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

Infection Prevention & Control Manual

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COVID-19 Infection Prevention & Control Amendment:

Lincoln Community Health Center employees, volunteers, and contractors should follow COVID-19 precautions as best possible throughout the duration of the pandemic and public health crisis. Supervisors should ensure that all individuals (employees, volunteers, patients, visitors, students, and contractors) are wearing masks based on applicable, current CDC and organization recommendations/requirements. Social distancing should be implemented, as much as possible, to reduce the risk of the spread of disease. Specific protocols and guidelines can be found in the LCHC COVID-19 Response Plan.

INFECTION PREVENTION AND CONTROL PLAN

I. PURPOSE:

A. Lincoln Community Health Center (LCHC) is committed to complying with all applicable regulations governing infection prevention and control and providing a work environment that minimizes the risk of exposure to bloodborne pathogens and other body fluids.
B. The goal of the LCHC Infection Prevention & Control (IPC) Plan is to establish a comprehensive program to ensure the organization has a functioning, coordinated process in place to minimize the risks of healthcare-associated infections (HAIs) in patients and health care workers while optimizing the use of resources through a strong prevention program.
C. The LCHC IPC Plan incorporates the following:
    1. Surveillance, prevention, and the control of infections throughout the organization.
    2. Development of procedures and protocols to address real and potential exposures.
    3. Selection and implementation of evidence-based protocols to minimize adverse outcomes.
    4. Evaluation and monitoring of results allowing for revision of policies, procedures, and protocols as needed.

II. PROCEDURE:

The Infection Prevention and Control Program at LCHC allows for a systematic, coordinated, and continuous approach. This program is guided by the following:

A. All pertinent and applicable federal, state, and local regulations pertaining to infection prevention and control. (OSHA, CDC, NIH, The Joint Commission, Infectious Diseases Society of America, Association for Professionals in Infection Prevention/Control and Epidemiology, etc.)

B. LCHC Infection Prevention and Control Risk Assessment Tool. (Attachment A)

C. In-service education for all employees via the learning management system, which begins at the date of hire and is included in annual required training. All employees are required to participate in the IPC training in an effort to reduce and control the spread of infection. The training includes the proper use of personal protective equipment (PPE), education on tuberculosis symptoms and modes of transmission, safe handling of sharps, and general infection prevention and control practices. Trainings will be updated as needed based on applicable changes to evidence-based practice recommendations.

D. Surveillance programs such as Hand Hygiene will be done by staff under the direction of the Infection Control Nurse (ICN).

E. Monitoring and evaluation of key performance aspects of infection control surveillance, prevention, and management which are:
- Medical instrument and equipment related infections
- Multi-drug resistant organisms
- Tuberculosis infections
- Occupational exposure to bloodborne pathogens (blood, body fluids, and other potentially infectious materials (OPIM))
- Employee health trends
- Other communicable diseases as indicated

F. Continuous monitoring of data to identify potential infectious outbreaks.

G. Utilization of sound epidemiologic principles and nosocomial infection research from recognized authoritative agencies.

H. Collaboration with all organizational policies and procedures impacting the prevention and control of infection.

I. Interaction with and reporting to federal, state, and local governmental agencies, as applicable.

III. RESPONSIBILITIES:

- The IPC Plan falls under the scope of the Risk Management Committee. The Risk Management Committee will review the plan at least annually and will propose changes to the Quality Improvement Committee and the Quality Improvement & Risk Management Director as indicated.
- The Infection Control Nurse is responsible for implementing policies and procedures related to infection prevention and control and recommending any necessary updates to the Risk Management Committee, as applicable.
- All staff are responsible for maintaining a clean and sanitary work environment, familiarizing themselves with the IPC Plan, and implementing infection control practices.

IV. IPC PROGRAM PLAN:

A. A corrective action plan will be formulated when there is an identified area of concern, a specific problem or an opportunity for improvement.

B. When problems or opportunities for improvement are identified, any actions taken and/or recommended will be documented in the minutes of the Risk Management Committee meeting.

C. If immediate action is necessary, the ICN, or delegate, has the authority to institute any surveillance, prevention, and/or control measures, if there is reason to believe anyone is at risk.

D. The ICN has the responsibility for infection prevention and control activities throughout the facility and satellites.

E. All personnel are accountable in the reporting of suspected infections, or any suspected Infection Control issues. Collaboration amongst departments is essential to identify issues and help to improve outcomes in the reduction and control of infections.

F. The coordination of surveillance, data gathering, aggregation, and analysis is the responsibility of the ICN, or delegate.

G. All personnel are advised that there are to be no food or beverages consumed in the clinical areas. All food and beverages must be in an employee break area or employee designated fridge.

H. The ICN will:

- Do periodic observation of personnel to verify standard precautions are being utilized appropriately.
- Review of hazardous waste/bio-hazard management and disposal throughout the facility.

- Generate and present reports to government agencies/representatives as needed.
- Identify and track key performance measures related to process and outcome in an effort to continuously improve the management of HAIs throughout the organization.

I. The ICN will oversee the offering of healthcare in-service education related to infection prevention and control practices to healthcare personnel as needed.

J. The ICN will monitor infection prevention throughout the facility and satellites and determine if procedures are working well or require revision.

- Monitoring of infection control program is achieved through:
  - Committee interaction
  - Daily job functions of the ICN
  - Comparisons of current information, historical data, bench marking or other updates
  - Review of policy and procedure; future inspections and surveys
  - Interaction with other network entities

V. REGULATORY COMPLIANCE:

i. IC.01.06.01: The Organization prepares to respond to an influx of potentially infectious patients.

LCHC has a comprehensive procedure imbedded in our Emergency Management Manual. The Infection Prevention and Control Nurse, Director of Operations, or their delegate, is the chair of the Environment of Care Committee and the Quality Improvement & Risk Management Director is the chair of the Risk Management Committee. Concerning information related to infections with potential for causing an influx is obtained from the CDC website and the North Carolina Department of Public Health. In the event an influx of potentially infectious patients should occur, the Incident Command Center would be activated per organization procedure.

ii. IC.02.01.01: The organization implements its infection prevention and control plan.

LCHC has Infection Prevention policies and procedures which outline strategies designed to reduce the risk of transmission of infectious agents among healthcare workers, patients, and visitors. Those policies and procedures are based on relevant evidence and guidelines, are approved by the Risk Management and Quality Improvement Committees, and are reviewed at least every 3 years or as needed.
Standard precautions will be utilized on all patients at LCHC.
Safe injection practices and respiratory hygiene/cough etiquette are incorporated in this Infection Prevention & Control Manual.

Additional procedures include but are not limited to:
- Appropriate cleaning, storage, disinfecting, sterilization and disposal of equipment;
- Appropriate use of personal protective equipment;
- Appropriate disposal of medical and regulated medical waste;
- Outbreak investigation

LCHC will conduct an evaluation of the Infection Prevention and Control Plan and goals at least annually, and as needed for significant changes.

iii. IC.02.02.01: The organization reduces the risk of infections associated with medical

equipment, devices and supplies.

Policies and procedures outline the process for appropriate cleaning, storage, disinfecting and disposal of equipment, medical equipment, devices and supplies.

- Critical items will be sterilized
- Semi-Critical items will receive high level disinfection
- Non-critical items will receive low level disinfection per manufacturer's recommendations

Reports related to sterilization and disinfection processes are monitored by the Infection Prevention Nurse. No reprocessing of single use devices is performed by LCHC staff.

iv. **IC.02.03.01: The organization works to prevent the transmission of infectious disease among patients, licensed independent practitioners, and staff.**

LCHC has a comprehensive Occupational Health Program designed to reduce the risk of transmission of infectious agents in staff.

This includes:

- Screening of staff for exposure and/or immunity to communicable disease
- Referral for assessment, potential testing, immunization, and/or prophylaxis of all staff identified as having a communicable disease or having been exposed to a communicable disease
- Referral for assessment, potential testing, immunization, and/or prophylaxis of all staff identified as having an occupational exposure
- In the event a patient is exposed to a communicable disease, they will be provided with or referred for assessment, testing, immunization, prophylaxis, treatment, or counseling, as applicable. Occupational Health Nurse and Risk Management Director, or their delegates, will maintain a log of all incidents of infection and communicable disease of all staff (patient care, non-patient care, employees, and volunteers).

v. **IC.02.01.01 through IC.02.03.01**

The activities of Infection Prevention and Control strive to be practical and involve collaboration between all organizational departments and staff. Everyone who works at LCHC has a role and holds others accountable. Important and pertinent Infection Prevention and Control information is made available to employees, students, contractors, and patients, as applicable. Standard and transmission-based precautions are used and any outbreak of infection within the organization or relevant patient community is investigated, as applicable.

vi. **IC.02.04.01: The organization offers vaccination against influenza to licensed independent practitioners and staff.**

LCHC along with the Occupational Health Department has an established annual influenza vaccination program that includes all staff and relevant volunteers, contractors, and students, as applicable.
Immunizations are offered on site and at no charge to staff at varying times and locations during influenza season. Processes have been implemented to assist medically and religious exempt individuals.
Immunization rates are compiled and reported annually to the Risk Management Committee.
Influenza vaccination is a required immunization for employment at LCHC unless an approved exemption is documented with the Human Resources Department.

vii. **IC.03.01.01: The organization evaluates the effectiveness of its infection prevention and control plan.**

The effectiveness of the Infection Prevention and Control Plan is reviewed at least annually by the Risk Management Committee and more frequently as necessary.

The review includes an evaluation of:

- Prioritized risks to determine opportunities for improvement
- Goals to determine outcomes
- Results of surveillance findings and analysis to determine future goals

Subsequent annual risk assessments and Infection Prevention and Control Plan will be revised based on the previous year's evaluation.

Hand Hygiene for All Healthcare Workers

Purpose:

To prevent the transmission of microorganisms from patient to patient and from inanimate surfaces to patient by the hands of all health providers. All employees, volunteers, and contractors of Lincoln Community Health Center (LCHC) and its satellites will adhere to this procedure.

- Hand hygiene shall be practiced before and after each patient contact (even if gloves are worn). All employees are required to wash, rinse, and dry their hands or apply an alcohol hand rub before beginning work, after using the rest room, and prior to leaving work.
- Antiseptic (antimicrobial) handwashing products or alcohol hand rub shall be used for hand hygiene.
    - If a patient is identified as having C.diff (*clostridium difficile*), or other infectious agent that is not sensitive to alcohol hand rub, individuals are expected to use soap and water for all hand hygiene as needed before, during, and after patient contact.
- An alcohol hand rub may be used for hand hygiene in place of an antimicrobial soap hand wash. Hands that are grossly contaminated must be washed with lotion soap prior to hand disinfection with an alcohol hand rub.
- Gloves shall be worn when exposure to blood or any other body fluids, excretions or secretions is likely.
- For a given patient, site care shall start at the cleanest site (e.g., mouth care) and progress to the dirtiest site (e.g., genitourinary care). When going from a dirty site to a clean site, hands shall be washed, or an alcohol hand rub applied between sites.

Procedure:

- Use warm water to wet the hands.
- Apply antiseptic soap (containing chlorhexidine).
- Apply with vigorous contact on all surfaces of the hands.
- Wash hands for at least 20 seconds.
- Rinse, avoid splashing.
- Keep hands down so that run off will go into the sink and not down the arm.
- Dry well with paper towels and use the paper towels to turn off the faucet.
- Discard the paper towels into the appropriate container.

Hand Antiseptics:

An alcohol hand rub may be substituted for antimicrobial soap. The following technique should be used:

- If hands are visibly soiled, wash hands with lotion soap prior to application of alcohol hand rub.
- Apply enough alcohol hand rub to cover the entire surface of hand and fingers.
- Rub the solution vigorously into hands until dry.
- Use of alcohol hand rubs may result in a sticky residue on the hands. Wash with lotion soap periodically to remove the hand rub residue.

Allergic Contact Dermatitis Associated with hand Hygiene Products:

Allergic reactions to products applied to the skin may present as delayed type reactions or less commonly as immediate reactions. If a Healthcare worker suspects allergic contact dermatitis, they will be instructed to go to the Occupational Health Nurse and fill out an Employee Incident Form. The Occupational Health Nurse will assess the situation and further steps will be given. If an allergic contact dermatitis is diagnosed by a physician,

the healthcare worker will present the documentation to the Occupational Healthcare Nurse and appropriate action will be taken.

