Placentia-Linda Hospital Tenet Health Pacific Coast	**No. PLA HIS 7**
	Page: 1 of 11
Manual: Health Information Services	**Effective Date:** 04/22/2009
Title: PLA HIS 7 Employees Access to Medical Information Non-Patient Care	**Previous Versions:**
	Medical Staff Approval Date:
	Governing Board Approval Date:

I. SCOPE:
This policy applies to all employees with access to any Hospital Clinical Data System and/or Electronic Medical Record system.

II. PURPOSE:
To ensure access to patient information is in accordance with State and Federal HIPAA regulations and Hospital Confidentiality Policies, this includes patient's who are employees of the hospital.

III. POLICY**:**
It is the policy of Placentia Linda Hospital that employee access to medical information for use outside the scope of patient care or hospital related duties requires written authorization from the patient.

IV. PROCEDURE:

1. Identification of Misuse of Hospital Systems

A. HIS Director monitors on a monthly basis employees who access records for patient's with the same or similar last name.

2. Notification to Employee

A. Letter will be sent to employee (attachment A) if it is determined that medical information was accessed outside the scope of their job duties. A copy of the letter will be sent to Human Resources as well as the Department Director..

3. Disciplinary Action

A. If employee continues to access medical information in appropriately, Human Resources and Department Director will be notified to proceed with corrective action as necessary.

Placentia-Linda Hospital Tenet Health Pacific Coast	**No. 105** **Page 1 of 5**
Manual: Medical Staff	**Effective Date: 06/12/2023**
Title: Code of Conduct/ Disruptive Behavior	**Previous Versions:** 01/11,04/15,01/20,12/21 **Medical Staff Approval Date: 05/23/2023** **Governing Board Approval Date: 06/12/2023**

PURPOSE

It is the policy of this hospital that all individuals within the facility be treated with courtesy, dignity and respect. To that end, the Medical Staff requires all Medical Staff and Allied Health Professional Staff practitioners to conduct themselves in a professional and cooperative manner in the hospital. It is expected that all practitioners will conduct themselves in such a way as to promote respect, teamwork and a safe environment for effective communication.

If an employee fails to conduct him or herself in the required manner, the matter shall be addressed in accordance with hospital employment policies. If a practitioner appointed to the Medical or Allied Health Professional Staff fails to conduct himself/herself appropriately, the matter shall be addressed in accordance with the following policy.

POLICY

The Joint Commission Standard, LD.3.10 requires that "Leaders create and maintain a culture of safety and quality throughout the hospital."

The Elements of Performance for LD 3.10 include:

- Leaders create and implement a process for managing disruptive and inappropriate behaviors.
- The hospital/organization has a code of conduct that defines acceptable and disruptive and inappropriate behaviors.

Definition of Behavior Adversely Affecting Patient Care

Such conduct that has the effect of creating a hostile, intimidating or offensive work environment, undermines morale and creates turnover among staff, leads healthcare workers to avoid discussing patient care with the healthcare team for fear of being treated poorly, or otherwise unreasonably interferes with an individual's work performance and interferes or tends to interfere with high quality patient care.

Harassment includes any form of personal abuse or verbal abuse of such significant character and nature that no person of reasonable sensitivity would be expected to tolerate.

Disruptive behavior includes, but is not limited to:

- Threatening, profane or disrespectful language;
- Name calling;
- Sexual comments;
- Racial or ethnic jokes;
- Throwing of objects;
- Degrading comments;
- Threatening behavior that suppresses input from other providers;
- Intimidation, retaliation or harassment of persons who report or witnessed disruptive behavior.

I. Inquiry Into Reports of Disruptive Conduct

1. While it is not mandatory to have a written account of an incident, documentation of disruptive conduct is critical and encouraged as it is ordinarily not one incident that justifies action, but rather a pattern of conduct. Whenever possible, that documentation shall include:

   A. the date and time of the questionable behavior;
   B. if the behavior affected or involved a patient in any way, the name of the patient;
   C. the circumstances which precipitated the situation;
   D. a description of the questionable behavior limited to factual, objective language as much as possible;
   E. the consequences, if any of the disruptive behavior as it relates to patient care or hospital operations; and
   F. record of any action taken to remedy the situation including date, time, place, action and names(s) of those intervening.

2. The report/complaint shall be submitted the Chief of Staff or his/her designee for appropriate action. All reports determined to be significant shall be reported to the Chief Executive Officer (CEO) by the Chief of Staff or designee. Appropriate action may include:

   A. Trending;
   B. Referral to the appropriate Department Chair;
   C. Ad Hoc Committee for action

   In all cases, the physician/practitioner will be made aware of all incidents/complaints.

3. An inquiry may be made into the incident by an Ad Hoc Committee (Ad Hoc) of the Medical Executive/Quality Improvement Committee (MEC). Membership of this Ad Hoc will comprise at minimum the Chief of Staff, the Immediate Past Chief of Staff, and the Department Chair.

   For those reports that appear to have merit and warrant a discussion with the practitioner, the Ad Hoc shall initiate that discussion and afford the practitioner an opportunity to respond to the allegation(s). The practitioner may be provided with a summary of any allegations but may not see the original complaint(s) in order to protect the individual(s) filing the complaint and shall not be provided the name of the person filing the complaint. The practitioner shall be reminded that the Medical Staff prohibits retaliation, harassment or intimidation of those who the practitioner believes may have filed the complaint or witnessed the reported behavior. This meeting and all meetings of this type will be documented and filed in the practitioner's peer review file. The outcome of this meeting(s) will be reported to the MEC.

4. If such behavior continues, the Ad Hoc shall meet with the practitioner again to ascertain the circumstances and if warranted, again educate the practitioner that this conduct in unacceptable and must cease. It shall be followed with a letter memorializing the conversation.

5. Each incident will be addressed individually. However, if it appears that a pattern of disruptive behavior has developed, the Ad Hoc will determine what further actions may be warranted (e.g. either disciplinary action or referral to the Medical Staff Advisory Committee for evaluation).

6. The practitioner in question shall be given notice of any compulsory meeting(s). Failure to attend the meeting without good cause shall result in temporary suspension of privileges until such time has the practitioner meets with the committee, unless the Ad Hoc Chair determines it the practitioner provided good cause to be excused for failing to attend.

7. If, as a result of the inquiry into any incident, there is reason to believe the practitioner may be physically or mentally impaired, the matter shall automatically be referred to the Medical Staff Advisory Committee for evaluation.

8. All witness statements and inquiry documents shall be maintained as confidential peer review documents, and therefore not subject to discovery.

II. Reporting Patient's Written Allegation of Sexual Misconduct

If the Medical Staff receives a written allegation from a patient or a patient's representative that alleges sexual abuse or sexual misconduct by a member of the Medical or Allied Health Professional Staff, or a licensee with privileges to practice or provide care for patients, an 805.8 report must be filed with the applicable California licensing agency (e.g. Medical Board of California) within 15 days after receiving the written allegation. Sexual misconduct means inappropriate contact or communication of a sexual nature. The report must be

filed even if the Medical Staff has not completed its review or has determined during the 15-day time frame that the allegation is unsubstantiated or not credible.

Placentia-Linda Hospital Tenet Health Pacific Coast	**No. AD 1.27**
	Page 1 of 6
Manual: Administrative Policy	**Effective Date:** 12/21/2023
Title: Controlled Substance Diversion Prevention and Detection	**Previous Versions:** 06/13/2017, 10/30/19,08/2021,4/11/2022
	Medical Staff Approval Date: 11/28/2023
	Governing Board Approval Date: 12/21/2023

1) SCOPE:

This policy applies to (1) Tenet Healthcare Corporation and its wholly-owned subsidiaries and affiliates (each, an "Affiliate"); (2) any other entity or organization in which Tenet Healthcare Corporation or an Affiliate owns a direct or indirect equity interest greater than 50%, and (3) any hospital or entity in which an Affiliate either manages or controls the day-to-day operations of the entity (each, a "Tenet Entity") (collectively, "Tenet").

2) PURPOSE:

The purpose of this policy is to establish controls for Controlled Substance security and monitoring to prevent and detect Diversion.

3) DEFINITIONS:

A. "**Automated Dispensing Machine**" means a mechanical system that performs operations or activities relative to the secure storage and distribution of medications for administration and which collects, controls and maintains all transaction information (e.g., Pyxis or Omnicell).

B. "**Authorized Personnel**" means a person approved or assigned to perform a specific type of duty or duties.

C. "**Controlled Substance**" means drugs and or other substances that are considered Schedule II through Schedule V Controlled Substances under the Controlled Substances Act or State Regulation, including propofol or any other item deemed necessary by the Tenet Entity.

