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Environment of Care Manual

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Environment of Care Committee

PURPOSE

To plan, establish, and monitor policies and procedures and provide guidance for the implementation of Lincoln Community Health Center's Environment of Care (EOC) program in accordance with the accreditation standards of The Joint Commission.

RESPONSIBILITIES

The EOC Committee is responsible for planning and implementing safety policies and procedures and training staff in the same to ensure an organized process for any anticipated event which will endanger the safety of the patients and/or staff of the Center. The EOC Committee is responsible for the maintenance of written plans for managing, at minimum, the following risk areas:

- Environmental safety of everyone who enters the organization’s facilities
- Security of everyone who enters the organization’s facilities
- Hazardous materials and waste
- Fire safety
- Medical equipment
- Utility systems

The Committee will evaluate each EOC written management plan at least annually. This evaluation will include a review of the plan’s objectives, scope, performance, and effectiveness.

EOC trainings are held at the time of new employee orientation and additional safety trainings are conducted annually at a general staff meeting by the Safety Officer, or delegate.

The EOC Committee will oversee the collection and maintenance of information regarding inspection, testing, and maintenance of the Center’s equipment and systems. This information should include, but is not limited to, manuals, procedures provided by manufacturers, technical bulletins, and other relevant information.

The Center’s Quality Improvement & Risk Management Director, or delegate, will oversee the management of risks and will coordinate risk reduction activities in the physical environment with the help of the Center’s Safety Officer. The Quality Improvement and Risk Management Director will collect deficiency information related to risks via the **Confidential Incident Reporting Procedure/Form** and will disseminate summaries of actions and results to the EOC Committee at least quarterly.

COMMITTEE ORGANIZATION

The EOC Committee will consist of a core group of required committee members and will invite additional attendees for representation from each department, satellite location, and Duke provided services associated with the Center, as applicable. The core committee members will include, at minimum, the Safety Officer, Quality Improvement & Risk Management Director, Dental Director, Director of Nursing, or their delegates, and at least one individual from the pharmacy, lab, Duke and LCHC off-sites, security services, and environmental services. Representatives on the EOC Committee may represent more than one department. The Safety Officer, or delegate, will serve as the chair of the committee. The EOC Committee will meet at least quarterly, as directed by the committee chair.

AUTHORITY

The EOC Committee is a quality subcommittee and the Quality Improvement Committee (QIC) has delegated responsibility for overall coordination of the Center's EOC program to the committee; the committee shall report to the Safety Officer, or delegate. Any unresolved problem areas shall be brought to the QIC for further review. The EOC Committee will use the results of data analysis to identify opportunities to resolve environmental safety issues and will act on these identified opportunities to resolve environmental safety issues, reporting results to the QIC at least quarterly.

Environment of Care Training & Competence Assessments

PURPOSE

Lincoln Community Health Center acknowledges the need to provide safety training for employees to meet the changing needs of the workforce and organization. Training must be pertinent, concise, and commensurate with safety issues likely to be found in the healthcare environment.

PROCEDURE

This training is divided into six units, which coincide with the six aspects of the Environment of Care as defined by the Joint Commission. The six units include information on:

- General Safety
- Security
- Hazardous Materials/Wastes
- Fire Safety
- Medical Equipment Management
- Utilities Management

These guidelines will be used for training of new employees and at annual review. Each new-hire orientation includes competency testing.

Additional training is provided by the following means:

- Fire Drills.
- Annual Active Shooter Learning Module
- Annual General Staff Meeting related to the six units of EOC.

RESPONSIBILITIES

Testing, scoring, evaluation, and follow-up will be conducted through the Human Resources Department under the advisement of the Quality Improvement & Risk Management Director and the Center's Safety Officer.

Department Heads will keep copies of all employee orientation, training, and testing records. The Human Resources Department will be responsible for maintaining data on training/testing.

COMPETENCIES

Competencies are evaluated through the Learning Management System with Modules that pertain to the six units of the Environment of Care. The Learning Modules are completed at the time of the Employee Orientation and then done on a yearly basis. Modules are updated as needed based on changes to applicable regulatory organizations and/or applicable changes to organization policy and procedure guidelines.

Confidential Incident Reporting Procedure

PROCEDURE STATEMENT, INCLUDING PURPOSE

Lincoln strives to foster a culture of safety for all. As such, LCHC has established a procedure for the reporting of quality issues such as medical errors, potential medical errors, incidents, any unexpected/unintended outcome, and quality of care and service issues. Reporting of these events is of great benefit to LCHC because investigation and peer review can occur as appropriate, and tracking and trending of events can help illuminate system issues to be corrected. Every employee should contribute to quality care in the workplace and for our patients by reporting any incidents in which they witness through the procedure as outlined below.

All incident and near-miss events will be documented and reported to the Quality Improvement and Risk Management Director (QI Director), or delegate, under this procedure. All reporting should occur in a timely manner as outlined in the procedure. Reporting of incidents and near miss events is a confidential process meant for quality improvement and should not be included in the patient medical record or treated as a punitive process. Failure to comply with this procedure may result in disciplinary action, up to, and including, termination.

DEFINITIONS

- **Incident** – An occurrence or undesired outcome, not expected within the normal course of care or treatment, disease process, condition of the patient, or delivery of services that happens to a patient, visitor, employee, or property. Any event which is inconsistent with LCHC's policies and procedures or routine operations, inconsistent with intended care, injurious, or has potential to result in injury, property harm, or negative consequences.
- **Medical Error** – Failure of a planned action to be completed as intended or use of a wrong plan to achieve an aim.
- **Near Miss** – An event or situation that could have resulted in an accident, injury, or illness, but did not, either by chance or through timely intervention.
- **Quality Issue** – An employee or patient-identified quality issue with any department. For example, quality of care issues regarding providers, nursing, reception, pharmacy, lab, etc. related to issues of access (wait times, referral availability, appointment scheduling), communication or behavior (manner, time spent, explanation, education, communication of results), coordination of care, technical competence and appropriateness (diagnosis, competence), or facility or environmental issues.

PROCEDURE

1. **Immediate Actions:** When a person reports an incident to an employee or an employee witnesses an incident, the employee will:
   - Ensure patient and/or visitor safety by providing the necessary emergency treatment, as applicable, evaluation by appropriate medical or nursing staff, notification of the immediate supervisor, and any corrective actions needed to prevent immediate danger to others.
   - If there is an urgent medical need, follow the **Emergency Response Procedure**.
   - Assist the person to the appropriate LCHC department or employee, as indicated.
   - The employee witnessing or receiving the initial report of an incident should initiate the incident reporting process by accessing and completing all required sections of the electronic Incident Report Form **(preferred method, link in Appendix A)** or by submission of the paper Incident Report Form (alternate method ONLY when electronic submission is not available, form attached as Appendix B) and recording the date, time, and appropriate patient identifier for any patient involved in the incident.

- If multiple employees witness the incident, the senior level employee, or delegate, should initiate the Incident Reporting Process and should collect statements from any other witnessing employees as supporting documentation.

2. **Reporting:** The employee witnessing, receiving report of, or involved in, the incident or near miss should fill out the electronic Incident Report Form, as applicable. At minimum, the employee should complete all sections marked as "required" as indicated by a red asterisk. The electronic Incident Report Form contains additional details and instructions for completion within the form once it is accessed. All LCHC employees have access to the electronic Incident Report Form via a desktop icon on their LCHC computer, the LCHC Intranet Home Page, and the link provided in this document.
   - Complete the required and pertinent sections of the electronic Incident Report, recording all known details of the incident facts in an objective and legible manner. Do not record assumptions or opinions. State what the person said -- for example, "person states he/she fell."
   - If electronic Incident Reporting is not available due to internet downtime, computer inaccessibility, or other cause, record and report the incident using the paper Incident Report Form, attached as Appendix B and available via the LCHC Intranet for printing. Further instructions for form completion will be provided on the form.

3. Once the employee has completed the electronic Incident Report Form, they should "Submit" the form and notify their supervisor of the submission. The QI Director, or delegate, will be notified via email of the submitted form and will proceed with appropriate follow-up, as needed. The QI Director, or delegate, will send an electronic copy of the completed form to the supervisor for further review and input as indicated below.
4. If completing the report on paper, once the employee has completed their part of the paper Incident Report Form, they should submit the form to their immediate supervisor before the end of their shift for further review.
5. For all incidents, regardless of electronic or paper Incident Report Form submission, the supervisor, or delegate, will be responsible for facilitating any immediate response necessary.
   - As applicable, the supervisor will ask a medical provider or nursing staff to evaluate the individual named in the incident and to provide input on the Incident Report by completing an evaluation of the patient and offering a statement to indicate the condition of the patient and the plan of care. If the person refuses treatment, document this on the Incident Report.
   - The supervisor should ensure that all details regarding the Severity of Incident and Outcome of the Event are completed as outlined on the form.
   - The supervisor, as applicable, should include a Corrective Action Plan that will be implemented to reduce the risk of repeat incidents in the future. This plan should include any details on environmental changes, staffing changes, employee education/competency checks, and a timeline, as applicable.

6. Once completed, the supervisor will then give the incident report directly to the QI Director, or delegate, within 2 business days of their receipt of the report for final review.

