Joe Lombardo
Governor

Richard Whitley, MS
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

Cody Phinney, MPH
Administrator

Ihsan Azzam, Ph.D., M.D.
Chief Medical Officer

June 27, 2023

Brenda Erdoes
Director of the Legislative Counsel Bureau
Legislative Building
401 S. Carson Street
Carson City, NV, 89701-4747

Dear Ms. Erdoes,

As required by Nevada Revised Statutes 439.877(4)(d), I am respectfully submitting the 2023 annual report from Southern Nevada Adult Mental Health Services.

Should you have any questions or concerns, I can be reached at 702-486-5387 or mespinosa@health.nv.gov.

Respectfully,

Margy Espinosa, RN, BSN
Rawson Neal Hospital Patient Safety Officer
Quality Assurance and Performance Improvement Department
Southern Nevada Adult Mental Health Services
1650 Community College Drive, Las Vegas, NV 89146

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Summary Report July 2022-June 2023

Southern Nevada Adult Mental Health Services (SNAMHS) continues to develop, review, revise and implement protocols and procedures to promote and improve the physical and behavioral health of the population that the agency serves. SNAMHS strives to maintain compliance with licensure and regulatory standards, to align protocols with Division of Public and Behavioral Health policies and procedures and to remain up to date with evidence-based practices.

The following checklists were revised or developed between July 2022 through June 2023:

- The Seclusion and Restraint (S&R) Documentation checklist was revised to ensure that all S&R packets are reviewed for completion of required provider signatures, documentation of time frames for when criteria are met and documentation of patients' acknowledgment of understanding regarding the rationale for theuse of S&R and the behavioral criteria set for release.
- A Seclusion and Restraint Charge Nurse Documentation worksheet was developed to help charge nurses thoroughly review, for completeness and accuracy, all documents, attachments and notes for each episode of seclusion and restraint.
- The Incident Report – SNAMHS inpatient worksheet was revised to ensure that information and documents needed to be reviewed by ordering medical staff are attached to the completed worksheets.
- A log was developed to track and document the monthly cleaning and disinfection of washing machines in all civil inpatient units.

Other agency initiatives taken between July 2022 through June 2023:

- The SBAR communication sheet and monitor boards were revised to reflect color codes assigned to signify any identified risks associated with each patient.

- Policies and procedures related to COVID 19 were regularly monitored and periodically revised to ensure compliance with guidelines set forth by the Center for Disease Control and Prevention.

- A civil inpatient hospital policy was developed for identification of patients' risk for sexually inappropriate or sexually assaultive behavior and steps to be taken to mitigate identified risks.

- The Token Economy and Treatment Mall Steering Committee continue to work towards developing upgrades to the civil inpatient Token Economy System. The token economy program was started at the Rapid Stabilization Unit to introduce patients to active treatment group earlier in the course of their treatment. New staff were trained on the Treatment Mall and Treatment Economy Programs to allow for more participation from different disciplines and departments.

For patients who are unable to attend groups, alternative activities and health education were developed to provide them with continuous access to active treatment.

- The Patient Safety Committee, Environment of Care Committee, other active hospital committees and the Quality Assurance and Performance Improvement Department, with the support of and in collaboration with the Executive Leadership Team, continues to monitor safety incidents, complete risk assessments, conduct audits and gather data to guide initiatives geared towards the reduction of safety risks and improvement of hospital practices.

Rawson-Neal Psychiatric Hospital ● Southern Nevada Adult Mental Health Services
1650 Community College Drive ● Las Vegas, NV 89146 ● (702) 486-8341 ● Fax (702) 486-7152 ● dpbh.nv.gov

REPORT TO THE DIRECTOR OF THE LEGISLATIVE COUNSEL BUREAU
PURSUANT TO NEVADA REVISED STATUTES 439.877(4)(d)
SUBMITTED BY:
Southern Nevada Adult Mental Health Services
Rawson Neal Psychiatric Hospital
Phone: 702-486-4400
Patient Safety Officer for Rawson-Neal: Margy Espinosa, RN BSN
(FY captured July 1, 2022-June 30, 2023)

1 | Policies/Checklists Developed Related to the Following Specific Types of Treatment: Patient Room and Environmental Sanitation

Policy	Title	Effective Date	New Policy	Policy Reviewed	Department(s) Responsible
OF-EC-45	Hospital Custodial Protocol Attachment: (1) Custodial Discharges Infection Control Sheet, (2) Custodial Cleaning Checklist for Patient Bedrooms	22-Aug	No	Y	Housekeeping/ Maintenance
OF-SP-26	Cleaning and Disinfection of Non-Critical Reusable Patient Care Equipment	23-Mar	No	Y	Nursing/ Housekeeping/ Maintenance
OF-SP-29	Bed Bug Management Attachments: (1) Periodic Bed Bug Inspection Checklist by Unit, (2) Assessment of Pest Control Agent for Bed Bugs	22-Feb	No	Y	Infection Control/ Nursing/ Housekeeping/ Maintenance
OF-SP-08	Scabies or Pediculosis (lice) Infestation Attachments: (1) Admission Checklist for Fungal Infection/Parasitic Infestation	23-Mar	No	Y	Infection Control/ Nursing/ Housekeeping/ Maintenance

**** Policy Reviewed: Y-Yes, N-No, P-pending**

2 | New Statewide Polices/Checklists Related to the Following Specific Types of Treatment: Patient Room and Environmental Sanitation

Policy	Title	Effective Date	New	Policy Reviewed	Department(s) Responsible
SWC-01	Bathroom Cleaning Procedure	21-Jun	No	Y	Housekeeping
SWC-02	Bedroom Cleaning Procedure	21-Jun	No	Y	Housekeeping
SWC-03	Single-Bucket Wet and Damp Mopping Procedure	21-Jun	No	Y	Housekeeping
SWC-04	Mopping and Wet Vacuuming Guidelines	21-Jun	No	Y	Housekeeping
SWC-05	Dusting Guidelines	21-Jun	No	Y	Housekeeping
SWC-06	Vacuuming Guidelines	21-Jun	No	Y	Housekeeping
SWC-07	Carpet Cleaning Procedure	21-Jun	No	Y	Housekeeping
SWC-08	Strip and Wax Floor Procedure	21-Jun	No	Y	Housekeeping
SWC-09	Spray Buffing procedure	21-Jun	No	Y	Housekeeping
SWC-10	Preparing and Using Solutions Guideline	21-Jun	No	Y	Housekeeping
SWC-11	Auto-scrubber Procedure	21-Jun	No	Y	Housekeeping

3 | Policies/ Checklists Related to the Following Specific Types of Treatments: Hand Hygiene Nationally Recognized Standard Precautionary Protocol

Policy	Title	Effective Date	New	Policy Reviewed	Department(s) Responsible
OF-SP-22	Hand Hygiene Policy Attachment: Hand Hygiene Monitoring Tool	23-Mar	No	Y	Agency Wide
NSG VII-01	Hand Washing Protocol	22-Jun	No	Y	Nursing

**** Policy Reviewed: Y-Yes, N-No, P-pending**

4 | Policies/Checklists Related to Specific Types of Treatments: Infection Control

Policy	Title	Effective Date	New	Policy Reviewed	Department(s) Responsible
OF-SP-01	Infection Control of Ice Machine	22-Feb	No	Y	Maintenance/Infection Control
OF-SP-02	Prospective Employee Health Screening and Standing Order for Employee Health Testing and Vaccinations	22-Apr	No	Y	Agency-wide
OF-SP-03	Infection Control Program Overview	23-Apr	No	Y	Agency-wide
OF-SP-04	Isolation techniques- Transmission Based Precautions	23-Apr	No	Y	Agency-wide
OF-SP-05	Standard precautions (Universal Precautions)	21-Jul	No	Y	Agency-wide
OF-SP-06	Use of Disposable Gloves During Handling of Food and Fluids	21-Aug	No	Y	Agency-wide
OF-SP-10	Airborne Pathogen Exposure Control Plan	23-Apr	No	Y	Agency-wide
OF-SP-13	Infectious Waste Management	23-Apr	No	Y	Agency-wide
OF-SP-17	Exposure Control Plan OSHA Bloodborne Pathogens Attachments: (1) Needlestick, Blood or Body Fluid Exposure Log	21-Aug	No	Y	Agency-wide
OF-SP-18	Respiratory Protection Program	23-Mar	No	Y	Infection Control /Employee Health
OF-SP-19	Seasonal Influenza Vaccination Program	21-Aug	No	Y	Agency-wide
OF-SP-23	Outbreak Investigation	23-Feb	No	Y	Agency-wide
OF-SP-27	Infection Prevention Surveillance	23-Apr	No	Y	Infection Control
OF-SP-32	Infection Prevention Committee	21-Aug	No	Y	Members agency-wide
OF-SP-34	Antimicrobial Stewardship Protocol	23-Feb	No	Y	Agency-wide
OF-SP-35	Prevention and Control of Legionella	22-Mar	No	Y	Infection Control /Maintenance
OF-SP-39	COVID 19 Vaccination Program - Patients	21-May	No	Y	Infection Control
NSG II-53	BinaxNOW Antigen Test	22-Jan	Yes	Y	Infection Control

**** Policy Reviewed: Y-Yes, N-No, P-pending**

5 | Policies and Checklists Related to: Admission, Transfer, Discharge and Patient Identification

Policy	Title	Effective Date	New	Policy Reviewed	Department(s) Responsible
PF-CC-55	Patient Identifier	23-Jan	No	Y	Agency-wide
NSG II-02	Outpatient Direct Admits to Hospital	22-Jun	No	Y	Nursing
NSG II-03	Post Incarceration Direct Admits	22-Jun	No	Y	Nursing
NSG II-04	Transportation of Inpatients Attachments: (1) Inpatient Transportation Request	22-Apr	No	Y	Nursing
NSG II-05	Physician/Patient Transfer	23-Jul	No	Y	Nursing, Psychiatry
NSG II- 08	Inpatient Admission Procedure Attachment: (1) Patient Admission Checklist, (2) Patient Transfer – Transferring Unit Checklist, (3) Patient Transfer – Receiving Unit Checklist	23-Feb	No	Y	Nursing, Psychiatry
NSG II-09	Patient Property	22-Sep	No	Y	Nursing, Social Services
NSG II-11	Admissions from Lakes Crossing or Stein	22-Jun	No	Y	Nursing
NSG II -18	Patient Identification Procedure	22-Jun	No	Y	Agency-wide
NSG II- 22	Contraband Searches	23-Feb	No	Y	Nursing
PF-AST-04	Hospital Admission/ Discharge Criteria	23-Apr	No	Y	Agency-wide
OF-MOI-05	Secure Transportation of Client Charts	22-Jul	No	Y	Agency-wide
OF-MOI-12	Psychiatric Discharge Summary	23-Apr	No	Y	Agency-wide
SW-03	Social Services Treatment Plan Procedure	22-Jun	No	Y	Social Services
SW-04	Psychosocial Assessment Procedure	22-Jun	No	Y	Social Services
PF-COC-18	Discharge Planning and Continuity of Care Plan	21-Mar	No	P	Social Services
OF-PI-25	Personal Property	21-Jul	No	Y	Agency-wide
01-134	Post Discharge Follow- Up Phone Call Procedures	23-Jun	No	Y	Medical Staff
PF-COC-02	Inter-hospital Patient Transfers and COBRA Compliance	22-Jan	No	Y	Nursing, Social Services

**** Policy Reviewed: Y-Yes, N-No, P-pending**

6 | Protocols, Procedures and Checklists Related to: Competency and Accuracy of Orders/Treatment

Policy	Title	Effective Date	New	Policy Reviewed	Department(s) Responsible
NSG I-05	Development Needs and Competency Assessment	22-Jun	No	Y	Nursing
NSG I- 06	Re-assignment of Nursing Staff Related to Allegations of Abuse or Neglect	22-Jun	No	Y	Nursing
NSG II-37	Medical Staff's Boards	22-Jun	No	Y	Nursing
PF-CC-88	Patient Observation	22-Jan	Yes	Y	Nursing
NSG IV-05	Documentation Standards	23-Apr	No	Y	Nursing
NSG IV-07	Kardex	22-Jun	No	Y	Nursing
NSG VI-09	Evaluating Contract Nursing and Certified Nursing Assistants	22-Jun	No	Y	Nursing
NSG VI-14	Contract Employee Orientation for Nursing Department	21-Jun	No	Y	Nursing
SWMS 01-114	All Medical Staff Procedures	23-Apr	No	Y	Medical Staff
II-44 Nursing 1001 Laboratory	Quest Diagnostic Laboratory Ordering, Patient Sample Labeling and Phlebotomy Procedures	22-Jun	No	Y	Laboratory Department, Nursing

7 | Other Protocols, Procedures and Checklists Include but Not Limited to: Surveillance, Safety, Staffing, Incidents, Sentinel Events and Life Safety

Policy	Title	Effective Date	New	Policy Reviewed	Department(s) Responsible
NSG I-03	Inpatient Staffing Plan	22-Dec	No	Y	Nursing
NSG II-12	Visiting	23-May	No	Y	Nursing
NSG II-15	Cobra and Escort of an Inpatient to Emergency Room	22-Jan	No	Y	Nursing
NSG II-16	Escort and or Supervision-Meal times	22-Jun	No	Y	Nursing
NSG II-17	Nursing Staff Responsibilities- Medical Emergency	23-Jun	No	Y	Nursing
NSG II-19	Security on the Adult Inpatient Unit	22-Jun	No	Y	Nursing
NSG II-41	Patient Bathroom Security	22-Jun	No	Y	Nursing
OF-PI-28	Sentinel Events	23-Mar	No	Y	Agency-wide
NSG II-07	Sexual Contact/Physical Contact/Assault Between Hospitalized Patients and Patient Allegations of Abuse Attachment: Nursing Checklist for Allegations of Abuse/Neglect	22-Mar	No	Y	Civil Nursing

**** Policy Reviewed: Y-Yes, N-No, P-pending**

7 | Other Protocols, Procedures and Checklists Include but Not Limited to: Surveillance, Safety, Staffing, Incidents, Sentinel Events and Life Safety (*cont.)*

Policy	Title	Effective Date	New	Policy Reviewed	Department(s) Responsible
PF-RRE-02	Seclusion or Restraint of Patients - Civil	21-Oct	No	Y	Agency Civil Inpatient Services
MS IV-11	Qualified Registered Nurse (QRN) Attachments: (1) Competency / Training Checklist for Qualified Registered Nurse One Hour Face to Face Evaluation	22-Jun	No	Y	Agency Civil Inpatient Services
PF-CC-51	Fall Prevention Protocol	23-Apr	No	Y	Agency-wide
PF-CC-86	Elopement	22-Jan	No	Y	Agency Civil Inpatient Services
PF-CC-89	Civil Hospital Sexual Assault/Abuse	23-May	Yes	Y	Agency Civil Inpatient Services
OF-EM-00	Safety Management Plan	22-Aug	No	Y	Agency-wide
OF-EC-03	Employee Safety, Health and Environmental Concerns	21-May	No	Y	Agency-wide
OF-EC-08	Emergency Codes Use of Public Announcement System	22-Jan	No	Y	Agency-wide
OF-EC-25	Hazardous Materials SDS and Waste Management	22-Jan	No	Y	Agency-wide
OF-EC-30	Fire, Emergency and Disaster Plan	22-Sep	No	Y	Agency-wide
OF-EC-47	Management and Care of Medical Equipment Attachment: (1) Monthly AED Check Log, (2) Annual AED Check Log	22-Mar	No	Y	Agency-wide
OF-EC-43	Construction Safety and Security	21-Aug	No	Y	Agency-wide
OF-EC-46	Interim Life Safety Plan	22-Aug	No	Y	Agency-wide
OF-EC-04	Health and Safety Inspections Attachment: Checklist for Environment of Care Rounds	23-Feb	No	Y	Agency-wide
OF-EC-05	Storage of Oxygen Tanks	21-Aug	No	Y	Agency-wide
OF-EC-48	Inpatient Facilities Life Safety Drawings	21-Dec	No	Y	Civil Inpatient
OF-EC-53	Civil Camera Security System	21-Jun	No	Y	Civil Inpatient
OF-EM-02	Campus Lockdown	21-Jul	No	Y	Agency-wide
OF-EM-35	Life Safety Management Plan Attachments: (1) Quarterly Fire Safety Checklist, (2) Fire Watch Checklist and Log	21-Sep	No	Y	Agency-wide

NSG III-02	Emergency Cart Attachments: (1) Emergency Cart Checklist	22-Jun	No	Y	Nursing
NSG VII-06	Refrigerators and Freezers Attachments: (1) Staff Refrigerator Temperature and Cleaning Log, (2) Client Refrigerator Temperature and Cleaning Log, (3) Biohazard Refrigerator Temperature and Cleaning Log	21-Jun	No	Y	Nursing

**** Policy Reviewed: Y-Yes, N-No, P-pending**

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY WIDE

SUBJECT: Hospital Custodial **NUMBER:** OF-EC-45

EFFECTIVE DATE: 08/2022 **REVIEW DATE:** 08/2024

APPROVED BY: /s/ Susan Lynch, MBA, CPM
Hospital Administrator

SUPERSEDES: 10/12; 05/13; 01/14; 04/16; 06/18; 08/20

I. PROTOCOL:

It is the protocol of SNAMHS to establish hospital custodial procedures to maintain a clean environment for the health and safety of patients and staff within the inpatient hospital.

II. PURPOSE:

The purpose of this protocol is to establish procedures to maintain the safety and cleanliness of all SNAMHS inpatient hospital facilities.

III. DEFINITIONS:

A. *Custodial* shall mean housekeeping.

B. *Hospital* shall mean the Rawson-Neal Psychiatric Hospital and any other SNAMHS-owned building designated as an inpatient facility.

C. *Housekeeping* shall mean the custodians of the SNAMHS Custodial department.

D. *Patient* shall mean any client who has entered into SNAMHS inpatient services.

IV. PROCEDURES:

A. GENERAL CLEANING

1. Custodial staff is expected to wear appropriate clothing and protective equipment, such as gloves and protective footwear.
   a. For spills or clean up where splashing might occur, a mask, rubber apron, and goggles are highly recommended.
2. Restrooms are to be cleaned and disinfected daily.
3. Frequently contacted surface areas such as chairs, tables, light switches, desks, etc., should also be cleaned and disinfected daily.
4. Floors with hard surfaces are to be mopped daily.

a. Sweeping and dry mopping are not permitted as microorganisms may be redistributed.
b. Carpets are to be dry vacuumed only.

5. Dusting is to be performed with a wet cloth
   a. Dry dusting is not permitted as microorganisms may be redistributed.

B. PATIENT ROOM CLEANING

1. Before and after a discharge of a patient, or when it is discovered that the patient suffers an infection or becomes sick, the Custodial staff will perform a thorough cleaning to include, but not limited to:
   a. Vacuuming
   b. Walls, baseboards, and furniture cleaning
   c. Surface disinfection
2. If cleaning towels used to the clean the room become stained with blood, or body fluids etc., they shall be placed in the provided heavy-duty plastic linen bags, secured, and placed in the soiled linen cart, in the soiled utility room. (See policy OF-SP-05 Standard Precautions).
3. When there is any evidence of bed bugs, the room must be treated by a licensed pest control agency and cleaned by Housekeeping before another patient is admitted to that room.
   a. Do not vacuum the room as vacuuming can pick up bed bugs and adhere to surfaces and brushes making the vacuum cleaner a source of bed bug distribution.
   b. Vacuum cleaners that have been used in the bed bug infested area before discovery, need be thoroughly disinfected, bags and canisters are to be emptied, placed in a red infectious waste plastic bag and disposed of in the infectious waste container in the soiled utility room. Brushes shall be disinfected or replaced.
   c. Seal mattresses and box springs in encasements. Bed bugs inside a sealed encasement cannot bite through it or escape and will eventually die.
   d. Drying items such as clothing or linen in a hot dryer for a minimum of twenty (20) minutes will kill all stages of bed bugs.

C. CHEMICALS USED

1. All chemicals (cleaners, sanitizers, disinfectants) used for cleaning sanitation or disinfection are reviewed approved by Infection Control. The associated Safety Data Sheets are maintained in the SNAMHS SDS binder and on the SNAMHS server.
2. All chemicals for cleaning, sanitization and disinfection will be used according to manufacturer’s specifications, on dilution, contact time, and disposal.

3. For general cleaning:
   a. Neutral cleaner/disinfectant r
   b. H202 (Hydrogen Peroxide) multi-surface cleaner
4. For hard surfaces:
   a. Broad-spectrum hard surface cleaner/disinfectant
5. For wood surfaces:
   a. Duster-polisher
6. For floors:
   a. Non-acid cleaner/sanitizer

D. Storage of Equipment and Chemicals

1. Housekeeping cleaning chemicals will only be stored in designated secured storage areas with appropriate ventilation.
2. Housekeeping cleaning equipment will only be stored in designated secured equipment areas with appropriate ventilation.
3. No chemicals or equipment will ever be stored in non-approved areas, including but not limited to the server room, the electrical room, the boiler room or impeding any egress or any closed areas without proper ventilation.
4. Ensure all items on Housekeeping cleaning carts are secure while using them in public and patient areas.

V. REFERENCES:

A. OF-SP-05 Standard Precautions

B. OF-SP-29 Bed Bug Management

C. Georgia Division of Public Health. *Bed bug Handbook.* Available online at: https://dph.georgia.gov/sites/dph.georgia.gov/files/related_files/document/ADES_Bed_Bug_Handbook.pdf

D. Illinois Department of Public Health. *Prevention of Bed Bugs in Health Care Facilities.* Available online at: http://www.idph.state.il.us/envhealth/BedBugs_HealthCareFacilities.pdf.

VI. ATTACHMENTS:

A. OF-EC-45 Hospital Custodial Attachment A

B. OF-EC-45 Hospital Custodial Attachment Buo

OF-EC-45 Attachment B **SNAMHS**

Custodial Discharges Infection Control Sheet

Instructions: Place check in the appropriate box (Yes or No) at the right of each item.

Unit / Area:

CLIENT ROOMS BASIC DISCHARGE CLEANING ROUTINE

- **Furniture:** Clean with a neutral disinfectant cleaner in accordance with manufacture's labeling, and polish with furniture polisher.
- **Window**: Clean and disinfect window and frame with a germicidal disinfectant cleaner in accordance with manufacture's labeling, and glass cleaner.
- **Door**: Check walls, doors, jambs, hardware, and baseboards on a daily basis. Clean as needed with a germicidal disinfectant cleaner in accordance with manufacture's labeling.
- **Floor**: Mop floors with neutral disinfectant cleaner in accordance with manufacture's labeling. Sweep floors and remove gross soil before application of disinfectant.
- **Bed**: Remove mattress from bed frame, and clean front and back, including the sides, with a disinfectant cleaner in accordance with manufacture's labeling. Clean and disinfect bed frame with a disinfectant cleaner in accordance with manufacture's labeling.

Completed? Yes	Completed? No	Room #
☐	☐	

CLIENT ROOMS UNDER CIRCUMSTANCES WHICH INVOLVE BODILY FLUIDS:

BLOOD, SEMEN, URINE, FECAL MATTER, VOMIT, ETC. THIS DOES NOT BEGIN UNTIL AFTER AN MHT OR NURSE HAS PICKED UP THE BULK.

1. Clean / Machine scrub contaminated area with a disinfectant cleaner.
2. Complete the daily basic cleaning routine
3. Place all cleaning rags in a clear plastic bag (separate from the rest of the linen) tie- off bag and place in Soil utility room.

Completed? Yes	Completed? No	Room #
☐	☐	

TERMINAL CLEANING OF ALL ROOMS AT THE TIME OF DISCHARGE

1. Vacuum vents, every nook and cranny and each piece of furniture.
2. Clean furniture with a disinfectant cleaner in accordance with manufacture's labeling. and polish with furniture polisher
3. Clean and disinfect windows and frames with a disinfectant cleaner in accordance with manufacture's labeling and glass cleaner.
4. Remove mattress from bed frame, and clean front and back, including the sides, with a disinfectant cleaner in accordance with manufacture's labeling.
5. Clean and disinfect bed frame with a disinfectant cleaner in accordance with manufacture's labeling .
6. Clean walls, doors, jambs, hardware, and baseboards with a disinfectant cleaner in accordance with manufacture's labeling.
7. Mop floors with disinfectant cleaner in accordance with manufacture's labeling.
8. Sweep floors and remove gross soil before application of disinfectant.

Completed? Yes	Completed? No	Room #
☐	☐	

Cleaned by: _____ Time: _____ Date: _____

Print Name Signature

SNAMHS
Custodial Cleaning Checklist > Patient Bedroom

Instructions Place check in the appropriate box (Yes or No) at the right of each item.			**Unit / Area:**	
DAILY BASIC CLEANING ROUTINE				
• **Furniture:** Clean with a hospital approved disinfectant cleaner in accordance with manufacture's labeling, and polish with furniture polisher. • **Window**: Clean and disinfect window and frame with a hospital approved disinfectant cleaner in accordance with manufacture's labeling, and glass cleaner. • **Door**: Check walls, doors, jambs, hardware, and baseboards on a daily basis. Clean as needed with a hospital approved disinfectant cleaner in accordance with manufacture's labeling. • **Floor**: Mop floors with a hospital approved disinfectant cleaner in accordance with manufacture's labeling. Dust mop floors and remove gross soil before application of disinfectant.	**Completed?** Yes ☐	No ☐	Comments:	
PATIENT ROOMS UNDER CIRCUMSTANCES WHICH INVOLVE BODILY FLUIDS: BLOOD, SEMEN, URINE, FECAL MATTER, VOMIT, ETC. THIS DOES NOT BEGIN UNTIL AFTER AN MHT OR NURSE HAS PICKED UP THE BULK.				
1. Clean / Machine scrub contaminated area with a hospital approved disinfectant cleaner. 2. Complete the daily basic cleaning routine 3. Place all cleaning rags in a clear plastic bag (separate from the rest of the linen) tie- off bag and place in Soil utility room.	**Completed?** Yes ☐	No ☐	Comments:	
TERMINAL CLEANING OF ALL ROOMS AT THE TIME OF DISCHARGE				
1. Vacuum vents, every nook and cranny and each piece of furniture. 2. Clean furniture with a hospital approved disinfectant cleaner in accordance with manufacture's labeling. and polish with furniture polisher 3. Clean and disinfect windows and frames with a hospital approved disinfectant cleaner in accordance with manufacture's labeling and glass cleaner. 4. Remove mattress from bed frame, and clean front and back, including the sides, with a hospital approved disinfectant cleaner in accordance with manufacture's labeling. 5. Clean and disinfect bed frame with a hospital approved disinfectant cleaner in accordance with manufacture's labeling . 6. Clean walls, doors, jambs, hardware, and baseboards with a hospital approved disinfectant cleaner in accordance with manufacture's labeling. 7. Mop floors with a hospital approved disinfectant cleaner in accordance with manufacture's labeling. 8. Dust mop floors and remove gross soil before application of disinfectant.	**Completed?** Yes ☐	No ☐	Comments:	

Cleaned by: _____ Time: _____ Date: _____
Print Name Signature

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY WIDE

SUBJECT: Cleaning and Disinfection of Non-Critical Reusable Patient-Care Equipment

NUMBER: OF-SP-26

EFFECTIVE DATE: 03/2023

REVIEW DATE: 03/2025

APPROVED BY: /s/ Susan Lynch, MBA, CPM
Hospital Administrator

SUPERSEDES: OF-SP-26 dated 04/13; 04/15; 04/17; 04/19; 01/21

I. PROTOCOL:

It shall be the protocol of Southern Nevada Adult Mental Health Services (SNAMHS) to ensure appropriate technique in cleaning and disinfection of non-critical reusable patient-care equipment.