D. "**Discrepancy**" means the inventory count of a Controlled Substance is incorrect.

E. "**Directly Supervised**" means under supervision of a licensed pharmacist who is on the premises at all times while tasks are being performed; who is fully aware of all delegated tasks being performed; and who is readily available to provide assistance and direction throughout the time the delegated tasks are being performed.

F. "**Diversion**" means the illegal distribution or abuse of prescription drugs or their use for purposes not intended by the prescriber. This may include deflection of prescription drugs from medical sources into the illegal market.

G. "**Non-retrievable**" means the process utilized to permanently alter the substance's physical or chemical condition or state through irreversible means and thereby render the substance unavailable and unusable for all practical purposes. A substance is considered "Non-retrievable" when it cannot be transformed to a physical or chemical condition or state as a Controlled Substance or Controlled Substance analogue. If the Controlled Substance is a patch, the patch should be cut prior to being placed into containers that render the Controlled Substance "Non-retrievable."

H. Regarding "**Significant Loss**," there is no single objective standard that can be established and applied to all DEA registrants to determine whether a loss is significant. Any unexplained loss or Discrepancy should be reviewed within the context of a registrant's business activity and environment. When in doubt, registrants should consult Tenet Regulatory Counsel for determination.

4) POLICY:

In order to detect intentional or unintentional breach of procedure in the management of Controlled Substances, each Tenet Entity procuring Controlled Substances shall establish processes for Controlled Substance procurement, inventory, storage, access, wastage and monitoring to prevent and detect Diversion.

5) PROCEDURE:

a) Controlled Substance Procurement and Inventory

i) Each Tenet Entity procuring Controlled Substances shall have and maintain an inventory system that assures accuracy of all Controlled Substances.

ii) The individual who performs the ordering of Controlled Substances must not be the same as the individual who receives the Controlled Substances, unless mitigating circumstances prevent this from occurring

iii) Unused DEA 222 forms must be kept secured and separate from all other records

iv) All Controlled Substances procured (e.g., wholesaler, manufacturer, borrowed) shall be delivered directly to the Pharmacy Department and/or received by Authorized Personnel.

v)

b) Controlled Substance Storage and Access

i) Automated Dispensing Machine

(1) Only Tenet Entity pharmacy or IT Authorized Personnel shall have access to the Automated Dispensing Machine system server. Only the Director of Pharmacy or Tenet Entity Pharmacy Authorized Personnel may have access to create users or reset passwords. Only the Director of Pharmacy, Nurse Manager/Supervisor or pharmacy Authorized Personnel shall have the ability to create temporary users at the cabinet. Temporary usernames shall remain active for no more than 24 hours.

2. If users with Automated Dispensing Machine access have changes in employment/contract status or Tenet Entity privileges which would preclude them from having access to medications, the user's access shall be promptly deactivated by notifying the Director of Pharmacy or Tenet Entity Pharmacy Authorized Personnel or by disabling via the Active Directory authentication process 3. Controlled Substance inventory count Discrepancies should be resolved by the user prior to departure from their scheduled shift. If unable to resolve a Controlled Substance Discrepancy, pharmacy shall be contacted to assist with an in-depth analysis. .

4. Each Tenet Entity shall maintain a process to review Automated Dispensing Machine overrides for appropriateness, as required by Administrative Policy AD 1.21 Pharmacy Control Processes.

ii) Controlled Substances Stored Outside of Automated Dispensing Machines

(1) Controlled Substances not stored in Automated Dispensing Machines are to be locked in a safe or cabinet of substantial construction stored in a secured area, and the inventory must be fully accounted for Patient-owned Controlled Substances should be sent home with family members or patient representative when possible. Patient-owned Controlled Substances not sent home shall be logged, kept in secure location, and separate from pharmacy inventory. Patient-owned Schedule I Controlled Substances should never be stored in pharmacy

iii) Propofol shall be kept physically secure and only accessible to Authorized Personnel, and waste shall be rendered Non-retrievable. In patient care areas, propofol stock quantities should be limited to only an anticipated amount needed per day. In states where propofol has been classified as a Controlled Substance, the Tenet Entity shall ensure compliance with all state rules and regulations. .

c) Controlled Substance Wastage

i) Any Controlled Substance packaged in an amount larger than the dose being administered (i.e., excess Controlled Substance not administered) must be wasted in a timely manner and prior to the end of each shift. Wastage destruction shall occur with a witness and render the substance Non-retrievable.

ii) Controlled Substance inventory not dispensed or returned with a Reverse Distributor that is destroyed by the Tenet Entity, including in-date and expired Controlled Substances, should be documented on a DEA Form 41. Destruction shall occur with a witness and render the substance Non-retrievable

d) Prescription Pad and Paper Security

i) 1. Prescription pads and paper shall be stored in a secure location and controlled to prevent unauthorized prescribing of prescription medications.

ii) 2. Printers used for electronically printing prescriptions should be secured and inaccessible to unauthorized individuals

e) Controlled Substance Surveillance and Audits

i) Pharmacy and nursing shall conduct reviews of Automated Dispensing Machine Controlled Substance usage reports to identify potential Diversion. The facility Chief Nursing Officer shall be responsible to ensure nursing leaders of clinical areas are conducting reviews.

ii) Anesthesia, epidural, PCA (patient-controlled anesthesia) or other infusions utilizing Controlled Substances shall be audited to ensure ordering, administration and wastage is properly documented

f) Drug Diversion Prevention Committee and Tenet Entity

(1) Each Tenet Entity shall establish a multidisciplinary Drug Diversion Prevention Committee, which is tasked with preventing, monitoring, investigating and responding to incidents of drug Diversion

(2) The Drug Diversion Prevention Committee and/or Authorized Personnel assigned by the Tenet Entity's Chief Executive Officer shall review Controlled Substance trend and usage pattern reports at least quarterly.

(3) The Drug Diversion Prevention Committee and/or Authorized Personnel assigned by the Tenet Entity's chief executive shall promptly investigate all known or suspected Controlled Substance thefts and/or Significant Losses. Confirmed or suspected Diversions, Significant Loss or patterns of loss shall be reported to the Entity's chief executive, Compliance Officer, Human Resources, Tenet Regulatory Counsel, Tenet Vice President of Ancillary Services, Tenet Vice President, Clinical Operations/Chief Nursing Officer and Tenet Director of Controlled Substance Utilization and Diversion Prevention

(a) Discovery of theft, regardless of amount, or Significant Loss shall be reported to the Drug Enforcement Agency (DEA), and to local law enforcement and State regulatory agencies, if required by state law. When circumstances of theft or Significant Loss are immediately known, a DEA Form 106, Report of Theft or Loss of Controlled Substances, shall be completed to detail the circumstances. When details concerning the specific circumstances

surrounding the theft or Significant Loss are unknown at the time of discovery, the DEA should be notified of the theft or Significant Loss and the Tenet Entity should seek Tenet Regulatory Counsel guidance on how to complete the DEA Form 106

(c)California Board of Pharmacy - Any controlled substance loss (significant or not), must be reported to the California Board of Pharmacy **within 14 calendar days from the date of loss for losses due to licensed employee theft** (pursuant to Business and Professions Code, §4104), or **30 calendar days** (pursuant to California Code of Regulations, Title 16, §1715.6**) for any other type of loss.**
To report an impaired licensee, file a complaint with the California State Board of Pharmacy within 14 days of discovery. A copy of the DEA-106 form can be sent to the Board of Pharmacy if one was completed and submitted to the DEA. (You can complete and submit the DEA 106 form on-line to the DEA at https://www.deadiversion.usdoj.gov/webforms/app106Login.jsp
Notifications can be sent to the Board of Pharmacy in one of three ways:
By email to DEA106@dca.ca.gov,
By fax to (916) 574-8614, or
By mail to: 2720 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833

g) Enforcement

All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

6) ATTACHMENT:

CLN.10.05 Pharmacy Control Processes (AD 1.21)

Placentia-Linda Hospital Tenet Health Pacific Coast	**No HR 7** **Page 1 of 2**
Manual: Human Resources	**Effective Date: 10/09/2023**
Title: Legal Posting	**Previous Versions:** 01/93,12/07,10/13,05/20 **Medical Staff Approval Date: 09/26/2023** **Governing Board Approval Date: 10/09/2023**

PURPOSE

To provide Human Resources managers and supervisors with appropriate guidelines regarding obligations to post legally required Human Resources related information.

POLICY

It is the policy of Tenet to comply with all applicable local, state, and federal Human Resources laws requiring the posting of information. Posted information will be place in a conspicuous location for viewing.

GENERAL

Legally required postings typically include federal, state, or local regulatory body information.