7. It is the goal of LCHC that all Incident Report Forms will be reviewed and closed within 14 business days of the event.

8. Questions regarding this procedure can be directed first to the immediate supervisor and to the QI Director, or delegate, when necessary.

9. Any incident that may lead to an insurance claim or possible legal action requires the immediate notification of the Business Office Supervisor and the Director of Operations, or their delegates. The QI Director, or delegate, will provide a copy of the completed incident report to the Business Office Supervisor and Director of Operations as soon as possible so it may be reviewed by the appropriate representatives from the insurance company and/or legal counsel, as applicable.

NOTE: This is the procedure for incident and near miss reporting. If an incident is evaluated to include blood borne pathogen exposure, please refer to the **Blood Borne Exposure Procedure** and Blood Borne Exposure Form. If the quality issue is not an incident, but involves a patient complaint, please refer to the **Patient Feedback Procedure** and Patient Feedback Report.

The Incident Report Form is an internal document. It should not be given to anyone but the supervisor, QI Director, or delegate. It should not be scanned into the Electronic Health Record (EHR).

The QI Director, or delegate, will report to the Environment of Care, Risk Management, and Quality Improvement Committees a Summary of Incident Reports received at least quarterly. They will also provide a summary of all incident reports to the Board of Directors at least annually.

APPENDIX A: Link to Compliatric Electronic Incident Reporting System

https://lincolnchc.secure.force.com/

All LCHC employees, contractors, and volunteers who use LCHC computers during their time of service will have access to the electronic Incident Reporting Form via a desktop icon on their LCHC computer. The link can also be found on the LCHC Intranet Home Page. Individuals are able to complete the electronic Incident Report Form anonymously or they may include their name, but all reports require an email address for the reporting party to allow the QI Director, or delegate, to contact the reporting individual with follow-up questions, as necessary.

APPENDIX B: Incident Report Form
Attachment begins on next page as separate document. Form can also be located on the LCHC Intranet for printing. Printed forms should **ONLY** be used as the means of reporting incidents when electronic reporting is not available.

Lincoln Community Health Center

Paper Incident Report Form

**Please complete incident report via electronic reporting if available, https://lincolnchc.secure.force.com/

MRN #: ______________________ If **NOT** LCHC patient: Name/DOB: ______________________ Contact #: ______________________	*Check one:* ☐ Contractor ☐ Employee ☐ Patient ☐ Student ☐ Visitor ☐ Volunteer	**INCIDENT:** Date: ______________ Time: ______________ Specific Location: ______________

1. Describe what happened: (Be concise, objective, factual, and include any statements of patient/visitor in quotes. Include details surrounding the event and other extenuating circumstances)

____

____

____

____

____

____

____

____

2. Person Completing Form: (attach statements from additional witnesses to this form as needed)

____

Name (Please print) Date Dept/Unit Phone/Extension

Witnesses:

____

Name (Please print) Date Dept/Unit Phone/Extension

____

Others (Please print name(s))

3. Condition of Patient and Plan of Care:

Provider Report, Nursing Observations, Patient Status, and/or any follow-up plans or recommendations for further treatment or evaluation:

____

____

____

____

Name of Clinical Staff: ______________________ DATE: ______________

Refused treatment/care? ☐ Yes ☐ No ☐ N/A

CONFIDENTIAL INCIDENT REPORT – NOT PART OF THE MEDICAL RECORD

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4. Severity of Incident: *(Check one)*

☐ **Class I – Emergent, Harm ***
Unexpected, event involving death or serious injury.

☐ **Class II – Urgent, Harm ***
Event resulting in injury or change in condition.

☐ **Class III – Non-urgent, No harm**
Event not resulting in injury or change in condition.

**** Class I & II require immediate attention and response. Contact your supervisor immediately.***

5. Outcome of Event:

Check all that apply:

GENERAL:	
☐ Cardiac/Respiratory Arrest	☐ Patient Care Related, Explain: ______________________
☐ Death	____
☐ Delayed Treatment/Diagnostic Test	
☐ Dental Related	
☐ Emergency Management Event	☐ Other Illness, Explain: ___________________________
☐ Employee Incident/Near Miss	
☐ EMS Call	____
☐ Environment of Care Incident/Near Miss/Concern	
☐ Fall/Trauma	☐ Other Injury, Explain: ____________________________
☐ Infection	
☐ Med Admin: Incorrect med or dose administered	____
☐ Med Dispensing: Incorrect product pulled	
☐ Med Distribution: Pt. receives another's Rx	POSSIBLE CAUSES:
☐ Med Dosage: Incorrect strength	☐ Confusing Abbreviation/Name Confusion
☐ Med Prescribing: RX w/incorrect med/dose/freq.	☐ Equipment/Property failure, damage, contamination
☐ Mental Status Change	☐ Inaccurate dose calculation
☐ Nurse STAT Call	☐ Label/packaging
☐ Possible HIPAA Violation	☐ Lack of training/New process or task
☐ Property Damage	☐ Needed help – did not call
☐ Repeat Test/Procedure	☐ Order missed or sent to incorrect location
☐ Security/Safety Issue	☐ Patient impaired at time of incident
☐ Unplanned ER/Hospital Admission	☐ Staffing levels/distribution
☐ Unplanned Surgery	☐ Verbal or Written miscommunication
	☐ Other: ____

6. Management Follow-up/Corrective Action Plan:

____

____

____

____

________________________________ ______________
Name of Supervisor Date

7. Additional Follow-Up:

____

____

____

****QI Director, or delegate, to enter and finalize paper report within electronic incident report management system. https://lincolnchc.secure.force.com/**

CONFIDENTIAL INCIDENT REPORT – NOT PART OF THE MEDICAL RECORD

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Safety Management Plans

OBJECTIVE

This plan has been established for the purpose of:

- Providing a safe environment for employees, patients, and visitors
- Developing and implementing policies and procedures which reduce or eliminate safety hazards
- Controlling costs by preventing or minimizing personnel, property, net income, or liability losses.
- Complying with Federal, State, Local, Industry, and Organizational safety standards, as applicable.

PROCEDURE

Lincoln Community Health Center is committed to providing a work environment that is safe and free from occupational hazards. The Center's endeavors are to provide employees with the necessary training to prevent occupational illness and injury. Employees are required to report all safety hazards to their immediate supervisor, Safety Officer, or Human Resources Department.

If an employee experiences a work-related illness/injury, they must report the illness/injury immediately to their supervisor. Employees must notify their immediate supervisor within 24-hours of any work-related injury or illness. If the supervisor is not available, they should report to the Safety Officer or Human Resources Department. The employee shall be required to complete an Employee Occupational Illness/Injury Report. Lincoln Community Health Center will provide immediate medical attention through the Occupational Health Department/Nurse; however, ongoing medical care must be coordinated with the Worker's Compensation carrier using established medical providers.

Employees should report all accidents involving patients and visitors immediately. The Confidential Incident Report Procedure/Form should be completed and the Center will provide immediate medical attention to the patient, as applicable.

SCOPE

This plan establishes policies/procedures that address:

- Facilities, equipment, and grounds maintenance
- Proactive risk assessment relating to facilities, grounds, equipment, occupants, and internal physical systems that affect patients and public safety.
- Engaging appropriate representatives from administration, clinical services, and support services in evaluating safety hazards, plans for corrective actions when hazards are found, and oversight of proper implementation of corrective actions.
- Reporting and investigating incidents of property damage, patient, employee, and visitor injury, and security incidents.
- Hazard surveillance, including response to product/equipment/supply safety recalls/alerts
- Appointing a qualified individual to oversee development, implementation, and monitoring of safety management.
- Identifying individual(s) to securely intervene when immediate threats to life, safety, health, equipment, or facilities are identified.
- Review of Product Safety Recalls as pertains to LCHC inventory.

EDUCATION

This plan establishes policies/procedures that address:

- Center awareness through:

    - New employee orientation
    - Annual employee safety reviews
    - Annual department-specific safety reviews
    - Ad hoc safety training
    - Environment of Care Training and Competency Assessment through the Learning Management System
- Education focus is on:
    - Identification of safety-related competencies
    - Comprehensive preparatory training for new hires
    - Concise, brief review and confirmation of continued safety-related competence for existing employees
    - Early detection, reporting, and intervention for safety hazards
    - Locating/obtaining assistance with unfamiliar safety hazards
- Training is documented in:
    - Departments
    - Human Resources

PERFORMANCE STANDARDS

This plan establishes policies/procedures that address:

- Level of staff participation in safety management activities
- Monitoring and inspection activities
- Review of safety policies and procedures on a yearly basis

The objectives, scope, performance, and effectiveness of the General Safety Management Plan are to be evaluated annually by the Environment of Care Committee.

Security Management Plans

SECURITY PROCEDURE

PURPOSE

It is the intent of the Security Procedure to describe information, security objectives, and strategies of Lincoln Community Health Center (LCHC). The Security Management Plan ensures a safe and secure environment for patients, staff, visitors, and property. Armed and unarmed security at LCHC Main is a contracted service provided by Duke Regional Hospital (DRH).

