after the Q in “QD” can be mistaken for an “I” and the</td>
</tr>
<tr>
<td>4</td>
<td>QOD</td>
<td>“every other day”</td>
<td>“O” in “QOD” can be mistaken for “I”.</td>
</tr>
<tr>
<td>5</td>
<td>Trailing zero (X.0 mg)</td>
<td>Never write a zero by itself after a decimal point (X mg)</td>
<td>Decimal point is missed. (10-fold increase in value)</td>
</tr>
<tr>
<td>6</td>
<td>Lack of leading zero (.X mg)</td>
<td>Always use a zero before a decimal point (0.X mg)</td>
<td>Decimal point is missed. (10-fold increase in value)</td>
</tr>
<tr>
<td>7</td>
<td>MS</td>
<td>Write “morphine sulfate”</td>
<td>Confused for one another. Can mean morphine sulfate or magnesium sulfate.</td>
</tr>
<tr>
<td>8</td>
<td>MSO4</td>
<td>Or “magnesium sulfate”</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>MgSO4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>µg (microgram)</td>
<td>Write “mcg”</td>
<td>Mistaken as “mg” (milligram).</td>
</tr>
<tr>
<td>11</td>
<td>HS</td>
<td>Write “at bedtime” or “half strength”</td>
<td>Mistaken for half-strength or hours of sleep. Q HS mistaken for every hour.</td>
</tr>
<tr>
<td>12</td>
<td>TIW or tiw</td>
<td>Write “3 x week” or “three times a week”</td>
<td>Mistaken for three times a day or twice weekly.</td>
</tr>
</tbody>
</table>

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1 The Joint Commission (JC) has established National Patient Safety Goals to improve patient safety. In keeping with goal NPSG.02.02.01, which is to improve the effectiveness of communication among caregivers, the JC and San Francisco General Hospital and Trauma Center issued this list of required “Do Not Use” abbreviations. (Rev. 03/04)
Patient Rights

You have the right to:

1. Considerate and respectful care, and to be made comfortable. You have the right to respect for your personal values and beliefs.
2. Have a family member (or other representative of your choosing) and your own physician notified promptly of your admission to the Hospital.
3. Know the name of the physician who has primary responsibility for coordinating your care and the names and professional relationships of other physicians and non-physicians who will see you.
4. Receive information about your health status, course of treatment and prospects for recovery in terms you can understand. You have the right to participate in the development and implementation of your plan of care. You have the right to participate in ethical questions that arise in the course of your care, including issues of conflict resolution, withholding resuscitative services, and forgoing or withdrawing life-sustaining treatment.
5. Make decisions regarding medical care, and receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse a course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved, alternate courses of treatment or non-treatment and the risks involved in each, and the name of the person who will carry out the procedure or treatment.
6. Request or refuse treatment, to the extent permitted by law. However, you do not have the right to demand inappropriate or medically unnecessary treatment or services. You have the right to leave the Hospital even against the advice of physicians, to the extent permitted by law.
7. Be advised if the Hospital/personal physician proposes to engage in or perform human experimentation affecting your care or treatment. You have the right to refuse to participate in such research projects.
8. Reasonable responses to any reasonable requests made for service.
9. Request or reject the use of any or all modalities to relieve pain, including opiate medication, if you suffer from severe chronic intractable pain. The doctor may refuse to prescribe the opiate medication, but if so, must inform you that there are physicians who specialize in the treatment of severe chronic intractable pain with methods that include the use of opiates.
10. Formulate advance directives. This includes designating a decision-maker if you become incapable of understanding a proposed treatment or become unable to communicate your wishes regarding care. Hospital staff and practitioners who provide care in the Hospital shall comply with these directives. All patient rights apply to the person who has legal responsibility to make decisions regarding medical care on your behalf.
11. Have personal privacy respected. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. You have the right to be told the reason for the presence of any individual. You have the right to have visitors leave prior to an examination and when treatment issues are being discussed. Privacy curtains will be used in semi-private rooms.
12. Confidential treatment of all communications and records pertaining to your care and stay in the Hospital. Basic information may be released to the public, unless specifically prohibited in writing by you. Written permission shall be obtained before medical records are made available to anyone not directly concerned with your care, except as otherwise may be required or permitted by law.
13. Access information contained in your records within a reasonable time frame, except in certain circumstances specified by law.
14. Receive care in a safe setting, free from verbal or physical abuse or harassment. You have the right to access protective services including notifying government agencies of neglect or abuse.
15. Be free from restraints and seclusion of any form used as a means of coercion, discipline, convenience, or retaliation by staff.
16. Reasonable continuity of care and to know in advance the time and location of appointments as well as the identity of the persons providing the care.
17. Be informed by the physician, or a delegate of the physician, of continuing health care requirements following discharge from the Hospital.
18. Know which Hospital rules and policies apply to your conduct while a patient.
19. Designate visitors of your choosing, if you have decision-making capacity, whether or not the visitor is related by blood or marriage, unless:
   - No visitors are allowed.
   - The facility reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, a member of the health facility staff, or other visitor to the health facility, or would significantly disrupt the operations of the facility.
   - You have told the health facility staff that you no longer want a particular person to visit. However, a health facility may establish reasonable restrictions on visitation, including restrictions on the visiting hours and on the number of visitors.

20. Have your wishes considered, if you lack decision-making capacity, for the purposes of determining who may visit. The method of that consideration will be disclosed in the Hospital policy on visitation. At a minimum, the Hospital shall include any persons living in your household.

21. Exercise these rights without regard to sex, economic status, educational background, race, color, religion, ancestry, national origin, sexual orientation or marital status, or the source of payment for care.

22. File a grievance and/or file a complaint with the California Department of Public Health and/or the Hospital and be informed of the action taken. You may call the SFGH Patient Advocate at 206-5176 or the California Department of Public Health at 1-800-554-0353. If a concern or complaint involving your care is not resolved using the method offered by San Francisco General Hospital and Trauma Center, you may contact the Joint Commission at (800) 994-6610 (8:30 to 5:00 p.m., Central Time, weekdays).

**Positive Patient Identification**

Always begin each patient encounter by ensuring that the patient is who you think they are! When initiating contact always ask for the patient’s first and last name in addition to their birth-date. These two independent pieces of information will help to ensure that you are with the correct patient.
**Abuse Reporting**

All San Francisco City and County employees are expected to comply with federal and state laws regarding reporting victims of violence and abuse. The following tables represent warning signs of potential abuse and mandatory reporting situations:

### WARNING SIGNS OF ABUSE

<table>
<thead>
<tr>
<th>All Patients</th>
<th>Children, Elders and Dependent Adults</th>
<th>Children Under 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Injuries and bruising</td>
<td>• Lack of care or poor hygiene</td>
<td>• Pattern bruising</td>
</tr>
<tr>
<td>• Unexplained injuries</td>
<td>• Malnourished</td>
<td>• Startled responses</td>
</tr>
<tr>
<td>• Injuries inconsistent with Hx.</td>
<td>• Injuries healing at different stages</td>
<td>• Sudden changes in personality</td>
</tr>
<tr>
<td>• Evasive Responses</td>
<td>• Lack of caregiver follow-up</td>
<td>• Sudden changes in eating or sleeping habits</td>
</tr>
<tr>
<td>• Delay in seeking medical care</td>
<td>• Unresponsive caregiver</td>
<td>• Changes in school performance</td>
</tr>
<tr>
<td>• Repeated medical visits for vague complaints</td>
<td>• Abandonment</td>
<td></td>
</tr>
<tr>
<td>• Genital injuries</td>
<td>• S.T.D.s</td>
<td></td>
</tr>
</tbody>
</table>

### MANDATED REPORTING

<table>
<thead>
<tr>
<th>Affected Population</th>
<th>Reportable Incidents</th>
<th>Mandated Reporters</th>
<th>Report Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependent Adult/Elder</td>
<td>Physical Abuse, Fiduciary Abuse, Neglect, Abandonment</td>
<td>All licensed healthcare providers</td>
<td>Phone Report: 557-5230 (immediately) Written report mailed within 48-hours Adult Protective Services P.O. Box 7988 (G-180) San Francisco, CA 94120 Ombudsman (SNF): 751-9788</td>
</tr>
<tr>
<td>Child Abuse</td>
<td>Physical Abuse, Emotional Abuse, Sexual Abuse, Psychological Abuse, Neglect</td>
<td>Licensed healthcare providers, public health employees and any profession or paraprofessional working with children</td>
<td>Phone report: 558-2650 (immediately) Written report mailed within 36-hours DHS Children’s Emergency Services P.O. Box 7988 San Francisco, CA 94120</td>
</tr>
<tr>
<td>Child Sexual Abuse</td>
<td>Licensed healthcare providers, public health employees and any profession or paraprofessional working with children</td>
<td>Special Resource/Consult Child and Adolescent Sexual Abuse Resource Center 206-8386 (24-hour line) Exams, reporting &amp; Counseling</td>
<td></td>
</tr>
</tbody>
</table>
## MANDATED REPORTING

<table>
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<tr>
<th>Affected Population</th>
<th>Reportable Incidents</th>
<th>Mandated Reporters</th>
<th>Report Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assaultive and Abusive Behavior</td>
<td>Injuries suspected to be from physical violence or violence including domestic violence or sexual abuse</td>
<td>Licensed providers of medical care (Mental health practitioners are exempt)</td>
<td>For Police Response: 553-0123 For phone report only 553-9220 Written report mailed with 48-hours SFDPH General Work Detail 850 Bryant St San Francisco, CA 94103</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>Injuries suspected to be from domestic violence or abuse</td>
<td>Licensed providers of medical care (Mental health practitioners are exempt)</td>
<td>For Police Response: 553-0123 For phone report only 553-9220 Written report mailed with 48-hours SFDPH General Work Detail 850 Bryant St San Francisco, CA 94103</td>
</tr>
<tr>
<td>Adult Sexual Assault &amp; Attempted Sexual Assault</td>
<td>Suspected sexual assault</td>
<td>Licensed providers of medical care (Mental health practitioners are exempt)</td>
<td>Special Resource/Consult S.F. Rape Treatment Center 821-3222 (24-hour response for medical care) Counseling available</td>
</tr>
</tbody>
</table>

### Reminders and Resources for Reporting Abuse

- Inform other members of the care team in order to coordinate patient care and to determine if a mandated report has already been made.
- Document the nature, location, and treatment of injuries, as well as relevant patient statements in the medical record.
- Obtain consultations as needed.
- For children and adults who have been the victims of sexual violence or molestation, the hospital has consultation resources with specialized expertise in forensic interview, documentation, and evidentiary collection.
- Report (if not previously reported) and document the reporting procedure.
- For Adults and Emancipated Minors:
  - Explore safe housing options
  - Explore safety plan
    - For Minors
  - Involve Pediatrics in all cases of suspected child abuse and neglect
  - Obtain police hold, if needed, by calling 553-0123 or 911 in an emergency

Medical Social Workers at SFGH are available for consultation by calling 206-8436, M-F 8:30 am to 5:00 pm. On Saturday and Sunday a Social Worker is available 8:30 am to 5:00 pm by paging extension 1877-9296. The Emergency Department Social Worker is available evenings, weekends and holidays at 206-5514 or by paging extension 1877-9252.
Advance Health Care Directives

Advance Health Care Directives are patient instructions that state choices or patient wishes for medical treatment and/or designates who should make such decisions if the patient lacks medical decision-making capacity (by appointing a Power of Attorney for Health Care). Advance Health Care Directives include: written and oral communications including the Advance Health Care Directive (AHCD) and documentation by the primary care provider which conveys the patient’s stated wishes, such as resuscitation orders or wishes about treatment based on religious beliefs (e.g. Jehovah Witness’s refusal of blood transfusions). A physician or nurse caring for a patient is expected to know whether or not the patient has an advance health care directive and to share this information with other clinicians that may be caring for the patient.

Who can execute an Advance Health Care Directive?

- Anyone 18 or older and emancipated minors can execute an Advance Health Care Directive.
- If a patient turns 18 years of age during their hospital stay they should be informed of their right to state their treatment wishes and to designate a surrogate.

Why do we need to know about a patient’s Advance Health Care Directive?

- Unless we know a patient’s wishes about medical treatment, we cannot provide the care the patient would want.
- The Patient Self Determination Act passed by Congress in December 1991 requires hospitals, that participate in Medicare and MediCal (Medicaid) programs, to inform patients about their rights to make decisions directing their medical care (Advance Health Care Directive).
- A California law passed July 1, 2000 consolidates California’s previous advance directive laws to make it easier for individuals to make their preferences known through written and oral communication. It replaces previous advance directive forms, such as the Natural Death Act Declaration, and the Durable Power of Attorney for Health Care.

How do I find out if a patient has an Advance Health Care Directive (AHCD)?

- Admitting/registration staff begin the process by asking patients (or their families if the patient cannot respond) whether or not they have an AHCD or would like information about an AHCD. This information is documented on the face sheet.
- Registered Nurses are responsible to determine whether or not the patient has an Advance Health Care Directive when the patient is admitted to a unit. If the patient does have an AHCD, the RN checks to see that any AHCD legal document (e.g. DPOA, Natural Death Act) is in the medical record. If the patient wants additional information about AHCD the RN provides the patient with additional information by giving/reviewing the pamphlet, "Your Right to Make Decisions regarding Medical Treatment" (available in several languages) and documents this patient education on the Advance Directive/Patient Treatment Wishes Progress Note.
- There are several places in the Medical Record you can check for this information:
  - Face sheet,
  - In the Advance Directive section of the medical record,
  - In the Conditions of Admission signed by the patient at admission,
  - Social work notes,
  - Interdisciplinary Patient Discharge Plan and
  - In the LCR/AD section of the Health Maintenance Screen.
Cultural Competency

What is Cultural Competence?
Cultural competence is the collection of qualities which foster the provision of quality health care to diverse populations. These qualities include awareness, knowledge, skills, experience and attitude. Providers must develop an individual awareness of how personal biases and assumptions can affect the quality of care he or she provides to patients and families. For example, some cultures believe that lack of eye contact during conversation means that someone is hiding something or is dishonest. Other cultures believe that eye contact during conversation is rude or hostile. No matter what you believe, it is most important to know how your belief can shape how you look at and care for others who are different from you.

Why are we concerned about cultural competence?
At San Francisco General Hospital & Trauma Center we care for a very diverse patient population. Diversity means that our patients come to us with cultural differences, such as ethnicity, language, age, spirituality, socio-economic status, sexual orientation and health status. These differences shape the patient’s view of health, illness, decision-making, death and dying. To provide the highest quality care to our patients, we must be sensitive to cultural beliefs and practices, and work with the patient and family to incorporate these beliefs and practices into the plan of care. Cultural competence gives a twist to the "Golden Rule": Take care of your patients the way that they would like to be taken care of.

How can we incorporate the patient’s cultural beliefs and values into their care?
The first step is to assess their view or perception of their illness, condition or situation. The following questions may be helpful:

- What do you call your illness/condition? What do you think caused your illness/condition?
- What do you do to stay healthy? What do you think will help you get well?
- Are you seeing any other health care provider or spiritual healer from your own culture?
- Are you taking any herbs or traditional medicine from your own culture? What about treatments?
- Who should we include in decision-making about your care and treatment?

It is important to realize that there is no "cookbook" for how to take care of patients from different cultures. It is our responsibility to assess the patient’s beliefs and practices related to their current admission or contact.

Additional Resources:
- Patient Education Resource Center (PERC) - has patient education materials available in different languages
- SFGH Interpreter Service
HIPAA: Patients’ Privacy and Confidentiality

The Health Insurance Portability and Accountability Act (HIPAA) was passed to establish national health privacy and security standards. The 3 parts of HIPAA are:

- The Privacy Rule
- Transaction and Code Set Standards
- Security Rule

SFGH protects every patient’s right to privacy (see SFGH policy 13.10: Health Information Services: Confidentiality, Security, and Release of Protected Health Information). Observations and communications regarding a patient’s medical history, mental or physical conditions and treatment are considered confidential.

Protected health information (PHI) may be released only for approved direct patient care purposes along with proper patient authorization and as required by federal or state law. Release of patient PHI consists only of the minimum information necessary to fulfill the legitimate intended use.

The HIPAA Privacy Rule requires that individually identifiable health information must be protected from unlawful access or disclosure.

Patient rights under the Privacy Rule include:

- Request of confidential communications
- Refusal to authorize disclosures of PHI for purposes other than treatment, payment and healthcare operations
- Obtaining a written Notice of Privacy Practices
- Accessing medical records
- Requesting restrictions on the use and disclosure of PHI for treatment, payment and health care operations (TPO)

DPH providers may use the patient’s entire medical record to provide care. When using a patient’s PHI for TPO, an employee does not need to ask a patient for approval. When an employee discloses a patient’s PHI outside of DPH, a patient may need to sign a release or authorization. In California, it is against the law to disclose certain kinds of health information about HIV/AIDS, STDs, mental health, minors and substance abuse without a patient’s authorization to release such information. A patient’s authorization is required for disclosures of PHI to a life insurance company or to an employer.

DPH is required to document all patient complaints regarding their privacy rights and is prohibited from intimidating patients who wish to register a complaint. DPH has a non-retaliation policy for employees that register complaints. All complaints regarding privacy should be referred to the Privacy Hotline at 206-2354.

For more information regarding DPH privacy policies and procedures, visit the HIPAA training site the CHN Intranet.
Zero Tolerance Policy for Patient Abuse

San Francisco General Hospital and Trauma Center is dedicated to maintaining an environment that promotes patient safety and is committed to protecting patient rights, including the prevention and prohibition of all types of abuse. San Francisco General Hospital and Trauma Center has a ZERO Tolerance Policy regarding patient abuse! Staff members found to be in violation of this hospital policy are subject to disciplinary action, including possible termination, and reporting to the appropriate licensing board.

Definition of Abuse

Patient abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting harm, pain or mental anguish.

Types of Abuse include:

- Mental Suffering
  - Withholding of Comfort Measures
  - Misappropriation of Patient Property
  - Neglect
  - Physical Abuse
  - Sexual Abuse
  - Verbal Abuse
  - Physical Restraint (Non-Clinical Indication)

- Withholding of Comfort Measures – This includes willfully withholding comfort interventions as a means of punishment.
  - Withholding of food
  - Withholding of clothing
  - Withholding of pain medications
  - Withholding of warmth (blankets)
  - Withholding of personal hygiene

- Misappropriation of Patient Property is a pattern or deliberate misplacement, exploitation, or wrongful temporary or permanent use of a patient’s belongings or money without a patient's consent.
  - Theft
  - “Borrowing”
  - Selling
  - Hiding

- Neglect is the failure to provide the goods or services necessary to avoid physical harm, mental anguish or illness.

- Physical Abuse – Examples Include:
  - Hitting
  - Slapping
  - Pinching
  - Kicking
  - It also includes controlling behavior through corporal punishment

- Sexual Abuse is any physical contact with any area of the body not considered socially acceptable, with sexual intent. It is accomplished without consent through violence, force, fear, menace or duress. This includes, but is not limited to:
– Sexual harassment
– Sexual coercion
– Sexual assault

• **Verbal Abuse** is the use of oral/written or gestured language that willfully includes disparaging and derogatory terms to patients and/or families or within their hearing distance; regardless of their age, ability to comprehend or his/her disability.
  – Name calling
  – Finger gestures
  – Overt disrespect
  – Racism
  – Sexism
  – Ageism

• **Physical Restraint** (Non-Clinical Indication) This includes any device that inhibits a patient’s normal ability to move freely or physical holds of any type. See SFGH Administrative Restraint Policy (18.09)

**Reporting of Patient Abuse**

As a healthcare professional you are required ethically and by law to report all types of abuse.

**Process for Reporting**

If an employee observes abuse, suspects that abuse has occurred, is the first employee to learn of abuse of any patient or is the first employee to learn of a patient-to-patient altercation.

**The employee must:**

– Identify the patient
– Notify the responsible manager, physician and Administrator on Duty.
– Complete an Unusual Occurrence (UO) form

The UO form is sent to Risk Management and Regulatory Affairs for investigation.

**Process for Reporting (Cont.)**

**Immediate response must include:**

– Immediate measures to assure patient safety
– RN assessment of the patient, documentation of findings (i.e. update care plan, nursing notes), and notification of the attending physician

**LET’S BE PERFECTLY CLEAR!**

Patient/Client abuse of any type is not tolerated at San Francisco General Hospital and Trauma Center. You must know what constitutes abuse, be aware when there is potential for abuse, and report abuse when you observe it.

•
Performance Appraisal and Competency Assessment

San Francisco General Hospital & Trauma Center shall ensure:

- Safe and competent patient care and support services;
- Department managers, supervisors, and human resource services (HRS) staff define qualifications and competencies needed for the department based on the scope of service;
- HRS staff will provide support and consultation in developing job specifications, job announcements, and job descriptions in accordance with civil service rules, regulatory standards, labor contract provisions, and organizational standards. The minimum qualifications specified in the job specifications and job announcements and the criteria set forth in the job description in the performance appraisal, together, will serve as the criteria upon which the employee's performance is evaluated and assessed;
- Department managers will review the qualifications of job applicants including educational background, job experience, licensing and/or certification,
- Human Resources staff will coordinate and facilitate the hiring process and maintain records of orientation and performance appraisal tools in accordance with city policy, labor contract provision, SFGH procedures, and regulatory standards;
- Assessment of competency at the time of hire, during orientation, at time of transfer between a specialty area or departments, and probationary periods, and on an ongoing basis through the competency assessment and performance appraisal process;
- SFGH and University of California San Francisco (UCSF) staff are responsible for complying with hospital policies and demonstrating and maintaining required licenses and competencies.
- SFGH and UCSF leaders are accountable for the competency of clinical, support and management staff;
- All contract, as needed, and agency staff must meet SFGH competency standards; and
- Physician competency validation occurs at the time medical staff privileges are granted, and every 2 years thereafter during the re-credentialing process.

DEFINITIONS

**Competency** - The ability to perform a particular job in a specific setting in accordance with regulatory, organizational, and professional standards. This includes ongoing acquisition of new knowledge, and demonstration of skills and/or behaviors.

- Age specific competency requires that staff possess the knowledge, skills and abilities to provide care or services appropriate to the patient’s age and level of development.
- Cultural competency is the knowledge, skills and abilities to provide care of services to culturally diverse populations to include: gender, sexual orientation, nationality, ethnicity, social, economic and spiritual factors.
- Orientation is a time specific period introduction to the work setting or job for newly hired and transferred employees. The purpose of orientation is to ensure that all new employees meet minimum standards for health and safety, environment of care and job specific competencies.
- Training is the provision of knowledge and demonstration of skills related to a particular job or assignment.
Performance Improvement and Patient Safety

SFGH maintains a Performance Improvement and Patient Safety (PIPS) program to:

- Promote a uniform monitoring and evaluation process for performance improvement and patient safety activities;
- Promote the involvement of care providers in defining quality, establishing standards, and developing mechanisms to monitor, evaluate, and improve the processes and patient outcomes;
- Promote a culture geared toward proactive risk assessment to reduce errors and reporting of medical errors and adverse events.
- Prioritize initiatives to enhance patient outcomes/safety based on analysis and assessment of the data, and in accordance with the organization's mission, vision, care and services provided, and the population served;
- Facilitate an interdisciplinary, collaborative approach to improving the quality of care, patient safety, and utilization of resources through the designation of continuous performance improvement and patient safety initiatives;
- Guide SFGH in meeting legal, professional, accreditation, and regulatory requirements; and
- Provide education and communication on performance improvement principles and tools.