II. PURPOSE

The purpose of this protocol is to ensure all non-critical, reusable patient-care equipment is routinely cleaned and disinfected before and after use.

III. DEFINITIONS:

A. Cleaning – The physical removal of foreign material, e.g., dust, oil, organic material such as blood, secretions, excretions, and micro-organisms. Cleaning reduces or eliminates the reservoirs of potential pathogenic organisms. It is accomplished with water, detergents, and mechanical action.

B. Disinfection – The inactivation of disease producing organisms. Disinfection does not destroy high levels of bacterial spores. Disinfectants are used on inanimate objects. Disinfection usually involves chemicals, heat or ultraviolet light. Levels of chemical disinfection vary with the type of product used.

C. Non-Critical Equipment – Those items that either touch only intact skin but not mucous membranes or do not directly touch the patient (e.g., reusable electronic thermometers, and blood pressure cuffs).

IV. PROCEDURE:

A. **RESPONSIBILITIES:** Cleaning and disinfection will be responsibility of the Nursing staff (nurses and mental health technicians, infection control, or designee).

B. Cleaning and maintenance processes will follow manufacturer's recommendations.

C. Thermometers:

1. SNAMHS uses reusable electronic thermometers; the Exergen Temporal Scanner, Spot Vital Signs, and Sure Temp Plus.

   a. The thermometers should be cleaned and disinfected with 70% isopropyl alcohol per manufacturer's recommendation.

   b. The thermometers including the probe shall be cleaned and disinfected when contamination occurs and on a routine basis following the manufacturer's recommendations.

   c. For thermometers with scanner lens, clean with a cotton swab dampened with 70% isopropyl alcohol wipes on a routine basis.

D. Blood pressure cuffs:

1. SNAMHS uses reusable vinyl blood pressure cuffs. These items will be cleaned with 70% isopropyl alcohol wipes or prep pads after each patient use.

2. Blood pressure tubing and port fittings shall be cleaned on a weekly basis by wiping with 70% isopropyl, then allowed to air dry.

3. Blood pressure cuffs shall be cleaned and disinfected on a weekly basis by following the procedure below:

   a) Infection Control department shall be responsible for collecting and returning the BP cuffs to the units after cleaning and disinfecting and shall maintain documentation. (See Attachment A.)

   b) To prepare, remove the FlexiPort fitting and tubes from cuff, seal the open port with accessory plug. Close the hook and loop.

   c)) Prepare enzymatic detergent according to manufacturer's instructions.

   d) Apply port-cap to cuff.

   e) Spray detergent solution liberally onto cuff and use a clean brush to agitate the detergent solution over entire cuff surface for five minutes.

   f) Rinse continuously with water for five minutes.

   g) To disinfect, first follow the cleaning steps above, then spray cuff with 10% bleach solution until saturated, agitate with a clean brush over entire cuff surface for five minutes.

   h) Rinse continuously with water for five minutes.

   i) Wipe off excess water with clean cloth and allow cuff to air dry.

E. Finger Pulse Oximetry:

1. Clean and disinfect the rubber touching the finger inside the Oximeter, with 70% isopropyl alcohol wipes before and after each test.

F. EKG Welch Allyn

1. Unplug the EKG machine before cleaning.
2. Clean and disinfect the exterior of the EKG machine and patient cables before and after patient use with 70% isopropyl alcohol prep pads or alcohol wipes.

G. The application of tape on patient care equipment is discouraged.

H. All health care workers must exercise routine practices (i.e., hand hygiene and/or hand sanitize) and wear the required personal protective equipment (PPE) as indicated for the task.

I. Any damaged equipment must be reported to the unit supervisor for decision regarding replacement or the ability to be cleaned.

J. Special, additional cleaning may be required in an outbreak situation. Procedures will be determined in consultation with the Infection Preventionist.

K. Disposable patient care equipment and supplies shall be immediately discarded after use.

L. Personal care items/effects (such as lotions, razors, skin cleansers) are single use patient items and are not to be shared between patients.

M. The Housekeeping Manager and the Infection Preventionist must approve all products used for cleaning/disinfection process.

V. REFERENCES:

A. SNAMHS Share-SDS Folder- Vital Signs Device Manuals

VI. ATTACHMENTS:

A. OF-SP-26 BP Weekly Cleaning Log Attachment A

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY WIDE

SUBJECT: Bed Bug Management **NUMBER:** OF-SP-29

EFFECTIVE DATE: 02/2022 **REVIEW DATE:** 02/2024

APPROVED BY: /s/ Susan Lynch, MBA, CPM
Hospital Administrator

SUPERSEDES: OF-SP-08 Bed Bugs segment; 04/13; 01/14; 12/15; 12/19

I. PROTOCOL:

It shall be the protocol of Southern Nevada Adult Mental Health Services (SNAMHS) to manage bed bugs as potential health concern to patients and the environment.

II. PURPOSE:

The purpose of this protocol is for staff to be observant for potential infestations of bed bugs and take appropriate actions.

III. DEFINITIONS:

A. Bed bugs are a potential health concern to patients in healthcare facilities. Although not known to transmit disease to humans, bed bug bites can cause a variety of negative physical, mental, and economic consequences. Many people have mild to severe allergic reactions to the bites with effects ranging from no reaction to a small bite mark to, in rare cases, anaphylaxis (severe, whole-body reaction). These bites can also lead to secondary infections of the skin such as impetigo, ecthyma (deep impetigo), and lymphangitis. Bed bugs may also affect the mental health of patients. Reported effects include anxiety, insomnia and systemic reactions.

IV. PROCEDURE:

A. Patients will be monitored for visible bite marks, welts, or other signs of insect bites upon admission and during length of stay.

1. Upon admission, patients will be assessed to determine if bed bug bites exist. (use OF-SP-08 Attachment C) A visual inspection of the patient's belongings to confirm the presence of bed bugs.

2. If patients have visible bite marks, an assessment will be done to rule out whether the bites may have come from other pests, including scabies, body lice, pubic lice, etc.
3. Bites and/or allergic reactions will promptly be given appropriate treatment.
4. Contact precautions will be observed when caring for patients with confirmed or suspected bed bugs until patients and their belongings have been decontaminated or bed bugs have been ruled out.
5. For in-patients, an assessment should include a visual inspection of the patient's room to confirm the presence of bed bugs or their droppings. See below for inspection criteria.

NOTE: Lack of bite marks do not necessarily rule out bed bugs, as many people do not have reactions to bed bug bites. Conversely, if bite marks are found, they are not necessarily those of bed bugs. The most reliable indicator of an infestation is bed bugs themselves, their droppings or exoskeletons.

B. If bed bugs are suspected:

1. The patient should be bathed or showered, given clean clothes, treated for bed bug bites, and moved to another room.
2. The patient's room will be thoroughly inspected for signs of infestation.
3. Items shall be removed from the room until inspection rules out the presence of bed bugs on those articles.
4. The patient's personal items will be bagged and decontaminated before moving to another room.
5. The patient's clothing and linen will be laundered and dried on the hottest setting possible for a minimum of twenty (20) minutes drying time.
6. The affected room will not be used until it has been treated and the infestation eliminated.
7. **Notify Infection Control**

C. Education and Training

1. All personnel, including Environmental Services staff, will receive training in such topics as:
   a. Signs of bed bug infestation
   b. Life cycle, feeding habits, and usual habitats of bed bugs
   c. Inspection procedures
   d. Housekeeping/maintenance procedures (e.g., appropriate disposal of waste)

D. Environmental Services will perform ongoing periodic inspections of patients' rooms (using attachment A).

1. Sites to be inspected include:
   a. Mattresses: seams, buttons, labels or corner protectors
   b. Headboards
   c. Bedding/Linen
   d. Bedside furniture: inside and behind drawers, crevices, corners
   e. Upholstered chairs, ottomans, or other furniture; seams, under and between cushions, underneath base
   f. Walls: baseboards, cracks, or other areas near the walls where bed bugs may crawl between rooms
   g. Waiting rooms, visitor lounges, common areas, laundry rooms
   h. Equipment such as wheelchairs and food carts
2. The inspection will look for the following signs of infestation:
   a. Bed bugs, live or dead
   b. Exoskeletons of bed bugs
   c. Eggs (nits) of bed bugs
   d. A sweet musty odor
   e. Rusty-colored blood spots (blood-filled fecal material of bed bugs)

E. If any signs of infestation are found, samples of bed bugs, bed bug exoskeletons, eggs, or excrement will be taken and assessed to confirm infestation.

F. All personnel performing room inspections will wear appropriate PPE including gown and gloves when entering rooms suspected to be infested with bed bugs.

G. If bed bugs are confirmed, the facility will take the following actions:

1. The agency will employ the services of a licensed pest control agency that is registered with the purchasing department at SNAMHS. The pest control agency will be screened to ensure its experience and effectiveness against bed bugs.
2. The selected pest control agency will treat all affected rooms in accordance with the bed bug elimination Integrated Pest Management (IPM) principles of the EPA. (http://www.epa.gov/pesticides/factsheets/ipm.htm)
3. Treatment should include rooms adjacent to the room where infestation was found.
   a. If necessary, consideration will be given to treating all the rooms on one wing or unit, as bed bugs are known to be able to crawl between walls or travel on articles carried between rooms (e.g., laundry carts).
   b. If there is heavy infestation, consideration will include also treating common areas, such as waiting rooms, lounges, dayrooms, etc.
   c. Vacuum cleaners may disperse bed bugs and spread infection. See item 4.b. below for Vacuum cleaner use.
4. The room must be cleaned by a licensed pest control agency before another patient is admitted to that room.

a. Do not vacuum the room as vacuuming can pick up bed bugs and adhere to surfaces and brushes making the vacuum cleaner a source of bed bug distribution.
b. Vacuum cleaners that have been used in the bed bug infested area before discovery, need be thoroughly disinfected, bags and canisters are to be emptied, placed in a red infectious waste plastic bag and disposed of in the infectious waste container in the soiled utility room. Brushes shall be disinfected or replaced.
c. Seal mattresses and box springs in encasements. Bed bugs inside a sealed encasement cannot bite through it or escape and will eventually die.
d. Drying items such as clothing or linen in a hot dryer for a minimum of twenty (20) minutes will kill all stages of bed bugs.

5. Environmental services will employ additional measures to eliminate infestations, including:
   a. Mattresses will be steam-cleaned, then encased in a plastic mattress cover.
   b. Any upholstered furniture in the room will be steam cleaned.
   c. Bed linens, towels, patients' clothing, and other cloth items will be placed in plastic bags, then laundered and dried in a dryer set to the highest temperature possible that will not damage the items for a minimum of 20 minutes drying time.
   d. Patients' personal articles, care equipment, and other items in the room will be bagged and inspected. If no sign of bed bugs are found, the items should be cleaned and disinfected according to the facility's policies on cleaning and disinfection and moved to another room.
   e. After bed bugs are removed, any cracks or crevices in ceiling, floor or walls will be repaired, and wallpaper will be glued down, if loosened.
   f. Environmental services will perform ongoing, thorough inspections of affected rooms until infestation is eliminated.

V. REFERENCES:

A. Georgia Division of Public Health. *Bed Bug Handbook.* Available online at: http://health.state.ga.us/pdfs/epi/zvbd/Bed%20Bug%20Handbook.pdf. Accessed 7/9/12.

B. Illinois Department of Public Health. *Prevention and Control of Bed Bugs in Health Care Facilities.* Available online at: http://ww.idph.state.il.us/envhealth/BedBugs_HealthCareFacilities.pdf. Accessed 7/9/12.

C. Centers for Disease Control and Prevention and U.S. Environmental Protection Agency (EPA). *Joint statement on bed bug control in the United States from the U.S. Centers for Disease Control and Prevention (CDC) and the U.S.*

Environmental Protection Agency (EPA). Atlanta: U.S. Department of Health and Human Services; 2010. Available online at: http://www.cdc.gov/nceh/ehs/publications/bed_bugs_cdc-epa_statement.htm. Accessed 7/9/12.

D. U.S. Environmental Protection Agency (EPA). *Bed Bug Information Page.* Available online at: http://www.epa.gov/bedbugs/. Accessed 7/9/12.

E. U.S. Environmental Protection Agency (EPA). *Citizen's Guide to Pest Control and Pesticide Safety:* http://www.epa.gov/oppfead1/Publications/Cit_Guide/citguide.pdf. Accessed 7/9/12

F. OF-SP-05 Standard Precautions

G. OF-SP-08 Scabies or Pediculosis (Lice) Infestation

H. OF-EC-45 Hospital Custodial

V. ATTACHMENTS:

A. OF-SP-29 Bed Bug Management Attachment A

B. OF-SP-29 Bed Bug Management Attachment B

PERIODIC BED BUG INSPECTION CHECKLIST BY UNIT

Name/department of person doing inspection:	**Date Inspected:**	**Unit**

INSTRUCTIONS: Fill in room number below, and then place a checkmark underneath if the following are observed for each location in the room: **bed bugs, bed bug excrement (dark, reddish-brown spots), bed bug exoskeletons, or sweet, musty odor with no other known cause**.
If any checkmarks are made, supervisor should do follow-up confirmation/assessment, then further action is warranted (i.e., contact infection preventionist).

ITEM	**ROOMS:** (fill in room numbers below)														
BEDS	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
• **Mattress** - seams, mattress covers, underneath mattress, headboard/footboard	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
• **Bedding/Linens**	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
• **Headboard/Footboard**	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
• **Legs**	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
FURNITURE - other than bed	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
• **Drawers or cabinets i**nside and underneath	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
• **Tables or bedside stands**	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
• **Chairs -** underneath base, legs, crevices or cracks	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
ROOM	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
• **Walls** - corners and baseboards	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
• **Floor** - tile grout, carpet edge, baseboards, corners	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
• **Wall covering -** crevices, seams or cracks	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
• **Built-in cupboards, sink cabinets, or wardrobes** - crevices, corners, joints, bolts	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
• **Closet/Wardrobe**	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑

SUPERVISOR'S CONFIRMATION/FOLLOW-UP

❑ **CONFIRMED BED BUGS**	**FURTHER ACTIONS NEEDED**	**ACTIONS TAKEN**	**Initials/Dept.**
Room #s			

❑ **NO SIGNS OF BED BUG INFESTATION**	**DATE NEXT INSPECTION:**	Initials

ASSESSMENT OF PEST CONTROL AGENT FOR BED BUGS

Name of Pest Control Agent:	Date of Assessment	
▪ Is the company licensed to operate in the state in which the facility operates? If NO, assess another pest control agency. Otherwise, if YES, continue.	❑ Yes	❑ No
▪ Does the company have experience in treating for bed bugs? If NO, assess another pest control agency. Otherwise, if YES, continue.	❑ Yes	❑ No
▪ How long has the company been treating for bed bugs?		
▪ Can the company provide references from other healthcare facilities?	❑ Yes	❑ No

If YES, follow up on references, asking each facility whether any recurrent infestations occurred, how often they had to call the agent, and other pertinent questions.

Reference	Contact Information	Date Contacted	Notes

▪ What is the cost of the treatment? (Ask for a detailed estimate that ideally includes minimal fees for initial inspection and repeat treatments, if needed.)	
▪ How long will treatment take to be effective?	
▪ What is the treatment regimen?	

▪ What chemicals are used?

	❑ Suspend SC ❑ Bedlam ❑ Phantom Steri-fab	❑ Deltadust ❑ Gentrol ❑ Diatomaceous earth ❑ Other:_____

▪ What non-chemical treatments are used?

Pest Control Agent Assessed by:	Date:
Approved by:	Date:

Adapted from: Central Ohio Bed Bugs Taskforce. *Choosing a Pest Management Professional to Treat Bed Bugs.* Available online at: http://centralohiobedbugs.org/pdf/exterminators.pdf. Accessed 9/20/11.

DIVISION OF MENTAL HEALTH AND DEVELOPMENTAL SERVICES
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY WIDE

SUBJECT: Scabies or Pediculosis (Lice) Infestation **NUMBER:** OF-SP-08

EFFECTIVE DATE: 03/2023 **REVIEW DATE:** 03/2025

APPROVED BY: /s/ Susan Lynch, MBA, CPM
Hospital Administrator

SUPERSEDES: OF-SP-08, 12/01, 8/06; Deletes OF-SP-11 dated 08/06; 01/09; 01/11; 04/13; 10/16; 10/18; 02/21

I. PROTOCOL:

It shall be the protocol of Southern Nevada Adult Mental Health Services (SNAMHS) to prevent the spread of communicable diseases/states to patients, employees, visitors, and the general public.

II. PURPOSE:

It is the purpose of this protocol to establish a procedure to identify, adequately treat, and control scabies, pediculosis, infestations to prevent transmission to others, and to manage infestation in the environment.

III. DEFINITIONS:

A. Head Lice: Pediculosis Capitis – Infestation with head lice. Head lice appears as minute gray-white nits (eggs) firmly attached to the hair shaft close to the scalp (the tiny gray lice can sometimes be seen). They are usually found on the scalp and hair at the back of the head and behind the ears. Patients with lice will experience intense itching. The resulting scratching may lead to complications such as impetigo and enlarged cervical lymph nodes.

B. Body Lice: Pediculosis Corpori**s** – Infestation of body lice. The body louse lives chiefly in the seam of undergarments and other clothing, to which it clings. The lice move to the skin for blood feedings and then return to the clothing. Body lice are associated with transmission of tick typhus, trench fever, or relapsing fever.

Areas of the skin involved are those that come in closest contact with the undergarments (neck, trunk, thighs). The bite causes characteristic minute hemorrhagic points. Itching, resulting in widespread excoriation may appear on the back or shoulders. Secondary bacterial infections and dermatitis may occur.

C. Pubic Lice: Phthirius Pubis – Infestation of crab lice generally confined to hairs of genital region, but hair of the axilla, eyebrows, eyelashes, beard, and hairy individuals' body surface may be involved. The pubic louse is chiefly transmitted by sexual contact and is usually localized to the pubic area, but may infest the hairs of chest, axillary hair, beard, and eyebrows/lashes. Like the head lice, the nits are attached to the hair shaft. The main symptom is itching. A reddish brown "dust" (formed from the excretion of the louse) may be found on/in underclothing. Gray-blue macules (spots 1-3 cm diameter) may be seen on the trunk, thighs, and axilla.

D. Sarcoptes Scabiei –A highly communicable skin disease caused by an Arachnid, Sarcoptes Scabiei, known as the itch mite. Scabies is an infectious disease of the skin caused by the *Sarcoptes scabiei* or itch mite. Transmission occurs most often by close personal contact; prolonged casual contact also can result in transmission. Bedding and clothing (freshly contaminated) can sometimes be a source of transmission.

IV. PROCEDURE:

A. Mechanism of Transmission

1. Scabies -:
   - Scabies usually is spread by skin-to-skin contact with a person who has scabies.
   - It sometimes is spread indirectly by sharing items such as clothing, towels, or bedding used by an infested person.
   - It can spread easily under crowded conditions where close body and skin contact is common.

2. Lice:
   - **Head lice** are usually spread among children crowded together in an urban daycare center and primary schools. They have **no wings, so they CANNOT JUMP, HOP or FLY from person to person**; they move by **crawling quickly** (Up to 30 cm/ minute) or by **grasping** a shaft of hair with tiny front claws and then **swinging** from one hair strand to another. In this way, they travel by:
     - **Direct *head to head contact*** when children play with their heads close together
     - **Indirectly through *hats, coat hooks, scarves, bike helmets, headphones, hairbrushes, toys, or bedding***.
   - **Body lice** are usually found among homeless people who live in situations in which bedding, and clothing are not changed regularly. It can be transmitted ***indirectly through sharing towels and through sheets and clothing.***
   - *Poor hygiene does play a role in body lice but does not in head lice.*

- **Pubic ("crab") lice** are transmitted by ***direct sexual contact***, mainly among adolescents and young adults, but also can be transmitted by ***sharing towels and through sheets and clothing.***

B. Isolation/Precautions:

1 . **Contact Precautions**: perform hand hygiene and wear gown and gloves when entering patient room.

2. Contact precautions will be observed when caring for patients with confirmed or suspected infestation until 24 hours after patient receives effective treatment.

3. Isolate for 24 hours after effective treatment.

C. Examination

1. Each patient will be examined by the nursing staff for the presence of scabies, lice, infestation and bed bug bites upon admission. Attachment C "Admission Checklist for Fungal Infection / Parasitic Infestation" will be used in the assessment.

2. Patients will be monitored for visible bite marks, welts, or other signs of insect bites upon admission and during length of stay.

3. If patients have visible bite marks, an assessment will be done to rule out whether the bites may have come from scabies, lice, or bed bugs, etc.

4. For suspected or confirmed cases of bed bug infestation, refer to SNAMHS OF-SP-29 Bed Bug Management.

5. Bites and/or allergic reactions will promptly be given appropriate treatment.

6. Patient belongings will be sealed in plastic bags and remain sealed until decontamination period is completed, or infestation has been ruled out. Bagged personal items belonging to patient may be stored in patient property room in designated bin, provided that bags are sealed and free from rips/tears. These bags must be clearly labeled with date and time to ensure adequate decontamination period is followed.

D. Lice

1. Any patient with positive evidence of Pediculosis Capitus (head lice), Pediculosis Corporis (body lice) or Pediculosis Pubis (pubic lice) will be treated upon physician's order. ALL suspected or diagnosed cases should be reported to the Infection Preventionist.

2. Infestation can be identified by:

a. Look for signs of lice, scabies (small red dots), or mites (tiny white or grayish lumps) on hairs or dark burrow marks often between the fingers or on the arms, legs, or chest areas.
b. Adult head and body lice appear as dirty white or grayish specks; nits as dandruff-like particles on hair.
c. Pubic lice may cause bluish maculae on the thighs or trunk.
d. Lice set up housekeeping in clothing, and live among body hairs, especially in the scalp and genital area. Adult lice and nits cause intense itching and are spread primarily by skin-to-skin contact. They can also spread by their presence or the presence of their eggs on articles of clothing, towels, pillows, bed linens, and other intimate articles used by a person afflicted with an infestation.

3. Treatment of Infestation:
a. Treatment of pediculosis must be ordered by the physician. This can be a telephone order, in order not to delay treatment. Treatment products are available on the after-hours pharmacy cart in C-Annex.
b. Explain to the patient, family member (if possible) and health care workers what the problem is and how it is transmitted from person to person. Educate the patient, family, and staff on the need for maintaining cleanliness of person, clothing, and bedclothes. Advise all people who have had close contact with the patient to watch for signs of infestation and to see a physician for treatment (treatment is recommended ONLY when evidence of infestation is present).

c. <u>HEAD LICE</u>
i. Obtain a physician's order for treatment and report to Infection Preventionist.
ii. Explain the procedure to the patient.
iii. Before starting the treatment, be sure that the patient has clean clothing to put on. The person doing the treatment should wear gloves, gown and head covering (if warranted).
iv. Apply the treatment per directions of the product.
v. If directions permit, rinse thoroughly and rub hair dry with a towel (DO NOT use a hair dryer).
vi. If directions permit, when hair is dry, any remaining nits (eggs) may be removed with a fine-tooth comb or tweezers (vinegar may be applied to soften the nits and help removal).
vii. If directions permit, have the patient bathe with soap and water (do not re-wet hair) following treatment and put on clean clothes.
viii. While treatment is being done, **<u>bedding, clothing and towels</u>** used by infested persons anytime during the three days before treatment should be decontaminated by **<u>sealing</u>**

in a plastic bag for at least 72 hours then washing in hot water and drying in a hot dryer. Scabies mites generally do not survive more than 2-3 days away from human skin.

ix. **Un-washable items** are placed in a plastic bag and **sealed for 7 days** to ensure eggs are killed.

x. Comb and brush should be cleaned.

xi. Bagged personal items belonging to patient may be stored in patient property room in designated bin, provided that bags are sealed and free from rips/tears. **All plastic bags must be clearly labeled with date and time to ensure adequate decontamination period is followed.**

xii. Be sure the patient has CLEAN clothing and CLEAN bed linens. Remove all infested items from the room.

xiii. The following day, have the patient take a thorough bath and shampoo. Make sure that patient has clean clothes and clean bed linens each day for at least 72 hours.

xiv. Check the patient closely to see that treatment was effective. If ineffective, follow product directions for second treatment.

d. BODY LICE

i. Obtain a physician's order for treatment and report to Infection Preventionist.

ii. Explain the procedure to the patient.

iii. Before starting the treatment, be sure that the patient has clean clothing to put on. The person doing the treatment should wear gloves, gown and head covering.

iv. Apply the treatment per the product directions. (Be careful not to get the product in face or eyes).

v. While treatment is being done, **bedding, clothing and towels** used by infested persons anytime during the three days before treatment should be decontaminated by **sealing in a plastic bag for at least 72 hours then washing in hot water and drying in a hot dryer.** Scabies mites generally do not survive more than 2-3 days away from human skin

vi. **Un-washable items** are placed in a **plastic bag** and **sealed for 7 days** to ensure eggs are killed.

vii. Bagged personal items belonging to patient may be stored in patient property room in designated bin, provided that bags are sealed and free from rips/tears. **All plastic bags must be clearly labeled with date and time to ensure adequate decontamination period is followed.**

viii. Be sure that the patient has CLEAN clothing and CLEAN bed linens and that all infected items have been removed from the room.

ix. Have the patient bathe thoroughly following the time indicated on the product directions. Make sure the patient has clean clothes and bed linens each day for at least 72 hours.

e. **PUBIC LICE**

i. Obtain a physician's order for treatment and report to Infection Preventionist.
ii. Explain the procedure to the patient.
iii. Before starting the treatment, be sure that the patient has clean clothing to put on. Person doing the treatment should have on gloves, gown and head covering.
iv. Have the patient bathe with soap and water. After the bath, allow the skin to dry and cool before applying the treatment.
v. Apply the treatment per directions of the product.
vi. If directions permit, nits (eggs) may need to be manually removed by using tweezers or cotton applicators dipped in vinegar.
vii. While treatment is being done, have the, bedding, clothing and towels used by infested persons anytime during the three days before treatment should be decontaminated by sealing in a plastic bag for at least 72 hours then washing in hot water and drying in a hot dryer. Scabies mites generally do not survive more than 2-3 days away from human skin. Un-washable items are placed in a plastic bag and sealed (write date and time on bag) for 7 days to ensure eggs are killed. Comb and brush should be cleaned.
viii. Bagged personal items belonging to patient may be stored in patient property room in designated bin, provided that bags are sealed and free from rips/tears. **All plastic bags must be clearly labeled with date and time to ensure adequate decontamination period is followed.**
ix. Be sure that the patient has CLEAN clothing and CLEAN bed linens and all infested items have been removed from room.
x. Have the patient bathe thoroughly following the time indicated on the product. Make sure the patient has clean clothes and bed linens each day for at least 72 hours.
xi. May need to repeat the treatment per the product directions.