Some examples of legal areas having posting requirements include:

- Discrimination laws
- Wrongful termination law
- Privacy law
- Hiring law
- Sexual harassment
- Safety laws
- Compensation and benefit laws
- Labor laws

PROCEDURES

Employees and Supervisors

1. Refer all questions or concerns regarding legally required postings to the Human Resources Department.

Placentia-Linda Hospital Tenet Health Pacific Coast	**No HR 7**
	Page 2 of 2
Manual: Human Resources	**Effective Date: 10/09/2023**
Title: Legal Posting	**Previous Versions:** 01/93,12/07,10/13,05/20
	Medical Staff Approval Date: 09/26/2023
	Governing Board Approval Date: 10/09/2023

Facility Human Resources

1. The Human Resources Department will be responsible for ensuring that the is in compliance with this policy and all applicable employment related laws requiring the display of posters, bulletins, notices, or other materials.

2. All legally required posters, bulletins, or other material shall be prominently displayed in locations designated by the Human Resources Department. If possible, a locked, glass-enclosed bulletin board will be made available for this purpose.

3. A member of the Human Resources Department shall be designated as the person responsible in each facility for determining the legally required postings and for obtaining, posting, documenting, and maintaining, and updating, if necessary, all appropriate posters, bulletins or other material.

Placentia-Linda Hospital Tenet Health Pacific Coast	**No. PLA ADM 30**
	Page: 1 of 4
Manual: Administrative	**Effective Date:** 08/17/2020
Title: PLA ADM 30 Photography, Video, Or Use of Wireless Communication Devices	**Previous Versions: 08/2013**
	Medical Staff Approval Date: 03/24/2020
	Governing Board Approval Date: 04/13/2020

I. Scope: Placentia Linda Hospital

II. Purpose:

A. To establish guidelines for the use of cameras, videos, or wireless communication devices by staff, patients, and visitors.

B. To establish guidelines for photography, videotaping, and audiotaping patients or other individuals using any type of device.

C. To protect patient privacy by limiting the potential for unauthorized disclosure of protected health information.

III. Definitions:

A. Photography: any recording of an individual's likeness including but limited to: cameras, cellphone, or personal wireless devices

B. Audiotaping: the use of any device to record voice or sounds including but not limited to: cellphones, personal wireless devices, or tape recorders.

IV. Policy

A. Photography for Any Purpose: Photography or videography may be stopped or not permitted by any staff member responsible for the care of the patient if it interferes with patient care or treatment. No staff member may photograph any patient, patient's family member or visitor for any purpose not in accordance with this policy.

B. Based on the information currently available, there is no evident risk which would require the need to restrict patients and visitors from using cellular or wireless devices in patient care areas.

V. Procedure

A. Clinical Purposes

1. Generated or maintained as a record of care.

a. Authorization is part of the Condition of Service.

b. Separate consent is not required

c. Photography, videography, and/or audiotaping any care that being rendered to a patient is strictly prohibited, except for furtherance of the patient's medical treatment for the purpose of medical education or quality improvement. No taping of any Patient/Family/Team conference is permitted.

d. Patient photographs, videotapes, and audio tapes obtained by hospital personnel are the property of the hospital and may be shared with other practitioners as deemed appropriate for educational or quality purposes.

e. With appropriate written authorization, patients may receive copies of any

photography or video tapes that are contained in the medical record. Any costs incurred for such reproduction may be charged to the authorized requestor of the record.

f. Use of personal wireless devices for clinical purposes (ie. Looking up medications or treatments) is permitted.

2. Education or Teaching

a. Authorization is part of the Conditions of Service when used as an internal educational tool.
b. Separate authorization must be obtained, and filed in the medical record, if the education or teaching material is being used externally.
c. A new authorization must be obtained, and filed in the medical record each time the purpose for photography changes. This form remains valid unless and until the patient or the patient's authorized representative withdraws or restricts the authorization, except to the extent that we have already used it.

3. Documentation of Abuse or Neglect

a. Photographs taken to document abuse or neglect do not require written authorization from the patient.
b. These photographs may be submitted to the investigating agency but should not be used for other purposes without patient consent.

4. Part of a Research Protocol

a. Photography as part of a research project must be approved by the Institutional Review Board (IRB).
b. Authorization for such photography must be incorporated into the consent form the patient signs to participate in the research project.

B. Non-Clinical Purposes

1. By Patient's Family and Friends

a. Written authorization by the patient is generally not required; however, the patient or the patient's representative may restrict any such activity.
b. Not permitted during any procedure.
c. Will only be allowed inside the patient's room.
d. Every prudent effort will be made to ensure the privacy and confidentiality of other patients, visitors, or medical staff.
e. Photography of staff by patients, families, or visitors is not permitted

f. This includes still photography, videography, social media sources like, but not

limited to, Skype.

2. Media or Law Enforcement

a. Permission to photograph patients may be given to the media and law enforcement agencies under the following conditions:
   i. The patient or patient's representative signs a written authorization form agreeing to the photography AND
   ii. The patient's physician does not feel it would be detrimental to the patient
   iii. Risk Management should be notified of requests for photography by the news media.

3. Publicity or Marketing Activity

a. Written authorization must always be obtained, and filed in the medical record, before using a patient's photograph for any type of publicity or marketing activity.
b. Authorization must be obtained even in the patient is not identified by name.
c. Marketing must be contacted whenever there is a request for photography for marketing purposes.
d. A new authorization must be obtained, and filed in the medical record each time the purpose for photography changes. This form remains valid unless and until the patient or the patient's authorized representative withdraws or restricts the authorization, except to the extent that we have already used it.

4. Staff: for personal use

a. Use of wireless devices or personal cell phones may be used during official breaks provided that such use does not interfere with the work or productivity of others and does not create or contribute to an unsafe work condition.
b. The use of some recording devices without the knowledge and consent of the parties may be a violation of federal and/or state privacy laws and could serve to foster an environment of distrust and adversarial relationships.
c. The use of personal electronic devices is not permitted in proximity to hospital patients or visitors at any time.
d. If there is an emergent reason that such devices must be available the department Director will be notified and the device must be placed on silent/vibrate so as not to disrupt patient care.

e. Employees who violate this policy are subject to progressive discipline, up to

and including termination of employment. In addition, suspension and/or termination may be imposed for a first offense by any employee who uses a recording device without the knowledge and consent of the individual being recorded.

Placentia-Linda Hospital Tenet Health Pacific Coast	**Page:** 1 of 10
	Effective Date: 10/10/2022
Manual: Nursing	**NO: NURS 26**
Title: Skin Integrity/Wound Care	**Previous Versions:** 03/10,10/17,12/19
	Medical Staff Approval Date: 09/27/2022
	Governing Board Approval Date: 10/10/2022

I. Scope: This policy applies to nursing, medical staff and other departments (pharmacy, central supply, physical therapy) involved in the prevention and treatment of patients at risk for/or with actual alteration in skin integrity.

II. Purpose: To provide guidelines for the identification, assessment, prevention, management, and documentation of care of patients at risk for/or with existing alteration in skin integrity.

III. Policy

A. All patients admitted to Placentia-Linda Hospital will be assessed for potential and actual skin breakdown. This assessment will be done and documented in the Adult Admission Assessment by a registered nurse.

B. The Braden Risk Assessment Tool/Scale is used to assess and document patients at risk for skin breakdown. This Scale is to be completed by a registered nurse on admission; and by a licensed nurse every shift, at transfer, and with a change in medical condition. This assessment is to be documented in INET under physical assessment.

C. The Skin Assessment will include but is not limited to: all pressure injuries, burns, bruises, incisions, lacerations, leg/foot wounds, significant scars, skin tears, lesions, rashes, amputations, and diabetic (neuropathic) ulcers. The skin assessment is to include all bony prominences and areas at risk for potential breakdown (heels, buttocks, elbows, ears, ankles, shoulders, knees and under all tubing and devices)

D. Role specific Responsibilities:

1. Unit/Department Director: It is the responsibility of each Unit/Department Director to ensure that any Registered Nurse (RN) receives education and demonstrates annual competency in pressure injury/wound assessment. It is the Unit/Department Director's responsibility to maintain documentation

attesting to staff competency in pressure injury/wound(s) assessment as well as monitoring compliance of staff with this policy.

2. Wound Care Nurse: it is the responsibility of the Wound Care Nurse (WCN) to provide clinical consultation on pressure injury/wound(s) and education to staff, patient and patient's significant others as necessary. It is the responsibility of the WCN to monitor the performance improvement data related to pressure injuries.