The PIPS Committee implements the objectives of the organization-wide performance improvement and patient safety program. The PIPS Committee takes an interdisciplinary and proactive approach in the prevention of adverse events, medical errors and near misses, and promotes patient outcomes/safety as the core value in providing quality patient care.

The PIPS Committee focuses on performance improvement activities related to major aspects of care and clinical process/outcome/safety indicators. The committee makes recommendations based on an evaluation of the care provided (e.g. efficacy, appropriateness) and how well it is done (e.g. availability, timeliness, effectiveness, continuity with other services/practitioners, safety, efficiency, and respect and caring).

The responsibility for providing quality services is shared by all staff. Staff shall:

- Assist in identifying opportunities for improvement of the quality of patient care/safety;
- Participate in performance improvement and patient safety activities;
- Incorporate performance improvement and patient safety findings into patient care or service delivery; and
- Report medical/health care errors and near misses.

The clinical departments, inpatient and outpatient care areas, and clinical support departments are responsible for developing and maintaining performance improvement and patient safety programs based on the SFGH's prioritized system initiatives. The PIPS Committee identifies and ensures appropriate follow-up of organization-wide trends, patterns, and opportunities to improve aspects of patient care and safety through the review and analysis of data.
Quality Improvement

The purpose of the SFGH’s Quality Improvement Program is:

- To continuously improve the health status and outcomes of patients by utilizing a systematic process to measure, assess, and improve care delivery and the organizational functions, which support the delivery of this care.
- All SFGH staff members are involved in improvement programs, which may be large or small, formal or informal, and have positive impacts on our patients.

SFGH uses the following model for improvement

1. **PLAN** the improvement and the data collection
2. **DO** the improvement and the data collection
3. **STUDY** the results of the implementation
4. **ACT** to hold the gain & continue Improvement

Rapid Testing to Achieve Improvement
Staff of each unit/department should be able to answer these questions:

- What improvement process has the unit or department developed in the last year?
- What aspects of care or other activities provided in the unit or department are measured, analyzed and improved?
- How are individual staff members involved in this process?

The following are examples of data that SFGH routinely collects and analyzes for improvement:

- Trauma data
- Patient Classification System
- Patient demographic data
- Patient satisfaction surveys
- Infection control data
- Blood Transfusions
- Medication use
- Significant event reviews
- ORYX Indicators
- Immunization rates
- Patient Concerns
- Utilization Data such as readmission’s
- Facilitator indicators for long-term care
- Unusual Occurrences
- Compliance
- Culture of Reporting
Unusual Occurrence Reporting

**Unusual Occurrence** – an Unusual Occurrence is any event or condition that has had or may have an adverse effect on the health or safety of a patient/resident, visitor, volunteer, student, or employee.

**Sentinel Event** – a sentinel event is an unexpected occurrence involving the death or actual or potential serious physical or psychological injury related to assessment and/or treatment. This includes any process variation for which a recurrence would carry a significant chance of a serious outcome, or which otherwise adversely affects the quality of service or operations of SFGH.

SFGH has established a system for reporting and investigating unusual occurrences (UOs) in order to:

- Identify events or conditions which have or may have an adverse effect on the health or safety of patients/residents, visitors, volunteers, students, or employees;
- Institute corrective action which will address immediate needs and prevent similar future incidences; and,
- Identify patterns/trends, analyze findings and make recommendations for quality improvement.
  - SFGH personnel use a campus-wide online, electronic unusual occurrence reporting system for reporting and investigating unusual occurrences.
  - The Performance Improvement and Patient Safety (PIPS) reviews and evaluates summary data from the unusual occurrences (U/Os) to identify organization-wide patterns and trends as part of the SFGH Performance Improvement and Patient Safety Program.
  - Quality/Risk Management Department will maintain the UOs.
  - UOs are an integral part of the SFGH's Performance Improvement and Patient Safety Program. These reports are not subject to discovery in legal proceedings under California Evidence Codes sections 950 et seq, 1156 and 1157.
  - The Unusual Occurrence reports are not disclosed outside of the Performance Improvement and Patient Safety process, thus preserving the confidentiality of the Unusual Occurrence system.

Following the discovery of an unusual occurrence, event or condition that has had or may have an adverse effect on the health or safety of a patient, visitor, volunteer, student, or employee, frontline staff shall:

Initiate immediate risk containment measures to prevent and reduce further adverse outcomes including, but not limited to the following:

- Providing appropriate patient care;
- Notifying the responsible physician if the incident involves the clinical care of a patient; and/or
- Ensuring the environment is safe
Reporting the Unusual Occurrence:

- The employee and/or manager/supervisor must immediately inform the Administrator on Duty/Hospital Supervisor and Risk Management (206-6600) of significant events and complete an Unusual Occurrence report as soon as risk containment measures permit.
- The AOD/HS will determine if immediate action or additional follow-up is required and whether notification of the SFGH Executive Administrator is warranted.
- The Risk Management staff will evaluate the occurrence to determine if it needs to be reported to external regulatory agencies (i.e. Department of Health Services, California Occupational Safety and Health Administration, and San Francisco Department of Public Health, Occupational Safety and Health Section.
- The University of California at San Francisco (UCSF) (AOD/HS) Risk Management (RM) at SFGH will ensure that the SFGH RM staff is informed of all unusual occurrences that come to their attention. The SFGH RM staff will ensure that UCSF Risk Management staff is informed of unusual occurrences involving UCSF staff working at SFGH.
- If the incident involves the clinical care of a patient, document the event, clinical response, physician notification, and monitoring activities in the patient’s medical record. (Please refer to SFGH Nursing Department Policies and Procedure 11.2, Documentation of the Nursing Process.) The individual completing the UO must not document in the medical record that a UO has been completed.
- If patient abuse is suspected, immediately notify the AOD/HS and Risk Management (206-6600).
Violence in the Workplace

SFGH adheres to the citywide policy prohibiting violence in the workplace. The City and County of San Francisco will not tolerate any assaults, battery, threats, verbal abuse, harassment or acts of violence in the workplace.

What is my reporting responsibility?

- All employees should call the SFGH Sheriff's Office, 206-4911, if the threat is immediate and life threatening.
- All employees have the responsibility for reporting any threats or acts of violence in the workplace to their respective supervisors.
- Supervisors and managers, through the department head, Human Resource official, or designee have the responsibility to investigate any reported incidents, threats or acts of violence by any employee and to take appropriate action.
- Any employee can call the Management Response Team (MRT) to get assistance in handling incidences of workplace violence.
- When notified by a healthcare provider of a threat against an employee, the department head, human resource official or designee shall notify the affected employee as soon as possible. This is called a Tarasoff Warning.

What is the Management Response Team?
The MRT is a resource and consulting body available to all personnel: supervisors, managers and staff.

### SFGH Management Response Team Grid

<table>
<thead>
<tr>
<th>Management Response Teams</th>
<th>Management/Team Leader Contact for Team Mobilization</th>
<th>Human Resources</th>
<th>Sheriff's Deputy/Security</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>LHH – Campus</td>
<td>Tel: 759-4658 Page: 809-7876 Cheryl Austin (Alternate) Tel: 759-2349 Page: (888) 380-0800</td>
<td>Willie Ramirez Tel: 759-3008 Arleen Lum (Alternate) 759-2966</td>
<td>Sgt. Derrick Pressly Tel: 759-2319 SFSD Officer on Duty (Alternate)</td>
<td>CHN Incident debriefing team/ designee RM/QM 206-6600</td>
</tr>
</tbody>
</table>
SFGH Management Response Team Grid

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</thead>
<tbody>
<tr>
<td>Central Administration</td>
<td>Edwin Batongbacal</td>
<td>Michael Brown</td>
<td>Sgt. Martin Lee</td>
<td>CHN</td>
</tr>
<tr>
<td>Population Health and Prevention</td>
<td>Tel: 255-3446</td>
<td>Tel: 554-2590</td>
<td>Tel: 206-3987</td>
<td>Incident debriefing team/designee</td>
</tr>
<tr>
<td></td>
<td>Cell: (510) 589-0599</td>
<td>James Peavey</td>
<td>Cell: 819-3873</td>
<td>255-3421</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Alternate)</td>
<td>Page: 207-3246</td>
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<tr>
<td></td>
<td></td>
<td>Tel: 554-2589</td>
<td>Sgt. Restauro</td>
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<tr>
<td></td>
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<td>(Alternate)</td>
<td>(Alternate)</td>
<td></td>
</tr>
<tr>
<td>Forensics</td>
<td>Collaborative effort with Sheriff's Department</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Jo Robinson will coordinate discussions, contact 995-7100).</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Use Human Resources contact for Central Administration</td>
<td></td>
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<tr>
<td></td>
<td>(Michael Brown and James Peavey)</td>
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</tbody>
</table>

What are resources for dealing with workplace violence?

The hospital offers monthly classes for staff at risk for workplace violence. For more information call 206-3453. Additionally, the Employee Assistance Program offers regular training, consultation and counseling for managers and staff. Call EAP at 554-9580

<table>
<thead>
<tr>
<th>Organization</th>
<th>Function</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commission on the Status of Women</td>
<td>Discrimination</td>
<td>(415) 252-2570</td>
</tr>
<tr>
<td>Employee Assistance Program</td>
<td>Consultation, training, counseling participation on the MRT</td>
<td>(415) 554-9580</td>
</tr>
<tr>
<td>Equal Employment Opportunity (EEO)</td>
<td>Sexual Harassment Issues (first contact your manager)</td>
<td>(415) 557-4832</td>
</tr>
<tr>
<td>Human Rights Commission</td>
<td></td>
<td>(415) 252-2500</td>
</tr>
<tr>
<td>Occupational Health Services at SFGH</td>
<td>For injuries incurred while working</td>
<td>(415) 206-8998</td>
</tr>
<tr>
<td>The SAFE Program</td>
<td>Offers free work-site lectures on personal, office, home, street and child safety.</td>
<td>(415) 673-SAFE</td>
</tr>
</tbody>
</table>
SECTION 3:
ENVIRONMENTAL HEALTH & SAFETY
Your Rights as an Employee

SFGH is committed to a safe and healthful environment for employees, patients and visitors. As an EMPLOYEE, you have the RIGHT to the following:

- A safe and healthy environment
- Review and request a copy of your medical records kept by your employer
- Any chemical exposure measurements taken in your work area
- Report unsafe/unhealthy work or environmental conditions or acts anonymously
- Report unsafe/unhealthy work or environmental conditions or acts without fear of reprisal
- Refuse work assignment – only when there is immediate danger to life or limb also without fear of reprisal

Injury and Illness Prevention Program Implementation

Environmental Health and Safety (EH&S) Department - EH&S coordinates programs, evaluates hazards, promote safety practices, reviews policies and provides consultation related to industrial hygiene, safety, and state and local regulations.

EH&S coordinate the environmental health and safety program and services which promote a safe and hazard-free environment for patients, visitors and staff located at the SFGH Medical Center.

Committees - Several Committees have been established to address health and safety concerns.

- The Environment of Care Safety Committee ensures that the Hospital manages the hospital environment so that patients, visitors, and employees are protected and can deliver quality healthcare services. It ensures that processes are in place as required by JCAHO.
- The Employee Health and Safety Committee is dedicated to addressing worker health and safety concerns. It ensures that there is ongoing communication between labor and management concerning health and safety program implementation.
- The Bloodborne Pathogen Safe Device Committee is dedicated to reducing the risk of sharps exposures and needle-sticks. The Committee selects sharps safety device, identifies improved work practices, and identifies training content to reduce the risk of exposures.
- Radiation Safety Committee and Laser Safety Sub-Committee.
- The SFGH Disaster Committee is a multi-disciplinary group dedicated to on coordinating and improving the Hospital’s preparedness for and response to internal and external emergencies, multi-casualty incidents, and large scale disasters, with a strong focus on patient safety and staff protection for all disaster hazards.

Policies and Procedures: Managers and supervisors are responsible for:

- Ensuring employees follow written/oral safety and occupational health P&Ps
- Developing departmental safety P&Ps
- Reviewing and updating departmental/unit-specific health and safety P&Ps
**Education and Training** – Environmental Health and Safety and the Department of Education and Training (DET) provide initial and annual training on hazardous materials, hazardous waste, respiratory protection, hearing conservation, asbestos and other health and safety concerns in order to:

- Ensure supervisors and staff are properly trained to perform duties
- Provide job-specific training for staff who conduct special procedures, use personal protective equipment (PPE) or use hazardous materials
- Ensures staff are familiar with the emergency response procedures for:
  - Security Emergencies/Bomb Threat
  - Utility Failures and Electro-medical Safety
  - Chemical/Hazardous materials spills
  - Medical emergencies (injury/illness of staff)
  - Fire and Earthquakes
  - Code Pink
  - Evacuation Plans (departmental, hospital and campus)
  - Overall Emergency Preparedness, Disaster and Mass Casualty Incident Response and Recovery, and the Hospital Incident Command System (HICS)

**Hazard Recognition** – All staff members have the responsibility to be aware of the environment and to report all identified or perceived hazards first to your immediate supervisor.

- If the outcome is not satisfactory, you may report these hazards to the Environment Health and Safety office anonymously and without fear of reprisal by filling out the "Employee Safety Information Form". See the appendix for a copy of Employee Safety Information Form or call Environmental Health and Safety at 206-5482 for copies of the Form. All issues reported on this form will be discussed at the Employee Health and Safety Committee.

Environmental Safety Surveys and Environmental Rounds are detailed checklists for review of individual department safety programs completed annually by each Department Manager and reviewed by the Safety Officer. Environmental Rounds are actual physical inspections of each department conducted at least semi-annually for all patient care areas and at least annually for all other hospital campus areas:

- Identify potential hazards or items for improvement (also reviews specific procedures)
- Initiate corrective action for identified hazards or items for improvement
- Requests assistance/guidance from EH&S or appropriate department/service
- Review/verify abatement of identified hazards
- Follow-ups on items identified for resolution

**Incident Investigations** are conducted of accidents to identify causal factors and ensure corrective actions to prevent recurrences.
Health and Safety Responsibilities
It is the responsibility of all personnel to ensure a safe and healthful environment at SFGH.

Supervisors are responsible for:
- Initiating, controlling, or eliminating workplace hazards
- Notifying Environmental Health and Safety (EH&S) when new substances, processes, or procedures are introduced or changed that represent a safety or health hazard
- Investigating and documenting of all unsafe-unhealthy conditions and/or employee injuries/illnesses identified or reported in your area of responsibility
- Providing training and re-training to ensure employee compliance with safe work practices
- Requiring employees to follow safe work practices including the use of personal protective equipment (PPE)
- Providing PPE
- Ensuring staff are familiar with the emergency response procedures
- Notifying EH&S immediately of Cal-OSHA inspections
- Posting safety posters and Cal-OSHA citations
- Holding monthly safety meetings and retaining meeting minutes for EH&S review upon request.

Employees are responsible for:
- Working in a safe manner
- Using Personal Protective Equipment
- Reporting safety or health hazards first to their supervisor
- Reporting occupational injuries and illnesses to a supervisor
- Attending initial and annual training on health and safety, hazard communication, and if applicable, infection control, bloodborne pathogens, or tuberculosis (if in contact with patients or with blood respiratory secretions or other body substance contact)
- Participating in medical surveillance examinations
- Referring unresolved issues to your Supervisor or to SFGH Environmental Health and Safety.
Hazardous Materials and Waste Management

HAZARD COMMUNICATION

Your Rights as an Employee
As an EMPLOYEE, you are protected under the Cal/OSHA Hazard Communication regulation which states that YOU have the RIGHT TO KNOW the following information:

- Hazard Communication Plan
- The chemicals you work with
- Safe practices for the chemicals you work with in routine and non-routine jobs
- Material Safety Data Sheets (MSDS) for products you use
- Training on all of the products you use (MSDS or Hazard class)

Inventory Products That Contain Hazardous Materials

Chemical management begins by knowing what chemicals are used. The inventory of products that contain hazardous materials are updated:

- Periodically at the request of the Environmental Health and Safety (EH&S) Department. All Units and Departments that use products that contain hazardous materials must update their inventory.
- Whenever a new product is introduced to a Unit or Department.

Information on Hazardous Materials

The two most common sources of information on the products in your work area that contain hazardous chemicals are:

- **Label on the container.** It will list the hazardous chemicals, possible symptoms if you are exposed, and precautions/work procedures to follow to minimize the exposures.
- **Material Safety Data Sheet (MSDS).** It provides detailed information on the chemical, hazards, and precautions. You should know where MSDS’s are available in your Unit or Department and review them periodically.

Call the Environmental Health and Safety Department at 206-5482 for MSDS information or any concerns you may have regarding chemicals or other environmental and occupational hazards.

Storage of Hazardous Materials

Store hazardous materials appropriately at all times in the designated locations. The following is partial list of standard practices that you must follow:

- Secure compressed gas cylinders to prevent tipping or falling.
- Store acids and caustics separately to prevent mixing during storage.
- Store partially full containers in secondary containers to contain spills and drips.
- Store hazardous wastes in secondary containers to contain spills and drips.

Training on Hazardous Materials

You will be trained on hazardous materials: before starting work for the first time as a new employee; before starting work on a new procedure that is introduced for the first time; and annually when refresher training is needed.
HAZARDOUS MATERIALS SPILL RESPONSE

Large Spill or Spill of Unknown Material

- If you spill a hazardous material (chemical or radiation), protect yourself and others. Don’t become a victim. Follow proper spill response procedures.

- **Secure the Spill Area.** Evacuate the immediate area. Close the door to the spill area. Do not step in spilled material. Restrict access to the area. Request help from Security if needed.

- **Assist Injured or Contaminated Person.** If any person is visibly contaminated, instruct that person to remove all contaminated clothing and rinse the affected area (skin and/or eyes) for 15 minutes in emergency eyewash or shower. If no emergency eyewash or shower is immediately available, alert the ED of the imminent arrival of a contaminated patient and escort or transport the person to the ED Decon Shower area in the external gurney storage area near the Ambulance Bay. Use a route outside of the hospital whenever possible and avoid contact with other persons to limit additional contamination. Once gross decontamination has been completed, employees with minor injuries should be sent to Employee Health Services during day shift. All other persons and employees with minor injuries occurring on evening, night or weekend shifts should be sent to the Emergency Department. Any significant injury or illness to an employee or other person resulting from a hazardous materials incident should be evaluated by the Emergency Department.

- **Call for Assistance.**
  - For a Large Chemical Spill: Call Plant Services at 206-8522.
  - For a Large Blood or Body Fluid/Substance Spill: Call Environmental Services (Housekeeping) at 206-8009.

Small Spill Response – Only for Staff Trained to Clean Up Material

Nurses who have been trained in proper spill response procedures may clean up a chemotherapy spill. Spill kits are available through the Pharmacy and should be kept readily available on each unit that uses chemotherapy products.

If you spill a hazardous material (chemical or radiation), protect yourself and others. Don’t become a victim. **You must be trained before you can clean up a small spill.** Follow proper spill response procedures for a SMALL spill.

- **Secure the Spill Area.** Evacuate the immediate area within 10 feet of the spill. Do not step in spilled material. Restrict access to the area. Request help from Security, if needed. Close the door to the spill area.

- **Assist Injured or Contaminated Person.** If any person is visibly contaminated, instruct that person to remove all contaminated clothing and rinse the affected area (skin and/or eyes) for 15 minutes in emergency eyewash or shower. If no emergency eyewash or shower is immediately available, alert the ED of the imminent arrival of a contaminated patient and escort or transport the person to the ED Decon Shower area in the external gurney storage area near the Ambulance Bay. Use a route outside of the hospital whenever possible and avoid contact with other persons to limit additional contamination. Once gross decontamination has been completed, employees with minor injuries should be sent to Employee Health Services during day shift. All other persons and employees with minor injuries occurring on evening, night or weekend shifts should be sent to the Emergency Department. Any significant injury or illness to an employee or other person resulting from a hazardous materials incident should be evaluated by the Emergency Department.

- **Select Spill Control Supplies.** Select appropriate spill clean up supplies: Absorbent pads, waste bag, apron, nitrile gloves, and goggles.

- **Protect Yourself.** Put on an apron, goggles, and gloves. Avoid breathing mist from spilled liquid. Keep liquid off your skin, clothing, and shoes. Do not step in spill. Approach it from the side.
• **Clean Up the Spill.** Cover spill with pads. Allow liquid to absorb into pads. Pick up pads and put into hazardous waste bag. Repeat as necessary to clean up spill.

• **Final Clean Up of Spill Area.** Wipe up residual material with pads. Call Environmental Services to clean up the floor.

• **Collect the Waste.** Put contaminated materials into a hazardous waste disposal bag.

• **Decontaminate Yourself.** Wash hands, face, and other exposed skin that may have been in contact with the hazardous materials with soap and water.

• **Dispose of Waste.** Check the work area and pick up remaining waste and put it into the waste bag. Seal the waste bag: Tape or tie closed. Fill out “Chemical Waste Disposal Form”. Contact Environmental Health and Safety (206-5482) to verify name and amount of waste, and to complete Form. Take completed documentation and bagged waste to Plant Services (206-8522) for disposal in designated hazardous waste shed or cage.

• **Reporting.** Prepare written report that describes spill and response to clean it up, and submit report to Environmental Health and Safety (Building 30, Room 3100).

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**HAZARDOUS WASTE**

Hazardous waste must be managed and disposed of properly to protect the environment, the community, and our employees. There are several different types of hazardous waste and each must be disposed of properly.

- Chemical waste
- Chemical waste: Recyclable batteries
- Chemotherapy waste
- Medical waste: infectious waste
- Medical waste: sharps
- Radioactive waste

**Chemical Waste**

- **Examples of Waste.** Corrosive, ignitable, reactive, or toxic waste; waste that is listed by Cal/EPA; or hazardous waste according to EPA such as formalin, acids, caustics, ethylene oxide, solvents, oil, and fuel that are no longer wanted.

- **Waste Container Description.** Collect chemical waste in a leak resistant, puncture resistant, and sealed container such as a drum or bottle with tight cap.

- **Label on Waste Container.** Label with a complete hazardous waste label.

- **Chemical Waste: Recyclable Batteries**

- **Waste Container Description.** Leak and puncture resistant container. Use gray battery collection container (designed to look like a small garbage can) labeled: “Recycle Batteries Here”.

**Chemotherapy Waste**

- **Examples of Waste.** Any object that is contaminated with or has come in contact with chemotherapy such as an empty medication container, empty vial, IV set up, syringe, gauze, soiled diaper, soiled chux pad, towels, wipes, gloves, Foley bags, bedpans, goggles, and disposable apron. DO NOT POUR LEFTOVER CHEMOTHERAPY SOLUTION DOWN DRAINS.

