Hospital-wide Policies & Procedures Submitted to

JCC for Approval on March 10, 2015

New Policies and Procedures		
Policy Number	**Title**	**Comments/Reason(s) for Development**
LHHPP 26-06	**Meal Tray Service Galley Sanitation**	Establishes sanitation procedures for ware washing when it is carried out on the neighborhood galleys. Approved by NEC and HEC.
LHHPP 80-12	**Lactation Accommodation For Employees at the Workplace**	Establishes facility procedures to meet AB 1025 Lactation Accommodation Legislation. Approved by HEC.
Revised Policies and Procedures		
Policy Number	**Title**	**Comments/Reason(s) for Revision**
LHHPP 24-24	**Nurse-Physician Communication During Quiet Hours Between 10pm To 6am**	Clarifies and provides examples of emergent/urgent situations for nurse-physician communication between 10pm to 6am.
LHHPP 29-05	**Interpreter Services and Language Assistance**	Change in contact procedure on Attachment A Guidelines (No. 1)
31-02	**Hospital Equipment and Supplies**	Minor edit to Procedure No. 1
LHHPP 45-03	**Donations**	Clarifies staff responsibilities for processing donations
LHHPP 72-01 A1	**Infection Control Manual** **Infection Control Committee (ICC) Authority**	Re-written to describe ICC policies, purposes and procedures as written in the Medical Staff Bylaws
LHHPP 73-07	**Aerosol Transmissible Disease (ATD) Exposure Control Plan**	Re-written to reflect current procedures
LHHPP 80-03	**Student, Volunteer and Consultant Orientation**	Removes employee procedures described in LHHPP 80-05
LHHPP 80-05	**Staff Education Program**	Includes list of responsibilities that are routinely carried out by Human Resources, Department of Education & Training, and managerial staff that were not previously described
For Deletion		
Policy Number	**Title**	**Comments/Reason(s) for Deletion**
None	N/A	N/A

*HEC – Hospital Executive Committee; MEC – Medical Executive Committee; NEC – Nursing Executive Committee

MEAL TRAY SERVICE GALLEY SANITATION

POLICY:

Neighborhood Galley dishwashers may be used to clean, wash and sanitize meal trays and dishware according to established procedures.

PURPOSE:

To properly sanitize resident's meals trays in the Galley for proper warewashing when necessary and maintain food service operations for resident meals.

PROCEDURE:

1. Nursing staff shall return soiled meal trays to the Galley for proper warewashing by the Food Service Worker.

2. Prior to the ware washing process, the Food Service Worker shall record the dishwasher machine temperatures to ensure that it is operating within standards (Temperatures: Wash: 150*F; Final Rinse: 180*F; Pressure: 20).

   The chemicals used in the Galley include:

   - Ecotemp Ultra Dry
   - Solid Power Plus
   - Mikroklene
   - Liquid Assure
   - Super Trump

3. The Food Service Worker shall wash and sanitize all meal trays and dishware, mugs and silverware through the dishwasher machine located inside the Neighborhood Galley.

4. The Food Service Worker will use the three-bucket cleaning procedure for the following:

   - The delivery carts
   - The work counters
   - The dishwasher machine

(Reference to Nutrition Services Policy: 1.164 General Cleaning and Sanitizing work Surfaces and Kitchen or Galley Equipment)

5. All cleaned and sanitized ware shall be brought back to the Tray Service Area by the Food Service Worker before the next meal service.
6. The Food Service Worker will sweep and mop galley floors at the end of each warewashing process.
7. The Food Service Worker is responsible for locking and securing the Galley at end of the warewashing process.
8. A Porter will dispose of compost, recycle and garbage.
9. The Food Service Supervisor and Team leaders are responsible for monitoring the Galleys for sanitation compliance.

ATTACHMENT:

None

REFERENCE:

Reference to Nutrition Services Policy: 1.164 General Cleaning and Sanitizing work Surfaces and Kitchen or Galley Equipment

Original adoption: 15-03-10

LACTATION ACCOMODATION FOR EMPLOYEES AT THE WORKPLACE

POLICY:

Laguna Honda Hospital will provide a private space, supportive environment and reasonable time for lactation purposes for nursing mothers who working at Laguna Honda.

The Lactation Room is located on the 2nd floor in the H Building (connecting corridor between Administration Building and Hospital) across from the Mailroom. The Lactation Room is a private room with capacity for one individual using the room at a given time.

The Lactation Room is available 24 hours a day, 7 days a week.

PURPOSE:

1. The Lactation Room provides a reasonable private, non-bathroom location for nursing mothers to express breast milk during the work day.

2. Lactation accommodation goals are to:

    - Ease the transition of mothers who return to work following the birth of a child.
    - Assist mothers to return to work rather than having to take time away from work to express milk.
    - Ensure that women who are pregnant or considering pregnancy know that breastfeeding will be accommodated by their employer.
    - Assist employees to experience work-life balance by providing a motivating, employee-supportive work environment.

PROCEDURES:

1. The Department of Human Resources at Laguna Honda shall provide this policy to any employee who submits a request for maternity or pregnancy disability leave.

2. Upon return from leave, the employee (nursing mother) and direct supervisor will work together to plan a reasonable schedule to accommodate time for lactation.

3. The Lactation Room is available on a first come, first serve basis. The Lactation room is available when the Lactation sign says “Vacant.” The Lactation room is not available when the Lactation sign says “Occupied.”

4. Lockers for employees using the Lactation Room are available in the locker room (located next door to the Lactation Room) to store their breast pump and other necessary accessories. Employees are responsible to provide their own lock.

5. Employees who use the Lactation Room shall leave the room clean and tidy.

ATTACHMENT:

None

REFERENCES:

San Francisco Department of Public Health – Policy and Procedure, Lactation Accommodation at the Workplace (HUR23)

AB 1025 Lactation Accommodation Legislation

Original Adoption: 2015/03/10

NURSE-PHYSICIAN COMMUNICATION DURING QUIET HOURS BETWEEN 10PM TOAND [GEM1]6AM

POLICY:

Laguna Honda physicians are on site 24/7. On-call weekends and between the hours of 5 pm and 8 am Monday through Friday, physician coverage is provided during quiet hours (10 PM to 6 AM) for emergent[GEM2]/urgent situations that only and patient issues that would pose a risk to patient safety and wellbeing if not assessed by a physician prior to the next regular woreek day shift shift.

PURPOSE:

1. To provide all Laguna Honda residents with assessment and care/management in a timely manner appropriate to the situation at hand.[GEM3]

2. To prioritize resident needs for physician evaluation. minimize unnecessary callsinterruptions for nurses[GEM4] andto on-call physicians.

To standardize use of Situation, Background, Assessment, Recommendation, Now (SBARN) for nursing-physician communication.

BACKGROUND:

1. Laguna Honda physicians are on site 24 hours/day, 7 days per week.

3.2. On-call physician coverage occurs on weekends, holidays, and between the hours of 5 PM to 8 AM Monday to Friday for emergent/urgent clinical issues.overage begins from 5 pm to 8 am.

PROCEDURE:

1. Guidelines

a. Quiet hours are established between 10 pm toand 6 am. During this time, the only calls to the physicians should be those requiring immediate/emergent physician assessment/action.

b. Examples of appropriate calls during quiet hours are those involving a symptomatic significant change in condition n or abnormal vital signs such as: [GEM5]; i.e.

i. A significant change from baseline –vital signs and O2 saturationBP 250/110 [GEM6]with severe headacheassociated symptoms,
- Ttemperature of 39.5 degrees Centigrade
- Desaturating O, and new hypoxia [GEM7]with O2 sat < 90%

ii. R; or a resident complaint of chest pain or symptoms of a heart attack unless otherwise ordered

iii. Resident is having seizures unless otherwise ordered

iv. Resident is manifesting possible signs , stroke (facial droop, weakness, slurred speech)

v. ,N new or worsening confusion

b.vi. ; Aand all other clinical conditions findings where the RN believes requirefeels that an immediate physician assessment is warranted.

c. Examples of inappropriate calls during quiet hours are:

i. Mmedication error from last week newly discovered

ii. , discovery of an old bruise[GEM8]

iii. e, Rrash without other symptoms

iv. , Rrequest for routine laxative order

v. , Ffall without injury; notification of physician via clipboard

vi. R, ran out of non-urgent medication and cannot give dose

c.vii. L, or laboratory results that are within normal range.

2. Information to prepare for calling the physician (SBARN*)

a. Remember SBARN* – situation, background, assessment, recommendation, now (do you need to call now)

b. Include symptoms, vital signs, physician assessment, background, recent history for resident, what was already done, what you are requesting the physician do.