3. Primary/Staff RN: it is the responsibility of the RN caring for the patient to perform pressure injury/wound(s) assessment(s) and initiate pressure injury/wound care as follows:
   a. For inpatient units, photograph pressure injury/acute wound(s) upon admission or discovery and then weekly and within 24 hours prior to discharge. Photographs are to be attached to Photographic Wound Documentation Sheet.
   b. Document pressure injury(s)/acute wound(s) each shift per policy.
   c. Initiate nursing protocols for pressure injury/acute wound(s) and Braden Risk scores of 18 or less and initiate appropriate care plan.
   d. Notify the wound care nurse for consultation of any pressure injury/wound(s) staging greater than stage 2 or if pressure injury/wound(s) is unstageable (including deep tissue injuries), venous and arterial, or diabetic wounds. The wound care nurse may be called as needed for wound consultation.
   e. Notify attending physician of any pressure injury/acute wound(s) greater than stage 2, of any pressure injury/wound(s) that is unstageable (including deep tissue injuries), of wound care nurse consult, and of initiation of protocols.
   f. Document continued wound care orders in Depart.

IV. Procedure:

A. Definitions: Pressure injury/acute wound(s) must be uniformly described in order to establish a baseline, to evaluate interventions, to facilitate communication among staff and to ensure accurate assessment of the progress toward healing. The description is as follows:

1. Pressure Injury: Localized damage to the skin, and/or underlying soft tissue, usually over a bony prominence or related to a medical or other device. The injury can present as intact skin, or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, comorbidities and condition of the soft tissue.

2. Stage 1: Intact skin with a localized area of non-blanchable erythema, which may appear differently in ~~in~~ darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these changes may indicate deep tissue pressure injury.

3. Stage 2: Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).

4. Stage3: Full thickness skin loss. Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle,

tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss, this is an unstageable pressure injury.

5. Stage 4: Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an unstageable pressure injury.

6. Unstageable Pressure Injury: Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, and intact without erythema or fluctuance) on an ischemic limb or the heel(s) should not be removed.

7. Deep Tissue Injury: Intact or non-intact skin with localized area of persistent non-blanchable deep red~~,~~ maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions.

8. Medical Device Related Pressure Injury: results from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally conforms to the pattern or shape of the device. The injury should be staged using the staging system.

9. Mucosal Membrane Pressure Injury: found on mucous membranes with a history of a medical device in use at the location of the injury. Due to the anatomy of the tissue, these injuries cannot be staged.

10. PVD/Venous Ulcer: a wound caused by a decrease in blood flow return from the lower extremities to the heart. Common characteristics: brown (hemosiderin) staining, edema, venous dermatitis, irregular borders, shallow, painless, heavy exudate, hyperkeratotic crusts.

11. PVD/Arterial Ulcer: a wound caused by impaired arterial blood flow. Common characteristics: painful, well defined borders, leg/foot cool, diminished pulses.

12. Neuropathic/Diabetic Ulcer: an ulcer often caused by sensory, motor, and autonomic neuropathy.

B. Assessment: Assessment is to be done on admission by a registered nurse and documented in the Adult Admission Assessment. Assessments are also to be done every shift by a Licensed nurse utilizing the Braden Scale and documented in the Adult Shift Assessments and other forms as indicated.

1. Skin assessment will include but not be limited to: all pressure injuries, abrasions, burns, bruises, incisions, lacerations, venous, arterial and diabetic ulcers, scars, skin tears, lesions, rashes, and amputations, the skin assessment is to include all bony prominences, and areas at risk for the development of pressure injury. Special garments, shoes, socks, heel and elbow protectors, orthotic devices, restraints, and protective wear are to be removed for assessment. Specific vulnerable pressure points include the occiput, scapula, elbow, spinous process, sacrum, and heels for the supine patient. For the sitting and side lying patient inspect and assess the ischial tuberosities, trochanter, iliac crest, coccyx and ~~malleolous~~ malleolus.

2. Pressure Injuries are to be assessed for size in cm (length, width, depth, undermining, tunneling), drainage, odor, color of wound, periwound (surrounding skin), pain level, and anatomical location.

3. Assess for immobility. Patients who are confined to bed, wheelchair bound, non ambulatory and need assistance with repositioning should be monitored for pressure injury development.

4. Assess for friction and shearing.

5. Assess for incontinence. Moisture from incontinence causes maceration that contributes to pressure injury development.

6. Assess nutritional status and obtain dietary consult when appropriate

7. Any dressing found at time of admission will be removed and the condition of the tissue covered by the dressing will be assessed and documented as per above.

C. Reassessment:

1. Reassessment of tissue integrity is to occur every shift and with any change in primary RN, and is documented in INET. Also, tissue should be reassessed with each significant change in patient condition and/or following any procedure requiring the patient to remain in one position for a significant period of time. To insure the identification of patients “at risk” for pressure injury development, the Braden Risk Assessment Scale is to be completed every shift.

2. The reassessment of tissue integrity will be completed by the RN.

~~3.~~ Inspection of tissue condition under any dressing:-Removal of dressing will
   a. Occur on admission unless specifically ordered by the physician not to be removed.

b. Follow orders after initial assessment

D. Documentation: Upon discovery of skin/tissue impairment or a pressure injury on admission or during hospitalization, initiate the following:

1. Present on Admission/Intake Assessment Form to be completed by a Registered Nurse with documentation of the skin/tissue integrity problem or the presence of a pressure injury.

2. The Braden Risk Assessment and score will be documented in Cerner on admission and every shift by a licensed nurse. If the score is 18 or less, the patient is at risk for injury or impaired skin integrity. This issue needs to be addressed on the Interdisciplinary Plan of Care.

3. Upon the discovery of a patient with a Braden Score of 18 or less (Mild risk) notify the physician and obtain a physician order for Pressure Injury Prevention and initiate the Placentia-Linda Hospital Skin Integrity Wound Plan in Cerner. Initiate the Interdisciplinary Plan of Care, document on outcome notes every shift for Braden Risk Assessment scores of 18 or below or for any existing pressure injuries.

4. Upon the discovery of a pressure injury, or any other acute wound, initiate Skin Integrity/Wound Plan in Cerner, and the Photographic Wound Documentation Form. Directions are:
    a. One sheet per photo
    b. A full assessment and photo is to be completed on admission or discovery. Information to be included in the photograph is date, medical record number, wound site, measurement guide and initials of person taking photo.
    c. Assess wounds with each dressing change to determine if modifications are needed. Documentation is to be completed by RN in Cerner and includes, but is not limited to, description of the wound. If

decline in wound noted, place new wound care consult. Date any and all pressure injury/wound dressings.

d. Reassessment including measurements, is a complete assessment and includes a photo.

e. A full assessment and photos is to be completed on admission or discovery. Information to be included in the photograph is date, medical record number, wound site, measurement guide and initials of person taking photo. Reassessment is to be done weekly, with any significant change and upon discharge or transfer.

5. Changes in the patient condition may necessitate changes in the plan of care and subsequent intervention/protocols.

6. Wound Documentation: Tissue integrity is to be assessed each shift. Documentation of pressure injury/wound(s) is to be done each shift and as needed in INET: Incision/Wound. One dynamic grouper is to be used per wound and should be completed each shift.

7. I&O/INET:
   a. Hygiene, skincare: Document assessment and care each shift
   b. Skin Integrity: If patient is on prevention protocol for low Braden scores, document turning every 2 hours under ADL's

8. Notification:
   a. Primary care nurse will notify the attending physician of the identified alteration in skin integrity and the nursing protocol initiated. In accordance with nursing policies, nurses and or wound care nurse may initiate protocols
   b. All tissue integrity issues need to be reported through the eSRM reporting system. This includes community acquired as well as hospital-acquired tissue integrity issues.

E. Treatment: For patients identified at risk for skin/integrity problems or for patients with existing or acquired wounds/pressure ~~ulcers,~~ injuries, initiate the following:

1. Consult MD/Wound Care Nurse/Dietician as applicable.

2. For Braden Score 18 or less, notify the physician and obtain physician order for Pressure Ulcer Prevention. General Management Measures include but are not limited to the following interventions depending upon the patients condition and the physician order:
   a. Positioning
   b. Bathing
   c. Evaluating and managing incontinence
   d. Nutrition
   e. Manage Friction and Shear
   f. Support Surfaces/Specialty Bed

3. For patients with existing wounds/pressure ~~sore~~ injury regardless of the Braden Scale Score, initiate the following:
   a. Notify the physician for orders and treatment plan
   b. Topical Care/Wound Cleansing: Healing is optimized and potential for infection is decreased when necrotic tissue, exudate and metabolic waste are removed from the wound.
      1. Cleanse initially with saline and with each dressing change unless otherwise indicated
      2. Use skin barrier protective wipe to protect periwound (surrounding skin) as indicated.
      3. Remove tape/dressings slowly, peel away from anchored skin or pull one corner of tape at angle parallel to skin. Plain tap water can help break the bond with skin, or may use adhesive remover (which has drying effect).