- **Waste Container Description.** Sealable labeled plastic bag (e.g., Ziplock). Put bag in designated yellow or white puncture resistant chemo waste container located in the soiled utility room. Alternatively, put bag into designated chemotherapy waste container mounted on wall, on the counter, or standing on the floor provided container is large enough to hold the bag.
• Place syringes with needles into a chemotherapy waste sharps container (white or yellow puncture resistant containers). DO NOT RESHEATHE NEEDLES.
• Label on Container. “Chemotherapy Waste” on sharps container or disposal bag.

Medical Waste: Infectious Waste
The biohazardous waste from Clinical Labs (Microbiology) is sterilized before leaving the site. The remaining infectious waste is collected and transported to the Sani-Pack for sterilization.

• Example of Waste. Any object that is contaminated with blood or body fluids such as blood, blood products, IV bags and tubing, IV tubing, needleless syringes, contaminated gauze, wipes, gloves, and tissue specimens.
• Waste Container Description. Red bag is inside a container that is puncture resistant, non-leaking, and has a closable lid. These are available from Environmental Services.
• Label on Container. Red bag is labeled with the universal biohazard symbol and marked with “Infectious Waste”.

Medical Waste: Sharps

• Example of Waste. Any sharps object that is contaminated with blood or body fluids such syringes, sharps, blades, needles, and other objects that can lacerate or puncture the skin.
• Waste Container Description. Red sharps container that is puncture resistant and sealable.
• Label on Container. Universal symbol for bloodborne pathogens.

Radioactive Waste

• Example of Waste. Any sharps object that is contaminated with or has come in contact with radioactive materials such as paper, glass, plastic, sharps, pipettes, blades, liquids, blood, syringes, specimens, urine, bedding, towels, wipes, gloves, goggles, and apron.
• Waste Container Description. Yellow waste bags in metal drums.
• Label on Container. Universal symbol for radioactive material.

Non-Hazardous Waste: Regular Trash

• Example of Waste. Recycle paper and cardboard to minimize waste. Plastic, packaging materials, paper towels, used gloves (no blood).
• Waste Container Description. Waste containers are non-leaking cans with lids which should remain closed. The container is lined with a brown plastic bag that should be tied shut when full and removed to the central trash storage area.
• Label on Container. None required.
Emergency Preparedness and Disaster Response and Recovery

ALL EMPLOYEES MUST BE FAMILIAR WITH THEIR DEPARTMENT OR UNIT-BASED EMERGENCY RESPONSE PLAN

Make assignments and implement your Departmental Plan at the level activated by the Hospital Command Center (HCC). If the Hospital Command Center (HCC) has yet to contact your department - activate your plan at a level that seems most reasonable for the event. Do you have adequate staff, supplies, and equipment to implement you departmental plan? If not, request resources from the Hospital Command Center (HCC) in 2A6.

Complete Your Departmental Operating Status Report (DOSR). When you receive notification, IMMEDIATELY complete the DOSR (Refer to Section 9 of the Emergency Response Plan) and hand deliver the report to the Hospital Command Center (HCC) in Room 2A6.

NOTIFICATION OF DISASTERS AND EMERGENCIES

On-duty Hospital Staff are notified that a disaster situation exists using the following methods:

Overhead Paging System: Hospital Operators and other authorized persons will use the Main Hospital overhead paging system to announce: "The Hospital Incident Command System (HICS) is now in effect." The announcement will indicate the level of disaster activation, and "Code Triage" if multi- or mass casualties are expected. If the activation is a drill, that will also be announced.

Alert Phone System: Outside of the Main Hospital, key departments and individuals will hear HICS activation announcements over select speaker phones.

Administrative Fan Out: The Hospital AOD / Incident Commander will direct staff to notify members of the HICS Incident Management Team via telephone and the Disaster Pager Group text messages.

Departmental Fan Out: Clinical and key support departments will receive a secondary notification and specific instructions via telephone.

Departmental Call Downs: If needed during a disaster activation, the Incident Commander may direct specific departments to call in additional staff by activating the departmental call-down process.

During a disaster activation, the HICS Incident Management Team will issue situational updates and specific directives from on the Disaster Information Hotline at 206-4000 (ext. 4000). Updates to the Disaster Information Hotline will be announced on the Overhead Paging System.

FOLLOW ALL INSTRUCTIONS FROM THE HOSPITAL COMMAND CENTER (HCC)!

Levels of Disaster Response The purpose of disaster level 1, 2, 3 is to facilitate an organized, rapid hospital-wide response with a minimum of instruction. During an actual disaster, the Hospital Command Center (HCC) may issue different, event-specific instructions that contradict your departmental plan. If so, follow Hospital Command Center (HCC) instructions.

Level 1: A Level 1 Disaster will be declared at SFGH whenever there is an internal disaster that may impact the Hospital's capabilities to provide care, or when the San Francisco Emergency Medical Services (EMS) System announces a Red Alert Multi-Casualty Incident (MCI), or whenever there are a significant number of patients from any situation that overwhelms the immediately available, in-house Emergency Department
SFGH Orientation Handbook

(ED) resources. SFGH uses "Code Triage" to indicate that multiple casualties are expected. This triggers specific actions as indicated in the Disaster Plan and each Department’s unit-based plan to facilitate surge capacity - the ability to provide care to a large number of patients. Examples of a Level 1 Disaster would include a PG&E power failure outside of the hospital causing SFGH to be on emergency generator power only, or a large motor vehicle collision resulting in more than 10 seriously injured patients.

**Level 2:** A Level 2 Disaster will be declared at SFGH whenever there is a significant internal event affecting multiple departments or impacting the Hospital's overall capabilities, or when there is an external event expected to result in a large number of casualties. A Level 2 Disaster requires hospital-wide mobilization in order to continue to provide care to existing patients and incoming casualties. Examples of a Level 2 Disaster include a critical circuit power failure affecting key areas within SFGH, or a major BART or Muni train crash.

**Level 3:** A Level 3 Disaster will be declared at SFGH following any event that results in significant damage and/or casualties requiring an extensive, coordinated response to sustain services and provide patient care. A citywide or regional Level 3 Disaster would be declared following a devastating earthquake or terrorist attack that significantly damages buildings or infrastructure, disrupts normal services or systems, and results in a large number of casualties. A Level 3 Disaster may also be activated following a severe internal disaster at SFGH (e.g., an explosion, major fire, or unresolved power outage or other infrastructure failure) that may require evacuation of all or part of the Hospital.

**Evacuation**

The SFGH Evacuation Plan can be found in the SFGH Disaster Manual, Section 7. All staff should be familiar with their Departmental or unit-based evacuation plan before an actual event. This plan is activated by the Hospital Administrator-on-Duty (AOD)/Incident Commander.

**Disaster Response**

Upon becoming aware of any situation that could result in evacuating any portion of SFGH, employees must immediately notify the Hospital AOD by voice paging 1180-371, unless there is an extreme and obvious emergency that requires immediate evacuation to prevent the loss of life.

The evacuation of the Main Hospital, the Behavioral Health Center and other outlying outpatient and service buildings will be considered only under extreme emergency conditions. Once the decision has been made, evacuating should be done quickly and quietly, with a minimum of confusion, duplication of efforts, and risk to patients and staff.

In the event that it is determined that immediate evacuation of all or part of the facility is necessary, a Level 3 Internal Disaster will be declared by the Incident Commander. Horizontal evacuation always occurs before vertical evacuation. Each Hospital Department manager is responsible for staff education on evacuation.

Each disaster is different, therefore, the Hospital Command Center (HCC) may instruct you to evacuate in a more efficient method for the amount of resources and time available. FOLLOW ALL ORDERS FROM THE HOSPITAL COMMAND CENTER (HCC).

Refer to CHN SFGH Disaster Manual for evacuation and Hospital Emergency Incident Command System (HEICS) Policies.
Earthquake Preparedness

During an Earthquake

- Protect yourself and your patient or client until the shaking stops. REMAIN CALM.
- Do not try to exit the building. Advise patients, clients, staff, and visitors not to exit the building unless specifically ordered to do so by the Hospital Command Center (HCC) or the Fire Department.
- Take shelter if possible. Get under a strong table, counter, desk or move toward an inner wall away from windows. Move away from objects that may topple and fall.

After an Earthquake

- If working in a clinical area, check all patients and visitors for injuries
- Proceed carefully. Floors may be covered with broken glass, water, sewage or hazardous materials.
- Clear hallways and potential evacuation routes. Remove all carts, chairs, wheelchairs and other items that may block the hallways or slow passage in the event of an aftershock and evacuation.
- Move patients away from windows. Pull curtains to protect from flying glass.
- Be careful opening cupboards and closet - thing may fall out.
- Follow all instructions in “What to do in the Event of any Disaster”
- Prepare for aftershocks. Remove heavy items from upper shelves and place on the floor. Secure all hazardous and/or breakable containers. Lock all drawers, cabinets, and filing cabinets. Set locks on all rolling carts and beds.

Evacuate to the next safest area on your floor if there is damage in your immediate area and wait for further instruction. Move patients and clients away from windows. Pull curtains closed.

Do no use elevators or stairwells unless instructed to do so.

In the outlying brick buildings, evacuate down the stairs, outside, and away from the building. Proceed carefully. Floors may be covered with broken glass, water, sewage, and/or hazardous materials. Be careful opening storage units and closets – things may topple out.
Fire Safety

FIRE RESPONSE

Code Red

When the fire bells alarm or the overhead paging system announces “Code Red” or “Code Red Drill: LISTEN, OBSERVE, CLOSE DOORS, STAY ALERT!

R-A-C-E – Implement R-A-C-E during a fire or fire drill:

<table>
<thead>
<tr>
<th>R</th>
<th>A</th>
<th>C</th>
<th>E</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rescue:</td>
<td>Pull the Fire Alarm (located at every exit).</td>
<td>Close doors and windows.</td>
<td>To operate a fire extinguisher. Remember P-A-S-S</td>
</tr>
<tr>
<td>Alarm and Alert:</td>
<td>Call 911</td>
<td>Shut off oxygen sources in immediate area</td>
<td>Be sure you know where the fire extinguishers and evacuation maps are located in your area (do not use the elevators!)</td>
</tr>
<tr>
<td>Contain:</td>
<td>Call out “Code Red” to other staff in the area</td>
<td>If necessary, evacuate patients and staff to the nearest safe area on your floor</td>
<td>If you work in a brick building, evacuate to the outside</td>
</tr>
<tr>
<td>Extinguish and/or Evacuate:</td>
<td>Person in immediate danger</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Fire Response to Fire Bell Chimes

Three sets of bells will chime, with pauses in between, when a fire alarm is activated in the main hospital and “M” clinic building.

First Set of Bells: Gives the fire area building location
5 Bells = Building 5, Main Hospital, and M Clinic Building

Second Set of Bells: Identifies the floor on which the fire is occurring
1 Bell = Basement
2 Bell = 1st Floor
3 Bell = 2nd Floor
And so on ...

Third Set of Bells: Identifies the code number and location of the activated alarm device.
The Mental Health Rehabilitation Facility alarms are on a voice annunciation system.
Buildings 1, 9, 10, 20, 40, 80, 90, and portions of 100 no longer have the chime system. Strobe lights and/or horns will sound when the fire alarms are activated in these areas.

P-A-S-S

Fire extinguishers are intended for small fires such as in a waste container. For large fires, implement R-A-C-E. Use a fire extinguisher only if you have been trained.
How to Use a Fire Extinguisher

Remember P-A-S-S when using a fire extinguisher:

1. **Pull** the pin

2. **Aim** low. Point the extinguisher nozzle at the base at the base of the fire.

3. **Squeeze** the handle. This releases the extinguisher agent.

4. **Sweep** from side to side. Keep the extinguisher aimed at the base of the fire and sweep back and forth until appears to be out.

Smoke-Free Campus

It is the policy of SFGH to PROHIBIT the use of smoking materials in throughout the SFGH hospital campus. Lack of compliance with this policy can result in disciplinary action. All employees and medical staff are responsible for informing visitors, contractors, volunteers, students and other individuals of the policy. To sign up for smoking cessation classes, call 206-4076.
Utility and Equipment Failure

Who to Contact

- Call SFGH Plant Services for Electrical Failure, Loss of Water, Floods, Medical Gas or Non-Medical Equipment Problems at 206-8522.
- Call SFGH Biomedical Engineering at 206-8726 for Medical Equipment Problems.

Electrical Failure

Before

- Know where emergency lighting and red emergency power outlets are located.
- Know where your flashlights are kept.
- If you work in a patient care area, know where the emergency power is for patient equipment.
- If you work in a non-patient care area, know your departmental plan for backup of all critical computer information systems.

After

Remain calm. SFGH has back-up emergency power generators that will restore emergency electricity and lighting to patient and client care areas.

If you work in a patient care area:

- Check your patients. Make sure they are safe, calm, comfortable and accounted for.
- If patients are on life sustaining equipment, be sure all equipment is functioning properly.
- If there is any delay in power restoration, evaluate patients for any changes in status due to power failure. Check all equipment to be sure it is functioning properly.
- At no time during a power failure should patients be evacuated from the hospital without instructions from the Hospital Command Center (HCC).

If you work in a non-patient care area:

- Check office equipment for problems.
- Call the SFGH Information Services Help Desk if you need assistance restoring your computer systems at 206-5035.

Conserve Energy!

YOU have an impact on how much electrical energy SFGH, the Community, and your family uses each day. Be aware of and practice energy conservation.

Conservation Measures

Conserve energy whenever possible.

- Turn off unused lights and **NON-ESSENTIAL EQUIPMENT** when no one is present during work and at the end of the work shift.
- Turn off unused lights when no one is present.
- Use task lighting.
- Open curtains or shades for light.
• Turn your computer monitor off when not in use.
• Turn off battery chargers when not in use.
• Reduce the use of NON-ESSENTIAL EQUIPMENT.
• Identify essential equipment: Is it critical to patient care?

Curtailment Measures
• If curtailment procedures are announced, take the following actions:
  • Turn off NON-ESSENTIAL EQUIPMENT.
  • Turn off personal computers, copiers, lights, scanners, etc.
  • Turn off/unplug battery chargers.
  • Turn off/unplug water coolers.

What is Non-Essential Equipment at Work?
Identify, tag, and manage non-essential equipment appropriately. The following are considered to be NON-ESSENTIAL EQUIPMENT since they are not vital for delivering clinical care directly to patients:

- Audiovisual equipment
- Battery chargers
- Calculators
- CD players
- Coffee makers
- Copy machines
- Fax machines
- Fans
- Ice machines
- Machinery tools
- Microwaves
- Personal computers
- Radios
- Scanners
- Shredders
- Television sets
- Water coolers
- Many others
Medical Equipment Safety

Electro-Medical Equipment Safety and Care

Electro-medical equipment care refers to those clinical areas that care for the electrically sensitive patient who may have one or more of the following therapies: pacemaker, central line IV, chest tube, IV pump, feeding tube, cardiac monitor, mechanical ventilator, telemetry, pulse oximeter, automatic blood pressure monitor, indwelling catheter(s), or other invasive devices. These patients are especially susceptible to "micro shock" from very small amounts of electricity.

Guidelines for electrical safety

- All direct patient care electro-medical equipment must be inventoried and inspected by Biomedical Engineering prior to use on patients. All devices will be inspected annually. Devices that have been inventoried will bear a Control Number sticker (see example). Devices that have been inspected will bear a sticker indicating the date of the most recent inspection. If you find a device with a sticker date older than one year or one that does not bear a control number, you must notify Biomedical Engineering of the location of that device. Devices without control numbers must be removed from use until they are inventoried and inspected.
- Non electro-medical equipment that may be involved in patient treatment (such as lamps, fans, beds, etc) are inventoried and inspected by the Facility Services department.
- If you suspect that you or a patient have experienced an electrical shock or believe that a device is faulty, you must remove the suspected device from use, tag it with a "Red Tag" (see example), and notify Biomedical Engineering or Facility Services. (See PTRR" below).

Examples:

BME Control Sticker (Red)
(Call 206-8726 for Service)

Inspection Sticker

Facility Control Sticker (Blue)
(Call 206-8522 for Service)
• **PULL** the defective device from use

• **TAG** the device to identify it for others as defective

• **REPORT** the device to the appropriate service group

• **REPORT** any patient risk that occurs as a result of a faulty device by completing an “unusual Occurrence” form. This may not be necessary with every failed piece of equipment, only if the device caused specific risk to a patient’s health.

**Example Red Tag:**

• As a precaution against static shock to patients, touch a grounded surface prior to touching a patient who has indwelling pacing leads or other such invasive connections. A good ground source is the metal case or grounding pin (a bare metal stud on the back of many devices, identified by the symbol for “ground”: a triangle with a circle within it or, a series of horizontal lines forming a triangle) on any electrical device that is plugged into a wall. Also, metal screws on wall outlets or light switches are a good grounding spots. Devices that are operating off of batteries or wall plug power supplies will not provide a ground; neither will IV poles or non-metallic device cases.

• Avoid placing fluids on top of electrical equipment or in places where fluids could spill into or onto electrical equipment.

• The use of extension cords is generally discouraged but when they are necessary only “hospital grade” extension cords should be used. Such cords must be approved by Facility Services in advance.

• Do not operate electrical equipment that you are unfamiliar with or have not been properly trained to use.
Cellular Telephones and Communication Devices

Cell phones and other personal communication devices that use radio waves are known to interfere with the operation of electronic medical equipment. Use of these devices is not allowed in areas of the hospital where electronic instrumentation is in use. Cell phones, cordless phones, or walkie-talkies are not to be activated within six (6) feet of electronic medical instruments. All critical care areas are prominently marked with signs cautioning against the use of wireless devices, however, many portable devices attached to patients who are being moved from ward to ward may also be sensitive to radio waves. Be aware of the patients around you and when in doubt, use a wall phone. **Cell phones must be TURNED OFF in posted areas since they will interfere with medical instrument even when they are in “standby” mode.** Pagers do not interfere with patient devices and may be left on at all times.

Other Wireless Devices

Due to the rapid growth of “wireless” technology and the possibility that these devices may have an impact on patient care, patient confidentiality, security systems, or other electro-mechanical equipment; the purchase and use of wireless devices within SFGH is limited. Authorization to use such devices can be obtained through the Facility Services Department on a case by case basis.

Magnetic Resonance

You may see warning signs indicating “Strong Magnetic Field” about the hospital. Do not go beyond these signs unless you have been trained to work around a Magnetic Resonance Imager (MRI). The magnetic field that surrounds these devices is strong enough to pull an oxygen cylinder off a gurney.

Security Management

PERSONAL SAFETY

- Be aware of your surroundings! Be Alert!
- Report any suspicious activity or non-urgent security issues to the SFGH Sheriff’s office 206-8063.
- Call the Sheriff’s office, 206-4911 regarding any employee emergency safety or security issue.

SFGH Identification (I.D.) Badge Policy

- **Employees must wear the SFGH or UCSF photo identification badges at all times.** If you lose or misplace your photo identification, replace it as soon as practical at the Human Resource Department, CHN HQ, 2789 – 25th Street, 3rd floor. Hours for I.D. badges are Monday, Wednesday, and Friday from 9:00 to 9:30 am or Tuesday and Thursday from 2:00 to 2:30.
- Refusal to wear a required photo I.D. badge could result in disciplinary action.
- If you see an unfamiliar person in your work area, ask “May I help you?” Notify the SFGH Sheriff’s office at 206-8063 if an unauthorized person is in your area.

Exits and Alarms

- All entrances to SFGH are locked with the exception of the Main Hospital Lobby Entrance. The Outpatient Lobby Entrance is locked after 5pm. Doors can still be exited for fire safety. Alarms will sound when anyone uses these exits.
- Do not use unauthorized exits unless there is an emergency.
- If you hear an audible alarm go off, report to the SFGH Sheriff’s office immediately, at 206-4911.
Employee Escort Services

- CHN at SFGH Sheriff’s office provides car escorts for employees to their vehicles, the nearest bus stop, or the 24th and Mission Street BART station (after the shuttle has ceased operations). This service is provided from 5pm to 1am.
- Employees requesting escorts should call 206-8063, or after 8pm report to the Information Desk at the Main Lobby.

Bomb Threat or Suspicious Package

If You Receive a Bomb Threat by Phone

If you receive a call from anyone that claims a bomb or explosive device may be located in the Hospital or on the SFGH campus, take the following actions:

- Use the “Bomb Threat Checklist” (see next page) and gather as much of the information as possible.
- Do NOT interrupt the caller. Record all pertinent information on the Checklist.
- When you finish the phone call, immediately notify the SFGH Sheriff’s office at 206-4911.
- Notify your immediate supervisor.

The SFGH Sheriff’s Office Will Direct Your Response

The SFGH Sheriff’s office Watch Commander in collaboration with the Incident Commander will determine the appropriate course of action based upon available information, (i.e., search, area evacuation, etc. The Departmental Notification Fan out will be used to alert staff of the course of action.

If the location of the bomb or the threat is suspected or known, the following will occur:

- The SFGH Sheriff’s office Watch Commander or designee will dispatch an officer(s) to conduct a search of the area.
- The SFGH Sheriff’s office may direct staff to search their workplace for suspicious or out of the ordinary package(s), equipment, etc. Individual employees will know best what belongs in their work area and may assist in searching the work area
  - Staff member should remove all purses, backpacks, lunch boxes, and personal items to facilitate the search;
  - If no unusual items are found, the staff member must leave a note on the office door or entrance to the workspace stating "nothing found", along with the date, time, and their signature;
  - If the staff member identifies an item that he/she feels is suspicious or does not belong in this area, they should leave the area and immediately notify the SFGH Sheriff’s office.

AT NO TIME SHOULD STAFF OR SHERIFF’S DEPUTY TOUCH OR MOVE THE DEVICE OR SUSPICIOUS PACKAGE.
Bomb Threat Received by Phone – Checklist

Information sheet for the person RECEIVING the call

Do not interrupt the caller. If possible, ask the following questions:

- Are you trying to hurt the hospital or me?
- When is the bomb going to explode?
- Where is it right now?
- What type of bomb is it?
- What is your name?
- What will cause it to explode?
- What does it look like?
- Did you place the bomb?
- Why?
- Where are you?