4. **TO AVOID REINFESTATION**

a. Transport clothing, bedclothes, etc. in plastic bags. Wash clothes and bedding in HOT soapy water (allow time between loads for full recovery of hot water) and dry on HOT cycle of dryer.

i. Place un-washable clothes or articles (pillows, blankets, etc.) in a plastic bag and seal for 7 days to ensure eggs are killed.
ii. Disinfect hair brushes and combs by washing them thoroughly with a germicidal solution and hot water, and then soak for fifteen (15) minutes in isopropyl (rubbing) alcohol.
iii. Wipe down beds and mattresses with a germicidal solution.
iv. Special cleaning of rooms is not needed. **Fumigation of rooms is not recommended for lice but may be necessary for bed bugs (See OF-SP-29).**
v. Confining the patient to his/her room for twenty-four (24) hours after treatment is desirable but may not be practical or possible in the behavioral health setting.
vi. Precautions for health care workers consist of wearing gloves and/or a gown if in close contact with infested person or things (i.e. applying treatment, handling clothes, bedding, etc.). This is necessary before treatment and for twenty-four (24) hours after treatment. Following hand hygiene protocol is the best technique for protection of oneself and others.

E. Scabies:

1. Any patient with positive evidence of Scabies (*Sarcoptes scabiei*) must be treated upon physician's order. ALL suspected or diagnosed cases should be reported to the Infection Preventionist.

2. Scabies are caused by mites that tunnel under the skin. Scabies cause intense itching and are spread primarily by skin-to-skin contact. They can also spread by their presence or the presence of their eggs on articles of clothing, towels, pillows, bed linens, and other intimate articles used by a person afflicted with an infestation.

3. Scabies begins with intense itching, popular eruptions, usually in the inter-digital spaces, but other areas can be involved. These areas may include the skin over the wrists, elbows, anterior axillary folds, belt line, thighs, nipples, abdomen, lower portion of the buttocks in women, and external genitalia in men. The scabies mite burrows under the skin and these burrows look like short, zigzag, grayish-white lines. The eruptions are caused by immature stages of the mite and/or sensitization to the protein produced by the mite. In persons without previous exposure, a period of two to six (2-6) weeks usually elapses before the onset of symptoms. Persons who previously have been infected develop symptoms one to four (1-4) days after exposure.

4. Look for signs of lice, scabies (small red dots), or mites (tiny white or grayish lumps) on hairs or dark burrow marks often between the fingers or on the arms, legs, or chest areas.

5. Treatment
   a. Obtain a physician's order for treatment and report to the Infection Preventionist.
   b. Explain the procedure to the patient.
   c. Before starting the treatment, be sure that the patient has clean clothing to put on. Persons doing the treatment should have on gloves and a gown.
   d. If the patient can perform this, have patient trim finger/toe nails.
   e. Have the patient bathe with soap and water. After the bath, allow the skin to dry and cool before applying the treatment.
   f. Apply the treatment per directions of the product.
   g. While the treatment is being done, have bed stripped (place bedding in plastic bag 72 hrs before sending to laundry); all washable clothing, etc. that has been in recent contact with the patient should be placed in a plastic bag to be washed. Un-washable items should be placed in a plastic bag and sealed for seven (7) days (label bag with name, date, etc.).
   h. Bagged personal items belonging to patient may be stored in patient property room in designated bin, provided that bags are sealed and free from rips/tears. **All plastic bags must be clearly labeled with date and time to ensure adequate decontamination period is followed.**
   i. Be sure the patient has CLEAN clothing and CLEAN bedding; make sure all infested items have been removed from the room.
   j. All furniture, mattresses, pillows, etc. should be wiped down with a germicidal solution.
   k. Have the patient bathe thoroughly after the time indicated on the product. Make sure the patient has clean clothes and clean bed linens each day for at least 72 hours.
   l. Repeat the treatment as indicated per the product directions.
   m. Treatment is available in the after-hours pharmacy cart in C-Annex, to avoid treatment delay.

Note: It is recommended that the treatment begin at bedtime. If treatment is to be repeated, follow the same procedure.

6. **TO AVOID REINFESTATION**
   a. Clean ALL clothing, bedclothes, etc. that have been in recent contact with the patient. Transport these items in plastic bags. Wash clothes and bedding in HOT soapy water (allow time between loads for full recovery of hot water) and dry on HOT cycle of dryer. Place un-washable clothing and articles in a plastic bag and seal for seven (7) days (the mites do not survive for more than three to four (3-4) days without contact with the body).
   b. Wipe down beds, pillows, mattresses, furniture, etc. with a germicidal solution.
   c. Special cleaning of rooms is not needed. **Fumigation of rooms is not recommended.**

d. Confining the patient to his/her room for twelve to twenty-four (12-24) hours after treatment is desirable but may not be practical or possible in the behavioral health setting.

e. Contact precautions for employees consist of wearing gloves and a gown if in close contact with an infested person or things (i.e. applying gloves, bedding, etc.). This is necessary before treatment and for twelve to twenty-four (12-24) hours after treatment. Hand hygiene is the best technique for protection of oneself and others.

7. Treatment Precautions

a. It is important to treat the patient immediately to prevent contamination of our patient areas and to prevent spread to other patients and staff. Make entries on the patient's problem list and the treatment plan.

b. Adverse Effects

i. Mild and transient burning and stinging are the most common adverse effects.

ii. Pruritus also is a frequently reported adverse effect. Oral antihistamines and/or topical corticosteroids may be used to help relieve itching.

iii. Skin redness, numbness, tingling, and rash have been reported in 1 to 2% of patients.

iv. Permethrin has not been associated with phototoxic or photosensitization reactions.

8. Precautions And Contraindications

a. Contact with the eyes should be avoided during the application of permethrin since ocular irritation may occur. If accidental contact with the eyes occurs, the affected eye(s) should be flushed thoroughly with water.

b. Avoid contact of the 1% lotion with mucous membranes such as inside the nose, mouth, or vagina.

c. Contraindicated in patients with a history of hypersensitivity to the drug or any components in the respective formulation.

9. Pregnancy, Fertility And Lactation

a. Permethrin 5% cream is the scabicide of choice in pregnant and lactating women for the treatment of scabies. Permethrin is also recommended for the treatment of pediculosis in such women.

b. It is not known whether permethrin is distributed in human milk. A decision should be made whether to discontinue nursing temporarily or withholding the drug while the mother is nursing, taking into account the importance of the drug to the woman.

10. Staff must supervise each step of the treatment process and patients must **never** be left alone to use these medication products.

F. Staff Exposure of lice or scabies:

1. If a staff member manifests signs and symptoms of work-site related infestation, the Supervisor and the Infection Preventionist shall be notified immediately, by telephone, electronic communication, or fax. The Medical Physician shall then be contacted for evaluation and treatment.
2. Supervisor shall complete an Employee Health Tracking Form (Attachment B) and submit to the Infection Preventionist upon completion of treatment.

V. REFERENCES:

A. APIC Text, Chapter 101 Parasites | Healthcare Associated Pathogens, 2019

B. Mayo Clinic- Lice - https://www.mayoclinic.org/diseases-conditions/head-lice/symptoms-causes/syc-20356180

C. Centers for Disease Control and Prevention Recommendations for the treatment and control of Lice, Retrieved, October 2019

D. Michael F. Potter and G. Mark Beavers. Lice, Mite, and Bed Bug Control. Kentucky Pesticide Education Program, 2016 University of Kentucky Department of Entomology

E. SNAMHS OF-SP-29 Bed Bug Management

VI. ATTACHMENTS:

A. OF-SP-08 Scabies and Pediculosis (Lice) Infestation Attachment A

B. OF-SP-08 Scabies and Pediculosis (Lice) Infestation Attachment B

C. OF-SP-08 Scabies and Pediculosis (Lice) Infestation Attachment C

Admission Checklist for Fungal Infection / Parasitic Infestation

Has patient been thoroughly checked for head lice?	Yes □ No □
Was evidence of a head lice infestation found?	Yes □ No □
Has patient been checked for body lice?	Yes □ No □
Was evidence of body lice found?	Yes □ No □
Has patient been checked for scabies infestation?	Yes □ No □
Was evidence of scabies infestation found?	Yes □ No □
Has patient been checked for bed bugs / bed bug bites?	Yes □ No □
Was evidence of bed bugs / bed bug bites found?	Yes □ No □
If lice or bed bugs present, were patient's personal clothing items properly handled?	Yes □ No □ N/A □
Has patient's feet been assessed for athlete's foot?	Yes □ No □
Was evidence of athlete's foot found?	Yes □ No □
Does patient present potentially infectious skin lesions requiring further medical evaluation?	Yes □ No □
Was physician notified?	Yes □ No □ N/A □
If evidence of a parasitic infestation was found were the appropriate PPE and contact isolation precautions used?	Yes □ No □ N/A □

MHT Name (Print)	Date	*Signature*
RN Name (Print)	Date	*Signature*

COMMENTS**:**

Southern Nevada Adult Mental Health Services Nursing/Infection Control Admission Checklist for Fungal Infection / Parasitic Infestation IP # 8 Rev: 02/2023	NAME: _____ MRN: _____

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: STATEWIDE

SUBJECT: Bathroom Cleaning Procedures **NUMBER:** SWC - 01

EFFECTIVE DATE: 06/01/2021 **NEXT REVIEW DATE:** 06/01/2023

APPROVED BY: /s/ Ed Ackerman
Facility Manager

SUPERSEDES: New

This procedure applies to SNAMHS

I. PURPOSE:

The purpose of this procedure is to establish standard work for all Custodial cleaning process in inpatient hospital facilities.

II. PROCEDURE:

- **Safety** Conduct hand hygiene put on (PPE), Example: gloves, including non-latex for those allergic to latex; masks, respirators, goggles, eye protection, face shields, resuscitation devices with barrier mouth pieces. Always place "Wet floor" signs around the area you are mopping.
- **Activity/Task**
- Gather Supply Cleaning Cart.
- Enter Bathroom
- Conduct hand hygiene, put on gloves (PPE), and collet pan and broom.
- Pan and broom where necessary. Starting at first stall on the left side proceed through all stalls, during process, complete visual inspection of each stall including re-stock items and trashcans.
- Return pan and broom to utility cart. Collect sanitary trash bag and any paper goods that need to be re-stocked in bathroom stalls. Starting at first stall on left side proceed through all stalls emptying trash that needs to be emptied and re-stocking any paper goods that need to be changed. Return trash bag to utility cart and collect Jonny mop, clean rag and hospital approved disinfectant (I.E Stride and Oxiver).
- Starting at first stall on left side proceed through all stalls. Spray toilet bowl, seat, toilet flush handle, wall, doors, and door handles – inside and out and dividers with a hospital approved disinfectant. Clean all urinals and toilets with Jonny Mop and approved Toilet bowl cleaner, Wipe down toilet flush handle, wall, doors and handles-inside and out and dividers with Oxiver and a clean Rag.

- Return Jonny mop to utility cart and collect a clean rag and any soap that needs to be re-filled at sink stations.
- Starting at first sink on left side proceed through all sinks area. Spray sink, water faucets, counter with a hospital approved disinfectant. Clean sink, water faucets, and counter. Spray hospital approved window cleaner on mirror, light fixture, and clean. Refill soap (If needed)
- Return soap to utility cart and collect brush, green scrubbing pad, clean rag, hospital approved lime scale remover, and hospital approved disinfectant.
- Proceed to shower area. Beginning at first shower on left side, spray hospital approved disinfectant to cover shower area and clean. Scrub hospital approved lime scale remover around fixtures with stiff brush or a green scrubbing pad to loosen heavy deposit build-up. Immediately rinse thoroughly. Spray shower curtains with hospital approve disinfectant. Clean shower curtain.
- Return brush, green scrubbing pad to utility cart and collect mop and wet floor sign.
- Set floor sign out in bathroom area. Beginning at back of bathroom mop all areas in restroom with a hospital approved disinfectant.
- Return mop, hospital approved disinfectant, and floor sign to utility cart and exit restroom.

III. REFERENCES: NA

IV. ATTACHMENTS:

- OF-EC-45 Hospital Custodial Attachment A
- OF-EC-45 Hospital Custodial Attachment B

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: STATEWIDE

SUBJECT: Bedroom Cleaning Procedures **NUMBER:** SWC-02

EFFECTIVE DATE: 06/01/2021 **NEXT REVIEW DATE:** 06/01/2023

APPROVED BY: /s/ Ed Ackerman
Facility Manager

SUPERSEDES: New

This procedure applies to SNAMHS Custodial

I. PURPOSE:

The purpose of this procedure is to establish standard work for all Custodial cleaning process in inpatient hospital facilities.

II. PROCEDURE:

- **Safety** Conduct hand hygiene put on (PPE), Example: gloves, including non-latex for those allergic to latex; masks, respirators, goggles, eye protection, face shields, resuscitation devices with barrier mouth pieces. Always place "Wet floor" signs around the area you are mopping.
- **Activity/Task**
- Gather Supply Cleaning Cart.
- Enter Bedroom
- Conduct hand hygiene put on gloves (PPE)
- Inspect bedroom and report any issues
- If present, have nursing staff remove Patent's personal belonging. Remove all lines and place in soiled linen liner.
- Remove all trash and infectious waste
- Vacuum vents, every nook and cranny and each piece of furniture
- Spray furniture with a hospital approved disinfectant and clean. Polish with a hospital approved furniture polisher as needed.
- Spray window and window frame with a hospital approved disinfectant (I.E. Glance) and clean. Spray window with a hospital approved window cleaner and clean.
- Remove mattress from bed frame, spray front and back, including the sides, with a hospital approved disinfectant, and clean. Spray entire bed frame with a hospital approved disinfectant and clean. Place mattress up right on bed frame.
- Spray walls, doors, jambs, hardware, and baseboards with a hospital approved disinfectant and clean

- Dust mop floor and remove gross soil. Collect mop and wet floor sign, set floor sign out in bedroom area. Mop all areas in bedroom with a hospital approved floor cleaner.
- Return mop, wet floor sign to utility cart and exit restroom.

III. REFERENCES:

- OF-SP-05 Standard Precautions
- OF-SP-29 Bed Bug Management
- Georgia Division of Public Health. Bed bug Handbook. Available online at: https://dph.georgia.gov/sites/dph.georgia.gov/files/related_files/document/ADES_Bed_Bug_Handbook.pdf
- Illinois Department of Public Health. Prevention of Bed Bugs in Health Care Facilities. Available online at: http://www.idph.state.il.us/envhealth/BedBugs_HealthCareFacilities.pdf.

IV. ATTACHMENTS:

- OF-EC-45 Hospital Custodial Attachment A
- OF-EC-45 Hospital Custodial Attachment B

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: STATEWIDE

SUBJECT: Single-Bucket Wet and Damp Mopping/ Procedures

NUMBER: SWC-03

EFFECTIVE DATE: 06/01/2021

NEXT REVIEW DATE: 06/01/2023

APPROVED BY: /s/ Ed Ackerman
Facility Manager

SUPERSEDES: New

This procedure applies to SNAMHS Custodial

I. PURPOSE:

The purpose of this procedure is to establish standard work for all Custodial cleaning process in SNAMHS inpatient hospital facilities.

II. PROCEDURE:

- **Safety** Conduct hand hygiene put on (PPE), Example: gloves, including non-latex for those allergic to latex; masks, respirators, goggles, eye protection, face shields, resuscitation devices with barrier mouth pieces. Always place "Wet floor" signs around the area you are mopping.
- To perform this procedure, you will need a clean mop bucket, a single mop and hospital approved chemical cleaning solution. You may also need a wet vacuum, if required or preferred.
- Soak the mop in a hospital approved chemical solution until it is completely drenched.
- For wet mopping, wring the mop just enough to remove excess solution. For damp-mopping, wring the mop tightly.
- Mentally divide the floor area into sections. A section of about 10 feet by 10 feet usually works well.
- Mop each floor section using a figure "8" or "S" pattern.
- For wet mopping, mop each section once to apply the hospital approved solution. Allow the solution to remain on the floor for a few minutes, but don't allow it to dry. Using a tightly-wrung mop or a wet vacuum, go over each section a second time to remove most of the moisture from the floor.
- If you have used a wet vacuum, damp rinse the area to remove any remaining dirt and solution. Use a mop that has been soaked in **water** and then wrung out tightly.

- Repeat the procedure for each floor section, overlapping slightly onto the previous section.

III. REFERENCES: NA

IV. ATTACHMENTS:

- OF-EC-45 Hospital Custodial Attachment A
- OF-EC-45 Hospital Custodial Attachment B
- Custodial Procedures\Microfiber Mop Procedure .docx

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: STATEWIDE

SUBJECT: Mopping and Wet Vacuuming/Guidelines

NUMBER: SWC-04

EFFECTIVE DATE: 06/01/2021

NEXT REVIEW DATE: 06/01/2023

APPROVED BY: /s/ Ed Ackerman
Facility Manager

SUPERSEDES: New

This procedure applies to SNAMHS Custodial

I. PURPOSE:

The purpose of this guideline is to establish standard work for all Custodial cleaning process in inpatient hospital facilities.

II. PROCEDURE:

- **Safety. Follow these guidelines to avoid injury to yourself and other:**
- Always use "Wet Floor" signs to warn people of slippery conditions.
- Wear slip-resistant footwear. For convenience, several manufacturers make slip-resistant shoe covers or overshoes.
- Do not allow cleaning solutions to flow into inaccessible areas, such as under doors, fixtures or heavy equipment. Floor surfaces can be damaged by solution that is hidden and left behind.
- Never leave cleaning solutions in puddles.
- Dilute chemicals properly.
- Place cleaning equipment out of the way to avoid trips and falls.
- Try not to cause injury with mop handles.
- If there is foot traffic in the area you are cleaning, watch where you are going. Avoid accidents by being courteous and letting others pass by.
- Before using a wet vacuum, check all electrical connections. Be sure that the plug has a third prong for grounding. If the prong is missing or broken off, don't use the vacuum until the plug is fixed.
- **Equipment Care.** Always return equipment to its proper storage area. To keep items ready for use. Care for them as follows:
- Thoroughly rinse all buckets and wringers and leave them tipped up to dry. Clean the outsides of the buckets, too.
- Never leave used chemical solutions in buckets for long periods of time.

- Rinse mop heads and clean mop handles. Hang them up with the mop head facing away from the wall.
- Clean putty knives and any other tools used in the operation.
- Before using a wet/dry vacuum, check to make sure the dry-pickup bag is not inside the tank. Follow the manufacturer's instructions to ready the vacuum for wet use.
- If you have used a wet vacuum, clean the wand, hose, tool, tank and outside surfaces.

III. REFERENCES:

- Single-Bucket Wet and Damp Mopping Procedure

IV. ATTACHMENTS:

- OF-EC-45 Hospital Custodial Attachment A
- OF-EC-45 Hospital Custodial Attachment B
- Custodial Procedures\Microfiber Mop Procedure .docx

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: STATEWIDE

SUBJECT: DUSTING/ GUIDELINES **NUMBER:** SWC-05

EFFECTIVE DATE: 06/01/2021 **NEXT REVIEW DATE:** 06/01/2023

APPROVED BY: /s/ Ed Ackerman
Facility Manager

SUPERSEDES: New

This procedure applies to SNAMHS Custodial

I. PURPOSE:

The purpose of this guidelines is to establish standard work for all Custodial cleaning process in inpatient hospital facilities.

II. PROCEDURE:

- **Safety** Conduct hand hygiene put on (PPE), Example: gloves, including non-latex for those allergic to latex; masks, respirators, goggles, eye protection, face shields, resuscitation devices with barrier mouth pieces.
- Use ladders, scaffolds or extension tools when dusting high surfaces. Most vacuums have attachments that allow operators to clean high areas while standing on the floor. Many feather and lambs-wool dusters also have telescoping handles.
- **Professional Conduct.** Do not read any pateint materials left anywhere in the room while dusting or performing other cleaning tasks. Some documents may be personal or sensitive. Occupants of rooms must be confident that custodians will not read or disturb their materials or allow them to end up in anyone else's hands.
- **Dust High to Low.** Always dust high surfaces first. It makes no sense to clean a low surface and then push dust back onto it from a higher surface.

III. REFERENCES: NA

IV. ATTACHMENTS:

- OF-EC-45 Hospital Custodial Attachment A
- OF-EC-45 Hospital Custodial Attachment B

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY WIDE

SUBJECT: VACUUMING/ GUIDELINES **NUMBER:** SWC-06

EFFECTIVE DATE: 06/01/2021 **NEXT REVIEW DATE:** 06/01/2023

APPROVED BY: /s/ Ed Ackerman
Facility Manager

SUPERSEDES: New

This procedure applies to SNAMHS Custodial

I. PURPOSE:

The purpose of this guidelines is to establish standard work for all Custodial cleaning process inpatient hospital facilities.

II. PROCEDURE:

- **Safety.** Always follow these rules to avoid injury to yourself and others:
- Never use the power cord to pull a plug out of an outlet. Always grasp and pull the plug itself. Always place a wet floor sigh next to the vaccum cord plugged into the wall.
- Do not bump furniture or other fixtures with vacuum cleaners.
- Remember that backpack vacuums can limit your mobility in tight areas and narrow doorways.
- Follow the manufacturer's directions when attaching a backpack vacuum to your body. Adjust shoulder straps and hip belts properly to prevent back strain.
- **Equipment Care.**
- Always return vacuuming equipment to its proper storage area. To keep items ready for use, clean and care for them as follows.
- Empty collection bags daily to get rid of excess weight. This will make vacuums easier to carry and push
- Check cords, cord restraints, switches, hoses, hose fitting and tools for proper operation. Repair any malfunctioning parts before using the vacuum again.
- Properly clean vacuums weekly to maintain proper operation of the equipment.

III. REFERENCES: NA

IV. ATTACHMENTS: NA

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: STATEWIDE

SUBJECT: Carpet Cleaning Procedures **NUMBER:** SWC-07

EFFECTIVE DATE: 06/01/2021 **NEXT REVIEW DATE:** 06/01/2023

APPROVED BY: /s/ Ed Ackerman
Facility Manager

SUPERSEDES: New

This procedure applies to SNAMHS Custodial

I. PURPOSE:

The purpose of this procedure is to establish standard work for all Custodial cleaning process in inpatient hospital facilities.

II. PROCEDURE:

- **Safety** Conduct hand hygiene put on (PPE), Example: gloves, including non-latex for those allergic to latex; masks, respirators, goggles, eye protection, face shields, resuscitation devices with barrier mouth pieces. Always place "Wet floor" signs around the area you are shampooing.
- **Hot Water Extraction** Using a carpet cleaning machine, carpet extractor, or similar hot water extraction type carpet cleaning equipment, add 5 ounces of hospital approved carpet extraction per gallon of water in chemical solution tank. The use of hot water will provide better cleaning of the carpet. Clean carpet according to machine manufacturer's directions. Drying time is normally 12-24 hours.
- **Bucket and Wringer Method** Place a clean bonnet in a bucket containing a solution of hospital approved Carpet Extraction, diluted at 5 ounces per gallon of water. Wring Bonnet WELL. Place bonnet under rotary floor machine and buff an area approximately 100 square feet. Turn and rinse the bonnet as necessary. Move to another 100 square foot area and repeat the procedure. Carpet dries in 30 minutes to an hour.

III. REFERENCES: NA

IV. ATTACHMENTS:

- OF-EC-45 Hospital Custodial Attachment A
- OF-EC-45 Hospital Custodial Attachment B

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: STATEWIDE

SUBJECT: Strip and Wax Floors Procedures **NUMBER:** SWC-08

EFFECTIVE DATE: 06/01/2021 **NEXT REVIEW DATE:** 06/01/2023

APPROVED BY: /s/ Ed Ackerman
Facility Manager

SUPERSEDES: New

This procedure applies to SNAMHS Custodial

I. PURPOSE:

The purpose of this procedure is to establish standard work for all Custodial cleaning process in inpatient hospital facilities.

II. PROCEDURE:

- **Safety** Conduct hand hygiene put on (PPE), Example: gloves, including non-latex for those allergic to latex; masks, respirators, goggles, eye protection, face shields, resuscitation devices with barrier mouth pieces. Always place "Wet floor" signs around the area you are buffing.
- Line mop bucket with trash bag for easy cleanup, and to preserve the bucket for other use.
- Pour a hospital approved floor finish stripper and water into bucket according to the manufacturer's instructions.
- Fill a second bucket with clean water. This will be used to rinse off the floor stripping solution after it has removed the finish from the floor.
- **Tools-** You'll need two mops, one for the hospital approved stripping solution and one for the water. At least one scraping tool is usually necessary. Such as a poll scraper or putty knife. A toothbrush and scrubbing pads
- **Clear obstacles-** Clear area if any desks, tables, rugs and anything else that could be in the way. Once all the furniture has been removed, sweep and inspect the floor. Be sure to remove anything you see stuck on the tile such as stickers, gum or tape
- **Blockade-** Areas to be stripped or sealed. Floors will become very slippery when stripper is applied. **Exercise Caution**.
- **Apply stripper-** Apply liberal amounts of solution uniformly on the floor with a mop. If splashing occurs, wipe off surfaces with a clean rag dampened with water. Let stripper solution soak in for 10-15 minutes. Increase soak tine if

using cool water. Keep areas to be stripped wet. Pick-up all the solution with a clean mop, wet vac, or an automatic scrubber.