Hand Hygiene Tracking Log:

Secret hand hygiene volunteers/staff will monitor appropriate hand hygiene on a frequent basis. This could be daily to weekly depending on the area and the frequency the monitor is able to be in that area. Hand Hygiene monitoring instructions will be given by the ICN through face-to-face education. All data will be logged by ICN and action plans put in place for noncompliance. Lincoln Community Health Center’s goal for organization wide hand hygiene compliance is to maintain at least 85% compliance with the procedure as outlined above.

Hand Hygiene Observation Log

Rules for conducting hand hygiene observations:

1. Observe for hand hygiene upon ENTRY & EXIT from Patient Environment.
2. A person may use the hand sanitizer dispenser outside the room door, the dispenser inside the room, or the sink.
3. Do not guess. If your view is blocked and you can't confirm if person performed hand hygiene simply mark unsure.
4. Do not exceed 3 observations per person in one session.

Identify Role of Observed Person					Identify Method of Hand Hygiene
unknown	RN	MD	EVS		unsure
	LPN	DO	other		hand sanitizer (HS)
	MA	APP			soap & water (SW)
					none

Observation	Date/Time	Circle one	Role	Method	Comments
1		ENTER / EXIT			
2		ENTER / EXIT			
3		ENTER / EXIT			
4		ENTER / EXIT			
5		ENTER / EXIT			
6		ENTER / EXIT			

DEPARTMENT/CLINIC: _____

NAME OF OBSERVER: _____

SIGNATURE: _____ DATE: _____

Infectious Disease Incident Management Protocol

Purpose

To describe the LCHC response to an infectious disease event of either natural or potentially malicious (i.e. bioterrorism) origin. This plan may be used toward the following scenarios:

- An event involving an agent of unknown etiology, and/or
- An event involving a known, highly contagious organism (e.g., H1N1 Influenza, Avian Influenza (H5NI), SARS-CO-V, Anthrax, Smallpox, Plague) or any Novel infectious agent.

Concept of Operations

LCHC's response to an infectious disease event is based on five principles.
These are:

- Identification
- Isolation
- Notification
- Mobilization
- Evaluation and treatment or facilitate transportation to area hospital

Identification:
Early identification of an infectious disease event is critical to ensuring a proper medical response as well as to ensure the protection of other patients, staff, and visitors.

In general, any patient presenting with the following clinical syndromes is of concern:

- Influenza-like illness (fever >100, sore throat, cough)
- Acute severe pneumonia or respiratory distress with no history of respiratory disease
- Acute onset of neuromuscular symptoms
- Unexplained rash with fever
- Fever and bleeding from mucous membranes
- Unexplained acute jaundice
- Massive diarrhea with dehydration and collapse

Presence of any combination of the following characteristics with the above syndromes should immediately increase the provider's index of suspicion:

- Clusters of patients presenting with similar symptoms, closely clustered in time
- Patient has recently traveled internationally or to an affected area, or has had contact with person who has traveled internationally
- Patient is < 50 years of age or >65 years of age
- Immunologically intact
- Patient in good health prior to acute syndrome

With the exception of laboratory testing, no one characteristic by itself is an indicator of infectious disease. It is the appearance of more than one element that should prompt the provider to "consider" the possibility of an infectious disease event.

Notification:
Infection Control Nurse, Director of Nursing, Safety Officer, CEO, Human Resources, Risk Management, Lab, Radiology, Security, Pharmacy, Environmental Services, Behavioral Health, Engineering, Materials Management should be notified of all actual or suspected infectious disease events.

Once an infectious disease event is suspected, it is important to begin the notification process. The Nurse Managers should notify the ICN and DON. The ICN then notifies DCHD, who will notify area hospital ICN and the State Public Health Department who will notify Centers for Disease Control (CDC).

Isolation:

■ Proactively isolate anyone suspected of having an infectious disease using both contact and special respiratory isolation precautions.

■ Nursing staff must have on hand and know how to use appropriate personal protective equipment (PPE).

Any patient with symptoms of concern should be immediately isolated in a private room. Staff should utilize contact and respiratory precautions. The patient should be masked and staff entering the room should utilize N95 masks, gloves, disposable lab coats, shoe covers before coming into contact with the patient. Visitors accompanying the patient should remain with the patient.

- Special Respiratory and Contact isolation signage should be placed on the door of any exam room with symptomatic patients.
- Isolation precautions may be relaxed upon the direction of the Medical/Pediatric Chief or their delegate.

Front Line Staff:

- Should be familiar with contact and respiratory isolation protocols.
- Should ensure that they have appropriate PPE.
- Environmental Services should be familiar with the process of decontamination of isolation rooms on contact/respiratory status.

Mobilization:

Mobilization in response to an infectious disease event should be done in a systematic fashion to ensure that all affected departments are notified and on alert.

In the event of an infectious disease event, our EOC (Emergency Operations Center) will be activated using Conference Rooms A & B. (See Center's Disaster Plan).

The Safety Officer will mobilize those key persons to man the EOC.

Responsibilities:

- Consult with ICN, DON, Nurse Managers, and Providers on the number of symptomatic patients in the facility.
- Keep a record of patients' arrivals, discharge, and deaths.
- Determine the facility's needs --- decontamination, equipment, personnel, PPE, etc.
- In the event of deaths in the facility, The Dead Storage area (1st level) will be used to store the deceased until transportation away can be arranged. Stats must be kept on any deceased.
- Ensure the Durham County and State Public Health Departments have been notified.
- Alert Human Resources regarding staffing issues/concerns.
- Alert Behavioral Health to concerns from staff, patients, and visitors.
- Advise on the need for external triage sites, alternate care sites etc. The following facilities may be utilized as secondary triage sites:
    - Walltown Clinic
    - Live Well Clinic

Providers and staff at these sites should be on standby in case of an infectious disease event.

- EOC will ensure that all potentially affected services are briefed on the event of concern.
- EOC will advise security in the event of a mandatory quarantine or facility lock-down.
- If numbers of patients entering the Center becomes unmanageable for our existing human resources, the Safety Officer will impose a lock-down of the facility.
- Lobby areas may become triage sites as exam rooms become full.

Evaluation and Treatment:
LCHC is not an acute care/facility. The sickest patients will be assessed and efforts made to have these patients transported to acute care facilities. Supportive and comfort measures will be used for those patients who are non-acute. Every effort will be made to transport symptomatic patients to other facilities for care.

LCHC will follow the Centers for Disease Control (CDC) case definition for any infectious event.

LCHC will follow the CDC's and the NC Department of Public Health's guidance and algorithms for the care and treatment of patients.

Isolation Precaution Protocols

Airborne Isolation

Airborne Isolation precautions are used to prevent transmission of organisms by airborne droplet particles less than 5um or droplets containing microorganisms that remain suspended in the air and can be dispersed by air currents within a room or over long distances. Diseases for which Airborne Precautions are recommended are:

- Measles
- Varicella (including disseminated Zoster)
- Tuberculosis (pulmonary)

Recommendations: Handwashing before and after contact with patients. Masks with special filtration (N95) must be worn for all persons entering the room of patients with TB or rule out TB. Standard mask for all non-immune persons entering room of patient with Measles or Varicella. Door to exam room to remain closed at all times.

Contact Precautions

Contact Precautions are designed to prevent transmission of highly communicable epidemiologically important infections (colonization). All diseases or conditions included in this category are spread primarily by close or direct contact or indirect contact (touching) with environmental surfaces or patient-care items in the patient's environment. Thus, gowns and gloves are required. Some diseases for which Contact Isolation can be recommended are:

- Acute respiratory infections in infants and young children
- Gastroenteritis
- Herpes simplex, disseminated
- Impetigo
- Multiple-resistant bacteria, infection or colonization
- Gram–negative bacilli resistant to all aminoglycosides
- Methicillin or (Oxacillin) resistant to all aminoglycosides
- Pneumococcus resistant to penicillin
- Haemophilus influenzae resistant to ampicillin or chloramphenicol
- Klebsiella pneumonia resistant to Ceftazidime.
- Pediculosis
- Respiratory syncytial virus (RSV)
- Scabies
- Scalded skin syndrome, Staphylococcal
- Skin, wound or burn infection
    - Major ((draining and not covered by dressing or dressing does not adequately contain the purulent material) including those infected with Staphylococcus aureus or Group A Streptococcus.

Recommendations: Hand washing, Gowns, Gloves to be worn. If equipment is being used, appropriate cleaning with disinfectant before and after is needed.

Droplet Precautions

Droplet Precautions are designed to prevent transmission of infections transmitted by droplets (large particle droplets larger than 5um in size) that can be generated by the patient during coughing, sneezing, talking, or the mist generating procedures such as suctioning and bronchoscopy. Transmission via droplets requires close contact between source and recipient persons because droplets don not remain suspended in the air and generally travel less than 3 feet. Special air handling and ventilation are not required to prevent droplet transmission. Some diseases for which Droplet Precautions are recommended are:

- Epiglottitis caused by H. Influenza
- German measles (rubella)
- Influenza
- Neisseria Meningitides (meningococcal)
- Mumps
- Pertussis (whooping cough)
- Diphtheria
- Streptococcal pharyngitis, pneumonia or Scarlett fever in infants or young children

Recommendations: Hand washing, gloves, and masks are required.

Bloodborne Pathogens Exposure Control Plan

PURPOSE

Lincoln Community Health Center (LCHC) is committed to providing a safe and healthful work environment for our staff and patients. In pursuit of this endeavor, the following bloodborne pathogen exposure control plan is provided to eliminate or minimize occupational exposure to blood and body fluids or other potentially infectious materials (OPIM) and is intended to comply with the requirements of OSHA standard 29 CFR 1910.1030, "Occupational Safety and Health Standards: Bloodborne Pathogens." The Bloodborne Pathogens Exposure Control Plan serves to clarify the process for medical investigation following significant exposures (which includes blood, body fluids, or OPIM via percutaneous route), i.e., needle stick injury, mucosal contact, ocular splash/exposure, oral splash/exposure, and open skin areas.

POLICY

The bloodborne pathogen exposure control plan (ECP) is a key document to assist our organization in implementing and ensuring compliance with the standard, thereby protecting our patients and employees.

This ECP includes:

- Determination of employee exposure
- Implementation of various methods of exposure control, including:
    - Universal precautions
    - Engineering and work practice controls
    - Personal protective equipment
    - Housekeeping and removal of regulated waste
    - Decontamination processes
- Hepatitis B vaccination
- Post-exposure evaluation and follow-up
- Communication of hazards and training to employees
- Recordkeeping
- Procedures for evaluating circumstances surrounding an exposure incident.
- Documentation of annual consideration of safer medical devices and the selection of effective engineering and work-practice controls
- Employee training programs and schedules

The methods of implementation of these elements of the standard are discussed in the subsequent pages of this ECP.

RESPONSIBILITY

- The Quality Improvement & Risk Management Director (QI/RM Director), or delegate, will be responsible for the implementation of the ECP. The QI/RM Director, or delegate, will maintain, review, and update the ECP at least annually, and whenever necessary to include new or modified tasks and procedures. This annual review will include the review and updates, as applicable, to safe medical devices and effective engineering and work-practice controls.
- Those employees who are determined to have occupational exposure to blood or other potentially infectious materials (OPIM) must comply with the procedures and work practices outlined in this ECP. Exposure determinations will be outlined for employees in their job description.
- The Safety Officer, or delegate, will maintain and provide all necessary personal protective equipment (PPE), engineering controls (e.g. sharps containers), labels, and red bags as required by the standard.

The Safety Officer, or delegate, will ensure that adequate supplies of the aforementioned equipment are available in the appropriate sizes.

- The Occupational Health Nurse, or delegate, will be responsible for documenting all employee exposure incidents and ensuring that all medical actions required are performed and that appropriate employee health and OSHA records are maintained.
- The Safety Officer, or delegate, will be responsible for training, documentation of training, and making the written ECP available to employees, OSHA, and NIOSH representatives, as applicable.
- The QI/RM Director will be responsible for reviewing and reporting all exposure incidents as outlined in the Confidential Incident Reporting Procedure.