Exact wording of the threat

<table>
<thead>
<tr>
<th>Callers Voice:</th>
</tr>
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<tbody>
<tr>
<td>Calm</td>
</tr>
<tr>
<td>Angry</td>
</tr>
<tr>
<td>Excited</td>
</tr>
<tr>
<td>Slow</td>
</tr>
<tr>
<td>Rapid</td>
</tr>
<tr>
<td>Slurred</td>
</tr>
<tr>
<td>Laughter</td>
</tr>
<tr>
<td>Loud</td>
</tr>
<tr>
<td>Crying</td>
</tr>
<tr>
<td>Normal</td>
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<tr>
<td>Distinct</td>
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<tr>
<td>Stutter</td>
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<tr>
<td>Nasal</td>
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<tr>
<td>Lisp</td>
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<tr>
<td>Raspy</td>
</tr>
<tr>
<td>Deep</td>
</tr>
<tr>
<td>Ragged</td>
</tr>
<tr>
<td>Disguised</td>
</tr>
<tr>
<td>Clearing throat</td>
</tr>
<tr>
<td>Deep Breathing</td>
</tr>
<tr>
<td>Cracking voice</td>
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</tbody>
</table>
| Familiar, who do they sound like?:

<table>
<thead>
<tr>
<th>Background Sounds:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street noise</td>
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<tr>
<td>Voices</td>
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<td>PA system</td>
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<tr>
<td>Music</td>
</tr>
<tr>
<td>House noises</td>
</tr>
<tr>
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</tr>
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<td>Long Distance</td>
</tr>
<tr>
<td>Local</td>
</tr>
<tr>
<td>Booth</td>
</tr>
<tr>
<td>Factory machinery</td>
</tr>
<tr>
<td>Office machinery</td>
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<tr>
<td>Other:</td>
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</table>

<table>
<thead>
<tr>
<th>Threat Language:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well-spoken</td>
</tr>
<tr>
<td>Foul</td>
</tr>
<tr>
<td>Irrational</td>
</tr>
<tr>
<td>Taped</td>
</tr>
<tr>
<td>Incoherent</td>
</tr>
<tr>
<td>Accent</td>
</tr>
</tbody>
</table>

Gender of Caller:   [ ] Male   [ ] Female  Approximate age: ______________________________

Length of Call: ______________________________  # Where call received ______________________________

Time: __________  [ ] AM  [ ] PM  Date: ______________________________

Evacuation

If a suspicious device is found or if there is sufficient evidence that there could be a safety threat to staff or patients, the Sheriff's Deputy Watch Commander or designee in conjunction with the Incident Commander shall order an evacuation of the area within a 300 ft radius around the device. The Incident Commander may use the departmental notification system to alert staff of the need to evacuate. Refer to Hospital Emergency Response Plan and Unit based evacuation plans.

Staff with keys to doors, desks, filing cabinets, etc. should be on hand in the event the SFPD EOD need to inspect these areas.
Conducting a Search for a Bomb

The goal of the persons who conduct a search is to search for and report only suspicious devices. Never move, jar, shake or touch an object or anything attached to that object.

In order to save time and limit confusion, staff conducting the search should be familiar with that area.

As each area is searched and no suspicious items are found, a note should be placed on the door stating "nothing found", the time and the initials of the person who searched.

The size of the area should determine the number of persons who search. This number should be limited so that areas are not bypassed, noise is limited and there is no redundancy of actions.

Searching the Work Area

Step 1. Close your eyes and simply listen for 30 seconds. Note any unusual noises or absences. Repeat this action facing all four directions.

Step 2. Search from the floor to waist level. Divide the room according to the number of persons conducting the search.

- FIRST SWEEP: Start with search party members back to back. Begin searching the wall areas. When members meet again at the division point, search the center of the room.
- SECOND SWEEP: Search from waist to head level; proceed as with first sweep.
- THIRD SWEEP: Search from head to ceiling level; proceed as with first sweep.

If You Find a Suspicious Object

- Note the time the object is found, the exact location, and report the description to the Incident Hospital Command Center (HCC) or Sheriff's Deputy immediately.
- Do not cover, bury, submerge, move or tamper with the device in any way.
- Doors and windows should be left open.

Code Pink – Infant or Child Abduction

"CODE PINK" ON OVERHEAD PAGE

If you discover that an infant has been abducted, call 206-4911 IMMEDIATELY

A Code Pink is initiated when there is a suspected or actual infant/child abduction. You will hear "Code Pink" on the overhead page. When a Code Pink is initiated, specific individuals are assigned to secure critical exit doors and perform floor by floor searches of the main hospital.

"CODE PINK" Response

Direct all persons who wish to leave the Main Hospital to exit through the Main Lobby.

Personnel are mobilized to

- Minimize harm to the infant/child and reunite the family as quickly as possible.
- Provide support to the infant/child’s family through coordinated communication with the parents, the hospital staff, and the media.

Employees are expected to become "extra alert" when they hear the overhead page "Code Pink. If your normal work area is the Main Hospital Building, your department may assign you to assist in conducting searches for the infant/child within and around your work area.

This includes:

- Searching wastebaskets, bathroom stalls & garbage cans, stairways
- Looking for infant clothing, abandoned infant items, and/or abandoned adult items
• Looking for diapers, tee shirts, blankets, or adult caps, jackets, shirts, scrub outfits that might have been used to cover up abductor(s) own clothing or appearance
• Report all suspicious persons and finding to 206-4911

At no time are you expected to confront a suspected abductor, but you may be expected to describe the individual(s) who are acting in a suspicious manner or you might be asked what direction the individual(s) took.

If your normal work area is in one of the red brick buildings, you must be alert to suspicious individual(s) and inform the Sheriff's Department of any unusual behaviors.

**Ergonomics**

**COMPUTER USER SAFETY**

**Helpful Hints for Repetitive Computer Keying**

• Avoid static loads and fixed work postures. Avoid leaning to the front or the side.
• Avoid holding an extremity in a bent or extended positions.
• Avoid bending the torso forward or backward for extensive periods of time.
• Fingertips should be relaxed and near the keys. Key softly!
• Relax your thumbs while keying.
• Relax your shoulders.
• Sit tall.
• Use gliding movements for control while keying.
• Fingers, hands and forearms should be warm when you begin to type.
• A good wrist/forearm rest should be well padded, easy to glide over, and elevated sufficiently that the wrists are in a neutral position while keying.
• Mini-breaks, 1-2 minutes, should be taken after 30-40 minutes of sustained repetitive work.
• Stretches at work can promote circulation, reduce stiffness, maintain flexibility, and reduce the chances of disabling injury. Take a break from keying for 15 minutes after 2 hours of keying.

**Making an Ergonomically Safe Work Station**

• Have a comfortable work surface height (two inches below elbow level) when sitting.
• Your chair and work surface height should be adjusted so your hips and knees are approximately level and your feet are flat on the floor.
• Have total work area within easy reach to eliminate straining, reaching, and twisting. Easy reach is from just above the shoulder to just below the hip. An excessive reach is greater than 16 inches.
• Support your limbs. Utilize elbows, wrist, arm, foot and back rests where needed
• Remove boxes and clutter from below your table/work space to allow knee space while working.
• Utilize document holders held at eye level.

**Computer Work Station Guidelines**

Learn how to adjust your workstation so it fits you.

• **Adjust your chair.** A properly adjusted chair will assist in preventing cramping and stiffness in you legs. It also helps to prevent stress and tension in you neck and shoulders. Facing the computer, adjust the height of the chair until your arms are parallel to the floor and your wrists are straight at the keyboard. Move your feet forward until the knees are a 90-degree angle. Your feet must rest firmly on the ground. If your feet cannot reach the ground, use a footrest.
• **Adjust your backrest.** Sit at your workstation. Lean back slightly with your back firmly against the chair. Your lower back must fit snugly against the backrest. If you cannot adjust the backrest, use a small, thin, firm pillow or a rolled up towel to support your lower back.

• **Adjust your screen height.** A proper screen height can reduce eye strain and muscle tension in your neck, shoulders, and upper back. Adjust the screen height until the top of your monitor is at or below eye level while sitting in your chair. The screen should be approximately an arm’s length from your eyes.

• **Adjust your hand position.** Place your fingers on the middle row of the keyboard. Your wrist should be relaxed and straight. A wrist rest can be used to assist in keeping your wrist relaxed.

• **Adjust work station materials.** Arrange all work materials and tools directly in front of you to reduce wrist twisting motions. Place telephones, staples, and pens within easy reach. Place items you do not use frequently further away. Place your document holder and screen at the same height and distance. If you use a telephone frequently, consider the use of a headset.

• **Avoid lighting glare.** Glare is the reflection on your screen that makes it hard to see the screen clearly. Glare may be caused by sunlight on your screen or by inside light such as overhead and desk lamps. Subtle light adjustments can help minimize glare and reduce strain on your eyes. Adjusting your screen’s contrast and brightness can help improve viewing comfort.

• If you are unable to figure out how to adjust your furniture, ask your supervisor or a knowledgeable co-worker for assistance. If you begin to have pain while working, notify your supervisor or the Environmental Health and Safety Officer at 206-3755.

LIFTING AND BODY MECHANICS REMINDERS

• **Ergonomic Workstation**

• **Six Commandments of Lifting**

• **Body Mechanics: Do's and Don'ts For Your Back**

• **Your Back at Work: Patient Care Personnel**

**Ergonomic Workstation**

**Posture:** Sit all the way back into the chair for proper back support. Back and neck should be comfortable straight ahead. Knees should be slightly lower than hips. Don't cross legs or shift weight to one side.

**Screen:** Eyes should be level with the top of the screen. The screen should tilt vertically and swivel horizontally. User should remain 18” to 28” from the monitor.

**Keyboard:** Position the keyboard to allow hands and forearms to remain straight and parallel to the floor. A wrist rest will aid proper keyboard position.

**Document Holder:** Mount the document holder at the same height and distance from the user as the screen, so that the eyes can remain focused as they look from one surface to the other and neck movement is minimized.

**Chair:** Seat contours should follow your back. Adjust chair height so you do not feel pressure on your tailbone (seat too low) or lower thighs (seat too high). Adjust chair height and seat back so that you can key with straight hands and wrists.

**Desk:** A comfortable desk is particularly important if you keep the keyboard on your desk. The work area should allow for legroom and posture adjustments.

**Feet:** The entire sole of the foot should rest comfortably on the floor or footrest and point towards the workstation.
Comfort Stretches
THE SIX COMMANDMENTS OF LIFTING

1. Get a firm footing. Keep your feet apart for a stable base; point toes out.

2. Bend your knees. Don’t bend at the waist. Keep the principles of leverage in mind at all times. Don’t do more work than you have to.

3. Tighten stomach muscles. Abdominal muscles support your spine when you lift, offsetting the force of the load. Train muscle groups to work together.

4. Lift with your legs. Let your powerful leg muscles do the work of lifting, not your weaker back muscles.

5. Keep load close. Don’t hold the load away from you body. The closer it is to your spine, the less force it exerts on your back.

6. Keep your back upright. Whether lifting or putting down the load, don’t add the weight of you body to the load. Avoid twisting; it can cause injury.

Patient Care Personnel
Your job requires you to perform a variety of physical tasks, including lifting, pushing, and reaching. In addition, you work in different locations and positions. Good posture and body mechanics are necessary to protect your back and help reduce fatigue. With practice, good posture and safe techniques for lifting and moving will become good habits that don’t require extra time.

Learn to recognize your limits. Don’t stay in any one fixed position too long. Get help moving objects or patients that are too heavy to move safely by yourself.
**Working at the Bed Side**

- Stand close to the patient. Move bedside tables or chairs out of your way.
- Adjust the height of the bed so that you don’t need to bend over.
- Lower the bed-rail so you don’t need to reach over it.
- If you need to reach across the bed, rest one knee on the bedcovers. Bend forward at your hips, not your waist.
- Have a second person help you if you need to move the patient up to the head of the bed.
- Raise the bed rail for safety before you leave the patient.

**Working at the Chair Side**

- Position yourself close to the patient so you won’t need to bend forward.
- Sit on a chair or stool if possible and appropriate to the task. This puts you at the patient’s level without bending.
- If you cannot sit, bend your hips and knees. Do not bend forward at the waist.
- Keep your head and chest lifting to help maintain your neutral spine position.

**Lifting from a Low Surface**

- Stand close to the object
- Bend at your hips and knees. Do not bend forward at the waist.
- Keep your head and chest lifted and your buttocks out slightly to keep your spine in neutral.
- Tighten your abdominal muscles
- Move with control. Don’t rush.
Pushing Beds or Carts

- PUSH rather than pull heavy objects whenever you can.
- Tighten your abdominal muscles and keep your neutral spine position.
- Stand close to the bed or cart you are pushing. Bend your elbows and keep your shoulders down.
- Keep your trunk as upright as possible. If the cart or bed is too low, bend at your knees. Don’t bend forward at the waist.

Assist Falling Patient

- If the patient has mild unsteadiness, you may be able to help him or her regain balance and sit in a nearby chair. Do not grab a patient’s arm.
- If a patient is falling, don’t try to prevent the fall. Lower the patient to the floor gently.
- Bend at your hips and knees; do not bend forward at your waist. Stay with the patient.
- Get help as needed and try to make the patient comfortable.
- Have a second person help lift the patient to a chair when the situation has stabilized.
SECTION 4:
CLINICAL STAFF ORIENTATION
Privacy and Confidentiality

What does privacy and confidentiality mean in health care?
- Privacy and confidentiality in health care means ensuring the integrity and privacy of all information, written and spoken, regarding a patient’s health, and personal and medical record information (paper or electronic).
- Patient information may not be accessed, used, discussed or released except as required in the performance of an employee’s duties within the Department of Public Health.

Who is responsible for maintaining privacy and confidentiality?
- Anyone who comes into contact with a patient.
- Anyone who has access to medical records and protected health information.
- Anyone who is responsible for transmitting protected health information via telephone, fax or computer.
- Anyone who uses protected health information in the performance of job duties.

Why is maintaining confidentiality important?
- Patients have a basic and legal right to privacy.
- All personnel who have access to protected health information need to make sure that any release of patient data is in accordance with guidelines and laws that govern the release of protected health information.
- Breaks in confidentiality can have devastating effects on patients and their ability to recover from illness.
- Lack of confidentiality can destroy family relationships, damage trust between the patient and care providers, or diminish the patient’s position in the community.
- If confidentiality is not maintained, the patient has the right to sue the institution and the people involved.

What do I need to do to maintain confidentiality?
- Follow policies and procedures regarding handling of protected health information.
- Maintain the security of your computer sign-on and password when looking up any information related to a patient such as charting, ordering, or reviewing medical or financial data (do not display your password or let others use your password).
- Do not talk about patients in public areas (like the elevator, hallways, cafeteria, local restaurants, or on your cell phone in public areas).
- Remind others about privacy and confidentiality if you hear them discussing protected health information in public areas.
- Be careful about what you say and how loudly you are talking when discussing patient care issues at a nursing station.
- Do not visibly display patient information in public areas where it can be seen (for example, patient census boards with extensive information, leaving a patient chart in the room where other people can look at it, or leaving open charts around the nurses’ station).
- Do not transmit protected health information via e-mail.
- Do not look at patient information unless it is related to your job responsibilities.
- Log out of clinical computer systems when leaving a workstation. You may be held responsible if others access information using your sign-on.
- Do not give out information about the patient to family members or friends unless authorized to do so by the patient.
- Do not release protected health information except as defined by hospital policy 6.1 and 3.10.
What are the consequences of violating patient privacy and confidentiality?

- You may be subject to legal prosecution as required by current federal and state laws. Recent California laws created penalties for individuals involved in a breach confidentiality.
- You may be subject to progressive discipline up to and including termination.

What should I do if there is a major problem regarding patient confidentiality?

- Report to your supervisor or call compliance hotline at (415) 642-5790.

Where do I go for more information?

Hospital Policies:

- 6.1 Transmitting Confidential Medical Information via Fax
- 9.10 Information Systems: Confidentiality and Security of CHN Patient Data
- HIS: Confidentiality, Security, and Handling of Medical Record information and the Release and Use of Data

Adverse Drug Reactions

What is an Adverse Drug Reaction (ADR)?

- An adverse drug reaction is a serious, noxious, unintended, or undesirable clinical event (symptom, sign, or lab finding) caused by a drug administered for prophylactic, therapeutic or diagnostic purposes. Treatment failures and effects of intentional poisoning or drug abuse are not considered ADRs.
- An ADR can be an allergic reaction or can effect any organ system.
- An ADR is any unexpected effect possibly related to administration of medication.

What are some examples of ADRs?

- Onset of rash after initiating a new drug.
- Hives, respiratory distress after IV contrast.
- Respiratory depression or excessive sedation due to opiates or benzodiazepines.
- Significant hypoglycemia related to the administration of insulin.
- Angioedema secondary to ACE inhibitors.
- Abnormal facial movement and/or neck stiffness secondary to phenothiazines.
- Unexpected bleeding due to Coumadin.
- Excessive hypotension due to antihypertensives.
- Evidence of renal failure (- creatinine), hepatic failure (- LFTs), rhabdomyolysis, or diarrhea after a new medication is started.

Why is it important to report ADRs?

- For patient safety.
- To prevent recurrence
- JCAHO requires reporting.
- To identify and report previously unknown drug interactions and reactions to a national database.
- Institutional recommendations and policies on medication dosages, systems of administration, and monitoring parameters may be adjusted as a result of the analysis.

How are ADRs analyzed?

- A pharmacy representative reviews the case and medical record.
- The case and literature review of the ADR is analyzed.
• ADRs are a significant part of our hospital’s performance improvement activity.
• ADRs are reported to the Performance Improvement and Patient Safety Committee (PIPS).

How are ADRs documented?
• ADRs are listed on the patient’s problem list and in the Lifetime Clinical Record (LCR).

Who can report an ADR?
• Any medical caregiver (e.g. MDs/ RNs/ LVNs/ students or pharmacists) can report an ADR.

How is an ADR reported?
• Call the 24 hour ADR Hotline at 206-4282.
• Complete an ADR form, which is located in all nursing units and clinics. Additional forms may be obtained from the Inpatient Pharmacy at 206-8460.
• Reporting is confidential.
• You do not need to give your name. However, if you would like a follow-up report, please leave your name and address.
• Report even if you’re unsure and always complete an Unusual Occurrence Report
Reference: Hospital Policy and Procedure 1.9

Blood Transfusion/Administration

What is a blood transfusion?
• A blood transfusion is the infusion of whole blood or blood components directly into the blood stream.

Who may administer blood products?
• RNs may administer blood with a physician order.
• LVNs, under the supervision of a RN may administer if I.V. certified by the State of California.

How are blood products obtained from the Blood Bank?
• The physician writes the order in the Medical Record indicating the # of units of a specified product to be infused.
• Personnel transcribing the order complete the Blood Bank requisition (either computerized or paper copy) and send it to the Blood Bank.
  – The requisition must include the physician's name and beeper #, and the signature of the person drawing the specimen.
  – The Blood Bank will notify the Messenger to deliver the blood product to the specified unit when the product is available.

What checks are in place to ensure safe administration of blood products after delivery to the unit?
The RN/LVN or MD must:
• Confirm that the product delivered is labeled for the correct patient and sign the delivery receipt with their name and time of delivery.
• Check the written physician order.
• Verify that the patient signs the Transfusion Consent.
• If the transfusion is an emergency, the consent form must be in the record with the "Situation Box" checked and the physician's signature authorizing the transfusion.
• 2 individuals, (RN, LVN, or MD) one of who is the transfusionist must, while at the patient's bedside.
  – Obtain verbal identification from the patient by asking him/her to state their name, if able.
– Read aloud and compare the stated name with the name on the Identification band and on the Blood Bank Transfusion Report (attached to the blood product)
– Read aloud the ABO/Rh type of recipient and donor on the Transfusion Report and on the donor label affixed to product.
– Read aloud the expiration date of product.
– Read aloud any special requirements.
– Sign the Transfusion Report, including the date and time the transfusion began.

• The RN/LVN or MD must return untransfused or unused product to the Blood Bank (via Messenger) within 30 minutes if any discrepancies are noted, or if the integrity of the blood bag or product raises suspicion (i.e. leaks, discoloration, presence of clots or clumps)

What special considerations should be given when transfusing the product?
• The patient should be taught to report any unusual signs or symptoms (including, but not limited to itching, shortness of breath, flushing, low back pain).
• Medications to lessen or prevent reactions may be ordered.
• Intravenous access is ideally with an 18-gauge needle.
• All blood must be infused within 4 hours from the time of issue from the Blood Bank.
• Starter solutions are limited to Normal Saline and Plasmalyte 148. All other solutions will cause hemolysis and clotting.
• Medications may not be added to any blood product transfusion.
• Vital signs should be checked pre-transfusion, 15 minutes and 1 hour after the start of transfusion, and one hour after the transfusion is completed.
• Whole blood and packed cells must be administered with filtered blood tubing.
• Blood tubing must be changed every 4 hours, or when the ABO type changes with a new unit.
• Blood products other than whole blood and packed cells may have different tubing requirements. Please refer to Nursing Policy 3.1 for details.
• Infusion pumps may be used if the pump model has been approved for blood administration by the manufacturer and is operated according to the manufacturer’s specifications.
• Blood warmers may be used according to specific unit policy.

Be aware that different procedures are followed depending upon the age of the person receiving the transfusion and the type of product being transfused. Please refer to Nursing Policy 3.1 for the specific procedures to follow.

**Code Blue / Checking Crash Carts**

**What should I do if I find someone unresponsive?**
• Shake the person gently to check responsiveness. If they are not responsive call for help.
• Check for breathing. If no breathing, activate a Code Blue.
• **Dial 1122** if you are in the Main Hospital Building, Building 100, or in any temporary diagnostic trailer. Many hospital unit phones have pre-programmed Code Blue buttons.
• **Dial 9-911** if you are located in any other area of the SFGH Campus including the Mental Health Rehabilitation Facility.
• Prompt notification of the code team and arrival of the crash cart and defibrillator will minimize delays and maximize the patient’s chances of survival. For many code blues, early defibrillation is essential.
• Staff trained in Basic Life Support (BLS) should begin cardiopulmonary resuscitation (CPR) as soon as possible.
What are the responsibilities of Code Blue Team members?

- The hospital’s code blue team responds to all codes in the main building outside of the Emergency Department.
- The **unit Charge Nurse** assigns/coordinates staff activities: Starting CPR, bringing the Crash Cart, setting-up equipment/supplies, administering medications and documenting in the CPR record.
- The Medical Critical Care Resident and Medicine/Cardiology Resident direct the code team.
- The **Anesthesia Resident** and **Respiratory Therapist** are responsible for airway support.
- The **Critical Care Nurse** assists the nursing staff with the resuscitation.
- The **Nursing Supervisor or Administrator on duty** is responsible for completing the Code Blue Monitoring Tool and assisting in transfers, etc. after the Code.

My department has a crash cart, how often am I required to check it?

- Every crash cart must be checked three times a week (e.g. M-W-F). Documentation indicates that:
  - cart is locked
  - cart expiration date has not passed
  - Defibrillator has been tested and discharges correctly at 100j.
  - defibrillator pads, leads and other specified equipment are on top of the cart
  - The crash cart checklist is complete.

Who is responsible for assembling the crash cart?

- Respiratory Care Services is responsible for:
  - assembling the respiratory module
  - Checking the oxygen tank and the emergency suction device on daily rounds.
- Pharmacy Services is responsible for:
  - assembling the medication module
  - Ensuring that the earliest medication expiration date is printed on the module.
- Central Processing Department staff are responsible for:
  - Ensuring that the contents and set up of the crash carts conforms to the standardized modular system.

How are quality improvement issues related to Code Blue reviewed?

- The Code Blue Monitoring Tool is the quality improvement documentation reviewed by the Code Blue Committee. The Committee provides reports to the Quality and Utilization Committee.

References: Hospital Policy & Procedure 3.6 Code Blue Response, 3.12 Resuscitation of Patients and Nursing Policy & Procedure 5.10 Checking Crash Carts.

Drug Nutrient Interactions

What is a drug-nutrient interaction?

- A drug-nutrient interaction occurs when the ingestion of nutrients causes a change in absorption, action or effect of a medication.

What are some examples of drug-nutrient interactions?

- Food intake may affect the absorption of antiretroviral medications, by either increasing or decreasing their absorption.
- Tyramine-containing foods may cause a hypertensive crisis in patients treated with monoamine oxidase inhibitors.
• Excessive intakes of foods high in vitamin K, such as nutritional supplements, may inhibit the effects of warfarin (coumadin).