- **Floor scrubber-** After the stripper has been allowed to dwell, proceed to scrub off the old wax. This can be done either manually or by an electric floor scrubber. Areas, such as corners, receive less traffic and thus have more wax build-up. Make sure to take your time in these areas as to remove any build-up. Pick-up all the solution with a clean mop, wet vac, or an automatic scrubber
- **Rinse-** Thoroughly rinse floor with clear water. After you have rinsed the floor with the water, once again use the wet/dry vac to suck up the remaining water. This is an important step as any remaining stripper on the floor will result in the wax peeling off later.
- **Waxing- Use a flat wax applicator with backpack is best suited for this purpose,** since the wax can be poured directly onto the floor and applied with the applicator pad.
- **Work in an area with good air flow.** Most finishes are not as harmful as floor stripping solution, but they can still cause damage if too many fumes are inhaled.
- **Apply wax in sections with a wax applicator and Backpack.** Get your Wax applicator pad damp with wax by creating a puddle on the floor and let the pad soak up the wax. Apply a thin coat over the floor, working in sections from one end of the room to the other. Leave the section nearest the exit until last to avoid getting trapped.
- **Apply additional layers the same way.** Most finishes and waxes require two to five layers for a good, protective seal. Read the label on your product to determine how many layers to use. Allowing each layer to dry completely for 30-45 minutes before applying the next layer keeps the wax even and avoids buildup of excess wax.
- **Buff the floor if necessary.** Many modern waxes and finishes do not require buffing, or polishing. If the product advertises “no buffing” or if the floor looks glossy and attractive once dry, you may skip this step. Otherwise, polish the floor with a burnishing machine to hasten the process.

III. REFERENCES: NA

IV. ATTACHMENTS:

- OF-EC-45 Hospital Custodial Attachment A
- OF-EC-45 Hospital Custodial Attachment B

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: STATEWIDE

SUBJECT: Spray Buffing Procedures **NUMBER:** SWC-09

EFFECTIVE DATE: 06/01/2021 **NEXT REVIEW DATE:** 06/01/2023

APPROVED BY: /s/ Ed Ackerman
Facility Manager

SUPERSEDES: New

This procedure applies to SNAMHS Custodial

I. PURPOSE:

The purpose of this procedure is to establish standard work for all Custodial cleaning process in SNAMHS inpatient hospital facilities.

II. PROCEDURE:

- **Safety** Conduct hand hygiene put on (PPE), Example: gloves, including non-latex for those allergic to latex; masks, respirators, goggles, eye protection, face shields, resuscitation devices with barrier mouth pieces. Always place "Wet floor" signs around the area you are buffing.

1. Dust mop, and sweep entire floor
2. Using a putty knife or chewing gum remover, remove gum or any other sticky substance from floor.
3. Using a mop wringer and bucket set, mop the entire floor with water only. Corners and edges may need to be cleaned by hand. Let floor dry.
4. Using a spray bottle dilute 1oz of hospital approved buffing solution and 15oz of water. Apply the spray buff solution to a 10'X 10' area.
5. Run a 1500 rpm buffer with white or pink pad over area until the area is dry.
6. Repeat steps 4 and 5 until the entire floor area is spray buffed, replacing pads when necessary.
7. Always follow product use instructions, and never mix product unless specified in the label direction. Each situation reacts differently, and results may vary.

III. REFERENCES: NA

IV. ATTACHMENTS:

- OF-EC-45 Hospital Custodial Attachment A
- OF-EC-45 Hospital Custodial Attachment B

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: STATEWIDE

SUBJECT: Preparing and Using Solutions/ GUIDELINES **NUMBER:** SWC-10

EFFECTIVE DATE: 06/01/2021 **NEXT REVIEW DATE:** 06/01/2023

APPROVED BY: /s/ Ed Ackerman
Facility Manager

SUPERSEDES: New

This procedure applies to SNAMHS Custodial.

I. PURPOSE:

The purpose of this guidelines is to establish standard work for all Custodial cleaning process in inpatient hospital facilities.

II. PROCEDURE:

- **Safety.** Safety measures cannot be over looked. You are responsible for protecting yourself and others, as well as the surfaces you work on.
- Read labels carefully and follow manufactures warnings and recommendations exactly. Documents such as Material Safety Data Sheets (MSDS) also provide important safety information.
- Never mix a chemical with anything but water and follow dilution instructions exactly.
- **Never combine chemicals!** Mixing ammonia and bleach, for example, produces a poisonous gas that can kill you quickly.
- To avoid harming floor finishes, use only cool water for dilution.
- Use a clean mop bucket and apply solutions with a clean mop.
- Change the solution when it first appears dirty, to avoid redepositing dirt onto other floor areas.
- **It's the Law.** Many on-the-job chemical safety practices are required by federal and state government agencies, such as the U.S. Occupational Safety and Health Administration (OSHA), Don't put lives in danger, or put your employer at risk, by ignoring these rules. For more information, go to www.osha.gov

III. REFERENCES:

- U.S. Occupational Safety and Health Administration (OSHA)

IV. ATTACHMENTS: NA

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: STATEWIDE

SUBJECT: Autoscrubber/ Procedure **NUMBER:** SWC-11

EFFECTIVE DATE: 06/01/2021 **NEXT REVIEW DATE:** 06/01/2023

APPROVED BY: /s/ Ed Ackerman
Facility Manager

SUPERSEDES: New

This procedure applied to SNAMHS Custodial

I. PURPOSE:

The purpose of this procedure is to establish standard work for all Custodial cleaning process in inpatient hospital facilities.

II. PROCEDURE:

- **Daily Activity/Task**
- Conduct hand hygiene put on (PPE), Example: gloves, including non-latex for those allergic to latex; masks, respirators, goggles, eye protection, face shields, resuscitation devices with barrier mouth pieces
- Raise the squeegee assembly off the floor and wipe the blades down with a hospital approved disinfectant. Store squeegee in the UP position.
- Tilt machine back (after squeegee is in UP), then remove and clean the pad driver (s) brush (es) with a hospital approved disinfectant.
- Drain both recovery and solution tanks completely of water and solution.
- Rinse out recovery tank with clean water and remove any debris from inside tank. Remove clear lid off the tank and remove drain hose cap to allow tank and hose to dry/breathe.
- Remove the float shut-off filter inside the recovery tank and rinse it with clean water.
- Clean the machine with a hospital approved disinfectant and damp towel.
- Recharge the batteries. Always follow the battery charging directions.

- **Battery Maintenance Weekly**

- Conduct hand hygiene put on (PPE), Example: gloves, including non-latex for those allergic to latex; masks, respirators, goggles, eye protection, face shields, resuscitation devices with barrier mouth pieces
- Check fluid level in batteries.

- Check batteries for loose or corroded cables. Avoid contact with battery acid always.
- Use a hospital approved battery terminal cleaner and protector. Shake can well before using. Spray on cables, clamp terminals, brackets, and over entire battery surface. Be sure cell covers are tightly closed prior to spraying.
- After a few minutes, flush off with water or a damp cloth. Formula is yellow but turns red in presence of acid. Spray will neutralize any acid on battery.
- Check battery connections for wear and loose terminals. Replace if necessary.

- **Monthly Maintenance**
- Check the scrubber for leaks and tighten any loose fasteners.
- Lubricate all grease points and pivot points with silicon spray or approved grease.
- Place machine over a floor drain. Flush the solution system by pouring 3 gallons of hot water and hospital approved disinfectant into the solution tank and running the machine (with solution control on) for 45 seconds. Turn machine off and let it sit overnight. The next day, drain the remaining solution and rinse the solution tank out with clean water.

III. REFERENCES: DAYTON OWNERS MAMUAL

IV. ATTACHMENTS:

A. SWC-11 Dayton Scrubber Procedure Operating Manual Attachment A
B. SWC-11 Advance - CONVERTAMATIC 26D MANUEL.pdf

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH SERVICES
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY WIDE

SUBJECT: Hand Hygiene Policy **NUMBER:** OF-SP-22

EFFECTIVE DATE: 03/2023 **REVIEW DATE:** 03/2025

APPROVED BY: /s/ Susan Lynch, MBA, CPM
Hospital Administrator

SUPERSEDES: 07/10; 12/12; 04/13; 01/16; 08/18; 12/19; 02/21

I. PROTOCOL:

It shall be the protocol of Southern Nevada Adult Mental Health Services (SNAMHS) to maintain a safe and sanitary environment for employees, patients, and visitors. Hand hygiene is the cornerstone for reduction in transmission of pathogens in a healthcare setting. SNAMHS bases its policy on the CDC's Hand Hygiene Monograph.

Hand hygiene is generally considered the single most important procedure for preventing healthcare-associated infections. Although antiseptics and other hand hygiene agents do not sterilize the skin, they can reduce microbial contamination depending on the type and the amount of contamination, the agent used, the presence of residual activity and the hand hygiene technique followed.

II. PURPOSE:

To decrease the risk of transmission of infection, by appropriate hand hygiene. The purpose of these hand hygiene audit tools is to determine health care worker (HCW) compliance with hand hygiene practice. Hand hygiene refers to cleaning your hands by using an alcohol-based hand rub (e.g. Purell), or by washing hands with soap (antimicrobial or plain) and water.

III. PROCEDURE:

A. Handwashing: When hands are visibly dirty or contaminated with proteinaceous material or are visibly soiled with blood or other body fluids, and in case of a resident with a spore-forming organism (e.g., C. difficile), after going to the restroom, and before eating, perform hand hygiene with soap and water.

B. Hand Washing Technique:
   1. Duration of the procedure: 20-30 seconds
   2. Adjust the water to a warm temperature and rinse hands.
   3. Apply enough (approximately quarter sized) soap to cover all hand surfaces.

4. Rub hands palm to palm: right dorsum over left dorsum with interlaced fingers and vice versa.
5. Rub backs of fingers to opposing palms with fingers interlaced.
6. Rub both thumbs using rotational motion.
7. Wash each wrist by vigorously sliding the opposite hand around its surface area.
8. Interlace fingers and thumbs and slide them back and forth, clean under your nails with the fingertips and nails of the opposite hand.
9. Thoroughly rinse each hand from the wrist down
10. If hands are grossly soiled repeat the steps above
11. Dry hands with a single use disposable towel
12. To protect hands from the contaminated surface of the faucet handle turn off the faucet by placing a dry section of disposable towel over the handle.

C. Routine hand washing should always occur:
1. Before and after touching a patient
2. Before and after a clean or aseptic procedure
3. After a body fluid exposure
4. Before and after handling patient food and food tray
5. Before and after staff breaks
6. Before and after eating
7. Before and after caring for a patient
8. After handling patient personal belongings
9. After going to the restroom
10. After glove removal

D. If hands are not visibly soiled, rubbing them with an alcohol-based formulation is acceptable. Use the following procedure:
1. Duration of procedure: 20 seconds
2. Apply a palm full of product in a cupped hand and cover all surfaces.
3. Rub hands palm to palm: right dorsum over left dorsum with interlaced fingers and vice versa.
4. Rub backs of fingers to opposing palms with fingers interlaced.
4. Rub both thumbs using rotational motions.
5. Rub each wrist by vigorously sliding the opposite hand around its surface area.
6. Interlace fingers and thumbs and slide them back and forth.
7. Continue to rub hands together until all product has evaporated and/or dried.

E. Monitoring will be by direct observations of trained staff via either overt or covert methods.
1. During *overt* observations, trained staff observers will identify themselves and their purpose. Overt observers will provide immediate feedback to those being observed. The purpose of overt observations will be to encourage adequate hand hygiene and reduce the risk of infection, not to

criticize or embarrass the one being observed.

2. During *covert* observations, observers will make every effort to conceal their purpose to prevent staff awareness and ensure accuracy of data collected. *Covert* observations may be conducted by trained staff at any time. In addition, "secret shoppers" may be randomly assigned by the Infection Control Coordinator, or unit managers to conduct *covert* observations.
3. All direct observations, *overt* or *covert*, will be recorded using either the attached form or the "Peer-to-Peer Hand Hygiene Surveillance" online survey. Completed forms will be submitted to the Infection Control Coordinator via interoffice mail, or email on or before the fifth day of the following month.
4. All trained staff will conduct at least one *covert* observation per month. They may use either the attached form, or the "Peer-to-Peer Hand Hygiene Surveillance" online survey to record their observation(s).
5. Each month, at least ten (10) direct observations will be performed by each of the following: (a) infection control coordinator, (b) laboratory personnel or designee,; and (c) one "secret-shopper" per unit.
6. The total number of direct observations performed each month will be determined by the Infection Control Coordinator and may be adjusted quarterly by the Infection Control Committee according to staffing levels and patient census.
7. Trained staff observers will record the occasions they observe where a staff member should carry out hand hygiene, called "opportunities". Examples of hand hygiene opportunities include:
    a. Before touching a patient.
    b. Before touching medications or food.
    c. After handling body fluids.
    d. After removal of gloves.
    e. After touching the patient, environment, or objects involved with patients' care.

F. Observation Record Requirements: Each observation record will be complete and accurate.

1. When using the attached form, the observer will fill in all areas of the form for each observation. The Infection Control Coordinator, or designee can provide a sample form and/or guidance on how to complete the form.
2. The "Peer-to-Peer Hand Hygiene Surveillance" online survey will include prompts to ensure all necessary data is collected for each observation. The Infection Control Coordinator, or designee can provide guidance on how to complete the online survey.
3. At no time will the observer include any identifiers or names of individuals observed.
4. Necessary observation data includes:
    a. Unit/department name

b. Date (including month, day, year)
c. Shift (day, evening, night)
d. Healthcare worker type
e. Type of hand hygiene (soap/water, hand sanitizer, gloves, none)
f. Point of observation (before/after contact with patient, environment, or objects)

G. Fingernails and Artificial Nails
1. Part of Hand Hygiene is the grooming of nails. Per the Center for Disease Control (CDC) and The Joint Commission National Patient Safety Goals, due to infection control and safety risks, natural fingernails must be short trimmed and clean.
2. Freshly applied nail polish does not increase the number of bacteria recovered from periungual skin, but chipped nail polish may support the growth of larger numbers of organisms on fingernails (D, E).
3. Several studies provide evidence that wearing artificial nails poses an infection hazard. These studies have shown that HCWs who wear artificial nails are more likely to harbor gram-negative pathogens on their fingertips than are those who have natural nails, both before and after hand washing (F, G).
4. For reasons stated above and in accordance with SNAMHS OF-LDR-07 "Dress and Grooming Guidelines" policy, section C-Direct Care Employees, #8.
a. Natural nails can be ¼ inch maximum length as viewed from the palm side of the hand.
b. Artificial nails including sculptured nails gels, acrylics, press-on etc., are not permitted.

H. Hand Hygiene Supplies
1. Hand hygiene supply data will be collected by the Infection Control Coordinator from the Supply Department for consumption analysis.
2. Hand hygiene supplies to be tracked will include hand soap and hand sanitizer.

IV. REFERENCES:

A. Hand Hygiene Resource Center; www.handhygiene.org
B. CDC Guideline for Hand Hygiene in Health-Care Settings, MMWR, May 3, 2018
C. Boyce, J., & Pittet, D. (2002). Guideline for Hand Hygiene in Health-Care Settings: Recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force. Infection Control & Hospital Epidemiology, 23(S12), S3-S40. doi:10.1086/503164
D. MMWR; Guideline for Hand Hygiene in Health-Care Settings; Boyce, John M. et al March 25, 2016/51 (RR16); 1-44
E. Hewlett AL, Hohenberger H, Murphy CN, Helget L, Hausmann H, Lyden E, Fey PD, Hicks R. Evaluation of the bacterial burden of gel nails, standard nail polish,

and natural nails on the hands of health care workers. Am J Infect Control. 2018 Dec;46(12):1356-1359. doi: 10.1016/j.ajic.2018.05.022. Epub 2018 Jul 6. PMID: 30509357.

F. Measuring Hand Hygiene Adherence: Overcoming the Challenges. Oakbrook Terrace, Illinois: The Joint Commission; 2009.

G. SNAHMS agency policy OF-SP-05 Standard Precautions (Universal Precautions)

H. Nursing Procedure VII-01 Hand Washing

V. ATTACHMENTS:

A. OF-SP-22 Hand Hygiene Attachment A

Hand Hygiene Monitoring Tool

Facility: Rawson Neal Psychiatric Hospital Unit:_____

HCW Type Key:
1= Physician
2 = Physician Assistant/Nurse Practitioner
3 = Registered Nurse
4= Mental Health Technician
5 = Physical, Occupation, Speech Therapy
6 = Dietician
7 = Dietary Staff
8 = Environmental Services/Maintenance
9 = Social Worker
10 = Administrator/Manager

Observation Key:
HR= Alcohol Hand Rub
HW= Hand Washing
Y= Yes/N= No/NA= Not Applicable

#	Date	Shift	HCW Type	Hand Hygiene BEFORE Touching Resident				Hand Hygiene AFTER touching Resident, Environment, or Equipment				On Contact Precautions		Gloves Worn		
	(MM/DD/YY)	Day, Eve, Night	See Key	Yes HR|	Yes HW	NO	NA	Yes HR	Yes HW	NO	NA	Y	N	Y	N	NA
1																
2																
3																
4																
5																
6																
7																
8																
9																
10																

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
NURSING DEPARTMENT

SUBJECT: Hand Washing **NUMBER:** VII-01

EFFECTIVE DATE: 06/22 **NEXT REVIEW DATE:** 06/24

APPROVED BY: /s/ Earl Farinas, RN
Director of Nursing II

SUPERSEDES: 10/02, 10/15, 12/16, 6/17, 01/19, 01/20

I. PURPOSE:

Proper hand washing is the single most important procedure for preventing nosocomial infection and safeguarding employee health. The purpose of this procedure is to establish proper hand washing techniques.

II. PROCEDURE:

A. It shall be the responsibility of the Nursing Department to instruct and annually review proper hand washing techniques of all nursing staff.

B. Hand washing is indicated after situations in which microbial contamination of the hands is likely to have occurred even if gloves were worn.

C. Hand Washing Technique:

1. Before washing hands, remove rings, watches or bracelets to facilitate thorough cleansing and drying
2. Adjust the water to a warm temperature and rinse hands
3. Apply enough soap to cover all hand surfaces
4. Rub hands palm to palm: right dorsum over left dorsum with interlaced fingers and vice versa
5. Rub back of fingers to opposing palms with fingers interlaced
6. Rub both thumbs using rotational motions
7. Wash each wrist by vigorously sliding the opposite hand around its surface area
8. Interlace fingers and thumbs and slide them back and forth, clean under your nails with the fingertips and nails of the opposite hand

9. Work up a generous lather by rubbing hands together vigorously for about 15 – 20 seconds

10. Thoroughly rinse each hand from the wrist down

11. If hands are grossly soiled repeat the steps above

12. Dry hands with a single use disposable towel

13. Turn off the faucet using a dry disposable towel

D. Routine hand washing should always occur:

1. Before and after handling patient food and food tray

2. Before and after staff breaks

3. Before and after eating

4. Before and after caring for a patient

5. After handling patient personal belongings

6. After going to the restroom

7. After glove removal

8. Before and after a clean or aseptic procedure

9. After a body fluid exposure

10. Before and after touching a patient

III. REFERENCE:

OF-SP-22 Hand Hygiene

OF-SP-05 Standard Precautions

Center for Disease Control and Prevention (CDC). (2022, March 14). *When and how to wash hands.* https://www.cdc.gov/handwashing/when-how-handwashing.html

IV. ATTACHMENTS:

N/A

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY WIDE

SUBJECT: Infection Control of Ice Machine **NUMBER:** OF-SP-01

EFFECTIVE DATE: 02/2022 **REVIEW DATE:** 02/2024

APPROVED BY: /s/ Susan Lynch, MBA, CPM
Hospital Administrator

SUPERSEDES: Infection Control of Ice Machine, #729 #2; 06/97; 03/01; 06/03; 10/08; 01/09; 01/11; 01/14; 01/20; 03/20

I. POLICY:

It shall be the policy of Southern Nevada Adult Mental Health Services (SNAMHS) to maintain a safe and sanitary environment for employees, patients, visitors, and the public.

II. PURPOSE:

The purpose of this policy is to establish a protocol for safe, pathogen-free dispensing of ice for use in the Hospital and throughout the Agency.

III. DEFINITION:

The food codes of all 50 States and Canada define ice as a food. In the Federal Food Protection Unicode drafted by the U.S. Food and Drug Administration, "ice" is specifically included in the definitions of "food."

IV. PROCEDURE:

A. Ice shall be dispensed only by employees using scoops, tongs, or other utensils that have been approved by the Health Authority or by automatic equipment.

B. Employees must wash and glove both hands before scooping, bagging, or otherwise touching the ice, which will be used for consumption or come in contact with items handled by client.

C. Utensils used for dispensing ice must be stored on a clean surface and washed with soap and warm water daily or upon use. Scoops shall not be stored in the ice bin and care shall be taken to prevent the handles from touching the ice.

D. Receptacles used to transfer ice will be clean and stored so that they are protected from contamination when not in use.

E. Bins used for storage of ice shall be drained through an air gap.

F. Every 3 months, equipment shall be cleaned and sanitized as recommended per manufacturer's instructions to prevent the accumulation of legionella, mold, fungus, and bacteria.

1. The maintenance department or service technician shall monitor and service the ice machine units every three (3) months referring to the instruction manual and labels provided with the ice dispenser.
2. Housekeeping shall maintain the exterior components of the individual units
3. Ice that has been sitting in the ice maker for more than 10 days will be removed so the ice maker may prepare fresh ice.

G. Legionella testing will be done quarterly on select ice makers.

H. If the ice maker has been shut down for any period of time, it must be cleaned and sanitized.

I. Ice will be discarded after equipment maintenance.

J. Contact: Facility Manager/Maintenance for any noted problems.

V. REFERENCES:

A. NAC 446.175, Preparation and Service of Ice

B. CDC Guideline for Environmental Infection Control in Health-Care Facilities, 2003

C. FDA 1999 Food Code Chapter 4 Equipment, Utensils, and Linens, 4-602.11(E)(4)

D. Hoshizaki® Cublet Ice Dispenser Instruction Manual, issued Nov. 29, 2000, revised , April 25, 2017 pages 15-19.

VI. ATTACHMENTS:

A. OF-SP-01 Infection Control of Ice Machine Hoshizaki Attachment A

B. OF-SP-01 Infection Control of Ice Machine Manitowoc Attachment B

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY WIDE

SUBJECT: Prospective Employee Health Screening and Standing Order for Employee Health Testing and Vaccinations

NUMBER: OF-SP-02

EFFECTIVE DATE: 04/2022

REVIEW DATE: 04/2024

APPROVED BY: /s/ Susan Lynch, MBA, CPM
Hospital Administrator

SUPERSEDES: Policy #10.10, 3/93; #5, 7/96; OF-SP2, 03/03; 09/03; 10/06; 01/09; 10/11; 04/13; 05/15; 05/17; 04/20

I. PROTOCOL:

It shall be the protocol of Southern Nevada Adult Mental Health Services (SNAMHS) to maintain a safe and sanitary environment for employees, patients, visitors, and the general public.

II. PURPOSE:

The purpose of this protocol is to establish guidelines in order to assure that all SNAMHS prospective employees will have a documented pre-employment-health screening, including history and physical, tuberculosis screening, Respiratory Fit Testing and will have access to the Hepatitis B Vaccine Series and the Seasonal Influenza Vaccine (if the pre-employment health screening occurs during influenza season).). A confidential, online system NVWEBIZ will be used to keep a record of an individual's immunizations by authorized user.

III. DEFINITIONS: N/A

IV. PROCEDURE:

A. Employee Physical Examinations:

1. Before initial employment, all prospective employees and contractors must have/provide evidence of a physical examination/certification from a licensed medical doctor or other designated professional (see number 3 below) stating that he/she is free of communicable disease in a contagious stage and that he/she is fit to perform the duties they are being hired for. These services, including certain diagnostic blood work if indicated, shall be provided free of charge to the prospective employee if performed by the assigned SNAMHS Physician. Examinations/certifications

documented within the six (6) months immediately preceding employment are acceptable.

2. A report of the physical examination/certification shall be sent to the Infection Control Nurse by the Human Resources Office, Physician, and other designated professional or by the prospective employee.

   a) The designated professionals recognized as acceptable to perform the examination/certification are Doctors of Osteopathy, Advanced Practitioners of Nursing and Physician Assistants.

   b) New Employee Tuberculosis (TB) Testing:

3. A 2-step baseline Tuberculin Skin Test (TST) (Attachment B) shall be used for all new employees, volunteers and contract workers, who have not had or cannot provide a documented negative TB skin test result during the preceding 12 months. Exception would be an employee with two (2) documented negative TSTs s within the last 12 months; one being in the last 90 days.

   a) If a positive skin test is found, a chest x-ray is required (Attachment C).

   b) A Quantiferon Gold blood test may also be performed and is ordered at the discretion of the Physician, Infection Control Nurse or Medical Nurse.

   c) All abnormal Quantiferon Gold results will be followed by a chest x-ray to ensure the absence of active TB.

   d) Prospective employees with a documented history of a positive TB skin test must have a chest x-ray which demonstrates that he/she is free from a communicable pulmonary disease (TB) in a contagious stage. If the prospective employee has a documented chest x-ray within the 365 days immediately preceding employment stating there is no pulmonary disease (TB) in a contagious stage, he/she needs only to complete the Tuberculosis Signs and Symptoms form (Attachment D) at the time of hire

B. Employee Annual: TB surveillance program in accordance with updated CDC guidelines for screening of health care workers.

1. Employees with history of negative testing: no further testing or screening is required.

2. Asymptomatic employees with history of positive TB testing and who have received treatment: no further testing or screening is required.

3. Asymptomatic employees with history of positive TB testing who have not received treatment: will be followed annually by signs/symptoms

questionnaire and tracking will be done according to previous signs/symptoms questionnaire on file. These employees will be encouraged to receive prophylactic treatment per CDC recommendations.

