HACKETTSTOWN REGIONAL MEDICAL CENTER
ADMINISTRATIVE POLICY MANUAL

SAFETY MANUAL

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Cross Referenced:		**Origin:**	**Safety Committee**
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SCOPE

This policy applies to all departments hospital-wide.

PURPOSE

To provide a resource for staff members to use during safety, risk and emergency management issues.

DEFINITIONS

Definitions are noted throughout manual.

POLICY

Employees will use the Safety Manual (attached) as a resource for any issues pertaining to safety, risk and emergency management. Sections include: Safety Management, Security Management, Hazardous Materials and Waste Management, Emergency Management, Fire Safety Management, Medical Equipment Management, Utility Management, Bloodborne Exposure Control Plan and Tuberculosis Control Plan. Specific issues are located within the sections.

PROCEDURE

The Safety Manual is reviewed annually and maintained by the Safety Committee. The Safety Manual is also located on the shared drive. It is available hard copy in the Emergency Department, Safety Officer's office, Administration (Boardroom), and Nursing Administration.

REFERENCES

References are noted throughout the manual specific to issues discussed.

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ENVIRONMENT OF CARE

The environment of care is made up of three basic components: buildings, equipment and people. The goal in managing the environment of care is to provide a safe, functional, supportive and effective environment for patients, staff members and other individuals in the facility. Doing so can improve patient safety, achieve good outcomes and provide quality patient care.

Effective management of the environment of care includes using processes and activities that do the following:

- Reduce and/or control environmental hazards and risks
- Prevent accident's and injuries
- Maintain safe conditions for patients, staff and others coming to the hospital's facility
- Maintain an environment that is sensitive to patient needs for comfort, social interaction and positive distraction
- Maintain an environment that minimizes unnecessary environmental stresses for patients, staff and others coming to hospital's facility.

While no hospital can ensure that patients, staff and others coming to hospital's facilities will never experience an accidental injury, there are ways to minimize avoidable risks and injuries. These can be done through sound planning, allocation of resources, effective training, implementation and ongoing monitoring and improvement of risk reduction activities.

This manual contains information showing how Hackettstown Regional Medical Center manages the environment of care. The seven management plans include, Safety, Security, Hazardous Materials and Waste, Emergency Management, Fire Safety, Medical Equipment and Utilities.

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SECTION 1 - SAFETY MANAGEMENT

No hospital can ensure that patients, staff, and others coming to the hospital's facilities will never suffer an accidental injury. However, hospitals can minimize avoidable risks and injuries through sound planning, resource allocation, effective training, implementation, and ongoing monitoring and improvement of risk reduction activities. These activities can be accomplished through the management process, staff activities, and/or technology.

Each hospital has inherent safety risks associated with providing services for patients, the performance of daily activities by staff, and the physical environment in which services occur. It is important that each hospital identifies these risks and plan to implement processes to minimize the likelihood of those risks causing incidents.

Smoking

Hackettstown Regional Medical Center is a smoke-free campus. Smoking and/or use of tobacco is not permitted on the entire hospital campus. "Campus" is defined as the main hospital campus, including all of the parking lots, medical office buildings and sidewalks on campus and located anywhere on the perimeter of the campus and offsite locations including the Center for Healthier Living and the Counseling Center Refer to Administrative Policy & Procedure Manual, Ad 106.

Equipment (See section 6)

Safety Committee

The hospital has a Safety Committee that meets at regular times throughout the year. It discusses environmental safety issues relating to patients, visitors, staff, hospital buildings and grounds, equipment, utilities, infection control, security and emergency management. The Safety Committee approves changes and/or revisions to the management plans and policies of the "Safety Manual".

The Safety Officer is the Chairperson of the Safety Committee. If you have an environmental safety concern, you can put it into writing to this committee and send it to the Safety Officer. The committee will respond within 2 weeks.

Patient Safety Committee

Patient safety and preventing medical errors is a top priority at the hospital. The Patient Safety Committee is dedicated to addressing patient safety issues. The committee is chaired by the Chief Nurse Executive and the Risk Management Coordinator/Patient Safety Officer. Other members include the Chief Medical Officer, the Director of Nursing Operations, the Manager of Education; the Safety Officer, the Performance Improvement Director and the Pharmacy manager.

This team meets monthly to address medication and other safety issues that can potentially impact patient safety. The team reviews trends of all actual and potential incidents that are reported (via incident reports) and oversees root cause analysis as indicated.

Patient safety is EVERYONE'S responsibility. If you have issues or ideas you feel can impact patient safety, you can contact the Patient Safety Officer or the Safety Officer.

New Jersey's "Patient Safety Act" became effective on October 24, 2004 and was revised in March 2008. It establishes a statutorily mandated reporting system for certain adverse event that occurs in any licensed health care facility. New Jersey has always required certain events to be reported to the Sate Department of Health. This law replaces the previous reporting mandate. Hospitals will notice few changes in what types of events must be reported to the Department of Health.

Refer to the Administrative Policy Manual, AD 86 for the Patient Safety Program.

Latex Allergies

All patients should be asked if they have a latex allergy. If a patient is identified as having a latex allergy, he will be identified with a green bracelet. A stop sign will be placed on the door that says "Latex Allergy". The Latex Protocol is found in the Hospital's Administrative Manual. Look at labeling on products to see if they are latex free. You can also call the product company's 1-800 number for information on latex.

Note: No latex balloons are allowed in the hospital.

Risk Management

Incident Reports

The purpose of Risk Management is to:
1. Improve the safety of patients, visitors or employees
2. Reduce physical and financial loss for the organization
3. Enhance the quality of patient care

The Coordinator of Risk Management oversees Risk Management activities for the hospital.

The Coordinator of Risk Management's responsibilities include:
1. Investigating patient and visitor incidents
2. Interacting with insurance carriers and attorneys on behalf of employees
3. Going to court when required
4. Assisting with staff education on Risk Management issues

An incident is any event NOT part of routine hospital operations and is NOT consistent with routine patient care, or could have or did compromise patient safety. You must complete an incident report using HERCULES, our on-line incident reporting tool when an incident happens. Examples included: falls, medication incidents, treatment/procedure problems and equipment problems, etc.

Incident reports are important because they:
1. Identify problems or potential problems
2. Assists in establishing a clear picture of the event
3. Preserves information for future use

Incident reports are **NEVER** documented in the medical record, or documented that one was completed. Objectively document the facts of event, without assigning blame or giving opinions about what occurred.

All employees are responsible for completing incident reports if they are the one most closely involved or if they discover the incident. Refer to Administrative Policy #AD 64 for additional information.

Confidentiality

Confidentiality is a right that is federally protected for each patient in order to protect their right to privacy. Simple rules:
1. Do not discuss patients in public areas (elevators, cafeteria, hallways, etc.)
2. Do not discuss patients with persons outside the hospital
3. Do not allow family members or visitors access to the medical record without written permission from the patient

NOTE: Any violation of the confidentiality of medical information may result in actions including termination of employment.

Other Legal Issues

1. All subpoenas should be served through Human Resources. If they relate to possible liability for the hospital, they are forwarded to Risk Management. Subpoenas for physicians cannot be accepted by the Hospital on the physician's behalf. It must be served to him/her directly.
2. If you receive any legal paper or contact regarding a hospital occurrence or incident, please contact the Risk Management Department.
3. Never speak to an attorney or others on the outside regarding hospital occurrences without consulting the Risk Management Department.
4. If you leave employment at HRMC and are contacted regarding a patient or an incident which occurred here, please notify Risk Management.

Disclosure

Disclosure is a process for communication of adverse events or unanticipated outcomes to patients and/or families regarding the results of a diagnostic test, medical treatment or surgical intervention to the patient that results in harm to a patient. Harm can range from bruising, cuts, extra monitoring, additional laboratory or diagnostic studies to patient anxiety, pain, surgery, fractures and increased length of stay.

An adverse event is a negative consequence of care that results in unintended harm or illness, which may or may not have been preventable.

An unanticipated outcome is a result that differs significantly from what was anticipated to be the result of a treatment or procedure. Unanticipated outcomes may be positive or negative and should always be disclosed.

The patient's attending physician, or other health care professional discloses information to the patient and/or family of all outcomes related to the care and treatment rendered by the physician. This must be done within 24 hours of time the facility discovers the event. The patient's attending physician must document in the disclosure in the patient's medical record. When the outcome follows care and/or treatment by an employee of the hospital, the department manager or director is responsible to inform the patient and/or family. In this situation, the attending physician should be notified and available for further discussion with the patient and/or family if necessary.

For additional information, see Administrative Policy #AD41 "Disclosure Policy"

EMTALA

1. W**hat is the Emergency Medical Treatment and Labor Act (EMTALA)?**
   The Emergency Medical Treatment and Labor Act (EMTALA) is a federal statute that was enacted by Congress in 1986. The provisions of EMTALA are codified in Section 1867(a) of the Social Security Act. EMTALA is also known as the hospital **anti-dumping** law, **patient transfer** law, **COBRA** AND OTHER NAMES. EMTALA was a response to a growing concern that patients were being denies care or unjustifiably transferred to other facilities due to a patient's lack of ability to pay or because they were uninsured.

2. **What is the purpose of EMTALA?**

Purpose of EMTALA is to prevent discriminatory treatment of anyone seeking emergency care and treatment. All individuals, regardless if insured or indigent, a minor or illegal alien, must be provided with a medical screening examination to determine whether they have an emergency medical condition. It allows access to care for the uninsured when a medical emergency is present.

3. **Key Components of EMTALA**

Under EMTALA, Medicare participating hospitals are required to provide a medical screening examination for all patients who come to the hospital regardless of whether that person has the ability to pay. This includes a woman in labor or an individual expressing thoughts and/or gestures that are harmful to self or others.

If an individual presents to the emergency department (ED) and a request is made for an examination or treatment of a medical condition, the hospital must provide:

- An appropriate medical screening examination (MSE)
- Stabilizing treatment, if necessary
- Appropriate transfer

The hospital must provide an appropriate MSE within the capabilities of the hospital's ED, including ancillary services routinely available to the ED, i.e., laboratory, radiology, cardiology, etc. The MSE must be uniformly applied for all patients who patient have an emergency medical condition.

There can be no delay in the MSE to inquire about a patient's ability to pay or to obtain pre-authorization for care.

If an MSE is conducted and a determination is made that the patient does not have an emergency medical condition, then the hospital has no further obligations under EMTALA, e.g., the patient may be then discharged for follow-up care.

4. **How can you obey the Law?**

a) If someone approaches you and asks if the Emergency Department is busy DO NOT ever say yes and suggest they go elsewhere for treatment. That is an EMTALA violation and could result in a fine. A correct response would be "our staff would be happy to care for you."
b) We can not ask a patient who comes to our Emergency Department about their insurance or ability to pay to determine whether we will provide care. All patients, regardless of insurance or ability to pay will receive needed treatment and care.

All patients with emergencies have the right to receive emergency care regardless of race, religion, color, sex or ability to pay. **It's the law!**

For Policies and Procedures that govern EMTALA, see the Administrative Policy and Procedure Manual.

AD111	EMTALA
AD12A	Patient Leaving Against Medical Advice (AMA)
AD52	Elopement for the Emergency Department (LWBS)
AD119	Whistle Blower Protection

For any specific questions or concerns, talk with your manager.