**Why is this important?**

• The drug effect may be significantly altered when administered with food and can lead to drug toxicity or ineffectiveness of the drug.

**How is information about drug-nutrient interactions communicated to clinicians working with patients?**

• Nutrition Services:
  – Screens for potential drug-nutrient interaction during their screening, assessment and reassessment process (e.g. patient on tube feedings who are receiving phenytoin).
  – Provides education to the patient, family, or health care worker.

• Pharmacy Services:
  – Counsel outpatients when medications are dispensed.
  – Reviews all investigational drugs for potential drug-nutrient interactions.
  – In SureMed, the signature line will indicate whether the drug should be taken with food or on an empty stomach (e.g. "BID FOOD", "BID EMPTY").

• Nurses:
  – Provide group education for patients admitted to psychiatry
  – Schedule medications to optimize effect or minimize drug interaction.
  – Refer patients to Nutrition Services for counseling as indicated.

• Physicians:
  – Counsel patient when prescribing medications as indicated.

**Where do I go for more information?**

• Call the Inpatient Pharmacy at 206-8460, or the Outpatient Pharmacy at 206-8108.
## Medications that Require Special Administration Times Due to Potential Drug-Drug or Drug-Nutrient Interactions

<table>
<thead>
<tr>
<th>Classification</th>
<th>Medication</th>
<th>Times</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antilipids</td>
<td></td>
<td>with dinner</td>
<td>With meals</td>
</tr>
<tr>
<td>Antacids</td>
<td></td>
<td>before meals</td>
<td></td>
</tr>
<tr>
<td>Anticoagulants</td>
<td>Warfarin (Coumadin)</td>
<td>evening dosing</td>
<td>To verify am labwork results if there was need to adjust dose</td>
</tr>
<tr>
<td>Anticonvulsant</td>
<td>Phenytoin(Dilantin)</td>
<td>at bedtime</td>
<td>[Do not give with tube feeding]</td>
</tr>
<tr>
<td>Anti-Retroviral</td>
<td>Didanosine (ddl, Videx)</td>
<td>one hour after meals</td>
<td>Needs alkaline environment for absorption</td>
</tr>
<tr>
<td>Anti-Retroviral</td>
<td>Ritonavir (Norvir)</td>
<td>with meals</td>
<td>Needs adequate fat intake/food for absorption</td>
</tr>
<tr>
<td>Anti-Retroviral</td>
<td>Saquinavir (Invirase)</td>
<td></td>
<td>Abacavir (Ziagen) associated with hypersensitivity reaction; notify MD if patient c/o of flu like symptoms</td>
</tr>
<tr>
<td>Anti-Retroviral</td>
<td>Nelfinavir (Viracept)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anti-Retroviral</td>
<td>Abacavir (Ziagen)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anti-Retroviral</td>
<td>Amprenavir</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anti-Retroviral</td>
<td>Efavrinex (Sustiva)</td>
<td>HS</td>
<td>May cause CNS disturbances, give at bedtime to minimize</td>
</tr>
<tr>
<td>Anti-Retroviral</td>
<td>ndinavir (Crixivan)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anti-Fungal</td>
<td>Etoconazole</td>
<td></td>
<td>Needs acidic environment for absorption</td>
</tr>
<tr>
<td>Anti-PCP</td>
<td>Dapsone</td>
<td>(at least 1-2 hours before meal)</td>
<td>Needs acidic environment for absorption: Never give at same time as ddl</td>
</tr>
<tr>
<td>Anti-PCP</td>
<td>Atovaquone</td>
<td>give with meals</td>
<td>Needs adequate fat intake/food for absorption</td>
</tr>
<tr>
<td>Antibacterial</td>
<td>Azithromycin</td>
<td>Give at least 1 hour ac, or 2 hours pc or at hs</td>
<td>Should not be given with meals</td>
</tr>
<tr>
<td>Antibacterial</td>
<td>Ciprofloxacin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antibacterial</td>
<td>INH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antibacterial</td>
<td>Rifabutin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antibacterial</td>
<td>Rifampin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anti-PCP</td>
<td>Trimethoprim/ Sulf (Septra)</td>
<td>Give on empty stomach Give at least 1 hr ac, or 2 hrs pc or at hs</td>
<td>May cause nausea &amp; vomiting; avoid meal time administration</td>
</tr>
<tr>
<td>Antibacteria</td>
<td>Ethambutol</td>
<td>Give on empty stomach Give at least 1 hr ac, or 2 hrs pc or at hs</td>
<td></td>
</tr>
<tr>
<td>Antibacteria</td>
<td>Clarithromyci</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anti-CMV</td>
<td>Foscarnet</td>
<td>1000 - 2200</td>
<td>** Change to 0600- 1800 day of discharge</td>
</tr>
<tr>
<td>Antifungal</td>
<td>Fluconazole</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Antidepressants</td>
<td>Desipramine</td>
<td>HS</td>
<td>Used for neuropathic pain</td>
</tr>
<tr>
<td>Classification</td>
<td>Medication</td>
<td>Times</td>
<td>Rationale</td>
</tr>
<tr>
<td>----------------------</td>
<td>--------------------------</td>
<td>-------------</td>
<td>-------------------------------------------------------------</td>
</tr>
<tr>
<td>Medication</td>
<td>Amitriptyline</td>
<td>HS</td>
<td>Sedating; dosed 1x daily at HS</td>
</tr>
<tr>
<td>Medication</td>
<td>Venlafaxine (Effexor)</td>
<td>With meals</td>
<td></td>
</tr>
<tr>
<td>Mood Stabilizer</td>
<td>Lithium</td>
<td>With meals</td>
<td></td>
</tr>
<tr>
<td>Cardiac</td>
<td>Furosemide (Lasix)</td>
<td>Not after 1800</td>
<td></td>
</tr>
<tr>
<td>Hypoglycemic Agents</td>
<td>Insulin</td>
<td>AM before eating</td>
<td>To prevent BS after eating</td>
</tr>
<tr>
<td>Hypoglycemic Agents</td>
<td>Oral agent</td>
<td>AM before eating</td>
<td></td>
</tr>
<tr>
<td>Narcotic</td>
<td>Methadone</td>
<td>Give on arising</td>
<td>For prophylaxis of heroin withdrawal; Methadone used as analgesics may be dosed q 4-8 hours</td>
</tr>
<tr>
<td>NSAIDS</td>
<td>(Ibuprofen) Motrin</td>
<td>With meals</td>
<td></td>
</tr>
<tr>
<td>Nutritional Support</td>
<td>TPN/PPN</td>
<td>1700</td>
<td>Standard hospital start time</td>
</tr>
</tbody>
</table>

**Infant Abandonment**

**What the law requires if someone says that they want to give up their newborn infant?**

According to SFGH policy only authorized on duty personnel in the Emergency Department can accept a surrendered infant. You should accompany the individual and the infant to the Emergency Department.

**Who in the ED is authorized to accept custody of an infant?**

Only the following classifications of on duty ED personnel are authorized to accept physical custody of surrendered newborn infants:

- Registered Nurse (RN),
- Attending Physician, or
- ED Medical Social Worker

**What type of care does the newborn receive?**

The newborn will receive a medical screening examination and any necessary medical care.

**Who should be notified?**

The Emergency Department charge nurse or designee should notify the:

- Administrator-On-Duty/Hospital supervisor,
- Emergency Department Medical Social Worker, and
- Child Protective Services (CPS)

**Where to refer questions or requests to reclaim custody of the surrendered newborn?**

Refer questions to the Emergency Department Medical Social Worker.

- A parent or other person having lawful custody who voluntarily surrendered their newborn may reclaim the infant from CPS (415. 558-2650) within 14 days of the surrender by filing a petition and producing the coded identification bracelet.
• If the infant is still in the custody of SFGH, the parent or other person having lawful custody must still contact CPS to reclaim the infant.

**Infection Control**

Please refer to Section 5: Infection Control and also the Infection Control Site on the CHN Intranet. 
http://in-sfghweb01.in.sfdph.net/SFGHInfectionControl/

NOTE: Handwashing is a patient safety issue. Let your patients see you wash your hands. Encourage them to speak up if they think you did not wash your hands.

**Inpatient Functional Screening and Assessment**

**What is Functional Screening?**

• Functional screening is a process for identifying functional deficits. Hospital Policy 1.17 and JCAHO require that all hospitalized patients be screened for functional deficits within 24 hours of admission to the hospital.

**Who is responsible for screening?**

• Functional screening is an interdisciplinary process:
  – The RN screens the patient within the first 24 hours of admission using criteria on the Admission Database.
  – Physicians and Medical Social Workers also screen for deficits.

**Who writes the order for a functional assessment?**

• The physician writes the order for assessment by Rehabilitation Services.
• Per Title 22, orders from Nurse Practitioners or Physician Assistants must be co-signed by a physician.

**What is a functional assessment and who is responsible for performing it?**

• A functional assessment is part of an evaluation that is performed by qualified rehabilitation specialists: occupational, physical and speech therapists.
• Therapists assess functional mobility and gait, ability to perform activities of daily living (ADLs), self-care, cognition, swallowing functions, communication, and ability to learn and work.
• This assessment also considers the environment in which the patient lives, the level of assistance available at home, and environmental barriers that must be negotiated for community living.
• Tests, measures and projected goals of a functional assessment are appropriate to a patient’s chronological age and developmental stage, previous level of function, overall medical condition and prognosis, mental capacity, cultural background and ability to learn.

**What are the most common deficits?**

• Problems with mobility, balance, or coordination
• New uncompensated motor deficit
• Decreased range of motion, strength, or endurance
• Deconditioning secondary to bedrest, or bedrest > 48 hours
• New speech or swallowing deficits
• Decreased ability to dress, feed, toilet, bathe, or to work
• New visual or hearing loss
• Change in cognition or mental status from baseline
• A change in learning style, motivation, readiness, or ability to learn.
Why is a functional assessment important?

- A functional assessment identifies patients who are in need of rehabilitation services and adaptive equipment, both while in the hospital and at home.
- A functional assessment provides for safe and appropriate discharge planning.
- A functional assessment is important for the optimization of an interdisciplinary approach to patient care and safety.

How is information from a functional assessment used?

- The information is used to assess fall risk.
- The information is used to encourage and assist the patient in regaining mobility, the ability for self-care and safety during feeding.
- The information is also used to optimize mental functioning.
- The information is used to help determine the appropriate level of care at discharge, including out of home placement and necessary equipment.

What are the Rehabilitation Department’s criteria for discharge from their service?

- The attainment of goals of therapy and the patient have been met.
- The attainment of their maximal functional abilities with no further progression.
- Inability or unwillingness to participate in the therapeutic process, or a change in medical or cognitive status.

Whom do I call for more information about rehabilitation and functional assessments?

Call the Rehabilitation Department at 206-8014 or FAX at 206-5777.

Mental Health Holds and Danger to Self

A mental health hold is the involuntary psychiatric detention or commitment of an individual for evaluation and treatment of a mental disorder. To be involuntarily committed the individual, as a result of a mental disorder, must meet one of the following criteria:

- Danger to self
- Danger to others
- Gravely disabled (defined as one who lacks the mental capacity to provide for her or his food, clothing or shelter)
- An involuntary mental health hold is authorized by California law under Welfare & Institutions Code section 5150 and is often referred to as a "5150-hold".
- The duration of a "5150-hold" is 72 hours, but based on the mental health provider’s evaluation of the individual it may be terminated earlier or extended. The "5150-hold" can be extended for 14 days pursuant to Welfare & Institutions Code section 5250. This is referred to as a "5250-hold".

Who may initiate a 5150-hold?

There are designated staff members on the Psychiatric Service, including the Psychiatric Emergency Service and Psychiatric Consultation Liaison Service, who are certified to initiate, terminate and extend 5150-holds. There are also individuals in the community, including some police officers who are certified by the Community Mental Health Services of the San Francisco Department of Health to initiate 5150-holds.
How are 5150-holds documented?
In addition to progress notes, there are forms specific for 5150-holds including the Psychiatric Hold form, the Involuntary Patient Advisement form, the Psychiatric Hold Physician Order Sheet form and when applicable, the Consent to Psychiatric Medication form.

Do I need to obtain consent for treatment from a patient on a 5150 hold?
A patient on an involuntary psychiatric hold retains the right to consent to both medical and psychiatric treatment. It is the responsibility of the treating clinician to obtain the patient's informed consent before administering psychiatric medications unless there is an emergency situation. An emergency situation is one where there is a marked sudden change in the patient’s condition that necessitates immediate action to preserve the life of, or to prevent serious bodily harm to, the patient or others.

What are the guidelines for caring for a patient who has been identified as being at risk for harming himself or herself?
• Familiarize yourself with service and unit protocols for caring for patients on an involuntary hold and / or suicide precautions. Be sure to use any forms designated for this purpose.
• Physicians, nurses and other clinical staff need to continuously and consistently assess and monitor a patient on suicide precautions. Among other things, the physician and nursing staff must assess the continuing need for suicide, flight or assault precautions; develop, implement and continuously evaluate a treatment plan; monitor the patient and implement emergency interventions when indicated. All aspects of the patient’s care need to be documented in the patient’s medical record.
• All staff need to be responsible for maintaining an environment that is safe for patients and staff and need to be vigilant for any physical conditions, situations and behaviors that might be unsafe
• In general, assess for suicide by asking the following three questions:
  – Do you have a history of depression?
  – Have you ever felt like or tried to hurt yourself?
  – Do you feel like hurting or harming yourself now? (Repeat this question with each reassessment.) If the patient does feel like hurting/harming self, do they have a plan and the mean of carrying it out?
• If a patient on an involuntary hold or on suicide precautions attempts to leave the unit or hospital, make a stat call to the SFGH Sheriff’s office at 206-4911 and the Psychiatric Consultation Liaison Service at 206-8426.
• All staff, including allied professionals such as social workers, respiratory therapists, rehabilitation therapists and others, should be alert to changes in the behavior or language of any patient that might suggest that the patient is at risk for harming herself or himself. If the patient appears to be at risk for self-harm, the staff should request a consultation by the Psychiatric Consultation Liaison Service.

What are some indications of a patient at risk for self-harm or suicide?
• A patient admits needing medical care for self-inflicted injuries.
• A patient verbalizes the desire or intent to harm him or herself.
• A patient verbalizes or exhibits signs of depression, including hopelessness, guilt or shame, anger, rage, social withdrawal and / or expresses current thoughts about death or dying.
• A psychotic patient describes auditory hallucinations, particularly self-directed derogatory hallucinations or command hallucinations to inflict self-harm.
• A patient demonstrates poor impulse control or signs of self-destructive behavior.

What are resources for more information?
• Psychiatric Consultation Liaison Service at 206-8426
• Psychiatric Emergency Service at 206-8125
Nutrition Screening

What is Nutrition Screening?
- Nutrition Screening is an ongoing, multidisciplinary process involving physicians, nurses, and clinical nutrition staff to identify patients at nutritional risk.
- The Nutrition Assessment is the responsibility of a registered dietitian (RD).

Who receives nutritional screening?
- For acute care, JCAHO requires that all patients be screened for nutritional risk within 24 hours of admission to the hospital.
- For the Skilled Nursing Facility & the Mental Health Rehabilitation Facility, screening is required within 72 hours of admission.
- Nutritional consultation is available in the outpatient setting with a physician referral.

Why is this important?
- Many medical and surgical patients are malnourished on admit or are at high risk of malnutrition.

What are some nutritional risk factors?
- Appetite loss or poor PO intake (< 70% of meal intake for more than 3 days per nursing flow sheet).
- Unintentional weight change of > 10 pounds in 6 months, obesity, severely underweight appearing.
- GI complaints: nausea, vomiting, diarrhea, constipation, difficulty chewing or swallowing.
- NPO or Clear Liquid diet for more than 3 days, parenteral nutrition, tube feeding
- Drug-nutrient interactions: Dilantin/tube feeding, HIV medications/meal time,Coumadin/vitamin K.
- Education requirements: NEW Diabetic, Ostomy, Renal, or Cardiac patients
- Diagnosis, i.e.: acute pancreatitis, burns/non-healing wounds, failure to thrive, altered mental status, head and neck cancer, CVA with neurological deficits, pregnancy-related hyperemesis.

How are high-risk patients identified?
- Nurses will weigh the patient, screen for risk factors & document positive findings on the nursing admission database, IPDP, and the Nursing Kardex/Plan of Care.
- Dietitians and Diet Techs screen patients based on diet order, age, medications, and length of stay.
- Other disciplines also screen for risk factors based on diagnosis and clinical observation.
- Physicians order nutrition consults based on their assessment of the patient.

What do I do if a high-risk patient is identified?
- Nutrition consults are obtained from the Department of Food and Nutrition via Invision, telephone (206-8604), individual RD pager (available at 206-8604), or interdisciplin ary rounds.

Where can I go for more information?
- Contact the ward or unit's assigned dietitian.
- Refer to the Diet Manual located in every unit and clinic.
- Refer to the Medical Surgical Nursing Clinical Practice Guidelines regarding Nutritional Deficits
Organ and Tissue Donations

What is the difference between organ donation and tissue donation?
- Organ donation is the collection of a solid organ such as kidneys, lungs, or heart for immediate transplantation into another person with a very serious illness. The potential donor is declared brain dead. However, ventilator support continues for oxygenation of the vital organs until they are recovered for transplant in the OR.
- Tissue donation is the collection of corneas, muscle, or cartilage, or other tissues and can be accomplished at or shortly after the time of death of the donor. Ventilator support is not needed for tissue donation.

What organization is responsible for coordinating organ and tissue procurement?
- The California Transplant Donor Network (CTDN).
- The CDTN is affiliated with the University of California, San Francisco Tissue Bank will make appropriate referrals.
- CDTN performs organ procurement; UCSF Tissue Bank retrieves tissues.

As a clinician, what is my responsibility related to tissue procurement when someone dies?
- Federal Regulation requires that all deaths occurring in the hospital be reported to an organ procurement organization for the purpose of screening for potential organ and tissue donors.
- All deaths includes adult, pediatric, medical, surgical, critical care, Medical Examiner cases, and fetal deaths > 36 weeks gestation.
- If a patient dies on your unit, the primary care provider or the charge nurse notifies CTDN at 1-800-55-DONOR or (1-800-553-6667).
- The clinician is responsible for ensuring that a call is made to the CTDN.

What screening criteria do I use before I call the California Transplant Donor Network?
- None. All deaths should be reported.
- The Donor Network prefers to assess each patient’s donor potential before the family is approached concerning donation.

What types of information will the CTDN be requesting when I make the call?
- The CTDN/Tissue Bank coordinator may request the following information: next-of-kin, cause of death, lab results, IV fluid/blood products received, and past medical history.

What happens if the potential tissue donor is a Medical Examiner’s case?
- The CTDN/Tissue Bank Coordinator will consult with the San Francisco Medical Examiner’s Office prior to the removal of any organs and/or tissues.
- Hospital staff are still responsible for reporting the death to the San Francisco Medical Examiner’s Office.

Where can I obtain more information about organ and tissue donation?
- Hospital Policy #15.3 - “Organ and Tissue Donations”.
- Hospital Policy #4.2 "Determination of Death by Brain Criteria”.
- Contact the SFGH Donor Committee.
- ICU and OR “Transplants” reference materials.
Patient Education

What is patient education?
Patient education is the process of providing patients with the information and skills they need to actively participate in their own care. The goal of patient education is to improve health outcomes by promoting healthy behaviors and encouraging patients to be involved in their care and care decisions. It involves not only sharing of information but also respecting patients' wishes and priorities. It often involves working with patients to understand their ambivalence regarding health practices and treatments. The mission of the Patient Education program is to provide and support culturally and linguistically appropriate health education opportunities for SFGH’s patients and their families. Topics may include health promotion, illness management, and disease prevention.

Who is responsible for patient education?
The hospital plans for the organization and coordination of patient education activities. The Patient Education program, under the direction of the Patient Safety Officer, is responsible for developing and implementing policies, procedures, programs, materials, and services related to patient education. Throughout the hospital, interdisciplinary teams maintain and deliver patient education programs and services to SFGH’s patients and their families.

What are the standards for delivering patient education?
Patient profiles (age, language, literacy level, culture, ethnicity, socioeconomic status, physical condition, and cognitive ability) are considered in determining the content, style, and direction of the education plan. Patients’ learning needs are assessed during the initial assessment phase. This assessment includes:

- Ability to learn
- Motivation to learn
- Learning style preferences (i.e. learns best by seeing, hearing, doing, etc.)
- Barriers to learning (i.e. substance use, physical or cognitive limitations, etc.)

What are other considerations for assessing and documenting the learning needs of our patients?
When assessing a patient’s learning needs, you need to consider the cultural and spiritual values of the patient and those of his or her family. You also need to consider the patient’s literacy level and the language the patient communicates in most comfortably. An interdisciplinary patient education record must be completed to document an assessment of the patient’s learning needs, ability to learn, motivation to learn, preferences, and barriers to learning.

Where can I find resources for patient education?
- The Patient Education Links page on the CHN Intranet provides links to patient education handouts, including over 3,000 Krames On Demand titles. See the Appendix F for more information. [http://in-sfghweb01.in.sfdph.net/PatientEducation/PtEd-Resources.htm](http://in-sfghweb01.in.sfdph.net/PatientEducation/PtEd-Resources.htm)
- Hospital Policy 5.14 Patient/Family Education Program
- For questions, consultation, or more information about patient education, please call 206-5120 or 206-4699.
- Individual departments and patient care settings receive data and analysis of specific results related to their services and are asked to use this information in quality improvement initiatives.
- Patient concern data are also reported to hospital-wide committees and individual departments for use in improvement efforts.
Reporting Victims of Violence, Abuse, or Neglect

What are the 3 areas of mandated reporting for violence, abuse, or neglect?
The three major areas of mandated reporting are:

- Physical, fiduciary (financial), and neglect of dependent or older adults (Elder abuse)
- Physical, emotional, sexual and psychological abuse and neglect of children and adolescents
- Assault and abuse of adults, which includes domestic violence and sexual assault

When and how are mandated reports made?
The making of an actual report to a protective agency or law enforcement authority varies according to the age of the victim, the type of abuse, and the profession of the potential reporter:

- All licensed healthcare providers are mandated reporters of known or suspected Dependent Adult, Elder Abuse, and Child Abuse
- Licensed healthcare providers providing direct medical treatment are mandated to report known or suspected physical assault and abuse in adults, including domestic violence and sexual assault

Are there any special resources at the hospital for working with victims of sexual abuse?
Victims of sexual abuse call for highly specialized care, especially when it comes to interviewing victims. The hospital has two resources with staff specially trained in the care and treatment of victims of sexual assault and abuse:

- For patients under age 18 there is CASARC, the Child and Adolescent Sexual Abuse Resource Center, at 206-8386.
- The Rape Treatment Center, serving patients 18 years and older, is available at 821-3222. Both services have expertise in forensic interviews, medical record documentation, and evidence collection available 24 hours a day, 7 days a week.