4. These new requirements apply to all employees, even those who are not in direct patient care positions.
5. Any employee may elect to continue with annual TB screening or request one-time TB screening at any time during his/her employment whenever an employee is concerned about possible exposure to TB.
6. The CDC guidelines emphasize the treatment of the employees who have latent TB (positive testing but asymptomatic) to minimize risk of reactivation and introduction of active TB into the healthcare setting.
7. All chest X-Rays will be ordered at the discretion of the physician.
8. All healthcare workers will be required to complete annual training/education on tuberculosis via NVelearn.
9. Those who are unable to provide written proof will have titers drawn to determine immunity.
10. If titers show no or low levels of immunity, booster vaccinations for each will be offered to the employee.
11. If the employee refuses the vaccines, as signed declination will be placed in employee file.

C. Hepatitis A and B Vaccine:

1. All prospective employees shall be provided with information explaining Hepatitis B infection, its risks, and the risks versus benefits of vaccination, and cost free vaccinations shall be offered.
2. All prospective employees shall sign a Hepatitis B Informed Consent/Declination Form (Attachment A) assigning themselves to one of three Employee Risk Groups:
   a. At significant risk, vaccine desired
   b. At significant risk, vaccine declined
   c. At significant risk, vaccine declined, previously received.
3. The Hepatitis B Vaccine shall be administered by the Employee Health Nurse or designee per protocol. (see SNAMHS Policy Hepatitis B Vaccine Protocol)

D. Seasonal Influenza Vaccine:

1. All prospective employees shall be provided with the CDC Vaccine Information Statement (VIS) explaining seasonal influenza, its risks and the risks versus benefits of vaccination. Seasonal influenza vaccination will be offered to all prospective new employees free of charge.

2. All prospective employees shall sign a Seasonal Influenza Vaccine Informed Consent/Declination Form (Attachment E).

3 The Influenza Vaccine shall be administered by the Infection Control Nurse or designee, per protocol. (See: OF-SP-19 Seasonal Influenza Vaccination Program).

E. Respiratory Fit Testing:

1. All prospective employees will complete a Respiratory Medical Evaluation Form (Attachment F), and at the time of the history and physical examination, the Physician will review the form and through medical evaluation of the prospective employee will determine the employee's ability to proceed with respiratory fit testing (See: OF-SP-18 Respiratory Protection Program).

2. All prospective employees medically cleared to undergo fit testing will have their respiratory fit testing completed during the new employee Orientation.

F. A record of the dates of the physical examination/certification, initial TB screening, subsequent annual TB screening, and Hepatitis B screening and Seasonal Influenza Vaccination shall be maintained by the Infection Preventionist / Employee Health Nurse.

G. Employee health testing (e.g. PPD) and vaccinations (e.g. Hepatitis B and Influenza Vaccinations) shall be directed and over seen by SNAMHS Medical Director or licensed designee by means of standing orders.

H. All prospective employees shall provide COVID 19 vaccination or religious or medical exemption documentation

V. REFERENCES:

A. NAC 441A.375 (3), (4)
B. Protecting HealthCare Personnel HAI/CDC 10/27/2016
C. SNAMHS Policy OF-SP-03 Infection Control Plan
D. SNAMHS Policy OF-SP-07 Hepatitis B Vaccine Protocol
E. SNAMHS Policy OF-SP-10 Tuberculosis Exposure Plan
F. DPBH SP 7.1 Clinical Services Branch Seasonal Influenza Vaccination Program
G. SNAMHS Policy OF-SP-18 Respiratory Protection Program
H. NVHealth Response.nv.gov

VI. ATTACHMENTS:

A. OF-SP-02 Prospective Employee Health Screening & Standing Order for Emp Health Testing and Vac Attachment A
B. OF-SP-02 Prospective Employee Health Screening & Standing Order for Emp Health Testing and Vac Attachment B
C. OF-SP-02 Prospective Employee Health Screening & Standing Order for Emp Health Testing and Vac Attachment C
D. OF-SP-02 Prospective Employee Health Screening & Standing Order for Emp Health Testing and Vac Attachment D
E. OF-SP-02 Prospective Employee Health Screening & Standing Order for Emp Health Testing and Vac Attachment E

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY WIDE

SUBJECT: Infection Control Program Overview **NUMBER:** OF-SP-03

EFFECTIVE DATE: 04/2023 **REVIEW DATE:** 04/2025

APPROVED BY: /s/ Susan Lynch, MBA, CPM
Hospital Administrator

SUPERSEDES: Infection Control General Policies; 01/06 & OF-PI-24 Infection Control Performance Improvement Plan 01/09; 01/11; 04/17; 08/18; 02/19; 02/20; 04/21

I. PROTOCOL:

A hospital must fulfill its responsibility to its patients, staff, and the community by ensuring that proper safeguards are instituted to identify and prevent healthcare associated infections.

II. PURPOSE:

The Infection Control Program establishes a comprehensive program, that meets the standards of participation of Joint Commission and Centers for Medicare (CMS), and to ensure that the organization has a functioning coordinated process in place to reduce the risks of healthcare acquired infections, in patients and health care workers by optimizing the use of resources through a strong preventive program.

The goals of the Infection Prevention Program are to:

A. Decrease the risk of infection to patients and personnel.
B. Monitor for occurrence of infection and implement appropriate control measures.
C. Identify and correct problems relating to infection prevention practices.
D. Maintain compliance with state and federal regulations as well as applicable accreditation standards relating to infection prevention.

III. DEFINITIONS:

A. **Hospital Associated Infections (HAI)/Nosocomial**: is an infection that develops during or is a result of a hospitalization and is not present or incubating before admission to the hospital.

1) When the incubation period is unknown, an infection is called hospital acquired if it develops at any time after admission or identified 72 hours or more post admission.
2) An infection present on admission can be classified as HAI, but only if it is related directly to or is the residual of a previous admission. (Refer to: APIC Text of Infection Control and Epidemiology 4th Ed)/chapter Behavioral Health.
3) All infections that fail to satisfy these requirements are classified as community acquired.

B. **The Infection Prevention Program (IPP)**: is a comprehensive program that addresses detection, prevention, and control of infections among patients, personnel, and the environment.

C. **Infection Control Committee (ICC)**: is a multi-disciplinary staff team.
1) Members of the ICC shall include representation from the medical staff, nursing, laboratory, pharmacy; housekeeping/maintenance supervisors, nutrition services, outpatient services and other ancillary staff available on a consultative basis.
2) Meetings: The infection Control Team shall meet as often as is necessary or at least three (3) times per year. Documentation of the meeting's minutes shall be kept and submitted to Performance Improvement and Leadership by the appointed AA.
3) Responsibility: The team shall be responsible for recommending all aspects of hospital policy relating to infection control. Leadership is responsible for prompt review and implementation of recommended infection control policy formulated by the committee.
4) Review of Reported Infections: The ICC will be kept informed of infections within the hospital and ancillary agencies.
5) Team Chairperson: The Director of Infection Control/Employee Health will be the chairperson.

IV. PROCEDURE

A. The IPP continuously provides surveillance of infections with implementation of control measures and prevention of infections
1) There is on-going monitoring for infections among patients and personnel and subsequent documentation of infections that occur.
2) Prevention of spread of infections is accomplished by use of hand hygiene, standard precautions and other barriers, appropriate treatment and follow-up, and employee work restrictions for illness.
3) Staff and patient education focus on risk of infection and practices to decrease risk.
4) Protocols, procedures, and aseptic practices are followed by personnel in performing procedures and in decontamination of equipment.

5) Immunizations are offered as appropriate to personnel to decrease the incidence of preventable infectious diseases.

B. Outbreak Investigation

1) Systems are in place to facilitate recognition of increases in infections as well as clusters and outbreaks.

C. Protocol and Procedure Review and Revision

1) Protocol and procedures for infection prevention are reviewed on a regular schedule and updated as needed and in response to changes in regulations and standards, new equipment, or new procedures.

D. Staff Education

1) Training of staff in infection prevention begins with orientation of new hires, occurs at least annually and as necessary.

E. Quality Assurance/Performance Improvement (QA/PI)

1) Infection Prevention is a component of the facility's quality assurance/performance improvement program.

2) Infection prevention reports are made to the QA/PI program. Infection prevention monitoring is done to assess the level of quality provided and actions for improvement are taken as needed.

F. Consultation

1) The infection preventionist serves as a resource for all staff and all departments relating to prevention of infections.

G. Infection Control Preventionist Functions

1) The Infection Control Preventionist is under the supervision of the Director of Nursing and serves as a staff member to the ICC.

2) Coordinates Surveillance.

   a. Reviews microbiology laboratory results for isolations and origin of specimens and receives those reports from laboratory personnel daily.
   b. Reviews provided antimicrobial reports from the pharmacy weekly. Reports include patient chart number/name, medical diagnosis, and duration of the prescribed antimicrobial/anti.microbials.
   c. Reviews nursing reports supplied by the unit nurses, using the Southern Nevada Adult Mental Health Services Infection Control Surveillance Report, entering data electronically.

   d. The Infection Control Surveillance Report is the responsibility of the unit nurses to complete and return to the Infection Control Preventionist After the completion of treatment.

3) The Infection Control Preventionist is familiar with local, state, and national health problems such as influenza, hepatitis, and TB, etc.
4) Participates in environmental rounds with the Housekeeping department monthly.
5) Interfaces with local community resources, professional and government agencies.
   a. Communicate with staff, students/trainees, volunteers, family members and visitors about infection prevention and control issues, including their responsibility in prevention of infection.
6) Maintains Records:
   a. Keeps all reports of hospital acquired infections and actions taken.
   b. Prepares and presents a quarterly report for the Infection Control Committee containing results of surveillance, control procedures instituted, and hospital acquired infections.
   c. Maintains and submits a copy of all reportable infections to the Southern Nevada Health District.
   d. Keeps copies of the ICSR (Infection Control Surveillance Reports) listing infections and antimicrobial usage and results.
   e. Keep records involving staff participation in the Hepatitis, Influenza and COVID-19 Vaccination program offered at SNAMHS.
   f. Keeps records of patients and staff TB results.
   g. Keeps exposure logs and documentation
   h. Conducts environmental checks
   i. Monitors refrigerator logs
7) Keeps staff informed: When hospital acquired infection hazards exist, the following shall be informed.
   a. Director of Infection Control/Employee Health
   b. Hospital administrator
   c. Medical Director
   d. Physicians and nurses clinically involved with the situation.
   e. Chairperson of the ICC
   f. Director of Nursing
   g. Other departments as appropriate.
8) Supervises Isolation Procedure: Guidelines shall be based on the latest revision from the CDC Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings current edition and SNAMHS policy and procedure.
9) Reports to Southern Nevada Health District Office of Epidemiology, Clark County, Nevada: reports all specified diseases, food borne

illness outbreaks and extraordinary occurrences of illness to appropriate personnel as required by regulation.

10) Assists the Infection Control director with investigations of:
    a. Clusters of infections above expected levels
    b. Single cases of unusual hospital acquired infections
    c. Other infection control surveys and studies
11) Performs Education Functions Through:
    a. Information, reports, memos, pamphlets, emails and one to one interaction with patients and staff.
    b. Lectures, meetings, and in-service education.
    c. Newcomer orientation and an annual in-service education, regarding infection control based on established policy and procedure, including but not limited to; hand hygiene, PPE, gloves, Standard Precautions, transmission risks of disease, including risks of TB, Hepatitis B and C and the OSHA Bloodborne Pathogens Standard.
    d. Maintenance of reference sources for policies and procedures.
12) Monitors Employee Health Program:
    a. Immunization, including but not limited to, yearly influenza vaccine.
    b. Exposure investigation/Contact tracing
    c. Tuberculin testing, initial two (2) step upon employment if employee is unable to present documentation of prior TST for 12 months.
    d. For new employees with documented sensitive to TST derivative or prior history of positive TB test new employees will have QuantiFERON Gold drawn or CXR done.
    e. Annual TB signs/symptoms questionnaire and Risk Assessment will be done by SNAMHS employee who is concerned of possible exposure to TB
    f. CXR if indicated or not previously done.
    g. Offer and monitor series of Hepatitis B vaccinations.
    h. Offer and monitor series of Covid-19 vaccinations.
13) Maintains and revises Infection Control Plan as necessary with assistance from ICC.
14) Maintains current and revises as necessary the Infection Control Plan and Employee Health and Infection Control Policies.
15) Maintains current and revises as necessary the Exposure Control Plan bi-annually and as needed.
16) Evaluates the effectiveness of the infection control interventions and, as necessary, redesigns the infection control interventions.
17) Assists with education and evaluation activities that address all requirements of Infection Control and Employee Health as specified by OSHA, TJC, federal, state, and local laws.
18) Written policies and procedures shall be updated at least every two-years except for those that OSHA requires annual review.

19) Signatures of the Hospital Administrator and Infection Control Coordinator will be affixed to the documents after thorough review.

H. Surveillance**:**

1) There will be one (1) full time Infection Preventionist to carry out the daily function of the Infection Prevention and Employee Health programs. This includes infection surveillance, prevention, and control activities.
   A. Types of surveillance: House wide and targeted
   B. Special studies will be conducted as needed. These may include:
      i. The investigation of clusters of infections above expected levels.
      ii. The investigation single cases of unusual or epidemiological significant hospital acquired infections.
      iii. The comparison of a group of infected patients with or uninfected control group to detect statistically significant risk factors for which control measures can be developed.
   C. These studies may include prevalence and incidence studies, collection of routine or special data as needed and sampling of personnel or the environment as needed.

I. Responsibilities:

A. The Director of Infection Control/Employee Health is responsible for the administration of the IC program. Reporting surveillance and IC reports to the various leadership committees.
B. Nursing Staff are responsible for being familiar with Infection Control policies and procedures.
C. The Infection Control Preventionist is responsible for following policies and procedures related to Infection Control and updating as needed.
D. Hospital Administration is responsible for supporting the Infection Control Program and the Infection Control Committee, by supporting efforts to prevent and control the spread of infection.

J. Evaluation and Reporting**:**

1) When evaluation identifies an area of concern, a specific problem, or an opportunity for improvement, a corrective action plan will be formulated. The corrective action plan is collaborative in nature.
2) When problems or opportunities for improvement are identified, actions taken/recommended will be documented in SNAMHS ICC minutes.
   i. Minutes are forwarded to Performance Improvement for review and assistance in resolution as necessary.
3) If immediate action is necessary, the Infection Control Committee, or its designee has the authority to institute any surveillance, prevention,

and control measures if there is reason to believe that any patient or personnel is at risk.

4) The responsibility and direct accountability for the surveillance, data gathering, aggregation and analysis is assigned to the Infection Control Coordinator.
5) Hospital personnel and medical staff members share accountability in reporting of isolation cases, suspected infection, and reports of positive cultures to the Infection Control Coordinator.
   i. There is collaboration between departments as well as the Infection Control Coordinator to identify any nosocomial trends or pattern that may occur, or opportunities to improve outcomes in the reduction and control of infections.
6) Hospital personnel and residents of treatment units are advised that food and beverages other than water, need to be consumed and stored in designated areas of the treatment units.
   i. No food or beverages other than water can be stored or consumed in patient rooms unless indicated by treatment restrictions (e.g.: patient is in seclusion).

K. Updating the Infection Prevention Plan

1) The Infection Prevention Plan will be reviewed annually and updated as indicated by changes in services, changes in the population served, or other changes as appropriate.

2) The Infection Prevention and Control Plan will have an annual facility risk assessment that is weighted and prioritized.
   a. The Risk Assessment will be conducted annually.
   b. The plan will be approved by the ICC and the Medical Executive Committee.

V. REFERENCES:

1) APIC Text of Infection Control and Epidemiology. 4th Edition. Chapter 53: Behavioral Health Washington, DC: APIC: 2014
2) APIC Infection Prevention Manual for Behavioral Health, 3rd Edition. Published by APIC Washington¸ DC, 2015.
3) SNAMHS Annual Infection Control Plan

VI. ATTACHMENTS: N/A

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY WIDE

SUBJECT: Isolation Techniques –Transmission Based Isolation Precautions **NUMBER:** OF-SP-04

EFFECTIVE DATE: 04/2023 **REVIEW DATE:** 04/2025

APPROVED BY:
/s/Susan Lynch, MBA, CPM
Hospital Administrator

SUPERSEDES: Isolation Techniques, OF-SP-4, dated 04/13; 01/02; 01/04; 01/07; 11/09; 01/11 04/15; 04/17; 08/17; 02/19; 04/21

I. PROTOCOL:

It shall be the protocol of Southern Nevada Adult Mental Health Services (SNAMHS) to maintain a safe and sanitary environment for employees, patients, visitors, and the public.

II. PURPOSE:

The purpose of this protocol is to establish guidelines of Isolation Techniques in preventing the spread of communicable/contagious diseases, though transmission-based precautions.

III. DEFINITION:

Communicable/contagious disease is defined as being able to be spread person to person by direct or indirect contact, by the causative agent of a disease.

IV. PROCEDURE:

A. Admissions:

1. Unless otherwise instructed by the Medical Director, all patients with communicable diseases shall be transferred as soon as practical to a facility that has appropriate control measures for isolation and/or spread prevention.

B. Categories of Isolation:

1. Categories of Isolation have been established to assure that appropriate Isolation Techniques are implemented when necessary.
2. SNAMHS Isolation Procedures fall into the following transmission-based categories:

a. Contact - Contact Precautions shall be used in addition to Standard Precautions for patients with specific infections that can be transmitted by direct and indirect contact.
   i. Direct Contact Transmission – microorganisms are transmitted directly from person to person.
   ii. Indirect Contact Transmission – transfer of the infectious agent through a contaminated intermediate object or person.

b. Droplet - Droplet Precautions shall be used in addition to standard precautions for patients with infections that can be transmitted by droplets. Droplet transmission involves contact of the conjunctiva or mucous membranes of the nose or mouth of a susceptible person with large-particle droplets containing microorganisms generated from a person who has a clinical disease or who is a carrier of the microorganism. Droplets may be generated by the patient's coughing, sneezing, or talking.

c. Airborne Precautions (*see Policy OF-SP-10 Tuberculosis Exposure Plan and OF-SP-18 Respiratory Protection Program*)

3. Procedures for each have been developed to assure the proper provision of care and technique used to prevent the spread of communicable diseases.

C. Authorization/Placement in Isolation:

1. When any patient is suspected or diagnosed as having any communicable, contagious, or infectious disease, the Charge/Staff Nurse shall immediately notify the patient's attending Physician or authorized designee and the Infection Control Coordinator for appropriate Isolation Procedures.

2. All Orders concerning Isolation shall be implemented as soon as practicable.

   a. The Physician's Orders shall be documented in the patient's medical record, and validated within twenty-four (24) hours.

   b. In the absence of appropriate orders from the attending physician, the Infection Control Coordinator, following collaboration with the ICC Chairperson and/or the Director of the Infection Control function or the Medical Director, shall have the authority to institute isolation or any appropriate control measures or studies, when it is reasonably felt a danger exists to any patient or personnel.

3. When Isolation is implemented, the patient shall be moved into a private room designated as an Isolation Room/Designated Isolation Pod, and the nursing staff shall implement the appropriate Isolation Procedures as recommended by the Infection Control Coordinator.

4. The failure of the Attending Physician or Nursing Services to take appropriate action concerning a suspected or confirmed infectious or contagious disease shall be promptly reported to the Medical Director and Hospital Administrator.
5. In the event the Attending Physician fails to take appropriate action, the Medical Director, Director of Nursing, or the Infection Control Nurse shall have the authority to implement Isolation Procedures.
6. Only authorized staff shall be allowed to enter Isolation Rooms.

D. Confirmation of Diagnosis:

1. The Attending Physician or alternate shall examine the patient within twenty-four (24) hours of the patient being placed in Isolation.
2. When the presence of an infectious or communicable disease has been confirmed, the Physician shall determine an appropriate course of treatment including patient transfer to a medical facility.

E. Cultures/Laboratory Testing:

1. A Physician ordered culture/laboratory test should be obtained and completed as soon as practical. All test results shall be reported to the Physician and the Infection Control Nurse as soon as the results are obtained.
2. Cultures or other specimens obtained by this facility are tested by a "Contract Laboratory."
3. Completed culture/laboratory reports shall be filed in accordance with established record keeping requirements (i.e., Medical Record, Infection Control Committee, etc.).

F. Reporting of Diseases:

1. A record shall be maintained of all infectious, contagious, or communicable diseases identified within this facility.
2. Diseases that are required to be reported shall be reported to the appropriate Health Department Officials pursuant to State Reporting Guidelines.
3. Data shall be maintained and recorded on established forms approved by this facility.

G. Discharge from Isolation:

1. Patients placed in Isolation shall remain on Isolation until the Infection Control Coordinator, in collaboration with the ICC Chairperson and/or the Director of the Infection Control or the Medical Director, and based on CDC Guidelines for Transmission-Based Precautions recommends the discontinuance of Isolation.

a. Upon recommendation from the Infection Control Coordinator, the Attending Physician shall discontinue Isolation orders in the patient's medical record.

2. Should the patient, or official guardian, request the discharge of the patient from the facility during the time the patient is in Isolation, the Charge/Staff Nurse shall notify the patient's Attending Physician and the Infection Control Nurse of the situation.

3. The Charge/Staff Nurse shall inform the patient, or official guardian, of the potential hazards involved in the early discharge of the patient and shall request that the patient remain in the facility until such time as the Isolation Period has ended.

H. Release of Responsibility:

1. Should the patient, or official guardian, insist upon immediate discharge without the approval of the Attending Physician, the patient, or official guardian, shall be requested to sign a Release Form (Attachment A Release from Hospital Against Medical Advice).

2. Release Forms are maintained at each Nurse's Station and shall be filled out by the Charge/Staff Nurse.

3. Should the patient, or official guardian, refuse to sign the Release Form, such action shall be recorded in the patient's medical record and duly witnessed by a member of the staff.

I. Isolation Rooms/Units:

1. Certain patient rooms on the Units may be designated as Isolation Rooms/Units if the need arises but are otherwise regular patient care rooms.

2. When an Isolation Order has been obtained, the room shall be immediately converted to meet the patient's Isolation Requirements.

3. The room will be designated as having a "closed bed", and no admissions and/or transfers to that room will occur until termination of isolation and cleaning when indicated.

J. Supervision:

1. The Director of Nursing Services, the director of Infection Control or the Infection Control Nurse shall be responsible for ensuring compliance with SNAMHS Policies OF-SP-03 Infection Control Plan and OF-SP-10 Tuberculosis/COVID-19 Exposure Plan when Isolation becomes necessary.

2. The Charge/Staff Nurse of each unit shall be responsible for carrying out Isolation Procedures as directed. This responsibility shall also include supervision of staff and assurance that all staff and visitors follow all

established Isolation Procedures, as well as any Special Instructions that may be issued.

K. Nursing Care in Isolation:

1. All Nursing Care shall be performed as assigned, and as instructed by the Physician, to assure that the patient's proper level of care can be maintained as near normal as possible.
2. Nursing Services, and other support personnel involved, shall follow all established Isolation Procedures, as well as any special precautions that may be issued.

L. Laundry and Linen Services:

1. The Charge/Staff Nurse shall ensure that appropriate Isolation Procedures are followed for the handling and disposing of contaminated linen.
2. A plastic bag shall be placed in the Isolation Room, and soiled linen shall be rolled into a bundle and placed in the bag. Soiled linen shall be handled as little as possible to prevent the spread of infectious diseases.
3. Personnel changing the linen shall wear appropriate PPE (gloves, mask, gown, face shield if needed) To create a barrier between the soiled linen and own clothing.
4. After removing the soiled linen, gloves and used PPE shall be removed and staff must perform hand hygiene. New gloves shall be used when handling clean linen.
5. Bags removed from Isolation Rooms shall be disposed daily.

M. Food Service:

1. The Charge/Staff Nurse shall notify the Dietary Department Supervisor when Isolation Procedures are implemented and when terminated.
2. Patients placed in Isolation shall be served all meals on disposable trays, dishes, and utensils until such time as Isolation Procedures have been terminated, unless otherwise instructed.

N. Disposal of Infectious Material:

1. All disposable articles such as dishes, cups, etc., shall be placed in a plastic bag, located in the room, and disposed of daily. Trash cans shall be lined with disposable plastic bags and disposed of daily. Bags shall be placed in another sealable plastic bag prior to leaving the Isolation Room.
2. Urine, stool, and other liquid excreta shall be flushed down the toilet whenever possible.
3. Hands must be washed thoroughly prior to donning disposable gloves and after disposal of gloves.

O. Quarantines:

1. Should it become necessary to Quarantine a Unit or Units, all Visitation Rights to said Unit(s) shall be suspended until the Quarantine has been lifted, or visitors asked to don appropriate personal protective equipment.
2. Only the Agency Director, at the instruction of the Medical Director, shall have the authority to Quarantine this facility.
3. Only those personnel employed by this facility, our support agencies, and supply vendors will have access to the facility during the Quarantine.

P. Discontinuing Isolation:

1. The Charge/Staff Nurse shall be responsible for notifying Housekeeping/Maintenance when Isolation Procedures have been discontinued.
2. Disinfection and Sanitizing Procedures shall be implemented in accordance with established Procedures outlined in SNAMHS Housekeeping Policies and Procedures.

Q. Patient Care Equipment:

1. Insofar as practical, disposable patient care equipment shall be used during the patient's Isolation Period.
2. Reusable patient care equipment used during the treatment of patients in Isolation shall be thoroughly cleaned, disinfected, and sanitized before being used on another patient.

R. Assignment of Personnel:

1. Prior to personnel being assigned to provide direct patient care to persons placed in Isolation, a risk evaluation shall be conducted by the Director of Nursing Services or designee on such personnel to prevent the spread of infections to themselves, other patients or personnel, and visitors.
2. Any person who may be at risk of exposure to infectious agent(s) as a result of responsibility for the care of a patient shall be informed of that patient's diagnosis or possible diagnosis prior to such person providing the care to the patient.

S. Personal Protective Equipment:

1. Masks:
    a. Masks shall be used to prevent transmission of infectious agents through the air.
    b. Masks shall be used only once and discarded into the appropriate receptacle.

c. Procedures governing the use of masks are outlined in SNAMHS Policies OF-SP-10 Tuberculosis Exposure Plan and OF-SP-18 Respiratory Protection Program

2. Gowns:

a. Gowns shall be used to prevent soiling of clothing when taking care of patients in Isolation when soiling of the clothing with infective material is likely.

b. Gowns shall be worn by all personnel who enter the rooms of patients in Isolation with contagious infections.

c. When gowns are indicated, they shall be used only once and discarded into the appropriate receptacle.

d. Procedures governing the use of gowns are outlined in SNAMHS Standard Precautions (Universal Precautions) Policy #OF-SP-05.