3. Standard Triage and First Responder Protocols for Nursing

The following issues will be managed using standard triage and first responder protocols:

a. Management of superficial open areas

b. Management of bruises

c. Management of resident/family insistence to call physician during quiet hours

ATTACHMENT:

Standard Triage and First Responder Protocols for NursingNone

CROSS-REFERENCE:

NPP C 4.0 Physician Notification of Change in Resident Status
NPP C 4.0 Physician Notification of Change in Resident Status – Appendix A; Using SBARN Method of Communication
NPP G 7.0 Nursing Protocol for Non-Urgent Conditions
LHHPP 22-01 Abuse Protection Program: Prevention, Recognition, Reporting

REFERENCE:

None

Revised: N/A (Year/Month/Day)
Original adoption: 15/01/13

INTERPRETER SERVICES AND LANGUAGE ASSISTANCE

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) shall provide equal access to services for limited English-proficient (LEP) and hearing impaired/deaf residents through the use of Interpreter Services, designated bilingual hospital employees and contract agencies.

2. Family members shall not be used to interpret information/instructions regarding consents/authorization to treatment or in situations of child or elder abuse, domestic violence, assault, or other sensitive situations.

PURPOSE:

1. To ensure that limited English-proficient (LEP) residents and surrogate decision-makers are able to understand their medical conditions and treatment options.

2. To ensure that quality resident care are provided to LEP residents by Laguna Honda staff.

PROCEDURE:

1. Interpreter Services and Language Assistance

    a. Laguna Honda Human Resources Department shall compile, update and at a minimum annually distribute to Nursing Services a Designated Bilingual Employee Program roster of all staff and volunteers who are fluent in languages other than English and can provide language assistance related to resident care information and translate documents.

    b. Nursing Services shall maintain information on the location and shift of qualified nursing staff who are on the Designated Bilingual Employee Program.

    c. SFGHMC Interpreter Services (contact number: 206-5133) provides qualified interpreters, fluent in English and other languages, for telephone interpretations. SFGH will send staff to Laguna Honda for resident-caregiver services under special circumstances.

    d. If the resident or surrogate decision maker prefers the use of a friend or family member to provide them with language assistance for routine matters involving activities of daily living, Laguna Honda personnel may utilize the authorized friend or family member for language assistance.

2. Language Competency

a. All Interpreter Service Department interpreters must pass a language proficiency test provided by the office of Equal Employment Opportunity/Affirmative Action (EEO/AA) and successfully complete an Interpreter Training Program approved by the Department within one year from the hiring date.

b. Language proficiency examinations are offered periodically to all Department of Public Health (DPH) employees and medical residents in a variety of major languages spoken in San Francisco. Testing instruments are used to examine an individual's ability to fluently carry on a conversation within a medical or mental health setting. The oral exams are written specifically for DPH employees by culturally diverse medical and mental health care providers in consultation with the Interpreter Services Department. All employees and volunteers who use their second language must be tested for proficiency before providing language services.

3. Requests for Language Assistance

a. Call the Nursing office for language assistance.

b. The following information is required to secure the appropriate service:

i. The resident's name
ii. The language needed, i.e. Cantonese, Mandarin, Vietnamese, Spanish, Sign Language for the deaf/hearing impaired, etc. (Please plan ahead and let the Nursing office know when a resident is scheduled who speaks an uncommon language or who needs a sign interpreter. This is important because an ASL interpreter may not be available for a same day request).
iii. The name and location of the requesting department, contact person in the department, telephone number, and/or pager number.
iv. The name of the physician, nurse, or other staff member who will need language assistance.
v. The approximate amount of time needed for language assistance.

c. Nursing office documents and tracks all requests for language assistance.

4. Documentation of Language Assistance

a. Whenever language assistance is used to communicate with a resident, the provider (physician, nurse, or other clinician who is using the language assistance) shall document the need and how the need was addressed in the resident's medical record.

b. If a family member/friend provides language assistance for a resident, document the relationship of the person providing assistance, and the reason why assistance was provided.

ATTACHMENT:
Attachment A: Guidelines for the Care of the Hearing Impaired/Deaf Resident.

REFERENCE:
None

Revised: 98/11/16; 02/04/12, 13/01/29 (Year/Month/Day)
Original adoption: 89/09/01 Translation Services

ATTACHMENT A

GUIDELINES FOR THE CARE OF THE HEARING IMPAIRED/DEAF RESIDENT

1. To schedule an appointment with an American Sign Language interpreter please call Interpreter Services at 206-5133 between the hours of 8:00 am to 12:00 midnight. After midnight please contact the ~~Telephone Operator at 206-8000.~~Nursing office at extension 4-1501.

    - Sign language interpreters are arranged through an agency. When possible, please call to set up an appointment at least 48 hours in advance or sooner. If there is less than 48 hours notice, there will be an extra charge to Laguna Honda. Cancellations must also be made 48 hours prior to the appointment or Laguna Honda will be billed for the service. The sign language agency will also try to assist with immediate or urgent needs.
    - Remember to coordinate the appointment time with all health care providers and do not arrange for the sign language interpreter when the resident will be off the unit for diagnostic tests.

2. Obtain a packet of resource materials by contacting the Interpreter Services staff at 206-5133 and informing them of the resident's name, medical record number. Nursing office will arrange for the packet of resource materials to be delivered to the unit/location. The packet can also be obtained by picking it up from the Nursing office. The packet of resource materials includes the following:

    a. "Deaf Resident Alert" sign - For hospitalized residents, please place the sign at the head of the bed, not outside the door.
    b. "Deaf Resident Alert" stickers - Please place the stickers on the front of the resident's medical record, the Kardex, and call light system, as appropriate.
    c. Graphics Communication Sheet, pad of paper, and pencil- For hospitalized residents, please place at the resident's bedside.

3. Sign Language Agency information sheet.

HOSPITAL EQUIPMENT AND SUPPLIES

POLICY:

Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) shall have available equipment and supplies needed to render appropriate care to residents.

PURPOSE:

To ensure that physician-ordered care can be provided at all times through the use of equipment and supplies.

PROCEDURES:

1. **The Finance Manager ~~for Finance~~ or a Designee**
   a. Shall establish budgeting, appropriation management, purchasing and expenditure accounting policies and procedures.

2. **The Associate Administrator for Operations**
   a. Shall establish commissary inventory control policies and procedures.

3. **Division Heads**
   a. Shall be responsible during budget preparation to make adequate annual appropriation requests for suitable equipment and supplies for their divisions.

   b. Shall be responsible to expend appropriated funds to ensure that priority is given to equipment and supplies necessary to maintain essential services.

4. **Department Heads**
   a. Shall be responsible during budget preparation process to make adequate annual appropriation requests for suitable equipment and supplies for their departments and otherwise make every effort to enumerate all equipment and supplies deemed necessary to maintain a legally compliant and high standard of resident care;

   b. Shall be responsible to expend appropriate funds in a timely fashion to ensure that priority is given to equipment and supplies necessary to provide ordered or indicated services; and

   c. Shall be responsible to implement within their departments equipment life-cycle projections, inventory controls, and par estimates sufficient to assure that equipment and supply orders are placed in a timely fashion which take into account known order requirements, bid specifications, constraints, and order lag time of the City Purchaser.

ATTACHMENTS:

None

REFERENCES:

None

Revised: 02/01/02, 92/05/20, 07/12/18, 11/05/13, 15/03/10 (Year/Month/Day)
Original adoption: 88/01/22

DONATIONS

POLICY:

1. The hospital accepts and processes donations, including in-kind and financial donations, to the enhancement of its mission.

2. Generally, the hospital does not arrange for the pick up of donated in-kind items. The donors are responsible for getting donated items to the hospital.

3. The hospital respects the intention of its donors, and maintains the integrity of designated funds or items through proper procedures for the receipt, use, disposal, or return of donations or in-kind gifts, as well as the expenditure of funds that result from the liquidation of gifts and their conversion to cash.

4. The hospital maximizes the value of donations it receives, and sells or recycles materials not of immediate use.

5. All donations to the hospital are reported to the appropriate City entity including the Joint Conference Committee, the full Health Commission, and/or the Board of Supervisors.

PURPOSE:

To ensure that donations to the hospital are utilized appropriately for the benefit of the hospital and the residents it serves.