What happens when I make a report?
There is no one answer as to how a report will be handled by the individual agencies:

- In the case of children, adolescents, dependent adults, and elders, the response will depend on the nature and severity of the abuse. A record of previous reports may also affect how a case will be handled.
- Health practitioners’ reports of assaultive acts against adults are primarily informational. The exceptions are when a victim is making an official police report or when a practitioner feels there is imminent danger and the situation calls for immediate law enforcement involvement.

What if I need an immediate response by law enforcement?
SFGH Sheriff’s office are available 24 hrs/day, 7 days/week. Call 206-4911 in an emergency, or 206-8063.

In addition to reporting mandates, what else needs to be done for victims of abuse?
Besides physical care for the victim’s injuries, care for victims of abuse includes

- Documentation in the medical record on nature and location of injuries
- Prevention of future abuse through discussion or action, as appropriate to a patient’s age and situation
- Information on relevant resources for support and assistance at the hospital and in the community.

How can I keep all the information on mandated reporting current and at hand?
Hospital Policy 1.1 outlines identifiers of abuse, hospital and community resources, and procedures for mandated reporting, and includes a summary sheet of reporting information.
Use of Restraints

What are the major points in the restraint policy?
The key elements of the restraint policy are:

• Patients at SFGH have the right to be free from any form of restraint that is not medically necessary. Restraints will not be used as a means of coercion, discipline, convenience, or retaliation by staff. The goal is to **prevent**, **reduce** and **eliminate** the use of restraint and restraint-associated risk through the use of preventive strategies, alternatives, and process improvements.

• Clinical staff shall comprehensively evaluate the patient and his or her care needs to determine if the use of **less restrictive** measures poses a greater risk than the use of restraints. Chemical or physical restraint can only be used when less restrictive intervention/prevention measures have not been successful. There may be inherent risks to the patient associated with restraint use, including potential physical and psychological harm, loss of dignity, violation of rights, and death.

• There shall be a written modification to the patient's plan of care that addresses protection of the individual's health and safety and preservation of the individual's dignity, rights and well being when restraint and/or seclusion is used. Restraints can only be used in accordance with the order of a physician;

• Clinical staff will utilize an ongoing process of assessment, planning, intervention, evaluation and re-intervention with the goal of discontinuing restraints at the earliest possible time. All staff must be trained through a restraint education program to ensure competency in safe use of restraint with the goal of minimizing restraint usage.

• Seclusion and locked/buckle restraints are only used in specifically designated areas when clinically justified.

What is the difference between behavioral restraints and medical safety restraints?

• The type of physician restraint order is no longer determined by the type of restraint device or the area in the hospital where they are used. A restraint is now defined as any method (chemical or physical) of restricting an individual's freedom of movement, physical activity or normal access to the body. It is important to understand the difference between behavioral and medical safety restraints.

• **Behavioral restraints** are only used in crisis situations in any area of the SFGH campus, when the patient's behavior is aggressive or violent, presenting an **immediate, serious danger** to his/her safety or that of others. This may include physical restraint, seclusion and/or chemical restraint.

• **Medical safety restraints** are used to limit mobility or temporarily immobilize a patient following a medical, surgical, or dental procedure. More commonly, medical safety restraints are used as a protective intervention related to a medical condition or symptom - i.e.:
  - Falls or wandering protection
  - If patient is at risk for injuring themselves if the restraint is not used
  - Prevention of the patient pulling out IVs/ET tubes

What about a restraint used to immobilize a patient during a procedure?
The restraint policy does not apply in the following situations:

• A positioning or securing device used to maintain position, limit mobility, or temporarily immobilize during medical, dental, diagnostic, or surgical procedures.

• A voluntary mechanical support used to achieve proper body position, balance or alignment so as to allow greater freedom of mobility than would be possible without the use of such a mechanical support.

• Handcuffs or other restrictive devices applied by law enforcement officials for custody, detention, and public safety reasons that are not involved in the provision of health care.
How are behavioral restraints handled differently from medical safety restraints?

- The requirements related to physician assessment and order writing, nursing assessment and observation are different for behavioral restraints vs. medical safety restraints. The following table summarizes the differences between the two types of restraints:

<table>
<thead>
<tr>
<th>Behavioral Restraint (including Seclusion)</th>
<th>Medical Safety Restraint</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial MD Order</strong></td>
<td>The initial physician order must be a written order and is required within one hour of the initiation of the restraint and/or seclusion. Maximum duration of order is: • 4 hrs. for adults age 18 and older; • 2 hrs. for patients age 9 through 17; and • 1 hr. for patients under 9 years of age.</td>
</tr>
<tr>
<td><strong>MD Renewal Order</strong></td>
<td>To continue the restraint a telephone and/or a written physician order is required: • every 4 hrs. for up to 24 hrs. for adults age 18 and older • every 2 hrs. for patients age 9 through 17 • every 1 hr. for patients under 9 years of age. • A written physician order is required every 24 hrs. to continue restraint</td>
</tr>
<tr>
<td><strong>MD face to face assessment</strong></td>
<td>Initial assessment within 1 hr. of initiation of restraints and every 24 hrs. thereafter</td>
</tr>
<tr>
<td><strong>RN face to face Assessment</strong></td>
<td>Prior to initiation of restraint, and every 1 hr. thereafter</td>
</tr>
<tr>
<td><strong>Monitoring</strong></td>
<td>Every 15 minutes by RN, LVN, LPT, CNA, MEA, Radiology Technician.</td>
</tr>
<tr>
<td><strong>Observation</strong></td>
<td>Constant face to face observation by RN, LVN, LPT, CNA, Radiology Technician, MEA. For Seclusion Only: After first hour, observation may occur by video and audio equipment.</td>
</tr>
</tbody>
</table>

In the Department of Psychiatry, if the RN assesses that there is a need for continued restraints after 4 hours, the RN reports the assessment to the MD and a verbal order for continued restraints may be obtained. The MD must perform a face to face assessment every 8 hours and write orders if the restraint needs to be continued. For questions related to the restraint policy, please speak with your manager or supervisor or see SFGH Restraint policy 18.9 FAQ 2/5/02.

Visually and Hearing Impaired Patients

How does SFGH supports the rights of patients who are visually or hearing impaired?

- Under the American with Disabilities Act all persons regardless of disability have the right to access to care.

What are examples of services at SFGH for visually or hearing impaired patients?

- Elevators are equipped with Braille numbers and voice identification to enable the visually impaired patient to identify the correct floor and direction of the elevator.
• Hearing impaired clinic patients may request a sign interpreter through Interpreter Services to assist them at their appointment.

• Patients in the Emergency Department who are hearing impaired are identified by the triage nurse and the registration clerk. The Deaf Guideline appears on the registration screen, instructing staff to contact Interpreter Services for assistance.

• Teletype Delivery (TTD) phones are located at the following locations: Emergency Department, Patient Referral Center, Patient Visitor Center, & Family Health Center.

• Patients who admitted to the hospital are assessed for hearing and visual impairment and services are provided for their special needs.

How do I assist the patient who is visually or hearing impaired?

• Health care providers can communicate with patients who are deaf, deaf-blind or hard of hearing by providing auxiliary aids and services.

• Any staff members can provide direct assistance to patients as they move through the department or hospital setting

• For the visually impaired:
  – Ask the patient if s/he would like to be escorted.
  – Guide the patient in a manner s/he prefers e.g. leading or verbal cueing.

• For the hearing impaired:
  – Call Interpreter Services

What other services are provided for hearing and visually impaired patients?

• For patients admitted to the Emergency Department, Interpreter Services is notified to obtain a sign interpreter or provide resource packet with communicators and writing tools

• Place the pink alert bracelet from the resource packet on the patient.

• If the patient is admitted, include information about the hearing impairment in the unit report and transfer the resource packet with the patient.

• In the inpatient setting, place the packet’s alert stickers on the call light system, Kardex or Plan of Care, and medical record.

• Place the alert sign, communicators and writing tools at the patient’s bedside.

How do I notify Interpreter services for hearing deaf or hearing impaired patients?

• Contact Interpreter Services at 206-5133 for assistance in scheduling an appointment with an American Sign Language interpreter from the Bay Area Communications Agency (BACA).

• Interpreter Services is available Monday through Sunday 8:00 am to 12:00 midnight. After midnight, please contact the Telephone Operator at 206-8000.

• To obtain a packet of resource materials for deaf or hearing impaired patients, notify Interpreter Services at 206-5133 with Patient's Name, Medical Record Number and Location. Interpreter Services will bring the packet to the Unit or location of the patient.

Where are resources for more information?

Contact Interpreter Services at 206-5133, see Hospital Policy: Interpreter Services 9.5
SECTION 5: INFECTION PREVENTION & CONTROL
Infection Prevention & Control

For a comprehensive review of Infection Control practices, consult the SFGH Infection Control Manual available on the CHN Intranet site (refer to Appendix A for instructions on accessing).

BODY SUBSTANCE PRECAUTIONS (BSP)

All SFGH staff caring for all patients (both inpatient and outpatient) use Body Substance Precautions. This is the standard of care and no special signs or alerts are necessary. This is the primary strategy for successful prevention of hospital-acquired infections (HAI) at SFGH.

All principles of Universal Precautions and Standard Precautions (i.e., designed to protect healthcare employees from exposure to bloodborne pathogens) are incorporated into Body Substance Precautions.

BSP are based on preventing exposure to all body substances and are used for the care of all patients, regardless of their diagnosis or presumed infection status. They apply to:

- All body fluids and substances (including blood)
- Non-intact skin (including rashes)
- Mucous membranes

COMPONENTS OF BODY SUBSTANCE PRECAUTIONS (BSP)

Hand Hygiene

- The primary component of BSP is the consistent adherence to proper hand hygiene measures. The purpose of hand washing with soap and water is to remove dirt, organic materials and transient microorganisms. Waterless Alcohol-based sanitizer (ABS) may be used when hands have no visible soil present as there is no removal of organisms; instead the ABS kills any organisms that may be present on the skin. Hand hygiene is the most important factor for reducing hospital-acquired infections

ALL employees and staff must wash hands with soap and water at the beginning of work shift, before eating, before and after applying cosmetics or lip balm, after personal use of the toilet, and after sneezing, coughing, or using tissue; in addition the following times for hand hygiene (hand washing or ABS) apply:

- Before putting on gloves. Gloves are not used as a substitute for hand hygiene. Hands should be clean when putting on fresh gloves even when changing gloves during care of the same patient, for example going from one wound site to another or performing respiratory suction and then wound care.
- After direct contact with patient secretions even if gloves have been worn.
- Before invasive procedures even if gloves are to be worn.
- Before contact with high-risk, immunocompromised patients and newborns
- Between patient contacts.
- After contact with a source likely to contain microorganisms in high quantity (i.e., body fluids, mucous membranes, non-intact skin and inanimate objects likely to be contaminated) whether or not gloves were worn.
- Immediately after removing gloves.
- Upon exiting the room of a patient on Special Contact Isolation.
Hand Hygiene Techniques:

Hand washing:

Procedure:

- Wet hands with warm water (extreme temperatures, hot or cold, disrupt natural skin oils leading to chapping) before applying soap to prevent drying the skin of the hands
- Rub hands to produce lather that covers all surfaces and scrub for 15 – 30 seconds
- Ensure all surfaces are covered as shown in Figure 1.
- Rinse hands thoroughly under running water without splashing
- Dry hands thoroughly with paper towels to prevent skin chapping
- Turn water off with a dry/new paper towel to prevent recontamination to hands
- May need to use a clean paper towel to open a patient’s door to prevent recontamination of hands

Figure 1. Steps to Ensure Proper Surface Exposure for Effective Hand Hygiene

Waterless Alcohol-Based Sanitizer:

Procedure:

- Apply proper quantity; 3-5 milliliters or “dime-sized”; 1 pump or pull of dispensing lever.
- Ensure all surfaces are covered as shown in Figure 1.
- Rub until dry, approximately 30-60 seconds
- The proper amount and contact time are critical to achieve proper kill effect; PLEASE do not attempt to speed up the drying process by “fanning” hands or by using towels.

In addition to consistent hand hygiene, the following are components of Body Substance Precautions:

Respiratory Hygiene/Cough Etiquette: meant to help prevent the spread of all respiratory illnesses and consists of the following:

- Covering nose and mouth with a tissue (or sleeve if no tissue available) when coughing or sneezing
- Promptly disposing of used tissues in the regular trash can
- Properly cleansing hands after tissue disposal
- Wearing a disposable, molded surgical mask if fever is present
Personal Protective Equipment (PPE): various types are used separately or in combination to provide barrier protection to personnel depending on:

- Procedure to be performed
- Patient’s clinical status
- Patient’s age and mental competence
- Likelihood of contamination of clothing, skin, mucous membranes with blood/OPIM
- Types of PPE: gloves, masks, eye protection, face shields, gowns and shoe covers

**Gloves** are worn when the potential exists for touching blood or body fluids, mucous membranes, non-intact skin and contaminated items.

- Clean gloves are put on just prior to touching patient.
- Gloves are worn whenever using “shared” patient devices, such as blood pressure cuffs, IVAC thermometers.
- Gloves are removed promptly after use, before touching environmental surfaces, and before going to another patient or patient room.
- Hands are cleansed immediately after glove removal.

- **Mask/eye protection/face shield** is worn to protect the healthcare worker’s eyes, nose and mouth during procedures and activities that are likely to generate splashes or sprays of body fluids. Masks are removed as soon as possible and hand hygiene is performed.

**Gowns** are worn to protect skin and to prevent soiling of clothing during procedures that are likely to generate splashes or sprays of body fluids. Soiled gowns are removed as soon as possible and hand hygiene is performed.

**Patient-care equipment and supplies:** disposable, dedicated equipment is ideal but not always possible; if it is necessary to use re-usable items they must be adequately cleaned and disinfected before use on another pt.

**Compliance to SFGH Bloodborne Pathogen Exposure Control Plan** (BBP ECP) (IC Manual Policy 2.01, located on CHN intranet)

**NOTE:** Refer to the Infection Control Manual for complete information on additional considerations such as Environmental Controls, Linen Handling, and Patient Placement.

A summary of the BBP ECP components is provided later in this section. Should you have questions or concerns that cannot be answered by your unit manager, please contact Infection Control at 206-5466/8451. Please refer to the SFGH Bloodborne Pathogens Exposure Control Plan in the Infection Control Manual for complete information.
TRANSMISSION-BASED ISOLATION PRECAUTIONS: (use in both in and out patient settings)

Transporting of Infectious Patients: The benefits of the procedure must be weighed against the potential for disease transmission and the sending section must instruct the receiving section of the type of precautions being applied. Sending and receiving areas will coordinate when patient will have the procedure. Procedure area will coordinate when patient will be returned to the original unit. Isolation patients will not be left unattended in community waiting areas. The extent of barrier precautions worn by the patient and personnel will vary with nature of patient, nature of illness, nature of transport and nature of procedure. The wheelchair or stretcher used to transport the patient must be cleaned and disinfected before used with another patient.

High Level Respiratory Isolation (RED STOP SIGN): In addition to BSP, use this category for patients known or suspected to be infected with microorganisms transmitted by airborne particles that can be widely dispersed by air currents over a long distance

Room requirements: Private room (DO NOT cohort due to the possibility of Multi-drug Resistant Mycobacterium Tuberculosis (MDR-TB)), negative pressure room/negative air-flow with a minimum of 6-12 air changes/hr. The door remains closed to maintain the negative air-flow, and staff must post a “High Level Respiratory Isolation” sign on the outside of the door. Air is exhausted directly to the outside through a dedicated system or is re-circulated through HEPA filters.

PPE: NIOSH-approved N95 particulate respirator mask is worn by personnel when entering the room.

- HCWs must be fit-tested per the N95 mask to care for MTB patients
- Patients can wear the N95 particulate respirator mask or a surgical mask

Transporting the patient:

- Patient wears a surgical mask
- HCW has N95 mask available; wears N95 when in small, enclosed space, e.g. elevator or if required to provide “close medical care”

Examples of organisms requiring High Level Respiratory Isolation: TB (any form), red measles/rubeola, and any HIV infected or immunosuppressed patient admitted for evaluation of new undiagnosed pulmonary process. Chickenpox, SARS, Monkey pox, smallpox and Herpes zoster for patients who are immunocompromised or have the disseminated form require a combined isolation – both Contact and Airborne.

Low Level Respiratory Isolation (YELLOW STOP SIGN): in addition to BSP, Low Level Respiratory Isolation is designed for patients known or suspected to have Infectious illnesses transmitted by large particle droplets. Source patients generate droplets when they cough, sneeze, or talk and during performance of certain procedures such as suctioning. Droplets do not remain suspended in the air and generally travel only short distances, usually three feet or less.

Room requirements: private room is required; no special air-flow is required; during an outbreak, may cohort patients with same organism after approval from Infection Prevention & Control Department. Post “Low Level Respiratory Precautions” sign on the outside of door.
PPE: Surgical mask is indicated when within 3 feet of the patient's head

**Transporting** the patient: patient will wear surgical mask during transport
– to other areas of the hospital

**Examples** of organisms requiring Low Level Respiratory Isolation Precautions (not meant to be viewed as all inclusive list): R/O Neisseria meningitidis or meningococcal disease, influenza, pharyngeal diphtheria, German measles/rubella, mumps, Parvovirus B19, and Pertussis.

**Special Contact Isolation (BLUE STOP SIGN):** In some circumstances, additional patient care precautions may be needed to prevent transmission as defined by Infection Control for a category of patient isolation called "Special Contact Isolation." This type of isolation is used when:

- Patients are known or suspected to have infectious illness easily transmitted by direct contact or by indirect contact with fomites in the patient’s environment;
- Patients have conditions where body fluids are excessive and cannot be contained leading to excessive contamination of the patient's environment, and/or
- Patients are identified with multi-drug resistant bacteria or conditions that are especially difficult to treat.

**Ideal room** requirements: private room recommended; during an outbreak, cohort patients with same organism. A “Special Contact Isolation” sign is posted on the door

**PPE:** gloves required when working with patient and in contact with the patient's environment. Wear gowns upon entry into patient’s room. All PPE will be removed and appropriate hand hygiene performed prior to leaving the patient’s room.

**Transporting the patient:** the patient will have the area that is draining covered with a material that will hold the fluid and prevent spread. They will be provided a clean gown to wear prior to transportation.

**Examples of organisms requiring Contact Isolation Precautions:** Rotavirus, Impetigo, Pediculosis/Lice or scabies, major wound infections, draining abscess or cellulites, localized Herpes zoster/shingles in patients with intact immune system. **Smallpox, chickenpox, monkey pox and SARS require both High Level Respiratory and Special Contact Isolation.**

**EMPIRIC ISOLATION PRECAUTIONS:**

Certain clinical syndromes are concerning enough to warrant empiric initiation of enhanced precautions while waiting confirmation of diagnosis, either because of ease of transmission or severity of illness. Examples of clinical syndromes that warrant empiric isolation include chickenpox, TB, meningitis, SARS, or any patient with fever and rash or severe diarrhea of unknown etiology.

**Infection Control: Bloodborne Pathogens**

**Cal/OSHA Bloodborne Pathogens Standard Summary**

(A complete copy of the Cal/OSHA standard is maintained in the Infection Prevention & Control office and the SFGH Bloodborne Pathogens Exposure Control Plan is contained in the SFGH Infection Control Manual, available on the CHN website.)
The California Department of Industrial Relations Division of Occupational Safety and Health (Cal/OSHA) is the state agency that ensures that healthcare employers provide a safe and healthful workplace. 8 CCR 5193 Bloodborne Pathogens requires SFGH to establish a Bloodborne Pathogen Exposure Control Plan to protect workers from exposures to bloodborne illnesses, including Human Immunodeficiency Virus (HIV), Hepatitis B (HBV) and Hepatitis C (HBC). This regulation includes requirements for both the employer and the employee. The employer is required to do the following:

- Provide a clean and safe work environment
- Make available the appropriate PPE in all areas with a defined requirement.
- Make available needleless systems and sharps devices with e.s.i.p. (engineered sharps injury protection)* for employee use.
- Establish a program to evaluate and select needleless systems and sharps devices with e.s.i.p.* that includes front-line staff.
- Maintain a sharps injury log for trend analysis.
- Provide education on signs and symptoms of bloodborne pathogens, to include Hepatitis C as a specifically named bloodborne pathogen.
- Provide assessment, evaluation, and treatment should an exposure event occur.

The employee is required to do the following:

- Use the PPE provided for them.
- Use the needleless systems and e.s.i.p.* sharps devices
- Use safe work practices while performing daily activities
- Participate in evaluation and selection of new and/or improved needleless systems and e.s.i.p.* sharps devices when requested.
- Report all blood/body fluid exposures through the appropriate process
- Attend all educational programs offered on bloodborne exposure prevention and control.

*Engineered Sharps Injury Prevention Devices (Sharps Safety Devices)

Many percutaneous exposures (needlesticks and other sharps injuries) may be prevented by using medical devices with safety features designed to prevent injuries such as re-sheathing syringes and needles, re-sheathing butterfly needles for phlebotomy, needles with hinged, one-handed re-cappers, retractable needles, individual retractable lancets, safety IV catheters and needleless IV systems.

Training on needle and sharps safety devices is provided monthly at SFGH Orientation and whenever a new device is introduced into the workplace.

**CHN SFGH Bloodborne Pathogen Safe Device Committee**

A joint labor-management CHN SFGH Safe Devices Committee was established for active participation of frontline clinical staff in prevention of needlestick and sharps injuries. The committee evaluates work practices and recommends changes; identifies, evaluates, and selects sharps safety devices; and identifies training needs. For further information, contact the Committee Co-Chairs:

Environmental Health & Safety, 206-3756  
DPH Occupation Health and Safety, 554-2786

**Biohazard Signs and Labels**

Biohazard labels and signs are affixed to containers of biohazardous waste or sharps waste, refrigerators or freezers containing blood or OPIM, and other containers used to
store, transport or ship blood or OPIM. Biohazard containers are always covered during transportation.

EMPLOYEE WORK PRACTICES

The most important aspect of blood and body fluid exposure control management is implementation by healthcare workers of basic Infection Prevention & Control and Safe Work Practices. Many mucocutaneous (eyes, nose, mouth, and non-intact skin) exposures may be prevented by using appropriate barrier protection or Personal Protective Equipment (PPE) such as gloves, masks, eye protection and gowns which should be used whenever contact with blood or other hazardous body fluids may be expected. PPE is available in every CHN clinical area. The types, basis of selection, proper use, location, removal, handling, and disposal will be demonstrated during a new employee’s orientation or whenever a new procedure is introduced requiring PPE.

Infection Prevention & Control Work Practices

- Practice Body Substance Precautions (BSP). Wear PPE and follow all safety work practices.
- Always wear gloves
- Wear eye protection for potential blood, body fluid and other body substance exposures

Safe Work Practices for Handling Needles and other Sharps Devices

- Focus on the task
- Anticipate unexpected patient movement
- Always use the safety devices provided for you at work.

It is essential that you use safety devices properly, and that you activate the safety features each and every time you use one. The acronym “BE SAFE” was developed to help you remember your role in preventing blood and body fluid exposures both to yourself and your co-workers.

BE SAFE for a successful outcome (refer to Appendix B for complete details of each step)

B - BEST practice, BEST device, BEST training.
E - EVALUATE the work ENVIRONMENT for hazards.
S - Follow STANDARD SAFETY work practices.
A - ACTIVATE the safety mechanism.
F - FINISH the job. Clean up the work area and take care of the waste.
E - If you have an EMERGENCY, follow the appropriate procedure.