3. Gloves:

a. Gloves shall be worn when it can be reasonably anticipated that the employee may have hand/skin contact with blood, other potentially infectious materials, mucous membranes, non-intact skin, and when handling or touching contaminated items or surfaces.

b. Gloves shall be changed after contact with each patient, discarded into the appropriate receptacle, and hands washed immediately after gloves are removed.

V. REFERENCES:

A. Southern Nevada Adult Mental Health Services Policy OF-SP-05 Standard Precautions (Universal Precautions)

B. Southern Nevada Adult Mental Health Services Policy OF-SP-10 Tuberculosis Exposure Plan.

C. Southern Nevada Adult Mental Health Services Policy OF-SP-18 Respiratory Protection Program

D. Isolation CDC 2016-Search for Isolation CDC 2016-Health 247.com The Joint Commission CAMH Current Edition, Infection Control Chapter

E. https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html, Retrieved April 12, 2023

VI. ATTACHMENTS:

A. OF-SP-04 Transmission-Based Isolation Precautions Release from Hospital Against Medical Advice Attachment A

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY WIDE

SUBJECT: Standard Precautions (Universal Precautions) **NUMBER:** OF-SP-05

EFFECTIVE DATE: 07/2021 **REVIEW DATE:** 07/2023

APPROVED BY: /s/ Susan Lynch, MBA, CPM
Hospital Administrator

SUPERSEDES: Universal Precautions, OF-SP-05, March 2004, 10/06, 01/09; 01/11, 04/13; 10/13; 04/14; 02/16; 03/20

I. PROTOCOL:

Southern Nevada Adult Mental Health Services (SNAMHS) maintains a safe and sanitary environment for employees, patients, visitors, and the public.

II. PURPOSE:

Establishes guidelines for Standard Precautions in order to reduce the risk of transmission of blood borne pathogens and pathogens from moist body substances.

III. DEFINITIONS:

A. A pathogen is defined as a microorganism or substance capable of producing a disease.

B. Blood borne pathogens are any pathogenic microorganism that are present in blood or other potentially infectious material and can infect and cause disease in persons exposed to blood or body fluid/waste containing the pathogen. These pathogens include, but are not limited to Hepatitis B, HIV, and Hepatitis C.

C. Universal Precautions refers to safety measures taken to prevent exposure to blood or other body fluids containing potentially infectious pathogens by presuming all are infectious.

D. Standard Precautions is the CDC infection control guideline, introduced in 1996, which supersedes their guideline for Universal Precautions. Standard Precautions incorporate major features of Universal Precautions into a single set of precautions for use by all health care providers for all patients. Following Standard Precautions requires using control measures whenever there is the possibility of contacting: blood, any body fluids, secretions, excretions (except sweat), non-intact skin, or mucous membranes.

E. Alcohol-based hand rub is an alcohol containing preparation designed for application to the hands for reducing the number of viable microorganisms on the hands. Such preparations usually contain 60% - 95% ethanol or isopropanol.

IV. PROCEDURE:

A. Orientation and In-Service Training

1. All new employees and volunteers will be oriented to and trained on Infection Control Policies and Procedures regarding Standard Precautions.

B. Adherence to hand washing or use of alcohol-based hand rubs has shown to terminate outbreaks in health care facilities, to reduce transmission of antimicrobial resistant organisms, and reduce overall infection rates.

1. Hand washing facilities will be readily accessible to employees.
2. When hand-washing facilities are not available, alcohol-based hand rub will be provided.
3. Hand washing with soap and water is essential when hands are visibly soiled.
4. Employees will wash their hands before and after any single patient physical contact with their hands, use of bathroom, or contact with potentially contaminated materials such as blood, used syringes and needles, secretions, exudates, excreta, sneezing, or coughing.
5. Proper hand washing technique includes thoroughly wetting both hands under tepid running water, spreading soap over all areas of both hands, including fingernails, rubbing all surfaces of both hands together for a total of 15-20 seconds, rinsing and drying hands. If using non-pediolated sinks, the water is to be left running through the entire procedure and the faucet shut off with a paper towel after drying hands.
6. When using an alcohol-based hand rub, apply product to palm of one hand and rub hands together, covering all surfaces of hands and fingers, until hands are dry. Note that the volume needed to reduce the number of bacteria on hands varies by product.

C. All employees shall routinely use appropriate barrier precautions to prevent skin and mucous membrane exposure when contact with blood or other body fluids of any patient as anticipated.

1. **PERSONAL PROTECTIVE EQUIPMENT (PPE)**
   a. PPE will be provided to all employees. Each employee is responsible for knowing where PPE equipment will be kept in the department.
   b. The type of PPE used should be appropriate for the procedure performed and the type of exposure anticipated.

c. PPE available includes gloves, fluid resistant gowns or aprons, masks, and eye protection (or face shields), and resuscitation devices.

D. PPE Usage:

1. Gloves will be worn when it can be reasonably anticipated that the employee may have hand/skin contact with blood, other potentially infectious materials, mucous membranes, non-intact skin, and when touching contaminated items or surfaces.
   a. Disposable gloves will be readily accessible and used.
   b. Gloves will be changed after contact with each patient and hands washed immediately after gloves are removed or changed.
   c. Hands and other skin surfaces shall be washed immediately and thoroughly if contamination with blood or body fluids should occur.
   d. Gloves will be worn whenever an employee has cuts, scratches, or other breaks in the skin.
   e. Employees who have exudative or weeping dermatitis will notify their direct supervisor.
      1. The supervisor will coordinate temporary reassignment with the staffing office and the Infection Control program.
   f. Contaminated gloves will be placed in the infectious waste containers for proper disposal.
   g. Hypoallergenic gloves shall be accessible for those employees who are allergic to the gloves normally provided.
   h. Gloves will be removed by grasping the cuff and pulling off wrong side out.

2. Gowns and other protective body clothing will be worn if soiling of clothing with blood or body fluids are possible depending on the task or procedure being done.
   a. Gowns and other protective body clothing will be considered “appropriate” only if they do not permit blood or other potentially infectious materials to pass through to or reach the employee’s work garments.
   b. If blood or other potentially infectious materials penetrate a garment, the garment will be removed immediately or as soon as possible.
   c. All personal protective equipment (PPE) will be removed and discarded appropriately prior to leaving the work area.

3. Masks and/or eye protection will be worn when necessary to prevent splashing of blood and moist body substances onto the skin or mucous membranes.
   a. Staff shall wear eye protection such as face shields or goggles while on the floor working when there is a known patient to spit at

others. Staff may remove eye protection while at the nurses' station.

E. Precautions for Collection of Laboratory Specimen

1. All specimens of blood and body fluids will be put in a biohazard container with a secure lid to prevent leakage.
2. All persons handling blood and body fluid specimens shall wear gloves. Gloves will be changed, and hands washed after completion of specimen movement.
3. Specimens will be placed in a plastic zip lock bag to prevent leaking during transport.

F. Cleaning, Disinfection, and Decontamination of Blood/Body Fluid Spills.

1. Gloves will be worn while cleaning any spill of blood, body fluid, or other potentially infectious materials.
2. Small spills will be removed by nursing staff, using the provided spill kit on each unit/area. Manufacture instructions are provided with each kit and will be followed.
3. For large spills, nursing will flood the contaminated area with a hospital-approved product if compatible with the surface being decontaminated. Hazardous spill kits are in the medication rooms on all units of the hospital, and in the outpatient clinics. Nursing will notify housekeeping if additional cleaning supplies such as absorbent powder, are needed.
4. After blood, body fluid, or other body waste is removed by nursing, housekeeping will clean and disinfect the area.
5. All soiled disposable towels used to clean the spill will be placed in the provided heavy-duty plastic linen bags, secured, and placed in the soiled linen cart, in the soiled utility room.
6. Nursing staff will notify the Supply Clerk who will pick up the infectious waste container and dispose of it in the biohazard waste room
7. Nursing staff will notify housekeeping for deep cleaning when needed.
8. In the outpatient clinics, when infectious waste is present on the clinic floors, walls, furniture, etc. the contracted cleaning service will be called to clean the clinic site. The supply department monitors the need for infectious waste removal and arranges pick-up.

G. Needles and Syringes

1. All employees will take precautions to prevent injuries caused by needles and sharp instruments.
2. To prevent needle stick injuries, needles will not be recapped, purposely bent, or broken by hand.

3. All disposable needles and syringes and other sharp items such as razors will be placed in a puncture resistant container for disposal.

4. All nurses shall activate the retractable needle or the safety feature on syringes immediately after the time of an injection and prior to placing the used syringe into the puncture resistant container.

H. Linen

Soiled linen will be handled as little as possible. Gloves will be worn to handle linen wet with blood or body fluids. Soiled linen will be bagged in an impervious bag or placed in an unlined container provided for soiled linen.

I. Respiratory Hygiene

Respiratory hygiene shall be encouraged for all patients. This practice should be in use by all healthcare workers and families to reduce the spread of respiratory illnesses.

J. Hand washing/hand hygiene – refer to policy on Hand hygiene OF-SP-22.

K. Blocked Bed/Private Room - consider when patient hygiene is poor or in cases where blood/body fluids cannot be contained.

V. REFERENCES:

A. CDC. *Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007.* 2007; 1-219. Available online at http://www.cdc.gov/hicpac/pdf/isolation/isolation2007.pdf. Updated October 10, 2017.

B. CDC/HICPAC Guideline for Hand Hygiene in the Health Care Settings

C. The Joint Commission Comprehensive Accreditation Manual for Hospitals, Current Edition, Infection Control Chapter.

D. *Infection Prevention Manual for Behavioral health, 4th Edition. Published by APIC Washington, DC, 2014*

VI. ATTACHMENTS: N/A

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY WIDE

SUBJECT: Use of Disposable Gloves During Handling of Foods and Fluids **NUMBER:** OF-SP-06

EFFECTIVE DATE: 08/2021 **REVIEW DATE:** 08/2023

APPROVED BY: /s/ Susan Lynch, MBA, CPM
Hospital Administrator

SUPERSEDES: Agency Policy #720; 05/96; #2; 06/97; 03/01; OF-SP-06; 09/05; 10/06; 01/13; 01/09; 01/11; 04/13; 04/15; 04/17; 06/19

I. PROTOCOL:

It shall be the protocol of Southern Nevada Adult Mental Health Services (SNAMHS) to maintain a safe and sanitary environment for employees, patients, visitors, and the general public.

II. PURPOSE:

The purpose of this protocol is to establish guidelines to prevent the spread of pathogens while serving food and/or fluids to patients, staff, or visitors.

III. DEFINITION:

Pathogen - a microorganism or substance capable of producing a disease.

IV. PROCEDURE:

A. All eating surfaces shall be cleaned, disinfected and/or sanitized per hospital policy prior to serving of meals and snacks.

B. All staff shall wash their hands and exposed portions of their arms with warm water and soap prior to serving food and fluids.

1. Thorough hand washing is done by vigorously rubbing together the surfaces of lathered hands and arms for at least 20 seconds followed by a thorough rinse with clean water.
   a. Use a single-service towel or hot air dryer to dry hands. No special soaps, such as antibacterial soap, are needed.
2. Hand sanitizers may be used following appropriate hand washing, but not in place of hand washing.

C. After hand washing, all staff shall wear disposable gloves during the serving of foods and fluids and while collecting meal trays and related trash.

1. Disposable gloves shall be used for only one task, such as working with ready-to-eat food, or with raw animal food. Disposable gloves shall be used for no other purpose, and discarded when damaged, soiled, when interruptions occur in the operation, or when the task is completed.
2. Always change gloves if the gloves become compromised in any way~~,~~ (i.e., contamination, ripped, or torn).
3. Hands must be washed and dried thoroughly before donning new gloves.

D. All eating surfaces shall again be cleaned, disinfected and/or sanitized per hospital policy after meals and snacks.

E. Staff shall again wash their hands after removing the disposable gloves.

V. REFERENCES:

A. U.S. Food and Drug Administration and Centers for Food Safety and Applied Nutrition Food Code April 2016

B. Center for Disease Control Gloving Procedure

C. Mosby Clinical Nursing Guidelines for Food Handlers

VI. ATTACHMENTS: N/A

DIVISION OF MENTAL HEALTH AND DEVELOPMENTAL SERVICES
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY WIDE

SUBJECT: Airborne Pathogen Exposure Control Plan **NUMBER:** OF-SP-10

EFFECTIVE DATE: 04/2023 **REVIEW DATE:** 04/2025

APPROVED BY: /s/ Susan Lynch, MBA, CPM
SNAMHS Hospital Administrator

SUPERSEDES: OF-SP-10 - 9/04; 12/05; 11/06; 07/08; 01/11; 09/11; 09/12; 02/13; 02/18; 06/19; 03/21

I. PROTOCOL

SNAMHS has adopted and will enforce the latest recommendations of the Centers for Disease Control and Prevention (CDC) regarding prevention of occupational transmission of TB among its employees. The following procedures reflect the CDC guidelines of 2023 Occupational Safety and Health Administration (OSHA) regulations require the agency to provide a written exposure plan that covers the facilities' policies and procedures to prevent transmission of tuberculosis and other airborne transmissible diseases in the workplace. Employees of SNAMHS may have duties in more than one facility, whereby this exposure control plan is designed for all employees of SNAMHS. It will also include any diseases that are spread by airborne route. This policy covers for employees and hospitalized patients.

II. PURPOSE

To minimize employee exposure to, and subsequent infection with, tuberculosis (TB).and other airborne transmissible diseases. This policy establishes a comprehensive approach to control of diseases identified as either requiring "Airborne Precautions".

This program is designed to:

A. Help reduce exposure to airborne transmissible pathogens (ATP).
B. Identify infection control measures for airborne transmissible diseases (ATD)
C. Where feasible, exposure to contaminants will be eliminated by either engineering controls (i.e., general, and local exhaust ventilation, enclosure, or isolation), or substitution of a less hazardous process or material.
D. When effective engineering controls or substitution are not feasible, use of administrative controls such as personal protective respiratory equipment may be required.

III. ABBREVIATIONS

A. BCG: Bacillus Calmette-Guerin

B. HCW: Health-care worker
C. HIV: Human-immunodeficiency virus
D. INH: Isoniazid
E. MDR: Multiple-drug resistant
F. PPD: Purified Protein Derivative
G. TB: Mycobacterium tuberculosis
H. SARS CoV-2: Severe Acute Respiratory Syndrome Coronavirus -2

IV. DEFINITIONS:

A. ***Aerosols*** **-** Aerosols refer to the suspension in air of solid particles (e.g. tuberculosis bacteria)

B. ***Airborne Precautions*** **-** (for known or suspected active tuberculosis) - Airborne Precautions (for known or suspected active tuberculosis) requires the use of administrative, work practice and engineering controls designed to minimize the potential for cross-transmission of M. tuberculosis.

C. ***BCG*** **-** BCG is a live attenuated strain of tubercle bacilli used in some parts of the world to immunize subjects. It provides partial protection against the acquisition of M. tuberculosis and subsequent development of disease.

D. ***SARS CoV-***2- is a strain of Coronavirus that causes COVID-19, a virus that can cause respiratory illness in humans. It enters your body through your mouth, nose or eyes (directly from the airborne droplets or the transfer of the virus from your hands to your face)

E. ***Exposure*** **-** Health care worker exposure is defined as someone that has been in an area where they may have come into contact with a foreign substance called a pathogen(a virus, bacteria, or other tiny organism) that can cause a disease. CDC suggests that there is an increased risk of infection for people who are exposed to the virus being in close contact (within 6 feet for 15 minutes or longer). In the case of COVID-19, the pathogen is a respiratory virus. For TB, spread through the air from one person to another.

F. ***Healthcare Worker (HCW)*** **-** The term HCW refers to all paid and unpaid persons working at SNAMHS who have the potential of exposure to pathogens,, including but not limited to: physicians, nurses, aides, technicians, laboratory, students, part-time personnel, temporary staff not employed by SNAMHS, and persons not directly involved with patients but who have potential occupational exposure to M. tuberculosis and other Airborne transmissible diseases (e.g. dietary, housekeeping, maintenance, clerical, janitorial staff, grounds crews and volunteers). Direct contact is defined as entering a patient's care room and/or conversing with patients.

G. ***Infection Control*** **-** Infection Control refers to infection control and Infection Preventionist (IP) and program

H. ***Measles*** – is a highly contagious virus that is usually characterized by flu like symptoms with rash that spreads all over the body.

I. ***Multidrug Resistant (MDR)*** **-** Isolates of M. tuberculosis will be considered multidrug resistant if they are resistant to Isoniazid and Rifampin.

J. ***Mycobacterium*** **-** Mycobacterium refer to a group of microorganisms. These include M. tuberculosis, and a variety of Non-tuberculosis (NTB) mycobacteria. NTB may cause illness in humans, including pulmonary disease and systemic disease, especially in patients infected with HIV. NTB are acquired from the environment and not via person-to-person spread. Airborne Precautions are NOT required for patients infected with NTB.

K. ***Novel Flu Viruses*** – to differentiate between season flu, and novel flu viruses (e.g. SARS, H1N1, etc.).

L. ***Outbreak Investigation*** **-** Is a set of procedures used to identify the cause responsible for the disease, the people affected, the circumstances and mode of spread of the disease, and other relevant factors involved in propagating the epidemic, and to take effective actions to contain and prevent the spread of the disease. ***PPD*** **-** PPD (purified protein derivative) is an agent used in skin test preparations to aid in determining whether persons have been infected with M. tuberculosis. This agent is injected intradermally at a dose of 0.5 tuberculin units (5 TU). A "positive" reaction indicates tuberculosis infection but does not necessarily imply disease. Skin reactions of a small size may also result from a person's prior exposure to NTB.

M. ***Respiratory Protection*** **-** Respiratory protection refers to use of OSHA approved respirator that is adequate to protect the health of the employee and to reduce the risk of inhaling hazardous airborne particles including infectious agents.

N. ***Tuberculosis Infection*** **-** A person infected with M. tuberculosis as evidenced by a positive PPD but without evidence of active tuberculosis disease.

O. ***Tuberculosis Disease*** - Disease refers to persons with evidence of active disease due to M. tuberculosis. Such evidence includes, but is not limited to, the following: a chest x-ray with evidence of active tuberculosis, a sputum smear with evidence of tuberculosis bacteria, a culture of M. tuberculosis from anybody site and a positive PPD with symptoms of active infection. Such symptoms include, but are not limited to coughing, fever, fatigue, night sweats, unexplained weight loss; (more than ten pounds per month), blood in sputum, shortness of breath and chills.

P. ***Varicella and Herpes Zoster*** – Varicella causes chickenpox, and Herpes Zoster sometimes called Varicella zoster causes shingles.

Q. ***COVID-19*** **–** is a respiratory disease caused by SARS-C0V-2, a coronavirus discovered in 2019. The virus spreads mainly from person to person through

respiratory droplets and small particles produced when an infected person coughs, sneezes, or talks.

R. ***SNAMHS Employee*** - Southern Nevada Adult Mental Health Services employee includes but not limited to inpatient facilities and outpatient services.

S. ***High Risk Populations*** are not evenly distributed in all segments of the U.S. population. Persons who may be at high risk for Airborne Transmissible Diseases:

1. Persons with HIV infection.
2. Close contacts of infectious TB cases (e.g. persons who share the same living environment with confirmed or suspected TB cases).
3. Persons with silicosis, diabetes mellitus, chronic renal failure, gastrectomy, malnourishment, prolonged corticosteroid therapy, leukemia, lymphoma, and other malignancies.
4. Immigrants from countries with high endemic rates of tuberculosis.
5. Migrant farm workers.
6. Persons with a history of a positive PPD.
7. Low-income populations, the homeless, alcoholics, and IV drug users.
8. Current or past correctional inmates.
9. Residents of long-term care facilities (psychiatric and nursing home facilities).
10. Older adults, persons with chronic lung diseases and immunocompromised

T. **Diseases/Pathogens Requiring Airborne Infection Isolation:** The following is a list of airborne diseases and pathogens which are to be considered aerosol transmissible pathogens or diseases for the purpose of this policy.

A. Aerosolize spore-containing powder or other substance that can cause serious human disease, e.g. Anthrax/*Bacillus anthracis*
B. Avian influenza/Avian influenza A viruses (strains capable of causing serious disease in humans)
C. Any patient with active disseminated varicella zoster infection, e.g. chickenpox, or disseminated herpes zoster (shingles), with special attention to ruling out disseminated infection in immunocompromised patients with apparently localized herpes zoster (shingles)
D. Measles (rubeola)/Measles virus
E. Monkeypox/Monkeypox virus
F. Novel or unknown pathogens
G. Severe acute respiratory syndrome (SARS)
H. Smallpox (variola)/Variola virus
I. Tuberculosis (TB)/*Mycobacterium tuberculosis* -- Extrapulmonary, draining lesion; Pulmonary or laryngeal disease, confirmed; Pulmonary or laryngeal disease, suspected
COVID-19

J. Any other disease for which public health guidelines recommend airborne infection isolation

V. ADMINISTRATIVE CONTROLS

A. Assignment of Responsibility
B. Risk Assessment
C. Admissions
D. Prospective Employees
E. Annual Personnel Screening
F. Information and Training
G. Exposure Incidents
H. Documentation of Occupational Exposure

I. ENGINEERING CONTROLS

A. Isolation Rooms

1. Rawson-Neal Hospital is not equipped with negative pressure isolation rooms.
2. Any patients requiring airborne isolation will be immediately triaged (with surgical mask) and transferred to a medical facility.
3. Staff involved in the care of patients suspected or known to have active pulmonary TB or other airborne transmissible diseases must wear proper personal protective equipment (PPE) including NIOSH-certified fit -tested N-95 respiratory, gloves, gown, facial shield if necessary for their personal protection.
4. Potential exposure to other patients or employee will be followed up as described under "Exposure Incidents".
5. Leased spaces occupied by SNAMHS clinics are not equipped with negative pressure isolation rooms, or portable HEPA filtration units.
6. These clinics will rely on SNAMHS respiratory protection program, cough hygiene, and administrative controls for triage of clients suspected of airborne transmissible disease(s).

B. Patient Transport

1. Patients requiring transport while considered infectious with TB or COVID 19/other Airborne transmissible diseases will be provided with a standard surgical mask for the containment of respiratory secretions and to prevent expelling droplet nuclei into the air.

II. RESPONSIBILITY STATEMENT

A. Assignment of Responsibility

1. The Director of Infection Control (DIC) and Infection Preventionist (IP) are responsible for implementation of the Tuberculosis Control Program and development of COVID unit. The Infection Preventionist will be delegated some of the responsibility under the direction of the DIC.

B. Risk Assessment

1. A risk assessment will be conducted initially to assess the facility's risk for transmission of tuberculosis and other ATD, and to direct the TB control measures to be implemented. In addition, retrospective risk assessment will be conducted by the facility at the end of each calendar year.

2. The Infection Control Program will be responsible for the initial and annual risk assessment. It will be completed for the facility as a whole and for individual health care workers as deemed necessary.

3. The evaluation process will include:

   a. Community Prevalence
   b. Case surveillance – number of TB/ or COVID 19 patients admitted and treated and reported by facility.
   c. Analysis of health care worker TST (tuberculin skin test) screening data
   d. Review of TB/COVID 19 patient medical records
   e. Observation of infection control practices
   f. Engineering evaluation

   The data from the risk assessment will be used to determine control measures to be implemented by the facility to prevent the transmission of tuberculosis/ COVID 19. Evaluation of items a-c above can be documented using the risk assessment form included with this policy.

C. Overview of Control Measures

1. The key to preventing nosocomial transmission of TB/COVID 19 is early detection, isolation, and treatment of suspected persons with active TB/COVID 19.

2. As required by the CDC and OSHA, SNAMHS will utilize the use of administrative measures to reduce the risk of exposure to person with suspected TB/ or COVID 19 infection.

3. Admission of a patient with a known communicable, contagious, or infections disease shall be admitted contingent upon the nature of the infectious condition or disease, our capability of providing proper care to the patient, and to adequately safeguard the staff and other patients of the facility from secondary spread of infections.

4. Any patient, when suspected or diagnosed as having any communicable, contagious, or infectious disease, shall be evaluated pursuant to paragraph

2 above and/or placed in respiratory isolation. Limiting group and other communal activities.

5. Unless otherwise instructed by the Medical Director, all patients with communicable diseases, (including suspected tuberculosis) shall be transferred as soon as practical to a facility that can properly treat such diseases.

6. The Infection Control Program will maintain records of the results of all SNAMHS employee's PPD administration.

D. Admissions

1. Based on the TB risk assessment and state regulations, inpatients may be screened on admission for infection with tubercle bacilli. See the form "Immunization and TB Skin Testing Record."

2. If screening is done, it will consist of a TST (Mantoux) using 5 units of PPD injected intradermally.

3. Patients with a history of skin test positivity will be screened by a chest x-ray and a physician's clinical assessment with proper documentation being included in the admission progress notes.

4. Skin testing will employ the two-step procedure. (If the reaction to the first test is less than 10 mm, a second test will be given 1 week after the first one is placed). A positive second test is indicative of a boosted reaction and NOT a new infection. If the second test remains negative, the person is classified as uninfected.

5. For purposes of interpretation, a skin test reaction of > 10 mm induration is generally considered positive. TST reactions of 5mm or more are considered evidence of TB infection in HIV infected persons

6. The results of all skin tests, chest x-rays, sputum exams and treatment for TB infection and/or disease will be documented for each patient.

7. Potential patients who exhibit evidence of active tuberculosis will be deferred from admission until clinical evaluation can be done. Individuals with diagnosed tuberculosis will be admitted to the facility only after effective therapy has been initiated and the patient is no longer deemed infectious and cleared for admission by medical staff.

8. Individuals with confirmed cases of COVID 19 will be Moved to a private room or designated isolation unit and implement isolation precaution as ordered. Patient will remain in isolation until the order has been discontinued.

9. All cases of suspected or confirmed tuberculosis will be reported to the health department. All positive skin tests with no active infection (latent-TB) shall be clinically evaluated on an annual basis for signs and symptoms of TB.

10. All confirmed cases of COVID 19 will be reported to the health department.

11. All negative long-term patients shall be clinically evaluated with repeat annual skin testing with documentation regarding the presence or absence of symptoms consistent with tuberculosis. (See the form: Annual Tuberculosis Assessment for use with all patients.)