PROCEDURE:

1. In-kind Donations

    a. In-kind donations are non-financial donations of items such as clothing, furniture or equipment.

    b. The Volunteer Services Department is generally responsible for accepting and processing non-designated in-kind donations per Volunteer Services policy.

    c. The Volunteer Services Department maintains a list of acceptable items for donations and regularly makes that information as well as the hospital's policy on processing donated items available to the general public.

    d. A Gift Receipt form is completed for each donation.

        i. The donor may request an acknowledgement letter for the donation. That request is documented on the Gift Receipt Form. The Volunteer Services ~~Department~~Coordinator is responsible for generating an acknowledgement

letter ~~if requested~~from the Executive Administrator and Volunteer Services Coordinator (unless donor contact information is not known).

ii. Copies on all Gift Receipt Forms are kept on file for 3 years by the Volunteer Services Department.

e. Valuation. Undesignated non-monetary donations of clothing, jewelry, or other gifts do not have value placed upon them by hospital employees for purposes of donor tax obligation. As appropriate, a letter enumerating or describing the donation, but with no monetary value attached, is provided to the donor. Since valuation for donor tax purposes is the donor's responsibility, valuation processes, including appraisal fees, are the responsibility of the donor.

i. For new and unused donated items, if the donor can produce documentation, such as a receipt or an appraisal report, indicating the value of a donated item, the value of the donation will be recorded on the Gift Receipt Form.

ii. In the unusual circumstance where the hospital may receive a donation believed to have unrecognized extraordinary monetary or historical value (i.e., a book, antique, fine jewelry), the Executive Administrator may authorize use of hospital funds to obtain an appraisal for the hospital's purposes. The value of the donation is recorded on the Gift Receipt Form.

f. Designated non-monetary donations are distributed according to the terms of the donation if the hospital chooses to accept the donation; otherwise, the donation is declined with applicable reasons provided to the prospective donor

g. The Volunteer Services Department determines the disposition of undesignated non-cash donations. Undesignated donated items shall be distributed directly to hospital departments or directly to residents, sold at the hospital's gift shop, or sold/given to a third party organization to remove from the premises.

h. Revenue generated by sales of undesignated non-cash donations are distributed to the Resident Gift Fund.

i. Donated equipment and furniture that will be used by hospital staff and residents will be evaluated and certified by the Facility Services Department and must meet UL and NFPA regulations for hospital usage.

j. The Volunteer Services Department forwards a copy of all Gift Receipt Forms to the Finance Department on a quarterly basis for reporting purposes.

k. Retroactive acceptance of gifts already received. When a gift has already been received, it is possible to obtain retroactive acceptance by the above authorities via the same process as prospective acceptance. Retroactive acceptance of

gifts is intended for use only in the exceptional case (e.g., acceptance of expensive wheelchairs)

l. Donations are processed per San Francisco Administrative Code, Section 10.100-201.

2. Monetary Donations.

   a. Prospective donors are directed to the ~~Community Relations Director~~Accounting Department ~~Respresentative~~Representative, who will advise the donor as to options for making a monetary donation. Those options include:

      i. The Friends of Laguna Honda, 501(c)(3) NFP tax deductible.

      ii. The Resident Gift Fund, deductible as a gift to a fund of a charitable hospital.

         - Donations to the Resident Gift Fund may be designated to a specific program or grant code.
         - In the event a donation is made for a purpose or intent outside of the established grant codes, a new grant code may be established with the authorization of Laguna Honda's Executive Administrator and Chief Financial Officer.
         - Donations to the Resident Gift Fund are processed per LHHPP 45-01, Gift Fund Management, and San Francisco Administrative Code, Section 10.100-201.

      ~~iii. Laguna Honda Foundation, 501(c)(3) NFP tax deductible.~~

   b. The hospital also accepts monetary donation to the Resident Gift Fund via its website.

   c. Monetary donations to the Resident Gift Fund will be acknowledged by the Executive Administrator.

3. Solicitation for donations by hospital staff must be approved by the appropriate department head and the ~~Community Relations Director~~Accounting Department Representative using the Request for Solicitation form.

   a. Monetary and non-monetary donations resulting from solicitations by hospital staff are the property of Laguna Honda and the City and County of San Francisco. The use of donations must be processed as indicated on the approved Request for Solicitation form. Monetary and in-kind donations resulting from solicitation are processed in the same fashion as non-solicited donations.

b. Requests for the acquisition of equipment, supplies, and/or services through donations by ~~not-for-profit organizations such as~~ the Friends of Laguna Honda shall be made by the respective division head to the Director of Wellness and Therapeutic Activities. Requests to other not-for-profit organizations must be approved by the hospital's Executive Committee.

4. Use of the Laguna Honda name or logo for fund-raising.

a. Entities with ~~memoranda of understanding~~contracts with the hospital may use the hospital name and/or logo for the purpose of raising funds for donation to or future use by the hospital to the extent authorized in the mutual agreements.

ATTACHMENT:
None

REFERENCE:
LHHPP 45-01 Gift Fund Management
Volunteer Services Policy C 2.0, In-kind Donations
DPH Policy "Acceptance of Gifts"
San Francisco Administrative Code Section 10.100-201

Revised: ~~N/A~~15/03/10
Original adoption: 12/09/25 (Year/Month/Day)

DRAFT REVISION

AUTHORITY ~~STATEMENT~~OF INFECTION CONTROL COMMITTEE

POLICY:

1. The Infection Control Committee (ICC) is a medical staff committee responsible for the oversight of Laguna Honda's infection control (IC) program and activities.
2. ~~The Infection Control Manual contains the Infection Control Policies and Standards of Practice for Laguna Honda Hospital.~~ ~~These~~ Infection control policies and ~~standards~~ procedures, and clinical care guidelines ~~have been~~shall be approved by the ~~Laguna Honda Hospital Infection Control Committee~~ICC prior to implementation.

PURPOSE:

~~The Infection Control Committee is responsible for the Infection Control Program and activities at Laguna Honda Hospital.~~

~~To optimize resident and staff health and safety and to contribute to the health and safety of the Laguna Honda Hospital community by identifying, preventing, and controlling infections in residents, staff, volunteers and visitors.~~

1. To develop and monitor policies, procedures and practices which promote consistent adherence to evidence-based IC practices.
2. To provide IC program oversight that includes planning, organizing, implementing, operating, monitoring, and maintaining all of the elements of an effective IC program.

PROCEDURE:

~~1. Standards and protocols developed by other hospital disciplines and departments must reflect current and applicable infection control policy. All changes affecting infection control must have the approval of the Infection Control Committee. Proposed changes should be referred to the chair, an Infection Control staff member, or to the whole Committee for consideration.~~

1. Composition of the ICC

The ICC consist of the following interdisciplinary team members, as described in the Medical Staff Bylaws, who shall have duties as IC Officers for their respective departments:

i. At least two physician members of the active Medical Staff appointed on an annual basis by the Chief of Staff, one of whom will be appointed as Chair and one Vice-Chair of the committee;
ii. Director of Quality Management;
iii. Infection Control Nurse;
iv. One representative from Materials Management / Central Supply;
v. One administrative representative appointed by the Executive Administrator;
vi. One representative from Nursing Services appointed by the Chief Nursing Officer;
vii. One Pharmacist appointed by the Director of Pharmacy;

viii. One representative from Environmental Services appointed by the Chief Operating Officer;
ix. Director of Nutrition Services or designee;
x. Respiratory Therapy Supervisor or designee; and
xi. Any other department representative or consultant deemed advisable by the Chief of Staff.

2. Functions of the ICC include:

a. To develop and recommend to the Medical Executive Committee written standards for Hospital sanitization and medical asepsis. These standards shall include a definition of infection for the purpose of surveillance, as well as specification indications of the need for, and the procedures to be used in, isolation.
b. To be responsible for Quality Improvement in developing, evaluating, and revising on a continuing basis the procedures and techniques for meeting established sanitation and asepsis standards, including the routine evaluation of materials used in the Hospital's sanitation program. The evaluation may be based upon data supplied from reputable sources or upon in-use tests performed within the Hospital.
c. To develop a practical system subject to MEC approval for reporting, evaluating, and keeping records of infections in order to provide an indication of the endemic level of all nosocomial infections, and to trace the sources of infections and identify epidemic or potentially epidemic situations.
d. To develop and monitor infection control policies, subject to the approval of the Medical Executive Committee, for antibiotic resistant bacteria, influenza, and tuberculosis.
e. Coordinate medical staff education related to infection control issues.
f. Develop policies for communicating to potentially exposed staff.
g. To perform Quality Improvement activities related to the use of antibiotics and to present a summary of the findings of these activities at least quarterly to the Medical Quality Improvement Committee.
h. To report at least quarterly to the Medical Executive Committee on activities and findings.
i. To request of the Chief of Staff specific review of individual Medical Staff practices if deemed necessary.

3. Components of the IC Program include:

a. Process and outcome surveillance – staff compliance with infection control practices and the systematic steps of collecting/documenting individual cases of resident/patient infections and comparing the collected data to standard written definitions of infections using McGreer criteria;
b. Outbreak control – a system for detection, investigation, and control of infectious disease outbreaks;
c. Education – new employee and annual staff training on basic infection control standards for preventing the transmission of infectious diseases, including air-borne and blood-borne pathogens;
d. Hand hygiene program – vigorous promotion of hand hygiene, and neighborhood-based monitoring of compliance with good hand-hygiene practices;

e. Resident health program – annual tuberculosis screening, and vaccination programs for influenza, pneumococcal disease, tetanus, pertussis, diphtheria, and others, as clinically indicated;
f. Employee health program – annual tuberculosis screening and vaccination programs for hepatitis B, tetanus, diphtheria, pertussis, influenza, varicella, mumps, measles, and rubella;
g. Antimicrobial stewardship – promotion of judicious use of antimicrobials;
h. Disease reporting to public health authorities – as required by law;
i. Facility management – environmental sanitation, waste management, pest control disinfection, sterilization and asepsis procedures; handling and processing of linens; and managing food safety;
j. Quality improvement – the examination of HAI data for the purpose of identifying performance improvement opportunities with facility practices;
k. Emergency preparedness plans – annual review of the pandemic influenza preparedness program, and preparation for other potential serious outbreaks, for example anthrax or other bioterrorism attacks; and
l. The ICC meets every other month or more frequently as necessary to carry out the business of the infection control program of the Hospital.