Other measures to prevent sharps injury to yourself or others:

Sharps Handling:
- Keep your hands BEHIND THE DIRECTION OF MOTION of the sharps
- Do not cross hands while using a sharp
- Avoid passing a sharp from hand to hand
- Announce to other team members that a sharp in use
- Use the safety transfer dome with a syringe to fill lab specimen blood tubes
- Activate the Mechanism
- Activate all safety devices before disposal
During an Emergency:

- Announce to others whenever there is a sharp loose in the field
- Allow a loose sharp to fall
- Designate one person to control, pick up, and dispose of the sharp
- Take the sharps waste disposal container next to the sharps
- Do not handle an uncontrolled or unprotected sharp by hand. Use a clamp or forceps.

When searching a patient’s belongings:

- Wear gloves at all times
- Preferably, ask the patient to remove contents for your review
- Alternatively, empty contents of the bag onto a desk or table to search
- Avoid reaching your hand into a bag or pocket. If you must, use a long handle forceps or clamp.

Slow Down:

Two of the most consistent reasons given for sharps injury are being in a hurry and not paying attention to the sharp’s location. You are under stress at work and home. You rush, rush, and rush to get things done. Take your time when you are handling sharps!

**STOP! COUNT 1-2-3**

1 - Take a few deep breaths

2 - Relax

3 - Focus on the sharp for the next 10-20-30 seconds

You pick up a sharp and prepare to use it. The next 10-20-30 seconds are the most critical of your life. If you use the sharp successfully, you can continue rushing about and thinking about your boss, job, parents, kids, relationship, and bills. If you get a needlestick, you will have a new stress to manage that could change your life forever. BE SAFE, not sorry.

If you do sustain a sharp injury or some other type of exposure to another person’s blood and body fluids then certain steps must be initiated, these are outlined in the next section: Occupational Exposure to Bloodborne Pathogens.

**Occupational Exposure to Bloodborne Pathogens**

Occupational exposures should be considered urgent medical concerns to ensure timely post-exposure management and administration of hepatitis B immune globulin (HBIG), hepatitis B vaccine, and/or HIV post-exposure prophylaxis. A brief summary of the critical steps to follow are provided directly below with more in-depth information following.

**Immediate Steps for an accidental exposure to blood or body fluids:**

**STEP 1. CLEAN/DECONTAMINATE:** Wash wounds and contaminated skin with soap and water; rinse mouth, nose and eyes with water or saline.

**STEP 2. CALL THE OCCUPATIONAL INFECTIONOUS DISEASE PROGRAM (OID) NEEDLESTICK HOTLINE 469-4411 AS SOON AS POSSIBLE:** available 24 hours a day every day for expert assessment and advice regarding immediate treatment.
STEP 3. **INFORM YOUR SUPERVISOR:** Complete the two Workers’ compensation forms (DWC-1 and Employer’s First Report of Injury) and the Supervisor’s Investigation of Incident report (SIIR) with your supervisor.

STEP 4. **FOLLOW-UP WITH THE OCCUPATIONAL HEALTH SERVICE (OHS):** Make an appointment for baseline visit by calling 206-5507.

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**Infection Prevention & Control and Bloodborne Pathogens Resources**
- The Infection Control Manual is available on CHN Intranet home page
- Infection Prevention & Control Department: 206-5466/8451 or Pager 443-1566
- Needlestick Hotline 469-4411
- SFGH Occupational Health Service 206-6581
- UCSF Occupational Health Service 885-7580

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**SFGH EMERGENCY DEPARTMENT SERVICES**

The ED provides emergency care to workers with serious injuries requiring immediate treatment (e.g., lacerations needing suturing). ED registration is required for this type of service, and treatment will be recorded in your hospital chart.

The ED also provides emergency hepatitis B (HBIG) and tetanus prophylaxis to occupationally exposed workers on weekends and holidays **when arranged by the Needlestick Hotline Clinician**. ED registration is not required, and no identifying record of your exposure will be generated. Coded treatment records will be entered into your confidential exposure chart.

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**EXPOSURE TO BLOODBORNE PATHOGENS**

**FOLLOWING AN EXPOSURE, ALL WORKERS MUST GO TO THE OCCUPATIONAL HEALTH CLINIC AS SOON AS POSSIBLE, TO COMPLETE DOCUMENTATION AND TREATMENT EVEN IF THEY HAVE ALREADY RECEIVED TREATMENT IN THE EMERGENCY DEPARTMENT!**

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**Exposure Assessment, Treatment, and Counseling**

A detailed description of your accident will be obtained and recorded in a confidential Workers’ Compensation record, which is kept separate from your employee health chart. An assessment of your risk for acquiring hepatitis B, hepatitis C, HIV, and other infections will be made, and appropriate treatment and follow-up will be provided. Education regarding occupational transmission of bloodborne pathogens, as well as personal and occupational risk reduction is included in this visit. All services related to occupational exposures are free of charge.

You may be requested to have blood tested for hepatitis B, hepatitis C, and HIV. HIV testing will only be done with your express written consent. The purpose of baseline testing is to document your status at the time of the accident should you become infected in the future. In addition, you may be asked to have serum stored for future testing or other research projects.

Discussions with a licensed professional counselor to provide information and assistance in making decisions about follow-up testing, and coping with concerns regarding your exposure are available.
Source Patient Evaluation
The Needlestick Hotline clinicians will obtain information from you about the source patient involved in your exposure. Source patient testing will be arranged through the Needlestick Hotline. **Occupationally exposed workers should not initiate nor participate in source patient testing!**

Confidentiality Procedures
**Protecting your confidentiality is an essential part of this service.** All OHS exposure records including medical history, treatment, test results, counseling and workers’ compensation documentation are maintained in a numeric coded chart that is kept separate from your regular employee health record. The contents of this chart will only be available to clinicians involved in your care. Summary results without identifying information will be tabulated and used to evaluate occupational exposures at SFGH/SFDPH and in other city departments. Blood specimens and lab requests will be labeled only with your number code. Contents of your coded exposure record will not be released to any agency outside of OHS without your written consent.

**DISEASES DEEMED “HIGH RISK FOR BLOOD AND BODY FLUID EXPOSURES”**

**Human Immunodeficiency Virus (HIV)**
HIV, the virus that causes AIDS, is a bloodborne pathogen. HIV can also be transmitted through sexual activity, sharing needles to inject drugs, tattooing or piercing, or receiving blood transfusions before 1985.

The average infection risk from injuries involving HIV-infected needles or other sharp instruments is 1 in 300 or 0.3%. However, the following exposures pose an increased risk: an exposure from a terminally ill AIDS patient; an exposure with a needle used in a blood vessel; an exposure from a visibly bloody device; and a deep puncture. The risk of infection from a bloody splash to mucous membranes or to open skin is very low--probably less than 1 in 1000. 20% of the SFDPH/CCSF source patients from the reported exposures in 2001 were HIV-infected. We are able to test most source patients, and during 2001, we tested 235 source patients. We very rarely identify HIV-infected source patients who are not already known to be infected at the time of the exposure, and those source patients whom we have diagnosed have all had identifiable risk factors for HIV.

There is now strong evidence to suggest that post-exposure treatment decreases the chances of getting HIV after an exposure to infected blood or other hazardous body fluid.

A PEP treatment plan may include a variety of antiretroviral drug combinations.

**HIV EXPOSURES: POST-EXPOSURE PROPHYLAXIS (PEP)**
Treatment should begin as soon as possible following the exposure, preferably within the first hour. The treatment course is 4 weeks (28 days). This is expected to protect the exposed health care worker from becoming infected by treating with anti-HIV drugs during the time before HIV infection is established. PEP is available on a 24-hour basis through the SFGH in-patient pharmacy and some other DPH sites when arranged by the Needlestick Hotline Clinician.

Decisions about taking prophylactic treatment after an occupational exposure that poses a potential risk of HIV infection are difficult because we do not fully understand the toxicity of the new drugs, or the long-term effects. **THINKING ABOUT THIS ISSUE NOW, BEFORE AN ACCIDENT OCCURS, MIGHT MAKE YOUR DECISION EASIER.**
Hepatitis B

Hepatitis B is a form of viral hepatitis that causes inflammation of the liver and sometimes serious, long-term consequences such as cirrhosis or cancer of the liver. In the U.S., over 200,000 are infected each year and an estimated 1.25 million people are chronically infected.

Hepatitis B virus (HBV) is more contagious than HIV and is spread through blood, other body fluids such as semen and vaginal secretions, and from a used needle contaminated with hepatitis B virus. IV drug use, tattooing, ear or body piercing, sexual contact, needlesticks, sharp exposures and open skin breaks are the most common ways in which the virus is spread.

30% of adults who are infected with HBV do not show any symptoms, however, those who become ill after being infected with the virus show symptoms such as: flu-like illness- poor appetite, fatigue, weakness, nausea, vomiting, fever, headache, aching joints, skin rash or jaundice (yellowing of skin and whites of the eyes). In the U.S. every year, approximately 5,000 people, including 300 health care workers die of Hepatitis B or its complications. Healthcare staff at occupational risk for exposure include: physicians, nurses, dentists, lab technicians, environmental service workers and other healthcare workers in contact with blood or body substances.

Hepatitis B Vaccine. All SFGH healthcare workers (HCWs) not already immune to HBV are strongly advised to receive the HBV vaccine series free of charge from their employer. The vaccine is a noninfectious recombinant DNA derived from yeast. The 3 injections given over a 6-month period are 80 to 90% effective in providing long lasting immunity against HBV.

Side effects are few; 1 to 3% may experience local reactions such as soreness, redness and swelling at the injection site. Healthcare workers (HCWs) who choose not to receive the vaccine must sign a declination form.

Hepatitis B Exposures

The average risk of occupational infection from injuries involving HBV-infectious (hepatitis B antigenemic source patients) needlesticks or other sharp instruments is as high as 40%.

Approximately 10% of those infected become chronic carriers. Among persons who become chronically infected (carriers) 15-25% will die from chronic liver disease. Fortunately, only 3% of the SFDPH source patients tested during 2001 were infectious (antigenemic) with HBV.

All workers not already immune to hepatitis B virus are strongly advised to receive the HBV vaccine series through Employee Health. UCSF/Gladstone workers must go UCSF Employee Health. Exposed workers who are not immune to hepatitis B virus are encouraged to start the HBV vaccine series at the time of their OHS baseline visit. The best time to get immunized is BEFORE AN EXPOSURE OCCURS.

In cases of significant exposure where an exposed worker has not been immunized against HBV and/or does not have documented immunity to HBV AND the source patient is known to be an HBV carrier or is at high risk for HBV, we may recommend injection of HBV hyper-immune globulin (HBIG). Prophylactic treatment within 72 hours after parenteral exposure may be recommended.

Hepatitis C

The Centers for Disease Control (CDC) reports there are over 3.5 million Americans infected with Hepatitis C virus (HCV), making it the nation’s most common infection. People who inject illegal drugs, engage in unprotected sex, or who received blood transfusions prior to HCV testing in 1992 account for most carriers.
The incidence of HCV among healthcare workers is 1 to 2% following a needlestick or sharps exposure or blood splash to the conjunctiva.

Most people diagnosed with HCV are asymptotic. Fatigue and loss of appetite can be present along with right upper quadrant abdominal pain and occasionally jaundice.

Following acute HCV infection, 75 to 85% develop chronic infection, which is an estimated 30,000 new cases each year. HCV and alcohol abuse rank as the leading causes of liver disease. Fibrosis, cirrhosis, hepatic failure and hepatocellular carcinoma result from chronic infection making Hepatitis C disease the leading cause of liver transplantation.

HEPATITIS C EXPOSURES

We are very concerned about the risks of hepatitis C virus (HCV), because it is the most prevalent bloodborne pathogen currently detected in our source patients. During 2001, almost one-third (31%) of the source patients tested for HCV were infected. All source patients with positive HCV antibody have supplemental testing with HCV PCR; only those patients with positive HCV PCR have been documented to transmit the infection.

We believe that the risk from a needlestick or other sharps injury from an HCV-infected patient is higher than the risk of HIV but much lower than the risk of HBV. However, we still have much to learn about the occupational risks of HCV. At this time, we believe the risk from a percutaneous exposure to be about one percent or less.

There is currently no prophylaxis or vaccine available for HCV infection. Hepatitis C antibody testing is routinely done on source patients. It is important to complete serial testing at 3, 6 and 12 months after exposure to an HCV-infected source patient.

We use the following guidelines to determine the type of treatment required after an occupational exposure to blood and/or body fluids

Management of Occupational Exposures to HIV and Recommendations for Postexposure Prophylaxis
[Guidelines, U.S. Public Health Service for the; September 30, 2005 / 54(RR09);1-17 (http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5409a1.htm)]

and

Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Post-exposure Prophylaxis
Updated U.S. Public Health Service Guidelines for the; June 29, 2001 / Vol. 50 / No. RR-11 (http://www.cdc.gov/mmwr/PDF/rr/rr5011.pdf)

Sharps Injury Log

CHN SFGH maintains a Sharps Injury Log after an employee has sustained a needlestick, sharps, or mucous membrane exposure to blood or body fluids/substances for the purpose of trend analysis to be used for evaluating ways to prevent future exposures.

Information to be provided by employee who sustained the exposure:
• Brief description of incident (location, procedure being performed, body part exposed, type of exposure (needlestick, splash, or direct contact)
• Needle information (type: IM, IV, or SQ; gauge; brand name)
• Safe device – activated vs. not activated; possible equipment failure
• Sharp information (broken glass, metal, etc.)
• Job classification and department,
• Possible work practice or device to prevent reoccurrence, if applicable

Workers’ Compensation and other Benefits
Current regulations in California require filing a Workers’ Claim for Benefits, an Employer’s First Report of Injury and a Doctor’s First Report of Injury with the workers’ compensation carrier for all persons sustaining occupational injuries, illnesses, and some exposures. The purpose of these reports is to ensure adequate documentation so that you can claim benefits in the future, should you need them. These forms will completed by your supervisor and the OHS Clinic.

All services directly related to occupational exposure treatment and follow-up are available without charge. In the event you become ill, are unable to work, or require additional medical care as a consequence of your exposure, you may be eligible to file a claim for workers’ compensation benefits. OHS clinicians are available to assist you in this process.

Tuberculosis
TB has affected humans for centuries. Until the 1940s and 1950s, there was no antibiotic treatment for TB. After anti-TB drugs were discovered, many people with TB were treated, and the death rate for TB dropped dramatically. However, it remains one of the leading infectious causes of death worldwide.

What is TB?
Tuberculosis (TB) is a disease caused by germs that are spread from person to person through the air. TB usually affects the lungs, but it can also affect other parts of the body, such as the brain, the kidneys, or the spine. A person with TB can die if they do not get treatment.

What Are the Symptoms of TB?
The general symptoms of TB disease include:

• feelings of sickness or weakness,
• weight loss,
• fever,
• night sweats.

The symptoms of TB disease of the lungs also include:

• coughing,
• chest pain,
• coughing up of blood.

Symptoms of TB disease in other parts of the body depend on the area affected.

How is TB Spread?
TB germs are put into the air when a person with TB disease of the lungs or throat coughs, sneezes, speaks, or sings. These germs can stay in the air for several hours, depending on the environment.
Persons who breathe in the air containing these TB germs can become infected; this is called latent TB infection.

What is the Difference Between Latent TB Infection and TB Disease?

People with latent TB infection have TB germs in their bodies, but they are not sick because the germs are not active. These people do not have symptoms of TB disease, and they cannot spread the germs to others. However, they may develop TB disease in the future. They are often prescribed treatment to prevent them from developing TB disease.

<table>
<thead>
<tr>
<th>Latent TB Infection (LTBI)</th>
<th>TB Disease (in the lungs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inactive tubercle bacilli in the body</td>
<td>Active tubercle bacilli in the body</td>
</tr>
<tr>
<td>Tuberculin skin test or QuantiFERON®-TB Gold test results usually positive</td>
<td>Tuberculin skin test or QuantiFERON®-TB Gold test results usually positive</td>
</tr>
<tr>
<td>Chest x-ray usually normal</td>
<td>Chest x-ray usually abnormal</td>
</tr>
<tr>
<td>Sputum smears and cultures negative</td>
<td>Sputum smears and cultures may be positive</td>
</tr>
<tr>
<td>No symptoms</td>
<td>Symptoms such as cough, fever, weight loss</td>
</tr>
<tr>
<td>Not infectious</td>
<td>Often infectious before treatment</td>
</tr>
<tr>
<td>Not a case of TB</td>
<td>A case of TB</td>
</tr>
</tbody>
</table>

In some people with LTBI, the immune system cannot keep the tubercle bacilli under control and the bacilli begin to multiply rapidly, resulting in TB disease. This can happen very soon after infection or many years after infection. About 10% of people with LTBI will develop disease at some point, but the risk is greatest in the first year or two after infection. Also, the risk is higher for people with certain medical conditions, such as HIV infection, than for other people.

How Do You Get Tested for TB?

There are two tests that can be used to help detect TB infection: a skin test or a special TB blood test.

The Mantoux tuberculin skin test is performed by injecting a small amount of fluid (called tuberculin) into the skin in the lower part of the arm. A person given the tuberculin skin test must return within 48 to 72 hours to
have a trained health care worker look for a reaction on the arm. The special TB blood test measures how the patient’s immune system reacts to the germs that cause TB.

Here at SFGH we routinely use the TST for annual screening, however, in certain situations the blood test may be used. This will be based upon Occupational Health Services assessment of the healthcare worker.

**What Does a Positive Test for TB Infection Mean?**
A positive test for TB infection only tells that a person has been infected with TB germs. It does not tell whether or not the person has progressed to TB disease. Other tests, such as a chest x-ray and a sample of sputum, are needed to see whether the person has TB disease.

**Why is Latent TB Infection Treated?**
If you have latent TB infection but not TB disease, your doctor may want you to take a drug to kill the TB germs and prevent you from developing TB disease. The decision about taking treatment for latent infection will be based on your chances of developing TB disease. Some people are more likely than others to develop TB disease once they have TB infection. This includes people with HIV infection, people who were recently exposed to someone with TB disease, and people with certain medical conditions.

<table>
<thead>
<tr>
<th>TB infection and no risk factors (about 10% over a lifetime)</th>
<th>TB infection and diabetes (about 30% over a lifetime)</th>
<th>TB infection and HIV infection (a very high risk over a lifetime)</th>
</tr>
</thead>
<tbody>
<tr>
<td>For people with TB infection and no risk factors, the risk is about 5% in the first 2 years after infection and about 10% over a lifetime.</td>
<td>For people with TB infection and diabetes, the risk is 3 times as high, or about 30% over a lifetime.</td>
<td>For people with TB infection and HIV infection, the risk is about 7% to 10% PER YEAR, a very high risk over a lifetime.</td>
</tr>
</tbody>
</table>

*Figure 1.6 Risk of developing TB disease over a lifetime.*

**Epidemiology:** Despite national trends reflecting a steady decline in the number of TB cases, there are still several concerns: TB cases are increasing in some areas; TB continues to affect racial and ethnic minorities disproportionately; multi-drug-resistant TB still remains a problem; and over half of all TB cases (59%) in 2008 in the United States are among persons born outside of the United States (foreign-born).

Some groups of people are at higher risk for exposure to or infection with *M. tuberculosis*. This category includes close contacts of people with infectious TB disease; people born in areas of the world where TB is common (foreign-born); low-income groups with poor access to health care; people who inject illegal drugs; infants, children, and adolescents exposed to adults in high-risk categories; and high-risk racial or ethnic minority populations, as locally defined. It also includes people who live or work in certain settings such as nursing homes, correctional facilities, homeless shelters, and drug treatment centers and other people who may be exposed to TB on the job, such as health care workers.

The United States is collaborating with other national and international public health organizations to address the high rate of TB in foreign-born persons. About 83% of TB cases reported in the United States in 2008
were in racial and ethnic minorities. This is probably because a greater proportion of people in these groups have other risk factors for TB.

Table 2.1 Groups at High Risk for TB Infection and TB Disease

<table>
<thead>
<tr>
<th>People at High Risk for Becoming Infected with <em>M. tuberculosis</em></th>
<th>People at High Risk for Developing TB Disease after Infection with <em>M. tuberculosis</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Close contacts of people known or suspected to have TB</td>
<td>▪ People living with HIV</td>
</tr>
<tr>
<td>▪ People, including children, who have come to the United States within the last 5 years from areas of the world where TB is common (for example, Asia, Africa, Russia, Eastern Europe, or Latin America)</td>
<td>▪ People recently infected with <em>M. tuberculosis</em> (within the past 2 years)</td>
</tr>
<tr>
<td>▪ Low-income groups with poor access to health care, including homeless people</td>
<td>▪ People with medical conditions known to increase the risk for TB</td>
</tr>
<tr>
<td>▪ People who live or work in high-risk residential settings (for example, nursing homes, homeless shelters, or correctional facilities)</td>
<td>- silicosis</td>
</tr>
<tr>
<td>▪ People who inject illegal drugs</td>
<td>- diabetes mellitus</td>
</tr>
<tr>
<td>▪ Health care workers who serve high-risk clients</td>
<td>- severe kidney disease</td>
</tr>
<tr>
<td>▪ High-risk racial or ethnic minority populations, as locally defined</td>
<td>- certain types of cancer</td>
</tr>
<tr>
<td>▪ Infants, children, and adolescents exposed to adults in high-risk groups</td>
<td>- certain intestinal conditions</td>
</tr>
<tr>
<td></td>
<td>- organ transplant</td>
</tr>
<tr>
<td></td>
<td>- immunosuppressive therapy (including prolonged use of corticosteroids and tumor necrosis factor-alpha [TNF-α antagonists])</td>
</tr>
<tr>
<td></td>
<td>- low body weight</td>
</tr>
<tr>
<td></td>
<td>▪ People who inject illegal drugs</td>
</tr>
<tr>
<td></td>
<td>▪ Infants and children younger than 4 years</td>
</tr>
</tbody>
</table>
TUBERCULOSIS STATISTICS

NATIONAL SUMMARY: In 2008, a total of 12,898 incident tuberculosis (TB) cases were reported in the United States for a rate of 4.2 cases per 100,000 (3.8% rate decrease & 401 reported case decrease from 2007), the lowest rate recorded since national reporting began in 1953. After the resurgence of TB during 1985 – 1992, the annual TB rate has steadily decreased. However, since 2000, the pace of that decline has slowed from 7.3% per year during 1993 – 2000 to 3.8% during 2000 – 2008. To hasten the decline of TB in the United States, intensified efforts are required to address the disproportionately high rates of TB that persist among foreign-born persons and racial/ethnic minorities.
CALIFORNIA SUMMARY: In 2008, 2,696 cases of tuberculosis (TB) were reported in California, the lowest case count ever recorded. However, the rate of decline in the number of cases has stalled compared to earlier years. The number of TB cases reported in 2008 was almost equal to the number of cases reported in 2007. California continues to be one of four states (others are Florida, New York and Texas) that contribute the greatest number of cases to the nation’s total TB morbidity. Combined, these four states accounted for approximately half (49.2%) of all TB cases in 2008.