F. Education:

1. Provide education to patient, family and caregivers regarding the causes and risk factors for pressure injury development. Include information regarding assessment, treatment, equipment and expectations of participation in their healthcare.

2. Documentation of education will be noted on the Multidisciplinary Patient/Family Education Record.

Discharge: When the patient is discharged, the nurse and case manager will be jointly responsible for written instructions and communication with the next caregiver (nursing home, home health agency, family member).

1. Nursing Homes/SNFs will receive the state mandated Discharge Planning Patient Transfer Record which will be completed by nursing, case management and physician as applicable. The nurse and case manager will be responsible to supply applicable wound care protocols and care pathways to the receiving facility.

2. Family members and significant others assuming or sharing care responsibilities for the patient at discharge will be educated regarding physician orders for wound care, protocols to be continued at home and a physician orders for wound care, protocols to be continued at home and a referral number to call for any questions regarding wound care. Education will be documented on the Multidisciplinary Patient/Family Education Record.

Placentia-Linda Hospital Tenet Health Pacific Coast	**No. PLA HIS 16**
	Page: 1 of 5
Manual: Administrative	**Effective Date:** 12/22/2016
Title: PLA HIS 16 Unauthorized or Unlawful Access to Use or Disclosure Policy	**Previous Versions: 10/13**
	Medical Staff Approval Date: 11/22/2016
	Governing Board Approval Date: 12/22/2016

I. PURPOSE:

The purpose of this policy is to comply with California Senate Bill 541 (SB 541) and California Assembly Bill 211 (AB 211). These laws were approved by the California governor on September 30, 2008 and took effect January 1, 2009. In addition, this policy is to comply with California Assembly Bill 1755 (AB 1755), which was approved by the California governor on September 18, 2014, and took effect January 1, 2015. The statutes amend and augment sections of the California Health and Safety Code, Confidentiality of Medical Information Act, California Civil Code Sections 56-56.16, and the Federal Health Insurance Portability and Accountability Act (HIPAA).

SB 541 imposes specific reporting requirements on health facilities with respect to unlawful or unauthorized access to, or use or disclosure of, a California resident and patient's medical information; and authorizes penalties.

AB 211 requires every provider of health care in California to implement appropriate specified safeguards to protect the privacy of patient's medical information; and establishes within the California Health and Human Services Agency the Office of Health Information Integrity to assess and impose administrative fines for violations.

AB 1755 amends specific reporting requirements, delays, and methods of reporting for health facilities upon discovery of any unlawful or unauthorized access to, or use or disclosure of, a California resident and patient's medical information; and authorizes penalties.

II. DEFINITIONS:

A. "**CPL**" is a compliance issue that is entered and tracked in Compliance Central.

B. "**Compliance Central**" is the Tenet system utilized to log reported allegations or issues and document the investigation and the resolution.

C. "**HIPAA Breach Risk Assessment**" means the tool/process used to determine whether or not the HIPAA violation compromises the security or privacy of the protected health information.

D. "**Medical Information**" means any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care or contractor regarding a patient's medical history, mental or physical condition, or treatment.

E. "**Individually Identifiable**" means that the medical information includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the patient's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the individual's identity.

F. "**Patient**" means any natural person, whether or not still living, who received health care services from a provider of health care and to whom medical information pertains.

G. "**PIRT**" is the Privacy Incident Response Team at each facility that responds to alleged information privacy and security incidents through investigation and resolution.

H. "**Privacy Officer**" refers to the Regional Privacy Officer or Market Privacy Officer of the Tenet Healthcare Facility.

III. POLICY:

Facility will notify the California Department of Public Health and the affected patient(s) of any unlawful or unauthorized access, use or disclosure of patient medical information within fifteen (15) business days of discovery.

IV. PROCEDURE:

A. Facility Workforce Reporting Obligations

All unlawful or unauthorized access, use or disclosure of patients' medical information shall be reported **immediately** upon discovery.

1. All individuals are expected to report potential unlawful or unauthorized access, use or disclosure of patients' medical information immediately upon discovery or notification of the same to the Facility Privacy Incident Response Team (PIRT).

2. Any attempt to interfere with, prevent, obstruct, or dissuade an employee in their efforts to report a suspected violation is strictly prohibited and cause for disciplinary action, up to and including termination and possible prosecution to the fullest extent of the law. Any form of retaliation against an individual reporting or investigating information security problems or violations is also prohibited.

B. Investigation and Determination

1. The PIRT, Privacy Officer, Hospital Compliance Officer, Information Security Officer may receive reports, complaints, allegations, incidents and/or referrals of privacy violations.

2. Within fifteen (15) business days of discovery the PIRT, in coordination with the Privacy Officer will:

   a. Document the incident and Investigation in a CPL using Compliance Central.

   b. Evaluate the incident to determine evidence of any unlawful or unauthorized access, use or disclosure of patient medical information.

   c. Complete a HIPAA Breach Risk Assessment to determine if the violation triggers the Federal Breach Notification Rule and if yes, the PIRT will implement HIPAA Privacy Breach Procedure.

   d. Determine if the violation poses a potential for identity theft in accordance with California Senate Bill 1386 and if yes, the Compliance Officer will implement the Identity Theft Procedure.

e. Determine if the alleged privacy violation meets the state and patient notification requirement by determining if the information disclosed meets the definition of "medical information" and "individually identifiable" under the Confidentiality of Medical Information Act, California Civil Code Sections 56-56.16.

C. Notification

1. If the Privacy Officer determines there was unlawful or unauthorized access, use or disclosure of a patient's individually identifiable medical information, the PIRT, under the direction of the Privacy Officer, will:

   a. Notify the affected patient(s) by first class mail within fifteen (15) business days of discovery of the privacy incident (AB 1755); and

   b. Notify the California Department of Public Health by fax and first class mail within fifteen (15) business days of discovery of the privacy incident (AB 1755).

D. Documentation Requirements

1. It is the facility's burden to prove that all required notifications under this policy have been made. To that end, the PIRT, in coordination with the Privacy Officer, must thoroughly and timely document the incident in Compliance Central:

   a. the investigation of the incident;

   b. any and all steps taken to mitigate further disclosure;

   c. any required notification to federal or state agencies, and to patient(s);

   d. any and all analysis and steps taken to make the determination; any and all policy or process changes as a result of the privacy incident; and

   e. any appropriate employee disciplinary action and remedial training.

E. Responsible Person

The PIRT, Privacy Officer, Facility Compliance Committee and Facility Management will be responsible for ensuring that all individuals adhere to the requirements of this policy.

F. Enforcement

All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

V. REFERENCES:

- California Senate Bill 541 and California Assembly Bill 211; California Assembly Bill 1755
- Breach Notification for Unsecured Protected Healthy Information; Final Rule
- HIPAA Privacy Breach Procedure
- Identity Theft Procedure

Placentia-Linda Hospital Tenet Health Pacific Coast	**No. HRS.02.07** **Page 1 of 3**
Manual: Human Resources	**Effective Date: 04/11/2023**
Title: Violence in the Workplace	**Previous Versions:** 11/18,09/11,04/10,01/96,01/93 **Medical Staff Approval Date: 05/23/2023** **Governing Board Approval Date: 06/12/2023**

I. Scope:

This policy applies to Tenet Healthcare Corporation and its subsidiaries and affiliates other than Conifer Holdings Inc. and its direct and indirect subsidiaries (each, an "Affiliate"), any other entity or organization in which Tenet or an Affiliate owns a direct or indirect equity interest of greater than 50%, and any entity in which an Affiliate either manages or controls the day-to-day operations of the entity (each, a "Tenet Entity") (collectively, "Tenet").

II. Purpose:

To provide appropriate guidelines for preventing and responding to Workplace Violence.

III. Definitions:

Workplace Violence: Any intentional conduct which is sufficiently severe, offensive, or intimidating to cause an individual to reasonably fear for his or her personal safety or the safety of his or her family, friends and/or property such that employment conditions are altered or a hostile, abusive or intimidating work environment is created.

A. See Workplace Violence Prevention Program in the Security Manual (original 6/2016; annual review)

IV. Policy:

Tenet will not tolerate any acts or threats of physical violence, including intimidation, harassment, and/or coercion. Facilities operated by Tenet Entities (each a "Facility") must be prepared to respond to reports of violence in the workplace by developing and implementing a Workplace Violence prevention program that includes support from appropriate disciplines and functional areas.