~~2. The Infection Control Committee Chair, Infection Control Manager, or Infection Control Nurse may order appropriate control measures when he/she believes there is an imminent danger to the LH community from an infectious agent. The resident's attending physician, or designated representative, is informed of such measures as soon as possible.~~
~~When such measures substantially impact the operation of the institution, the Chair, Coordinator, or Infection Control Nurse consults with Administration before implementation.~~

~~3. Functions of the Infection Control Program at LH include:~~

~~a. To design and implement a strategic plan for surveillance and control of healthcare associated infections (HAI) based on the demographics of LH clients, the epidemiologically significant issues identified, and current standards of care.~~

~~b. To provide surveillance for healthcare associated infections and prevention activities through:~~

~~i. Data collection and reporting of infection trends.~~

~~ii. Periodic surveillance of targeted areas at high risk for healthcare associated infections.~~
~~iii. Investigation of outbreaks or unusual clusters of healthcare associated infections and infections deemed significant by the Infection Control Committee.~~

~~iv. Prevention and control activities appropriate to the type of infection and the potential susceptibility of the resident population.~~

~~v. Hospital-wide monitoring of healthcare associated infections deemed significant by the committee.~~

~~vi. Infection control environmental rounds.~~

~~c. To report healthcare associated infections and epidemiologically important infections to the Infection Control Committee, and to share these reports, with suggested intervention plans, with other relevant committees, departments and clinical units.~~

~~d. To identify trends and patterns in antimicrobial resistance.~~

~~e. To make available a current Infection Control Manual in all areas of the hospital.~~

~~f. To advise hospital departments and services in the development of specialty-specific standards of care, procedures and policies, which reflect current, accepted infection control standards and guidelines. The Infection Control Program reviews the development of policies and procedures as applied to:~~

~~i. Resident care practices.~~

~~ii. Aseptic techniques.~~

~~iii. Cleaning, decontamination, disinfection and sterilization procedures.~~

~~iv. Medical care products/devices/equipment pertinent to Infection Control~~

~~v. Environmental disinfectants.~~

~~vi. Medical disinfectants.~~

~~vii. Medical and biohazardous waste management.~~

~~g. To plan educational programs, including infection control orientation and education for all new employees and annual reviews for all clinical employees, which are conducted through cooperation between Infection Control and the Department of Education and Training.~~
~~For hospital wide education and training, Infection Control staff will:~~
~~i. Participate in orientation and education of hospital personnel, new and continuing, regarding the importance of the Infection Control Program, the responsibility of all personnel for their participation in the Program, personal hygiene, hand hygiene, respiratory hygiene and infection prevention and control measures.~~

~~ii. Provide information obtained from audits and other surveys to Medicine, Nursing, and other Departments for use in upgrading current practices.~~

~~iii. Serve as a resource to the community through information and teaching.~~

~~iv. Maintain current knowledge of infection control practices and regulations for use by the Infection Control Committee and other clinical Departments.~~

~~v. Provide unit-based training to staff as needed, related to infection control issues.~~

~~h. To investigate suspected epidemics of healthcare associated infections and outbreaks or exposures to infectious diseases.~~

~~i. To provide consultation on a wide variety of resident care practices, problem resolution, cleaning/disinfection/sterilization, and employee health issues related to infection control.~~

~~j. To participate in hospital functions such as risk management, quality management, utilization review, value analysis, product evaluation, and environmental health and safety.~~

~~k. To routinely review antimicrobial utilization. (Refer to Policy Number 25-07 number 4.)~~

~~l. To guide the scope and content of the Employee Health Program through the Infection Control Committee.~~

~~m. To evaluate the adequacy of laboratory services, including microbiological services for diagnosis, treatment, and epidemiologic purposes, within the Infection Control Committee.~~

~~n. To report all required diseases to the San Francisco Department of Public Health Division Communicable Disease Reporting sections, including Communicable Disease Control, and TB, divisions when appropriate or required.~~

ATTACHMENT:

None

REFERENCE:

~~None~~Medical Staff Bylaws

Most recent review:
Revised:
Original adoption:

AEROSOL TRANSMISSIBLE DISEASE (ATD) EXPOSURE CONTROL PLAN

POLICY

The Laguna Honda Hospital and Rehabilitation Center (LHH) is committed to maintaining a healthy work force by controlling occupational exposure of its employees to infectious diseases.

The Aerosol Transmissible Disease Exposure Control Plan (ATDP) is a program administered jointly by the LHH Industrial Hygienist, the LHH Infection Control Nurse, and LHH Employee Health. The ATDP shall require the same responsibilities for supervisors, employees and designated staff as the Illness and Injury Prevention Program (IIPP).

PURPOSE

The purpose of the ATDP is to implement and maintain effective procedures for controlling occupational exposure to ATDs, consistent with LHH policy and pursuant to Title 8 of the California Code of Regulations, Section 5199.

PROCEDURE

1. Definitions and Applicability of ATDP

a) Aerosol transmissible disease (ATD) or aerosol transmissible pathogen (ATP)

A disease or pathogen for which droplet or airborne precautions are recommended, as listed in Appendix A.

b) Airborne Infectious Disease (AirID)

Either: (1) an ATD transmitted through dissemination of airborne droplet nuclei, small particle aerosols, or dust particles containing the disease agent for which airborne infection isolation is recommended by the CDC or CDPH, as listed in Appendix A, or (2) the disease process caused by novel or unknown pathogen for which there is no evidence to rule out with reasonable certainty the possibility that the pathogen is transmissible through dissemination of airborne droplet.

c) Occupational Exposure

Occupational exposure is exposure from work activity that causes a higher risk of contracting disease than what would be considered ordinary for employees having direct contact with the general public outside of the healthcare setting. The ATDP applies to all LHH employees who have the potential to be

occupationally exposed. Job classifications of potentially occupationally exposed employees are listed in Appendix B.

d) Ebola Virus Disease

This ATDP does not apply to Ebola Virus Disease (EVD). Laguna Honda employees will not treat patients with EVD and will, therefore, not be occupationally exposed to EVD. If any person in the facility is suspected of having EVD, they will be isolated and transported to an appropriate acute care hospital according to the Laguna Honda Ebola Response Plan.

e) High Hazard Procedures

High hazard procedures are procedures performed on a resident who is a case or suspected case of an ATD in which the potential for exposure to an aerosol transmissible pathogen is increased due to the reasonably anticipated generation of aerosolized pathogens.

2. Methods of Controlling Exposures

a) Source Control

In the event a LHH resident is suspected of having an ATD, the following procedure shall be followed prior to transfer to an isolation room:

i. Resident will be instructed to remain at bedside with curtains drawn. If available, resident can be placed temporarily in a well-ventilated private room with doors closed.
ii. If tolerated, the resident should be encouraged to wear a surgical mask.
iii. Resident will be instructed to follow respiratory hygiene and cough etiquette protocol. This includes covering mouth and nose with tissue when coughing or sneezing, and to discard tissue in non-touch receptacle provided by nursing staff.
iv. Resident shall be encouraged to practice hand hygiene. Hand washing facilities and, if appropriate, alcohol hand sanitizer shall be made available.
v. Resident should only be allowed to leave room for essential purposes. If resident needs to leave the room he/she shall wear a surgical mask.
vi. The Nurse Manager/Charge Nurse shall be responsible for notifying unit staff and other personnel of special precautions that need to be followed until re-location occurs. The nursing staff will be responsible for notifying the receiving department of suspected diagnosis and source control measures which should be implemented.

b) Procedures for Airborne Infection Isolation (AII)

LHH has seven negative pressure AII rooms. The room numbers of the AII rooms are S628, S648, S528, S548, S428, S448, and PM56. Any resident who is

identified as a case or suspected case of ATD will be transferred to an AII room according to the following procedure.