IMPORTANT DEFINITIONS

Important definitions, as they pertain to this ECP, can be found in the OSHA standard 29 CFR 1910.1030(b). https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1030

METHODS OF COMPLIANCE

Standard (Universal) Precautions:
Standard Precautions shall be observed at LCHC to prevent contact with blood or other potentially infectious materials. Under circumstances in which differentiation between body fluid types is difficult or impossible, all body fluids shall be considered potentially infectious materials. Supervisors of employees working in job classifications who encounter occupational exposure to blood or other potentially infectious materials are responsible for ensuring that employees observe Standard Precautions at all times.

Exposure Control Plan:
Employees covered by the bloodborne pathogens standard receive an explanation of this ECP during their initial training and orientation session. It will also be reviewed in their annual refresher training. All employees have an opportunity to review this plan at any time during their work shifts by contacting their supervisor or the Safety Officer, or delegate. If requested, the Center will provide an employee with a copy of the ECP free of charge and within 2 business days of the request.

Engineering and Work Practice Controls:
Engineering and work practice controls shall be utilized at LCHC as a primary method for eliminating or controlling exposure to blood, blood particles, or OPIM. The following engineering controls will be used and enforced by department supervisors:

1. Sharps containers
2. Regulated waste containers
3. Availability of hand washing facilities

The following work practice controls will be utilized at LCHC and enforced by department supervisors:

1. Employees MUST wash their hands and any other exposed skin with soap and water, or flush mucous membranes with water immediately or as soon as feasible following contact of such body areas with blood or OPIM.
2. Employees MUST wash their hands immediately or as soon as possible after removal of gloves or other PPE.
3. Alcohol–based hand sanitizers are acceptable in place of soap and water but employees are required to wash their hands with soap and running water as soon as feasible after using an appropriate hand sanitizer. Hand cleaners or towelettes are acceptable only where hand washing facilities are not feasible.
4. Contaminated needles and other sharps shall not be bent, recapped, or removed unless no alternative is feasible or such action is required by a specific medical procedure. Such recapping or needle removal

must be accomplished through the use of a mechanical device or a one-handed technique. SHEARING OR BREAKING OF CONTAMINATED NEEDLES IS PROHIBITED.

5. Sharps disposal containers are inspected and maintained or replaced by clinic managers, or their delegates, every day or whenever necessary to prevent overfilling.
6. Contaminated reusable sharps shall be placed in appropriate containers immediately or as soon as possible after use until properly processed.
7. Eating, drinking, applying cosmetics or lip balm, and handling contact lenses are prohibited in work areas where there is a reasonable likelihood of occupational exposure.
7. Food and drink shall not be kept or placed in refrigerators, freezers, sinks, shelves, cabinets or on countertops or bench tops where blood or OPIM are present.
8. All procedures involving blood or OPIM shall be performed in such a manner as to minimize splashing, spraying, splattering, and generation of droplets of these substances.
9. Mouth pipetting/suctioning of blood or OPIM is prohibited.
10. Specimens of blood or OPIM shall be placed in a container which prevents leakage during collection, handling, processing, storage, transport, or shipping.
11. Only safety needle devices are utilized in clinic areas.
12. Equipment which may become contaminated with blood or OPIM shall be examined prior to servicing or shipping and decontaminated as necessary. If decontamination is not feasible, a readily observable label in accordance with 29 CFR 1910.1030 must be attached to the equipment stating which portions remain contaminated. The Safety Officer, or delegate, is responsible for informing affected employees, the servicing representative, and/or the manufacturer prior to handling, servicing, or shipping so that appropriate precautions can be taken.
13. The LCHC Risk Management Committee is an interdisciplinary committee that will identify the need for changes in engineering controls and work practices, evaluate new procedures and/or products, and suggest changes to the ECP to the QI/RM Director for consideration at least annually.

<u>Personal Protective Equipment:</u>

Where occupational exposure remains after institution of engineering and work practice controls, appropriate personal protective equipment (PPE) will be used. PPE will be considered "appropriate" only if it does not permit blood or OPIM to pass through to reach employee's work clothes, street clothes, undergarments, skin, eyes, mouth, or other mucous membranes under normal conditions of use. PPE is provided by LCHC at no cost to the employee. The department supervisors, or delegates, will be responsible for ensuring that employees wear appropriate PPE. PPE used at LCHC can include, but is not limited to the following:

Gloves, Masks, Eye Protection, Face Shields, Gowns, Aprons, and Other Protective Body Clothing

All employees using PPE must observe the following precautions:

- Wash hands immediately or as soon as feasible after removal of gloves or other PPE
- Personal protective equipment must be cleaned, and/or replaced as needed to maintain its effectiveness.
- If a garment is penetrated by blood or OPIM, this garment MUST be removed immediately or as soon as feasible. Disposable lab coats and scrubs are available from Central Supply. Soiled garments must be placed in a red biohazard bag and laundered at home separately.
- All personal protective equipment must be removed prior to leaving the work area.
- When personal protective equipment is removed, it must be placed in an appropriately designated container for disposal.
- Wear appropriate gloves when it can be reasonably anticipated that there may be hand contact with blood or OPIM, and when handling or touching contaminated items or surfaces; replace gloves if torn, punctured, contaminated, or if their ability to function as a barrier is compromised.
- Utility gloves may be decontaminated for reuse if their integrity is not compromised; discard utility gloves if they show signs of cracking, peeling, tearing, puncturing, or deterioration.
- Never wash or decontaminate disposable gloves for reuse.

- Wear appropriate face and eye protection when splashes, sprays, spatters, or droplets of blood or OPIM pose a hazard to the eyes, nose, or mouth.

Environmental Services:
In keeping with the concept of Standard Precautions, LCHC will ensure that the worksite is maintained in a clean and sanitary condition. The following is a written procedure for clean-up in clinical areas.

- Equipment: All equipment and environmental work surfaces shall be cleaned and decontaminated with an appropriate disinfectant after contact with blood or OPIM by nursing staff.
- Work Surfaces: Contaminated work surfaces shall be decontaminated with an appropriate disinfectant after completion of procedures or as soon as feasible when surfaces are obviously contaminated, after any spill of blood or OPIM, and at the end of the work shift by the nursing staff.

NOTE: Please consult with the Safety Officer for a list of registered sterilant for your specific cleaning and decontamination application.

- Protective Coverings: Protective coverings such as plastic wrap, or imperviously-backed absorbent paper used to cover equipment or environmental surfaces shall be removed and replaced as soon as feasible when they become obviously contaminated and at the end of the work shift by appropriate personnel.
- Trash Cans: All bins, pails, cans, and similar receptacles which have a reasonable likelihood for becoming contaminated with blood or OPIM will be inspected, cleaned, and decontaminated by appropriate nursing personnel as soon as feasible upon visible contamination.

NOTE: Regulated waste is placed in containers which are closable, constructed to contain all contents and prevent leakage, appropriately labeled or color-coded, and closed prior to removal to prevent spillage or protrusion of contents during handling.

- Sharps: Contaminated sharps shall be discarded immediately or as soon as feasible in approved containers. **CAUTION**: Broken glassware which may be contaminated shall not be picked up directly with the hands. It must be cleaned up using mechanical means such as a brush and dust pan, tongs, or forceps. (Furthermore, any mechanical device which is contaminated must be decontaminated following use or as soon as feasible.)

NOTE: Reusable sharps that are contaminated with blood or OPIM will be stored or processed so that employees do not have to reach by hand into the containers where these sharps have been placed.

- Sharps Containers: Sharps containers will be inspected daily by Nurse/Clinic Managers, or delegates, to ensure they are not allowed to become overfilled. Sharps containers must be closable, puncture resistant, leak-proof on sides and bottom, and labeled or color-coded in accordance the standard. Additionally, sharps containers will be located as close as feasible to the immediate area where sharps are used.
- Laundry: Contaminated laundry must be bagged or containerized at the location where it was used in an approved bag or container. Contaminated laundry must not be sorted or rinsed in the location of use. Laundry service is provided by a contract service. The laundry is aware of the potential for contamination by Bloodborne pathogens and notified of the need to use Standard Precautions. Soiled laundry is stored in a separate room until pick-up by the contract service.

HEPATITIS B VACCINATION

The Occupational Health Nurse, or delegate, will provide training to employees on hepatitis B vaccinations, addressing the safety, benefits, efficacy, methods of administration, and availability.

The Hepatitis B vaccination series shall be made available to all employees with occupational exposure at no cost to the employee. The Occupational Health Nurse, or delegate, is responsible for ensuring that all employees who may be working in areas with occupational exposure are allowed the chance to receive the Hepatitis B vaccination after the employee has received the training required (see Training). Vaccination is encouraged unless: 1) documentation exists that the employee has previously received the series, 2) antibody testing reveals

that the employee is immune, or 3) medical evaluation shows that vaccination is contraindicated.

Employees who decline the Hepatitis B vaccination will be required to sign a declination form. If an employee initially declines the Hepatitis B vaccine but later decides to accept, LCHC will make available the Hepatitis B vaccine at that time, assuming the employee still has an occupational exposure designation. Documentation of refusal of the vaccination is kept in the employee's file in the Occupational Health office. Vaccination, when applicable, will be provided by the Occupation Health Nurse at the Lincoln Main Site.

POST-EXPOSURE EVALUATION AND FOLLOW-UP

Any time an exposure incident occurs, employees must contact the Occupational Health Nurse, or delegate, to ensure the proper evaluation and follow-up.

- The Occupational Health Nurse, or delegate, will ensure that appropriate initial first aid (clean the wound, flush eyes or other mucous membranes, etc.) has been performed.
- The Occupational Health Nurse, or delegate, will advise the exposed individual how to access an immediately available confidential medical evaluation and follow-up care.
- The Occupational Health Nurse, or delegate, will collect the following information:
    - Document the routes of exposure and how the exposure occurred.
    - Identify and document the source individual.
    - Obtain consent to have the source individual tested as soon as possible to determine Human Immunodeficiency Virus (HIV), Hepatitis C Virus (HCV), and Hepatitis B virus (HBV) infectivity. The CMO, or delegate, will order all applicable labs and notify finance immediately, and prior to, signing the lab orders, to ensure no charges are generated for the source individual.
        - North Carolina statutes require that the source individual is tested. Document if testing of source individual is unavailable or if source is unidentified. If the source is identified and refuses testing, the Occupational Health Nurse, or delegate, will discuss next steps to pursue required testing with the local Health Department officials.
    - Document that the source individual's deidentified test results (HIPAA confidentiality requirements required) were conveyed to the exposed individual's healthcare provider once results are received, as applicable, for appropriate prophylactic care for the exposed individual. Results should be shared between the providers of the exposed and source individuals.
        - Copies of the source individual's lab results should not be shared with the exposed.
        - The exposed individual will be given directives on next course of action pending source results by their provider.
        - If you are the provider of a source patient, ensure that the source patient signs a medical release, allowing provider to provider communication of results.
        - In the event of an occupational exposure, do not provide copies of any lab results to an employer.
    - The Occupational Health Nurse will encourage the exposed individual to have their blood collected as soon as feasible after exposure incident, and test blood for HBV and HIV serological status. Note that initial testing of the exposed is strictly for the purpose of documenting baseline heath and immunity status. LCHC encourages employees to consult with the Occupational Health Nurse regarding information for follow-up lab testing, but testing is not required.
        - Document if exposed individual does not give consent to complete testing.
- The Occupational Health Nurse, or delegate, will ensure completion of the Notice of Accident and First Report of Injury as required by the North Carolina Industrial Commission for worker's compensation, as applicable.
    - The Occupational Health Nurse, or delegate, will notify exposed employees to contact the Human Resources Department immediately to obtain worker's compensation claim information

to cover any medical expenses related to the confidential medical evaluation and follow-up care.