The Director of Security for DRH maintains oversight of contracted security personnel. The Director of Operations and the Safety Officer at LCHC are the liaisons for security concerns and have responsibility for onsite day-to-day implementation of the Security Management Plan as outlined below.

The philosophy of the Security Management Plan is presence, not force. Security personnel are dressed in clearly defined attire. In concert with the philosophy of this plan, close relations are maintained with the Police Department.

SCOPE

There is at least one Security Officer per shift stationed at LCHC Main 24 hours per day, seven days per week. There is also a second security officer stationed at LCHC Main Monday through Friday. One security officer is provided at the Healthcare for the Homeless Clinic Monday through Friday. In addition, there is one Officer stationed at the HCH clinic every first and third Wednesday, during psychiatry clinic, when in session.

Current security services include, but are not limited to:

- Interior/exterior patrols, increased during hours of darkness including exterior door checks
- Personal escorts to and from parking areas
- Storage of lost and found property
- Investigation of visitor, employee, and patient incidents or thefts
- Response to emergencies and calls for assistance from those on the premises
- Conducting annual fire drills and other drills as needed in conjunction with the Safety Officer
- Applying only as a last resort the use of force to manage situations. The Police Department will be called in any situation that assistance is deemed necessary.
- De-escalating disruptive persons
- Crowd control
- Monitoring of parking lots
- Use of detaining powers when indicated
- Participation in other drills such as terrorism/disaster/active shooter drills
- Monitor temperature readings in the IT Server Room during off-hours

SECURITY CONCERNS REGARDING PATIENTS, VISITORS, STAFF, AND PROPERTY

The security department addresses security concerns regarding patients, staff, visitors, and property by immediately responding to requests 24 hours a day. Incidents are investigated and when appropriate, police assistance is requested.

All incidents reported to security are logged, and incident reports are initiated by security officers. Upon completion, reports are reviewed by the Safety Officer, submitted to the Quality Improvement & Risk Management Director, and copies are maintained in the Security Office.

Security activities are reported to the LCHC Environment of Care Committee and Quality Improvement Committee by the Safety Officer on a quarterly basis.

Patient incidents reported to security will be fully investigated and follow-ups conducted when necessary.

MEANS OF IDENTIFICATION OF PATIENTS, STAFF, AND VISITORS

NAME BADGE PROTOCOL

Each Lincoln Community Health Center employee will be issued a name badge on their first day of employment. The badge must be worn at all times while the employee is on duty. The name badge must be worn on clothing and attached above the waist. The name badge must be presented to Security if the employee wishes to re-enter the Center after duty hours. Failure to comply with this protocol will be considered a violation of the dress code and subject to disciplinary action.

Employees who change their name or transfer to another department will have the badge replaced at no cost.

ACCESS CONTROL

Security personnel have access to all areas of the Center except the restricted entries to Pharmacy and Radiology areas. Anyone requesting after-hours access to any department will first be verified as having been authorized by their department head.

SURVEILLANCE CAMERAS (CCTV)

CCTV units are positioned on the exit doors, hallways, and the parking lots. The security officer on duty is responsible for monitoring the units during periods when the clinic is closed. Any persons seen in these areas or any unusual occurrence observed on the monitors will require a security officer response. Suspicious persons in any sensitive area or parking lots will be investigated. The digital state-of-the-art system has recording capabilities, and copies of incidents are provided to the Durham Police Department when approved by the Director of Operations.

ALARMS

Door alarms are located on all exit doors. The alarm panel is located in security operations. When the fire alarm sounds, all officers will respond to determine if a fire exists. If a fire is found, attempts will be made to extinguish the fire and close any doors to reduce smoke from spreading to other areas of the facility. Security may assist in the evaluation of patients and/or injured personnel.

VEHICULAR ACCESS

Security will monitor parking lots and has the authority, upon agreement with the Director of Operations, or delegate, to facilitate towing of cars parking in “No Parking” zones. Security personnel have permission to relocate vehicles of patients who are unable to do so by themselves.

PATROLS

Observation reports of anything out of the ordinary involving either safety or security are documented by staff and forwarded to the Safety Officer. Investigation of persons not recognizable as having business in the Center will be made.

INVESTIGATIONS OF SECURITY INCIDENTS

All security incidents are to be reported immediately to security personnel by overhead page and/or phone call for urgent response. Anyone in the Center can report an incident or request security assistance. At LCHC Main, in the event security cannot be located, the person needing assistance will notify the Safety Officer. The Safety Officer will review all written reports. Quarterly reports will be made to the Center's Environment of Care Committee and the Quality Improvement Committee.

IDENTIFICATION OF SENSITIVE AREAS

LCHC has identified the following sensitive areas as part of its proactive risk assessment.

- Pharmacy: Access to the pharmacy shall be limited by key and/or Duke ID badge control. Access to the pharmacy while open shall be limited to those persons having pharmacy business. Door keys shall be kept by the Pharmacy Director and DRH Engineering only. Pharmacists and technicians shall have badge access privileges during the hours of operation. DRH Engineering, Assistant Pharmacy Director, Technician Supervisor, and Pharmacist in closest proximity to the center may access the pharmacy outside of hours of operation only with prior permission from Pharmacy Director or delegate. Security locks are on all metal windows. Pharmacists and technicians shall be responsible for securing windows and doors at the end of the work day. The pharmacy walls are extended to the roof with a fire wall that limits access to medications stored in the pharmacy. Pharmacy personnel ID badge shall indicate name, department and credentials.
- Pharmacy Cashiers: Located adjacent to the main Pharmacy, identified as a sensitive area due to a large volume of patients at any one time. Security maintains a high level of visibility.
- Pediatrics/WIC: Employees wear ID badges and proper identifying attire. All patients are checked in at the Intake Desk. Staff is trained to be very inquisitive to suspicious persons in the area. Security maintains a high level of visibility.
- Maintenance areas: Main shop is located on the first level of the Center. All areas have HVAC and electricity. Doors and access to these areas are secured by key entry.
- HIMS (Medical Records): Patients entering this area located on the first floor will be greeted by a receptionist. Daily access is limited to authorized employees. Identification badges are the primary recognition and serve as badge entry cards. After hours the department is locked.
- Finance Department: The location on first level makes it easy access for identified employees of the armored courier service to pick up funds daily. The area where the safe is located is secured at all times.
- Clinical Supply Area: Located on the first level, this room is within the material supply area and is accessible only by designated employees.
- Human Resources: Only authorized personnel have access to any of these offices when locked.
- IT Computer Room: Located on first level, this area is limited access only by authorized personnel. This area is locked at all times.

EDUCATION AND TRAINING

Orientation is provided for all newly-hired security employees at LCHC. All contract security personnel are mandated to participate in the Center's Environment of Care Training and Competence Assessment. The following topics are used as training tools for the security department:

- Security Emergencies
- Security Incident Reports
- Bomb Threats, Building Lockdown
- Emergency drills, i.e. fire drills, code blue, etc.
- Violent/Aggressive Behavior
- Building Access Control
- After Hours Access Control

- Security interface with departments
- Identification: patients, visitors, staff, and vendors
- Threats/harassment and violence
- Concealed weapons
- Domestic disturbances
- Infant/Child abduction
- Patients, visitors, and staff escorts
- Handling VIP situations
- Hostage negotiations
- Access control to sensitive areas
- Parking
- Trespassing
- Patient confidentiality
- Prisoner patients
- Report writing

The objectives, scope, performance, and effectiveness of the Security Management Plan are to be evaluated annually by the Environment of Care Committee.

PROCEDURES FOR ABUSABLE SUPPLIES

PURPOSE

Lincoln Community Health Center places a priority on the safety of its staff, volunteers, contractors, patients, visitors, and the community it serves. As is the nature of a health center, Lincoln acknowledges the presence within its clinics of substances and equipment that pose the hazard of abuse if not properly handled, stored, and secured. As such, the Center has developed plans to remove or reduce the risk of abuse of supplies that are considered high risk. These plans are outlined within this procedure.

CONTROLLED SUBSTANCES

Instructions:

- Narcotics may be ordered by electronic, printed, or written prescription only by LCHC Providers.
- Medication Assisted Therapy with controlled medications can only be prescribed by Providers that have the required waiver and such prescriptions must contain the X DEA number of the Provider.
- Electronic prescriptions are transmitted to the Pharmacy or the patient takes the printed or written prescription to the Pharmacy.
- Under North Carolina General Assembly S.L. 2011-349, the patient or designee picking up certain controlled medications must show an unexpired valid photo identification such as state issued driver's license, special NC Department of Motor Vehicles issued identification card, military identification card, or passport.

PRESCRIPTION PADS

Instructions:

Paper prescription pads will be ordered, managed, and securely stored as outlined in the *Prescription Pads for Use During EHR Downtime* Procedure. Prescription pads are unique to each clinic location and each prescription pad has a unique assigned set of sequential numbers to allow for prescription tracking.