i. Notify the Infection Control Nurse who will make the determination if an AII room is appropriate. In the event that the Infection Control Nurse is not available the Nurse Manager on duty shall be notified.
ii. The Infection Control Nurse will contact the bed control coordinator and Nurse Manager/Charge Nurse on the unit with the isolation room to let them know that a resident will be transferred for airborne isolation.
iii. The Infection Control Nurse/Nurse Manager on duty will notify the Watch Engineer that an isolation room will be activated. The Watch Engineer or other Stationary Engineer will assess and confirm the integrity of the negative pressure system and report back to the Infection Control Nurse/Nurse Manager on duty that the room is fit or unfit for occupancy.
iv. Transfer to the AII room must take place as soon as possible but no later than 5 hours after initial identification.
v. The door to the isolation room will be labeled notifying staff to “STOP”. Check with nurse before entering and N95 required.
vi. The resident will be instructed to remain in the isolation room with the door closed.
vii. N95 respirators and personal protective clothing will be made available in the ante room to all staff entering the isolation room. Additional supplies are available from Central supply.
viii. Any staff member who enters an AII room occupied by a resident with known or suspected AirID must wear an N95 or PAPR in accordance with the LHH Respiratory Protection Program (LHH 73-09). Employees who have not been medically cleared, fit tested and/or trained for N95 or PAPR use will not enter the AII room.
ix. Residents will receive all medical treatment in the AII room. Movement and transport of residents out of the AII room should be for medically essential purposes only and the resident will wear a surgical type mask and be escorted by hospital staff.

c) Maintenance of AII Rooms

i. AII room ventilation systems will be maintained, inspected and monitored by facility services for exhaust or re-circulation, filter loading and leakage at least annually, whenever filters are changed, and as needed.
ii. Negative pressure will be maintained in AII rooms occupied by a resident with known or suspected AirID with a ventilation rate of 12 or more air changes per hour (ACH). Negative pressure will be monitored continuously by the built-in, alarmed electronic monitor. Facility Services is responsible for negative pressure monitoring and recording of results. These records shall be maintained for a minimum of five years by the Chief Engineer.
iii. In addition to electronic monitoring, negative pressure will be visually demonstrated daily in AII rooms occupied by known or suspected AirID cases. This will be done by the Watch Engineer and results recorded in the Watch Engineer’s log.

iv. When occupied by a resident with known or suspected AirID, doors and windows to the AII room shall be kept closed at all times, except when doors are opened for entering or exiting.

v. When a case or suspected case vacates an AII room, the room shall be ventilated for 99.9% removal efficiency according to Table 1 below from the CDC Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health Care Settings before anyone enters the room without PPE.

TABLE 1. Air changes per hour (ACH) and time required for removal efficiencies of 99% and 99.9% of airborne contaminants*

	Minutes required for removal efficiency†	
ACH	99%	99.9%
2	138	207
4	69	104
6	46	69
12	23	35
15	18	28
20	7	14
50	3	6
400	<1	1

* This table can be used to estimate the time necessary to clear the air of airborne *Mycobacterium tuberculosis* after the source patient leaves the area or when aerosol-producing procedures are complete.
† Time in minutes to reduce the airborne concentration by 99% or 99.9%.

d) Procedure When No Available AII Room

i. If no Isolation room is available, the resident will be transferred to another facility with an available isolation room as soon as possible but no later than 5 hours after identification.

ii. The exception to the policy is if the unit physician or Medical Director has contacted SFDPH and determined that there is no airborne isolation room available in the county. This will be documented in the resident medical record after the initial 5 hours has passed and every 24hrs thereafter.

iii. LHH staff will follow all environmental control measures specified by the Infection Control Nurse and SFDPH.

iv. If the physician determines that transferring the resident would be detrimental to the resident's condition, the transfer can be put on hold. Employees caring for the resident, however, must use respiratory protection and PPE. The resident's condition shall be reviewed every 24 hours and documentation made in the medical record. Once determined that the resident can be safely transferred, transfer must be carried out per the protocol above.

e) Administrative and Work Practice Controls

i. Hand hygiene guidelines must be followed at all times.

ii. Designated isolation room treatment equipment will be utilized if possible. This includes, but is not limited to, BP cuffs, thermometers etc. The items will be dedicated to the resident in the isolation room until it is vacated.
iii. Procedures for cleaning occupied isolation rooms shall be the same as the cleaning procedures used in exam rooms (see LHH 72-01 Section G3) except that personnel performing cleaning procedures shall follow airborne precautions.
iv. Terminal cleaning of non-disposable medical equipment will be done after each discharge according to LHH Infection Control Policy Section G2. All other equipment will be discarded at discharge.
v. Terminal cleaning of AII rooms shall be done in accordance with LHH Infection Control Manual Section F2 after ventilating according to section 2(c)(v) of this plan.

f) Respiratory Protection

i. The following tasks require the use of at least an N95 respirator.

- Working in an airborne isolation room occupied by a resident with known or suspected ATD, including both patient care and cleaning/maintenance tasks.
- Transporting a resident with known or suspected ATD.
- Maintaining or repairing the ventilation system for isolation rooms when the room is not occupied by a resident with known or suspected ATD.

ii. A powered air purifying respirator (PAPR) must be worn for the following tasks:

- Performing or assisting a high hazard procedure (see Table 2).
- Performing maintenance or repair on the ventilation system for isolation rooms while a suspected or confirmed case of an AirID is occupying the room.

iii. All respirator use shall be in accordance with the LHH Respiratory Protection Program (LHH 73-09).

g) High Hazard Procedures

All high hazard procedures listed in Table 2 will be controlled as follows when performed on a case or suspected case of AirID:

i. High hazard procedures shall be conducted in the AII room.
ii. Only personnel necessary to perform the procedure shall be in the room during the procedure.
iii. Powered Air Purifying Respirators (PAPRs) must be worn by all employees who are in the room during the procedure.

Table 2. High Hazard Procedures and Job Classes Potentially Exposed

Procedure	Job Classes	Job Titles
• Sputum Induction • Respiratory Care (e.g. suctioning, trach care) • Nasal Aspirates • Aerosol Therapy (nebulizer) • Any other aerosol generating medical procedures	2536 2320 2312 2230 2232 2302 2303 2583	Respiratory Care Practitioner Registered Nurse Licensed Vocational Nurse Physician Specialist Senior Physician Specialist Nursing Assistant Patient Care Assistant Home Health Aide
• Maintenance/repair of isolation room ventilation systems when the room is occupied by a resident with a suspected or confirmed ATD	7334 7335	Stationary Engineer Sr. Stationary Engineer

3. Medical Services

a) Vaccinations

i. All employees will have available free of charge all vaccinations listed in Appendix C.
ii. Employees shall receive their initial vaccinations at the SFGH OHS clinic during their pre-employment health exam. After employees are hired they will receive subsequent vaccinations at the LHH Employee Health Clinic.
iii. Influenza vaccinations will be available to staff during the period designated by the CDC.
iv. Employees who decline vaccination must sign a declination form for the specified vaccine, which includes the statement in Appendix D. These forms once completed shall be maintained in the employee's LHH employee health file.
v. If an employee initially declines a vaccine they can anytime thereafter request and receive the vaccine from the LHH Employee Health Clinic.
vi. Employees who receive vaccinations which will protect them from exposures to ATD pathogens are still required to wear personal protective equipment, including respiratory protection when required by this policy.

b) Tuberculosis (TB) Surveillance Program

All employees will participate in the Tuberculosis Surveillance Program as follows.

i. All new employees will be given a two-step PPD skin test unless medical reasons exist to give no such test. The Medicine Clinic at San Francisco General Hospital (SFGH) or the Outpatient Clinic at LHH will document the PPD administration or reason for not completing it.

ii. The PPD skin test results will be maintained in the Employee Health records at Laguna Honda Outpatient Clinic.
iii. All employees shall receive annual tuberculosis screening at Laguna Honda. This will consist of an annual PPD skin test for those with prior negative tests and an annual symptom review for those with prior positive skin tests.
iv. Employees who convert their skin tests will receive a TB Symptom Review Survey, chest x-rays and referral to the Tuberculosis Clinic at SFGH. The results of the evaluation from the SFGH Tuberculosis Clinic will be sent to the Laguna Honda Outpatient Clinic. The Medical Director or Designee will review these results and provide clearance for the employee to continue work.