V. Procedure:

A. Risk Reduction

1. Facilities will have a Workplace Violence prevention program that includes:
   a. A designated leader,
   b. A process to report incidents to analyze incidents and trends,
   c. A process for follow up and support to victims and witnesses affected by Workplace Violence, including trauma and psychological counseling, if necessary, and

d. Reporting of Workplace Violence incidents to the governing body.

2. Establish a process(es) for continually monitoring, internally reporting, and investigating Workplace Violence.
3. Conduct an annual worksite analysis related to its Workplace Violence prevention program, including a proactive analysis of the worksite to mitigate or resolve Workplace Violence risks based upon the findings. The Workplace Violence prevention program shall also be reviewed and updated whenever necessary as follows:
    a. To reflect new or modified tasks and procedures which may affect how the program is implemented and newly recognized Workplace Violence hazards.
    b. To review and evaluate Workplace Violence incidents which result in a serious injury or fatality.
    c. To review and respond to information indicating that the program is deficient in any area.
4. Take action to mitigate or resolve Workplace Violence risks based upon findings.

B. Notification

Safety and security in the workplace are every employee's responsibility. Employees are expected to:

1. Report any acts or threats of physical violence, including intimidation, harassment, and/or coercion to his/her immediate supervisor, to Security staff, to Human Resources staff, or to administrative staff, as appropriate in the situation.
2. Report all acts or threats of physical violence to governmental agencies as required by law.

C. Training

1. Facilities will provide training, education, and resources to leadership, staff, and licensed practitioners regarding prevention, recognition, response, and reporting of Workplace Violence based on roles and responsibilities at the time of hire, annually, and whenever updates occur to the Workplace Violence prevention program.
2. Training shall address the Workplace Violence risks that employees are reasonably anticipated to encounter in their jobs and should be appropriate in content and vocabulary to the educational level, literacy, and language of employees.

VI. Enforcement:

- All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law. No reprisals will be taken against any employee who reports or experiences workplace violence and/or seeks assistance and intervention from local emergency services or law enforcement following an incident of workplace violence, which is in accordance with Tenet's "No Retaliation" policy HR.ERW.08.

VII. References:

The Joint Commission

VIII. California Addendum

In addition to the requirements outline above, Facilities operating in California must also implement a system to review the effectiveness of the Workplace Violence prevention program for the overall facility at least annually, in conjunction with employees and their representatives regarding the employees' respective work areas, services, and operations. The review shall include evaluation of the following:

A. Staffing,

B. Sufficiency of security systems,

C. Job design, equipment, and facilities, and

D. Security risks associated with specific units, areas of the facility with uncontrolled access, late-night or early morning shifts, and employee security in areas surrounding the facility.

Placentia-Linda Hospital Tenet Health Pacific Coast	**No HR 18**
	Page 1 of 5
Manual: Human Resources	**Effective Date: 10/09/2023**
Title: Dress Code	**Previous Versions:** 08/17,05/20
	Medical Staff Approval Date: 09/26/2023
	Governing Board Approval Date: 10/09/2023

SCOPE

Hospital Wide

PURPOSE

Employees contribute to the feeling and reputation of a company in the way they present themselves. Placentia-Linda Hospital maintains a "professional" dress code which is a notch above a traditional business casual environment. A professional appearance is essential to a favorable impression, not only internally, but externally with our key stakeholders and the communities in which we serve. Therefore, we require professional attire to reflect our pride and inspire confidence. This includes personal appearance and areas of dress, grooming and personal hygiene. Placentia-Linda Hospital recognizes that we have a diverse employee population and respect individuals religions and cultures. Please contact Human Resources for questions or clarifications related to such accommodations that you believe are needed in light of this policy.

RESPONSIBILITY

It is the responsibility of the Department Managers/Directors to disseminate this information and ensure the Dress Code Policy is enforced. All leadership should take an active part in this process by informing the Department Director when they identify an issue.

POLICY

It is the policy of Placentia-Linda Hospital that employees present a clean and neat appearance and dress according to the requirements of their positions through the use of dress, grooming and hygiene. Every employee affects the overall image of the facility in the eyes of patients, peers and the community.

PROCEDURE

When employees are in the hospital working, attending an in-hospital meeting, or representing the hospital outside of the facility, **the following general rules apply**:

1. All employees are required to present a clean and neat appearance and dress according to their positions.

2. Employees~~,~~ who fail to follow personal appearance and hygiene guidelines, will be sent home and directed to return to work in accordance with the Dress Code Policy. Under such circumstances, employees will not be compensated for the time away from work.

3. Placentia-Linda Hospital reserves the right to determine the appropriateness of employee appearance and attire. Continued failure to comply with this policy may result in corrective action.

4. Employees with beards, sideburns and mustaches should make certain the hair is clean, carefully trimmed and neatly shaven.

5. Use of perfume, clothing, jewelry, hairstyle, and cosmetics are expressions of self-image; therefore, employees should utilize good judgment in determining their dress and appearance.

6. Tattoos must be covered.

IDENTIFICATION

Identification badges must be worn above the waist at all times while on duty. Name and picture must be visible on the identification badge. In addition to the Placentia-Linda Hospital name badge, employees are permitted to wear official school or occupation service pins. No other insignia pins or buttons are permitted to be worn.

FRIDAY

Fridays are designated business casual dress day. Placentia-Linda Hospital branded shirts may be worn in lieu of usual & customary uniform or office attire as well as other appropriate business wear.

Some departments may require specific guidelines due to internal/external client, vendor, or community interactions regardless of the noted exceptions listed above.

Working in Clinical Areas:

1. **Clothing**

    a. Apparel should be clean and in good repair.

    b. Apparel is to be clean and either be plain or have detail that promotes a professional atmosphere.

    c. No hoods on any garment. Placentia-Linda Hospital jackets may be worn with uniforms.

    d. Each department director may set standards for uniforms. If applicable and subject to management approval, employees in these departments must wear the prescribed uniforms.

2. **Hair / Facial Hair** - Employees who come in contact with patients should have his/her hair be secured in such a way that does not interfere with patient care. Hair must be clean, combed, and neat.

3. **Perfumes** - Strong odors in general or use of perfumes or cologne in the clinical setting are not allowed.

4. **Shoes**

    a. Shoes are to be safe, clean and well maintained.

    b. Footwear standards will vary according to position. Please refer to the nursing department and/or Infection Control Director for standards related to direct patient care staff.

    c. Appropriate footwear is required not only for appearances, but also for safety reasons. Flip flops and open toed shoes are not allowed. Shoe soles should be in good condition and slip-resistant.

d. Patient care providers shall wear shoes that are well maintained and be suitable for the job being performed, i.e. offers protection from dropped items, no open toes or sandals, and must be of a material and style that is impervious to blood and body fluids.

5. **Jewelry**

a. Watches, wedding/engagement rings or other simple rings, school pins, service pins, small earrings, plain necklaces (with or without small pendant) are allowed.

b. Visible body piercing should be limited to ear while on duty. Body piercing in areas other than ear should be covered or removed.

Working in Non-Clinical Areas:

1. **Clothing**

a. Dress and skirt lengths should be long enough to avoid undue exposure.

b. In order to avoid confusing patients or visitors, white lab coats are to be worn only by clinical personnel.

c. Examples of unacceptable clothing include, but are not limited to: backless, braless, low neck, sheer blouses or dresses.

d. Active sportswear such as shorts, logo t-shirts and sweatshirts are not allowed (except Placentia-Linda Hospital sweatshirts and jackets).

e. No jeans are allowed.

f. Sleeveless tops may be worn but straps must be at least 2 inches in width.

g. No hoods on any garment.

h. No pants that are low-cut and/or expose skin or undergarments. Pants need to look professional (i.e. not baggy, sloppy in appearance).

2. **Hair / Facial Hair**

   a. Hair must be clean, combed, and neat. Must be professional in appearance.

   b. Employees with beards, sideburns and mustaches should make certain the hair is clean, carefully trimmed and neatly shaven.

3. **Perfumes / Makeup** – These should be in good taste. Makeup should be used minimally to represent a professional look. Remember, some colleagues are allergic to the chemicals in perfumes and makeup, so wear these substances with restraint. If anyone has an allergy to cologne/perfume, then these should not be worn in the workplace.

4. **Shoes**

   a. Shoes, boots, flats, open-toed and closed-toed shoes in a leather or dress material are appropriate and should be clean and polished.

   b. Tennis shoes, flip flops, plastic shoes, casual sandals etc. are not a part of professional dress.

5. **Jewelry**

   a. In general, use of jewelry should be professional in appearance.

   b. Visible body piercing should be limited to ear while on duty. Body piercing in areas other than earlobes should be covered or removed.