12. Repeat skin tests will be provided for TST negative patients after any suspected exposure to a documented case of active tuberculosis. In such an instance, a skin test conversion is defined as an increase of > 10 mm for a person less than 35 years of age or an increase of > 15 mm for a person 35 years of age or older. Following exposure, skin test converters will undergo chest x-ray and clinical evaluation for tuberculosis. If so diagnosed, such patients will be placed on Airborne Infection Isolation precautions (negative pressure, private room with directed outside exhaust) for 7 days following the initiation of effective therapy. If Airborne Infection Isolation precautions cannot be provided in the facility, the patient will be transferred off-site (hospital, home, etc.) until effective therapy has been documented (see 6. above).

13. Upon suspicion of a possible infectious status of person/patient in any area of SNAMHS, it is necessary at the start of the initial patient encounter to screen for potential signs and symptoms of TB. If needed for safety and transmission prevention, persons with positive signs including but not limited to: positive PPD, coughing for more than 3 weeks, night sweats, weight loss, fever, fatigue, coughing up bloody sputum, shortness of breath and chills, is to be moved to a private room designated on each pod, unit or ambulatory area, with instructions for proper cough etiquette. Placement of potentially infectious patient/person without delay to a room limits the number of exposed individuals occupying areas, e.g. examination rooms, common waiting areas, cafeteria, RT rooms etc.

14. On an ongoing basis, the infection control program will maintain records of the results of all PPDS placed for screening purposes (new employees, routine screening of current employees.

15. Patient/client PPD results will be incorporated into the MAR and recorded in their charts. Any abnormal PPD result will be conveyed to the IP.

16. It is the responsibility of the front-line nursing staff to notify the IP and the Internal Medicine physician(s) upon a patient's refusal of PPD testing.

E. Department Responsibility

1. Application of personal respiratory protection in situations of high risk include the disposable N-95 mask or similar agency approved respirators. These respirators will be used by designated front line HCWs treating those persons with suspected infection. Designated staff will be

determined by the Charge Nurse on each unit or in the ambulatory units, the managers of each domain will make the determination.

2. The Infection Preventionist will educate all staff on prevention and spread of tuberculosis and COVID-19 Education will cover topics as suggested by CDC guidelines and OSHA standards.

3. The IP will be responsible for reporting to the Southern Nevada Health District (SNHD).

III. EMPLOYEE HEALTH (Prospective Employees, volunteers, and contracted staff)

A. Screening of New Employees

1. All new employees will undergo evaluation for history of previous PPDs, including any history of positive PPDs. Any presence of signs and symptoms of active TB will be evaluated, using the Tuberculosis Screening Questionnaire.

2. A PPD (Mantoux PPD) will be placed on all new employees unless one of the following is met:
   a. Employee has a documented history of PPD reaction equal or greater than 10 mm in diameter, unless recent exposure to active TB, immunocompromised, etc.
   b. History of treatment for tuberculosis infection or disease.
   c. Documented allergy (e.g. immediate hypersensitivity) to PPD.
   d. Currently being treated with anti-tuberculosis drugs.
   e. Employee can provide documentation of negative TST during the preceding 12 months.

3. A 2-step baseline PPD shall be used for new employees who have not had a documented negative TB skin test result during the preceding 12 months (exception would be an employee with 2 documented negative PPDs within the last 12 months, one being in the last 3-6 months).

4. At initial evaluation, the full-time designated Medical Nurse or the Infection Preventionist will counsel the new employees of the need to report all tuberculosis exposures, and report to the IC department any signs or symptoms consistent with active tuberculosis including but not limited to, cough > 3 weeks, fever, night sweats and unexplained weight loss.

5. New employees with a positive PPD history will be required to have a QuantiFERON TB Gold Blood test at the time of hire. Any positive QuantiFERON Gold results must be followed up with a chest radiograph.

6. PPDs for employees will be administered and read ONLY by the designated Medical Clinic Nurse or designee or the Infection Preventionist. All positive results will be reported to the Infection Preventionist.

7. HCW with positive PPDs will be relieved from work until active disease is ruled out by appropriate screening methods, including chest x-ray and or laboratory. Grounds for removing a HCW from work may include, but not limited to the development of signs or symptoms suggestive of active tuberculosis.
8. Employees will return to work after a chest x-ray screening and the employee is deemed negative for active tuberculosis by a radiologist report.
9. Any employee who is pregnant or nursing shall be required to obtain a written excuse from her physician to exempt her from the PPD testing.
10. The pregnant employee shall be required to complete testing prior to returning to work after delivery.
11. QuantiFERON Gold may be offered in lieu of a PPD placement. This will be determined on an individual case by case basis.

B. Annual Screening of Employees

1. TB surveillance program in accordance with updated CDC guidelines for screening of Health Care Workers:
2. a. Employees with history of negative testing: No further testing or screening is required.
3. b. Asymptomatic employees with history of positive TB testing and who have received treatment : No further testing or screening is required.
4. c. Asymptomatic employees with history of positive TB testing who have not received treatment : will be followed annually by signs/symptoms questionnaire and tracking will be done according to previous signs/symptoms questionnaire on file. These employees will be encouraged to receive prophylactic treatment per CDC recommendations.
5. Per NAC441A.375, an employee with a documented history of a positive PPD (Mantoux) skin test is exempt for screening with skin tests. Existing employees with a positive PPD history will be required to have a baseline chest radiograph that is negative for TB on file. These individuals will need to have a face-to-face evaluation with one of the facility's Internal Medicine Physician's on an annual basis in order to rule out any signs and symptoms and the possibility of active TB. The TB Signs and Symptoms declaration (OF-SP-02 Attachment C/E) must be completed by the employee and signed off by the Internal Medicine Physician. This documentation must be submitted by the employee to the Infection Control Department and the Human Resources Department. Should the Internal Medicine physician decline signing off on the TB Signs and Symptoms form due to the employee reporting the presence of signs or symptoms of TB, a chest radiograph will be ordered to rule out TB Positive PPD (Mantoux) shall be defined as a reaction (induration) greater

than 10 mm in size and must be followed up by a chest x-ray, and/or other studies if needed.

6. Annual TB testing of health care personnel including Employees working at the Rural Clinic Sites (see OF-SP-02, Employee Annual TB surveillance Program) No further testing or screening is required for Employees with history of negative testing or asymptomatic with history of positive TB testing and who have received treatment. Asymptomatic employees with history of positive TB testing who have not received treatment will be followed annually by signs and symptoms questionnaire. Any employees may elect to continue with annual TB screening or request one-time TB screening at any time during his/her employment whenever an employee is concerned about possible exposure to TB.

C. Information and Training:
At the time of initial orientation, all new employees will receive information and training regarding measures to be employed for the prevention and control of healthcare-associated TB. Ongoing education for TB will be included in the annual infection prevention training.

HCWs should be provided annual training on multiple topics to include:

- Nature, extent, and hazards of TB disease in the healthcare setting.
- Reasons for using respirators.
- Environmental controls used to prevent the spread and reduce the concentration of infectious droplet nuclei.
- Reasons for selecting a particular respirator for a given hazard.
- Trainees should be provided resources as an adjunct to the respiratory protection program.
- Opportunities to handle and wear a respirator until they are proficient.
- Educational material for use as references.
- Instructions to refer all respirator problems immediately to the respirator program administrator (infection control and educational training staff).

D. Administration process of PPD (Mantoux) Skin Test

1. Subdural administration of 0.1 ml. dose of PPD into the anterior surface of the forearm after prepped with 70% alcohol solution by the designated full-time Medical Clinic Nurse or the IP.
2. A small bleb shall form after administration of agent.
3. The skin test shall be read by the designated full-time Medical Clinic Nurse or the IP between 48 and 72 hours after the administration.
4. The results will be documented on the Employee’s One or Two Step form and kept in the Infection Preventionist’s office, in the employee’s medical file.

E. Outbreak Investigations

1. Records of all patients from whom M. tuberculosis and other airborne transmissible diseases are isolated will be reviewed by the Infection Preventionist to ascertain that proper infection control procedures were maintained throughout stay. In the event that HCWs or other patients experienced respiratory exposure to an infectious patient or HCW, every attempt will be made to notify exposed HCWs and patients. The Infection Preventionist will notify department heads/supervisors of the potential exposure for their employees. It is the responsibility of the department heads/supervisors to identify and notify potentially exposed employees in the department/units. The Infection Preventionist will notify the patient's physician if the patient was exposed. It will be the responsibility of the exposed patient's primary physician to notify the exposed patient and arrange for appropriate follow-up. If an exposure is acquired in the community, it will be considered the responsibility of Southern Nevada Health District for appropriate follow up.

2. In the event it is difficult to determine those who are potentially exposed (e.g. source case is an employee who works in an open area); a system of evaluating close contacts may be employed. If close contacts reveal evidence of PPD conversion, working in concentric circles, until evidence of transmission is not found. This approach will be the responsibility of the Infection Preventionist.

3. Evaluation of Employees with newly Recognized Positive TB Signs and Symptoms declaration and HCP individual risk assessment a history of possible exposure will be obtained in attempt to determine the potential source of TB exposure.

4. The Infection Preventionist will provide the employee with a chest x-ray authorization form. The employee is to have chest radiograph (within 3 working days). The employee will be counseled and will be referred to the Southern Nevada Health District Tuberculosis Clinic. Employees may return to work after the Infection Preventionist receives a radiograph report of negative indications of active TB.

IV. MANAGEMENT OF PATIENTS WITH SUSPECTED TUBERCULOSIS and COVID-19

A. Recognition of Patients with Potential Tuberculosis and COVID-19

1. A diagnosis of TB should be considered in any patient persistent cough (> 3 weeks duration) or other signs and symptoms of Tuberculosis.

2. A presumptive diagnosis of COVID 19 should be considered when a patient presents with the following signs and symptoms: Fever or chills, Cough, Shortness of breath or difficulty breathing, Fatigue, Muscle or

body aches, Headache, New loss of taste or smell, Sore throat, Congestion or runny nose, Nausea or vomiting, and Diarrhea

3. Healthcare workers should realize that groups at high risk can include the following: HIV infected persons, immigrants from countries with high endemic rates of TB, migrant farm workers, persons who have been in incarcerated, immunocompromised persons, persons with positive PPD tests, persons who have been in contact with persons with active Tuberculosis or the homeless.

4. It will be the responsibility of all departments to monitor inpatient and outpatient clients for signs and symptoms of Active TB during their intake, clinic visits, or hospitalization. Each department will notify their immediate supervisor and infection control for further direction.

B. Patient Care

1. The primary TB risk to HCWs is the undiagnosed or unsuspected patient with infectious TB disease and or COVID 19. A high index of suspicion for TB disease and or COVID 19 and rapid implementation of precautions are essential to prevent and interrupt transmission.

2. In-Patient management of Patients
   a. Suspected TB Disease/ or COVID 19
      i. When a patient with suspected TB or with signs and symptoms congruent with TB are admitted to a SNAMHS inpatient facility, a blocked room will be made available until infectiousness has been ruled out or transfer to another facility is initiated immediately.
      ii. If patient exhibits symptoms or has a temperature greater than 100F, nursing staff will immediately notify medical staff for appropriate isolation procedures, and infection control staff for COVID-19 mitigation.
      iii. Staff entering the patient's room will have a hospital approved and fit-tested respiratory protective mask provided (e.g. disposable N95 mask).
      iv. Staff assigned to the COVID unit will wear PPE while on the unit which consists of disposable N95 mask, gown, face shield and gloves.
      v. Patient will wear a provided surgical mask covering both mouth and nose when not in private room. Nursing will educate the patient on wearing the mask and the importance of compliance. The patient will also be instructed on proper cough etiquette and hand hygiene.
      vi. Nursing staff will educate all patients placed on Respiratory Precautions, emphasizing the need to adhere to the guidelines e.g. masks, and the need for further evaluation.

vii. Instruct patient to cover all coughs and sneezes with a tissue if patient is unable to a wear mask.
viii. Patients with suspected tuberculosis should not ambulate outside the private room for precautionary reasons. Any exceptions to this policy must be approved by the medical physician, treatment team and the Infection Preventionist.

b. Confirmed TB Disease
i. Patients with confirmed TB disease should be promptly transferred to a setting in which the patient can be evaluated and managed properly.
ii. While waiting for transfer, the patient should be masked with a surgical mask and placed in a separate room with the door closed, apart from other patients and not in an open waiting area.
iii. The patient should wear a surgical or procedure mask (if possible) while waiting for transfer, in waiting areas, where others are present, and during transport. The patient should be instructed to keep the mask on and that the mask will need to be changed if it becomes wet.

3. Discontinuation of Precautions
a. For patients with suspected tuberculosis, Respiratory Precautions may be discontinued when a diagnosis other than pulmonary tuberculosis is confirmed and active tuberculosis is no longer considered a diagnosis.
b. Upon transfer to another facility, the patient is to wear surgical mask and is to keep it on for the duration of the trip. They will not return until effective therapy has been documented, and patient is no longer deemed infectious and is given clearance by medical staff.
c. A physician's or Infection Preventionist order is required to initiate and discontinue precautions.

V. MANAGEMENT FOR EARLY IDENTIFICATION OF PATIENTS WITH SUSPECTED TUBERCULOSIS: Out-patient Clinics

A. Patient Check In/Waiting Process

1. Front line personnel (front desk, information, and front door staff) should identify patients/clients with symptoms (see below) which may indicate potential tuberculosis/COVID-19 and immediately notify the charge nurse.

2. Front line personnel should note if there are comments associated with the appointment regarding the patient/client having symptoms/conditions that indicate that the person may have tuberculosis/COVID-19. These patients/clients should be brought to the attention of nursing personnel for further assessment.

3. Front line personnel should offer tissues to all patients/clients with coughs and encourage the person to cover his/her mouth and nose with a tissue when coughing or sneezing. Nursing staff should be notified of persons who are coughing excessively.
4. Patients/clients who have respiratory symptoms and report any of the high-risk situations should be brought immediately to the attention of the nursing staff for further evaluation.
5. Patients with known or suspected active pulmonary TB should be given a surgical mask to wear and placed in a private room.
6. If patient/client leaves the room for any reason, he/she should wear the surgical mask.
   a. The physician will be notified as rapidly as feasible.

B. Medical conditions which may indicate tuberculosis include a cough for more than 3 weeks, especially if any of the following are present:
1. Profound fatigue.
2. Unintentional weight loss.
3. Night sweats.
4. Fevers.
5. Hemoptysis (bloody sputum).
6. Anorexia (loss of appetite).

C. Medical conditions which may indicate COVID 19 include.
1. Fever or chills
2. Cough
3. Shortness of breath or difficulty breathing.
4. Fatigue
5. Muscle or body aches
6. Headache
7. New loss of taste or smell
8. Sore throat
9. Congestion or runny nose
10 Nausea or vomiting
11. Diarrhea

D. Historical facts which increase the risk of pulmonary tuberculosis
1. Exposure to others with active tuberculosis.
2. History of positive skin test (PPD).
3. History of therapy with anti-tuberculosis drugs.
4. HIV infection.
5. Immigrants from countries in Africa, Asia, or South America.
6. Migrant farm workers.
7. Persons who are or have recently been incarcerated.
8. Homeless individuals.

E. Nursing Assessment: Nursing personnel (or physician if nurse is not available) are responsible for evaluating patients who display symptoms or signs of active tuberculosis or are at high risk for active tuberculosis.

1. Nursing personnel should review the medical record of any patient/client at high risk for active pulmonary tuberculosis or COVID 19 to determine if symptoms, which could indicate active tuberculosis or COVID 19, are present.
2. Nursing personnel should immediately assess patients/clients with symptoms suggestive of tuberculosis or COVID 19 when notified by front line personnel. Patients should be removed from the waiting area and placed in an exam room or private room.
3. The patient will be provided with a surgical mask and shown how to wear the mask properly. Also, the patient will be instructed on proper cough etiquette. Inpatient Staff will don a disposable N95 respirator and appropriate PPE.
4. Arrangements should be made to transfer the patient/client as soon as possible e.g. ER, Hospital Infectious Diseases Clinic, or local Health Department as ordered by medical staff.
5. Patient/client is to wear a surgical mask during transfer.

F. Outpatient Patient procedure for placing a PPD on client for placement in programs that require client screening prior to placement and follow-up of positive/conversion PPD.

1. Based on the agency's TB risk assessment and state regulations, patients may be screened on transfer to group homes for infection with tubercle bacilli.
2. PPD skin test on clients does not require a physician's order to be placed and read by a registered nurse.
3. If screening is done, it will consist of a TST (Mantoux) using 1ml tuberculin syringe to administer 0.1ml dose of PPD injected intradermally.
4. Skin testing will employ the two-step procedure. (If the reaction to the first test is less than 10 mm, a second test will be given 1 week (7 days) later). A positive second test is indicative of a boosted reaction and NOT a new infection. If the second test remains negative, the person is classified as uninfected.
5. All cases of suspected or confirmed tuberculosis will be reported to the health department.
6. Outpatient clinics will refer clientele to the Southern Nevada Health District for follow-up of PPD positives or conversions.
    a. The TB Clinic at SNHD requires that when clients are referred due to a positive PPD that they come with a chest x-ray already

performed. The chest x-ray must be recent and performed within the last 60 days. **Our clients will require a medical staff's order/requisition to get the chest radiograph done**.

b. When the client returns from the visit to the TB clinic at the health district, a review and documentation of what the TB clinic has done as follow up will be entered in the client's chart.

VI. REFERENCES:

A. APIC Text Association for Professional in Infection Control and Epidemiology info @ apic.org Published: February 25, 2022 Chapter 2

B. Infection Prevention Manual for Behavioral Health, 4th Edition, Published by APIC, Washington, DC, 2014 Chapter 6

C. SNAMHS Protocol OF-SP-10 Current Employee's Annual PPD (Mantoux) skin testing and chest x-ray number.

D. SNAMHS Protocol OF-SP-03 Infection Control General Policies, number.

E. Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC, 2019

F. Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC, 2019

G. SNAMHS Protocol OF-SP-33 COVID_19 Safety Protocol

H. SNAMHS Protocol OF-SP-02 Prospective Employee Health Screening and Standing Orders

I. CDC COVID-19, reviewed December 19, 2022

J. CDC PPE, updated April 9, 2021

VII. ATTACHMENTS:

A. OF-SP-10 Airborne Pathogen Exposure Control Plan Attachment A
B. OF-SP-10 Airborne Pathogen Exposure Control Plan Attachment B
C. OF-SP-10 Airborne Pathogen Exposure Control Plan Attachment C
D. OF-SP-10 Airborne Pathogen Exposure Control Plan Attachment D
E. OF-SP-10 Airborne Pathogen Exposure Control Plan Attachment E

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY WIDE

SUBJECT: Infectious Waste Management **NUMBER:** OF-SP-13

EFFECTIVE DATE: 04/2023 **REVIEW DATE:** 04/2025

APPROVED BY: /s/Susan Lynch, MBA, CPM
Hospital Administrator

SUPERSEDES: OF-SP-13 dated 04/13; 01/11; 04/17; 12/17; 01/18; 01/19; 04/21

I. PURPOSE:

To decrease the potential of exposure to hazardous waste by appropriate management and disposal.

II. PROTOCOL:

A. DEFINITION OF INFECTIOUS (BIOMEDICAL/REGULATED) WASTE

1. OSHA has defined regulated waste to include:
   a. Blood and blood products
   b. Pathological waste
   c. Microbiological waste
   d. Contaminated sharps (e.g. needles, lancets, scalpel blades)

B. NEEDLES AND SHARPS

1. Sharps will be placed directly into impervious, rigid, leak-proof, and puncture-resistant containers to eliminate the hazard of physical injury. The containers will be appropriately marked with the bio-hazard symbol. Sharps receptacles should be placed at eye-level to personnel or at a locale allowing for easy access and visualization.
2. Sharps containers will not be overfilled. They should be replaced when ¾ full. When full, the Charge Nurse or designated staff member will be responsible to see that the containers are removed from the use area.
3. Used needles will not be recapped, purposely bent, or broken by hand, removed from disposable syringes, or otherwise manipulated by hand. Safer sharps devices will be used whenever commercially available as a substitute for a specific non-safety-engineered device.

C. BLOOD AND BLOOD PRODUCTS

1. If blood is collected in a tube and then needs to be discarded, it may be place in the tube in the needle disposal container to be disposed of with infectious waste.
2. Bloody fluids, e.g. bloody urine, may be discarded by carefully pouring it into the sanitary sewer. Appropriate personal protective equipment must be worn to prevent exposure to splashing/aerosolized liquids.

D. **LABELING (BIOMEDICAL/REGULATED)**

1. All containers must have affixed a universal biohazard label. The outside contractor must also affix the address and registration number to the outside of containers.

E. **STORAGE OF INFECTIOUS (BIOMEDICAL/REGULATED) WASTE**

1. Storage shall be in a manner and location which affords protection from animals, insects, and weather conditions; and which minimizes exposure to the public.
2. Licensed and contracted medical waste removal services will schedule pickups at least once per week, and more often if necessary**.**

F. **OTHER WASTES (NON-REGULATED)**

1. Fluid filled containers, e.g. Foley bags, will be emptied into the sewer prior to disposal of the container in the trash in the soiled utility room.
2. Patient care items (e.g., Foley bags) will not be discarded in the patient's room due to potential contamination and for aesthetic purposes.
3. Dressings will be bagged at the bedside and discarded in the soiled utility room trash can. Dressings are not considered infectious wasted unless they are soaked and dripping wet with blood. Otherwise, they can be contained in a regular, impervious trash bag and discarded with regular trash.
4. Final disposal of waste will be in accordance with local, State, and federal regulations by the contracted medical waste hauler. Facilities contracts with a waste disposal company to collect, transport, and dispose of the waste.

III. REFERENCES:

A. OSHA Hazardous Waste Management https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.120

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY WIDE

SUBJECT: Exposure Control Plan OSHA Bloodborne Pathogens **NUMBER:** OF-SP-17

EFFECTIVE DATE: 08/2021 **REVIEW DATE:** 08/2023

APPROVED BY: /s/ Susan Lynch, MBA, CPM
Hospital Administrator

SUPERSEDES: OF-SP-17 dated 11/07; 01/08; 03/10; 01/11; 04/13; 04/17; 04/18; 05/20

PROTOCOL:

The Southern Nevada Adult Mental Health Services Agency (SNAMHS) is committed to providing a safe and healthy work environment. In pursuit of this endeavor, the following exposure control plan (ECP) is provided to eliminate or minimize occupational exposure to blood borne pathogens in accordance with OSHA standard 29 CFR 1910.1030, "Occupational Exposure to Blood borne Pathogens." The sections which are not applicable to SNAMHS are not included.

The ECP is a key document to assist our facility in implementing and ensuring compliance with the standard, thereby protecting our employees. This ECP includes:

A. Determination of employee exposure

B. Implementation of various methods of exposure control
   1. Standard precautions
   2. Engineering and work practice controls
   3. Personal protective equipment
   4. Housekeeping

C. Hepatitis B vaccination

D. Post-exposure evaluation and follow-up

E. Communication of hazards to employees and training

F. Recordkeeping

G. Procedures for evaluating circumstances surrounding an exposure incident

H. Hepatitis B Infected Healthcare Providers

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

II. PURPOSE:

This standard applies to all occupational exposure to blood/body fluids or other potentially infectious materials as defined below and to assure that exposures are managed in such a manner so as to prevent unnecessary trauma to patients, agency staff and involved others

III. DEFINITIONS:

A. **Blood** – means human blood; human blood components and products made from human blood.

B. **Blood borne Pathogens** – means pathogenic microorganisms that may be present in human blood and can cause disease in humans. These pathogens include, but are not limited to: Hepatitis B virus (HBV), Hepatitis C virus (HCV) and Human Immunodeficiency Virus (HIV).

C. **Clinical Laboratory** – means a workplace where diagnostic or other screening procedures are performed on blood or other potentially infectious materials.

D. **Contaminated** – Means the presence or reasonably anticipated presence of pathogens in blood or any potentially infectious materials on an item or surface.

E. **Contaminated laundry** – means laundry which has been soiled with blood or other potentially infectious materials or may contain sharps.

F. **Contaminated Sharps –** means any contaminated object that can penetrate the skin including, but not limited to: needles, scalpels, broken glass, broken capillary tubes and lancets.

G. **Decontamination –** means the use of physical or chemical means to remove, inactivate, or destroy blood borne pathogens in a surface or item to the point where they are no longer capable of transmitting infectious particles and the surface or item is rendered safe for handling, use or disposal.

H. **Engineering Controls -** means controls (e.g., sharps disposal container, self-sheathing needles) that isolate, remove or minimize the blood borne pathogens hazard from the workplace.

I. **Exposure Control Plan (ECP)** – means the plan put in place to reduce exposure to infectious pathogens in the workplace.

J. **Exposure Incident** – means a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that result from the performance of an employee's duties.

K. **Hand Washing Facilities** – means facility providing an adequate supply of running water, soap and single use towels or hot air drying machine. Facility approved alcohol-based hand sanitizers are considered as effective as washing hands with soap and water when hands are not visibly soiled.

L. **Occupational Exposure** – means reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee's duties.

M. **Other Potentially Infectious Materials (OPIM)**

1. The following human body fluids: semen, vaginal secretions, cerebrospinal fluids, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluids, synovial fluid, amniotic fluid, saliva in dental procedures, any bodily fluid that is visibly contaminated with blood and all body fluids in situations where it is difficult or impossible to differentiate between body fluids.
2. Any unfixed tissue or organ (other than intact skin) from a human (living **or dead).**

N. **Parenteral** – means piercing mucous membranes or the skin barrier through such events as needle sticks, human bites, cuts and/or abrasions.

O. **Personal Protective Equipment** – means specialized clothing or equipment worn by the employee for protection against a hazard. General work clothes (e.g., uniforms, pants, shirts, or blouses) not intended to function as protection against a hazard, are not considered to be personal protective equipment. PPE equipment includes but not limited to: masks, face shields, gloves, gowns, protective head cover, shoe covers.

P. **Regulated Waste** – means liquid or semi-liquid blood or other potentially infectious materials; contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid state if compressed; items that are caked with dried blood or other potentially infectious materials and are capable of releasing these materials during handling, contaminated sharps and pathological and microbiological wastes containing blood or other potential infectious materials.

Q. **Sharps with Engineered Sharps Injury Protections** - means a non-needle sharp or a needle device used for withdrawing body fluids, accessing a vein or artery, or administering medications or other fluids with a built-in safety feature or mechanism that effectively reduces the risk of an exposure incident.