4. Exposure Incident Follow-Up

a) Employees who suspect an occupational exposure to an ATD will report the exposure immediately to their supervisor.

b) The supervisor will notify the Infection Control Nurse and the Industrial Hygienist and will complete injury/incident paperwork (Forms DWC-1, SIIR, and 5020) to be faxed to the DPH Occupational Safety and Health Section (OSH) at 415-554-2570.

c) The Infection Control Nurse will initiate a contact investigation to evaluate contacts for immunity, prophylaxis, work restrictions, isolation or precautions, as indicated by specific diseases to prevent secondary infection. The Centers for Disease Control Criteria will be used to confirm the ATD diagnosis.

d) The Infection Control Nurse will review the source resident's chart and interview the source resident and unit staff to determine who had a potential exposure. The Supervisor's Airborne Transmissible Disease Exposure Report (Appendix E) will be used to collect surveillance data and determine exposures. Once completed a copy of this form will be faxed to DPH OSH and it will be provided to the LHH Industrial Hygienist and the exposed employee.

e) Post-exposure medical evaluation shall occur as soon as feasible for employees who have had a significant exposure.

f) Employees will be referred to the SFGH OHS clinic for post exposure treatment during normal working hours. For exposures that occur during times when the SFGH OHS clinic is closed, the employee's supervisor shall refer the employee to SFGH Urgent Care Clinic for medical evaluation.

g) Employees who choose not to be evaluated by the SFGH OHS clinic or urgent care clinic may seek treatment at any of the Workers' Compensation Designated Clinics listed at http://dphnet.dph.sf.ca.us/node/626 or their pre-designated provider.

h) The LHH Infection Control Nurse/Nurse Manager shall obtain and provide the employee a copy of the written opinion from the medical provider within 15 working days. The written opinion shall be limited to the following:

- Employee's TB test status or other ATD test status.
- Employee's infectivity status.
- A statement that the employee has been informed of the results and offered any applicable treatment.
- A statement that the employee has been told about any medical conditions resulting from exposure and has been informed of treatment options.
- Any recommendations for precautionary removal from normal duties.

i) If the medical provider recommends temporary removal from work, the employee's manager shall code the employee's time away as paid administrative leave.

5. Procedures for Post-Exposure Communication of Disease Status of Exposure Source

a) The LHH Infection Control Nurse and Unit Nurse Manager shall communicate information regarding the disease status of the source resident to all affected LHH employees, students, family members, contractors and volunteers.

b) The LHH Infection Control Nurse shall be responsible for reporting the source case or suspected case to the local health officer.

c) The LHH Infection Control Nurse or designee will be responsible for reporting source cases or suspected cases to other employers such as paramedics, contractors, acute hospital no longer than 72 hours after the report to the local health officer.

d) The LHH notification to other employers shall include, date, time and nature of suspected exposure and any other pertinent information to help with surveillance. The identity of the source client shall not be provided to the other employer.

6. Procedures for Ensuring Adequate Supplies of PPE During Normal Operations and During a Medical Surge

a) The Materials Manager is responsible for ensuring an adequate supply of PPE, including N95 respirators in Central Supply for use during normal operations.

b) The LHH Medical Surge Plan can be found in the Emergency Response Manual (LHH 70-03 Appendix H5). If resources become limited during a medical surge, the Incident Commander will rely on the Logistics Section Chief in collaboration with the Safety Officer to develop a distribution plan customized for the specific product in short supply and the specific event. This may require re-use of PPE, including N95 respirators.

c) If sufficient supplies cannot be obtained from suppliers even with rationing and re-use, the Incident Commander shall request additional resources from the SFDPH DOC.

7. Education and Training

a) Training will be provided to all employees with the potential for an occupational exposure at the time of initial assignment to a job where occupational exposure may occur, at least annually thereafter, and whenever there are changes affecting exposures or control measures.

b) The LHH Industrial Hygienist or the DPH Occupational Safety and Health Section will develop the initial and annual ATD Training. The training will be available to all LHH employees online through the educational computer program, Health-Stream. The exception to this will be training offered to CNA's and PCA's, which will be held in a traditional classroom setting.

c) The LHH Department of Education and Training shall be responsible for making sure LHH staff complete the on-line training.

d) Training programs shall include an opportunity for interactive questions and answers with a person knowledgeable in the subject matter. Training not given in person shall include contact information for the LHH Industrial Hygienist, the LHH Infection Control Nurse, and the DPH OSH section so that questions can be answered within 24hrs by a knowledgeable person.

8. Recordkeeping

a) The Facility Services Department shall keep records of inspection, testing and maintenance of the AII rooms. These records shall be maintained for a minimum of 5 years and shall include the names and affiliations of the persons performing the test, inspection or maintenance, the date and any significant findings and actions that were taken.

b) The Director of Education and Training shall maintain all ATD training records for at least three years from the date on which training occurred. The training records shall include the dates of the training session, the contents or a summary of the training session, the names and qualifications of persons conducting the training, the names and job titles of all persons attending the training sessions.

c) LHH Employee Health shall maintain an accurate medical record for each employee with occupational exposure in accordance with Title 8 Section 3204, Access to Employee Exposure and Medical Records. The records shall include:

   i. The employee's name and any other employee identifier used in the workplace.
   ii. The employee's vaccination status for all vaccines required by this standard, any vaccination record provided by the employee, and any

signed declination forms. In cases where seasonal influenza vaccination is declined, the medical record need only contain a declination form for the most recent seasonal influenza vaccine.

iii. A copy of all written opinions provided by a medical provider in accordance with this standard, and the results of all TB assessments.

iv. A copy of the information regarding any exposure incident that was provided to a medical provider.

d) The employer shall ensure that all employee medical records required by this section are:

i. Kept confidential and not disclosed or reported without the employee's express written consent to any person within or outside the workplace except as permitted by this section or as may be required by law.

ii. The employer shall maintain the medical records required by this section for the duration of employment plus 30 years.

Appendix A: Aerosol Transmissible Diseases/Pathogens

This appendix contains a list of diseases and pathogens which are to be considered aerosol transmissible pathogens or diseases for the purpose of Section 5199. Employers are required to provide the protections required by Section 5199 according to whether the disease or pathogen requires airborne infection isolation or droplet precautions as indicated by the two lists below.

Diseases/Pathogens Requiring Airborne Infection Isolation

Aerosolizable spore-containing powder or other substance that is capable of causing serious human disease, e.g.
Anthrax/*Bacillus anthracis*
Avian influenza/Avian influenza A viruses (strains capable of causing serious disease in humans)
Varicella disease (chickenpox, shingles)/Varicella zoster and Herpes zoster viruses, disseminated disease in any patient.
Localized disease in immunocompromised patient until disseminated infection ruled out
Measles (rubeola)/Measles virus
Monkeypox/Monkeypox virus
Novel or unknown pathogens
Severe acute respiratory syndrome (SARS)
Smallpox (variola)/Varioloa virus
Tuberculosis (TB)/*Mycobacterium tuberculosis* -- Extrapulmonary, draining lesion; Pulmonary or laryngeal disease,confirmed; Pulmonary or laryngeal disease, suspected
Any other disease for which public health guidelines recommend airborne infection isolation
residents diagnosed with these diseases/pathogens will require a negative pressure isolation room

Diseases/Pathogens Requiring Droplet Precautions

Diphtheria pharyngeal
Epiglottitis, due to *Haemophilus influenzae* type b
Haemophilus influenzae Serotype b (Hib) disease/*Haemophilus influenzae* serotype b -- Infants and children
Influenza, human (typical seasonal variations)/influenza viruses
Meningitis
Haemophilus influenzae, type b known or suspected
Neisseria meningitidis (meningococcal) known or suspected
Meningococcal disease sepsis, pneumonia (see also meningitis)
Mumps (infectious parotitis)/Mumps virus
Mycoplasmal pneumonia
Parvovirus B19 infection (erythema infectiosum)
Pertussis (whooping cough)
Pharyngitis in infants and young children/Adenovirus, Orthomyxoviridae, Epstein-Barr virus, Herpes simplex virus,
Pneumonia
Adenovirus
Haemophilus influenzae Serotype b, infants and children
Meningococcal
Mycoplasma, primary atypical
Streptococcus Group A
Pneumonic plague/*Yersinia pestis*
Rubella virus infection (German measles)/Rubella virus
Streptococcal disease (group A streptococcus)
Skin, wound or burn, Major
Pharyngitis in infants and young children
Pneumonia
Scarlet fever in infants and young children
Serious invasive disease
Viral hemorrhagic fevers due to Lassa, Ebola, Marburg, Crimean-Congo fever viruses (airborne infection isolation and respirator use may be required for aerosol-generating procedures).Any other disease for which public health guidelines recommend droplet precautions
residents with these diseases/pathogens do not require negative pressure in the isolation room

Appendix B: Job Classifications with Potential Occupational Exposure

Class	Title	Class	Title
2230	Physician Specialist	2576	Supv Clinical Psychologist
2232	Senior Physician Specialist	2583	Home Health Aide
2302	Nursing Assistant	2587	Health Worker III
2303	Patient Care Assistant	2588	Health Worker IV
2305	Psychiatric Technician	2589	Health Program Coordinator I
2312	Licensed Vocational Nurse	2593	Health Program Coordinator III
2320	Registered Nurse	2624	Dietician
2322	Nurse Manager	2626	Chief Dietician
2323	Clinical Nurse Specialist	2736	Porter
2324	Nursing Supervisor	2738	Porter Assistant Supervisor
2424	X-Ray Laboratory Aide	2740	Porter Supervisor I
2430	Medical Evaluations Assistant	2785	Assistant General Services Mgr
2454	Clinical Pharmacist	2903	Eligibility Worker
2468	Diagnostic Imaging Tech II	2908	Hospital Eligibility Worker
2469	Diagnostic Imaging Tech III	2909	Hospital Eligibility Supervisor
2536	Respiratory Care Practitioner	2920	Medical Social Worker
2537	Respiratory Care Practitioner II	2922	Sr Medical Social Worker
2542	Speech Pathologist	2924	Medical Social Worker Supv
2548	Occupational Therapist	2930	Psychiatric Social Worker
2550	Sr Occupational Therapist	6138	Industrial Hygienist
2554	Therapy Aide	7205	Chief Stationary Engineer
2555	Physical Therapist Assistant	7334	Stationary Engineer
2556	Physical Therapist	7335	Sr. Stationary Engineer
2558	Senior Physical Therapist	7524	Institution Utility Worker
2574	Clinical Psychologist	P103	Special Nurse