Placentia-Linda Hospital
Tenet Health Pacific Coast

EXPOSURE TO BLOOD

What Healthcare Personnel Need to Know

OCCUPATIONAL EXPOSURES TO BLOOD

Introduction

Healthcare personnel are at risk for occupational exposure to pathogens, including Hepatitis B virus (HBV), Hepatitis C virus (HCV), and human immunodeficiency virus (HIV). Exposures occur through needle sticks or cuts from other sharp instruments contaminated with an infected patient's blood or through contract of the eye, nose, mouth, or skin with a patient's blood. Important factors that influence the overall risk for occupational exposures to bloodborne pathogens include the number of infected individuals in the patient population and the type and number of blood contacts. Most exposures do not result in infections. Following a specific exposure, the risk of infections may vary with factors such as these:

- The pathogen involved
- The type of exposure
- The amount of blood involved in the exposure
- The amount of virus in the patient's blood at the time of exposure

Your employer should have in place a system for reporting exposures in order to quickly evaluate the risk of infection, inform you about treatments available to help prevent infection, monitor you for side effects of treatments, and determine if infections occurs. This may involve testing your blood and that of the source patient and offering appropriate post-exposure treatment.

How can occupational exposures be prevented?

Many needle sticks and other cuts can be prevented by using safer techniques (for example, not recapping needles by hand), disposing of used needles in appropriate sharps disposal containers, and using medical devices with safety features designed to prevent injuries. Using appropriate barriers such as gloves, eye and face protections, or gowns when contact with blood is expected can prevent many exposures to the eyes, nose, mouth, or skin.

Placentia-Linda Hospital
Tenet Health Pacific Coast

IF AN EXPOSURE OCCURS

What should I do if I am exposed to the blood of a patient?

1. Immediately following an exposure to blood:

    - Wash needle sticks and cuts with soap and water;
    - Flush splashes to the nose, mouth or skin with water;
    - Irrigate eyes with clean water, saline or sterile solutions.

No scientific evidence shows that using antiseptics or squeezing the wound will reduce the risk of transmission of a blood pathogen. Using a caustic agent such as bleach is not recommended.

2. Report the exposure to the First Responder/Employee Health or Nursing Supervisor. Prompt reporting is essential because, in some cases, post-exposure treatment may be recommended and it should be started as soon as possible. Discuss the possible risk of acquiring HBV, HCV, and HIV, and the need for post-exposure treatment with the provider managing your exposure. You should have already received Hepatitis B vaccine (HBV); which is extremely effective in preventing HBV infection.

RISK OF INFECTION AFTER EXPOSURE

What is the risk of infection after an occupational exposure?

HBV

Healthcare personnel who have received Hepatitis B vaccine and developed immunity to the virus are virtually no risk for infection. For a susceptible person, the risk from single needle stick or cut exposure to HBV infected blood ranges from 6-30% and depends on the Hepatitis B antigen (HbeAg) status of source individual. Hepatitis B surface antigen (HVsAg) positive individuals who are HbeAg positive have more virus in their blood and are more likely to transmit HBV than those who are HbeAg negative.

While there is a risk for HBV infection from exposures of mucous membranes or non-intact skin, there is no known risk for HBV infection from exposure to intact skin.

HCV

The average risk for infection after a needle stick or cut exposure to HCV infected blood is approximately 1.8%. The risk following a blood exposure to the eye, nose, or mouth is unknown, but is believed to be very small. However, HCV infection from blood splash to the eye has been reported. There also has been a report of HCV transmission that may have resulted from exposure to non-intact skin, but no known risk from exposure to intact skin.

HIV

The average risk of HIV infection after a needle stick or cut exposure to HIV infected blood is 0.3% (i.e., three-tenths of one percent, or about 1 in 300). Stated another way, 99.7% of needle stick/cut exposure do not lead to infection. The risk after exposure of the eye, nose or mouth, to HIV infected blood is estimated to be, on average, 0.1% (1 in 1,000). The risk after exposure of non-intact skin to HIV infected blood is estimated to be less than 0.1%. A small amount of blood on intact skin probably poses no risk at all. There have been no documented cases of HIV transmission due to an exposure involving a small amount of blood on intact skin (a few drops of blood on skin for a short period of time).

How many healthcare personnel have been infected with bloodborne pathogens?

HBV

The annual number of occupational infections has decreased 95% since Hepatitis B vaccine became available in 1982, from >10,000 in 1983 to <400 in 20001 (CDC, unpublished data).

HCV

There are no exact estimates on the number of healthcare personnel occupationally infected with HCV. However, studies have shown that 1% of hospital healthcare personnel have evidence of HCV infection (about 3% of the U.S. population has evidence of infection). The number of those workers who may have been infected through an occupational exposure is unknown.

HIV

As of December 2001, CDC has received reports of 57 documented cases and 138 possible cases of occupationally acquired HIV infection among healthcare personnel in the United States since reporting began in 1985.

TREATMENT FOR THE EXPOSURE

Is a vaccine or treatment available to prevent infections with bloodborne pathogens?

HBV

As mentioned above, Hepatitis B vaccine has been available since 1982 to prevent HBV infection. All healthcare personnel who have a reasonable chance of exposure to blood or bodily fluids should receive Hepatitis B Vaccine. Vaccination ideally should occur during the healthcare worker's training period. Workers should be tested 1-2months after the vaccine series is complete to make sure that vaccination has provided immunity to the HPV infection after exposure. The decision to begin treatment is based on several factors, such as:

- Whether the source individual is positive for Hepatitis B Surface Antigen;
- Whether you have been vaccinated;
- whether the vaccine provided you immunity

HCV

There is no vaccine against Hepatitis C and no treatment after exposure that will prevent infection. Neither immune globulin nor antiviral therapy is recommended after exposure. For these reason, following recommended infection control practices to prevent percutaneous injuries is imperative.

HIV

There is no vaccine against HIV. However, results from a small number of studies suggest that the use of some antiretroviral drugs after certain occupational exposures may reduce the chance of HIV transmission. Post-exposure prophylaxis (PEP) is recommended for certain occupational exposures that pose a risk of transmission. However, for those exposures without risk of HIV infection, PEP is not recommended because the drugs used to prevent infection may have serious side effects. You should discuss the risks and side effect with your healthcare provider before starting PEP for HIV.

How are exposures to blood from an individual whose infection status is unknown handled?

HBV-HCV-HIV

If the source individual cannot be identified or tested, decisions regarding follow-up should be based on the exposure risk and whether the source is likely to be infected with a bloodborne pathogen. Follow-up testing should be available to all personnel who are concerned about possible infection through occupational exposure.***What specific drugs are recommended for post exposure treatment?***

HBV

If you have not been vaccinated, the Hepatitis B vaccination is recommended for any exposure regardless of the source of the person's HBV status. HBIG and/or Hepatitis B vaccine may be recommended depending on the source person's infection status, your vaccination status and, if vaccinated, your response to the vaccine.

HCV

There is no post-exposure treatment that will prevent HCV infection.

HIV

The Public Health Service recommends a 4-week course of a combination of either two antiretroviral drugs for most HIV exposures, or three antiretroviral drugs for exposures that may pose a greater risk for transmitting HIV

(such as those involving a larger volume of blood with a larger amount of HIV or a concern about drug resistant HIV). Differences in side effects associated with these drugs may influence which drugs are selected in a specific solution. These recommendations are intended to provide guidance to clinicians and may be modified on a case-by-case basis. Determining which drugs and how many drugs to use or when to change a treatment regimen is largely a matter of judgement. Whenever possible, consulting an expert with experiences in the use of antiviral drugs is advised, especially if a recommended drug is not available, if the sources patients' virus is likely to be resistant to one or more recommended drugs, or if the drugs poorly tolerated.

How soon after exposure to a bloodborne pathogen should treatment begin?

HBV

Post-exposure treatment should begin as soon as possible after exposure, preferably within 24hours, and no later than7days.

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Tuberculosis

How much do you know about Tuberculosis (TB), how it is transmitted, and how it can be controlled?

The following questions and answers are presented to give you better understanding of the disease, how it is transmitted, and how it can be controlled (particularly in the healthcare or dormitory setting).

TB: The Disease

Q: What exactly is Tuberculosis?

A: Tuberculosis is an infectious disease caused by the bacteria mycobacterium tuberculosis. It is characterized by the formation of tubercles (node-like lesions) which are elevated, round structures and cause generalized tissue damage, particularly in the lungs. The disease commonly affects the respiratory system but may also involve other organs.

Q: Does everyone who becomes infected with TB become sick?

A: No. Only an average of 1 in 10 infected people develop the disease in some time in their life.

Q: Who is most likely to contract TB?