- The Safety Officer, or delegate, will ensure completion of the **Bloodborne Exposure Reporting Form** for internal review and tracking of the exposure incident. Once completed, the Safety Officer, or delegate, will submit the form to the QI/RM Director.
- When medically indicated, post-exposure prophylaxis will be provided by the exposed individual's provider, as recommended by the U.S. Public Health Service and the CDC.
    - It is the recommendation of LCHC that exposed individuals receive follow-up testing, as indicated, at 3-months and 6-months post-exposure. This option should be discussed between the exposed individual and their provider. The Occupational Health Nurse, or delegate, should document if follow-up labs are completed, but will not be involved in this process and will not receive a copy of the lab results.
- Counseling will be made available to the exposed individual upon request.

POST-EXPOSURE PROPHYLAXIS RECOMMENDATIONS

LCHC aims to provide evidence-based services and care to all patients and staff. As such, LCHC will follow post-exposure prophylaxis guidelines as outlined by the Centers for Disease Control and Prevention (CDC). For complete and current guidance, providers should always refer to the CDC website for the most current recommendations.

ADMINISTRATION OF POST-EXPOSURE EVALUATION AND FOLLOW-UP

- The Occupational Health Nurse, or delegate, ensures that the health care professional evaluating an exposed individual after an exposure incident receives the following, as applicable:
    - A description of the employee's job duties relevant to the exposure incident
    - Route(s) of exposure
    - Circumstances of exposure
    - If possible, results of the source individual's blood test
    - Relevant employee medical records, including vaccination status

The exposed individual will work directly with their provider regarding any post-exposure evaluation, care, treatment, and follow-up. The exposed individual will request all medical documentation directly from their provider.

EMPLOYEE EXPOSURE – MEDICAL RECORDKEEPING

The Occupational Health Nurse, or delegate, is responsible for maintaining records regarding the ECP at LCHC, and for ensuring that all medical records are kept confidential. The following records will be kept on file:

- A file for each employee with occupational exposure to blood or OPIM including the name and social security number of the employee, a copy of the employee's hepatitis-B vaccination status, any medical records relevant to the employee's ability to receive vaccination.
- A copy of all results of medical testing, and follow-up procedures following an exposure incident.

The above records will not be disclosed or reported without the employee's express written consent to any person within or outside the workplace except as required by the Bloodborne pathogens standard or by law. Additionally, these records will be maintained for at least the duration of employment plus thirty (30) years.

EVALUATION OF EXPOSURE INCIDENTS

Due to the potentially severe consequences resulting in exposure incidents, the circumstances regarding these incidents will be investigated with the utmost priority. Employees must notify the Occupational Health Nurse, or delegate, immediately following any exposure incident. The Safety Officer, or delegate, will be responsible for investigating the circumstances of exposure incidents immediately following each incident and will report findings and suggestions to the QI/RM Director. The QI/RM Director and Safety Officer, or delegates, will review the circumstances of all exposure incidents to determine:

- Engineering controls in use at the time
- Work practices followed
- A description of the device being used (including type and brand)
- Protective equipment or clothing that was used at the time of the exposure incident (gloves, eye shields, etc.)
- Location of the incident (clinic site, location in building, etc.)
- Procedure being performed when the incident occurred
- Employee's training

If it is determined that revisions need to be made, the QI/RM Director, or delegate, under the advisement of the Risk Management Committee, will ensure that appropriate changes are made to this ECP. (Changes may include an evaluation of safer devices, adding employees to the exposure determination list, etc.)

BIOHAZARD LABELING

Warning labels shall be affixed to containers of regulated waste, refrigerators and freezers containing blood or other potentially infectious materials, and other containers used to store, transport, or ship blood or other potentially infectious materials. These labels shall include the following figure:

These signs shall be fluorescent orange or orange-red or predominantly so, with lettering or symbols in contrasting color. Alternately, red bags or containers may be substituted for labels. The Safety Officer, or delegate, is responsible for periodic review of compliance with labeling requirements.

TRAINING

All employees will be expected to participate in a training session that will be provided at the time of initial assignment to tasks where occupational exposure takes place, every year thereafter, and whenever changes such as modifications of tasks or procedures or institution of new tasks or procedures affect the employee's exposure. The Safety Officer, or delegate, will be responsible for maintaining accurate and up to date training materials.

Human Resources will keep a record on file concerning all training sessions. These records must be kept for a three-year period. Upon request, the employee or their representative must be given access to their training record. Training records will include:

- The dates of the training sessions
- The contents or a summary of the training sessions
- The names and job titles of all persons attending the training sessions

BLOODBORNE EXPOSURE REPORTING FORM

CENTER: _____ DATE/TIME: _____

EXPOSED INDIVIDUAL: _____

CONTACT INFORMATION: _____

SOURCE INDIVIDUAL: _____

CONTACT INFORMATION: _____

INCIDENT:

PROCEDURE BEING PERFORMED: _____

WHERE/HOW EXPOSURE OCCURRED: _____

TYPE OF EXPOSURE: NEEDLE, BUR, BLADE, OTHER _____

SKIN PUNCTURE: YES NO ENTRY: EYE, MOUTH, OPEN WOUND, FINGER, OTHER _____

HOW/WHEN DURING HANDLING DID EXPOSURE OCCUR? _____

DETAIL OF EXPOSURE (SEVERITY, FLUID, ETC): _____

_____

KNOWN PATHOGENS IN SOURCE MATERIAL: _____

EXPOSED INDIVIDUAL:

VACCINATION STATUS: _____

MEDICAL BLOOD WORK FOR EXPOSED INDIVIDUAL (HIV, HCV, HBV): _____

_____

DATE: _____ RESULTS: _____

RESULTS GIVEN TO EXPOSED INDIVIDUAL: YES NO DATE: _____

POST EXPOSURE MANAGEMENT/COUNSELING: _____

_____

DATE OF CONTACT FOR FOLLOW-UP BLOOD WORK: _____

DATE OF FOLLOW-UP BLOOD WORK: _____ RESULTS: _____

RESULTS GIVEN TO EXPOSED INDIVIDUAL: YES NO DATE: _____

****CONFIDENTIAL REPORT, INTERNAL USE ONLY, DO NOT PUT IN EMR****

SOURCE INDIVIDUAL:

SOURCE CONTACTED: YES NO DATE: _____ CALL/MAIL

SOURCE COMPLETE LABS: YES NO

MEDICAL BLOOD WORK FOR SOURCE (HIV, HCV, HBV): _____

_____

DATE: _____ RESULTS: _____

RESULTS GIVEN TO SOURCE: YES NO DATE: _____

DATES CONTACTED FOR 2nd TEST: _____ CALL/MAIL

DATE OF FOLLOW-UP BLOOD WORK: _____ RESULTS: _____

RESULTS GIVEN TO SOURCE: YES NO DATE: _____

PROCEDURES TO REDUCE RISK:

_____

_____

_____

_____

_____

_____

_____

_____

_____

SAFETY OFFICER: _____

DATE: _____

SUPERVISING PROVIDER (CMO): _____

DATE: _____

QI & RISK MANAGEMENT DIRECTOR: _____

DATE: _____

****CONFIDENTIAL REPORT, INTERNAL USE ONLY, DO NOT PUT IN EMR****

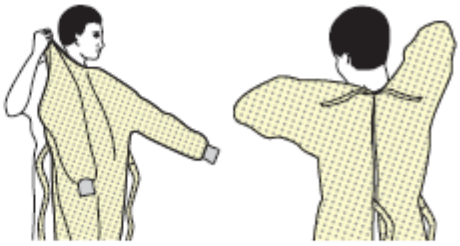
Safe Practices for Applying/Removing Personal Protective Equipment

SEQUENCE FOR PUTTING ON PERSONAL PROTECTIVE EQUIPMENT (PPE)

The type of PPE used will vary based on the level of precautions required, such as standard and contact, droplet or airborne infection isolation precautions. The procedure for putting on and removing PPE should be tailored to the specific type of PPE.

1. GOWN

- Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back
- Fasten in back of neck and waist



2. MASK OR RESPIRATOR

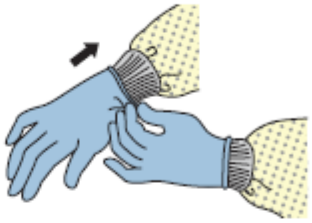
- Secure ties or elastic bands at middle of head and neck
- Fit flexible band to nose bridge
- Fit snug to face and below chin
- Fit-check respirator

3. GOGGLES OR FACE SHIELD

- Place over face and eyes and adjust to fit

4. GLOVES

- Extend to cover wrist of isolation gown



USE SAFE WORK PRACTICES TO PROTECT YOURSELF AND LIMIT THE SPREAD OF CONTAMINATION

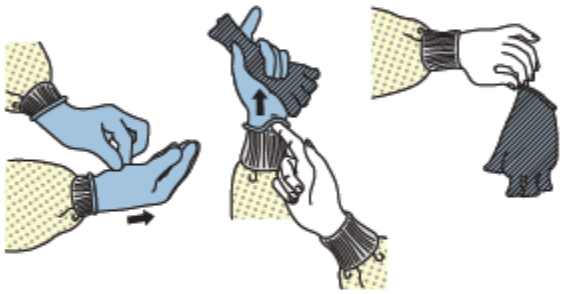
- Keep hands away from face
- Limit surfaces touched
- Change gloves when torn or heavily contaminated
- Perform hand hygiene

HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE) EXAMPLE 1

There are a variety of ways to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. Here is one example. **Remove all PPE before exiting the patient room** except a respirator, if worn. Remove the respirator **after** leaving the patient room and closing the door. Remove PPE in the following sequence:

1. GLOVES

- Outside of gloves are contaminated!
- If your hands get contaminated during glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Using a gloved hand, grasp the palm area of the other gloved hand and peel off first glove
- Hold removed glove in gloved hand
- Slide fingers of ungloved hand under remaining glove at wrist and peel off second glove over first glove
- Discard gloves in a waste container



2. GOGGLES OR FACE SHIELD

- Outside of goggles or face shield are contaminated!
- If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Remove goggles or face shield from the back by lifting head band or ear pieces
- If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container

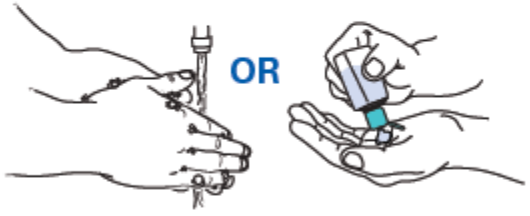
3. GOWN

- Gown front and sleeves are contaminated!
- If your hands get contaminated during gown removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Unfasten gown ties, taking care that sleeves don't contact your body when reaching for ties
- Pull gown away from neck and shoulders, touching inside of gown only
- Turn gown inside out
- Fold or roll into a bundle and discard in a waste container

4. MASK OR RESPIRATOR

- Front of mask/respirator is contaminated — DO NOT TOUCH!
- If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
- Discard in a waste container

5. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE



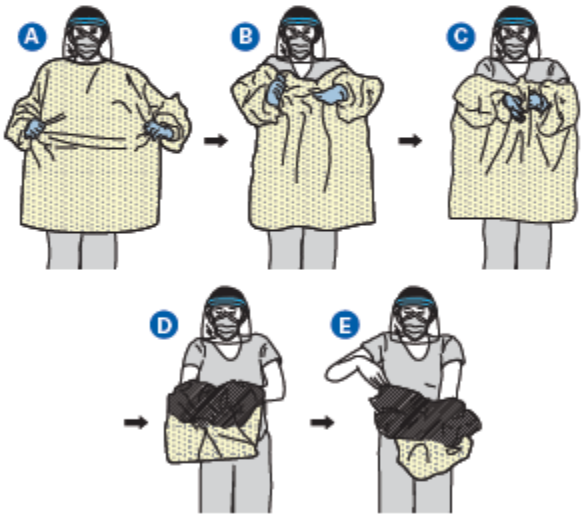
PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS BECOME CONTAMINATED AND IMMEDIATELY AFTER REMOVING ALL PPE

HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE) EXAMPLE 2

Here is another way to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. **Remove all PPE before exiting the patient room** except a respirator, if worn. Remove the respirator **after** leaving the patient room and closing the door. Remove PPE in the following sequence:

1. GOWN AND GLOVES

- Gown front and sleeves and the outside of gloves are contaminated!
- If your hands get contaminated during gown or glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp the gown in the front and pull away from your body so that the ties break, touching outside of gown only with gloved hands
- While removing the gown, fold or roll the gown inside-out into a bundle
- As you are removing the gown, peel off your gloves at the same time, only touching the inside of the gloves and gown with your bare hands. Place the gown and gloves into a waste container



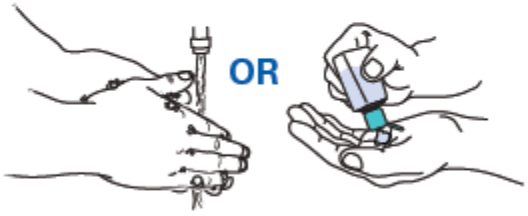
2. GOGGLES OR FACE SHIELD

- Outside of goggles or face shield are contaminated!
- If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Remove goggles or face shield from the back by lifting head band and without touching the front of the goggles or face shield
- If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container

3. MASK OR RESPIRATOR

- Front of mask/respirator is contaminated — DO NOT TOUCH!
- If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
- Discard in a waste container

4. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE



PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS BECOME CONTAMINATED AND IMMEDIATELY AFTER REMOVING ALL PPE

Communicable Disease Reporting

AUTHORITY TO REPORT: Under North Carolina (NC) General Statute §130A-135, physicians must report communicable diseases declared by the N. C. Commission for Public Health to the local health director of the county or district in which the physician is consulted. Diseases under communicable disease surveillance may be found in 10A NCAC 41A.0101.