NPSG POLICY
2011

5/15/09
Updated 1/27/11

GOAL #	POLICY TITLE	POLICY #
1	**Patient Identification**	
1.01.01	Two patient identifiers used when providing care, treatment and services	PC11
1.03.01	Eliminate transfusion errors related to patient misidentification	PC11
2	**Improve staff communication**	
2.03.01	Report Critical Results of Tests and Diagnostic Procedures Timely	PC07
3	**Safety use of medications**	
3.04.01	Medication Labeling On and Off the Sterile Field	PC22
3.05.01	Reduce the Risk likelihood of patient harm associated with Anticoagulation Therapy	CE 100, 100-101a, 101, 102
3.06.01	Maintain and communicate accurate patient medication information - formerly Medication Reconciliation Safety Goal #8	PC21 **begins July 1, 2011**
	1. Obtains list of medications patient is currently taking when admitted to hospital or outpatient setting. **2.** Defines types of medications to be collected in non-24 hour settings and different patient circumstances. **3.** Compare the medication information the patient brought to the hospital with the medications ordered for the patient by the hospital in order to identify and resolve discrepancies. **4** Provide the patient (or family as needed) with written information on the medications the patient should be taking when discharged or at the of the outpatient encounter. **5.** Explain the importance of managing medication information when the patient is discharged from the hospital or at the end of the outpatient encounter.	
7	**Prevent hospital acquired infections (HAI)**	
7.01.01	Hand Hygiene follow guidelines from CDC and WHO on hand cleaning	PC17 & AHC 1.20
7.03.01	Implement Evidence Based Practice (EBP) to prevent Hospital Acquired Infections (HAI) due to multidrug resistant organisms	IC0013, IC004, IC003, IC003a-f
7.04.01	Implement EBP to prevent central-line associated bloodstream infections	IC0013
7.05.01	Implement EBP to prevent surgical site infections	IC0013
15	**Suicide Risk Assessment**	
15.01.01	Identify patients at risk for suicide.	PC14
UP	**Prevent Errors in Surgery/Universal Protocol**	
01.01.01	Conduct a preprocedure verification process	PC 24
01.02.01	Mark the procedure site	PC 24
01.03.01	A time-out is performed before the procedure	PC 24
	PC = Patient Care	
	CE= Care Excellence	

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SECTION 2- SECURITY MANAGEMENT

Security Management involves the management of physical and personal security of patients, staff and individuals coming to the hospital's facilities. HRMC has security available round the clock. Maintenance staff also provide this service.

1. Hospital I.D. Badges must be worn, above the waist, at all times when you are on duty. It is a patient's right to know who is caring for them. It must also be shown to security on entrance to the hospital if there is any type of "lockdown" situation.

2. All vendors must check in with the Front Desk and obtain an I.D. pass. If, at any time you notice a visitor that's lost or out of place, ask if you can help them. If they seem evasive, call security. Dial 6940 during the day. After hours dial "0" to page them. When able, escort them to their destination.

3. If a patient or visitor becomes unruly or threatens the safety of you or others, dial 6000. Have the operator page **"Code Gray"**. (Administrative Policy & Procedure Manual, AD 48)

4. Report any lost or missing items for staff/hospital to Maintenance/Security. An incident report should also be made and forwarded to Risk Management. For missing personal property for patients, notify Environmental Services. The lost and found department can be accessed by dialing ext. 6945. On off-shifts/weekends/holidays page the EVS Group Leader. Administrative Policy & Procedure Manual, FA12.

5. As soon as a discovery of a missing child is made, dial 6000. Ask operator to page Code Amber. Immediately upon hearing **"Code Amber"**, staff from <u>each department</u> will
   - Go to the nearest exit and secure the exit
   - Remain at post until "Code Amber All Clear" is heard over the PA system
   - If the exit is a stairwell door, stand with the door held open to observe individuals using the stairs
   - Once exits are secure, additional staff must check public restrooms in their department
   - Note anyone carrying/wearing items out of place (i.e. coat or sweater in warm weather), large bags, blankets or shawls draped over the person
   - Do not endanger yourself by trying to prevent abductor from leaving the hospital
   - Try to get a description of the abductor (height, weight, nationality, male/female, etc.) and direction abductor took
   - Report any suspicious individuals or activities noted while securing exits/public restrooms to Security.
   - May be asked to put observations in writing once "Code Amber All Clear" is announced Follow the Infant Abduction Policy (Administration Policy & Procedure Manual, NU01)

6. A security risk assessment is conducted annually to evaluate the potential adverse impact of the security of patients, staff and other people coming to the hospital's facilities.

7. The Security Committee meets regularly, and is responsible for coordinating the workplace violence prevention program. (Administration Policy & Procedure Manual, AD121)

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SECTION 3 - HAZARDOUS MATERIALS AND WASTE MANAGEMENT

The Hazardous Materials and Waste Management Plan addresses hazardous materials and waste management issues to ensure the safety of employees, patients, visitors and the community by reducing their risk of exposure to hazardous materials Regulated hazardous materials included in this program are:

Regulated medical waste
Radioactive (nuclear) waste
Chemotherapeutic waste
Hazardous vapors and gases
Chemical waste

REGULATED MEDICAL WASTE (RMW)

Is any solid waste generated in the diagnosis, treatment (for example, provision of medical services) or immunization of human beings or animals, in research pertaining thereto, or in the production or testing of biologicals that is not excluded or exempted under the classification listed below.

The handling of RMW is controlled by State and Federal Regulations. The hospital will make every effort to maintain compliance with these regulations. The area of law that controls our operations are contained in NJAC 7:26-3A and 40 CFR 259. The requirements of these regulations were used to develop hospital policy for handling RMW. Accomplishment of the following policy will result in compliance with State and Federal requirements.

The EPA identifies seven classes of RMW as follows:

Class 1- Cultures and stocks
Class 2- Pathological wastes
Class 3- Human blood/blood products
Class 4-Sharps
Class 5-Animal waste
Class 6-Isolation waste
Class 7- Unused sharps

1) Cultures and stocks

Cultures and stocks of infectious agents and associated biologicals, including cultures from medical and pathological laboratories; cultures and stocks of infectious agents from research and industrial laboratories; wastes from the production of biologicals; discarded live and attenuated vaccines; and culture dishes and devices used to transfer, inoculated and mix cultures.

2) Pathological Waste

Human pathological waste, including tissues, organs, and body parts and body fluids that are removed during surgery or autopsy, or other medical procedures and specimens of body fluids and their containers.

3) Human Blood and Blood Products

Liquid waste- human blood, products from blood, items saturated and/or dripping with human blood, or items that were saturated and/or dripping with human blood that are now caked and dried human blood, including serum, plasma, and other blood components, and their containers, which were used or intended for use in either patient care, testing and laboratory

analysis or the development of pharmaceuticals. Intravenous base are also included in this category.

4) Sharps
Sharps that have been used in animal or human patient care or treatment or in medical research or industrial labs, including hypodermic needles, syringes (with or without the attached needles), Pasteur pipettes, scalpel blades, blood vials, needles with attached tubing, and culture dishes (regardless of presence of infectious agents). Also included are other types of broken or unbroken glassware that were in contact with infectious agents, such as used slides and cover slips.

5) Animal Waste
Contaminated animal carcasses, body parts, and bedding of animals that were known to have been exposed to infectious agents during research (including research in veterinary hospitals) production of biologicals or testing of pharmaceuticals. (HRMC specifically does not participate in research; this refers to anything that may have been brought in to the hospital.)

6) Isolation Waste
Biological wastes and discarded materials contaminated with blood, excretion, exudates, or secretion from humans who are isolated to protect others from certain highly communicable diseases, or isolated animals known to be infected with highly communicable diseases.

7) Unused Sharps
The following unused, discarded sharps, hypodermic needles, suture needles, syringes and scalpel blades.

Reference: N.J.A.C. 7:26 Subchapter 3A

Waste Management

Information on the handling of waste (garbage) from the hospital can be found in Environmental Safety Manual. Hospital waste must be separated as to whether it is classified as **Regulated Medical Waste- RED BAG** or Municipal waste- **CLEAR BAG.**

Red Bag Waste

1. **Any** item **saturated** with **blood or regulated body fluid** – bandages, chucks, gloves, gowns
2. All waste from Isolation Precautions
3. Blood administration sets
4. Chemotherapy tubing and medication vials
5. Discarded specimens of human or animal waste
6. Introducers/guidewires/cannulas
7. Blood bags
8. IV tubing **ONLY** if it has come into contact with blood or other regulated body fluid.

Definition: Human Blood and Blood Products

Liquid waste human blood; blood, items saturated and/or dripping with human blood; or items that were saturated and/or dripping with human blood that are now caked and dried human blood; including serum, plasma, and other blood components, and their containers, which were used or intended for use in either patient care, testing and laboratory analysis.

IV bags and Tubing

That **have not** come in contact with blood or regulated body fluids are discarded into **CLEAR BAG TRASH**. Drain the bag before placing it in the trash.

Sharps Containers

1. Needles, needles with syringes, syringes, butterflies
2. Vacutainer needles and holders
3. Scalpel blades, scissors, razors, trocars, lancets, razor blades
4. Test tubes (used), pipettes, capillary tubes, glass slides

Environmental Services

For a complete listing of items in each category: **Red Bag, Clear Bags, Sharps Containers** and **YELLOW BAG** contact Environmental Services at Ext. 6945.

Appropriate Disposal of Waste Items

WASTE ITEM	SHARPS CONTAINER	RED BAG	CLEAR BAG	YELLOW BAG
Needles/Syringes	√			
Lancets	√			
Sutures	√			
Scalpels	√			
Scissors	√			
Specimen tubes, used/unused	√			
Broken Glass	√			
Slides fixed or unfixed	√			
IV Catheters	√			
Pathological Waste		√		
Isolation Waste		√		
Gloves, gowns, masks (saturated w/blood)		√		
Wet/Bloody Gauze or Dressings		√		
Sump Tubes		√		
Blood Bags		√		
Hemodialysis tubings		√		
IV lines and bags (with blood)		√		
Pleuro-Vacs, Hemovacs		√		
Suction Canisters		√		
Bedpans, urinals, emesis basins			√	
Ventilator tubing			√	
Foley catheters and bags			√	
IV lines and bags (without blood)			√	
Gauze or dressings (without blood)			√	
Chux			√	
Diapers			√	
ET tubes and suction catheters			√	
Gloves, gowns, masks (without blood)			√	
Medication vials (non-chemo)			√	
Guiac cards			√	
Any Solid Waste or Regulated Medical Waste with Traces of Chemotherapy				√

Material Safety Data Sheet: MSDS

It is important that you are aware of what hazardous substances you work with. Information about a hazardous substance can be obtained from a MSDS (Material Safety Data Sheet) or HSFS (Hazard Substance Face Sheet). These sheets are kept in master MSDS binders in the Emergency Department. You can access MSDS online.

To access M.S.D.S. sheets online go to:
www.msds.com
Click on Login
Username: hrmcmsds
Password: hackettstown

A list of hazardous chemicals used in your department should be maintained in this Safety Manual on your unit.

Information on these sheets includes:

1. List of ingredients
2. Special Protection- what protective equipment you need to wear when working with this product.
3. Special precautions
4. First Aid procedures in the event of an exposure
5. Spill procedures – This tells you how to properly clean up a spill
6. Health Precautions- Is the a mutagen or carcinogen
7. Storage and handling
8. Reactivity

Hazard substances can enter your body in 3 ways.

- Inhalation
- Absorption
- Ingestion

Exposure-If you have an exposure, do the following:

1. Be seen by Employee Health or ER physician
2. Let your supervisor know what happened
3. Fill out an incident report

Spill Kits- Spill Kits are kept in different areas throughout the hospital.

a. Chemotherapy spill kits are kept in areas where Chemotherapy is given. There is also a Spill Kit in Pharmacy.
b. Mercury spill kit is in Environmental Services
c. Blood spill kit is in Environmental Services. **Blood is considered a hazardous material.** Contact Environmental Services for clean up of any blood spill or accumulation on a surface. ES staff has been trained in the proper clean up of blood.
d. If you have a question about cleaning up a spill, contact Environmental Services. Consult the MSDS Spill procedures for that product also.

It is your responsibility to know how a Hazardous Chemical arrives in your department, how is it used and how is it disposed. Make sure you know the flow process for the products you work with.

INFECTION CONTROL

OHSA Bloodborne Pathogen Standard 1910.1030

1. Bloodborne pathogens are infectious micro-organisms (germs) in the blood that can cause disease in humans, including Hepatitis B and C and HIV. Workers exposed to these pathogens risk serious illness or death.

2. The **OHSA Bloodborne Standard** details what employers must do to protect workers whose jobs put them at reasonable risk of coming in contact with blood and other potentially infectious materials.

    a. The employer must establish an **Exposure Control Plan** for their institution. This plan can be found in the Environment and Patient Safety Manual in each department.
    b. A copy of the **OSHA Standard** can be found in every department.
    c. Employers are required to use engineering controls that will isolate or remove the Bloodborne pathogen hazard from the workplace. Ex. Sharps, disposal containers, self-sheathing needles, and safer medical devices.
    d. Employers must enforce work practice controls that reduce the likelihood of exposure by changing the way a task is performed.
    e. The employer must provide personal protective equipment, such as gowns, masks and gloves.
    f. Hepatitis B vaccine must be made available to all employees whose job exposes them to blood and/or body fluids.
    g. Post-exposure follow-up must be provided to any employee who experiences an exposure incident.
    h. Labels and signs must be used to communicate hazards.
    i. Employers must provide information and training to employees on initial assignment and annually.
    j. Employee medical and training records must be maintained.

3. Exposure or Injury

Infection Control

Preventing infections within a hospital is the job of each employee. The CDC reported that 2.5 million patients annually developed nosocomial (healthcare associated) infections. Of that number, 30,000 patients died as a direct result of the infection they acquired as a patient and another 70,000 patients acquired nosocomial (healthcare associated) infections that contributed to their death.

1. Healthcare Associated Infections (previously called: **nosocomial** infections) are infections a patient acquires while in the hospital. The patient did not have the infection when they entered the hospital but acquired it during his/her hospital stay. The major goals of the Infection Control Department is to prevent patients from acquiring an infection, to prevent HCW's (Health Care Workers) from

obtaining an infection or passing it on another patient, and to educate Staff and HCW's on the techniques that will aid them in accomplishing these goals.

2. Responsibility for the control of the transmission of infections belongs to everyone who enters the hospital; HCW, physician, visitor.
3. **Transmission of infection** requires three elements: a source of infecting micro-organisms, a susceptible host, and a means of transmission for the micro-organism.
   a. **Source:** Human sources may be patients, personnel or visitors. Other sources can be the patient's own endogenous flora and inanimate environmental objects that have become contaminated.

   b. **Host:** Resistance to pathogenic micro-organisms varies greatly. Some people may be immune; others may have some resistance and become carriers, while those without immunity can develop clinical disease.

   c. **Transmission:** Micro-organisms may be transmitted by several different routes. The most common are: airborne, contact, droplet, common vehicle, and vector borne.
4. An **Infection Control/Isolation Manual** is located on each unit. Each of the Precautions is outlined in detail.
5. The section on Infectious Material is a directory of infectious agents and diseases. It lists the disease, infective material, the type of precautions to be used, and for how long.

Isolation Precautions

All isolation precautions are **hospital policy** and are based on the **CDC Guideline for Isolation Precautions in Hospitals.**

1. A. **Standard Precautions**

This level of precautions are **<u>used for the care of all patients</u>** in the hospital, regardless of their diagnosis or presumed infection status. Standard precautions are to be followed when you anticipate contact with:

1. Blood
2. All body fluids, secretions, excretions (except sweat) regardless of whether or not they contain visible blood
3. Non-intact skin
4. Mucous membranes
5. Unknown substances

Standard precautions are designed to reduce the risk of transmission of micro-organisms (germs) from both recognized sources and unrecognized sources of infection

PPE Required: Gloves

B. **Respiratory Hygiene/Cough/Etiquette**

These precautions are to minimize the transmission of respiratory pathogens. Everyone should cover coughs and sneezes with tissues or masks and wash their hands frequently. Wear gloves and gowns. Get your FLU and Pneumonia vaccines.

2. **Enhanced Precautions**

This level of precautions are used for patients documented or suspected to be infected with highly transmissible or epidemiologically important pathogens for which additional precautions combined with Standard Precautions are needed to interrupt transmission in hospitals. The same as blood or body fluid can get on your hands; therefore you need gloves "bacteria" can get on your hand and clothing. The bacteria do not die immediately; some can live for years. The bacteria can be passed from one patient to another by way of a HCW's clothing.

Wearing a gown is of critical importance if you are in any room with a patient that is on one of the transmission-based precautions; Airborne, Contact, and/or Droplet.

A. **Airbourne Precautions/Airborne Infection Isolation**

This type of precaution is designated for patients known or suspected to be infected with epidemiologically important pathogens that can be **transmitted by the airborne route.** Airborne transmission occurs by dissemination of either airborne droplet nuclei that can remain suspended in the air for long periods or dust particles containing the infectious agent. Examples: Tuberculosis, SARS, Varicella, Varicella-Zoster, Measles and Variola (Smallpox).

PPE required: Gown and gloves and N95 respirator mask.
Room required: Negative airflow

B. **Droplet Precautions**

This type of precaution is for any patient known or suspected to be infected with epidemiologically important pathogens that can be **transmitted by infectious droplets.** Droplets are generated from the source person primarily during coughing, sneezing or talking. Transmission requires close contact between source and recipient because droplets do not remain suspended in the air and generally travel short distances, usually 3 ft. or less, through the air. Examples: Rubella, Influenza, Neisseria meningitidis, Meningococcal pneumonia and Mycoplasma pneumonia, Mumps Pertussis, Streptococcal Pharyngitis and Scarlet Fever.

PPE required: Gowns and gloves and masks (NON N95) if within 3 ft.
Room required: Regular

C. **Contact Precautions/MDRO Contact Precautions:**

This type of precaution is for any patient known or suspected to be infected or colonized (presence of micro-organisms in or on patient but without clinical symptoms of infection) with epidemiologically important micro-organisms that be **transmitted by direct or indirect contact.** Direct-contact transmission involves skin-to-skin contact and physical transfer of micro-organisms (germs) to a susceptible host from an infected or colonized person, such as occurs with patient care

activities. Indirect-contact transmission involves contact of a susceptible host with a contaminated object in the patient's environment. Examples: Cellulitis with drainage, Clostridium difficile, infected decubitus ulcer, Impetigo, Multi drug resistant bacteria, RSV, Scabies, and Wound Infections.

PPE required: Gown and gloves Room required: Regular

D. **Protective Environment**
This is a classification for allogeneic HSCT patients. Whether or not to put a patient in a protective environment depends on the situation around the patient's condition and the environmental factors.
PPE required: Gown, gloves and mask
Room: Positive pressure or HEPA filtration

Resistant Micro-organisms/Bacteria

1. Drug resistant pathogens are a growing problem for all hospitals. While anyone may acquire a drug-resistant infection, patients in hospital are at increased risk. Up to 30 percent of S. pneumoniae are no longer susceptible to penicillin; nearly all strains of Staphylococcus aureus are resistant to penicillin, and many to the new methicillin related drugs.
2. Transmission of resistant micro-organisms/bacteria is the same as with any micro-organisms except the consequences are much more serious. Drug choices for the treatment of infections caused by a drug resistant organism is becoming increasingly limited and, in some cases, nonexistent.
3. Health-care associated pathogens can be recovered not only from infected or draining wounds, but also from frequently colonized areas of normal, intact patient skin. The patient may shed these organisms onto inanimate objects that a HCW may come into contact with, thereby passing the organism on to another patient if proper "hand hygiene" is not used. A patient or HCW (Health Care Worker) may be **"colonized"** by a resistant organism therefore not being "infected" themselves. An organism from a colonized person (one with no active infection) can become an **"infectious"** organism if passed on to a susceptible/immuno-compromised host.
4. Examples of some resistant organisms that are of clinical significance are: MRSA-oxacillin (methicillin) resistant Staphylococcus aureua; Amino -glycoside resistant Pseudomonas, Penicillin resistant Streptococcus pneumonia, VRE-vancomycin resistant Enterococcus, and VRSA- Vancomycin resistant Staphylococcus aureus.
5. To prevent the spread of resistant organisms proper precautions must be used. The **single most important** thing that must be done is **good hand hygiene/ "Hand washing"**. Using either soap and water or the waterless hand cleaner after contact with each patient is the most effective way to stop the spread of these organisms or **"Super Bugs"**.

CDC Campaign to Prevent Antimicrobial Resistance

CDC Campaign to Prevent Antimicrobial Resistance Among Hospitalized Adults And Nosocomial Infections – 12 steps

A. Prevent Infection
1. Vaccinate against Influenza and S. pneumonia
2. Get Catheters Out – Use catheters only when essential

B. Diagnose and Treat Infection Effectively
1. Target the Pathogen – Culture the patient
2. Access the experts – Consult infectious disease experts

C. Use Antimicrobials Wisely
1. Practice Antimicrobial Control
2. Use local data- know your antibiogram; know your formulary
3. Treat infection, not contamination- use proper antisepsis for blood cultures
4. Treat infection, not colonization- treat pneumonia, not tracheal aspirate
5. Know when to say "no" to vancomycin. MRSA may be sensitive to other antimicrobials
6. Stop antimicrobial treatment – when infection is not diagnosed or is unlikely

D. Prevent Transmission
1. Isolate the pathogen – **Use Infection Control Precautions**
2. Break the chain of contagion- **KEEP YOUR HANDS CLEAN**

Mycobacterium tuberculosis

1. TB is the leading cause of death due to an infectious agent in the world. Nearly one-third of the world's population is infected with TB. Transmission is most likely to occur from people who have undiagnosed active tuberculosis and are not on any anti-tubercular medication.
2. TB is a disease caused by infection with Mycobacterium tuberculosis. TB most commonly attacks the lungs but it can attack any organ.
3. Symptoms of active TB include cough, weight loss, fever, night sweats and hemoptysis
4. Transmission of TB is by the inhaling of the tubercle bacilli into the lungs in tiny nuclei droplets sprayed into the air by a person with infectious pulmonary tuberculosis.
5. Those who are at highest risk for contracting TB are those with impaired immunity and persons who have close contact with an infectious person, as the body has no natural immunity to TB.
6. Screen Test: TST (Tuberculin skin test)
   The TST test is done to detect the presence of infection with tubercle bacilli; it does not signify the presence of disease. The active disease process must be confirmed by additional testing. Chest x-ray and sputum cultures are the most useful in making a diagnosis of TB.
   d. Being **infected** is defined as having a positive TST and **no** signs or symptoms of active tuberculosis
   e. Being **infectious** is defined as having a positive TST **and** signs and symptoms of active disease.

f. **Infectious** persons **can spread** the micro-organisms to other; **infected** persons **cannot.**
g. The **TB Control Plan** is located on every unit in the **Environmental and Patient Safety Manual**

7. A 2-step TST is done at HRMC upon being employed. The TST is repeated yearly on the employee's anniversary of hire.

Guideline for Hand Hygiene

In addition to traditional hand washing with soap and water, CDC is recommending the use of alcohol-based hand rubs by health care personnel. Improved adherence to hand hygiene (i.e. hand washing or use of alcohol-based hand rubs) has been shown to terminate outbreaks in health care facilities, to reduce transmission of antimicrobial resistant organisms (e.g. Methicillin (oxacillin) resistant Staphylococcus aureus) and reduce infection rates.

The alcohol-based hand rubs are not intended to replace hand washing but to be used to address some of the obstacles that health care professional's face when taking care of patients. When health care personnel's hands are visibly soiled, they should wash with soap and water. When exposed to C. difficele, alcohol-based hand rubs are not sufficient; soap and water are recommended.

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SECTION 4 – EMERGENCY MANAGEMENT PLAN SUMMARY

Objective:
To establish and maintain a program to ensure effective response to emergencies affecting Hackettstown Regional Medical Center and the surrounding community.

Scope:
The Emergency Management Plan describes the process for all-hazard disaster readiness and management. The plan addresses the six critical areas of emergency response: Communication, Resources and assets, Safety & Security, Staff responsibilities, utilities management, and patient clinical and support activities. A detailed plan binder is maintained by the Emergency Management Coordinator. A copy is kept in the Board Room, (which usually serves as the Incident Command Center), and other selected locations.

Responsibility:
The Emergency Management Coordinator is responsible for overseeing the plan in collaboration with the Emergency Management Committee which is a sub-committee of the Safety Committee.

The current Emergency Management Coordinator is Gene Gast, Director, Emergency Medical Services extension 8802.

Hazard Vulnerability Analysis*:*
The Hazard Vulnerability Analysis, (HVA) is reviewed and revised annually by the Emergency Management Committee and the Safety Committee. The HVA determines what our most likely hazards are based on history, probability, vulnerability and the strength or weakness of our internal and external resources for responding to that hazard.

Community Coordination:
Hackettstown Regional Medical Center works collaboratively with the Hackettstown Office of Emergency Management, the Hackettstown Police Department, the Warren County Office of Emergency Management, the Warren County Department of Health and Senior Services, and the New Jersey Department of Health & Senior Services.

Mitigation, Preparedness, Response and Recovery (MPRR):
The plan identifies specific procedures that describe mitigation (lessening the severity and impact of potential emergency), preparedness (building capacity and identifying resources that may be used if an emergency occurs), response and recovery strategies, actions and responsibilities.

The MPRR Grid is on the following pages.

Hospital Incident Command System (HICS)
The HICS Organizational Chart for Hackettstown Regional Medical Center is on the following pages.
Please Note:

1. Positions will be activated only as needed
2. Assignments are made by Incident Commander based on need.
3. "Job Action Sheets" for each position exist and are handed out when the plan is activated.

Initiation of Plan:

The plan is initiated by the Incident Commander (CEO, COO, Administrator-on-Call, or Nursing Supervisor) in consultation with the ED physician and Chief Medical Officer as the need arises. The Incident Commander notifies the operator who announces either: "Code Triage", or "Leadership to the Boardroom STAT" depending on the circumstance. This alerts in-house hospital staff that the Emergency Management Plan is being activated. The Incident Commander, following the Hospital Incident Command Organizational Chart (see following page), calls (or delegates calling) those positions most immediately needed. The operator assists in calling individuals as directed by the Incident Commander or HICS Section Chiefs. Those whose participation is anticipated are called next.

Staff Notification:
A current Leadership Emergency Contact List and a current Departmental Backup Emergency Contact List is maintained in the Emergency Management Plan and by the hospital operator. The Manager/Director of each department is responsible to keep contact information for all staff within their department in case staff needs to be called in for an emergency.

Staff Assignments:
The Labor Pool (see HICS Organization Chart) coordinates staffing needs**.**

Identifying Care Providers:
Hospital personnel are required to wear their HRMC Identification Badge at all times. This identification badge has the employee's name, photograph, title and department. If an employee is called to come to the Hospital during a disaster, they must bring their ID badge. It may be needed to pass through police lines during a disaster, or to enter the hospital building.

Non-hospital personnel, authorized by the Incident Commander to perform certain emergent duties will be issued a temporary identification badge through Human Resources Labor Pool and supervised.

Vests identify various roles within the Hospital Incident Command System.

Communication Backup*:*
The Emergency Management Plan identifies various alternative means of communication in the event of system failure including: 2-way radios, "red" phones, radio link to 911 center, Hospital Alert Network 800 MHz radio, and GETS (Government Emergency Telecommunications Service)

Media Requests:

All requests for information from media or other individuals are to be directed to the Public Information Officer (PIO). The PIO is a position on the HICS Organizational Chart and is appointed by the Incident Commander.

Systems Failure & Basic Staff Response

(See department policies & procedures for additional details)

Failure of:	What to Expect:	Responsibility of Use:	Who to Contact:
Computer Systems	Systems down	Use backup manual/paper systems	•Information Systems
Electrical Power Failure Emergency Generators Work	Many lights are out; only RED plug outlets work	Ensure that life support systems are on emergency power (red outlets). Ventilate patients by hand as necessary. Complete cases in progress ASAP. Use flashlights	•Maintenance •Respiratory Therapy
Electrical Power Failure -Total	Failure of all electrical systems	Utilize flashlights. Hand ventilate patients. Manually regulate IV's and/or use battery back up; don't start new cases	•Maintenance •Respiratory Therapy
Elevators Out of Service	All vertical movement will have to be by stairwells	Review fire and evacuation plans. Establish services on first or second floor. Use carry teams to move critical patients and equipment to other floor. Food service transportation in bulk to floors and distribute	•Maintenance •All Managers
Elevators Stopped between floors	Elevator alarm bell sounding	Keep verbal contact with persons still in elevator and let them know help is on the way.	•Maintenance •Security
Fire Alarm System	No fire alarms or sprinklers	Institute Fire Watch. Minimize fire hazards. Use phone or runners to report fire.	•Maintenance •Security
Medical Gases	Gas alarms, No O_2 or medical air or Nitrous Oxide (NO_2)	Hand ventilate patients. Transfer patients, if necessary, use portable O_2 and other gases. Call for additional portable cylinders	•Maintenance •Respiratory Therapy
Medical Vacuum	No vacuum; vacuum systems fail and in alarm	Call Central Service for portable vacuum. Obtain portable vacuum from crash cart. Finish cases in progress, don't start new cases.	•Maintenance •Respiratory Therapy •Central Service
Natural Gas Failure or Leak	Odor, no flames on burners, etc.	Open windows to ventilate. Turn off gas equipment. Don't use any spark-producing devices, electrical motors, switches, etc.	•Maintenance
Nurse Call System	No patient contact	Use bedside patient telephone, if available Move patients. Use bells. Detail a rover to check patients.	•Maintenance •Nursing
Patient Care Equipment/Systems	Equipment/system does not function properly	Replace and tag defective equipment	•Biomedical Engineering •Materials Management
Sewer Stoppage	Drains backing up	Do not flush toilets. Do not use water.	•Maintenance •Infection Control
Steam Failure	No building heat/hot water; Sterilizers inoperative; limited cooking	Conserve sterile materials. Provide extra blankets. Prepare cold meals.	•Maintenance •Infection Control •Food Service
Telephones/Beepers	No phone service. No beeper service.	Use pay phones and radios. Use runners as needed.	•Information Systems •Maintenance
Water	Sinks and toilets inoperative	Institute Fire Watch. Conserve water. Use bottled water for drinking. Be sure to turn off water in sinks. Waterless hand washing materials are available from Materials Management.	•Maintenance •Materials Mgmt •Infection Control
Water Non-potable	Tap water unsafe to drink	Place "non-potable water - do not drink" signs at all drinking fountains and wash basins. Shut off H_2O	•Maintenance •Food Service •All Managers •Infection Control
Ventilation	No ventilation; no heating or cooling. No air flow.	Open windows if necessary (institute Fire Watch) or obtain blankets, if needed. Restrict use of odorous/hazardous materials	•Maintenance •Infection Control •PACU/OR •4S

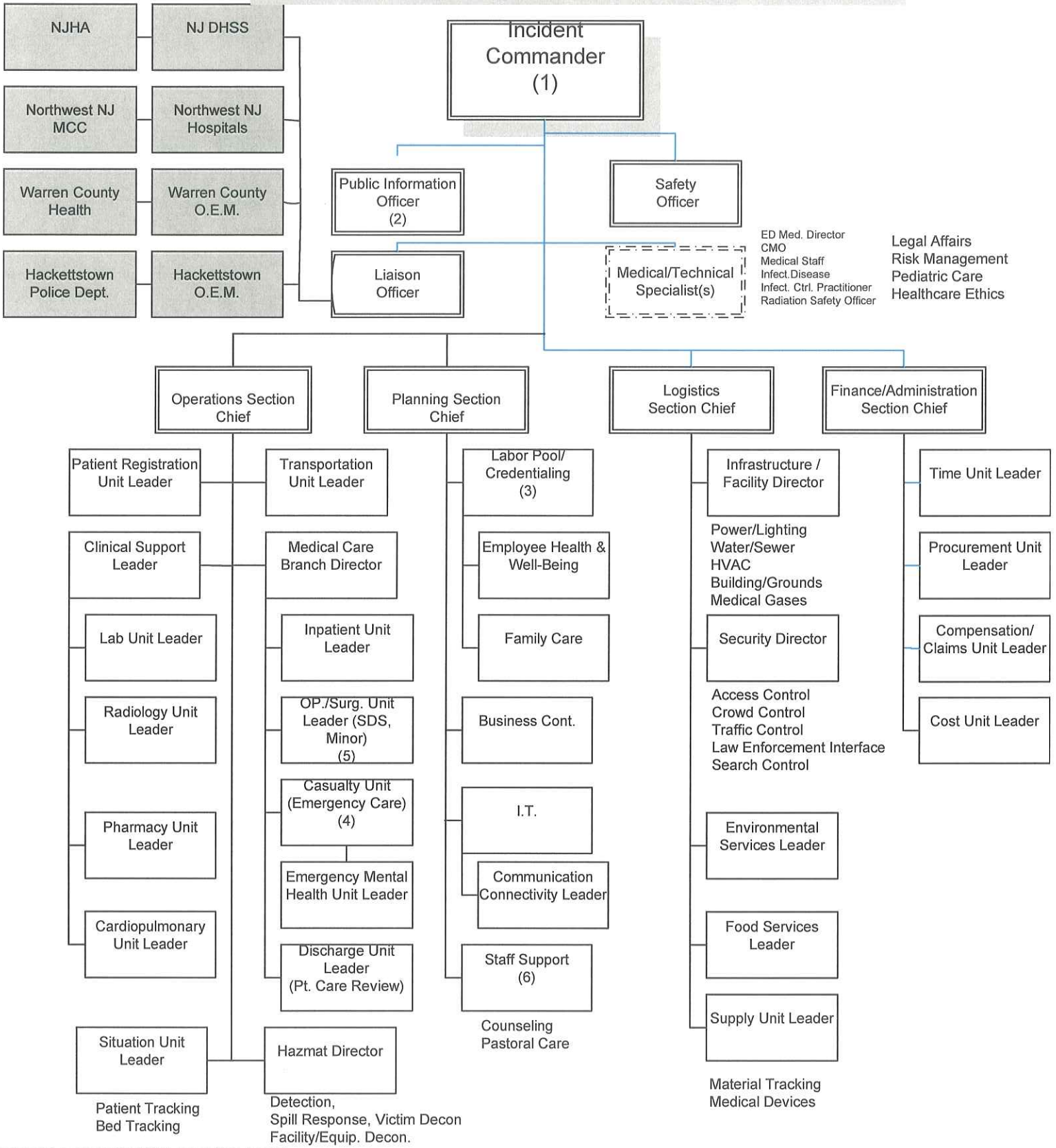
Revised: 7/12/06, Reviewed: 11/07

HACKETTSTOWN REGIONAL MEDICAL CENTER
MPRR Grid
Based on Hazard Vulnerability Analysis
Note: See also HICS Incident Response Guide Notebook

EMERGENCY	MITIGATION (lessen severity & impact)	PREPAREDNESS (build capacity & identify resource)	RESPONSE & RECOVERY
1. Extreme Weather	EM Plan in place AD 116 Extreme Weather Policy	Collaboration with town and county Office of Emergency Management.	Activate EM Plan Follow HICS response procedure
2. Utilities Failure	EM Plan in place Preventive Maintenance Utility Management Plan • Section 5, Patient Safety Manual Medical Equipment Mgmt Plan • Section 6, Patient Safety Manual	Alternative Utilities Contact List, Section 4	Activate EM Plan Follow HICS response procedure
3. External Disaster	EM Plan in place	Cooperative drills involving local squads and agencies.	Activate EM Plan Follow HICS response procedure
4. Workplace Violence/Hostage	RISES Training – Culture of Respect Security staff de-escalate as possible Collaboration between Security and local law enforcement	Security Mgmt. Plan, Section 2, Patient Safety Manual AD 48, Code Gray Policy	Activate “Code Gray” procedure

EMERGENCY	MITIGATION (lessen severity & impact)	PREPAREDNESS (build capacity & identify resource)	RESPONSE & RECOVERY
5. Bioterrorism	EM Plan in place "Best Practice for Hospital-based First Receiver of Victim from Mass Casualty Incidents involving the Release of Hazardous Substances"	Active in town OEM Active in County OEM and County Health Department Annual Drills Decontamination Tent / Trailer	Activate EM Plan Follow HICS response procedure
6. Hazmat	Hazmat Management Planning • Section 3, Patient Safety Manual NJ Hazmat Emergency Response Course, p. 79-106	Hazmat Management Plan	Follow emergency procedures as outlined in Hazmat Management Plan Activate Emergency Management Plan as necessary
7. Infant Abduction	Infant/child alarm system	NU01 Code Amber Policy	Follow Code Amber Policy
8. Bomb Threat	Bomb Threat Policy AD16 Evacuation Protocol in Life Safety Management Plan • Section 5, Patient Safety Manual	Collaborative relationship with law enforcement	Follow Bomb Threat Policy Trace call via Bomb Threat Policy Activate HICS response procedure if necessary
9. Radiologic Event	Please see "HRMC Responses" and HICS Incident Response Guide		
10. Fire	See Fire Safety Management in Patient Safety Manual		

Hackettstown Regional Medical Center
HICS Organizational Chart



Typical Locations for HICS Operation Areas:

1. Incident Commander : Board Room (441-1155, 1156, 1157, 1158 Red Phones: 813-1683, 813-1544)
2. Media Communication: Business Development Office (x 6836) or Finance Conference Room (x 8863)
3. Labor Pool: Human Resources: 6910, 8845
4. Casualty Care: ED (x6800)
5. Delayed and Minor Treatment Area: SDS (x 6858)
6. Support Area: CDR (x 6985) and Front Lobby (x 6977)

Other: Patient Business Meeting Room (441-1214), Staff Development Classroom (x 6988)

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SECTION 5 - FIRE SAFETY MANAGEMENT

Our facility is designed, constructed, maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. Because the safety of occupants cannot be ensured adequately by dependence on evacuation of the building, their protection from fire is be provided by appropriate arrangement of facilities; adequate, trained staff; and development of operating and maintenance procedures composed of the following:

- Design, construction, and compartmentalization
- Provision for detection, alarm, and extinguishment
- Fire prevention and the planning, training, and drilling programs for the isolation of fire, transfer of occupants to areas of refuge, or evacuation of the building

The hospital practices what is known as "Defend in Place", which refers to keeping patients safe and in the building during a fire emergency. The *Life Safety Code* requires that a building is designed, constructed and maintained with the capability of being fire safe.

Visitors to the facility expect that staff know what to do and how to respond in fire emergency. Fire drills are conducted so that staff becomes more familiar with procedures they are expected to follow during a fire emergency. Drills and actual alarms are reviewed to identify areas for improvement.

"Code Red" is our code word for a fire emergency.

The fire alarm system consists of a strobe light and sonic audio alarm system. When a fire alarm is pulled, the following occurs:

a) The White strobe light pulsates
b) The alarm light on the master panel activates, giving the operator the exact location.
c) The fire alarm system announce "Code Red and the location"
d) Relays the alarm to an off site company who alerts the fire department

RACE - 4 Basic Steps

Step 1: **R**escue – Rescue People in immediate danger while calling out "Dr. Firestone".

Step 2: **A**larm – Pull nearest fire alarm.

Step 3: Contain – Close doors and windows.

Step 4: **E**vacuate or extinguish small fires.

Evacuation in clinical areas that house patients do not evacuate unless instructed to do so by Maintenance/Security, Fireman, Safety Officer or Administrative Coordinator. To indicate that a room has been evacuated, place a pillow outside the door. This alerts individuals responding to help evacuate which rooms have been evacuated.

Fire Doors

There are doors that close automatically when the fire alarm is activated. It is important that these doors never be blocked with wooden wedges, wheelchairs, stretchers or other equipment. Their purpose is to prevent smoke and fire from entering other parts of the building.

Fire Extinguishers

When using a fire extinguisher, remember to use the proper extinguisher. It is dangerous to use a Type A (water) extinguisher on a grease or electrical fire. Remember to keep yourself between the fire and your means of exit. **Do Not** get trapped in the room.

PASS

P **Pull** the locking pin: Some extinguishers require a releasing lock latch, pressing a puncture lever, or taking another first step.
A **Aim** the nozzle at the base of the fire.
S **Squeeze** the handle/lever. This releases the contents of the extinguisher.
S **Sweep** from side to side at the base of the fire until it is out.

Do not block fire extinguishers with equipment!

While you are not expected to fight a fire, or use a fire extinguisher, it is your responsibility to know where they are located in the area where you work. You may be asked by staff responding to a fire emergency to get the fire extinguisher.

Oxygen Shut-off

Shutting off oxygen is the charge nurse's responsibility and/or Respiratory Care Dept. in collaboration with fire officials or HRMC maintenance staff.

Evacuation

Evacuation is the process where staff and patients are moved from a compromised smoke compartment (i.e., smoke or fire is too large for staff to control) to a different smoke compartment, generally located in close proximity the compromised compartment and separated by fire doors. The department, or area, listed below where you evacuate to, is located in a different smoke compartment than where you evacuate from.

If evacuation of a patient care area is necessary, a pillow is placed outside the evacuated room to alert responding staff that the room is free of patients.

First Floor-

Lobby or exit nearest your department and go to front of hospital

Second Floor-

OR evacuate to Minor Procedures or ER
PACU evacuates to SDS
Minor Procedures evacuates to OR or PACU
ER evacuate to OR or SDS
Radiology nearest exit and meet in Physician's parking lot
Cardio-Pulmonary nearest exit and meet in West Wing patient parking lot
West Wing Lobby nearest exit and meet in West Wing patient parking lot
Vascular/Cath lab evacuates to PACU or OR

Third Floor-

ICU evacuates to PCU
PCU evacuates to ICU or to 3 North or 3 South
3 North evacuates to PCU
3 South evacuates to PCU

Fourth Floor-

OB evacuates to L&D
L&D evacuates to OB

Medical Office Buildings and Offsite locations- Evacuate according to your department's policy.

Fire drills are done monthly on each shift. If you see a yellow light with a sign that says "I am a Fire. Report me.", pull nearest alarm and carry out all procedures except for patient evacuation. Keep hallways clear at all times in case evacuation of patients is needed.

Important – Know where the following are:

1. Safety Manual containing Fire Safety Plan
2. Closest fire pull station for your unit
3. Fire extinguisher location
4. Location of **smoke compartments** adjacent to your work area. This is where you would evacuate patients if necessary.
5. 0_2 shut off valves
6. Your responsibilities during a fire emergency.

Interim Life Safety Measures (ILSMs)

When building code deficiencies are identified and cannot be immediately corrected or during renovation or construction activities, the safety of patients, staff, and other people coming to the hospital's facilities is diminished. Hospitals need to proactively identify administrative actions (for example, additional training, additional inspections, additional fire drills, and so on) to be taken if these scenarios arise. These administrative actions are called Interim Life Safety Measurement (ILSM)

Hackettstown Regional Medical Center will institute and document ILSMs to temporarily compensate for the life safety hazard that may impact on the life safety of patients, employees, medical staff, or visitors. The Maintenance/Security Manager or his designee conducts inspections of the compromised areas whenever ILSM are in place.
Reference: Administration Policy Manual FA09, FA02

Electronic Statement of Condition (eSOC)

The electronic Statement of Conditions (eSOC) is a compliance document that helps create and maintain a fire safe environment of care. It is also a set of forms health care facilities use to determine whether their building(s) comply with the National Fire Protection Association's (NFPA) *Life Safety Code*. In completing the eSOC, a facility answers the questions "Do our buildings provide a reasonable level of life safety from fire and related threats, such as smoke, fumes or panic?"

The eSOC is a "living document" that is always being updated; both with newly discovered deficiencies and corrections made to a document deficiency. It is maintained electronically by the Maintenance Department.

Items that are placed on the eSOC include any items that would compromise life safety from fire and related threats. Fire doors that do not close properly, exit lights that are burnt out, and penetration in fire walls are examples of deficiencies that would be found on the eSOC.

If you see a fire hazard notify the Maintenance Department.

SECTION 6 - MEDICAL EQUIPMENT

Equipment

Medical equipment is a significant contributor to the quality of patient care. It is used in treatment, diagnostic activities and monitoring of the patient. It is essential that the equipment is appropriate for the intended use; that staff, be trained to use the equipment safely and effectively; and it is essential that the equipment is maintained appropriately by qualified individuals. Our facility contracts with an outside vendor to perform the duties and responsibilities of a Biomedical Department.

All medical equipment must be checked by Biomed prior to being put into use. This includes equipment brought in by physicians or vendors that will be used on a patient. Check for a current inspection sticker prior to using equipment. If it is not current, contact Biomed Department. You must attend an in-service on new equipment prior to using it so you learn how to operate it safely.

If equipment breaks, send it to Materials Management with a tag saying what the problem is. If equipment that is used on a patient malfunctions and causes harm to a patient, immediately tag it and send to the Materials Management office, or Administrative Coordinator on off- shifts, so the incident can be investigated. Remember to make out an incident report, and notify Risk Management. (Policy AD96A Administrative Policy & Procedure Manual)

Never use equipment that is broken or has frayed wires. When working with electrical equipment, make sure your hands are dry and you are not standing in water. Be sure equipment is properly grounded (3-prong plugs).

Recalls and Hazard Notices

Medical equipment hazard notices and recalls related to equipment and supplies are maintained by Biomed and Materials Management. These are reported at the Safety Committee. Materials Management is responsible for reporting these recalls and hazard notices that are sent to our facility. (Pharmacy monitors pharmaceutical recalls.)

It is the responsibility of departments receiving recalls and hazard notices to alert Materials Management and what corrective action, if any, has been done in response to the recall or notice.

Safe Medical Device Act (SMDA)

The SMDA of 1990 requires organizations to report to the FDA any medical device that may have caused or contributed to the death, the serious injury or serious illness to a patient.
A serious injury or illness means an injury or illness that is:

- Life threatening
- Results in permanent impairment of a body function or permanent damage to a body structure, or
- Necessitates immediate medical or surgical intervention to preclude permanent impairment of a body function or permanent damage to a body structure.

Should a medical device thought to have contributed to the death or serious injury/illness of a patient admitted to our facility, there are certain steps that must be followed.

1. Remove the device or equipment, if possible, and send it to Materials Management or to the Administrative Coordinator on off shifts to secure the device or equipment.
2. Notify the Risk Management Department by incident report **and** by telephone. You may leave a message on voice mail for Risk Management. Be sure to include your name and extension number and a brief description of the event.
3. Risk Management must report it to the FDA, the manufacturer and/or the State within **10 days** of notification
4. Risk Management must report semiannually to FDA on all reports previously reported. January 1st reports are July-Dec, July 1 reports cover Jan-June reports

The Act also requires that FDA listed Medical devices are tracked. The FDA defines a Medical Device as any item that is used for the diagnosis, treatment or prevention of a disease, injury, illness or other condition that is NOT a drug. The hospital collects, maintains and reports information on select permanent implantable devices and life support devices used outside of the hospital. (See Policy Ad96A and AD96b, in the Administrative Policy & Procedure Manual).

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SECTION 7 - UTILITIES MANAGEMENT

Utilities systems are essential to the proper operation of the environment of care and contribute to the effective, safe, and reliable provision of care to patients in healthcare organizations. Hackettstown Regional Medical Center maintains a utility systems management program that promotes a safe, controlled and comfortable environment that does the following:

- Ensures operational reliability of utility systems
- Reduces the potential for health care-acquired illness to be transmitted through the utility systems
- Assess the reliability and minimizes potential risks of utility system failures.

Utility systems may include electrical distribution, emergency power, vertical and horizontal transport, ventilating and air conditioning, plumbing, boiler and steam, piped gases, vacuum systems, and communication systems including data exchange systems.

Information regarding utility Management that all employees need to know include the following:

Generator

1. In the event that the hospital loses power, there is a generator for backup emergency power. Generators are tested on a monthly basis.
2. Be sure all vital patient equipment is plugged into a red outlet. These outlets are linked to the emergency generators, which become immediately operative in the event of a power failure.

Telephones

1. In the event the hospital phone system becomes disabled, there are phones which can be used as backup communication. These include pay phones and red phones located throughout building.
2. When the phone system is down the following steps will be taken:
   a. Runner may be assigned to the switchboard in the event of a "Code Blue." The runners will alert Emergency Room, ICU and Respiratory Staff.
   b. Security will provide two-way radios to different departments, depending on time of day. They will also increase rounds.
   c. Rounds will be made by the Administrator-On-Call, Director of Nursing and/or Administrative Coordinator to each unit to determine if there are any critical patients or situations.
   d. The switchboard operator will announce when the phones are once again working.

3. Hackettstown Regional Medical Center Emergency Phone List (note page 2 of this section)

TELEPHONE OPERATION DURING COMMUNICATION SYSTEM FAILURE

FLOOR	DEPT. LOCATION	PHONE NUMBER
BASEMENT	Maintenance Office	908-813-0946
1	Administration –by fax	908-813-1902
1	IS-Computer room	908-852-4685
1	Command Center – Boardroom #1	908-813-1683
1	Command Center – Boardroom #2	908-813-1544
1	Maintenance – by Sec'y desk	908-813-1134
1	Lab/Blood Bank – Front Desk	908-813-1463
1	Pharmacy-Front Desk	908-813-1489
1	Medical Records- Dictation	908-813-1590
2	ER-next to Police phone	908-852-5226
2	ER-Nurses station	908-850-5735
2	ER Lobby- Reg Desk	908-813-1035
2	Switchboard	908-813-0947
2	SDS-Nurses Station	908-813-1518
3	3 North Alcove	908-813-1533
3	PCU-Nurses Station	908-813-1542
3	ICCU- Monitor Tech Desk	908-813-1800
4	4 South Alcove	908-813-1637
4	OB Nurses Station	908-813-1584
MOB	Finance Conference room	908-813-2378

These phones are NOT on the Hospital Phone Network. They are separate Verizon lines that can be used for external communication, in the event that the Hospital Phone Switch, or its circuitry is down.

They are, however, NOT GUARANTEED to work should Verizon have a major issue where they are unable to provide phone service of any kind.

Negative Airflow Rooms

1. There are several rooms located through the facility that have negative airflow and are used for treatment of patients that have an airborne infection.

2. Maintenance monitors the airflow of these rooms on a daily basis when it is used by a patient on airborne precautions.

3. Negative airflow rooms include:
   - Room 10 in the Emergency Department,
   - Endoscopy Rooms 1,2, and 3 in Minor Procedures,
   - Rooms 15 and 16 in Same Day Surgery (SDS),
   - Room 8 in Post Anesthesia Care Unit (PACU),
   - Room 321 in the Progressive Care Unit (PCU),
   - Rooms 3 and 4 in the Intensive Care Unit (ICU),
   - Room 332 on 3 South,
   - Room 421 on OB

Code Button and/or Panic Buttons

Departments that have Code Buttons and/or Panic Buttons must check them weekly and log the date checked and the results. (See Administrative Policy & Procedure Manual Ad25 for Policy and Log) Maintenance must be notified immediately if there are problems identified.

Eyewash

Eyewash stations are located throughout the hospital near locations where corrosive chemicals or antineoplastic agents are mixed. Environmental Services maintain a weekly log indicating that it was checked according to the outlined parameters. Eyewash stations do not replace the need for using proper personal protective equipment.

Refrigerators

Refrigerators must be maintained to prevent the growth of bacteria/mold and to prevent /reduce the risk of hospital acquired infections in patients, visitors and staff.

a. Separate refrigerators are provided to the hospital for medications, lab reagent, specimens, patient's food and employee's food.
b. Policy FA17, Administrative Policy & Procedure Manual outlines how often and who checks the refrigerator. The log can be found behind the policy.

Problem with any Utility

If there is a problem with any utility, (i.e. water, electricity, suction, medical gas, etc) contact the Maintenance Department immediately

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SECTION 8 - BLOODBORNE EXPOSURE CONTROL PLAN

PURPOSE
To protect employees/volunteers from health hazards associated with bloodborne pathogens.
To reduce the work place risk of bloodborne disease transmission to health care workers.
To comply with OSHA standard 29 CFR part 1910.1030.

SCOPE:
This plan applies to all employees/volunteers with potential for occupational exposure to blood or other potentially infectious material; i.e., blood, body fluids, culture material, tissues/organs from a human (living or dead).

RESPONSIBILITY:
The Employee Health nurse and the Safety Officer will have the responsibility for overseeing and coordinating the Exposure Control Plan for Hackettstown Regional Medical Center.

The Infection Control Coordinator is responsible for developing, and reviewing annually, the Exposure Control Plan and working with Administration and department managers on the implementation of the plan. The Coordinator is also responsible for education of new employees at General Orientation.

Department Managers and Supervisors are responsible for implementation of the plan in their respective areas. They are also responsible for the initial training and orientation of new employees to the OSHA 1910.1030 Bloodborne Pathogen Standard and the yearly unit-specific education for their department. This education may be developed in conjunction with the Infection Control Department to ensure that proper exposure control procedures are followed.

The Department Managers and Supervisors shall ensure that the personal protective equipment is available and used appropriately for their department.

Employees/volunteers are responsible for the ultimate execution of the Exposure Control Plan. They shall:

- know what tasks they perform that have occupational exposure
- plan and conduct all operations in accordance with established work practice control
- develop good personal hygiene habits
- attend yearly bloodborne pathogen in-services

The Employee Health nurse will be responsible for the evaluation of circumstances surrounding exposure incidents, i.e. route of exposure and circumstances under which the exposure incident occurred and other trending identification.

Availability of Exposure Control Plan
The Exposure Control Plan is available to all employees/volunteers at any time. Copies of the Exposure Control Plan are easily accessible in all departments.

Review and Update
The Exposure Control Plan will be reviewed and updated annually on or before May 1, each year by the Infection Control and Safety Committees.

Procedures or new products will be evaluated by staff directly involved in the care of patients prior to Implementation
Whenever a new or modified task or procedure is implemented which affects occupational exposure of employees/volunteers, the unit-specific Exposure Control Plan will be updated, employees inserviced and the change forwarded to the Safety Officer by the department manager/supervisor.

Schedule of Implementation
The standard becomes effective March 6, 1992.
The Exposure Control Plan as required by paragraph (c) (2) of the standard shall be completed before May 5, 1992.
Information and Training (paragraph (g) (2) and Record keeping (paragraph (h)) shall be in effect by June 4, 1992.

Engineering and Work Practice Controls (paragraph (d) (2), Personal Protective Equipment (paragraph (d) (3), Housekeeping (paragraph (d) (4), Hepatitis B Vaccination and Post-Exposure Evaluation and Follow-Up (paragraph (f)) and Labels and Signs will be in effect by July 6, 1992.

METHOD OF COMPLIANCE

Standard Precautions

Standard Precautions as defined by the Centers for Disease Control, (Guideline for Isolation Precautions in Hospitals, January 1996) Atlanta, Ga., is based on Universal Precautions and is used with all employees, volunteers, visitors and patients, their body fluids and unknown substances in the hospital setting regardless of their diagnosis or presumed infection status.
A complete statement of Standard Precautions can be found is the Infection Control/Isolation Manual located on your unit.

ENGINEERING AND WORK PRACTICE CONTROLS

Engineering and work practice controls are used to eliminate or minimize employee occupational exposure to infectious substances in the work place to the lowest extent feasible.

Engineering controls include measures that remove or isolate bloodborne pathogens hazards from the workplace.

Work practice controls are ones that reduce the likelihood of exposure by altering the manner in which a task is performed.

Effective engineering controls used by this facility to prevent percutaneous injuries before, during and after use include the following:

- sharps disposable containers
- self-sheathing needles
- needless systems
- sharps with engineered sharps injury protection.
- Engineering controls are examined each time they are used, maintained and/or replaced as needed to ensure their effectiveness.

Types of engineering controls

Hand washing

- Hand washing facilities are provided by the hospital and are readily accessible to all employees.
- When soap or water is not available, the hospital will provide an appropriate antiseptic waterless hand cleaner.
- If an antiseptic waterless hand cleaner is used, hands will be washed with soap and water as soon as it is available.
- Hands will be washed immediately after gloves are removed.

If contact with blood or other potentially infectious material occurs, skin will be washed or mucous membranes flushed with water immediately or as soon as possible.

Contaminated Needles/Sharps

- Contaminated, disposable needles/sharps are not recapped, bent or broken, but placed whole, uncapped in an appropriate container. These containers are located in all patient care areas and where ever else needed.
- The individual using a needle or sharp is personally responsible for its prompt and proper disposal into the appropriate receptacle provided.
- Contaminated needle/sharp containers are puncture resistant, leak-proof, labeled and/or color coded as biohazardous in accordance with State and Federal regulations.
- When needle/sharp containers are full, they will be immediately closed/locked securely, and notify Environmental Services immediately to replace the container. An outside company comes weekly to collect and replace full containers.
- Contaminated, reusable needles/sharps are placed in a closed, puncture-resistant, leak-proof container that has been labeled **Biohazard**.

Work Area Restrictions

- Eating, drinking, smoking, applying cosmetics or lip balm and handling of contact lenses are prohibited in work areas.
- Food and drink is not kept in refrigerators, freezers, shelves, cabinet or on countertops or benchtops in the work area.
- All procedures involving blood or other potentially infectious materials shall be performed in such a manner as to minimize splashing, spraying, splattering or generation of droplets of these substances.
- Mouth pipetting/suctioning of blood or other potentially infectious material is prohibited.

Handling of Specimens

- Specimens of blood or other potentially infectious material will be placed in a container which prevents leakage during collection, handling, processing, storage, transport or shipping of these specimens.
- Because Standard Precautions are utilized in all departments by all employees/volunteers, specimens/containers that remain in the hospital do not have to be labeled or color coded as biohazardous.
- Any specimen, leaving the hospital will be in a container which prevents leaking during collection, handling**,** processing, storage, transport or shipping and will be labeled as biohazardous according to Federal legislation.
- If the outside of the specimen container becomes contaminated, it should be cleaned, disinfected or placed in a clear impervious bag or other container which prevents leakage during handling, processing, storage, transport or shipping.

Contaminated Equipment

- Any equipment needing repair or servicing that is contaminated with blood or other potentially infectious material will be decontaminated in Central Supply prior to servicing. If this is not feasible or the contamination is not readily observable, a biohazardous label will be attached and this information will be conveyed to all involved employees, servicing representatives and/or manufacturers.

PERSONAL PROTECTIVE EQUIPMENT

General Information

- When there is potential for occupational exposure to occur, Personal Protective Equipment will be provided for the employee at no cost by the hospital.
- Personal Protective Equipment will be used as indicated according to established policy. (See unit-specific section of each department manual.)
- Appropriate Personal Protective Equipment shall include gloves, gowns, laboratory coats, face shield, masks, eye protection, resuscitation or other ventilation devices.
- If an employee/volunteer temporarily declines to use Personal Protective Equipment when under rare and extraordinary circumstances the employee deems in his professional judgment that its use would have prevented the delivery of health care, the circumstances of this event shall be documented and investigated to identify changes needed to prevent future occurrences.
- Personal Protective Equipment will be readily accessible in all areas of the hospital where indicated.
- Personal Protective Equipment will be considered appropriate only if it does not permit blood or other potentially infectious material to pass through or reach the employees/volunteers work clothes, street clothes, undergarments, skin, eyes, mouth or other mucous membrane under normal conditions of use and for the duration of time which the equipment is used.
- If Personal Protective Equipment is penetrated by blood or other potentially infectious material, the Personal Protective Equipment will be removed/replaced immediately or as soon as feasible and the area exposed, washed or flushed with water.
- All Personal Protective Equipment will be removed prior to leaving the work area.
- When Personal Protective Equipment is removed, it will be placed in an appropriate area or container for storage, decontamination or disposal.
- The cleaning and/or disposal of Personal Protective Equipment shall be done at no cost to the employee/volunteer and according to established policy.
- Disposable Personal Protective Equipment will be used on one patient only and disposed of after use.
- Reusable gloves and goggles will be cleaned/disinfected after use on one patient by the employee using an appropriate germicide/disinfectant.
- Reusable gowns will be placed in an appropriate linen bag for laundering.
- Personal Protective Equipment will be repaired/replaced as often as necessary and as soon as feasible if torn, punctured or its ability to function as a barrier is compromised and at no cost to the employee.

Gloves

- Gloves are readily available in all patient care areas and other areas of the hospital as indicated.
- They are worn as per hospital policy and when it can be reasonably anticipated that the employee/volunteer will have contact with blood or other potentially infectious material,

mucous membranes or non-intact skin, or when performing vascular access procedures or handling or touching contaminated items or surfaces.

- Disposable (single use) gloves shall be replaced as soon as practical when contaminated or as soon as feasible if they are torn, punctured or when their ability to function as a barrier is compromised.
- Disposable (single use) gloves will not be washed, decontaminated or re-used.
- Utility gloves will be decontaminated for re-use if the integrity of the glove or their ability to function as a barrier is not compromised.

Masks, Eye Protection and Face Shields

- Masks in combination with eye protection devices i.e., goggles, glasses with solid side shields or chin length face shields , will be worn whenever splashes, spray, splatter or droplets of blood or other potentially infectious material may be generated, and eye, nose, or mouth contamination can be reasonably anticipated

Gowns, Apron and Other Protective Body Clothing

- Appropriate protective clothing i.e., gowns, aprons, lab coats, etc. shall be worn in occupational exposure situations.

Surgical caps or hoods and/or shoe covers shall be worn in instances when gross contamination can reasonably be anticipated.

HOUSEKEEPING

General

- The work place will be maintained in a clean and sanitary condition according to a written schedule, using an appropriate disinfectant.
- See the Environmental Services Manual.
- Work surfaces shall be cleaned immediately or as soon as feasible when overtly contaminated or after any spill of blood or other potentially infectious material.
- Any receptacle intended for re-use that has the potential for becoming contaminated with blood or other infectious material will be inspected and decontaminated/cleaned on a scheduled basis or as soon as feasible upon visible contamination.
- Broken glassware, which may be contaminated, will be removed using mechanical means; i.e., dust pan and brush, tongs, etc.
- Contaminated reusable sharps are not processed in a manner that requires employees to reach into the container where the sharps have been placed.

Regulated Medical Waste

- All contaminated sharps will be discarded as soon as feasible in conveniently located containers that are closable, puncture resistant, leak proof and labeled as biohazardous.
- When containers are full, they will be immediately closed/locked securely, and Central Supply notified to replace the container.
- Disposal of all regulated waste is done in accordance with State and Federal regulations. (See Environmental Services Manual).

Laundry

- Contaminated laundry shall be handled as little as possible with a minimum of agitation.
- It is placed in bags at the location where it was used and transported in bags or containers which prevent soak-through and/or leakage of fluids to the exterior.
- If soak-through and/or leakage of fluids to the exterior occurs or is possible, the laundry shall be placed in another container/bag that prevents soak-through from occurring.
- Contaminated laundry shall not be sorted or rinsed in the locations of its use.
- Personal Protective Equipment will be used by employees/volunteers handling contaminated laundry.
- Contaminated linen does not need to be labeled as biohazardous as the receiving facility HCSC-Laundry, Allentown, Pennsylvania, utilizes Universal Precautions when handling ALL soiled laundry (see HCSC Laundry Infection Control Manual in the Environmental Services or Infection Control Department.)

HEPATITIS B VACCINE

The Hepatitis B vaccine is available free of charge to all employees/volunteers who have an occupational exposure to blood or other body fluids as identified. (See Exposure Determination, unit-specific section.)
The Hepatitis B vaccine will be made available after the employee/volunteer has received the required training and within 10 working days of the initial assignment.
If the employee/volunteer declines to accept the Hepatitis B vaccination, a waiver will be signed.
If the employee/volunteer initially declines the Hepatitis B vaccine, but at a later date decides to accept it, it will be made available free of charge if the employee/volunteer has occupational exposure to blood or other body fluids as identified. (See Exposure Determination, unit-specific section)
The Employee Health Nurse has the responsibility of administering the vaccine and assuring that the above policies have been developed and implemented.
See Employee Health Manual for further information.

POST EXPOSURE EVALUATION AND FOLLOW-UP

Any employee/volunteer having an exposure to blood, body fluids or other potentially infectious material will:

1. Provide IMMEDIATE care to the exposed area by inducing bleeding, washing with soap and water or irrigating the area copiously.
2. Report the incident to their supervisor IMMEDIATELY.
3. Fill out an Employee Illness/Injury Report form.
4. Be seen by Employee Health/Emergency Room for a confidential medical evaluation, prophylaxis and follow-up as indicated for the employee and source patient according to current recommendations.

********Post exposure follow-up should be initiated within 1-2 hours of the incident in order to assess the need for and begin post-exposure prophylaxis**.******

All follow-up will be at no cost to the employee and provided according to an accepted standard of care as identified by the Centers for Disease Control, U.S. Public Health Service.

Post-exposure follow-up will include:

- A confidential medical evaluation
- Counseling
- Collection and testing of blood
- Evaluation
- Follow-up

The employee/volunteer will be given a copy of the evaluating health care professional's written opinion within 15 days of completion.

A sharps injury log will be maintained on all occupational exposure to sharps and will be used to help evaluate new products and/or procedures as necessary. The sharps injury log will maintain the privacy of the employee and include the following information:

- Description of the incident and it occurred
- Department or work area where the incident occurred
- Type and brand of sharp/device involved in the incident, if known.

Records of the evaluation of all reported exposures and a sharps injury log will be maintained in Employee Health.

See the Employee Health Manual for further information.

LABELS AND SIGNS

Biohazard labels will be affixed to containers of regulated waste, refrigerators and freezers containing blood or other potentially.

Infectious material and other containers used to store, transport or ship blood or other infectious material.

These labels will be fluorescent orange or orange/red with lettering or symbols in a contrasting color.

Red bags/containers can be substituted for labels.

If containers of blood, blood components or blood products are labeled as to their component and are released for transfusions, they do not need to be labeled.

Individual containers of blood or other potentially infectious materials that are placed in a labeled container during storage transport, shipment or disposal need not be labeled.

INFORMATION AND TRAINING

Information and training will be done at no cost to the employee/volunteer and during working hours.

Training will be provided at the time of initial assignment and annually thereafter by the person responsible for the orientation of new employees for that department.

Additional training will be provided whenever changes or modifications of tasks or procedures are instituted.

Material will be appropriate in content and vocabulary to the educational level and language of the employees/volunteers.

The person conducting the training will be knowledgeable in the subject matter as it relates to the work place that the training addresses.

Training will include at least the following elements:

1. An accessible copy of the regulatory text of this standard and an explanation of its contents;
2. A general explanation of the epidemiology and symptoms of bloodborne diseases;
3. An explanation of the modes of transmission of bloodborne pathogens;
4. An explanation of the employers exposure control plan and the means by which the employee can obtain a copy of the written plan;
5. An explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and other potentially infectious materials;
6. An explanation of the use and limitations of methods that will prevent or reduce exposure including:
    - Appropriate engineering controls
    - Work Practices
    - Personal protective equipment.
7. Information on the types, proper use, location, removal, handling, decontamination and disposal of personal protective equipment;
8. An explanation of the basis for selection of personal protective equipment.
9. Information on the Hepatitis B vaccine, including information on its efficacy, safety, method of administration, the benefits of being vaccinated, and the vaccine and vaccination will be offered free of charge;
10. Information on the appropriate actions to take and persons to contact in an emergency involving blood or other potentially infectious materials;
11. An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident and the medical follow-up that will be made available;
12. Information on the post-exposure evaluation and follow-up that the employer is required to provide for the employee following an exposure incident;
13. An explanation of the signs and labels and/or color coding.
14. An opportunity for interactive questions and answers with the person conducting the training session.

RECORD KEEPING

1. Medical Records
- Employee Health will establish and maintain accurate records for each employee/volunteer with an occupation exposure in accordance with 29 CFR 1910.1020 and 29 CFR 1910.1030.
- These records will be kept confidential and are not released without the employees written consent to anyone except as required by law.
- These records will be maintained for at least 30 years after the termination of the employee.

2. Training Records
- Education and training records will be maintained for at least 3 years from the date in which the training occurred by each department supervisor.
- The records will include:
- Date of training session
- Contents or summary of training session
- Name and qualification of person conducting the training session
- Name and job title of those of those attending the training session

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DEPARTMENT
OSHA BLOODBORNE PATHOGEN

UNIT-SPECIFIC MANUAL

The OSHA Bloodborne Pathogen Unit-Specific Manual has been reviewed, updated and a copy of any changes forwarded to the Safety Officer.

DATE	DEPARTMENT MANAGEMENT/SUPERVISOR
_____	
_____	
_____	
_____	
_____	
_____	
_____	
_____	
_____	
_____	
_____	
_____	
_____	

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Department _____

The following document has been developed in conjunction with OSHA, 29 CFR, Part 1910.1030 and the Exposure Control Plan for Hackettstown Regional Medical Center, and is specific to the above department.

I. Exposure Determination

A. Below is a list of job classifications for this department where employees/volunteers have NO exposure to bloodborne pathogens.

1.
2.
3.
4.
5.
6.
7.

B. Below is a list of job classifications for this department in which all employees/volunteers have exposure to bloodborne pathogens.

1.
2.
3.
4.
5.
6.
7.

C. The following pages list tasks and procedures in which occupational exposure occurs for these employees/volunteers along with the minimum requirements needed to protect them from potentially infectious materials for this department.

Method of Compliance

A. Universal Precautions have been observed in this department since 1988. Standard Precautions were implemented in November 1996.

B. Engineering Controls and Work Practices

1. Engineering controls as defined by OSHA are controls that isolate or remove bloodborne pathogens hazard from the work place.

In this department, the following engineering controls are utilized.

Control	Location	Replacement Responsibility	Frequency of Examination
Hand washing Facilities			
Antiseptic Waterless Hand Cleaners			
Sharps Disposal Containers			
Reusable Sharp Containers			
Regulated Medical Waste Containers			
Others:			

2. Work practice controls as defined by OSHA air controls that reduce the likelihood of exposure by altering the manner in which a task is performed.

When occupational exposure remains after the institution of engineering and work practice controls, personal protective equipment will be used.

Personal protective equipment will be provided to employees in the following manner for this department:

Equipment	Location	Disposal of	Replacement Responsibility
Gloves			
Lab Coats			
Impervious Gowns			
Eye Protectors/Goggles			
Face Shields			
Shoe Covers			
Others:			

C. The following areas of this department will be cleaned and decontaminated according to a schedule established by the Environmental Service Department and as needed using approved germicide:

Areas	Frequency	Responsibility
Floors		
Counter Tops		
Bins, Pails, Cans, other receptacles		
Spills of body fluid		

D. Laundry

Contaminated laundry will be placed in appropriate bags located in the following areas:

1.

2.

3.

Hepatitis B Vaccine and Post Exposure Evaluation and Follow-Up

See hospital-wide Exposure Control Plan.

Training

The person responsible for training of all employees for this department prior to initial assignment of tasks where occupational exposure may occur and annually thereafter is _____ .

The person responsible for education and training records for this department is

_____.

SECTION 9 - TUBERCULOSIS CONTROL PLAN

Purpose & Responsibility

The purpose of the Tuberculosis Control Plan is to protect employees, patients, and visitors from health hazards associated with tuberculosis by reducing the work place risk of tuberculosis transmission.

A task force consisting of the chief Safety Officer and representatives from Administration, Infection Control, Maintenance, Respiratory Therapy and Employee Health will have the responsibility for overseeing and coordinating the Tuberculosis Control Plan for Hackettstown Regional Medical Center.

The Infection Control Practitioner is the designated contact person for questions and/or problems related to Tuberculosis.

Infection Control is responsible for developing and reviewing annually the Tuberculosis Control Plan and working with Administration and department managers on the implementation of the plan.

Respiratory Therapy Department, Infection Control and Patient Education will be responsible for fit testing employees.

Employee Health Department will maintain records on all fit testing, post exposure follow up and TST testing of employees/volunteers.

Employees/volunteers are responsible for the ultimate execution of the Tuberculosis Control Plan. They shall plan and conduct all operations in accordance with established work practices.

Risk Assessment

An annual assessment of the risk of transmission of M. tuberculosis at Hackettstown Regional Medical Center will be performed according to the following elements, identified by the Centers for Disease Control.

1. A review of the community tuberculosis profile obtained from public health department data.

2. A review of the number of tuberculosis patients who were treated in each area of the facility (including inpatient and outpatient areas).

3. A review of the drug-susceptibility patterns of tuberculosis isolates of patients who were treated at the facility.

4. An analysis of TST tuberculosis skin test results of health care workers employed by the facility.

5. A review of the medical records of tuberculosis patients seen at the facility to evaluate infection control parameters by calculating intervals from:

   - admission until TB suspected;
   - admission until TB evaluation performed;
   - admission until acid-fast bacilli (AFB) specimens ordered;
   - AFB specimens ordered until AFB specimens collected;
   - AFT specimens collected until AFB smears performed and reported;
   - AFB specimens collected until cultures performed and reported;
   - AFB specimens collected until species identification conducted and reported;
   - AFB specimens collected until drug-susceptibility tests performed and reported;
   - admission until TB isolation initiated;
   - admission until TB treatment initiated; and
   - duration of TB isolation

   The following additional information will also be obtained:

   - Were appropriate criteria used for discontinuing isolation?
   - Did the patient have a history of prior admission to the facility?
   - Was the TB treatment regimen adequate?
   - Were follow-up sputum specimens collected properly?
   - Was appropriate discharge planning conducted?

6. An observational review of infection control practices related to tuberculosis.

7. A review of the most recent environmental evaluation and maintenance procedure.

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Tuberculosis Control Plan

A written report will be developed by Infection Control with the assistance of Employee Health and Maintenance to be presented to the Safety and Infection Control Committees annually by April 1.

The results of this assessment will be used to identify a level of risk in the facility according to the protocol established by the CDC. This level of risk determines the elements required for the tuberculosis infection control program. (see pages 3-8)

The Tuberculosis Control Plan will be reviewed and updated yearly based on the results of this assessment.

Identification, evaluation and treatment of patients suspected of or diagnosed with tuberculosis.

A nursing history and physical form is completed on every admission and the diagnosis of tuberculosis will be considered for any patient who provides a history or signs or symptoms compatible with active tuberculosis. i.e.

- ✓ persistent cough (lasting longer than 3 weeks)
- ✓ bloody sputum
- ✓ weight loss
- ✓ anorexia
- ✓ fever
- ✓ night sweats

If the diagnosis of tuberculosis is highly suspected, the physician will be contacted for further diagnostic testing and "airborne precautions" will be instituted if indicated. (See Infection Control/Isolation Manual)

All testing will be performed as ordered and test results communicated in a timely manner.

Anti-tubercular drug therapy will be administered by directly observed therapy (DOT). This is the process by which the health care worker observes the patient swallowing the medication.

Patients suspected of or diagnosed with tuberculosis will be reported immediately to the appropriate public health department by Infection Control.

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Tuberculosis Control Plan

Management of outpatients suspected of infectious tuberculosis.

Triaging of patients in outpatient areas of the hospital will include efforts to promptly identify patients who have active tuberculosis.

Patients with signs or symptoms suggestive of tuberculosis will be evaluated promptly.

Patients seen in the outpatient setting suspected of infectious tuberculosis will be given a surgical mask and a box of tissues and instructed in their proper use.

These patients will be scheduled at a convenient time with minimal exposure to employees and other patients and seen as soon as possible upon arrival.

Managing inpatients who have possible infectious tuberculosis.

Medical management of patients suspected of or diagnosed with tuberculosis will be as indicated by their private physicians.

Patients with suspected or confirmed infectious Tuberculosis will be placed on airborne precautions in anyone of the Airborne Infection Isolation (negative pressure rooms) rooms and Infection Control will be notified.

This room is maintained under negative air pressure directly vented to the outside of the hospital. Airflow will be monitored by Maintenance according to an established schedule.

1. See Airborne Precautions in the infection Control/Isolation Manual.

2. Transportation of the patient to other areas of the hospital will be discouraged. If transportation is absolutely necessary, the patient will wear an appropriate mask designed to provide a tight face seal and proper filtration of droplet nuclei and will be scheduled with the other area involved so that the transport can occur at a convenient time with minimal exposure to employees, visitors and patients. The patient will be returned to the isolation room as soon as possible.

3. The patient will be instructed to cover nose and mouth with a tissue during coughing or sneezing and to dispose of the tissue in a plastic lined trash container or paper bag.

Precautions will be discontinued when patient clinically improves, coughing has decreased and the number of organisms or sequential sputum smears is decreasing or negative on 3 consecutive days.

If an appropriate isolation room is unavailable, patients will be prioritized based on the following principles:

1. Highest priority should be given to patients with Laryngeal or Cavity T.B., AFB smear positive.

2. If a choice must be made between two patients with a similar risk of infectiousness, higher priority will be given to a patient with the drug resistant isolate or with active forceful coughing.

3. In rare circumstances, it may be acceptable to place two patients with tuberculosis in the same room if both patients involved:

    a. have culture confirmed tuberculosis
    b. have drug-susceptibility test results available on current specimens
    c. have identical drug susceptibility patterns
    d. are in effective drug therapy

Elective surgical procedures on patients who are diagnosed with tuberculosis should be delayed until the patient is no longer infectious.

Airborne precautions may be discontinued if:

1. the diagnosis of tuberculosis is ruled out
2. the patient is on effective therapy, is improving clinically and has three consecutive negative sputum AFB smears collected on different days.

Discharge planning for the patient will be coordinated by Social Services and will include an evaluation for:

1. compliance with therapy
2. housing status
3. responsibility for patients drug treatment program
4. notification of local tuberculosis control agency

Engineering recommendations

Hospital ventilation patterns have been developed and maintained in accordance with local and state requirements.

ASHRAE and HRSA recommendations for air exchanges and airflow in all areas of the hospital are monitored by the maintenance department.

See Maintenance Manual

Respiratory protection

Employees are provided with disposable masks that are worn when health care workers must share air space with a patient who has been suspected of or diagnosed with infectious tuberculosis.

These masks are designed to provide a tight face seal and to filter out particulates in the droplet nucleus size range (1-5 microns).

Use of respirator masks will continually be evaluated according to most recent OSHA, CDC and State regulations.

A written respirator protection program has been developed and instituted at Hackettstown Regional Medical Center in accordance with NJSDOH recommendations, CDC Guidelines and OSHA regulations.

Respirator masks will be provided by the hospital for employees to wear when taking care of patients suspected of diagnosed with tuberculosis or by those employees performing or assisting with procedures that are likely to produce bursts of droplet nuclei such as bronchoscopies, aerosolized medication treatments, sputum induction, endotracheal intubation and suctioning procedures and autopsies on a patient diagnosed or suspected of having tuberculosis.

All employees will receive training and testing prior to using a respirator mask by a qualified trainer.

Prior to training and fit testing, the employee must complete a written medical evaluation, which will be kept in the Employee Health file.

See "Qualitative Fit Testing of Respirator Mask" procedure (8762.007) and the "Respirator Mask" procedure (8762.008) for additional information.

If an employee cannot be fit tested due to a full-face beard or is unable to successfully complete the fit testing procedure, alternative masks will be made available to the employee.

Respirator masks are disposable but may be reused throughout the shift until it becomes visibly contaminated or their structural integrity is impaired.

To assure proper protection, the employee will inspect the mask for visible contamination and perform a fit check each time the mask is worn by inhaling and exhaling sharply while checking for blow-by or leakage around the edges of the mask.

When a patient, suspected of, or diagnosed with tuberculosis is admitted an appropriate mask will be used by employees that have been properly fit tested and trained. Respiratory Therapy, in conjunction with Infection Control, will be contacted to provide the education and fit testing of additional employees as necessary.

To ensure that a proper facial seal has been obtained, a negative pressure test must be performed by inhaling and exhaling sharply and checking for blow-by or leakage around the edges of the mask each time the mask is worn.

Respirator masks can be obtained from the Materials Management stockroom.

Cough inducing procedure

1. General Guidelines

   Procedures that involve instrumentation of the lower respiratory tract or induce coughing, i.e. endotracheal intubation and suctioning, diagnostic sputum induction, aerosol treatment and bronchoscopy, should not be performed on patients who may have infectious tuberculosis unless the procedure is absolutely necessary and performed with appropriate precautions.

   All cough-inducing procedures performed on patients who may have infectious tuberculosis will be performed using local exhaust ventilation devices or in a room that meets the ventilation requirements for Tuberculosis isolation.

   After completion of the procedure these patients will remain in the isolation rooms and not return to common waiting areas until coughing subsides.

Before the room is used for another patient, sufficient time will be allowed to pass for at least 99% of the airborne contaminants to be removed. (see chart)

2. Bronchoscopy

If a bronchoscopy is performed in a positive pressure room, tuberculosis should be ruled out before the procedure is performed.

If the bronchoscopy is being performed for the purpose of diagnosing pulmonary tuberculosis, the procedure will be performed in a room that meet Tuberculosis Isolation requirements or the Demistifier 2300 will be installed prior to performing the bronchoscopy.

Health Care Worker/Volunteer Training and Education

A. All employees/volunteers with patient contact will be trained regarding the hazards and control measures associated with tuberculosis.

B. Initial training will be provided upon employment, at the pre-placement physical, and during General Orientation and will include:

- The purpose, interpretation, and value of periodic skin testing;
- Procedures and techniques to prevent nosocomial TB transmission, including infection control and environmental techniques;
- The importance of compliance with preventive therapy for people infected with TB;
- The cause and transmission of TB;
- The distinction between TB disease and TB infection;
- The signs and symptoms of TB;
- The risk factors for TB disease development;

- The treatment of TB;
- The origin and prognosis of multiple drug resistant TB;
- The purpose and interpretation of TB skin testing, including the significance of a skin test conversion;
- The purpose of screening and the recommended follow-up of positive skin tests;
- The high risk of developing active TB if he/she is HIV positive;
- Site specific TB control program; and
- The definition of infectious tuberculosis.
- The purpose, proper selection, fit, use and limitations of personal protective equipment;
- The engineering controls in use in the person's work area; and
- The critical role of directly observed therapy in preventing the emergence of multiple drug resistant strains of TB.

Annual training will be included as part of the Annual Marathon in-service.

HCW Counseling and Screening

Employee/volunteer health policies have been developed and implemented in accordance with recommendations from the Centers for Disease Control, Atlanta, Georgia.

All employees/volunteers with previously negative tuberculin skin tests will be re-tested yearly as scheduled by the Employee Health Office.

Employees/volunteers with a previously positive tuberculin skin test will receive no additional testing or chest x-rays unless symptoms develop.

Pregnancy or BCG immunization is <u>not</u> a contraindication for annual tuberculin skin testing.

If an employee/volunteer is exposed to a patient highly suspected of or diagnosed with tuberculosis and appropriate infection control measures were not followed, the employee will:

1. Report the incident to their supervisor,

2. Fill out an Employee and Volunteer Injury/Illness Report Form, and

3. Contact Employee Health (ext. 6911) for further follow-up.

Evaluation of testing and possible nosocomial transmission

Epidemiologic investigations will be instituted by Infection Control in response to the identification of:

1. TST test conversions or active tuberculosis in Health Care Workers/volunteers.

2. Possible person-to-person transmission of tuberculosis.

3. Situations in which patients, Health Care Workers or volunteers with active tuberculosis are not promptly identified and/or isolated.

Results of these investigations will be presented to the Infection Control and Safety Committees.Coordinate efforts with Public Health

Infection Control will notify the appropriate public health authorities as soon as feasible when a patient, Health Care Worker or Volunteer is suspected or
diagnosed with active tuberculosis. In accordance with N.J.A.C. 8:57-1.5(a)

Infection Control will assist Social Service in the Coordination of services with the Health Department for discharge planning of the patient.

BIBLIOGRAPHY

"Guidelines for Preventing the Transmission of Tuberculosis in Health Care Settings, with Special Focus on HIV-Related Issues" MMWR - December 7, 1990, VOL 39, No. RR-17
Centers for Disease Control, Atlanta, Georgia

"Core Curriculum on Tuberculosis"
U.S. Department of Health and Human Services, Second Edition, April, 1991

OSHA Enforcement Guidelines for Occupational Exposure to Tuberculosis, U.S. Department of Labor, May 7, 1992

"Guidelines for the Prevention of Tuberculosis transmission in Health Care Facilities:" New Jersey State Department of Health, Division of Epidemiology, Environmental and Occupational Health Services, January 1993.

Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health-Care Facilities, 1994.