SHARPS

Instructions:

- All needles and syringes are used only once and then discarded in a puncture resistant sharps container.
  - Puncture resistant, disposable sharps containers are placed in each clinic area as assigned by the Director of Nursing, or delegate.
  - The Clinic Nurse Manager, or delegate, of each clinic location will be responsible for monitoring the sharps containers daily. All full sharps containers are sealed properly and placed in a biohazard box in the pick-up location.
- Unused needles and syringes are kept in secure locations with limited, clinical staff-only access, as applicable.
- All staff will take safety steps, as applicable, to decrease the likelihood of abuse of syringes and needles.
- All staff, as applicable, will implement safety measures to prevent needle stick injuries.

WEAPON POSSESSION PROCEDURE

PURPOSE

In order to ensure the safe operation of Lincoln Community Health Center, weapon possession is prohibited. Law enforcement officers, prison officials and security officers, when acting in the discharge of their official duties, are permitted to carry authorized weapons.

PROCEDURE

Lincoln Community Health Center (LCHC) prohibits the unauthorized possession of firearms, explosives, and weapons. The possession, sale, or use of weapons, dangerous instruments, or paraphernalia associated with a weapon is prohibited on LCHC main site and satellite campuses. This restriction includes, but is not limited to, parking lots, personal vehicles, sponsored events, and LCHC-owned vehicles.

All fully qualified Security Officers are authorized to carry firearms when acting in their official capacity. Law enforcement officers commissioned by the city, county, state, and/or federal governments may also be authorized to carry firearms in the discharge of official duties on LCHC property.

Other than those individuals identified above, no individual is permitted to bring on to LCHC property or store in LCHC facilities any weapons including any gun, rifle, pistol, explosive, switchblade, knife, dagger or other items that by their design or use can be considered weapons.

LCHC employees/volunteers conducting LCHC business are not permitted to carry any weapon, including any gun, rifle, pistol, explosive, switchblade, knife, dagger or other item that by their design or use can be considered a weapon while conducting LCHC business. This is inclusive of patient's residence/home, skilled nursing facility, assisted living facility or other location where the patient resides. Possession of a weapon is a gross violation of LCHC accepted workplace standards and will be subject to disciplinary actions up to and including immediate termination. In the event weapons are in the home environment, LCHC staff, supervisors and managers will work with the patient, family to maintain a safe environment in which LCHC staff may visit. If a LCHC employee/volunteer is concerned for their safety, the supervisor will be notified and a joint visit or escort arranged.

EXCEPTIONS

Kitchen knives, utensils, and other items normally found in a work place environment are for the convenience of staff and are not considered or intended to be used as weapons.

Sharps devices necessary for work performed are excluded from this procedure, for example, IV needles or box cutters used to open or break down boxes.

Exceptions to the weapons procedure must be approved beforehand by the Human Resources Director. Any weapon or dangerous instrument on LCHC-owned or leased premises may be confiscated. There is no reasonable exception of privacy with respect to such items in the workplace. Staff Members' desks, workstations, offices, lockers, bags, briefcases, files, etc. may be subject to security searches.

Any staff member who has a question as to whether an instrument, article, or substance is considered a weapon or dangerous instrument in violation of this procedure should ask for clarification from the Human Resources Director.

SMOKING PROCEDURE – TOBACCO FREE ENVIRONMENT

PURPOSE

Lincoln Community Health Center (LCHC) is committed to providing an environment that is free of health hazards and promotes wellness. Therefore, smoking and the use of tobacco products are strictly prohibited on LCHC premises including adjacent sidewalks, parking lots, and all satellite offices.

In an effort to fulfill our mission of being a quality health care institution, LCHC is a tobacco-free entity providing a healthy environment. All patients, employees, physicians, and visitors are expected to comply with the requirements of LCHC.

DEFINITIONS

Tobacco Products can include, but is not limited to: Cigarettes, Cigars, Chewing Tobacco, Snuff, and Pipe Tobacco. In addition to direct tobacco products, the Center also prohibits the use of any e-cigarettes, vapes, or similar products on Center premises.

Lincoln Community Health Center Premises: Buildings/Properties owned or leased by Lincoln Community Health Center; Center Parking Lots; Center Vehicles; and Sidewalks adjacent to the premises.

GUIDELINES

A. All smoking to include smokeless tobacco, electronic cigarettes (E-cigarettes) and vaping is prohibited.
B. The Center shall post signs that indicate the Center is enforcing a Tobacco-Free Environment.
C. This procedure applies to patients, employees and visitors at the main and satellite facilities, and vehicles and operations under the auspices of Lincoln Community Health Center.
D. The Durham County Board Smoking Rule designates sidewalks owned, leased, maintained or occupied by the City or County of Durham and abut the grounds of Durham County, the City of Durham, any public school or hospital, as non-smoking areas.
E. Employees who violate the smoking restrictions set forth in this procedure are subject to the standard disciplinary action as defined by Lincoln Community Health Center's Personnel Policy Manual, Work Rule #5.
F. Patients and visitors who violate the smoking restrictions set forth in this procedure are subject to a civil penalty that carries a $50 fine.
G. The Center shall provide information and assistance to employees, independent contractors, vendors, patients, and visitors on tobacco cessation, as applicable.
H. Each employee is responsible for the enforcement of this procedure. Employees should notify Security of any violations of this procedure and/or refer the violator to the Tobacco Cessation Program Coordinator, or delegate.

PROCEDURE

The Tobacco-Free Environment will be shared with applicants during the interviewing process. It will be reinforced that the Center does not require that employees be tobacco-free, but they not utilize tobacco products on the Center's premises. Additionally, the procedure will be reviewed as a part of new employee orientation.

SEXUAL & OTHER FORMS OF HARRASSMENT

STATEMENT

It is the policy of Lincoln Community Health Center that employee(s), patient(s), and visitor(s) will not engage in conduct that violates the organization's ability to provide an environment that promotes respect for all individuals. All forms of harassment are explicitly prohibited.

MANAGEMENT OF DISRUPTIVE PERSONS

STATEMENT

Lincoln Community Health Center and its satellite sites, ("Center") are committed to assuring a safe environment for all. Lincoln will address immediately any reports of inappropriate behavior. Disruptive employees are addressed in separate HR policies.

PURPOSE

To provide a safe environment for the Center's employees, patients, visitors, and vendors that is free of threats, harassment, intimidation, physical and/or verbal abuse.

The evaluation of the termination of medical services to the Center is an area of concern that is taken very seriously. As part of its decision, the Center considers the safety of its staff, patients, and visitors, as well as the medical condition of the persons involved.

A person is considered disruptive when they display threatening, harassing, intimidating, or physically or verbally abusive behavior.

PROCEDURE

The following are guidelines to be followed when presented with a disruptive person:

1. Page Code Gray (with location) and have security de-escalate the individuals according to their protocol.
2. Reporting: Confidential written documentation shall be prepared and given to the Safety Officer, or delegate, who will seek counsel as needed from the Director of Operations, Chief Medical Officer, or Chief Executive Officer, or their delegates. A copy of this documentation should also be filed appropriately. A form for such reports is attached and can also be found on LCHC's intranet under the FORMS or DEPARTMENT/ADMINISTRATION tab.
3. When the disruptive behavior does not include a physical altercation, the individual may be counseled on acceptable behavior when in the Center, preferably by a Behavioral Health staff member. This option for counseling is at the discretion of the Safety Officer, or delegate. A warning letter may be issued from the CEO, or delegate. The Patient Accounts Supervisor or the HIMS Director will flag the patient chart, as applicable. The person also may be given a copy of the Patient Rights and Responsibilities brochure.
4. When the disruptive behavior includes a physical altercation or communication of a threat against a person or the Center, the person will be trespassed from the Center. The trespass procedure would include a letter of termination of services stating clearly that the person is no longer allowed on Lincoln premises. If the person is seen on Lincoln property, the Durham Police Department may be called to remove the person by Lincoln's Security Department.

PROCEDURE FOR A WARNING

A letter signed by the CEO, or delegate, will be sent by certified mail, return receipt requested, and by regular mail to the disruptive person, and should include the following:

- Date(s) of disruptive behavior
- Type of disruptive behavior
- Warning of possible termination of services if disruptive behavior continues, if appropriate

The person will be given a copy of the Patient Rights and Responsibilities brochure with the letter, if appropriate.

PROCEDURE FOR TERMINATION AS A PATIENT OF THE CENTER

Center services may be terminated immediately, as described below:

- If a person physically assaults or threatens physical assault
- If a person communicates a verbal or nonverbal threat of physical harm to an individual or the Center
- Continued inappropriate behavior in spite of previous warnings
- Criminal behavior

A letter explaining the following, if applicable, and signed by the CEO, or delegate, will be sent by certified mail, return receipt requested, and by regular mail to the disruptive person:

- The reasons for termination
- Termination effective date
- The Center may only provide emergency services to the disruptive patient, if requested, during the 30-day period. In the case of an immediate dismissal, no 30-day emergency services will be provided.
- A suggestion that the patient locate alternative providers in the community
- Instructions on how to have the patient's medical records transferred

At the time the letter is sent, a copy of the signed letter shall be given to the following, if applicable:

- Director of Billing, or delegate, who will flag the patient's profile with the above information so that no future appointments will be made and inactivate the patient's account
- HIMS Manager, or delegate, who will place it in the patient's medical record
- Pharmacy Director, or delegate, who will properly notate Pharmacy records so no further medications will be dispensed to the patient

No reconsideration will be given in the case of termination of services.

LINCOLN COMMUNITY HEALTH CENTER

1301 Fayetteville Street ● P.O. Box 52119
Durham, North Carolina 27717 – 2119

CONFIDENTIAL
Disruptive Behavior Report

Name: ____ D.O.B.: ____________________

Mailing Address: ____

MRN #: _________________________ Date of Incident: ______________________________

Please provide a detailed explanation of person's disruptive behavior below:

____
____
____
____
____
____
____

Please provide a detailed explanation of actions taken by Lincoln Community Health Center's staff in response to person's disruptive behavior:

____
____
____
____
____
____
____

Please provide the name(s) of other staff who witnessed the person's disruptive behavior:

________________________________ ____
Name of Witness Witness' Signature

________________________________ ____
Name of Witness Witness' Signature

Requesting letter be sent to patient for:
___ Warning ___ Termination

____
Report Submitted by

____
Date

Please return completed form to the LCHC Safety Officer.

CONFIDENTIAL FORM

TRESPASS PROCEDURE

PROCEDURE

Issue of a verbal or written trespass notice requiring a person to leave Lincoln Community Health Center (LCHC) property is to be made in accordance with the provisions of the North Carolina General Statute 14-159.13 under Article 22B.

PROCEDURE FOR LOCATIONS WITH SECURITY OFFICERS

First Incident of Concern and Issue of Verbal Warning

If a person's behavior is causing concern:

- Where a staff member believes a person on LCHC premises is behaving in a manner that threatens, or may compromise the safety or care of staff, patients, clients, or visitors, a verbal warning to cease that behavior must, in ordinary circumstances, be given to a person before the issuing of a Trespass Notice can be considered.
- Support should be sought prior to discussing this behavior with the person concerned.
- Where the person's behavior is such that the immediate safety of people or property is at risk then assistance must be immediately sought from Lincoln Community Health Center Security Staff.
- Document the event with a Disruptive Patient Form and/or an Incident Report.

Serious or Second Incident of Concern and Issue of Trespass Notice

Where a person's behavior is threatening or intimidating to patients, staff, or the public at large, or a person continues or returns to carry on an inappropriate behavior they have previously been warned of and a decision is made that the person should leave the premises by the Security Staff or Senior Leadership, an agent or occupier of the premises must:

- Give a verbal warning to leave LCHC premises according to North Carolina General Statute 14-159.13 under Article 22B to the person; or
- Serve a LCHC Trespass Notice on the person.
- If the person refuses to leave the premises immediate assistance should be sought from Security Staff and/or the Durham Police.
- Document the event with a Disruptive Patient Form and/or an Incident Report.

Issue of Formal Trespass Notice

- To enact a formal Trespass Notice, the Durham Police Department must be contacted.
- Document the event with a Trespass Notice, and a Disruptive Patient Form and/or an Incident Report.

Recording and Review

- Trespass notices should be accompanied by a Disruptive Patient Form and/or an Incident Report that clearly states the:
  - Recipient's identifying information
  - Lincoln location of which the patient is banned
  - Department details
  - Reason(s) notice given
  - Date issued and any period of review
- A copy of both forms must be forwarded to:
  - Human Resources Director, Safety Officer, HIMS Director, and the CFO who will process an Alert if the individual is a patient; and
  - The Durham Police Department, as applicable
- Safety Officer must hold the original in a folder in their office.

PROCEDURE FOR LOCATIONS WITHOUT SECURITY OFFICERS

First Incident of Concern and Issue of Verbal Warning

If a person’s behavior is causing concern:

- Where a staff member believes a person on LCHC premises is behaving in a manner that threatens, or may compromise the safety or care of staff, patients, clients, or visitors, a verbal warning to cease that behavior must, in ordinary circumstances, be given to a person before the issuing of a Trespass Notice can be considered.
- Where the person’s behavior is such that the immediate safety of people or property is at risk then assistance must be immediately sought from the Durham Police Department.
- Document the event with a Disruptive Patient Form and/or an Incident Report.

Serious or Second Incident of Concern and Issue of Trespass Notice

Where a person’s behavior is threatening or intimidating to patients, staff, or the public at large, or a person continues or returns to carry on an inappropriate behavior they have previously been warned of and a decision is made that the person should leave the premises by an agent or occupier of the premises must:

- Contact the Durham Police Department
- Accompanied by the Durham Police Department, give a verbal warning to leave LCHC premises according to North Carolina General Statute 14-159.13 under Article 22B to the person; or
- Document the event with a Trespass Notice and a Disruptive Patient Form and/or an Incident Report.

Recording and Review

- Trespass notices should be accompanied by a Disruptive Patient Form and/or an Incident Report that clearly states the:
  - Recipient’s identifying information
  - Lincoln location of which the patient is banned
  - Department details
  - Reason(s) notice given
  - Date issued and any period of review
- A copy of both forms must be forwarded to:
  - Human Resources Director, Safety Officer, HIMS Director, and the CFO who will process an Alert if the individual is a patient; and
  - The Durham Police Department, as applicable
  - Maintain a copy of the information above on file at your location.
  - Interoffice the originals to the Safety Officer.

LINCOLN COMMUNITY HEALTH CENTER
1301 Fayetteville Street ● P.O. Box 52119
Durham, North Carolina 27717 – 2119

TRESPASS WARNING

TO: ____

1. The laws of the State of North Carolina provide that Lincoln Community Health Center (LCHC) has the right to forbid a person to come on or enter upon the premises of any of its facilities.

2. This constitutes notice and warning that you are forbidden to come on or enter upon LCHC property in the future.

3. If you do not leave this property immediately or are found on this property in the future, you will be arrested and charged with criminal trespass.

4. A complete report and copy of this warning will be filed with the Lincoln Community Health Center's Security Department.

Being in lawful possession of the property described as LCHC, I issue this warning.

____ ________________________
LCHC Representative's Signature | Time & Date

____ ________________________
Witness Signature | Time & Date

Safe Handling of Hazardous and Non-Hazardous Medication

Purpose

To promote safe work practices for all employees who prepare or administer hazardous and non-hazardous medications or clean up spills of these medications. It is important to minimize occupational exposure to medications because of the risk of adverse health effects. Information on specific drugs can be found on the Safety Data Sheet (SDS) located on Lincoln's desktop/intranet site.

Scope

This procedure applies to all departments with employees who handle hazardous and non-hazardous medications.

Pharmaceutical Waste

Pharmaceutical waste and hazardous pharmaceutical waste are produced from most clinical areas.

1. Pharmaceutical Waste: includes, but is not limited to unused, partially used, or expired prescription or over-the-counter medications (e.g., vials, tablets, capsules, powders, liquids, creams/lotions, eye drops, suppositories), full syringes, inhalers, glass vials and ampules, Medroxyprogesterone (Depo-Provera), Nexplanon Implant, carpujets, and tubexes. No controlled substances, no Lincoln Pharmacy medications.
2. Hazardous Pharmaceutical Waste includes, but is not limited to, syringes, tubexes (I.e.: all cytotoxic drugs, cyclosporine, mycophenolate, oxytocin, epinephrine, and nitroglycerin tablets). We will not be accepting these Hazardous Drugs. This waste stream also includes items that may contain mercury.

Procedure

1. Departments with employees who handle hazardous medications on a regular basis must: ensure that employees are informed of any potential hazard, hazardous medications are clearly identified/labeled, proper personal protective equipment is readily available, and that SDSs (Safety Data Sheets) are readily available for all drugs in liquid, powdered, and gaseous form.
2. Develop a plan for cleaning up spills (refer to Cleaning and Decontaminating Spills) of hazardous medications and provide spill kits to all areas if hazardous medications are administered.
3. Ensure that appropriate personal protective equipment (PPE) is available and worn by employees.
4. Ensure that tasks involving hazardous medications in powdered form are performed in the appropriate area. (Pharmacy has their own Policies and Procedures for the handling of these types of medications)
5. Report on any exposures (skin or eye contact or inhalation of an aerosol or dust) to their supervisors and to the Occupational Health Nurse, completing any occupational health and internal incident reporting documents as applicable.
6. Report spills to immediate supervisor and submit an incident report via the incident reporting system as applicable.
7. Occupational Health Nurse will provide consultation to employees who have been exposed to hazardous medications and may refer to the Emergency Department.
8. The Pharmacy will indicate when special handling precautions are necessary to the department representative picking up floor stock.
9. The Pharmacy will ensure that hazardous medications that will be used for patient treatment are handled according to their Pharmacy Policy and Procedures involving hazardous medications.
10. When handling liquid hazardous medications, employees should wear gloves that are protective against the hazardous medication they are using. (See SDS)
11. Gloves are required during handling of hazardous medications from start to finish.

12. All non-hazardous pharmaceutical waste should go into blue bin receptacles located in your department.
13. Only areas that utilize certain non-hazardous pharmaceutical waste should have blue bins for disposal of the non-hazardous pharmaceutical waste.
14. When a blue bin is ¾ of the way filled it should be disposed of in a separate bio-hazard red bag and inserted in the bio-hazard box located in the bio-hazard closet or wherever your bio-hazard area is located.
15. Please consult with the Occupational Health Nurse to see if further instructions are needed or if bio-hazard pharmaceutical bin is full.
16. All Hazardous Pharmaceutical waste is placed in a black RCRA container. Please call the Occupational Health Nurse for a black RCRA container and further instructions on handling and disposal.

Containers

Pharmaceutical waste is placed in the Blue pharmaceutical waste container.
Hazardous pharmaceutical waste is placed in the black RCRA waste container that meets the EPA requirements for disposal of P, U, and D-listed chemicals. We are not accepting Hazardous pharmaceutical waste.
(See hazardous waste stream container document that is attached)

Handling and Disposal

Pharmaceutical waste, including partially filled vials, syringes, and IVs with medication left, are placed into blue containers, and stored according to bio-hazard vendor specifications in a biohazard room and then transported by a certified biohazard waste management company for disposal. Call Occupational Health Nurse for any questions.
Hazardous pharmaceutical waste is placed into a black RCRA waste container and stored according to bio-hazard vendor specifications in a biohazard room, and then transported by a certified biohazard waste management company for disposal.

Hazardous Materials and Waste Management Plan

OBJECTIVE
Lincoln Community Health Center has developed a Hazardous Materials and Waste Management Plan for the purpose of the following:

- Protecting employees exposed to hazardous materials, products, or wastes
- Preventing environmental contamination
- Controlling costs through effective waste management
- Using, where possible, environmentally-friendly (green) materials
- Complying with Federal, State, Local, and Organizational hazardous materials/waste guidelines

SCOPE
This program establishes policies/procedures that address:

- Establishing criteria consistent with applicable laws, to identify, evaluate, and manage hazardous materials and waste
- Managing ALL wastes (i.e. General, Biohazardous, Chemical, Radioactive) in the safest, most cost-effective manner, from receipt to final disposal
- Providing adequate space for safe handling and storage of hazardous materials and waste
- Reporting materials/waste spills

EDUCATION
This program establishes policies/procedures that address:

- Corporate awareness through:
  - New employee orientation
  - Annual employee safety reviews
  - Environment of Care Training and Competency
- Educational focus is on:
  - Identification of hazardous materials/waste
  - Inventory of materials in each work area
  - Safety Data Sheets (SDS) for chemicals located online via LCHC Links – SDS (Safety Data Sheets), hyperlink will open SDS Library search tool
  - Labeling/storage of materials and waste
  - Training staff regarding safe handling/management of materials/waste
  - Documentation of all training, reviews, and incidents related to hazardous materials/waste
- Training is documented in:
  - Human Resources Department

PERFORMANCE STANDARDS
This program establishes policies/procedures that address:

- Proper employee training for hazardous materials/waste handling
- Safety Surveillance Surveys that note material handling/waste management discrepancies, require department managers to take corrective action and document corrective actions when actions are completed.
- Compliance with contract waste acceptance guidelines for packaging, labeling, and storage of wastes that meet Federal, State, and Local guidelines
- Personal Protective Equipment (PPE) availability, use, and maintenance
- Periodic review of policies/procedures/standards

The objectives, scope, performance, and effectiveness of the Hazardous Materials/Waste Management Plan are to be evaluated annually by the Environment of Care Committee.

Cleaning and Decontamination of Hazardous Spills

Purpose

To provide a clean and safe environment for employees by handling all bloodborne pathogens and other chemical substances in a manner acceptable to applicable federal, state, and local regulations, OSHA (Occupational Safety and Health Administration), The Joint Commission, and Health Department Guidelines.

Procedure

Standard Precautions apply to all cleaning procedures. When handling blood, body fluids, or other chemical spills employees are required to wear Personal Protective Equipment at all times.

Chemical Spills

- Assess the type of spill and degree of hazard involved before attempting to clean the spill. You can access the chemical information on how to proceed from the Safety Data Sheets located on our Desktop/Intranet by clicking the SDS (Safety Data Sheets) icon.
- Spill kits should be in your department. Please call the Occupational Health Nurse, or delegate, with any questions. You may need a few spill kits if the spill is large.
- Environmental Services should be called AFTER you have cleaned so they can disinfect the area. If you do not have access to Environmental Services, then clean and disinfect the area with the approved cleaning products that are available in your area.
- Always look up any unfamiliar product in the SDS.

Blood or Other Body Fluids

- Depending on where the spill occurs it may be necessary to close the area for cleaning.
- Call the Occupational Health Nurse, or delegate, if you have any questions.
- Please proceed with the manufacturer's instructions on the spill kit to clean the spill.
- Environmental Services should be called AFTER you have cleaned so they can disinfect the area. If you do not have access to Environmental Services, then clean and disinfect the area with the approved cleaning products that are available in your area.
- Always look up any unfamiliar product in the SDS.

1. **Personal Protective Equipment Includes:**
    a. Gloves – mandatory at all times
    b. Gowns – mandatory due to possibility of splashes on clothing
    c. Mask – mandatory based on organizational policies and procedures
    d. Face Shield – mandatory due to possibility of splashes on face

2. **Cleaning Procedure Includes:**
    a. Wear gloves, a gown, mask, and face shield
    b. Take the following supplies/equipment to the spill area:
        i. Gloves, gown, mask, and face shield
        ii. Spill Kit located in your department
        iii. Follow manufacturer's directions on back of spill kit
        iv. Dispose of RED bag with spill contents in Biohazard Room

v. Call Environmental Services to disinfect the floor or area where spill occurred, and contents have been removed
vi. Remove gloves, gown, and face shield and discard in Biohazard Room
vii. After the spill is cleaned up and equipment is discarded properly, wash hands thoroughly

Always observe Safety Precautions. Any exposure to blood/body fluids or chemicals needs to be reported to the Occupational Health Nurse or go to the Emergency Department immediately.

Waste Stream Disposal –Quick Sheet

	Non-hazardous	Hazardous	Controlled Substances	CHEMO	Additional Waste			
Disposal Location	BLUE Bins for Non-hazardous waste	Black Bins for Hazardous Waste	Storage and Waste Hauling Containers for Controlled Substances Only	Yellow Chemo Bin	Red Sharps Bins	Red Biohazardous Waste Bag	Regular Trash Bin	Drain
Instructions	For expired and non-recyclable non-hazardous/non-controlled drugs that cannot be returned for credit DO NOT PLACE chemo nor characteristic and/or P-/U-listdrugs. PLACE in the **BLUE** until you are told what to do	For characteristic and/or P-list/U-list drugs Packaging that held a P-listed drug must be put in the black bins. Place any P-listed packaging and waste in a zip-lock bag and dispose in **BLACK Bin** Place any alerted Black Container waste and partial sharp (syringes with or without needles, ampules)	For Controlled Substances Slots for solid (e.g. pills), liquid (e.g. oral liquid, injection) or patch waste. Document appropriate waste & REMOVE all OUTER packaging to expel contents directly into designated slot	For TRACE (Empty) Chemotherapy Waste with biohazardous/ infectious waste symbol Empty syringes, vials, ampoules, IV bags and trace contaminated PPE Excluding empty Arsenic Trioxide containers "P-Listed" Dispose of as "Incinerate Only" Regulated Medical Waste	For sharps (i.e. needles, broken glass vials/ ampules) (that did not contain chemotherapy nor characteristic and/or P-/U-listed drug)	Used on NURSING UNITS for bio-hazardous items and used IV bags and sets. (These are NOT for Regular Trash & NOT for Sharps)	If medication container is empty & it did not contain chemotherapy nor characteristic and/or P-/U-listed drug, then dispose of in regular trash	For IV bags with no medications, including sugars, salts, and electrolytes, these can be discarded down the sink. (Unused empty bags may be disposed in regular trash)
Examples	• Pills or tablets (e.g. amoxicillin, aspirin) • IV with medication left • Creams and ointments capped • Expired pre-packed medications • Epinephrine • Lidocaine • Depo-provera • Nexplanon	• Warfarin • Nicotine • Nitroglycerin • Physostigmine	• FentanNYL patches • HYDROcodone • Morphine • OxyCODONE *Some controlled substances will be incompatible to place in these containers, there will be a message on the Pyxis indicating that you call a Pharmacist for waste management*	• Trace PPE • Empty Chemo IV Bags • Empty Chemo Vials Anything that is not considered EMPTY is disposed in BLACK Container	• Needles • Broken glass vials/ ampules (that did not contain chemotherapy nor characteristic and/or P-/U-listed drug)	• Blood and blood product in plastic containers • Body fluids • Blood-saturated materials • Blood transfusion tubing and bags Chest tubes	• Empty IV bags • Medication wrappers • Uncontaminated gloves • Empty drug vials (that did not contain chemotherapy nor characteristic and/or P-/U-listed drug)	IV solutions or IVPB containing any of following • Potassium chloride • Potassium phosphate • Sodium phosphate • Calcium • Sodium bicarbonate • Dextrose Sodium Chloride
Sharps	YES with medication	YES with medication	NO	YES Empty sharp in YELLOW Partial sharp in **BLACK**	Empty Sharps ONLY	NO	NO	N/A
Controlled	NO	NO	YES – Follow institutional policy	NO	N/A – Follow institutional policy	NO	NO	N/A