SAN FRANCISCO CITY AND COUNTY SUMMARY: In 2008, 118 (14.6 per 100,000) new cases of active tuberculosis (TB) were diagnosed in San Francisco, representing a 17.5% decrease in cases from 2007 (143 cases) and the lowest TB incidence in San Francisco’s history. This resumes the decreasing trend that was interrupted last year. While the decline in active disease over the last decade is encouraging, the rate of TB in San Francisco is more than three times the 2007 national average of 4.4 cases per 100,000 and twice the 2008 California average of 7.0 cases per 100,000.

Eleven percent (11%) of TB cases were co-infected HIV; a slightly higher proportion than in prior years. HIV is common among African-American and white, non-Hispanic cases, and is present in 45% of cases from these racial groups. Among those with HIV co-infection, 5 (of 13) were also homeless. HIV infection is strongly associated with homelessness among cases of active TB disease in San Francisco.

General Healthy Habits:
Practicing the items listed below will help you stay healthy all the time. We in Infection Prevention and Control REQUIRE you to practice these habits while at work and we STRONGLY ENCOURAGE you to practice them outside of the hospital as well.

Avoid Close Contact: the “3 – 6 foot” rule is a good rule to apply in all situations, whether at work, home, or out in public, especially if you are around coughing people or you have a cough yourself. Research has shown that the majority of our respiratory spread illnesses are large enough that they settle to the ground immediately after exiting our bodies.

Stay Home When Sick: statistics show that health care personnel frequently report to work ill in an attempt to prevent a “staffing hardship” for their unit. It is better to have one day of potentially short staffing rather than sharing germs and causing a larger number of health care workers to miss work.

Cover Your Mouth & Nose: REMEMBER RESPIRATORY HYGIENE, it should be used at all times for staff, patients, and visitors.

Clean Your Hands: REMEMBER #1 METHOD TO PREVENT SPREAD OF GERMS

Avoid touching eyes, nose & mouth: Too frequently we miss opportunities to perform hand hygiene, when putting your hands to these areas you provide an opportunity for germs on your hands to enter your body.

Practice General Healthy Habits: Getting enough sleep, eating a healthy diet, taking vitamins, and getting regular exercise helps keep our bodies stronger, thereby providing a “stronger” immune system that aides us in fighting off illness.
Infection Control: Test Your Knowledge

What is the primary strategy for successful control of hospital acquired infections at SFGH?

- Body Substance Precautions are the primary strategy for control of hospital acquired infections.
- Body Substance Precautions emphasize handwashing and barrier precautions for use during contact with all moist body sites and body fluids.
- Body Substance Precautions are used for the care of all patients, regardless of their diagnosis or presumed infection status.

What must employees wear when taking care of a known or suspected pulmonary tuberculosis patient?

- For people known or suspected to have pulmonary TB, N95 particulate Respirators or other NIOSH approved respirators must be worn to protect health care workers.
- Particulate respirators are NOT to be worn by patients. They will wear regular mask.

What are some of the primary responsibilities of the SFGH Infection Control Program?

- Develop and review Infection Control policies and procedures for the hospital and individual departments
- Conduct surveillance for healthcare acquired infections, looking for trends and unusual occurrences
- Provide education to individuals and departments on principles and practices of Infection Control
- Investigate outbreaks or clusters of unusual diseases or conditions within the SFGH system
- Provide the San Francisco Department of Public Health with information concerning communicable diseases and conditions at SFGH
- Assist with monitoring departments for compliance with requirements of regulatory agencies such as DHS, JCAHO and OSHA
- Assist in conducting contact investigations following employee exposure to communicable diseases like TB

What is/are the easiest and most effective way(s) to prevent the spread of disease-causing germs at SFGH?

HAND HYGIENE – The purpose of performing hand hygiene is to decontaminate your hands. Handwashing requires soap and water and is used to remove dirt, organic material, and transient microorganisms. The use of waterless ABS product is an acceptable alternative in the absence of visible soil. HAND HYGIENE is the most important factor for reducing hospital acquired infections and their associated morbidity and mortality.

- Health care workers must wash hands thoroughly with soap and water prior to beginning their work shifts.

RESPIRATORY HYGIENE – Cover your coughs and sneezes with a tissue, dispose of tissue as soon as possible in an appropriate receptacle and wash your hands.

- Hand washing is preferred over waterless sanitizer if your cough or sneeze produces a “large quantity” of mucus or phlegm that isn’t fully contained by the tissue as this should be construed as “soiling” of hands with organic material.

NOTE: Hand Hygiene is National Patient Safety Goal #7 and a component in National Patient Safety Goal #13. Respiratory Hygiene is a component of Goal #13. As part of the “Speak Up” campaign we are educating patients on the importance of hand hygiene being done by their health care providers, their visitors and themselves. **Let your patients see you wash your hands.**
SECTION 6: APPENDICES
APPENDIX A: Employee Safety Information Form

This form is for use by any employee who wishes to provide a safety suggestion or report a hazardous condition or practice in the workplace. Complete the front side of this form and send or fax to:

**Environmental Health and Safety**
SFGH, Building 30, Room 3100
Phone: 206-5482
Fax: 206-4319

Date: ____________________________________________

Location of Hazard (Address, Building, Unit, Room, or Other Description): ____________________________________________

Describe Hazard or Suggestion: ____________________________________________

Suggestion for Correcting the Hazard/Improving Safety: ____________________________________________

If you wish to receive a follow up report of actions taken to address your concern, please provide this information. If you wish to remain ANONYMOUS, do NOT submit this information.

Employee Name: ____________________________________________

Department and Location: ____________________________________________

Phone Number: ____________________________________________

Has the hazard been reported to your supervisor? ☐ Yes ☐ No

Employees who report an unsafe work condition or practice by submitting this form or other means are protected by law. It is illegal for the employer to take any action against an employee in reprisal for exercising rights to participate in communications involving safety. EH&S will investigate all reports or questions submitted and provide a written response to the employee who provided the information or the workers in the affected area.
APPENDIX B: Asbestos Information Sheet

Asbestos Notification
Issued: June 26, 2001

WHY ARE WE ISSUING THIS NOTIFICATION?
We provide this information to comply with State of California regulations that require notification, not
ISSUED in response to a Cal/OSHA citation, union grievance, employee complaint, or increased risk of
exposure.

WHAT EMPLOYEE NOTIFICATION DOES THE ASBESTOS REGULATION REQUIRE?
The asbestos regulation requires the San Francisco General Hospital & Trauma Center (SFGH) to:
• Survey our buildings to identify asbestos-containing building materials.
• Inform you where asbestos-containing building materials are located.
• Protect you from exposures to asbestos fibers.
• Tell you what the possible health effects could be if you are exposed.
This information is summarized on the four pages that accompany this information sheet.

IS THERE ASBESTOS IN MY BUILDING?
Yes, asbestos-containing building materials are either assumed to be or have been sampled and confirmed
to be present in most buildings on the SFGH campus. Building surveyors can assume without confirmation
that a material contains asbestos. The preferred method to identify asbestos is to collect a sample of the
suspect material and have it analyzed by a laboratory.

ASBESTOS IS IN MY BUILDING. IS IT HAZARDOUS?
Asbestos is NOT hazardous to your health unless it has been disturbed or damaged and you inhale asbestos
fibers. We have removed the most hazardous asbestos-containing material that was in poor condition and
was easily damaged. The remaining asbestos-containing materials are hard and difficult to break, covered or
enclosed, or not accessible during routine work activities so there is little possibility of exposure to asbestos
fibers.

HOW DO WE PREVENT ASBESTOS EXPOSURES AT SAN FRANCISCO GENERAL
HOSPITAL?
Please follow health and safety precautions to minimize airborne asbestos fiber exposures to you and your
co-workers at SFGH:
• If you see damaged materials, report them to Environmental Health and Safety (206-5482) or Facilities
  Services (206-8522).
• Please follow restrictions that ask you NOT to mount, hang, or secure anything to the wall. Do NOT
disturb or damage the floors, walls, and ceilings in your workspace.
• Do NOT work on or handle asbestos-containing building materials unless you have been trained to do
so. Training must be acceptable to Environmental Health and Safety.
• If you need work done, contact the Facilities Services Department (206-8522). Many of the building
  engineers and painters have received specialized asbestos training, and they follow asbestos
  procedures when they encounter it.
• When a construction project will affect a large amount of asbestos-containing building materials, we
  have the asbestos removed by a certified asbestos abatement contractor inside of a temporary
  enclosure provided with negative pressure ventilation. The project is monitored daily to ensure your
  protection.

I HAVE MORE QUESTIONS. WHO CAN I TALK TO?
If you have questions, contact Environmental Health and Safety, at 206-3756.

Thank you for your assistance in managing asbestos at the SFGH.
APPENDIX C: Emergency and Disaster Response Plan

Please refer to the SFGH Disaster Manual (White Binder with Red & Blue lettering) for detailed unit specific plans!

SFGH utilizes an Emergency Response Plan based on the State of California mandated Hospital Incident Command System (HICS). The emergency response plan functions as an integrated part of the SFGH Emergency Preparedness and Disaster Response Program, the Department of Public Health Disaster Plan and the City and County of San Francisco Emergency Operations Plan.

In accordance with the City Charter, SFGH staff will function as disaster workers in the event of a disaster declaration in the City of San Francisco. It is the policy of SFGH that staff be adequately prepared to function in a competent and safe manner in response to either an internal or external disaster. It is the intent of SFGH that staff be prepared both in the home and the workplace for 72 hours of self-sustainment following a disaster.

For external disasters, the emergency response program includes the following:

- Rapid mobilization of resources under HICS to develop an incident specific action plan, project the needs of SFGH based on the event cause, and optimize the human and material resources of the hospital.
- Activating an emergency response plan which integrates with those of the San Francisco Mayor’s Office of Emergency Services (OES), the Department of Public Health, San Francisco Fire Department (SFFD), the San Francisco Police Department (SFPD) and other first responders or agencies as indicated.
- Planning, preparing for and receiving patients from an external disaster or multi-casualty incident (MCI) following the guidelines outlined in the Emergency Medical Services MCI Incident Plan.
- For internal disasters, the emergency response program includes the following: Development of hazard specific plans with the assistance of qualified experts as indicated. Hazard specific plans will utilize the four phases of emergency management: mitigation, preparedness, response and recovery.

APPENDIX D: How to Locate SFGH Infection Control Manual

Go to CHN Intranet Home page; on Left Column tool bar click on “Clinical Resources”; you will find link to the “Infection Control Site” half way down the column. Click on the link…YOU’RE THERE!
## APPENDIX E: BE SAFE WHEN HANDLING SHARPS DEVICES

<table>
<thead>
<tr>
<th>STEP</th>
<th>ACTION</th>
</tr>
</thead>
</table>
| **B** | Be prepared to apply:  
Best practice  
Best device  
Best training  
- Select the BEST device and BEST practice for a successful clinical procedure.  
- Practice, practice, practice the correct technique. If you're not sure, ask for help. Be safe, not sorry. If needed, request training from your supervisor and/or the Department of Education and Training.  
- Check your skill level. Can you handle the situation? If no, ask for help. |
| **E** | Evaluate the work environment for hazards  
- Evaluate the patient. Is there a history or signs of agitated or aggressive behavior? Needle phobia? Poor cooperation? Unpredictable outbursts? If yes, ask for help.  
- Check for patient traffic, staff traffic, crowded conditions or activity that might bump you while you use a sharp.  
- Check for noisy conditions that may prevent you from hearing the audible cue for safety mechanism activation or understanding instructions.  
- Check the lighting. Can you clearly see the critical area where the sharp will be used? Can you see the patient's vein?  
- Check for protruding sharps at the opening of the sharps container before you begin the procedure. If you could be exposed, replace the sharps container.  
- Replace the sharps container if it is 3/4 or more full, or is the inappropriate size for the device.  
- Lay out instruments and supplies for the clinical procedure in a logical sequence and so they are easy to reach. Minimize reaching, leaning, and awkward postures. |
| **S** | Follow standard safety work practices  
- Protect yourself at all times from exposure. Wear gloves and a gown. If you could be splashed, wear a face shield and/or other eye protection. Wear appropriate equipment designated for unusual hazard procedure.  
- Put the sharps waste container within easy reach.  
- If working in crowded or noisy conditions, announce to everyone that you will use a sharp. Ask them to remain still and quiet while you use the sharp. Some safety devices rely on an audible cue to indicate the safety mechanism has been activated.  
- Keep your hands behind the direction of motion of the sharp and the sharp itself.  
- Don't cross your hands/wrists. It blocks your vision, and when you will uncross your hands, you may expose your hand/arm to a contaminated sharp.  
- If you must recap a needle, there must be no other option. Use one hand to hold and recap the needle, and put the other hand behind your back.  
- Don't catch a falling or out of control sharp. |
## A
**ACTIVATE the safety mechanism**
- When finished with the sharps device, immediately activate the safety feature. Know the audible and tactile cues that indicate that the safety mechanism has been activated.
- Never leave an exposed contaminated sharp on a work surface.
- If you use a device, you activate the safety feature of the device.

## F
**FINISH the job; clean up and take care of the waste**
- When finished, immediately put the used activated sharp in the sharps container.
- If you use a device/sharp, you dispose of the device/sharp. Don't leave it for someone else.
- Inventory all sharps that you used. Check that all used sharps have been accounted for and disposed of properly.

## E
**If you have an EMERGENCY, follow the appropriate procedure**
- If you lose control of a sharp, STOP. Avoid being stuck in the next few seconds.
- Allow the sharp to land and stop moving. Announce to everyone in the vicinity that a sharp has fallen.
- Find the sharp and identify the hazardous point or edge. Do not touch it.
- Use forceps, layers of gauze padding, or other protective barriers to prevent contact with the sharp and your hand. Pick up the sharp. Protect yourself at all times.
- Put the device in the sharps container.
APPENDIX F: Patient Education Materials

On the CHN Intranet, Patient Education Links Page and Krames On Demand
To get into to Krames:
Go the Patient Education Links Page on the CHN Intranet.
http://in-sfghweb01.in.sfdph.net/PatientEducation/PtEd-Resources.htm
Click on the direct links on the orange banner or on one of the other direct links.

Note: You must log out of Krames (top-right corner of the screen) if you use different direct links. Otherwise, your system may take you to the previous direct link you used.

Inside Krames
1. Find and explore these sections
   - Support (top left corner of screen) / Click on
     o Training Resources to find Tutorials and on
     o Information to download user manuals.
   - Browse Tab / check out all the categories, which can you use?
   - Folders Tab / Become familiar with contents of the folders. Let your Krames Group Manager know which sheets you want to have bookmarked.
   - Medications Tab / Note that you can search for Medication Sheets by Name, Indication, or Classification
   - Search Box / You can quickly find healthsheets you need. Just type search terms and click go.
   - Education Cart Tab / This is a holding area where you can temporarily store titles you need.
   - Log Out / Use this to log out of the program. To get back in, you can just go to the Patient Education Links page and click on a direct link.

2. Open a Krames HealthSheet
   - In the Action section, select from the drop-down menu: Add to the education cart, View in, Print, etc.
   - Select Action and click on Go

3. Questions? Ask your Krames Group Manager or call 206-5120
APPENDIX G: Breastfeeding Initiative

Breastfeeding’s World of Benefits
Baby Friendly Hospital Initiative at San Francisco General Hospital

FOR BABY
Decreased risk of:
- Ear infections
- Respiratory infections, e.g. pneumonia
- Bacterial meningitis
- Infection of the blood
- Diabetes Mellitus Type I
- Overweight adolescence
- Asthma
- High cholesterol
- Diarrhea
- Gastro-enteritis
- Tummy upsets
- Less smelly diapers

FOR MOTHER
Decreased risk of:
- Ovarian cancer
- Breast cancer
- Postpartum anemia,

PLUS:
- Stronger bones in later life
- Faster return to pre-pregnancy figure
- Saves time and money

FOR THE COMMUNITY
- Estimated $3.6 billion savings in healthcare
- Parents miss fewer days of work due to children’s illness

SFGH supports breastfeeding patients and employees and their infants. SFGH makes private rooms to pump breast milk available to breastfeeding employees. These pumping rooms are in the Women’s Clinic (5M) and in the Nursery (6H). The California legislature encourages all California employers to strongly support and encourage the practice of breastfeeding.

Breastfeeding Help Line 206-MILK
APPENDIX H: Educational Resources for Staff

San Francisco General Hospital & Trauma Center
Department of Education and Training (DET)
1001 Potrero Avenue
Building 20, Ward 2300
San Francisco, CA 94110
FAX: (415) 206-4411
Registration: (415) 206-3675
http://insidechnsf.chnsf.org/DET/

Barnett Briggs Medical Library
1001 Potrero Building 30, Ground Floor
(415) 206-3114
http://sfghlibrary.ucsf.edu/
email: library@sfgh.ucsf.edu
Print and electronic resources for staff, patients, and families.

Training and Organization Development
The San Francisco City and County Department of Human Resource’s leadership and professional development series contains tools, knowledge, and skills to improve effectiveness and productivity.
(415) 557-4968
E-mail: DHR@ci.sf.ca.us

Employee Assistance Program (EAP)
EAP provides free of charge confidential educational and counseling sessions for all city/county employees.
For more information call:
(415) 554-9580

Tuition Reimbursement
Tuition reimbursement is available for employees who are members of applicable union bargaining unit.
Please consult with the San Francisco Department of Human Resources Intranet site:
http://www.sfgov.org/site/dhr_index.asp
APPENDIX I: SFGH - Online Resources

CHN Intranet Site
http://insidechnsf.chnsf.org/

Quality, Patient Safety, and Legal Affairs
http://in-sfghweb01.in.sfdph.net/CHNQM

Infection Control Manual
http://in-sfghweb01.in.sfdph.net/SFGHIInfectionControl

Report an Unusual Occurrence
http://insidechnsf.chnsf.org/RiskManagement/UOHome.htm

SFGH Education and Training
http://insidechnsf.chnsf.org/det/

SFGH Policies and Procedures, including Environment of Care Policies and Procedures
http://in-sfghweb01.in.sfdph.net/CHNpolicies/production/search/policies.htm

UCSF Dean’s Office at SFGH
http://medschool.ucsf.edu/sfghdean/

Barnett Briggs Medical Library
http://sfghlibrary.ucsf.edu/

Patient Education Resources Online
http://in-sfghweb01.in.sfdph.net/PatientEducation/PtEd-Resources.htm

Department of Public Health Intranet
http://dphnet.dph.sf.ca.us/

Internet Sites
San Francisco General Hospital and Trauma Center

SFGH Rebuild
http://www.sfdph.org/dph/RebuildSFGH/

San Francisco Department of Public Health Internet Site (for the public)
http://www.sfdph.org/dph/default.asp

City and County of San Francisco
http://www.sfgov.org/
APPENDIX J: Transportation Services

Parking availability is very limited at SFGH. We encourage you to use these resources to you plan your commute using alternative modes of transportation. You can get updated information on the Transportation Services Website at http://www.sfdph.org/dph/comupg/oservices/medSvs/SFGH/TransportSvcs/default.asp

**Commuter Benefits:** Save up to 40% on transit costs with pre-tax payroll deductions. For more information, visit the following:
SFGH – Enroll at www.myFBMC.com or call 1 (800) 342-8017.
UCSF – http://www.parking.ucsf.edu/transportation/ and click on “Pre-tax payroll deduction.”

**Emergency Ride Home Program**

For permanent, part-time or full time SFGH City and County employees who must leave the worksite in an emergency. To enroll and learn more visit http://www2.sfenvironment.org/aboutus/air/erh/index.htm.

MUNI bus lines within a four block radius of SFGH include: the 9, 19, 27, 33, 48, 53, and 90 lines. Routes, schedules, an maps in real time, are at http://www.sfmta.com/cms/home/sfmta.php or visit www.511.org.

**NEXT BUS** – Using satellite technology, this website gives you accurate predictions on the next bus arrival. For information, visit http://www.nextmuni.com/. You can even have the information delivered to your cell phone or PDA. A link to the site is on the CHN intranet. http://insidechnsf.chnsf.org/

**UCSF Intercampus Shuttle:** Two shuttle bus routes (gold and blue routes) run from SFGH campus to UCSF’s Parnassus, Mt. Zion, and Mission Bay campuses. In addition, the yellow line goes to the 16th Street BART station. The shuttle stop is at the SFGH Outpatient Entrance. For shuttle maps and times go to http://www.campuslifeservices.ucsf.edu/transportation/shuttles/timetables/default.php. Online shuttle arrival times are at http://www.parking.ucsf.edu/transportation/. Click on “Next Shuttle.”

**Bicycle Storage:** A bicycle cage and individual-keyed lockers are located south of SFGH’s Main Hospital entrance. To obtain keys, please complete a Bicycle Locker Agreement form. Call Facilities Management @ (415) 206-8550 or go to Building 10, Room 1118. The Institutional Police at SFGH recommends that you register your bicycle. You can do so in Room 1E12 in the Main Hospital near the Emergency Room.

**Biking Maps & Resources:** The SF Municipal Transportation Agency (SFMTA) offers safety tips and an interactive online bicycle map at http://www.sfmta.com

**Regional Transit Systems & 511 SF Bay Area:** To plan your commute to anywhere in the Bay Area using multiple transportation systems or to coordinate rideshare programs in your area, go to www.551.org.

**SFGH Main Lobby Transit Pass Sales:** In the coming months, the SFGH Main Lobby Cashier’s office will sell transit passes for MUNI, BART, A/C Transit, Alameda-Oakland Ferry, Samtrans, and Caltrain.

**Carpool Benefits:** Carpool parking permits (minimum of three employees required) offer a substantial discount of $60 per year. Contact Facilities Management at (415) 206-8550 or visit Building 10, Room 1118 to pick up an application.

**City CarShare** http://www.citycarshare.org/: SFGH employees may rent vehicles either for business or personal trips. Use of this service for SFGH business is at the discretion of employee supervisors and/or administrators. You must contact Facilities Management at (415) 206-8550 for a City CarShare Group Number. Each employee must complete an application form. For more information and to apply, call City
CarShare at (415) 995-8588 or visit https://denali.citycarshare.org/signup/signup.action?type=3. SFGH's membership covers the cost of City CarShare gas cards. The number of employees eligible to join is limited. SFGH campus four has City CarShare spaces, two at the north entrance of Building 1 and two 24th Street and Utah.

**For personal use of carshare services, you may use either City CarShare or ZipCar.** To apply for personal membership, you will need to provide a credit card number and do brief online orientation is required please call (415) 995-8588 or visit https://denali.citycarshare.org/signup/signup.action?type=2.

**ZipCar.** There are 2 ZipCars on the SFGH campus. These vehicles are located outside of the SFGH Emergency Department (SFGH map). To register for ZipCar, visit www.zipcar.com or call 1 (866) 4ZIPCAR (1-866-494-7227).

**SFGH Rebuild:** Find updates regarding anticipated loss of parking due to the Rebuild of SFGH on the SFGH Transportation Services website & in Dr. Katz’s Fast Facts Newsletter.
APPENDIX K: Maps – SFGH
SFGH Campus

Visit the CHN Intranet for these and other maps. http://dphnet.dph.sf.ca.us/maps.htm
Main Hospital by Floors:
Main Hospital by Floors: