CHLA IS A MAGNET HOSPITAL

- Magnet Status is the highest level of recognition that the American Nurses Credentialing Center can accord to organized nursing services in health care organizations.
# Updated - Emergency Response Codes
**February 1, 2016**

<table>
<thead>
<tr>
<th>New CHLA Codes</th>
<th>Code Description</th>
<th>Extension</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Code Red</strong></td>
<td>Fire</td>
<td>Dial “33” or pull closest fire alarm</td>
</tr>
<tr>
<td><strong>Code Blue</strong></td>
<td>Medical Emergency</td>
<td>“33”</td>
</tr>
<tr>
<td><strong>Code Orange</strong></td>
<td>Hazardous Material Spill</td>
<td>“33”</td>
</tr>
<tr>
<td><strong>Code Pink</strong></td>
<td>Infant abduction</td>
<td>“711”</td>
</tr>
<tr>
<td><strong>Code Purple</strong></td>
<td>Child abduction (toddlers and above)</td>
<td>“711”</td>
</tr>
<tr>
<td><strong>Code Yellow</strong></td>
<td>Bomb threat</td>
<td>“711”</td>
</tr>
<tr>
<td><strong>Code Gray</strong></td>
<td>Combative person</td>
<td>“711”</td>
</tr>
<tr>
<td><strong>Code Silver</strong></td>
<td>Person with weapon and/or active shooter and/or hostage situation</td>
<td>“711”</td>
</tr>
<tr>
<td><strong>Code Triage Internal</strong></td>
<td>Activate emergency operations plan for internal incident</td>
<td>“33” for any concern House Supervisor (Incident Commander) – activates</td>
</tr>
<tr>
<td><strong>Code Triage External</strong></td>
<td>Activate emergency operations plan for external incident</td>
<td></td>
</tr>
</tbody>
</table>

*Children's Hospital Los Angeles*  
*We Treat Kids Better*
# Fire and Evacuation Response Information

<table>
<thead>
<tr>
<th>Closest manual alarm pull station:</th>
<th>Dial 33</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting a fire</td>
<td>Dial 33</td>
</tr>
</tbody>
</table>
| The two closest evacuation routes are: | 1.  
2.  |
| My department assembly area is: | Code Red |
| Fire alarm code | Code Red |
| Fire response procedure | - Safety of Life. Remove occupants if safe to do so. Close the door  
- Notify / activate the manual pull station. Dial 33. Give your location, name, and extension  
- Return to use fire extinguisher if safe to do so  
- Remove occupants from the adjoining area if danger of fire spreading |
| To use a fire extinguisher | PASS  
- Pull the pin  
- Aim the hose / extinguisher  
- Squeeze the handle  
- Sweep from side to side |
| Evacuation | - Move horizontally beyond next fire/smoke door  
- Move vertically, two floors minimum or unit capable of receiving patient type  
- Meet at designated assembly area  
- Account for all staff and patients  
- Notify emergency operations center extension 12342 of status / missing persons |
| Patient evacuation priorities | - Those closest to danger  
- Ambulatory patients  
- Those you can evacuate yourself  
- Those you need help to evacuate  
- Medical records if safe to do so |
## DEVELOPMENTAL ASPECTS OF ILLNESS AND INJURY

<table>
<thead>
<tr>
<th>AGE</th>
<th>PSYCHOLOGICAL ISSUES</th>
<th>CONCEPTS OF ILLNESS</th>
<th>REACTION TO HOSPITALIZATION</th>
<th>PERCEPTION OF DEATH</th>
</tr>
</thead>
<tbody>
<tr>
<td>INFANCY</td>
<td>• Importance of parent-child bonding</td>
<td>• Generalized perception of discomfort and pain</td>
<td>• Need to have parents close by</td>
<td>• Fear of separation</td>
</tr>
<tr>
<td></td>
<td>• Need to be as close physically as is feasible</td>
<td>• Perceptions modulated by response of environment</td>
<td>• Parent's absence and reactions provide best support in handling fear, pain and separation</td>
<td></td>
</tr>
<tr>
<td>PRE-SCHOOL</td>
<td>• Need to boost sense of mastery</td>
<td>• Illness/injury seen as a punishment for bad behavior</td>
<td>• Presence of parents is of primary importance</td>
<td>• Death may be personified</td>
</tr>
<tr>
<td></td>
<td>• Need to prepare for medical procedures, separation, etc.</td>
<td>• Magical view, fullness</td>
<td>• Hospitalization perceived as rejection or punishment</td>
<td>• Often sees as violent</td>
</tr>
<tr>
<td></td>
<td>• Possibility of regressions and fears</td>
<td>• Adults seen as omnipotent with power to magically cure the illness/injury if they wanted to</td>
<td>• Fear of mutilation arises</td>
<td>• Don't always see death as permanent</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Treatment may be seen as punishment</td>
<td>• Death is a punishment for being bad</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Concerns about body penetrations by surgery or injections</td>
<td>• Dead people continue to live</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Simple explanations useful for maintaining trust</td>
<td>• Death is confused with separation and sleep</td>
</tr>
<tr>
<td>SCHOOL-AGE</td>
<td>• Need to be productive and learn</td>
<td>• Cause of illness/injury is from disobedient behavior but takes longer to express</td>
<td>• Primary concern is lack of body control and mastery</td>
<td>• Begin to understand the finality of death</td>
</tr>
<tr>
<td></td>
<td>• Begin to use knowledge and understanding of the body, cause of illness and the process of treatment</td>
<td></td>
<td>• Feelings of inadequacy arise</td>
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<td></td>
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</tr>
</tbody>
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</tr>
</thead>
<tbody>
<tr>
<td>SCHOOL-AGE</td>
<td>• Needs honest explanations</td>
<td>• Can begin to understand body processes and functions</td>
<td>• May become demanding or rebellious to maintain semblance of control</td>
<td>• Differentiation of living and non-living</td>
</tr>
<tr>
<td>CONTINUED</td>
<td>• Fear of loss of control and sense of body integrity</td>
<td>• Conceptualization characterized by internalization and contamination</td>
<td>• Knowledge about illness or injury effective in handling anxiety</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Separation from family and peers may interfere with developmental task mastery</td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADOLESCENCE</td>
<td>• Begins to deal with issues of illness/injury as an individual</td>
<td>• Focus on discrete symptom rather than overall impact of illness/injury</td>
<td>• Seen as threat to independence</td>
<td>• Able to acknowledge the fragility of life</td>
</tr>
<tr>
<td></td>
<td>• Relies less of family support</td>
<td>• Ability to intellectually question and deal with information about illness/injury</td>
<td>• Conflicts over control issues may become a focal concern</td>
<td>• Death may be viewed as philosophical problem in life or challenged and denial by risk-taking</td>
</tr>
<tr>
<td></td>
<td>• Difficulty with compliance of medical regimes proposed by adults (rebellion that jeopardizes death)</td>
<td>• May use denial of illness/injury or over compensation in areas not affected</td>
<td>• Concern about status in peer group after hospitalization</td>
<td>• Idea that death is not permanent may recur (suicide seen as retaliation but reversible)</td>
</tr>
<tr>
<td></td>
<td>• Intense preoccupation with body changes and sexuality</td>
<td>• Conceptualization is characterized by physiological and psychophysiological causes of illness/injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Concerns about being &quot;different&quot; heightened</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Illness/injury may impair ability to plan for future</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
# N-PASS

**Neonatal Pain, Agitation, & Sedation Scale**

Hummel & Puchalski, 2000

<table>
<thead>
<tr>
<th>Assessment Criteria</th>
<th>Sedation</th>
<th>Normal</th>
<th>Pain / Agitation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>-2</td>
<td>-1</td>
<td>0</td>
</tr>
<tr>
<td>Crying Irritability</td>
<td>No cry with deep painful stimuli</td>
<td>Moans or cries briefly with painful stimuli</td>
<td>Little crying Not irritable</td>
</tr>
<tr>
<td>Behavior State</td>
<td>No arousal to any stimuli No spontaneous movement</td>
<td>Arouses briefly to stimuli Little spontaneous movement</td>
<td>Appropriate for gestational age</td>
</tr>
<tr>
<td>Facial Expression</td>
<td>Mouth is lax No expression</td>
<td>Minimal expression with stimuli</td>
<td>Relaxed</td>
</tr>
<tr>
<td>Extremities Tone</td>
<td>No grasp reflex Flaccid tone</td>
<td>Weak grasp reflex ↓ muscle tone</td>
<td>Relaxed hands and feet Normal tone</td>
</tr>
<tr>
<td>Vital Signs HR, BP, RR, O₂ Sats</td>
<td>No variability with stimuli Hypoventilation or apnea</td>
<td>&lt; 10% variability from baseline with stimuli</td>
<td>Within baseline or normal for gestational age</td>
</tr>
</tbody>
</table>

Premature Pain Assessment
+ 3 if < 28 weeks gestation / corrected age
+ 2 if 28-31 weeks gestation / corrected age
+ 1 if 32-35 weeks gestation / corrected age
Children over 3 years of age

1. Determine if child can distinguish between “more” and “less” by showing the child two glasses of water with different levels and ask the child which container is more.

2. Introduce the scale to child/parent before painful event if possible. Explain that the scale will be used to determine the presence and severity of any pain so that we can intervene to manage the pain. Explain the scale to the child using the words on the FACES scale. INITIAL EXPLANATION MAY REQUIRE INTERPRETER.

3. Ask the child to point to the face that seems most like she is feeling now. Record the number indicated under the face chosen by the child.

4. Refer to Pediatric Pain Management Guidelines (appendix 1) for suggested intervention for mild (1-3); moderate (4-7); or severe (8-10) pain.

5. Reassess child within one hour of the intervention.

Reference:
## Quick Reference to Providing Age Specific Care

<table>
<thead>
<tr>
<th>Age</th>
<th>Nursing Care</th>
</tr>
</thead>
</table>
| **Neonates** | 1. Foster attachment to parents  
2. Meet needs promptly and gently  
3. Recognize avoidance behaviors: yawning, averting eyes, frowning, arching, gagging or regurgitation and finger splaying  
4. Recognize approach behaviors: sucking, hand to mouth, cooing and hand clasping  
5. Include parents as partners in care |
| **Infant**   | 1. Allow parents to remain with child  
2. Recognize fear of separation from parents  
3. Be aware of fear of strangers  
4. Console through rocking, holding, swaddling, touch and oral stimulation  
5. Know developmental milestones which are rapidly changing  
6. Maintain parents participation in care  
7. Maintain a safe environment: keep side rails up; never leave unattended in a highchair or wagon |
| **Toddler**  | 1. Establish honest communication in child’s own language  
2. Promote independence and encourage exploration through movement  
3. Recognize signs of separation anxiety: protest, despair and detachment  
4. Maintain daily rituals and routines and encourage parents to bring in familiar objects from home  
5. Keep teaching brief with emphasis on what child hears, sees, tastes and feels  
6. Maintain a safe environment: keep side rails up; avoid foods that are easily aspirated; supervise activities |
| **Preschooler** | 1. Encourage exploration  
2. Recognize tendency to use imagination in play and expanding on fears  
3. Maintain daily routines and rituals  
4. Encourage play; supervise activities  
5. Prepare for procedures with brief and simple explanations |
| **School Age** | 1. Allow responsibility for simple tasks  
2. Give detailed explanations and obtain their consent for all procedures and tests  
3. Set limits for behavior  
4. Maintain privacy  
5. Maintain contact with parents, siblings and peers  
6. Encourage play |
| **Adolescents** | 1. Recognize possible concerns about body image due to rapid physical and sexual changes  
2. Foster independence  
3. Recognize parental conflict may occur as adolescent and parents learn new roles  
4. Encourage contact with peers  
5. Recognize risk taking and negative peer group behaviors and set limits as necessary  
6. Maintain privacy  
7. Provide opportunity to express feelings  
8. Give detailed explanations and obtain their consent for all procedures and tests |
| **Adult**     | 1. Foster independence  
2. Provide detailed information on all aspects of care and allow patient to direct medical decisions  
3. Encourage participation in normal adult roles  
4. Recognize need to feel productive  
5. Maintain privacy  
6. Provide opportunity to express feelings |
The Key Elements of Family-Centered Care

- Incorporating into policy and practice the recognition that the family is the constant in a child's life, while the service systems and support personnel within those systems fluctuate.

- Facilitating parent/professional collaboration at all levels of hospital, home, and community care:
  - Care of an individual child;
  - Program development, implementation, evaluation, and evolution; and
  - Policy formation.

- Exchanging complete and unbiased information between families and professionals in a supportive manner at all times.

- Incorporating into policy and practice the recognition and honoring of cultural diversity, strengths, and individuality within and across all families, including ethnic, racial, spiritual, social, economic, educational, and geographic diversity.

- Recognizing and respecting different methods of coping and implementing comprehensive policies and programs that provide developmental, educational, emotional, environmental, and financial supports to meet the diverse needs of families.

- Encouraging and facilitating family-to-family support and networking.

- Ensuring that hospital, home, and community service and support systems for children needing specialized health and developmental care and their families are flexible, accessible, and comprehensive in responding to diverse family-identified needs.

- Appreciating families as families and children as children, recognizing that they possess a wide range of strengths, concerns, emotions, and aspirations beyond their need for specialized health and developmental services and support.

## The Key Elements of Family-Centered Care

<table>
<thead>
<tr>
<th>Key Elements</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Incorporating into policy and practice the recognition that the <strong>family is the constant</strong> in a child's life, while the service systems and support personnel within those systems fluctuate.</td>
<td>This first key element represents the driving force behind family-centered care. Encompassed in this element are two critical aspects. The first relates to the word &quot;family&quot;, and the diverse definition of the word. The second relates to the degree to which services are &quot;centered&quot; around the family members who play a pivotal role in the life and care of the child.</td>
</tr>
<tr>
<td>2. Facilitating <strong>family/professional collaboration</strong> at all levels of hospital, home, and community care: - care of an individual child; - program development, implementation, evaluation, evolution - policy formation.</td>
<td>Collaboration between and among families and professionals is the spirit behind family-centered care. Working together is a respectful way to humanize the delivery of health and developmental services, and it improves the outcome for children needing specialized care and support. A commitment to collaboration in hospital-, community-, and home-based health and developmental care settings represents the means to achieve the vision of family-centered care.</td>
</tr>
<tr>
<td>3. <strong>Exchanging complete and unbiased information</strong> between families and professionals in a supportive manner at all times.</td>
<td>Effective communication, a thread that weaves together all of the elements, is essential to the family-centered process. True collaboration demands that families and the professionals they work with openly exchange information, ideas, and concerns. This type of communication is the cornerstone of quality health and developmental services and supports for children and their families.</td>
</tr>
<tr>
<td>4. Incorporating into policy and practice the recognition and <strong>honoring of cultural diversity</strong>, strengths, and individuality within and across all families, including <strong>ethnic, racial, spiritual, social, economic, educational, and geographic diversity</strong>.</td>
<td>The fundamental idea of family-centered care is that children are best served when they are understood as inextricably linked to a larger living unit, the family. Disability and illness can affect any family, crossing all cultural, ethnic, racial, spiritual, social, economic, educational, and geographic lines. Family-centered care requires that each family be approached anew, with a recognition of and a respect for such diversity within and across each family. Decisions about care must be made by a collaborative exchange of information, not by predetermining child/family needs, strengths, concerns, or priorities based on assumptions.</td>
</tr>
<tr>
<td>5. Recognizing and respecting <strong>different methods of coping</strong> and implementing comprehensive policies and programs that provide developmental, educational, emotional, environmental, and financial supports to meet the diverse needs of families.</td>
<td>One critical aspect of honoring family diversity is recognizing and respecting the different ways in which families approach their child's illness or disability--the meaning they ascribe to it, the impact it has on family members, and the way they choose to meet the new challenges brought by it. While there are many issues that are common to families whose children need specialized services, care must be taken to respect each family's individuality in their adaptation to their child's needs and to address the specific goals expressed by each family.</td>
</tr>
<tr>
<td>6. Encouraging and facilitating <strong>family-to-family support</strong> and networking.</td>
<td>Most families establish individual networks of friends, relatives, or professionals such as clergy, on whom they rely for support as they encounter challenges of life. The birth of a child with a chronic illness or disability, or the diagnosis of a condition, may isolate families from the very sources of informal support that could be most helpful. Family-to-family support--from informal discussions with other parents in hospital lounges to membership in groups that meet regularly--is very powerful. In fact, one of the most effective ways to provide comprehensive support to children and families is by encouraging and facilitating family-to-family support.</td>
</tr>
<tr>
<td>7. Ensuring that <strong>hospital, home, and community service and support systems</strong> for children needing specialized health and developmental care and their families are <strong>flexible, accessible, and comprehensive</strong> in responding to diverse family-identified needs.</td>
<td>If anything can be anticipated in the life of a child with a chronic illness or disability, it is that the child and family will have a variety of needs that will require a myriad of services, that they will interact with a multitude of professionals and service systems, and that their needs will change across time.</td>
</tr>
<tr>
<td>8. <strong>Appreciating families as families</strong> and children as children, recognizing that they possess a wide range of strengths, concerns, emotions, and aspirations beyond their need for specialized health and developmental services and support.</td>
<td>It is essential for professionals to understand, accept, and support the fact that the child's health condition may not always be the family's only or most central priority. Furthermore, the concerns and priorities of children and families change across time.</td>
</tr>
</tbody>
</table>
PURPOSE:

Family-Centered Care is a philosophy that incorporates patient and family involvement in both the care provided by the hospital and the aspects of hospital operations that impact patients and families. As defined in this policy, Family-Centered Care is designed to strengthen a family’s ability to serve as a child’s primary advocate in the health care process. It is the policy of Children’s Hospital Los Angeles that each staff member provides health care services that are aligned with the principles of Patient and Family-Centered Care within the scope of their job description and professional expectations.

DEFINITION

Family-Centered Care is a model of care in which health care provider’s partner with families and, as appropriate for age, patients to make all health care decisions. Family-Centered Care is grounded in the belief that mutually beneficial partnerships between patients, families, and health care professionals lead to the best health outcomes, positively impacting both quality and safety. Families are recognized as the ones who know their child the best, are the constant in their child’s life and are essential members of a complete health care team. When Family-Centered Care is successfully implemented, a family can overcome feelings of helplessness and become empowered to actively participate in their child’s care.

PRINCIPLES

CHLA adopts and subscribes to the core principles of family-centered care as defined by the Institute for Patient- and Family-Centered Care as follows:

- **Dignity and Respect**: Health care practitioners listen to and honor patient and family perspectives and choices. Patient and family knowledge, values, beliefs and cultural backgrounds are incorporated in the planning and delivery of care.

- **Information Sharing**: Health care practitioners communicate and share complete and unbiased information with patients and families in ways that are affirming and useful. Patients and families receive timely, complete, and accurate information in order to effectively participate in care and decision-making.

- **Participation**: Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.

- **Collaboration**: Patients, families, health care practitioners, and health care leaders collaborate in policy and program development, implementation and evaluation; in facility design; and in professional education, as well as in the delivery of care. (Institute for Patient- and Family-Centered Care, 2006)
PROCEDURES:

A. Implementation of Family-Centered Care

While Family-Centered Care cannot be operationalized in a complete and definitive list of behaviors and tasks, there are some basic guidelines to foster successful implementation. It is acknowledged that different units and locations in the hospital will develop practices specific to work area, but the following minimum expectations must be met across the institution.

1. **Ensuring Family Presence**
   a. Parents are not visitors and should not be labeled or referred to as such.
   b. Encourage and empower families to stay with their child at all times in the inpatient setting and ensure that structures and processes are in place to support continuous family presence in all hospital units.
   c. Educate families about bedside chairs and other sleep options within close proximity to patient. Orient parents/families to outpatient and inpatient settings (use the CHLA Welcome Book for inpatient admissions and the Partners in Care patient safety brochure for outpatients). Inform parents/families of food available to them at CHLA (cafeteria, vending machines, McDonalds and “room service” for inpatients).
   d. Consult with services such as Clinical Social Work, Spiritual Care, Child Life and Diversity Services to maximize support for family.

2. **Partnering with Families for Effective Care**
   a. Include parents/families and, as appropriate for age, the patient as full members of the Health Care Team, incorporating their knowledge of their child and/or themselves.
   b. Partner with parents/families on all decisions regarding their child.
   c. Utilize the information parents and families share about their child.
   d. Link parents/families with hospital and community resources including and child-to-child and family-to-family supports. Consult with Clinical Social Work for assistance.
   e. Empower parents/families to actively participate in their child’s care through education, support and encouragement. Coach families to ask questions and participate in their child’s care plan.
   f. Prepare parents/families to positively participate during procedures. Give clear descriptions prior to the procedure, and give parents/families the option to remain with their child. Consult with Child Life for assistance.
   g. Whenever possible, schedule tests/procedures at times that are optimal for family participation/presence.
   h. Educate parents/families about the medications their child is receiving, and show them each dose of medication before their child receives it.
i. Effectively educate patients/families about CHLA’s rapid response team, “Team Help,” and ensure that families understand its function and purpose.

j. Inform parents/families about hand hygiene procedures and encourage them to feel free to remind others.

3. Provide Timely and Unbiased Information
   a. Integrate families in patient care rounds, including staff change of shift or “hand off” rounds.
   b. Provide families with results of tests/labs as soon as quickly as possible.
   c. Schedule frequent update meetings with all treating services and provide adequate supports for family to participate in a meaningful way (Clinical Social Work, Spiritual Care, etc.).

4. Honor the Individuality of Families:
   a. Speak respectfully to and about all family members and patients.
   b. Speak to families in their preferred language. Utilize interpreters and/or Qualified Bilingual Employees to ensure that communication is accurate and effective.
   c. Provide care and resources that support the families’ religious beliefs. Consult with Spiritual Care Services to ensure maximum support.
   d. Provide education through methods preferred by family as noted in the care plan.
   e. Respect families’ care decisions without judgment.
   f. Elicit information regarding cultural practices that could be observed during the hospital stay or possibly incorporated into the patient’s care.

5. Collaborate with Families for Quality Improvement
   a. Consult with CHLA’s Family Advisory Council (see below) for feedback on all proposed policy and procedure changes that would directly impact patients and families.
   b. Work areas are encouraged to identify potential family advisors from their specific populations who are passionate about improving the patient/family experience.
   c. Thoughtfully utilize data from patient satisfaction surveys to inform policy and process changes that affect patients and families.
   d. Include parents/families as members in key hospital committees subject to parent availability.
   e. Include patient and family experiences/feedback and patient satisfaction data on agendas for senior leadership and board meetings.

B. Oversight and Accountability

The successful implementation of Family-Centered Care requires fundamental culture change and can therefore not rest under the sole oversight of one person or governing body. It is the responsibility of each hospital staff member to ensure that the core principles are incorporated into his or her practice.
In order to monitor the hospital’s success/progress, the following entities have been developed:

- **Family Advisory Council (FAC):** The FAC is primarily comprised of parents and caregivers of current or former CHLA patients. The Council provides family feedback and the perspective of patients on issues of importance, particularly those around patient care and families’ access to hospital services. The Council meets monthly and is co-chaired by a parent and a hospital staff member.

- **Family-Centered Care Steering Committee:** This committee is primarily comprised of hospital staff. Its goal is to further the implementation of Family-Centered Care at CHLA through specific improvement projects and consultation with work areas. The committee also plans relevant educational offerings for staff and ensures the availability of speakers for hospital orientations. The committee meets monthly.

These two groups will closely track developments and initiatives within the hospital that impact patients and families and provide summaries and recommendations to hospital leadership through the Director of Family-Centered Care Support Services and the Chief Nursing Officer.

**REFERENCES:**


**REVIEWED BY:**

Scott Ferguson  
Family-Centered Care Steering Committee  
Family Advisory Council
PURPOSE:
To ensure that hand-off communications for patients, between caregivers of same and differing disciplines provides a comprehensive and succinct overview of the patient’s current situation and needs.

The primary objective of hand-off communications (for any SITUATION) is to:
• Provide accurate and clear information, using interaction communication, about a patient’s care, treatment and services, current condition and any recent or anticipated changes.

Consistent hand-off communication content and formats:
• Increases the amount of information staff members accurately transmit, record and recall.
• Improves their ability to plan patient care.
• Prevents the omission of information.

Hand-Off Communications for patients can occur:
• During shift changes.
• Temporary or permanent relief of coverage.
• Nursing and physician transition from an Emergency Department (ED).
• Various transfers of information or transitions in physical setting in the inpatient and outpatient settings.
• Or transfers to different hospitals, long-term care facilities and home and community health care.

(The transport Policy CC-88.0 provides greater detail, including transport Pyramid and Childrens Hospital Los Angeles round Trip Ticket-To Ride form)

DEFINITION:
Situation: the reason [or situation] a Hand Off Communication is required.

The following attributes of effective hand-off communications must be followed:
1. Hand-offs must utilize interactive communication that allows for the opportunity for questioning between the giver and receiver of patient information.
2. Hand-offs must include up-to-date information regarding the patient’s condition, care, treatment, medications, services and any recent or anticipated changes.
   2.1 The use of standardized templates or prompting tools are encouraged to prevent omission of important information.
   2.2 Medications must be reconciled and the hand-off must include information on the rationale for continuing, discontinuing, modifying or starting medications, if pertinent.
3. Hand-offs must include a method to verify the received information, including repeat-back or read-back techniques. If the information transmitted is unclear, the receiver of information should ask for verification and likewise, the giver of information should feel free to ask the receiver of.

*Except in temporary transport situation where the “Childrens Hospital Los Angeles Round Trip Ticket-To Ride” form is utilized AND there is not transfer of care.

**NOTE: The situation of the hand-off communication will determine which combination of the above should be utilized to most effectively communicate the patient information.
information to repeat or read back information to verify accurate receipt of that information.

4. Hand-offs must include an opportunity for the receiver of the hand-off information to review relevant patient historical data, which may include previous care, treatment and services. If review of historical data is required, then the medical record, whether paper or electronic should be available to the receiver of the information, as needed, during the hand off.

5. Interruptions during hand-offs must be limited to minimize the possibility that information would fail to be conveyed or forgotten.

6. Hand-off communications must occur prior to transfer of care, except in emergency situations
   6.1 In particularly emergent situations, e.g., ward-to-ICU transfers, the initial hand-off communication may be limited to information focused on the patient’s decompensation; however, complete hand-off communication must occur soon after transfer and before writing of the intensive care unit admission orders.
   6.2 If any change in the patient’s care, treatment and services, condition or recent or anticipated changes has occurred between the time of the last hand-off communication and the transfer of care those changes must be communicate, meeting the other requirements of this policy.

7. Physician-to-Physician Hand Off accountability
   7.1 Whenever any transfer of care occurs between physicians, the plan of care must be communicated between the transferring direct care physician and the accepting direct care physician and will adhere to the general principles of the Childrens Hospital Los Angeles Patient Hand-Off policy and procedure. For each type of physician-to-physician hand-off a standardized approach will be used that is within the SBARQ framework, described in PROCEDURE 2.
   7.2 The accepting attending must be notified of the transfer of care in a timely manner that assures the safety of the patient according to the Medical Staff Rules and Regulations.
   7.3 These physician-to-physician hand-off accountabilities will also apply to nurse practitioners and physician assistants.

PROCEDURE:
1. Methods for Hand-Off Communications:
   a. Must be verbal (either face-to-face or via phone)* and may be supplemented by:
   b. Beside, and/or
   c. Written

2. Format for Hand-Off Communication

*Except in temporary transport situation where the "Childrens Hospital Los Angeles Round Trip Ticket-To Ride" form is utilized AND there is not transfer of care.

**NOTE: The situation of the hand-off communication will determine which combination of the above should be utilized to most effectively communicate the patient information.
Hand-Off communication between caregivers should utilize the SBARQ format. Additionally, the CORE elements listed below for each category should be utilized, as appropriate, for the given Hand-Off Communication situation. (See Childrens Hospital Los Angeles Hand-Off Communication Prompting tool – this is to be used as a guideline for HOC and is NOT to be used as documentation as part of the permanent medical record).

a. **S – Situation**
   - Patient’s name/age/unit
   - Patient ID band check *(as appropriate to SITUATION)*
   - Patient diagnosis *(primary and secondary)*
   - And status, *(if applicable)*
   - Reason for Hand-Off Communication

b. **B – Background**
   - Be brief *(focused to discipline/system involved)*
   - Significant medical history
   - Current medications *(especially those which may affect status and as appropriate to SITUATION)*
   - Psycho/Social Issues for patient and/or family *(as appropriate to SITUATION)*
   - Primary Language for patient/family *(as appropriate to SITUATION)*
   - Allergies *(as appropriate to SITUATION)*
   - Isolation status and precautions *(as appropriate to SITUATION)*

c. **A – Assessment**
   - Systems head-to-toe *(as appropriate to SITUATION)*
   - Airway/breathing status or issues *(as appropriate to SITUATION)*
   - Current pain scale rating *(as appropriate to SITUATION)*
   - Most recent set of VS/parameters *(as appropriate to SITUATION)*
   - Nutrition status, e.g., NPO *(as appropriate to SITUATION)*
   - Invasive lines/tubes *(as appropriate to SITUATION)*
   - Surgical sites/wounds/fractures *(as appropriate to SITUATION)*
   - Skin integrity *(as appropriate to SITUATION)*
   - Falls risk *(as appropriate to SITUATION)*
   - Mobility limitations and precautions *(as appropriate to SITUATION)*
   - Equipment/monitors *(as appropriate to SITUATION)*
   - Do you have concerns? If so, what are they? How worried are you? Be specific.
   - Is there a problem that could be life threatening? What makes you think so?
   - Is anything pending that could not be completed by you?

*Except in temporary transport situation where the “Childrens Hospital Los Angeles Round Trip Ticket-To Ride” form is utilized AND there is not transfer of care.

**NOTE:** The situation of the hand-off communication will determine which combination of the above should be utilized to most effectively communicate the patient information.
d. **R – Recommendation**
   - State any interventions you are recommending
   - What would you like the incoming caregiver to do? Discharge planning? Additions/alterations to MPC?
   - What needs to be done so that the care of the patient is not interrupted and important issues are attended to?

e. **Q – Questions**
   - Do you have any questions for me? Do I need to clarify anything for you?
   - Receiver of information should utilize repeat-back or read-back techniques.

3. Each patient care unit/discipline/clinic should modify/supplement the above template to fit the specific needs of the patient population. For example, Rehabilitation patients will need to have therapy and splint schedules discussed. Surgical patients will need discussion related to diet tolerance, wound healing, activity, etc. Transplant patients will need specific review of I&O and so on.

4. A standardized approach to hand-off communication does not mean the same process must be used for all types of hand-off situations. Rather, each type of hand-off communication should follow a process that is standardized for that particular hand-off situation. *(See Childrens Hospital Los Angeles HOC Prompting tool as a guideline)*

**REFERENCES:**
TJC, Joint Commission Resources 2007, “Improving Hand-Off Communication”

Hand-Off Communications prompting Tool

*Except in temporary transport situation where the “Childrens Hospital Los Angeles Round Trip Ticket-To Ride” form is utilized AND there is not transfer of care.

**NOTE:** The situation of the hand-off communication will determine which combination of the above should be utilized to most effectively communicate the patient information.
First thing’s first...

- **Safety of Life** - Remove Occupants IF safe to do so. Close the door.
- **Activate** - the alarm/ manual pull station. **Dial 33.** Give your location, name, and extension.
- **Fight the fire** - if safe to do so. Use fire extinguisher
- **Evacuate** - Remove occupants from the adjoining area if fire is spreading

**The Fire Extinguisher:**

- **P** - Pull the pin
- **A** - Aim the hose/ extinguisher
- **S** - Squeeze the handle
- **S** - Sweep from side to side

**Let’s go, Let’s go!**

- Move horizontally beyond next fire/ smoke door
- Move vertically, two floors minimum or unit capable of receiving patient type
- Meet at designated assembly area
- Account for all staff and patients
- Notify emergency operations center extension 12342 of status/ missing persons

**Who to evacuate first? (In order of priority)**

- Those closest to danger
- Ambulatory patients
- Those you can evacuate yourself
- Those you need help to evacuate
- Medical Records if safe to do so
Infants or non-verbal children up to 7 years of age

1. Introduce the scale to the parent (if possible) before the painful event occurs. Explain that this scale will be used, with their input, to assess the child's level of pain and response to intervention.

2. Look for pain behaviors in each of the five identified categories. If available, seek parent's opinion.

3. Score pain behaviors in each category on a scale ranging from 0-2. This will result in a total score between zero and ten.

4. Refer to Pediatric Pain Management Guideline (appendix 1) for suggested intervention for mild (1-3); moderate (4-7); or severe (8-10) pain.

5. Within an hour of intervention, re-assess the patient. A decrease in pain behaviors suggests successful intervention. No change or increase in pain cues signifies need for further intervention.

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face</td>
<td>No particular expression, smile</td>
<td>Occasional grimace or frown, withdrawn, disinterested</td>
<td>Frequent to constant frown, clenched jaw, quivering chin</td>
</tr>
<tr>
<td>Legs</td>
<td>Normal position or relaxed</td>
<td>Uneasy, restless, tense</td>
<td>Kicking or legs drawn up</td>
</tr>
<tr>
<td>Activity</td>
<td>Lying quietly, normal positions, moves easily</td>
<td>Squirming, shifting back/forth, tense</td>
<td>Arched, rigid, or jerking</td>
</tr>
<tr>
<td>Cry</td>
<td>No cry (awake or asleep)</td>
<td>Moans, whimpers, occasional complaint</td>
<td>Crying steadily, screams, or sobs; frequent complaints</td>
</tr>
<tr>
<td>Consolability</td>
<td>Content, relaxed</td>
<td>Reassured by occasional touching, hugging, or talking to, distractible</td>
<td>Difficult to console or comfort</td>
</tr>
</tbody>
</table>

For example: Your assessment is as follows: face: grimacing occasionally when you touch him tummy (1), his legs a little tense (1), but you can move him easily (0). He occasionally whimpers (1) and he usually stops when mom carries him (1). His pain = 4/10.
INFECTION CONTROL
ORIENTATION MANUAL
FOR CONTRACTED SERVICES

Revised: 01/20/2015

Infection Prevention and Control
Childrens Hospital Los Angeles
323-361-5510

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About This Manual
This manual is required reading for all contractual staff, including physicians. It is meant to provide education and training in hospital-specific infection prevention and control policies that are required by law (Title 22, Section 7, 1288.95). This manual will cover topics such as hand hygiene, facility-specific isolation procedures, patient hygiene, and environmental sanitation procedures. For additional information, all infection control policies and procedures are available online at http://insidechla.org/. Go to Resources, then Documents Library, then Policies and Procedures Libraries and select Infection Control. Infection Control can also be reached directly by calling extension 1-5510.
Infection Prevention and Control Program
The CHLA Infection Prevention and Control Program is designed to strategically prevent and control hospital-acquired infections among patients, families, employees, medical staff, volunteers and visitors. It is an essential component of effective clinical programs integrating evidence-based practices designed to reduce the frequency of adverse events such as infection or injury.

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Infection Prevention and Control Education
Orientation and In-services
The Infection Prevention and Control Program will provide orientation and in-services upon request. Requests can be made by calling 323-361-5510.

Quick Reference Guides can be found in Physician workrooms and online at http://chlaportal/sites/ipc/SitePages/Home.aspx

Slide Decks with the information in this guide are attached as Appendices A-C of this Manual
Preventing Transmission of Communicable Diseases

Standard Precautions

Standard Precautions are based on the principle that all blood, body fluids, secretions, excretions except sweat, non-intact skin, and mucous membranes may contain transmissible infectious agents. Assume that every person is potentially infected or colonized with an organism that could be transmitted in the healthcare setting and apply the following infection control practices during the delivery of health care.

- Standard Precautions include: hand hygiene; use of gloves, gown, mask, eye protection, or face shield, depending on the anticipated exposure; and safe injection practices. Each will be discussed later in this document.
- Also, equipment or items in the patient environment likely to have been contaminated with infectious body fluids must be handled in a manner to prevent transmission of infectious agents (e.g., wear gloves for direct contact, contain heavily soiled equipment)

Transmission Based Precautions

There are five categories of Transmission-Based Precautions:

- Contact Precautions,
- Contact + Precautions,
- Combined-Droplet Precautions,
- Combined-Droplet + Precautions,
- Combined-Airborne Precautions

Transmission-Based Precautions are used when the route(s) of transmission is (are) not completely interrupted using Standard Precautions alone.

- **Contact Precautions**: To prevent transmission of pathogens, which are spread by direct or indirect contact with the patient or the patient's environment. Hand hygiene, donning gloves and gown are required for **every** room entry.
- **Contact + Precautions**: To prevent transmission of *Clostridium difficile* disease and Norovirus (when patient has diarrhea only) which are spread by direct or indirect contact with the patient or the patient's environment. Hand hygiene, donning gloves and gown are required for **every** room entry. Hand Hygiene with soap and water wash only is required for all opportunities after room entry.

- **Combined-Droplet Precautions**: To prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions. Because these pathogens do not remain infectious over long distances in a healthcare facility, special air handling and ventilation are not required. Hand hygiene, donning gloves, gown, and surgical masks are required for **every** room entry.
- **Combined-Droplet + Precautions**: To prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions in patients with *Clostridium difficile* disease or patients with Norovirus infection who are vomiting. Because these pathogens do not remain infectious over long distances in a healthcare facility, special air handling and ventilation are not required. Hand hygiene, donning gloves, gown, and surgical masks are required for **every** room entry. Hand Hygiene with soap and water wash only is required for all opportunities after room entry.

- **Combined-Airborne Precautions**: To prevent transmission of pathogens that remain infectious over long distances when suspended in the air (e.g., measles, chickenpox, *Mycobacterium tuberculosis*). Patients are placed into negative pressure rooms. Hand hygiene, donning gloves, gowns and N95 respirator masks are required for **every** room entry.
Donning and Removal of Personal Protective Equipment (PPE)

See IC Quick Reference Guide and IC 220 Standard Precautions for printed posters on correct sequence. General CDC recommendations for the appropriate use of PPE include:

Don PPE before patient contact and generally before entering the patient room. Once it is on, use PPE carefully to avoid contamination. Follow general safe-work practices including:

- Keep hands away from face.
- Work from clean to dirty.
- Limit surfaces touched.
- Change PPE when torn or heavily contaminated. Change PPE when entering/exiting area.

To don a gown: With the opening in the back, secure the gown at the neck and waist. If the gown is too small for full coverage, use two; the first with the opening in the front, and the second placed over it with the opening in the back.

To don a mask: Place it over the nose, mouth and chin. Fit the flexible nose piece over the bridge of the nose. Secure it on the head with ties or elastic.

Respiratory Hygiene/Cough Etiquette

Serious respiratory illnesses like influenza, respiratory syncytial virus (RSV), whooping cough, and severe acute respiratory syndrome (SARS) are spread by:

- Coughing or sneezing
- Unclean hands

To prevent the spread of illnesses to others, respiratory hygiene should be followed:

- Cover your mouth and nose with a tissue when you cough or sneeze.
- Put used tissue in the wastebasket.
- If a tissue is unavailable, cough or sneeze into your upper sleeve or elbow, not your hands.
- Perform hand hygiene often

Respiratory Protection and Aerosol Transmissible Disease Exposure Plan

All healthcare personnel who potentially interact with patients who have droplet or airborne transmissible respiratory diseases must participate in the facility respiratory protection program.

CHLA provides annual Fit Testing and Respiratory Protection Clinic in September every year. Appointments are required. The following is reviewed at the clinic:

- N95 Fit Testing is conducted
- Powered Air Purifying Respirator (PAPR) training is provided
- Proper PPE for care of patients with droplet and airborne transmissible infections is reviewed

Refer to IC 800: Aerosol Transmissible Disease Exposure Control Plan for further information.

Hand Hygiene

Performing proper hand hygiene is one of the most important infection control measures for preventing healthcare associated infections. Hands can become contaminated when touching body secretions, wounds and non-intact skin. However, they can also become contaminated when touching surfaces in the immediate vicinity of patients.
Hands should be cleaned according to recommendations outlined by the World Health Organization (WHO). They are as follows:

Washing hands with antimicrobial soap and water:

- When hands are visibly soiled or contaminated
- Before eating
- After using the restroom
- When you start and end your shift
- After sneezing or coughing
- After caring for patients with active *Clostridium difficile* disease

If hands are not visibly soiled, use an alcohol based hand rub for routinely decontaminating hands in the following situations:

- Before entering and after exiting a patient room
- Before/After direct contact with a patient
- After contact with inanimate objects in the immediate vicinity of the patient
- After removing gloves
- Before donning sterile gloves to insert a central venous catheter, peripheral venous catheter or other invasive device
- After contact with body fluids, mucous membranes, non-intact skin and wound dressings if hands are not visibly soiled
- When moving from a contaminated body site to a clean body site during patient care

**Multi-Drug Resistant Organisms**

**Reference IC 825:** Multidrug Resistant Organisms (MDRO) Preventing Transmission (MRSA, VRE, ESBL, GNB) and IC 317: MRSA Screening and Surveillance

Multi-Drug Resistant Organisms (MDROs) such as Methicillin Resistant Staphylococcus aureus (MRSA), Vancomycin Resistant Enterococcus (VRE) and *Clostridium difficile* (C.diff) have important infection control implications. This is because these organisms are highly resistant to one or more classes of antibiotics used against them.

Options for treating patients who are diagnosed with an MDRO are limited. Patients with MDROs have longer hospital stays, increased costs and increased risk for mortality.

Prevention of MDROs:

- KIDS/CERNER: Yellow banner bar will alert clinicians to patients diagnosed with MRSA, or VRE, ESBL.
- Follow standard precautions during all patient care encounters
- For patients with a known diagnosis of an MDRO like MRSA, VRE, ESBL **Contact Precautions** are implemented. This requires hand hygiene, gloves and gown for every room entry and patient contact.
- For patients with *Clostridium difficile* disease **Contact + Precautions** are implemented. This requires hand hygiene, donning gloves and gown for每一个 room entry. Hand Hygiene with soap and water wash only is required for all opportunities after room entry.
- For patients with a known diagnosis of MRSA, VRE, or ESBL and an artificial airway (trach, ET tube) **Combined-Droplet Precautions** are implemented. This requires hand hygiene, gloves, gown and mask for every room entry and patient contact.
- Judicious use of antimicrobial agents. This effort focuses on effective antimicrobial treatment of infections, use of narrow spectrum agents, treatment of infections and not contaminants, avoiding excessive duration of therapy, and restricting use of broad-spectrum or more potent
antimicrobials to treatment of serious infections when the pathogen is not known or when other effective agents are unavailable.

- Clean and disinfect surfaces that may become contaminated, especially those in close proximity of the patient and frequently touched surfaces. See IC policy # 716 for more information on Cleaning and Disinfection.
- Patients isolated with an MDRO should have dedicated equipment or single use disposable non-critical equipment, instruments and devices.

**MRSA**

MRSA is a type of bacteria that is resistant methicillin and other more common antibiotics such as oxacillin, penicillin and amoxicillin.

MRSA has become a prevalent nosocomial pathogen in the United States. In hospitals, the most important reservoirs of MRSA are infected or colonized patients. Although hospital personnel can serve as reservoirs for MRSA and may harbor the organism for many months, they have been more commonly identified as a link for transmission between colonized or infected patients. The main mode of transmission of MRSA is by direct or indirect contact with infected or colonized patients and by contact with the patient’s environment. (especially health care workers' hands) which may become contaminated by contact with a) colonized or infected patients, b) colonized or infected body sites of the personnel themselves, or c) devices, items, or environmental surfaces contaminated with body fluids containing MRSA.

All patients admitted to Children’s Hospital Los Angeles are screened for MRSA on the day of admission.

- Positive screening tests or cultures will result in an automated order for Contact Precautions and an alert will be sent to the Cerner inbox of the attending physician of record
- California State Law SB 1058 requires that patients be notified of MRSA positive results.
- At CHLA patient notification and education is the responsibility of the physician caring for the patient. Educational materials from CDC are available in multiple languages for the physician to provide to the patient and family.
- CHLA Infection Prevention staff will provide an email reminder to the physician of record with links to patient educational materials.
- Patients at high risk for acquisition of MRSA during their stay at CHLA are screened at discharge for MRSA. High risk populations are identified by the Infection Control Committee annually in the IC Risk Assessment and Plan.
  - Currently high risk patient populations are CTICU patients and Patients with a length of stay longer than 7days who are transferred to other hospitals.
- Please reference CHLA IC Policy 318: MRSA Screening for further details.

**VRE**

Enterococci are bacteria that are normally present in the human intestines and in the female genital tract and are often found in the environment. These bacteria can sometimes cause infections. Vancomycin is an antibiotic that is often used to treat infections caused by enterococci. In some cases, enterococci have become resistant to vancomycin and are called vancomycin-resistant enterococci or VRE. Most VRE infections occur in people in hospitals.

VRE is spread via direct or indirect contact with infected or colonized patients and by contact with the patient’s environment. VRE can get onto one’s hands after they have contact with other people with VRE or after contact with contaminated surfaces. VRE can also be spread directly to people after they touch surfaces that are contaminated with VRE. VRE is not usually spread through the air by coughing or sneezing.
**Clostridium difficile or C. Difficile**

*Clostridium difficile* is a bacterium which causes diarrhea and is primarily associated with healthcare settings. The majority of human cases of *C. diff* Infection (CDI) occur in association with inpatient stays in hospitals and long-term care facilities. The majority of cases occur among the elderly, but other people, including children, with other illnesses or conditions that weaken the immune system are at greater risk of acquiring this disease. Antibiotic use to treat other infections is a major risk factor for CDI. These drugs decrease the body’s natural protection against CDI.

The main way *C. difficile* is spread by direct contact with the patient and/or the patient’s stools and by contact with the patient’s environment. People can become infected if they touch items or surfaces that are contaminated with feces and then touch their mouth or mucous membranes. Healthcare workers can spread the bacteria to other patients or contaminate surfaces through hand contact.

*C. difficile* is known to inhabit the gastrointestinal tracts of infants. For this reason *C. Difficile* screening tests should not be ordered in patients under 1 year of age.

Patients who have had *C. Difficile* disease have been known to screen positive for a period of time following resolution of symptoms. For this reason please do not order screening tests following treatment or resolution of symptoms. At CHLA patients with *C. Difficile* disease may be de-isolated 48 hours after resolution of the watery diarrhea. No additional laboratory testing is required for de-isolation as long as symptoms have resolved and the appropriate time period has passed. Prolonged shedding of *C. difficile* following infection in cancer patients has been well documented. For this reason oncology patients who develop *C. difficile* disease shall remain isolated for the length of that admission even if symptoms resolve during the admission.

**Bloodborne Pathogen Exposure**

The following body fluids, tissues and substances are potential sources of HIV, Hepatitis B and Hepatitis C exposure and should be taken into consideration in the post-exposure assessment:

- blood or blood containing body fluids, tissues or substances visibly contaminated with blood;
- amniotic, cerebrospinal, pericardial, peritoneal, pleural or synovial fluids;
- inflammatory exudates;
- semen and vaginal secretions;
- human milk (at CHLA);
- Viral cultures, regardless of the age of the specimen.

Principal Routes. The principal routes of exposure to substances that carry a potential risk of HIV transmission are:

- percutaneous injuries (i.e.: skin puncture from contaminated needle or laceration from contaminated sharp objects);
- exposure of mucous membranes;
- Exposure of non-intact skin.

All bloodborne pathogen exposures must be reported and exposed staff must be offered medical evaluation.

- HCWs sustaining an exposure should immediately flush the exposed area copiously with water (sterile water or saline may be used for eye exposure), removing any foreign material embedded in the wound if present and washing the wound thoroughly with soap and running water (betadine may be used).
- When EHS is closed, exposed HCWs should report the incident IMMEDIATELY to the house supervisor/designee (pager 236) and complete both CHLA #45-1540 “Report of Employee &
Volunteer Accident/Injury" form to document the exposure and the "Employee Exposure" questionnaire. (refer to Appendix A of this policy). Every effort should be made to evaluate high-risk exposures within an hour of the incident.

- On weekdays, when EHS is open, refer to Appendix B of this policy for "CHLA Blood/Body Fluid Exposure when EHS is Open".
- The exposure evaluation by EHS will include a review of hepatitis B vaccine status, serologic testing and prophylaxis if indicated.

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Related Policies for Review:

IC 212: Hand Hygiene
IC 220: Standard Precautions
IC 301: Transmission Based Precautions
IC 317: Clostridium Difficile- Preventing Transmission
IC 318: MRSA Screening and Surveillance
IC 716: Cleaning and Disinfection
IC 601: Management of Blood Borne Pathogen Exposure
IC 602: Employee Exposures
IC 800: Aerosol Transmissible Disease Exposure Control Plan
IC 825: Multidrug Resistant Organisms (MDRO) Preventing Transmission (MRSA, VRE, ESBL, GNB)

MHR 62.0: Influenza Vaccination

References:


PURPOSE:

1) To protect patients, staff, employees, family members, and the community from influenza infection through annual immunization of all personnel subject to this policy.

2) To comply with California Department of Public Health mandates concerning influenza vaccination.

PROCEDURE:

Immunization

1. This policy applies to the following personnel (regardless of their employer) who work for any portion of a day at any location in which CHLA is responsible for the care of and provides services to patients including, but not limited to hospitals, outpatient clinics, home health, student and employee health centers, dental clinics, and pharmacies:

   all faculty, CHLA employees, volunteers, licensed health care professionals, medical staff members, residents, fellows, researchers, medical students, nursing students, nurse practitioner/physician assistant students, pharmacy students, respiratory therapy students, radiation technology students, all other students receiving training at a CHLA health care facility, vendors, representatives or distributors of a manufacturer or company who visit for the purpose of soliciting, marketing, or distributing products or information regarding the use of medications, products, equipment and/or services.

2. All individuals covered by this policy must be vaccinated or granted an exception by November 1st each year. Dates of the influenza vaccination program will be announced by CHLA Employee Health Services acting with the advice of Infection Prevention and Control and the Division of Infectious Diseases.

3. If there is a shortage of vaccine, the Medical Director of Infection Prevention and Control, Infection Prevention and Control, Employee Health Services, and Pharmacy staff will establish a prioritization schedule for personnel. Individuals not applying for an exception who have not received a vaccination because of the shortage will be given a reprieve from disciplinary action for so long as the shortage exists.

4. Influenza vaccine is available free of charge to all personnel identified in Item (1.) above.

5. Any person vaccinated through services other than CHLA Employee Health (for example, by a private physician, public clinic, or pharmacy) must provide adequate proof of immunization to Employee Health.
6. Failure to comply with this immunization policy will result in a written warning. If an individual is not vaccinated or granted an exception within five business days of the warning, they will be subject to further disciplinary action up to and including termination of employment.

Exceptions

1. Exceptions to immunization may be granted by CHLA for medical reasons or religious beliefs. Individuals requesting exemption due to medical reasons must provide a Physician Letter completed by a California licensed physician who has examined them. Medical reasons will be evaluated individually based upon recommendations from the Centers for Disease Control and Prevention. Acceptable medical reasons would include documented adverse reaction to influenza vaccine or documented allergy to a vaccine component. Pregnancy will not be accepted as a medical contraindication. Individuals requesting a religious accommodation must provide a letter from clergy supporting the exception and the request must be consistent with prior vaccination history.

2. Exceptions to immunization on other grounds will be evaluated individually by Employee Health.

3. No exception will be granted unless the individual completes a declination form provided by CHLA. If an exception is granted, it is granted for one year only. The individual must reapply each flu season.

4. An exception will only be granted under the condition that the individual sign a declination and wear a surgical mask throughout the influenza season. Mask use is required for all unvaccinated health care personnel to maintain compliance with the Health Officer order issued by Los Angeles County Department of Public Health (LACDPH) in October 2013. Influenza season is defined in the LACDPH Health Officer order as November 1st through March 31st. The mask must be worn at all times in any geographic location where there might be contact with CHLA patients, families, or other CHLA personnel, which includes, but is not limited to, CHLA shuttles, parking lots, entrances, meeting rooms, bathrooms, the cafeteria, off-site facilities where patient care is delivered, and waiting rooms. This is in addition to strictly adhering to all other respiratory, hand, and other hygiene practices and isolation precautions applicable to CHLA personnel generally. If an unvaccinated individual with an exception fails to comply with the masking policy following a written warning, they are subject to further disciplinary action up to and including termination of employment.