Appendix C: ATD Vaccination Recommendations for Susceptible Health Care Workers

Vaccine	Schedule
Influenza	One dose annually
Measles	Two doses
Mumps	Two doses
Rubella	One dose
Tetanus, Diptheria, and Acellular Pertussis (Tdap)	One dose, booster as recommended
Varicella-zoster (VZV)	Two doses

Source: California Department of Public Health, Immunization Branch

Appendix D: Vaccination Declination Statements

General Vaccination Declination Statement

I understand that due to my occupational exposure to aerosol transmissible diseases, I may be at risk of acquiring infection with _____ (name of disease or pathogen). I have been given the opportunity to be vaccinated against this disease or pathogen at no charge to me. However, I decline this vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring _____, a serious disease. If in the future I continue to have occupational exposure to aerosol transmissible diseases and want to be vaccinated, I can receive the vaccination at no charge to me.

_____ _____

Employee Signature Date

Seasonal Influenza Vaccination Declination Statement

I understand that due to my occupational exposure to aerosol transmissible diseases, I may be at risk of acquiring seasonal influenza. I have been given the opportunity to be vaccinated against this infection at no charge to me. However, I decline this vaccination at this time. I understand that by declining this vaccine, I continue to be at increased risk of acquiring influenza. If, during the season for which the CDC recommends administration of the influenza vaccine, I continue to have occupational exposure to aerosol transmissible diseases and want to be vaccinated, I can receive the vaccination at no charge to me.

_____ _____

Employee Signature Date

Appendix E: Supervisor's Airborne Transmissible Disease Exposure Report

The Supervisor/Nurse Manager must complete this form when there is an alleged or suspected worker exposure to an airborne transmissible disease. The supervisor should give a copy to the potentially exposed employees to take with them when they seek medical services. The form must be immediately faxed to the OSH Section at 554-2570.

1. DPH/Division:

☐ San Francisco General Hospital ☐ Community Health Programs ☐ Jail Health Services ☐ Central Administration
☐ Laguna Honda Hospital ☐ Community Health & Safety ☐ Primary Care ☐ Other _____

2. Source Patient Diagnosis

☐ Aerosolizable spore-containing powder
☐ Avian Influenza
☐ Diphtheria pharyngeal
☐ Haemophilus influenzae
☐ Measles (rubeola)/Measles virus
☐ Meningitis
☐ Meningococcal disease sepsis
☐ Monkepox
☐ Mumps
☐ Novel or Unknown Pathogens
☐ Pertussis (whooping cough)
☐ Pneumonic plague
☐ Rubella virus infection
☐ Severe acute respiratory syndrome (SARS)
☐ Smallpox (variola) Variola virus
☐ Tuberculosis (TB)
☐ Viral hemorrhagic fevers due to Lassa, Ebola, Marburg, Crimean-Congo fever viruses
☐ Other disease for which public health guidelines recommend airborne infection isolation. Please Specify:

3. Exposure source patient (First, Last, MI)	**4. Location of Contact**	**5. Incident Date and Time** AM/PM
6. Date Source Pt. presented	**7. Laboratory Confirmed Diagnosis** ☐ Yes ☐ No	**8. Date of Diagnosis**
9. Were Isolation Procedures Employed? Please Describe	**10. If isolation procedures were not employed, please explain:**	
11. Was patient masked? ☐ Yes ☐ No	**12. Describe nature of unprotected contact**	**13. Duration of unprotected contact**

14. Were aerosol generating procedures (e.g., sputum, induction, aerosolized administration of medications, etc.) performed during the exposure incident? If yes please explain:

15. Was all appropriate Personal Protective Equipment (PPE) used? If not, explain why:

16. Were employees of any other employer involved? If so, list employer and potentially exposed employees:

17. In your opinion, what could have been done to prevent this exposure incident? Please explain:

18.Supervisor's signature: **19. Supervisor's phone number:** **Date:**

21. **Potentially exposed employees:**

Name (Last, First, MI)	Job Class #	Emp Phone #	Exposure Description	PPE Used
				☐ N95 ☐ Gloves ☐ Eye ☐ Mask ☐ Gown Protection ☐ Other ____________
				☐ N95 ☐ Gloves ☐ Eye ☐ Mask ☐ Gown Protection ☐ Other ____________
				☐ N95 ☐ Gloves ☐ Eye ☐ Mask ☐ Gown Protection ☐ Other ____________
				☐ N95 ☐ Gloves ☐ Eye ☐ Mask ☐ Gown Protection ☐ Other ____________
				☐ N95 ☐ Gloves ☐ Eye ☐ Mask ☐ Gown Protection ☐ Other ____________
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				☐ N95 ☐ Gloves ☐ Eye ☐ Mask ☐ Gown Protection ☐ Other ____________
				☐ N95 ☐ Gloves ☐ Eye ☐ Mask ☐ Gown Protection ☐ Other ____________

22. Supervisor's signature:	23. Supervisor's phone number:	24. Date:

~~EMPLOYEE~~ STUDENT,~~AND~~ VOLUNTEER AND CONSULTANT ORIENTATION

POLICY:

~~All new~~ New ~~employees, in-house consultants, long-term~~ students, consultants and volunteers ~~must~~ are required to attend an orientation ~~group~~training prior to rendering care and supportive services to residents at Laguna Honda Hospital.

PURPOSE:

To assure the delivery of resident-centered care~~, all employees, in house consultants, long term students, and volunteers shall receive timely orientation regarding~~ according to standard Hospital operating procedures.

PROCEDURE:

1. ~~Within the first 60 days of employment or the~~ Prior to commencing of ancillary activity within the Hospital, all new persons will be scheduled to participate in a documented orientation ~~group~~training:

Orientation Target Group	Responsible Manager
Non-employees	
Volunteers	Manager/Coordinator, Volunteer Department
~~Long-term student~~Student/ interns	~~M~~anager/Coordinator responsible for respective student/intern
Non-employee consultants	Manager/Coordinator responsible for contract/agreement
~~**Employees**~~	
~~Employee hires (except those below)~~	~~Manager, DET & Manager, Human Resources~~
~~Nursing classes (CNA, LVN, LPT, RN)~~	~~Manager, DET & Manager, Human Resources~~
~~Physician Specialists (2230 & 2232)~~	~~Assistant Medical Director~~

2. Failure to comply with this policy will result in appropriate ~~personnel~~ action, ~~including but not limited to: failure of probation, employee disciplinary action or~~ denial of ancillary participant's privileges.

~~3. Human Resources Services will provide information on general Hospital standards and operating procedures to all employees.~~

3. ~~DET~~ Staff from Volunteer Services, Department of Education and Training (DET), Nursing Education, or the responsible manager/coordinator ~~will orient~~shall provide orientation in ~~at least~~ these areas: tour of the hospital ~~facility~~, resident population

served, ~~employee~~-specific job ~~description (or volunteer~~ duties), ~~work site~~introduction of relevant ~~staff~~personnel, ~~and~~ ~~work site~~hospital policies and procedures, including abuse reporting, fire safety response, emergency preparedness, infection control, hazard communication, smoke free campus and confidentiality of resident health information~~.~~

4. DET shall review departmental orientation materials for students, volunteers, and consultants for compliance with regulatory requirements at least annually.

~~5. Refer questions concerning rules or policies to Human Resources Services.~~

REFERENCES:

- LHHPP 80-02 Employee and Volunteer Identification
- NPP A5.0 Nursing Educational Affiliations

Revised: 97/06/11, 02/11/14, 08/04/22, 15/03/10 (Year/Month/Day)
Original adoption: 92/05/20

STAFF EDUCATION PROGRAM

POLICY:

1. Laguna Honda Hospital and Rehabilitation Center (Laguna Honda) shall maintain an effective staff training, orientation, and education program to uphold and improve staff competence in the provision of person-centered, culturally respectful and inclusive interdisciplinary services.

2. Laguna Honda education and training programs will be consistent with Laguna Honda strategic goals and regulatory requirements.

3. Laguna Honda education programs will support individual development and group needs identified through the performance improvement activities and performance appraisals.

~~3.~~4. Human Resources staff shall notify the Department of Education and Training of the names of new hires and their start dates~~,~~; staff who have left and their separation dates;~~,~~ and staff who are on an extended leaves and their anticipated return dates.