DEFINITION: N.C. Commission for Public Health – The rulemaking body for N.C.

PROCEDURE:

A. Once a laboratory report confirms a positive reportable communicable disease, the medical provider will send a message to the LCHC STI Reporting pool in the Electronic Health Record (EHR).

B. The Director of Nursing (DON), or delegate, will complete Part 1-NC Communicable Disease Report (DHHS 2124). The DON, or delegate, is responsible for seeing that the completed form is faxed to the Department of Public Health in the county in which the patient resides. Incomplete forms will be returned to sender for completion. If available, include laboratory reports and/or recent office visit notes, as applicable.

C. In the absence of the DON, or delegate, the provider will continue to message all positive reports to the LCHC STI Reporting pool in the EHR, as the DON will assign continuous coverage of this pool.

D. The following information should be documented by the provider in the EHR in order to complete form 2124:
   a. Was patient symptomatic for the disease?
   b. Did patient travel to an area where there was an outbreak of disease?
   c. Treatment date(s), medication (s), dosage, duration

E. For Duke Affiliated Clinics and Early Intervention Clinic (EIC), Nursing staff and/or Medical Assistant (MA) is responsible for reporting communicable diseases to Local Health Departments, using form DHHS 2124, Part I.

F. **To Report:** **Fax DHHS 2124 to**:
   Durham County Department of Public Health, Communicable Disease Prevention - 919-560-7716
   - Must obtain fax # for other County Health Departments

G. For questions, call Durham County Department of Public Health, Communicable Disease & Prevention: (919) 560-7896 or (919) 560-7886

WEBSITES:
http://dcopublichealth.org/services/communicable-diseases
https://epi.publichealth.nc.gov/cd/lhds/manuals/cd/reportable_diseases.html

NOTE: DHHS 2124 Reporting Form can be obtained from
http://epi.publichealth.nc.gov/cd/docs/dhhs_2124.pdf
OR from LCHC Intranet: Go to Clinical Tools, Sub Folder Clinical Forms.

Employee Immunization Policy

POLICY STATEMENT:

Lincoln Community Health Center (LCHC) is an ambulatory health care facility and presents potential risk for exposure to patients who may be diagnosed with infectious disease. Therefore, for the safety of all staff, visitors, and patients LCHC requires that employees, contractors, and volunteers provide documentation of immunizations at the beginning of the relationship.

REQUIRED VACCINATIONS:

1. **COVID-19 Vaccine*** – Employees, contractors, and volunteers serving in a LCHC clinic must receive an FDA (Food and Drug Administration) approved COVID-19 vaccine following all guidelines for immunity as outlined by the respective vaccine of their choice.
   a. Effective October 1, 2021, all employees must provide documentation to the Occupational Health Department supporting their immunization status.
      - In lieu of documentation to support immunization status, employees may provide an approved statement of medical or religious exemption.
   b. Employees, contractors, and volunteers who have not received a COVID-19 vaccine and do not possess an exemption status can receive an FDA approved COVID-19 vaccine by the Occupational Health Nurse, or delegate, at no cost.
   c. FDA approval can be through emergency use authorization or full authorization.
   d. Any questions or concerns regarding immunization or vaccination status related to COVID-19 should be addressed by the Occupation Health Nurse, Chief Medical Officer, or the individual's primary care provider.

   *For further requirements and details, refer to the **COVID-19 Vaccine Requirements Policy**, which shall supersede this document shall any information present as conflicting.

2. **Measles, Mumps, and Rubella (MMR)** - Employees must provide proof of immunity or a statement of medical exemption. Proof of immunity is any combination of the following:
   a. A titer from any licensed laboratory indicating adequate immune titer results.
   b. Employees born before 1957 - documentation of a diagnosis of measles or mumps by a licensed medical provider; or laboratory evidence of the disease and laboratory evidence of immunity; or documentation of two doses of the MMR vaccination.
   c. Employees born after 1957 - documentation of a diagnosis of measles or mumps by a licensed medical provider; or laboratory evidence of the disease and laboratory evidence of rubella immunity; or documentation of two doses of measles or mumps vaccination after 12 months of age, separated by 28 days or more and documentation of at least one dose of the live rubella vaccination.

3. **Varicella** - Employees must provide proof of immunity or a statement of medical exemption. Proof of immunity is any combination of the following:
   a. Documentation of a diagnosis of prior chickenpox or herpes zoster (shingles) by a licensed medical provider.
   b. Documentation of two doses of varicella vaccination separated by 28 days or more; laboratory evidence of immunity; or laboratory confirmation of the disease.
   c. A titer from any licensed laboratory indicating adequate immune titer results for varicella.

4. **Tetanus-diphtheria-acellular pertussis (Tdap) -** Employees must provide documentation or a statement of medical exemption.
    a. Documentation of at least one Tdap vaccination
    b. If employee, contractor, or volunteer cannot provide documentation, they will receive one dose of Tdap during the first two weeks of the relationship.
    c. After the initial dose of Tdap is administered/recorded, it is recommended, but not required, that healthcare personnel receive a dose of Td or Tdap every 10 years.

5. **Seasonal Influenza (Flu)**
    a. Employees, Contractors, or Volunteers who start during the Flu season must provide documentation of vaccination at the time of hire or medical or religious exemption.
    b. Employees, Contractors, or Volunteers who cannot provide documentation will be provided the Flu vaccine by the Occupational Health Nurse, or delegate.
    c. LCHC's Occupational Health Department will provide Flu vaccines to all employees, contractors, and volunteers annually.
    d. Employees who fail to provide documentation of Flu vaccination or document medical or religious exemption by December 1st of each year will be subject to formal disciplinary action up to and including termination of the employment relationship.
    e. Employees, contractors, or volunteers who have not provided documentation or who have provided a medical or religious exemption and have direct patient contact will be required to wear a mask during patient contact.
    f. All Medical Providers (Physicians and Advanced Practice Providers) must have an annual flu vaccination as a condition of employment; as their rights and access to the Electronic Health Record will be terminated if documentation is not provided to Duke Regional Hospital.

RECOMMENDED VACCINATIONS:

1. **Hepatitis B -** Employees who have direct patient contact and/or potential exposure to blood or body fluids are strongly encouraged to receive the vaccination. LCHC will provide the vaccination to employees and contractors at no cost.

PROCEDURE:

1. The Human Resources Department will require documentation of immunizations as a part of the pre-employment process. The documentation will be forwarded to the Occupational Health/Infection Control Nurse, or delegate, for review and approval.
2. New employees are scheduled to meet with the Occupational Health/Infection Control Nurse, or delegate, within the first week of employment to review immunizations and discuss documentation. Employees who do not have documentation or titers will be provided the required immunizations within the first two weeks of employment at no cost to the employee.
3. All immunization records will be documented in the employee health record to be maintained in the Occupational Health department.

COVID-19 Vaccine Requirements Policy

PURPOSE:

Lincoln Community Health Center (LCHC) is committed to high standards and compliance with all laws and regulations which support a safer work environment.

The purpose of this Policy is to establish how LCHC will comply with the Federal COVID-19 Vaccine Mandate, as established in the CMS Interim Final Rule with Comment Period entitled "Medicare and Medicaid Program; Omnibus COVID-19 Health Care Staff Vaccination" published on November 5, 2021 (hereafter referred to as the "IFR").

POLICY:

This Policy and Procedure will apply to the following individuals, regardless of clinical responsibility or patient contact.

1. General Applicability
   a. Health Center Employees
   b. Students, Residents, Trainees, and Volunteers (This includes members of LCHC Board of Directors subject to clarification below.)
   c. Independent Contractors including Temporary Employees and Vendors

2. Exceptions
   a. Individuals who provide services to LCHC patients or to the organization exclusively from locations that are separate from any LCHC sites whether administrative or clinical
      and
   b. Individuals who have no direct contact with LCHC patients or Staff

3. Patient Board Members
   a. Patient Board members are in a unique situation, as the IFC vaccine requirements explicitly apply to Board members, while Section 330 rules simultaneously prohibit LCHC from requiring patients to be vaccinated in order to receive care. Therefore, this policy applies to patient Board members when they are acting in their capacity as a Board member, but not when they are acting in their capacity as a patient.

General Requirements and Exceptions:

The following requirements apply to all individuals who are subject to this policy as described above.

1. General vaccination requirements: Subject to exemptions and delays as described below and to definitions of fully vaccinated which may change:

   a. All individuals described above will receive at a minimum the first of a two dose COVID-19 vaccine or a one dose vaccine by:
      i. October 1, 2021 for employees, contractors, and vendors per LCHC's **Employee Immunization Policy** revised 7/2021
      ii. January 27, 2022 per CMS IFR Vaccination Mandate for other individuals including Board Members
      iii. Prior to the employment date for new hires
      iv. Prior to the first day of contractual relationships for vendors and Independent Contractors

b. All Individuals who receive the first dose of a two dose COVID-19 vaccine must receive the second dose by:
   i. 30 days from the date of the first dose or employment
   ii. February 22, 2022 per CMS IFC Vaccination Mandate
   iii. 30 days from the effective date of contractual relationships for vendors and Independent Contractors

c. All Individuals are required to receive COVID-19 Boosters by February 22, 2022 or as soon as eligible per CDC and vaccine manufacturer guidelines.

2. Exemptions and Delays:

   a. Under Federal law, employees may request:
      i. A temporary delay of the vaccine requirements for documented medical reasons
      ii. An exemption from vaccine requirements for medical reasons
      iii. An exemption from vaccine requirements for religious reasons

   b. As outlined in the Procedures Section, LCHC has established a process by which:
      i. Individuals may request delays and exemptions from the Federal Vaccine mandate based on applicable Federal law
      ii. LCHC will evaluate and respond to requests for delays and exemptions
      iii. LCHC will track and securely document requests for delays and exemptions and its responses

   c. Approval of delays or exemption must meet the criteria established by LCHC and leadership must determine that it can accommodate the request without undue hardship.

   d. In cases where the delay or exemption is approved, the Individual will be subject to additional precautions to mitigate the transmission and spread of COVID-19

PROCEDURE:

LCHC will use the following procedure to implement the policy established above:

1. Tracking and documenting Individual Vaccination Status:

   a. Employees will provide documentation to the Occupational Health Nurse (OHN) of vaccination status. This documentation may include the vaccination card, medical statements etc. The OHN will validate documentation and store in a confidential file. New Hires will provide documentation or request for exemption to the Human Resources Department.

   b. Vendors and Independent Contractors will provide documentation to Human Resources or designee and records will be forwarded to the Occupational Health Nurse for validation.

   c. Board Members will provide documentation to Administration and records will be maintained in a confidential file in the OHN office.

d. The OHN will maintain an updated vaccination roster with the status of all Individuals in a safe, secure, and confidential manner.