A: Persons with HIV infections, those with close contacts of infectious TB cases, persons with medical conditions which increase the risk of TB, foreign-born individuals from high prevalence countries, low-income populations (including high-risk minorities), the homeless, alcoholics and intravenous drug users, prison inmates, and residents of long-term care facilities.

Q: What are the symptoms of TB?

A: Prolonged cough, fever, chills, night sweats, easy fatigability, loss of appetite, weight loss, and hemoptysis (coughing blood).

Q: Are some infected people more likely to progress to clinically active disease than others?

A: Yes. Persons who are infected with tubercle bacillus and are immune-suppressed (e.g., those with coexisting HIV infection) are at a considerably greater risk of developing clinically active disease.

Q: After being infected with TB bacteria, when is the greatest risk of it being progressing to clinically active disease?

A: Within the first year of contracting the infection (although disease may still occur many years later since it remains in the body in a dormant state).

Q: What happens when someone tests positive for clinically active TB disease?

A: Patients who are suspected or confirmed to have active TB are placed in isolation until they have negative AFB test results. These patients are treated with antibodies for 6-12months.

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TB: THE DISEASE

Q: What tests can be done to screen for TB?

A: Tuberculin skin test, chest radiography, and sputum smears test for AFB are all recognized procedures for diagnosing TB.

Q: Are these tests always accurate?

A: No. Among persons with HIB infection, the difficulty in making a diagnosis may be further compounded by impaired responses to tuberculin tests, low sensitivity of sputum smears for detecting AFB, or growth of cultures with mycobacterium avium complex (MAC among patients with both MAC and mycobacterium tuberculosis infections).

Q: What is the size of TB bacteria?

A: The average TB particle is a rod shaped particle that is 0.3-0.6 microns wide by a length of 1-4 microns.

Q: What is drug resistant TB?

A: Various strains of TB are resistant to the effects of the medications normally used to combat the progression of TB. Recently, multi-drug resistant (MDR) strains have also surfaced.

Q: How do drug resistant strains of TB occur?

A: Some occur naturally while others occur when patients stop their treatment program before the medication has its full effect on the bacteria.

Q: What is a droplet nuclei?

A: A droplet nuclei is the term used to describe the liquid particle in which the TB bacteria are usually carried. The droplet nuclei ranges in size from 1-5microns and is expelled from the body by coughing, sneezing, speaking, etc.

TB: TRANSMISSION OF THE DISEASE

Q: How is Tuberculosis spread?

A: Tuberculosis is usually spread when someone inhales in the airborne TB bacteria which are normally carried on droplet nuclei. The bacteria, because of its small size, is able to avoid most of the body's defense mechanisms and reaches the lower respiratory tract lodging in the alveoli of the lung.

Q: Where are outbreaks of TB presently occurring?

A: The spread of TB is now considered to be at an epidemic stage throughout many areas of the United States with certain regions experiencing a 30+% increase in active cases per year. The Center for Disease Control (CDC) reports that outbreaks of TB are occurring in health care facilities, shelters for the homeless, drug treatment facilities, and especially prisons.

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Q: Who may be at risk of becoming infected with TB?

A: Doctors, Nurses, Radiologists, Home Health Aids, Prison Guards, etc. In addition, those who are immunocompromised have a greater risk of developing the clinically active disease.

Q: Is there concern for transmission of TB once the bacteria come in contact with a surface?

A: That probability depends upon the concentration of infectious droplet nuclei in the air and the amount of time spent in the contaminated environment.

Q: How long can TB bacteria remain airborne?

A: Because of its small size, the bacteria is virtually weightless and can remain suspended in air almost indefinitely. Due to this characteristic, it is able to be carried by normal air currents throughout the room or facility.

Q: How much risk is a person in a healthcare facility?

A: Many factors vary that risk. Some considerations are the population served, job category, and where within the facility the worker functions as well as the amount of time spent with TB patients.

Q: Is there a greater risk in some areas than others?

A: There may be a higher risk where patients with TB are provided care before any positive diagnosis for TB takes place. This would include such areas as waiting areas and emergency rooms. Other areas of risk would be any place where an active TB patient spends time or received treatment.

Q: What are the responsibilities of the employee regarding minimizing TB exposures?

A: The employer will implement work practice controls and provide personal protective equipment to the employee to help prevent TB transmission from occurring. These will include: atmospheric isolation (negative pressure) and providing HEPA filter masks to the employees.

Q: How do these controls work?

A: Negative pressure isolation rooms remove the contaminated air of droplet nuclei of an infectious TB patient to the outside through HEPA filtration exhaust system. The HEPA filter masks filter out the droplet nuclei that may be in the air and thereby preventing the HCW from breathing it in.

TB: CONTROLLING ITS SPREAD BY USING NEGATIVE PRESSURE

Q: I've neem told that a negative pressure room helps to control TB bacteria. What constitutes a negative pressure room?

A: A room is said to be under negative pressure when more air is exhausted from the room than is being supplied to it.

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Q: How does this help control TB contaminants?

A: Direction of air flow is determines by the difference in air pressure between adjacent areas, with air flowing from high pressure areas to low pressure areas. If a TB patient's room is under lower (or negative) pressure to adjoining areas, contaminated air could not flow to the uncontaminated adjoining areas.

Q: Is it easy to maintain negative pressure in a room?

A: Proper air flow and pressure differentials between areas of a health care facility are difficult to control because of open doors, movement of patients and staff, temperature, and the effect of vertical openings. Air pressure differentials can best be maintained to completely closed rooms. An open door between two areas may reduce any existing pressure differentials and could reduce or eliminate the desired effect.

Q: Does a room under negative pressure protect those providing care within the contaminated room?

A: This depends on the volume of air being exhausted from the room and the frequency at which it is removed. The only protection provided to those within the room is contaminant removal by exhaust.

TB: CONTROLLED THE SPREAD REMOVAL BY HEPA FILTRATION

Q: What type of filter should be used to remove Tuberculosis bacteria from the air?

A: The Centers for Disease Control (CDC) recommends that HEPA filters be utilized to help reduce the amount of TB bacteria in the air.

Q: What is a HEPA filter?

A: A true certified HEPA filter is one which, when tested, maintains a minimum of 99.97% efficiency on particles 0.3microns in size when challenged with thermally generated DOP according to Federal Standard 209D or latest issue.

Q: If the rod shaped bacteria enters the filter "width wise" isn't it possible for bacteria to pass through the filter?

A: It would be highly unlikely for this to happen. HEPA filters depend on a captured mechanism known as diffusion in order to capture sub-micron size particles. Particles which are less than one micron in size collide with air molecules which cause them to move in an erratic manner. This random or zig-zag motion generally greatly increases the probability of the contaminant colliding with the filter fiber and ultimately being removed.

Q: Are there any other ways that PLH will help me from contracting TB, and what can I do to help?

A: PLH will continue to require annual TB skin testing of all employees, and some high risk employees will be required to have their tests every six months. You can help by reporting to Employee Health office when your TB skin test is due.

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Q: What is the criteria that is used to determine the results of my TB skin test?

A: Any reaction to the test will be measured. A reaction of 5mm or more of induration is considered POSITIVE if:

a. The employee has had close recent contact with an infectious case of TB.
b. Their chest x-ray is consistent with TB
c. They are immunocompromised.
d. They are a member of a group at high risk for HIV infection.

A reaction of 10mm or more of induration will be considered positive in all other persons.

Q: What will happen if I do have a POSITIVE TB skin test?

A: After reviewing your TB symptom review, a chest x-ray will be performed on you. Then we will refer you to a physician for treatment if needed.

Q: What kind of treatment would I receive?

A: Remember there is a difference between TB infection (latent TB) and TB Disease (active TB). With TB infection, the person is not infectious, and usually just one drug is required. However, TD disease always requires treatment with multiple drugs.

Q: Is drug treatment very important?

A: Drug therapy is the only way to beat TB. But the patient must be patient. Treatment for TB takes time. People commonly need to take TB drugs every day for 6-12 months.

Q: If my TB skin test is NEGATIVE, I have nothing to worry about?

A: In most cases, yes. But you must beware that HIV infection and other medical conditions may cause TB skin tests to be negative even if TB is present. If you are concerned about your immune system you are encouraged to talk confidently with the Employee Health Nurse or Infection Control Nurse. Further testing can be provided to you at your request to help determine if your immune system is working.

Q: Is there anything else I need to know?

A: Only that TB is a serious disease. But your local hospital is committed to keeping all employees safe as possible from TB transmission. We realize that TB transmission can be prevented if all employees follow these precautions set forth in our TB Exposure Control Plan. In addition, you are encouraged to see Employee Health/Infection Control Nurse with any further questions you may have regarding TB.