Fire Safety Management Plan

OBJECTIVE

This plan has been established for the purpose of:
- Protecting patients, personnel, visitors, and property from fire, smoke, and other products of combustion
- Maintaining compliance with Life Safety Code (NFPA 101, 1991 edition)
- Training Center personnel in emergency fire procedures and routinely testing staff knowledge of such procedures
- Reporting fire emergencies to appropriate personnel
- Critiquing staff knowledge and performance of fire procedures

Note: During renovations, contracted personnel and Duke Regional Hospital personnel follow Life Safety Policies and Procedures as pertains to Duke Regional Hospital. (Contact person: Director of Engineering 919-470-4160)

SCOPE

This plan establishes policies/procedures that address:
- Inspecting, testing, and maintaining fire alarm systems, components, and 911 ring-down lines
- Inspecting, testing, and maintaining automatic fire-extinguishing systems
- Inspecting and maintaining portable fire extinguishers
- Ensuring all window treatments and other furnishings meet applicable fire safety criteria
- Reporting and resolving fire protection deficiencies
- Utilizing Interim Life Safety Measures (ILSM) during construction and renovation projects

EDUCATION

This plan establishes policies/procedures that address:
- Personnel roles/responsibilities during fire emergencies
- Conducting fire drills at least annually
- Environment of Care Competence Assessment training and testing

PERFORMANCE STANDARDS

This plan establishes policies/procedures that address:
- Personnel knowledge, ability, and level of participation in performing fire procedures
- Monitoring and inspecting activities
- Routine procedures for emergency and incident reporting that specify when and to whom reports are communicated
- Enhanced fire safety surveillance activities during construction and renovation projects

The objectives, scope, performance, and effectiveness of the Life Safety Management Plan will be evaluated annually by the Environment of Care Committee.

FIRE AND EVACUATION PLAN

PURPOSE

To describe procedures to be followed by Security and staff, as applicable, in the event of a fire emergency or fire drill at Lincoln Community Health Center.

RESPONSIBILITY

The Safety Officer and Security, or their delegates, are responsible for planning and executing the annual fire drills at Lincoln Community Health Center.

GENERAL

The Lincoln Community Health Center building is protected by fire alarm devices and fire extinguishing equipment as described below:

- Smoke detectors and thermal detectors in corridors and work areas.
- Smoke and thermal detectors in the air-handling system.
- Sprinklers located ONLY in Dead Storage on the first floor (LCHC Main Site).
- Manual alarm pull stations.
- Portable fire extinguishers:
  - 5 lb. dry chemical extinguishers (Class "A, B, C" fires).

For the protection of the general public and Center staff, all personnel working in one of the Center buildings should be familiar with:

1. Fire emergency procedures*
2. Locations of the pull alarm stations
3. The location of the fire exits

***FIRE EMERGENCY PROCEDURES**

Fire Procedures to be taken upon discovery of a "Code Red" (fire)* in the Center are as follows:

R - **Remove** person(s) in immediate danger.
A - Pull manual **alarm** pull station nearest to fire
C - **Contain** the "Code Red" by closing all doors, making sure patients and staff are out of the area.
E - **Extinguish** the fire if possible, using portable fire extinguisher(s).

AND

P - **Pull** pin in extinguisher trigger
A - **Aim** extinguisher at base of fire
S - **Squeeze** trigger to activate extinguisher
S - **Sweep** material back and forth

- Total evacuation will be at the direction of the Safety Officer, or delegate, and/or the Fire Department.
- When a fire emergency response has been cleared by the Fire Department or by the Safety Officer or their designated representative, a "Code Red, All Clear" will be announced via the paging system.

PROCEDURE (for Security at Main):

At Lincoln Main the following steps will be taken by Security prior to and directly following an actual Fire or Fire Drill:

SECURITY:

Fire Alarm
The on-duty security officers will take the following action when a Code Red notification is received:

Officers will respond to the alarm location to determine if the alarm was tripped accidentally, or if there is an actual fire.

1. If the alarm was tripped due to an actual fire:
   - Proceed with the R.A.C.E. procedure as outlined previously.
   - One officer will direct persons on the upper level towards the nearest exits and assist with crowd control until Durham Fire Department arrives.
     - After the situation is contained, the officer will announce on the PA system, "Code Red Clear."
   - Another officer will immediately report to the Security Office to:
     - Silence the emergency door alarms, and
     - Answer the phone when monitoring service calls to inquire about the alarm.
     - The officer will assist with crowd control on the lower level and assist the Fire Department personnel in silencing the alarm in the Fire Panel.
     - After "Code Red Clear" is announced and everyone has returned to the building, the officer will reactivate emergency door alarms.
2. If the alarm was tripped by accident (i.e. child pulled the alarm, construction dust, etc.):
   - Proceed with the R.A.C.E. procedure as outlined previously.
   - After everyone is evacuated:
     - One officer will reset the pull station, and make a "Code Red Clear" announcement over the PA system.
     - Another officer will immediately report to the security office to 1) silence emergency door alarms and 2) answer the phone when monitoring service calls to inquire about the alarm. Tell them that it is a false alarm, and give them your name, location, and password. They will notify Durham Fire Department not to respond. The officer will also acknowledge, silence, and reset the alarm inside the Fire Panel.
     - After "Code Red Clear" is announced and everyone has returned to the building, the officer will reactivate emergency door alarms.

Security will be responsible for documentation of fire drills and events in compliance with the Joint Commission Standards. One fire drill per calendar year is required. All documentation of fire drills and events will be kept with the Safety Officer, or delegate.

In the event of an actual fire on LCHC property, the following personnel will be notified immediately by phone if they are not present:

- Safety Officer
- Director of Operations
- Security Director
- Security Operations Manager
- Director of Engineering

Planned/Scheduled Fire Drills:
Officers will:

- Notify monitoring service of the upcoming fire drill. Security will ask that the alarm system be taken off line for 45 minutes. Monitoring service will notify Durham Fire Department of the upcoming drill.
- Notify switchboard supervisor and IT of the upcoming drill. The Safety Officer will notify Duke Regional Hospital Switchboard that they will be answering our calls.
- Turn off emergency door alarms.

When ready:

- One officer will report to the security office area. The officer will silence and reset the alarm inside the Fire Panel when all personnel are outside. After "Code Red Clear" is announced and everyone has returned to the building, the officer will reactivate emergency door alarms and the Fire Panel, notify alarm monitoring service that the drill is completed, and instruct the Safety Officer to call DRH switchboard.
- Another officer will begin the drill by giving a staff member a red card marked with where the "fire" is located. Assist the staff member with how to proceed with the RACE/PASS procedure, to include an evacuation. Once the alarm pull station has been pulled, Security assisted by staff will direct all staff, visitors, and patients to the nearest exit. Once the fire drill is complete, the security officer will reset the fire alarm pull station, and announce on the PA system, "Code Red Clear."

PROCEDURE (for Staff at Main):

Upon hearing the fire alarm, each department or area will evacuate quickly. Check the restrooms, exam rooms, and/or offices in your immediate area, close doors, and assist persons to the nearest exit. The Environment of Care Committee members and other staff assigned to a monitoring post will immediately go to their post to direct traffic and take the nearest exit when their area is clear of persons. No one should use elevators until the drill/event is cleared.

Evacuees will report to either the last row of the front parking lot against the wall or across Spaulding Street from the back entrance. Once there, attendance can be taken by the supervisor of that department, who will check their roster of staff working at the time of the drill/event. Reports of staff unaccounted for will be given to the Director of Operations.

All satellite clinic staff will follow the emergency management plan for their facility, receive instructions from the Incident Commander on location, and inform the Director of Operations and/or Safety Officer, or their delegate, of the status of events.

FIRE DRILL RESPONSIBILITY FOR OFF-SITE CLINICS:

LCHC off-site clinics (all clinic and administrative locations other than the main site) will be responsible for coordinating or participating in their own annual fire drills as directed by the site. Responsibility for conducting and documenting annual fire drills for each site is as follows:

- Holton – Durham Public School System
- Hillside – Durham Public School System
- PCC – Durham County Human Services
- EIC – Durham County Human Services
- Lyon Park – Calvary Building Management
- Walltown, Livewell, Healthcare for the Homeless, and DRRC – LCHC delegate

Medical Equipment Management

PURPOSE

This plan has been established for the purpose of promoting safe and effective use of medical equipment; to maintain a systematic approach to medical equipment management at Lincoln Community Health Center, LCHC satellites, and the Duke-affiliated Clinics. This approach includes purchasing (for LCHC and LCHC satellites), inventory maintenance, repair, and annual preventive maintenance (PM).

SCOPE

This plan establishes policies/procedures that address:

- Selection and acquisition of medical equipment (Purchasing and testing of electrically-powered equipment for patient use per the Safe Medical Devices Act)
- Establishment of criteria which address identifying, evaluating, and inventorying of equipment to be included in the program:
    - Equipment function
    - Physical risk associated with use
    - Maintenance requirements
    - Equipment incident history, researched by Clinical Engineering, Duke Regional Hospital
- Assess and minimize clinical and physical risk associated with the use of specific equipment through inspection, testing, and maintenance (Clinical Engineering).
- Monitoring for corrective actions on equipment safety recalls/product alerts (Product Recall/Safety Alert Procedure)
- Investigating and reporting occurrences in which medical devices have possibly caused or contributed to death, serious injury, or serious illness of a patient or other individual as required by the SMDA Final Rule, 1996.
- Investigating and reporting medical equipment problems, failures, and user errors that had or could have had adverse effects on the environment of care.