5. In addition to wearing a surgical mask the person’s CHLA identification badge will be marked to allow supervisors and other staff to validate who should be wearing a mask.

Other
CHLA reserves the right to institute other measures in order to prevent or control the spread of influenza.

REFERENCES:
California Health and Safety Code Section 1288.7

REVIEWED BY:
Mary Virgallito, Infection Control and Human Resources
PURPOSE:
To develop user awareness of linen as a supply cost and focus on appropriate utilization in order to decrease linen expense for the organization while promoting patient safety and comfort.

PROCEDURE:
A. Bed linen will be straightened and refreshed daily and as needed. Bed linen changes will occur by item when soiled or a patient and/or family member requests an entire change. Patient and Parent Linen is the BMT unit is changed daily.

The following are examples of recommended linen usage.

1. Standard bed composition
   a. 1 fitted sheet
   b. 1 flat sheet
   c. 1 pillow
   d. 1 pillowcase
   e. 1 thermal spread

2. Pediatric crib composition
   a. 1 fitted sheet

3. Incontinent bed composition
   a. 1 fitted sheet
   b. 1 flat sheet
   c. 1 pillow
   d. 1 pillowcase
   e. 1 thermal spread
   f. 1 incontinent underpad

B. Additional linen will be available as required
   1. Pillow and pillowcase
   2. Bath blanket
   3. Gown/pajamas
   4. Wash cloth
   5. Bath towel

C. Do not layer linen under the patient.

D. Limit excess linen taken into patient rooms. Linen taken into patient rooms is limited to the amount needed for patient care provided in that day only.

   1. Clean linen is not to be stored in bed stands or closets for “just in case”.
   2. Once linen is in the patient room, it cannot be used on another patient and is considered contaminated.
3. When transferring patients to another unit, send all pillows and blankets and any clean linen in the room with the patient instead of putting it in the soiled hamper.

E. Bed should not be changed for patients who are anticipating discharge.

F. If needed, a sheet or bath blanket can be placed on top of the thermal blanket to create the needed insulation. This should be at the request of a patient or his/her family.

G. Isolation Gowns (Yellow Gowns) should be used according to the Infection Control Manual isolation Precautions Policy 304. The following are inappropriate uses for yellow gowns:
   1. As a warm up jacket.
   2. Outside the patient room. Isolation gowns should be removed before leaving the patient room and placed in the contaminated linen bag after a SINGLE use.
   3. For airborne precautions unless splattering is expected or holding a child.

H. All unusable torn and stained clean linen is to be placed in the reject linen hamper to be recycled for other uses. Reject linen hampers (yellow bags) are located next to the laundry cart in each unit.

I. Do not throw any linen in the trash. It is a valuable hospital asset, is costly to replace and can be recycled for other uses.

J. Do not use tape on linen for any purpose. Linen with tape on it gets destroyed in the laundry processes and becomes non-reusable.

K. Soiled linen is to be placed into an appropriate covered hamper and standard precautions are to be maintained.

L. Upon patient discharge or transfer to another facility: No hospital linen (including pajamas) is to go with the patient.

M. A bath blanket may be used when bathing a patient. Please do not use bath blankets as a bottom sheet or as a lift sheet.

N. Pillows, not blankets, should be used to position patients (excluding infants). The individual units will determine storage areas for pillows. Additional pillows can be obtained by contacting the laundry department. Soiled pillows are not to be placed in the linen hampers. Pillows are cleaned by EVS with a disinfectant in the same manner as the mattress so they should remain on the bed.
when a patient is discharged. Bed rails should not be padded with linen or pillows.

O. Reusable incontinent underpads should only be added upon assessment of patient need. They should be used for incontinence or containment of body fluids only.

P. Parent Linen is available upon request by contacting ext. 12236. Please remind parents to reuse the linen that is issued to them. Do not allow parents access to linen carts and cabinets. There is a limited PAR level of Parent Linen Packets available in the linen carts.

Q. Linen is not for employee personal use. Hospital personnel should provide their own attire for warmth and not use hospital linens.

R. The Linen Committee and Vice President Patient Care Services (CNO) at CHLA must approve any hospital/facility specific changes to this linen policy.

REVIEWED BY:
Linen Committee
PURPOSE:

This policy and procedure will provide an overview of immediate steps to be taken when a suspicion arises that a patient is the victim of child abuse. Detailed social work and medical response is provided in The Audrey Hepburn CARES Team (The CARES Team, CARES Team) Policy and Procedure Manual.

DEFINITION:

It is the policy of Childrens Hospital Los Angeles to report all known or suspected cases of child abuse (e.g. inflicted trauma, failure to thrive by reason of neglect/deprivation, child endangering and sexual molestation). Such reporting is mandatory in accordance with Section 11166 et al. of the California Penal Code. Telephone reporting to a Law Enforcement Agency or Child Protective Services agency must be done immediately (or as soon as practically possible) when "reasonable suspicion" of abuse arises. A written report must be forwarded within 36 hours of receiving the information regarding the incident (PC11166a).

Medical and non-medical practitioners (e.g. physicians, nurses, other health professionals) are mandated reporters under the law, and are required to identify and report any known or suspicion of child abuse. Employees hired after January 1, 1985 are asked to sign a statement to the effect that they have been informed of this requirement.

CHLA utilizes a “DESIGNATED REPORTER SYSTEM” to report suspicion for child abuse or neglect. A "DESIGNATED REPORTER SYSTEM" is utilized when more than one mandated reporter has knowledge about suspected child abuse. At CHLA the assigned social worker to the unit or service from the Division of Family-Centered Care Support Services is the "designated reporter" for most of CHLA's inpatient services and clinics.

The Clinical Social Work Department has responsibility, in collaboration with other health providers, in situations of suspected abuse/neglect, to ensure the safety and protection of children. This is done in accordance with applicable state, county & local regulations.

PROCEDURE:

Under the law, any mandated reporter has the obligation to report. However, for purposes of coordination, it is recommended that reporting of suspected child abuse cases be managed by the Clinical Social Work staff. Social workers may become involved through case finding efforts.

If suspicions of abuse or neglect arise, the hospital staff is to immediately contact the social worker, if available,
for evaluation and non-medical management of suspected child abuse or neglect. In most instances, the primary social worker assigned to the patient’s unit or medical service should be contacted. If the primary social worker is not available, please page the duty social worker at 61-1101.

- When no social worker is available (usually from 0200-0800 daily) and a question regarding a case of suspected child abuse arises, the Nursing Supervisor should be notified as soon as possible to contact the After-Hours On-Call social worker. During this time (0200-0800) the Designated Reporter is the attending physician.

The Audrey Hepburn CARES Team Policy and Procedure Manual is available on the Sharepoint Documents Library. This manual details medical and psychosocial management of cases involving suspected child abuse. Please refer to The CARES Team Manual as needed and contact The CARES Team at 14977 with questions.

ATTACHMENTS:
N/A

REFERENCES:

**Hospital and Community Resources**
CHLA Clinical Social Work Office: Extension 12485.
The CARES Team Coordinator: Extension 14977 Beeper (213) 209-1118.
County of Los Angeles Department of Children & Family Services Child Protection Hotline: (800)540-4000.
Los Angeles Police Department Dispatch: (877) 275-5273

AUTHORS:
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