PURPOSE:

The purpose of this policy is to delineate staff responsibilities related to the provision of staff education and development at Laguna Honda.

CORE PRINCIPLES OF LEARNING:

1. To promote learning that supports resident-centered care and improves outcomes at the bedside consistent with the hospital's mission and vision.

2. The model must be integrated, partnership-oriented, collaborative, and supportive of all Laguna Honda staff, based in the hospital's organizational development goals and linked to the neighborhoods.

3. Everyone learns and everyone teaches. All staff can participate in teaching opportunities. While the staff development team can provide the guidance, consultations and support in the delivery of training, all staff are engaged.

4. Compliance will continue to be a high priority of our education program, and we will exceed regulatory standards so that we can see long-lasting behavioral changes.

5. Education must be dynamic, participatory and customized for the learners. The facilitator or instructor must be able to apply teaching methods that the audience can relate to and find meaning which they can apply to their essential job functions and responsibilities.

6. Effective education supports all departments; clinical and non-clinical, and assesses interests and needs of staff and programs by identifying quality indicators in high risk, high volume, or problem-prone areas.

7. Education should promote effective communication and positive interactions among peers. Teaching opportunities can include both residents and staff.

8. Education is focused on developing individual and collective capacities for high performance, with training that leads to individualized care.

9. Learning opportunities are used to develop leadership skills at all levels that promote accountability and are linked to the hospital's goals and objectives.

PROCEDURE:

1. Staff Training and In-services

a. Human Resources shall schedule new employees to attend hospital-wide orientation upon hire. Alternative arrangements can be made under special circumstances, but no later than within the first 30 days of employment.

b. New employees will receive a 2-day in-person and computer based hospital-wide orientation training to the culture, strategic goals, safety (includes SMART training), and regulatory requirements of the hospital.

c. If a newly hired employee is not able to attend the full hospital-wide orientation program, an abbreviated training program shall be provided to the employee that meets the minimum regulatory requirements.

~~a.~~d. The new employee orientation program shall be scheduled at a minimum on monthly basis beginning the first business day of a pay period.

e. Annually, employees are provided with year round mandatory in-services that meet State, Federal and City requirements.

~~b.~~f. A monthly calendar of scheduled educational in-services is sent to staff electronically to staff with DPH email accounts, and posted on the intranet.

~~c.~~g. Nursing education provides live classes for CNAs, PCAs and HHAs ~~that~~ to meet the 24 hour CNA certification requirements.

~~d.~~h. Live classes may also be provided for specific staff audiences.

~~e.~~i. Computer based or live training is provided to other employees at the discretion of department supervisors.

~~f.~~j. Mandatory live classes are open to all staff, students and volunteers.

2. Employee Responsibilities

a. Every employee shall

i. Be accountable and responsible for their own development, competency, and compliance with educational requirements for licensure or certification~~.~~

ii. Participate in formal and informal needs assessment processes to identify learning needs.

iii. Participate in Laguna Honda orientation and mandatory in-service training, including Plans of Correction – related training.

iv. Participate in professional educational activities, with supervisory approval as needed, during paid time or continuing education leave.

v. Report learning needs and knowledge or skill deficiencies to their supervisor or manager during orientation, annual performance appraisal, and on an ongoing basis.

vi. Collaborate with their supervisor and manager in meeting identified learning needs.

vii. Perform duties within their respective scopes of practice, according to Laguna Honda policies and procedures in a culturally effective manner.

viii. Maintain adequate continuing education hours to meet the requirements of their license or certification.

3. Manager Responsibilities:

a. Department leaders and educators; including directors, supervisors, and managers; shall collaborate with Quality Management educator(s) to perform the following functions:

i. Provide department and unit based orientation for employees new to the department or to a job within the department.

ii. Assess, plan, develop, implement, and evaluate unit based orientation and educational activities within their own area(s) or departments.

iii. Utilize pertinent data, including aggregate data, concerning resident satisfaction, quality indicators, competency findings and other outcome data to assist in the needs assessment process.

iv. Provide in-service education documentation including original sign-in sheets, outlines, evaluations or post tests to the Quality Management department for inclusion into the Laguna Honda education database within 2 weeks of the training.

v. Monitor employee compliance ~~with completing~~ with mandatory in-services by reviewing the monthly compliance report, following up with individual staff who have not completed their mandatory in-services within 90 days of assignment and addressing timely completion of mandatory in-services as part of the annual performance appraisal process.

vi. Oversee that the environment is inclusive of diversity (i.e. pictures, role-modeling inclusive behavior) and supports cultural competency.

4. Staff Development Steering Committee (SDSC)

a. The Staff Development Steering Committee was developed to increase staff awareness and support Laguna Honda's core principles of learning.

b. The Staff Development Steering Committee comprise of an interdisciplinary team of members from Administration, Nursing, Medicine, Social Services, Clinical Nutrition, Therapeutic Activities, Pharmacy, Information Services, Environmental Services, Human Resources and Quality Management.

c. Additional members from other departments may join the Committee with approval from their Division head and the Chair.

d. Functions of Core Team Members:

i. Core team members shall meet, at a minimum quarterly, to discuss and collaborate on the development and implementation of the vision and strategic planning goals for learning for Laguna Honda.

ii. Participate in reviewing and developing hospital-wide education programs and their respective departmental education plans for current and new staff members, or assign this task to a staff member(s) within their division or department.

iii. Contribute to improving vertical and horizontal communications within the facility.

iv. Review and develop education policies and procedures.

v. Cultivate a culture of compliance to support the mission and vision of the organization.

vi. Promote continuous quality improvement approach to improve patient/resident outcomes and organizational effectiveness.

vii. Evaluate the effectiveness of education programs based on resident outcomes data and staff performance appraisal information.

viii. Establish annual hospital-wide educational priorities

e. Other Functions of a Sub-group of SDSC Members

i. Determine Laguna Honda's hospital-wide education and training needs by reviewing performance improvement data and reports:

- Resident outcome data, such as satisfaction surveys, quality indicators, State survey results, and demographics identifying the problems and needs of the resident population
- Performance Improvement Team and committee educational recommendations. (i.e. Infection Control, Safety, Code Blue, Abuse Prevention, etc.)
- Risk management data
- Department of Public Health recommendations
- Laguna Honda strategic goals
- Current evidence based practice and healthcare research
- Competency and Performance Appraisal trends provided by Human Resources
- Educational needs surveys
- Class / Course evaluations

ii. Develop and implement an annual hospital-wide education and training program and orientation programs that address identified needs and meet or exceed healthcare industry standards and regulatory requirements.

iii. Collaborate to develop and maintain Program Approvals (HS279A and B) for annual in-service and C.N.A. orientation from the California Department of Public Health (CDPH), licensing and certification division in collaboration with Nursing Education and the Chief Nursing Officer.

iv. Provide assistance and consultation to facility leadership to determine educational needs and to enhance competency, cultural effectiveness and performance.

5. Documentation of Formal Educational Activities

a. Educational activities are documented to meet minimum requirements of the State Department of Health Services and California Board of Registered Nurses or other pertinent regulatory bodies.

b. Documentation of in-services shall include:

   i. An in-service cover sheet containing the following information:

      - Title of the program
      - Date
      - Instructor(s)
      - Length (number of hours)
      - Assessed need (or purpose)
      - Performance/
      - Behavioral Objectives
      - Equipment needed
      - Materials needed
      - Outline of content (with adequate detail to discern what was taught)
      - Method of Evaluation (to assure that learning has occurred)

   ii. Original sign-in sheets
   iii. Course evaluations (a representative sample are kept on file after the end of the course)
   iv. Posttests or other evidence of evaluation of learning (a representative sample are kept on file after the end of the course)

c. Documentation for continuing education credits under Laguna Honda's Board of Registered Nursing provider number shall comply with the current BRN CEU requirements including:

   i. Title of Program
   ii. Date(s)
   iii. CE hours
   iv. Objectives
   v. Overview
   vi. Course Outline
   vii. Method of Evaluation
   viii. Course evaluations and / or posttests (kept on file in DET)
   ix. A brochure or flyer posted at least 30 days before the start of the class that includes the first 5 bullets, cost and refund policy if there is a fee, course cancellation policy and the required BRN CEU provider statement.

d. Transcripts of individual staff attendance are available to staff and managers.

e. Education compliance tracking reports are available through the computerized education database and can be accessed from the database by designated staff from Quality Management, Nursing Education or designees with administrative access to the database.

f. Designated staff from the Quality Management department maintains files of educational programs submitted for a minimum period of 4 years for in-services and continuing education courses.

g. Hospital-wide orientation records are maintained for a minimum of 10 years by Human Resources and Quality Management departments.

ATTACHMENT:
None

REFERENCE:
Visioning and Strategic Planning for Learning in the New Laguna Honda

Reviewed: 07/01/03, 08/11/25, 12/09/25, 15/03/10 (Year/Month/Day)
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