Safe Medical Devices Act of 1990 (SMDA)

DEFINITIONS

Medical Device: Anything that is used in treatment or diagnosis that is not a drug. The FDA defines a medical device as an instrument, apparatus or other article that is used to prevent, diagnose, mitigate or treat a disease or to affect the structure or function of the body, with the exception of drugs. Examples of medical devices are: x-ray machines, defibrillators, syringes, heating pads, gauze pad, wheelchairs, exam beds, EKG machines and vital signs monitors.

Safe Medical Device Act (SMDA): A federal program that requires reporting to the Food and Drug Administration (FDA) and the product manufacturer of a medical device occurrence that has or may have contributed to serious illness, serious injury, or death. This includes occurrences that may be attributed to user error.

Serious Illness or Injury: An injury or illness that 1) is life-threatening; 2) results in permanent impairment of a body function or permanent damage to a body structure; or 3) necessitates medical or surgical intervention to preclude permanent impairment of a body function or permanent damage to a body structure.

PROCEDURES

Purchase of New Medical Equipment:

1. LCHC purchases new medical equipment from manufacturers that are also utilized by Duke/Duke Regional Hospital (DRH). This facilitates the approval process and repair of patient care equipment. In the event LCHC requires equipment that is not on Hospital inventory, the Duke Clinical Engineering (CE) Operating Manager may approve LCHC equipment before purchase.

2. All new equipment is tested, tagged, and inventoried before going to the Clinics.

Equipment Inventory:

1. Clinical Engineering maintains an inventory of LCHC's equipment in a database. This database contains the type of equipment, manufacturer, CE #, PM, calibration, and repair dates.

2. CE also maintains an equipment inventory for the Lincoln/Duke Partnership Clinics. The Lincoln/Duke Partnership Clinics are responsible for purchase and reporting of broken equipment to CE.

Annual Preventive Maintenance:

CE performs PM on all equipment annually. During PM, the equipment is tested operationally and for electrical safety. Scales are calibrated at this time. The equipment is tagged with a new PM sticker/date, and the information is entered into the database.

Procedure for Medical Equipment Repair:

1. Staff identifies malfunctioning equipment.
2. Equipment is taken to the Director of Nursing Services' (DON) office OR left in the clinic with an "Out of service" tag. The DON, or delegate, is notified.
3. Email is sent or phone call made to the Operation's Manager, Clinical Engineering (OMCE).
4. The OMCE assigns repair to a technician.
5. DON, or delegate, is notified of date and time a technician will arrive.
6. Equipment may be repaired on site, taken back to the hospital, or sent to the manufacturer for repair.
7. Equipment that cannot be repaired due to lack of parts to support repairs, age, or extensive damage, is taken off inventory by CE and discarded by Lincoln.
8. *See below, "Contacts for Medical Equipment Repair."*

Staff Training:
Before equipment can be put into use in the clinics, all users are in-serviced on the equipment and a competency assessment completed, as applicable for new/upgraded equipment. New employees are oriented to equipment in their department or service area during orientation. This is facilitated by the Safety Officer and/or Clinical Nurse Managers, or their delegates. Education and training should include:

- Capabilities, limitations, and special applications of medical equipment
- Basic operating and safety procedures
- Emergency procedures for equipment failure
- Information and skills to perform maintenance
- Process for reporting medical equipment problems, failures, and user errors.
- Environment of Care training and competency testing.
- In-service training and competency assessment on all new medical equipment.

Process for reporting medical equipment failure that results in serious illness or injury to a patient:

1. Immediately take equipment out of service and notify the DON, or delegate.
2. DON, or delegate, will notify CEO, or delegate, who will assume responsibility for communication with the Food and Drug Administration (FDA) and any other applicable government agency and/or manufacturer should defects be found.
3. Event will also be reported to the Director of Risk Management and the Director of Operations.
4. Equipment will be sequestered and will not be put into use on the floor until the DON, or delegate, has received appropriate notification of clearance of equipment as being safe.
5. For more information: https://www.fda.gov/medical-devices/medical-device-safety

CONTACTS FOR MEDICAL EQUIPMENT REPAIR

Medical Equipment Repair:
Duke Clinical Engineering Operations Manager Telephone: (office) 919-470-8181
Equipment that can't be repaired by Clinical Engineering or Carolina sales will be repaired by Henry Schein Pro Repair. Telephone: 800-367-3674

Audiometer Services:
Audiometers are serviced by Carolina Sales and Services Audiometer Company. A technician can be called for routine repairs, as well as annual PM on audiometers at the Lincoln main site, LCHC Satellites, and the Lincoln/Duke Partnership Clinics. Telephone: 800-776-9046.
Welch Allyn Audiometers that cannot be repaired by Carolina Sales and Service will be sent to the manufacturer for repair by Lincoln.

Autoclave Services:
Autoclaves are serviced by Medco Service. Annual PMs are performed as well as general repairs. The contact number for the technician (cell): 910-977-0399.

Microscope Cleaning and Servicing:
Clinical Engineering (DRH/Duke), Telephone: 919-470-8181.
The objectives, scope, performance, and effectiveness of the Equipment Management Program are to be evaluated annually by the Environment of Care Committee.

Utilities Management

OBJECTIVE

This plan has been established for the purpose of promoting a safe, effective, comfortable, and reliable environment of care, assessing and minimizing the risk of utility failures and ensuring operational reliability of Duke Regional Hospital (DRH) utility systems as they pertain to LCHC.

SCOPE

This program establishes policies/procedures that address:

- Establishing criteria for identifying, evaluating, and inventorying critical operating components of utility systems to be included in the utility management program. These criteria address the impact of utilities on:
    - Infection control systems
    - Environmental support systems
    - Equipment support systems
    - Communications systems
- Inspecting, testing, and maintaining critical operating components.
- Developing and maintaining current utility operational plans for ensuring reliability.
- Investigating/reporting utility problems, failures, and user errors, including corrective actions taken.

EDUCATION

This program establishes an orientation and education program that addresses:

- Utility systems' capabilities, limitations, and special applications
- Emergency procedures for utility failures
- Information and skills necessary to perform maintenance
- Location and instructions for use of emergency shutoff controls
- Processes for reporting utility problems, failures, and user errors
- Environment of Care training and competency testing

PERFORMANCE STANDARDS

This program establishes policies/procedures that address:

- Skills of the maintainers of utility systems
- Level of maintainers of utility systems
- Emergency and occurrence reporting procedures specifying when and to whom reports are to be communicated
- Inspection, preventive maintenance, and testing of critical utility components

EMERGENCY PROCEDURES

This program establishes emergency procedures for utility system disruptions or failures that address:

- Specific procedures for utility system failures
- Identification of alternate sources of utilities
- Shut-off of malfunctioning systems and notification of staff in affected areas
- Obtaining utility repairs

For utilities problems or failures contact the following:

Main LCHC site – Engineering Department at Duke Regional Hospital, phone: 919-470-4159 for appropriate departmental response.

DRRC – Durham County General Services 919-560-7196

EIC/PCC/WIC at DCoDHHS – Durham County General Services 919-560-7196

Healthcare for the Homeless Clinic – Durham County General Services 919-560-7196

Hillside Wellness Center – 919-560-2000

Holton, Lyon Park, Walltown Clinics – 919-681-2930

Live Well – 704-749-7243

The objectives, scope, performance, and effectiveness of this utility management program are to be evaluated annually by the Environment of Care Committee.

Annual Hazard Vulnerability Analysis

2021 Lincoln Community Health Center Hazard Vulnerability Analysis

Location	Category	Event	Occurrence/Probability			Preparation Level		
			High	*Moderate*	*Low*	*Good*	*Fair*	*Poor*
LCHC including satellites	Weather	Flooding			X	X		
		High winds		X		X		
		Hurricane			X	X		
		Tornado		X		X		
		Winter storm		X		X		
	Utility Failures	Electricity (HVAC)	X			X		
		Life safety systems			X	X		
		Natural gas/fuel oil			X	X		
		Sewage			X	X		
		Telephone/Overhead paging		X			X	
		Water - Non-potable			X	X		
		Water - Potable			X	X		
	Security	Code Pink - Child Abduction		X		X		
		Code Yellow - Bomb threat			X	X		
		Civil disturbance		X		X		
		Proximity to gang-related activity	X				X	
		VIPs			X		X	
		Workplace violence		X			X	
	Other	Aviation/train crash			X	X		
		Chemical spill - internal			X	X		
		Code Orange - Chemical, Biological, Radiological, Nuclear, Explosive - CBRNE Incidents			X		X	
		Fire			X	X		
		Influx of patients with highly communicable infectious disease		X			X	
		Supply chain			X		X	
		Water leak - internal	X				X	

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