2. Exemptions and Delays:

   a. Employees seeking medical or religious exemptions or temporary delays from vaccination requirements must complete the appropriate request form and forward in the case of medical exemptions or delays to the OHN and/or Chief Medical Officer. In the case of Religious exemptions, the forms must be submitted to the Human Resources Department.

   b. Requests will be reviewed and evaluated. In some cases, additional information may be requested.

   c. LCHC will evaluate whether said request may be accommodated without creating an "undue hardship" to the organization.

   d. The Human Resources Department and OHN as appropriate will track all exemption requests and document responses. The information will be kept in a confidential manner and all medical information will be stored separate and apart from the employee's personnel file.

   e. The evaluation of Medical Exemptions must include specific identification documenting which of the authorized COVID-19 vaccines are clinically contraindicated.

   f. LCHC will not approve requests for medical exemption, if the request is not consistent with CDC's Summary Document for Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Authorized in the United States.

   g. In reviewing requests for religious exemptions, LCHC will adhere to the guidelines established by the EEOC.

   h. All requests for delays will be supported by medical documentation that is consistent with recognized clinical precautions and considerations as recommended by the CDC.

   i. LCHC will not approve requests for a temporary medical delay if the request is not consistent with the CDC's Summary Document for Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Authorized in the United States.

3. Additional Precautions for Individuals who are not Fully Vaccinated for COVID-19:
   Lincoln Community Health Center will review on a case by case basis and apply prevailing options, if necessary.

4. Contingency Plans:
   Lincoln Community Health Center will attempt to maintain appropriate staffing levels to include the use of Staffing Agencies and hiring additional Staff members.

Employee Tuberculin (TB) Screening & Exposure Plan

PURPOSE:

To provide a process for screening new employees for Tuberculosis prior to beginning work. To provide a process for reporting a change in TB risk status post-orientation screening. To provide a process for managing employees with possible or known exposure to an active TB infection.

PROCEDURE:

1. All new employees will:

    a. Provide documented evidence of PPD testing with negative results within the last 12 months AND individual baseline TB risk assessment; OR
    b. If the employee is unable to provide this evidence, report to Occupational Health to have a PPD placed.
        - The result will be read within 48-72 hours. If it is not read within this time frame, the test must be repeated.
        - Refer to the clinical procedure, "PPD (Purified Protein Derivative) Skin Testing (TST)" for reading the PPD.
        - Any employee who has a positive result will be referred to the Health Department for further evaluation and medical clearance.
    c. If the employee has had a positive result from a previous PPD test, provide documented evidence of a chest x-ray that shows the employee does not have active TB.
        - Complete a Tuberculin screening/questionnaire. Once the screening/questionnaire is completed and the requirement for testing or chest x-ray has been satisfied, no further action will be needed.

2. Testing and screenings will not be done annually; however, any employee experiencing a change in their risk status must report it immediately to the Occupational Health Nurse.
    a. As directed by the Occupation Health Nurse, employees with a change in their TB risk status will undergo the appropriate TB screening process, as indicated, following the guidelines in #1.
    b. Any employee with untreated latent TB infection will receive an annual TB symptom screen. Any positive screen will be referred to the Health Department for further evaluation and medical clearance.

3. Employees who have experienced an occupational exposure to an active TB infection will be notified by the Occupation Health Nurse of the exposure risk. If an employee experiences a known exposure outside of work, the employee should notify the Occupational Health Nurse immediately. Per CDC guidance, health care personnel with a known exposure to an active TB infection should receive a TB symptom screen and timely testing, as indicated.
    a. Health care personnel with a previous negative TB test result should be tested immediately and re-tested 8 to 10 weeks after the last known exposure. Any employee who has a positive result will be referred to the Health Department for further evaluation and medical clearance.

b. Health care personnel with a documented history of a positive TB test result should not be re-tested after TB exposure. They should receive the TB symptom screen and if symptoms are present, referred to the Health Department for further evaluation and medical clearance.

4. Annual education on TB risk factors, signs and symptoms of TB disease, and TB infection control protocols will be conducted and completion/compliance records maintained with the Human Resources Department for applicable employees.

RELATED FORMS: Employee TB Symptom Questionnaire

REFERENCES:

- CDC: TB Screening and Testing of Health Care Personnel, https://www.cdc.gov/tb/topic/testing/healthcareworkers.htm
- CDC: TB Fact Sheets – Infection Control & Prevention, https://www.cdc.gov/tb/publications/factsheets/prevention.htm

EMPLOYEE TB SYMPTOM QUESTIONNAIRE

Tuberculin Skin Testing is the best means for testing for exposure to Mycobacterium Tuberculosis (TB). TB usually infects the lungs, but it can infect any part of the body. If not treated properly, it can be fatal. TB is spread through the air from one person to another, usually from confined or prolonged close contact with a person with an active TB infection.

A positive skin test ***does not*** mean that you have TB, only that you have been exposed to someone who does. TB is much less prevalent in the United States than it used to be. It continues to be a major health concern.

Please answer the following questions:

Have you ever had a positive skin test in the past?	Yes	No
Do you currently have a persistent or productive cough?	Yes	No
Have you been coughing up or spitting up blood?	Yes	No
Are you having any night sweats or profuse sweating?	Yes	No
Have you had an unexplained weight loss in the past year?	Yes	No
Have you had any unexplained loss of appetite?	Yes	No
Have you had any unexplained or unusual fatigue?	Yes	No
Do you currently have a rash?	Yes	No
Are you immune-suppressed by disease or drugs (i.e. steroids)?	Yes	No
Have you ever been treated for TB in the past?	Yes	No
Have you ever been vaccinated against TB (i.e. BCG)?	Yes	No

_____ _____

Employee Signature Date

To be completed by occupational health nurse:

Manufacturer: _____ Lot #: _____ Exp Date: _____

0.1 ml PPD given ID to [ ] left forearm [ ] right forearm Date: _____ Time: _____

Given by: _____ Employee to return for reading on: _____

Date

RESULTS: _____mm Read by: _____

_____ mm Redness Date: _____ Time: _____

Comments: _____

Occupational Health Use Only rev06/2021

Instrument & Equipment Cleaning, Disinfecting, & Sterilization Procedure

PROCEDURE STATEMENT:

The delivery of sterile products for use in all Lincoln Community Health Center (LCHC) departments depends not only on the effectiveness of the sterilization process but also on the decontamination, disassembling, and packaging of the instruments, loading the sterilizer, monitoring, sterilant quality and quantity, and the appropriateness of the cycle for the load contents. LCHC instruments and equipment will be cleaned, disinfected, sterilized, and stored, using standard processes. Sterilizers will be regularly monitored for effectiveness.

PROCEDURE:

I. Instrument and Handpiece Cleaning and Sterilization

A. Only properly sterilized or single-use instruments may be used in patient treatment.

B. All instruments must be submitted for sterilization promptly following use in patient care.

C. Heavy duty utility gloves, mask, and eyewear should be worn when handling contaminated instruments.

D. Prior to being sterilized, all instruments must be cleaned. Ultrasonic or mechanical cleaning should be used whenever feasible instead of cleaning by hand. **All instruments will be cleaned/disinfected based on the manufacturer's cleaning/disinfection instructions.**

E. Only instruments that have been cleaned of debris, disinfected, and dried may be submitted for sterilization in accordance with the following procedures. **All instruments will be sterilized based on the manufacturer's sterilization instructions for each instrument.** To perform sterilization, employee will:
   1. Put on heavy-duty utility gloves.
   2. Rinse, ultrasonically clean, and rinse instruments again, as applicable. Otherwise, with heavy gloves, scrub debris from a few instruments at a time using hot water, disinfectant, and a scrub brush. **Avoid squeezing sharp ends of double-ended instruments that can penetrate heavy gloves.**
   3. Dry instruments thoroughly with paper towel.
   4. Process no more than 22 clean and dry instruments in a heavy bag.
   5. Date and sign sterilization pouches with built in indicators and place instruments inside.
   6. Seal and/or fold bag.
   7. Place instruments in sterilizer.
   8. Do not overload sterilizer. Place bags a finger's width apart on the shelves.
   9. Expiration dates should be on all instrument packs.

F. **Instrument Storage:** After sterilization, instruments should be stored in their sealed packages, until they are used in treatment. Whenever this is not possible, the instruments must be submitted for re-sterilization prior to use in patient care. Instruments not used prior to their expiration date should be re-sterilized.

G. **Supply Containers:** Materials and supplies that are available on mobile carts which have been used/contaminated during patient treatment, must be sprayed wet with disinfectant and wiped dry with a paper towel after use.

H. **Handpiece Sterilization:** Sterilization of handpieces is required. Sterilization and maintenance of handpieces will follow **manufacturer's cleaning and sterilization directions**. Before autoclaving a handpiece, clean externally, clean internally with appropriate cleaner, operate handpiece to remove cleaner; lubricate and operate handpiece again, and autoclave. Handpieces are then distributed to dispensaries.

1. If the handpiece is stiff, the staff member will:
    a. Fit a bur and rotate it with gloved fingers to start it.
    b. Operate the handpiece for 30 seconds or until it works freely.
    c. If the handpiece will not function properly, place a note on it and notify the appropriate personnel based on the department.
2. Do not sterilize slow speed motors but disinfect them with alcohol and keep them covered with a plastic sleeve during patient care based on manufacturer's instructions.

3. Hand pieces should be packaged and expiration date on the package.

II. Sterilization Monitoring for Individual Sterilizer

A. Sterilization unit and assigned staff shall monitor the effectiveness of sterilization equipment based on manufacturer's instructions and in accordance with the following procedures

B. Assigned staff will:

1. Bag instruments in sterilization pouches that have external and internal processing indicators. Indicators are built into the pouch to ensure proper sterilization conditions are met.
2. **Examine t**he pouch when the pack is removed from the sterilizer to check for the designated color change.
3. **Reject** the pack if the pouch has not changed color. Sterilize the pouch again and document the fact that it had not changed color. **Assume that the load is not sterile and reprocess.**
4. Use a spore strip in a randomly selected instrument pack one day each week and send it to the Microbiology Lab for processing.
5. Communicate immediately to the person responsible for that sterilizer any positive results indicating a problem. Monthly reports will be issued to each sterilization unit. **NOTE: The Microbiology Lab sends immediate notification upon positive testing via phone and /or fax.**
6. Mark the current date, load, and sterilizer number on each sterilization pouch being sterilized.
7. Maintain a daily sterilization record in a notebook:
    a. Include monthly spore strip reports received from the Microbiology Lab.
    b. Document and report to appropriate supervisor all problems with sterilizers and all remedial action taken to correct these problems.

III. Sterilizers: Considerations of Times and Temperatures

A. **For small sterilizers used in offices, the major causes of failure are operator errors, including overloading and errors in time and pressure settings. However, power failures and mechanical errors are not uncommon.** Assigned staff will NOT OVERLOAD STERILIZERS. READ THE MANUAL, READ GAUGES and MONITOR STERILIZATION.

B. **Steam pressure sterilization (autoclave):** Steam must circulate and penetrate all packs for the prescribed time. Assigned staff will:
    1. Not overload or cram packs together.
    2. Package instruments to protect from contamination during storage.
    3. Ensure that packaging does not block steam penetration.
    4. Leave closed containers on their sides with lids open or ajar.

    Caution: Time required for the sterilizer to reach temperature is not included in the sterilization times given.
    5. **Begin timing after sterilizer has reached temperature.**
    6. **Place packs so steam can circulate and penetrate.** Crack door at cycle end to let packs dry.
    7. **Always check that proper setting/cycle is selected for items being sterilized.**

    CAUTION: **Instruments cannot be added during a sterilization cycle without starting timing over.**
    8. Assigned staff will:
        a. Use special nylon bags, foil or paper wrapped packs, or metal trays for instruments.
        b. Place packs/trays at least a centimeter apart to allow heated air to circulate.

Risk Assessment for Infection Surveillance, Prevention, and Control Programs in Ambulatory Healthcare Settings

Explanation of Risk Assessment Tool and the Template for a Risk Assessment Report

This Risk Assessment tool, beginning on page 6, can be used to conduct a facility risk assessment for acquiring and transmitting infections in a variety of ambulatory healthcare settings. The results of the risk assessment can then be reported using the accompanying template for a Risk Assessment Report (beginning on page 3). **The findings of the risk assessment should be used to provide information about where an organization should focus its infection surveillance, prevention and control activities**.

A facility risk assessment is conducted by identifying and reviewing potential risk factors for infection related to the care, treatment, and services provided and to the environment of care in a specific healthcare setting. The identified risks of greatest importance and urgency are then selected and prioritized. **Based on these identified risks, facility personnel should develop the organization's Infection Surveillance, Prevention, and Control (ISPC) Plan (i.e., an action plan).**

The ISPC Plan should include a goal for reducing the risk of infection associated with each of these identified risks, a measurable objective for each goal, and evidence-based strategies for meeting each of these objectives. The Plan should also identify the personnel responsible for implementing the strategies and include mechanisms for evaluating the effectiveness of meeting the ISPC Plan's objectives.

Assessment Process

1. Conduct the risk assessment.
2. Identify potential risk factors in each of the following categories:
   - Community and populations served
   - Potential for specific infection
   - Treatment and care practices
   - Instrument and medical device cleaning, disinfection and handling
   - Environment of care
   - Emergency management
   - Others identified by the organization
3. Assess and score each potential risk factor based on the following:
   a. **Potential impact** of the event/condition on patients and personnel, determined by evaluating the potential for patient illness, injury, infection, death, need for admission to an inpatient facility; the potential for personnel illness, injury, infection, shortage; potential to impact the organization's ability to function/remain open; and degree of clinical and financial impact.
   b. **Probability of the event/condition occurring** determined by evaluating the risk of the potential threat actually occurring. Information regarding historical data, infection surveillance data, the scope of services provided by the facility, and the environment of the surrounding area (topography, interstate roads, chemical plants, railroad, ports, etc.) are considered when determining this score.
   c. **Organization's preparedness** to deal with the event/condition determined by considering policies and procedures already in place, staff experience and response to actual situations, and available services and equipment.
4. After risk scores are assigned in the three assessment groups, total the numbers in each group to provide a numerical risk level for each event/condition.
5. Rank the events/conditions from the highest to lowest score in the table provided. Select the risks with the highest scores for priority focus for developing the annual ISPC Plan. NOTE: Some events/conditions with a lower score may be selected because they are an accreditation or regulatory requirement.

The risk assessment and ISPC Plan should be reviewed and approved by the organization's quality assurance and performance improvement committee (or other designated committee). The risk assessment and ISPC Plan should be reviewed annually (and sooner if circumstances change).

Cover Page for Risk Assessment Report

Risk Assessment Report for Infection Surveillance, Prevention and Control (ISPC) Program
Year: 2022

Organization Name: Lincoln Community Health Center
Date of Report: 3/25/2022

Overview

A facility risk assessment for acquiring and transmitting infections should be conducted annually in each healthcare facility. [Note: An annual risk assessment is required for organizations accredited by The Joint Commission and other accreditation organizations.] The risk assessment provides a foundation for the Infection Surveillance, Prevention and Control Program because it is used is used to provide information about where an organization should focus its infection surveillance, prevention and control activities.

This facility risk assessment was conducted by identifying and reviewing potential risk factors for infection related to the care, treatment, and services provided and to the environment of care in a specific healthcare setting. The identified risks of greatest importance and urgency were selected and prioritized and are noted below. Based on these identified risks, facility personnel will develop the organization's Infection Surveillance, Prevention and Control (ISPC) Plan (i.e., an action plan, with goals and measurable objectives.)

The ISPC Plan includes a goal for reducing the risk of infection associated with each of the prioritized risks, a measurable objective for each goal, and evidence based strategies for meeting each of these objectives. The Plan also (1) identifies the personnel responsible for developing the Plan and implementing the ISPC Program strategies and (2) includes mechanisms for evaluating the effectiveness of the meeting the ISPC Program's objectives.

Assessment Tool Organisms

An organizational Infection Risk Assessment **tool** (below) was reviewed and adapted for use by (LCHC) by the following personnel:

1. Infection Prevention Coordinator
2. Quality Director
3. Leadership
4. Quality Committee

The Risk Assessment tool was used to identify potential infection risk factors in each of the following categories:

- Community and populations served
- Infectious Diseases
- Multi Drug Resistant
- Instrument and medical device cleaning, disinfection and handling
- Environment of care
- Emergency management
- Others identified by the organization

Process

The following personnel conducted the risk assessment:

1. Infection Control Nurse
2. Quality Improvement & Risk Management Director

The group identified, assessed and scored each potential risk factor based on the following:

1. **Potential impact** of the event/condition on patients and personnel, determined by evaluating the potential for patient illness, injury, infection, death, need for admission to an inpatient facility; the potential for personnel illness, injury, infection, shortage; potential to impact the organization's ability to function/remain open; and degree of clinical and financial impact.
2. **Probability of the event/condition occurring,** determined by evaluating the risk of the potential threat actually occurring. Information regarding historical data, infection surveillance data, the scope of services provided by the facility, the environment of the surrounding area (topography, interstate roads, chemical plants, railroad, ports, etc.), and health department data, are considered when determining this score.
3. **Organization's preparedness** to deal with the event/condition, determined by considering policies and procedures already in place, staff experience and response to actual situations, and available services and equipment.

Ranking of Scores

After risk scores are assigned in the three assessment groups, the numbers in each group were totaled to provide a numerical risk level for each event/condition. The numerical risk level can range from 0 (lowest vulnerability) to 9 (highest vulnerability). The risk factors (i.e., events/conditions) were then ranked from highest to lowest risk level in the table below. The risks with the highest scores will be used for priority focus for developing the annual ISPC Plan. NOTE: Some events/conditions with a lower score may be selected because they are an accreditation or regulatory requirement, or can be quickly and easily implemented.

Distribution of Risk Assessment

The Risk assessment was shared with others, such as the Environment of Care & Risk Management Committees, to solicit comments. The original group evaluated and incorporated the comments, as needed, and finalized this risk assessment. The risk assessment will be taken to the Quality Improvement Committee and the Board of Directors for final approvals. After final approval of the risk assessment findings, the ISPC Plan will be developed by the Infection Control Nurse, or delegate, with periodic reports back to the Environment of Care, Risk Management, & Quality Improvement Committees until the Plan has been fully implemented. The Quality Improvement & Risk Management Director, or delegate, will report a summary of plan findings and activities to the Board of Directors at least annually.

Results

A numerical risk level of 7 is identified as the highest perceived potential risk.

Event or Condition	Score
Hand Hygiene	8
Cleaning High Level Disinfecting Process	7
Dental Sterilization Monitoring	7
Minor Surgical Instrument Sterilization	7
Bioterrorism agents	6
COVID 19 Outbreak	6
Immunizations pre-employment	6
TB Screening of Patients	6
COVID 19 and variants	5
COVID 19 Vaccinations	5
Infection from inadequate air handler	5
Lack of PPE	5
Medication fridge temp logs	5
Needle safety	5
Norovirus Influenza and other Respiratory infections	5
Social Distancing practices	5
Bloodborne pathogen plan	4
C-Diff	4
Infection from inadequate water system	4
MRSA	4
Regulated Waste Management Program	4
Standard Precautions	4
Tuberculosis plan	4
VRE	4
Appropriate prophylactic antibiotic	3
Baseline TB Screening Employees	3
Communicable Diseases	3
Community ID risk/lice, scabies, bed bugs	3
Current policies and procedures related to Infection Control and Prevention	3
Established policy and procedure safe injection practice	3
Staff Influenza Immunization Program	3

Risk Assessment for the Infection Surveillance, Prevention and Control (ISPC) Program

Year: 2022

Organization Name: Lincoln Community Health Center

Date of Report: 3/22/2022

Event or Condition	What is potential impact of event/condition on patients and staff?				What is probability of event/condition occurring?				What is organization's preparedness to deal with this event/condition?				Numerical risk level
	High (3)	Med (2)	Low (1)	None (0)	High (3)	Med (2)	Low (1)	None (0)	None (3)	Poor (2)	Fair (1)	Good (0)	Total
COMMUNITY & POPULATIONS SERVED:													
Uninsured/underinsured		X			X							X	5
Refugee		X			X							X	5
Homeless		X			X							X	5
ESL		X			X							X	5
INFECTIOUS DISEASES													
COVID 19 and variants	X					X						X	5
Community ID Risk-lice/scabies bedbugs			X			X						X	3
Norovirus/Influenza/Other Respiratory infections	X					X						X	5
Communicable Diseases			X			X						X	3
MULTI DRUG RESISTANCE ORGANISMS:													
MRSA		X				X						X	4
CDIFF		X				X						X	4
VRE		X				X						X	4
PREVENTION ACTIVITIES:													
Hand Hygiene program	X				X					X			8
Standard Precautions		X				X						X	4
TB Screening of patients	X					X					X		6
Appropriate prophylactic antibiotic			X			X						X	3

Event or Condition	What is potential impact of event/condition on patients and staff?				What is probability of event/condition occurring?				What is organization's preparedness to deal with this event/condition?				Numerical risk level
	High (3)	Med (2)	Low (1)	None (0)	High (3)	Med (2)	Low (1)	None (0)	None (3)	Poor (2)	Fair (1)	Good (0)	Total
INSTRUMENT & MEDICAL DEVICE CLEANING, DISINFECTION & HANDLING													
Dental Sterilization Monitoring (AUTOCLAVE)	X				X						X		7
Minor Surgical instrument sterilization	X				X						X		7
EMPLOYEE HEATH:													
Social distancing practices		X				X					X		5
Baseline TB screening employees		X					X					X	3
Staff Influenza immunization program		X					X					X	3
Bloodborne pathogen plan		X				X						X	4
Tuberculosis Plan		X				X						X	4
COVID Vaccine		X			X							X	5
Immunizations pre-employment		X				X				X			6
Needle Safety		X				X					X		5
ENVIRONMENT OF CARE:													
Medication Refrigerator Temp Logs			X		X						X		5
Infection from inadequate air handling	X						X				X		5
Cleaning High level disinfection process	X				X						X		7
Regulated Waste Management Program		X				X						X	4
Lack of PPE		X				X						X	4
Infection from inadequate water system		X					X				X		4
POLICY PROCEDURES:													
Current policy and procedures related to infection control and prevention.			X			X						X	3
Established policy or procedures safe injection practices.			X			X						X	3

Event or Condition	What is potential impact of event/condition on patients and staff?				What is probability of event/condition occurring?				What is organization's preparedness to deal with this event/condition?				Numerical risk level
	High (3)	Med (2)	Low (1)	None (0)	High (3)	Med (2)	Low (1)	None (0)	None (3)	Poor (2)	Fair (1)	Good (0)	Total
EMERGENCY MANAGEMENT:													
Bioterrorism Agents	X					X					X		6
OTHER:													
COVID 19 Outbreak	X				X							X	6

1. **Potential impact of the event/condition on patients and personnel**: determined by evaluating the potential for patient illness, injury, infection, death, need for admission to an inpatient facility; the potential for personnel illness, injury, infection, shortage; potential to impact the organization's ability to function/remain open; and degree of clinical and financial impact.
2. **Probability of the event/condition occurring**: determined by evaluating the risk of the potential threat actually occurring. Information regarding historical data, infection surveillance data, the scope of services provided by the facility, and the environment of the surrounding area (topography, interstate roads, chemical plants, railroad, ports, etc.) are considered when determining this score.
3. **Organization's preparedness to deal with the event/condition**: determined by considering policies and procedures already in place, staff experience and response to actual situations, and available services and equipment.

Developed by: K. Arias, M. Patrick, K. Delahanty and S. Odachowski

Infection Prevention & Control Program: Evaluation & Plan

Results Evaluation Year: 2021
Organization Name: Lincoln Community Health Center
Plan Goals Year: 2022

Category	Risk	2021 Goal Result	2021 Evaluation	2022 Goals	2022 Plan	Responsibility
1. Community or population served. uninsured, underinsured, ESL.	Uninsured and under insured population at times not compliant. English as a second language.	Translators, information in English and Spanish. Many staff are bilingual where Spanish is their primary language.	Goal achieved to have signs, patient education and more bilingual staff to accommodate patients' needs. Language line used for other languages other than Spanish.	Enhance language services by adding different communication devices besides language line.	Evaluate other products such as stratus audio visual iPad for other languages.	Clinic leadership or designee.
2.1 Infectious Diseases, COVID 19 and variants.	Transmission of these infections to patients/staff results in infections potentially could have an outbreak at the clinic.	Identify patients/staff for potential COVID exposure. Staff screening patients for S&S of COVID, Occupational Health Nurse to be notified of possible employee exposures.	Patients not always stating COVID exposure or illness because of wanting to be seen by provider. Employees are notifying Occupational Health nurse when COVID S&S most of the time.	All patients screened and sent to provider are not displaying COVID S&S. Employees will continue to call Occupational Health Nurse for triage of COVID S&S. All staff vaccinated and boosted.	Come up with different screening questions to separate out poss. COVID positive patients before getting back to provider. Continue to reinforce need for employees to call OHN to triage employees for S&S of Covid staff can remain home. All staff vaccinated and boosted in given timeframe.	COVID Task Force and occupational Health Nurse.

Category	Risk	2021 Goal Result	2021 Evaluation	2022 Goals	2022 Plan	Responsibility
2.2 Community ID Risk-Scabies, headlice.	Develop current policy per CDC guidelines for staff to follow with these occurrences.	Policy updated and approved 2021.	Staff utilizing the updated policies and notifying Infection Control Nurse when these occurrences arise.	Work with EVS to streamline cleaning process when these issues occur.	Meet with EVS team and go over policy and procedure for terminal cleaning of treatment rm.	Infection Control Nurse and Nursing Leadership
2.3 Norovirus/ Influenza/ Other Respiratory infections.	Transmission of these infections to patients/staff results in potential outbreak at the clinic.	Identify patients/staff for potential exposure. Staff screening patients for S&S of infection. Occupational Health Nurse to be notified of possible employee infections.	Screeners have a difficult time differentiating other Respiratory infections vs. COVID. Must treat any respiratory Infection as COVID.	Screeners need to continue to scrutinize any patient presenting with Respiratory Symptoms as possible COVID especially during peak season.	Continue to evaluate different screening questions to separate out potential infectious patients. Continue to reinforce need by OHN to triage calls from sick employees to help with next steps and differentiate what Influenza vs COVID or other respiratory condition.	COVID Task Force Group and OHN.
3. MRSA/CDIF/ VRE Multi drug resistant organisms.	Inappropriate use antimicrobials are a patient safety issue and can lead to adverse outcomes including increased antimicrobial resistance.	Update antibiotic Stewardship policy. Designate physician director and set one goal	MET Updated antibiotic Stewardship policy in 2021 and 2 directors named. A goal was developed and placed in the policy.	Antimicrobial stewardship goal implementation will be developed by the directors and their team.	Roll out implementation plan to providers and start data collection at designated times.	Antimicrobial Stewardship team. Pharmacy and Providers
4.1 Hand Hygiene program	Lack of Hand Hygiene promotes the transmission of multi-drug resistant pathogens, device-related infections as well as other infections.	Still need to have all satellites participate in the Hand Hygiene data collection	Establish a hand Hygiene Program with a Goal of 90%. Some Satellites entities have not contributed to data collection for Hand Hygiene.	Increase participation of all satellites for 90% Hand Hygiene compliance	Continue to focus efforts on those satellites that have not participated in the Hand Hygiene program.	Satellite administrator and all staff

Category	Risk	2021 Goal Result	2021 Evaluation	2022 Goals	2022 Plan	Responsibility
4.2 Standard Precautions	Lack of Standard precautions can lead to clinic infections not only staff but also transmitted to patients.	Staff to wear masks at all times. Patients to wear appropriate masks when entering the building. Surgical masks at all entrances given to staff and patients.	All staff are appropriately masking.	Appropriate masks distributed to all staff. Patients not allowed cloth masks and given surgical masks to wear.	OHN has supply of masks for distribution to staff and will continue to make further adjustments concurrent with updates to CDC guidelines. Various managers also have supply of masks for staff. Screeners to give surgical masks to patients who do not have a mask or have a cloth mask. Security also on alert for patients who do not comply in wearing a mask in the building at all times.	All leadership and staff and security
4.3 TB Screening of patients.	Possible exposure to staff.	Always have appropriate PPE available to staff. Screen patients for history of TB, cough or respiratory issues vs COVID.	Exposure very minimal due to required masking by staff and patients.	Continue to monitor TB exposure of staff when occurrence happen.	Review and evaluate current plan and make recommendations as appropriate.	Infection Control Nurse.
4.4 Appropriate prophylactic antibiotic. As described in #3.	Inappropriate use antimicrobials are a patient safety issue and can lead to adverse outcomes including increased antimicrobial resistance.	Update antibiotic Stewardship policy. Designate physician director and set one goal	MET Updated antibiotic Stewardship policy in 2021 and 2 directors named. A goal was developed and placed in the policy.	Antimicrobial stewardship goal implementation will be developed by the directors and their team.	Roll out implementation plan to providers and start data collection at designated times.	Antimicrobial Stewardship team. Pharmacy and Providers

Category	Risk	2021 Goal Result	2021 Evaluation	2022 Goals	2022 Plan	Responsibility
4.5 Appropriate dress attire	Appropriate PPE to be worn to decrease transmission of infection.	Goal MET	All staff will identify themselves to the patient and wear the necessary PPE.	Continue to have staff identify themselves to patients. Also, transmission of infections is at a low-risk when staff and patients are masked and PPE utilized by staff.	Not in 2022 IC Risk Assessment.	Infection Control Nurse.
5.1 Dental Sterilization Monitoring (Autoclave)	Improperly disinfected devices pose a risk of transmitting infections to patients.	Education and competencies developed. Auditing tool developed and oversight established.	Identified targets for improvement.	New Autoclave with printers for documenting physical and chemical parameter. Daily maintenance, on sight spore count and enzymatic cleaning gels rolled out.	Competencies for chemical and temperature parameters completed by 2/28/22. Monitor all processes concerning issues associated with Joint Commission survey on a quarterly basis for 2022.	Director of Dental or Designee and Infection Control Nurse.
5.2 Minor Instrument sterilization.	Improperly disinfected devices pose a risk of transmitting infections to patients.	Education and competencies developed. Auditing tool developed and oversight established.	Identified targets for improvement.	New Autoclave with printers for documenting physical and chemical parameter. Daily maintenance, on sight spore count and enzymatic cleaning gels rolled out.	Competencies for chemical and temperature parameters completed by 2/28/22. Monitor all processes concerning issues associated with Joint Commission survey on a quarterly basis for 2022.	Director of Dental or Designee and Infection Control Nurse.
6.1 Social Distancing	Noncompliance with social distancing requirements can lead to multiple staff exposures to COVID due to Omicrons transmissibility.	Communication related to social distancing through zoom meetings, emails and observations by leadership.	At times especially during lunch staff not always compliant. Direct observation is done and corrected when seen.	Continue to monitor staff through direct observation. Need to continue social distancing as directed by CDC.	Continue to remind staff about the need to social distance through zoom staff meetings and email reminders. Also, through direct observation when in the break room.	Leadership and all employees

Category	Risk	2021 Goal Result	2021 Evaluation	2022 Goals	2022 Plan	Responsibility
6.2 Baseline TB screening of employees	Possible outbreak in clinic staff if baseline TB test not completed on new employees.	MET	100% of all new employees have had baseline TB testing.	All new employees will have a baseline TB test.	During the first day of orientation the OHN will administer a TB test to the new employee.	OHN
6.3 Staff influenza Immunization program	Noncompliance with influenza vaccination can lead to infections as well as increased sick days used by employees.	MET	This is included in a condition of employment by Lincoln. Lincoln is committed in reducing the transmission of vaccine preventable illnesses.	Continue vaccine program.	Continue current vaccine program. Continue to provide information to staff and offer flu blitz and site visits for influenza vaccine.	OHN
6.4 Bloodborne pathogen plan	The plan serves to clarify the process for medical investigation following significant exposures.	To investigate incidents of exposure and understand how a defect in the system could have caused the exposure.	Review of the plan in 2021. Includes follow-up with employee and investigation/evaluation of issue to identify root cause and mitigate through an action plan.	Continue to investigate any and all exposures.	Evaluate all exposures for causes and develop mitigation plan if needed.	Quality Director OHN CMO
6.5 Tuberculosis Plan	Possible outbreak in clinic staff if baseline TB test not completed on new employees.	MET	100% of all new employees have had baseline TB testing. TB plan was reviewed 2021.	All new employees will have a baseline TB test. Annual education will be in the Learning Management System.	100% new employees will have TB testing. 100% of Employees will do an annual TB competency in our Learning Management System.	OHN and HR, leadership
6.6 COVID Vaccine	Noncompliance with COVID vaccination can lead to infections as well as increased sick days used by employees.	MET	This is included in a condition of employment by Lincoln. Lincoln is committed in reducing the transmission of vaccine preventable illnesses.	Continue vaccine program.	Continue current vaccine program. Continue to offer employees COVID vaccines from OHN and COVID Vaccine Clinic.	OHN

Category	Risk	2021 Goal Result	2021 Evaluation	2022 Goals	2022 Plan	Responsibility
6.7 Immunizations pre-employment	Noncompliance with pre-employment vaccinations can lead to infections as well as increased sick days used by employees.	MET	This is included in a condition of employment by Lincoln. Lincoln is committed in reducing the transmission of vaccine preventable illnesses.	Continue vaccine requirements.	Continue current vaccine requirement according to CDC guidelines. If missing any immunizations need to present letter and have employee sign to validate that they have received this condition of employment.	OHN
6.8 Needle Safety (safe injection Practices) SIP	Misuse and reuse of injection supplies and medication increases risk for BBP cross-transmission between patients and injury to staff.	Ensure safe injection practices are used throughout the organization	Monitor incidents of unsafe injection practices. Look for common themes of employee exposure or patient injury/cross transition.	Continue to ensure safe practices used throughout the organization.	Increase voluntary reporting of needle injuries and lapses in SIP.	Quality Director and OHN
7.1 Infection from inadequate air handling	Maintaining a clean air handling system for the organization and providing ongoing monitoring is integral in preventing outbreaks of air related healthcare associated infection.	Have an air testing plan from DRH.	We continue to wait for DRH to develop an air handling plan for our main campus.	Have an air exchange system in the treatment/exam areas where patients are seen	HEPA machines in all exam rooms and in areas where needed.	Leaders in those designated areas
7.2 Infection from inadequate water system	Maintaining a clean supply of water for the organization and providing ongoing monitoring is integral in preventing outbreaks of water-related healthcare-associated infection.	Water management plan from DRH.	The water management plan tests our water at the site periodically during the year.	Continue with the DRH water management plan. Look to see when our water fountains can be flushed and reopened.	Contact DRH maintenance department to set up an appointment for flushing and testing our water fountains	OHN

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8. Current policy and procedures related to infection control and prevention	Failure to update policies and procedures puts the organization at risk for outdated information that could cause harm.	All infection control policies should be reviewed every 3 years or when an event that is not in the policy occurs.	Updated policy and procedure 2021	Continue with current 3-year cycle of updating policies and procedures or when a significant event occurs that is not in the policy.	Reviews will occur on a cycle or if any events happen that needs to be included in the policy.	Infection Control Nurse and Quality Director
9 Bioterrorism Agents	An attack could impact operations and pose a risk to the community.	MET	Continue to monitor external bioterrorism agents diseases or threats based on public health, CDC and other communication.	Maintain an awareness of public health data and events from national and local agencies to prevent potential outbreaks.	Participate in emergency planning committees to ensure appropriate PPE and materials. Annual review of Policies and procedures addressing influx of patients.	Infection Control Nurse, Safety, Leadership and Quality Director and emergency preparedness
10.COVID 19 Outbreak	An outbreak and potential influx of patients with contagious infectious disease can impact operations and pose a risk to the patient population.	MET	Continue to monitor external and internal infectious diseases or threats based on public health, CDC and other communication.	Maintain an awareness of public health data and events from national and local agencies to prevent potential outbreaks.	Participate in emergency planning committees to ensure appropriate PPE and materials. Annual review of Policies and procedures addressing influx of patients.	Infection Control Nurse, Safety, Leadership and Quality Director Safety