R. **Source individual** – means any individual, living or dead, whose blood or other potentially infectious materials may be a source of occupational exposure to the employee. Examples include, but are not limited to: hospital and clinical patients and human remains.

S. **Sterilize** – means the use of a physical or chemical procedure to destroy all microbial life including highly resistant bacterial endospores.

T. **Standard Precautions** – is the benchmark for infection control. Standard Precautions mandate that all human blood and certain body fluids are treated as if they are infectious for HIV, HBV, HCV and other blood borne pathogens.

U. **Supervisor** – for the purpose of this policy supervisor is defined as the Nurse III or designee on each inpatient unit and shift, outpatient med clinic or the Clinic Director or designee.

V. **Universal Precautions** – is an approach to infection control. According to the concept of Universal Precautions, all human blood and certain human body fluids are treated as if known to be infectious for HIV, HBV and other blood borne pathogens.

W. **Work Practice Controls** – means controls that reduce the likelihood of exposure by altering the manner in which a task is performed (e.g. prohibiting recapping of needles by a two-handed technique).

IV. PROGRAM ADMINISTRATION

The Infection Preventionist is responsible for the implementation of the ECP. *The Infection Preventionist* will maintain, review, and update the ECP at least annually, and whenever necessary to include new or modified tasks and procedures.

- Contact location/phone number:
- IC Preventionist 702-486-7122

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.

The supplies department 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 supplies department shall ensure that adequate supplies of the aforementioned equipment are available in the appropriate sizes.

- Contact location/phone number: Supplies Department 702-486-0672

Infection Preventionist will be responsible for ensuring that all medical actions required are performed and that appropriate employee health and OSHA records are maintained.

- Contact location/phone number: Infection Control Program 702-486-7122/AAII 702-486-6875.

Training/Education Department will be responsible for training, documentation of training, and making the written ECP available to employees, OSHA, and NIOSH representatives.

- Contact location/phone number: Curtis Edwards 702-486-9663

V. EMPLOYEE EXPOSURE DETERMINATION

The following is a list of all job classifications at our establishment in which **all** employees have occupational exposure:

A. Southern Nevada Adult Mental Health Services (SNAMHS) has employees with potential risk to occupational exposure and therefore a written Exposure Control Plan designed to eliminate or minimize employee exposure. Employees, volunteers and visitors are covered under this exposure plan. Those employees at risk for exposure include but not limited to are:

B. All non-clerical health services employees;

1. Medical Doctors, Psychiatrists, Nurse Practitioners, Medical Assistants, Psychologists)
2. Nursing staff; (e.g. nurses (R.N. and L.P.N.), Mental Health Techs, CNAs)
3. Pharmacy staff
4. Laboratory staff
5. Dietary (e.g. kitchen staff, dietician)
6. Social Services staff
7. Housekeeping/custodial personnel including supervisors
8. First Response personnel
9. Sports and recreation personnel

C. Job titles that do not typically involve exposure to blood, body fluids, or other infectious material but may require interaction and contact with blood borne pathogens include but are not limited to:

1. SNAMHS security personnel
2. Maintenance personal

D. All other job titles, where exposure to blood, body fluids or other infectious materials are not required for employment can include but not limited to; (However; OSHA requires all staff to complete a Blood borne Pathogen training annually):

1. Education staff
2. Clerical personnel

E. Other staff who may provide services for inpatients or outpatients may request review of their duties for inclusion on this list.

F. This exposure determination shall be made without regard to the use of PPE.

G. The Exposure Control plan shall contain at least the following elements.

1. The exposure determination as listed section IV, Item A.

2. The schedule and method of implementation. (E.g. Methods of Compliance, Hepatitis B Vaccination and Post-Exposure Evaluation and Follow-up, Communication of Hazards to Employees and Recordkeeping.

3. The procedure for the evaluation of circumstances surrounding the exposure incident.

H. The agency shall ensure that a copy of the Exposure Control Plan is accessible to employees by placement in the SNAMHS policy and procedure manual (through the SNAMHS server) and shall be considered by SNAMHS to satisfy the requirements in accordance with 29 CFR 1910.1020(e).

I. The exposure control plan shall be reviewed and updated at least annually and whenever necessary to reflect new or modified tasks and procedures which affect occupational exposure and to reflect new or revised employee positions with occupational exposure.

J. Non-managerial employees responsible for direct patient care who are potentially exposed to injuries from contaminated sharps shall be solicited for their input in the identification, evaluation and selection of effective engineering and work practice controls when feasible.

K. The Exposure Control Plan shall be made available to OSHA upon request for examination and copying.

L. Any employee who has a desire to obtain a copy of the original standard may do so from the Infection Preventionist.

VI. EXPOSURE LOG

A. An exposure log shall be kept on each inpatient unit, in all medication clinics and in urgent care areas and in the laboratory.

B. All employees who experience an exposure shall complete the log immediately**.**

1. If an employee is unable to complete the log, the supervisor shall complete the log immediately. The log is to be completed in its entirety with no blanks.

2. Examples of exposure include, but are not limited to: needle sticks, human bite, blood ingestion, open wound contamination, eye splash, injury from razor, scalpel or other sharp instruments.

3. The Infection Preventionist is to be contacted immediately when an exposure occurs.

C. The supervisor shall route all logs monthly (blank logs, "no exposure"~~)~~ are to be routed as evidence of zero (0) exposures) to the Infection Control Office monthly by the fifth (5^{th}) working day of the following month.

D. For all exposures, staff shall follow policies **OF-PI-04*, Internal incident and/or accident Reports and* OF-MHR-08*, Workers Comp Injuries and Early Return to Work Program***. The supervisor shall ensure that the **C-1 form*, Notice of Personal Injury is*** completed and routed to Human Resources.

E. The Infection Preventionist will follow up on all needle stick, blood or body fluid exposures via the protocol. **(**See Attachments, B and C).

VII. METHODS OF COMPLIANCE

A. Standard Precautions

1. Standard Precautions apply to blood; all body fluids, secretions and excretions except sweat, regardless of whether they contain visible blood, non-intact skin; and mucous membranes.

2. Shall be preserved 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.

B. Engineering and Work Practice Controls

1. Engineering and work practice controls shall be used to eliminate or minimize employee exposure. Where occupational exposure remains after institutions of these controls, personal protective equipment shall be used.

2. Engineering controls shall be examined and maintained or replaced on a regular schedule to ensure their effectiveness.

3. The agency shall provide hand washing facilities which are readily available to employees.

4. When provision of hand washing facilities is not feasible, the agency shall provide an appropriate antiseptic hand cleanser.

5. The agency shall ensure that employees wash their hands immediately or as soon as feasible after removal of gloves or other personal protective equipment.

6. The agency shall ensure that employees wash their hands and any other skin areas 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 other potentially infectious materials.

7. Contaminated needles and other contaminated sharps shall not be bent, recapped or removed. Shearing or breaking of contaminated needles is prohibited.

8. ***Immediately after use, contaminated reusable sharps shall be placed in appropriate containers until properly reprocessed. These containers shall be:***

9. ***Puncture resistant;***

10. ***Labeled or color-coded in accordance with these regulations;***
    a. Leak proof on the sides and bottom; and
    b. Not constructed so as to require employees to reach by hand into the containers where these sharps have been placed,
    c. Razors and needles will be contained in separate containers.
    d. Used razors shall be place in containers and stored in the soiled utility room until approved bio waste disposal.
    e. Sharps disposal containers are inspected and maintained or replaced by supply department and/or housekeeping whenever necessary to prevent overfilling.

11. Eating, drinking, smoking, applying cosmetics or lip balm and handling contact lenses are prohibited in work areas where there is a reasonable likelihood of occupational exposure.

12. Closed water bottles may be used at the nurse's desk per policy **VI-01; *Employees Duties and Responsibilities.***

13. All procedures involving blood or other potentially infectious materials shall be performed in such a way as to minimize splashing, spraying, splattering and generation of droplets of these substances.

14. Mouth pipetting/suctioning of blood or other potentially infectious materials is prohibited.

15. Specimens of blood or other potentially infectious materials shall be placed in a container which prevents leakage during collection, handling, processing, storage, transport and shipping.
    a. The container for storage, transport and shipping shall be labeled or color-coded according to this policy and closed prior to being stored, transported or shipped.
    b. If outside contamination of the primary container occurs, the primary container shall be placed within a second container which prevents leakage during handling, processing, storage, transport or shipping and is labeled or color-coded according to this policy.
    c. If the specimen could puncture the primary container, the primary container shall be placed within a secondary container which is puncture-resistant in addition to the above characteristics.

16. Equipment which may become contaminated with blood or other potentially infectious materials shall be examined prior to servicing or shipping and shall be decontaminated as necessary, unless the agency can

demonstrate that decontamination of such equipment or portions of such equipment is not feasible.

a. A readily observable label in accordance with this policy shall be attached to the equipment stating which portions remain contaminated.
b. The agency shall ensure that this information is conveyed to all affected employees, the servicing representative, and/or the manufacturer as appropriate prior to handling, servicing or shipping so that appropriate precautions will be taken.

C. Personal Protective Equipment – P.P.E.

1. When there is a risk of occupational exposure, the agency shall provide at no cost to the employee appropriate personal protective equipment such as but not limited to gloves, gowns, laboratory coats, face shields or masks, eye protection, mouthpieces, resuscitation equipment, pocket masks or other ventilation devices. Personal protective equipment will be considered "appropriate" only if it does not permit blood or other potentially infectious materials to pass through to or reach the employee's work clothes, undergarments, skin, eyes, mouth or other mucous membranes under normal conditions of use and for the duration of time which the protective equipment will be used.
2. Employees must use appropriate P.P.E. unless the employee temporarily and briefly declines to use P.P.E. when under rare and extraordinary circumstances, it is in the employee's professional judgment that in the specific instances its use would have prevented the delivery of health care or would have posed an increased hazard to the safety of the worker or co-worker.
3. Accessibility: PPE is located on each unit in the nursing station and may be obtained through the supplies department.
4. The agency shall ensure that appropriate P.P.E. in the appropriate sizes is readily accessible at the worksite or is issued to employees. Hypo-allergenic gloves, glove liners, powder less gloves or other similar alternatives shall be readily accessible to those employees who are allergic to the gloves normally provided.
5. Cleaning, Laundering and Disposal: The agency shall clean, launder, and dispose of required P.P.E. equipment.
6. Repair and Replacement: The agency shall repair and replace P.P.E. as needed to maintain it effectiveness at no cost to the employee.
7. Contaminated Garments: If a garment is penetrated by blood or other potentially infectious materials, the garment shall be removed immediately or as soon as feasible.
8. All personal protective equipment shall be removed prior to leaving the work area.

9. When personal protective equipment is removed, it shall be placed in an appropriately designated area or container for storage, washing, decontamination or disposal.

10. Gloves shall be worn when it can be reasonably anticipated that the employee may have hand contact with blood, other potentially infectious materials, mucous membranes and non –intact skin when performing certain vascular access procedures; and when handling or touching contaminated items or surfaces.
    a. Disposable (single use) gloves such as surgical or examination gloves shall be replaced as soon as practical when contaminated or as soon as feasible if they are torn, punctured or when their ability to function as a barrier is compromised.
    b. Single use gloves may not be re-used, cleaned or decontaminated.
    c. Utility gloves may be decontaminated for re-use if the integrity of the glove is not compromised. However, they must be discarded if they are cracked, peeling, torn, punctured, or exhibits other signs of deterioration or when their ability to function as a barrier is compromised.

11. Masks, eye protection and face shields: Masks in combination with eye protection devices, such as goggles or glasses with solid side shields, or chin length face shields, shall be worn whenever slashes, spray, splatter or droplets of blood or other potentially infectious materials may be generated and eye, nose, or mouth contamination can be reasonably anticipated.

12. Gowns, Aprons and Other protective Body Clothing: Appropriate protective clothing such as, but not limited to: gowns, aprons, lab coats, clinic jackets, or similar outer garments shall be worn in occupational exposure situations. The type and characteristics will depend upon the task and degree of exposure anticipated.

D. Housekeeping

1. SNAMHS shall ensure that the worksites are maintained in a clean and sanitary condition. There shall be appropriate written schedules for cleaning and method of decontamination based upon the location within the agency, type of surface to be cleaned, type of soil present, and tasks or procedures being performed in those areas.

2. All equipment and environmental and working surfaces shall be cleaned and decontaminated after contact with blood or other potentially infectious materials.
    a. Contaminated work surfaces shall be decontaminated with an appropriate disinfectant after completion of procedures; immediately or as soon as feasible when surfaces are overtly contaminated or after any spill of blood or other potentially

infectious materials/ and at the end of the work shift if the subsurface may have become contaminated since the last cleaning.

b. Protective coverings, such as plastic wrap, aluminum foil, or imperviously backed absorbent paper used to cover equipment and environmental surfaces, shall be removed and replaced as soon as feasible when they become overtly contaminated or at the end of the work shift if they may have been contaminated during the shift.

c. All bins, pails, cons and similar receptacles intended for reuse which have a reasonable likelihood for becoming contaminated with blood or other potentially infectious materials shall be inspected and decontaminated on a regularly scheduled basis and cleaned and decontaminated immediately or as soon as feasible upon visible contamination.

d. Broken glassware which may be contaminated shall not be picked up directly with the hands. It shall be cleaned up using mechanical means such as a brush and dust pan, tongs or forceps.

E. Regulated Waste

1. Contaminated sharps discarding and containment

a. Contaminated sharps shall be discarded immediately or as soon as feasible in containers that are:

i. Closable;
ii. Puncture resistant;
iii. Leak proof on sides and bottom;
iv. Labeled or color-coded in accordance with section VI.

b. During use, containers for contaminated sharps shall be:

i. Easily accessible to personnel and located as close as is feasible to the immediate area where sharps are used or can be reasonably anticipated to be found (e.g. laundries).
ii. Maintained upright throughout use; and replaced routinely and not be allowed to overfill (e.g. ¾ full).

c. When moving containers of contaminated sharps from the area of use the containers shall be:

i. Closed immediately prior to removal or replacement of prevent spillage or protrusion of contents during handling, storage, transport or shipping.
ii. Placed in a secondary container if leakage is possible. The second container shall be:
(1) Closable;
(2) Puncture resistant;
(3) Leak proof on sides and bottom;
(4) Labeled or color-coded in accordance with section VI.

d. During use, containers for contaminated sharps shall be:

i. Easily accessible to personnel and located as close as is feasible to the immediate area where sharps are used or can be reasonably anticipated to be found (e.g. laundries).
ii. Maintained upright throughout use; and
iii. Replaced routinely and not be allowed to overfill (e.g. ¾ full).

e. When moving containers of contaminated sharps from the area of use the containers shall be:
f. Closed immediately prior to removal or replacement of prevent spillage or protrusion of contents during handling, storage, transport or shipping.
g. Placed in a secondary container if leakage is possible. The second container shall be:
i. Closable;
ii. Constructed to contain all contents and prevent leakage during handling, storage, transport or shipping; and:
iii. Labeled or color-coded as stated in section VI;
iv. Closed prior to removal to prevent spillage or protrusion of contents during handling, storage, transport or shipping.
v. Reusable container shall not be opened, emptied or cleaned manually, or in any other manner, which would expose employees to risk of percutaneous injury.
vi. Disposal of all regulated waste shall in accordance with applicable regulations of the United States, States and Territories, and political subdivision of states and territories.

F. Laundry

1. Contaminated laundry shall be handled as little as possible with a minimum of agitation.
a. Contaminated laundry shall be bagged or containerized at the location where it was used and shall not be sorted or rinsed in the location of use.
b. Contaminated laundry shall be placed and transported in bags or containers labeled or color-coded in accordance with section VI. When a facility uses Standard Precautions in handling of all soiled laundry, alternative labeling, or color-coding is sufficient if it permits all employees to recognize the containers as requiring compliance with Standard Precautions.
c. Whenever contaminated laundry is wet and presents a reasonable likelihood of soak-through of or leakage from the bag or container, the laundry shall be placed in bags or containers which prevent soak-through and/or leakage of fluids to the exterior.

G. Hepatitis B Vaccination and Post-Exposure Evaluation and Follow-up

1. General

a. The agency (SNAMHS) shall make available the Hepatitis B Vaccine and vaccination series to all employees who have occupational exposure and post-exposure evaluation and follow-up to all employees who have had an exposure incident.
b. SNAMHS shall ensure that medical evaluations and procedures including Hepatitis B vaccine and vaccination series and post-exposure evaluation and follow-up, including prophylaxis are:
    i. Made available at no cost to the employee;
    ii. Made available to the employee at a reasonable time and place;
    iii. Performed by or under the supervision of another licensed healthcare professional; and
    iv. Provided according to recommendations of the U.S. Public Health Service current at the time these evaluations and procedures take place, except as specified.
c. The agency shall ensure that all laboratory tests are conducted by an accredited laboratory at no cost to the employee.

H. Hepatitis B Vaccination

1. Hepatitis B Vaccination shall be made available after the employee has received the training required in Section VIII and within ten (10) working days of initial assignment to all employees who have occupational exposure unless the employee has previously received the complete Hepatitis B vaccination series, antibody testing has revealed that the employee is immune, or the vaccine is contraindicated for medical reasons.
2. The agency shall not make participation in a prescreening program a prerequisite for receiving Hepatitis B vaccination.
3. If the employee initially declines the Hepatitis B vaccination but at a later date while still covered under the policy decides to accept the vaccination, the employer shall make available Hepatitis B vaccination at that time.
4. The agency shall assure that employees who decline to accept the Hepatitis B vaccination series offered by the hospital; sign the declination on the Hepatitis B form provided to each employee at orientation.

I. Post-Exposure Evaluation and Follow-Up

1. Should an exposure incident occur, contact your supervisor. An immediately available confidential medical evaluation and follow-up will be conducted by a licensed health care professional.
2. Following a report of an exposure incident, the agency shall make immediately available to the exposed employee a confidential medical evaluation and follow-up, including at least the following elements;
    a. Documentation of the routes of exposure, and the circumstances under which the exposure incident occurred;

b. Identification and documentation of the source individual unless the agency can establish that identification is infeasible or prohibited by state or local law;
   i. The source individual's blood shall be tested as soon as feasible and after consent is obtained in order to determine viral hepatitis and HIV infectivity. If consent is not obtained, the agency shall establish that legally required consent not be obtained. When the source individual's consent is not required by law, the source individual's blood, if available, shall be tested and results documented.
   ii. When the source individual is already known to be infected with viral hepatitis or HIV, testing for the source individual's known viral hepatitis or HIV status need not be repeated.
   iii. Results of the source individual's testing shall be made available to the exposed employee, and the employee shall be informed of applicable laws and regulations concerning disclosure of the identity and infectious status of the source individual.

J. Collection and Testing of Blood for Viral Hepatitis and/or HIV Serological Status

1. The exposed employee shall be referred to an outside provider for follow-up per Section V.
   a. The exposed employee's blood shall be collected as soon as feasible and tested after consent is obtained.
   b. If the employee consents to baseline collection, but does not give consent at that time for HIV serologic testing, the sample shall be preserved for at least 90 days. If, within 90 days of the exposure incident, the employee elects to have the baseline sample tested, such testing shall be done as soon as feasible.
2. Post-Exposure prophylaxis, when medically indicated as recommended by the local Public Health Service;
3. Counseling; and
4. Evaluation of reported illnesses.

K. Information Provided to the Healthcare Professional

1. The agency shall ensure that the healthcare professional responsible for the employee's Hepatitis B vaccination is provided with a copy of this regulation.
2. The agency shall ensure that the healthcare professional evaluation of employee after an exposure incident is provided the following information:
   a. A copy of this regulation;

b. A description of the exposed employee's duties as they relate to the exposure incident;
c. Documentation of the route(s) of exposure and circumstances under which exposure occurred;
d. Results of the source individual's blood testing, if available; and
e. All medical records relevant to the appropriate treatment of the employee including vaccination status which are the employer's responsibility to maintain.

L. Healthcare Professional's Written Opinion

1. The agency (SNAMHS) shall obtain and provide the employee with a copy of the evaluating healthcare professional's written opinion within fifteen (15) days of the completion of the evaluation.
   a. The healthcare professional's written opinion for Hepatitis B vaccination shall be limited to whether Hepatitis B vaccination is indicated for an employee, and if the employee has received such vaccination.
   b. The Healthcare professional's written opinion for post-exposure evaluation and follow-up shall be limited to the following information:
      i. That the employee has been informed of the results of the evaluation; and
      ii. That the employee has been told about any medical conditions resulting from exposure to blood or other potentially infectious materials which require further evaluation or treatment.

M. **PROCEDURES FOR EVALUATING THE CIRCUMSTANCES SURROUNDING AN EXPOSURE INCIDENT**

1. The ICP/DON and/or Medical Director will review circumstances of all exposure incidents to determine:
   a. engineering controls in use at the time
   b. work practices followed
   c. a description of the device being used (including type and brand)
   d. protective equipment or clothing that was used at the time of the exposure incident *(gloves, eye shields, etc.)*
   e. location of the incident (*day room, patient room, etc.)*
   f. procedure being performed when the incident occurred
   g. employee's training
   h. Supervisors will record all percutaneous injuries from the contaminated sharps in the Sharps Injury Log.
   i. If it is determined that revisions need to be made, the ICP, DON and/or Medical Director 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.)

VIII. LABELS

A. Labels

1. 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, except as provided in section VII A. 5, 6, and 7.

2. Labels required by this section shall include the following legend:

BIOHAZARD

3. These labels shall be fluorescent orange or orange-red or predominantly so, with lettering and symbols in contrasting color.

4. Labels shall be affixed as close as feasible to the containers by string, wire, adhesive, or other method that prevents their loss or unintentional removal.

5. Red bags or red container may be substituted for labels.

6. Individual containers of blood or other potentially infectious materials that are placed in a labeled container during storage, transport, shipment or disposal are exempted from the labeling requirement.

7. Labels required for contaminated equipment shall be in accordance with this paragraph (A.) and shall also state which portions of equipment remain contaminated.

IX. INFORMATION AND TRAINING

A. SNAMHS shall ensure that all employees with occupational exposure participate in a training program which must be provided at no cost to the employee during working hours.

B. Training shall be provided as follows:

1. At the time of the initial assignment to tasks where occupational exposure may take place;

2. At least annually thereafter.

C. Annual training for all employees shall be provided within one (1) year of their previous training.

D. The agency shall provide additional training when changes such as modification of tasks or procedures or institution of new tasks or procedures affect the employee's occupational exposures are created.

E. The training program shall contain at a minimum the following elements:

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

X. RECORDKEEPING

A. Medical Records

1. This record shall include:

2. The agency shall establish and maintain an accurate record for each employee with occupational exposure as part of their employee health records.

3.
   a. The name and employee ID number;
   b. A copy the employee's Hepatitis B vaccination status, including the dates of all Hepatitis B vaccinations and any medical records relative to the employee's ability to receive vaccination as required by Section VI. H.;
   c. A copy of all results of examinations, medical testing, and follow-up procedures as required by Section VI. I.;
   d. The agency's copy of the healthcare professional's written opinion as required by Section VI.;
   e. A copy of the information provided to the healthcare professional as required by Section VI. K. b.c.d.

4. Confidentiality
   a. The agency shall ensure that employee medical records required by VI. are:
      i. Kept confidential; and
      ii. Are not disclosed or reported without the employee's <u>expressed voluntary written consent</u> to any person within or outside the workplace except as required by this section or as may be required by law.

5. The agency shall maintain the records required by section IX for at least the duration of employment plus 30 years.

B. Training Records

1. Training records shall include the following information:
   a. The dates of the training sessions;
   b. The contents or a summary of training sessions;
   c. The names and qualifications of persons conduction the training; and
   d. The names and job titles of all persons attending the training sessions.

C. Availability

1. The agency shall ensure that all records required to be maintained by this section shall be available to OSHA for examination and copying.

2. Employee training records required by this section shall be provided upon request for examination and copying to employees, to employee representatives and to OSHA.

3. Employee medical records required by this section shall be provided upon request for examination and copying to the subject employee, to anyone

having written consent of subject employee, and to OSHA in accordance with 29 CFR 1910.1020.

D. Transfer of Records

1. The agency shall comply with the requirements involving transfer of records set forth in 29 CFR 1910.1020 (h).

2. If the agency ceases to do business and there is no successor employer to receive and retain the records for the prescribed period, the employer shall notify OSHA, at least three (3) months prior to their disposal and transmit them to OSHA, if required by OSHA to do so, within the three (3) month period.

E. Sharps Injury Log

1. The agency shall establish and maintain a sharps injury log for the recording of percutaneous injuries from contaminated sharps.

2. The information in the sharps injury log shall be recorded and maintained in such manner as to protect the confidentiality of the injured employee.

3. The sharps injury log shall contain, at the minimum:
   a. The type and brand of device involved in the incident;
   b. The department or work area where the exposure incident occurred; and
   c. An explanation of how the incident occurred;
   d. The requirement to establish and maintain a sharps injury log shall apply to any employer who is required to maintain a log of occupational injuries and illnesses under 29 CFR 1904;
   e. The sharps injury log shall be maintained for the period required by 29 CFR 1904.6.

F. Effective Date

1. The OSHA Bloodborne Pathogen Final Standard shall become effective on March 6, 1992.

XI. Hepatitis B Infected Healthcare Providers

A. SNAMHS, within its scope of services, does not perform any procedures that would be defined by the CDC as patient exposure-prone procedures. However, given the variety of procedures, practices, and providers, each HBV-infected healthcare provider performing potentially exposure-prone procedures will need individual consideration. Consult Figure I: CDC classification of exposure-prone patient procedures for determination.

B. HBV infection alone should not disqualify HBV-infected persons from the practice or study of medicine, surgery, dentistry, or allied health professionals.

C. For most chronically HBV-infected providers who conform to current standards for infection prevention, HBV infection status alone does not require any curtailing of their practices or supervised learning experiences. These standards include:
   1. Strict adherence to Standard Precautions
   2. Use of safety engineered sharps
   3. Implementation of work practice controls (e.g., not recapping needles)

D. The following criteria should be used when determining whether a HCP poses a risk for blood borne virus transmission to patients:
   1. HCPs must have an injury (e.g., a puncture wound) or a condition (e.g., non-intact skin) that allows exposure to his/her blood or other infectious body fluids.
   2. The HCP's blood or infectious body fluid will come in direct contact with a patient's wound, traumatized tissue, mucous membranes, or similar portal of entry during an exposure-prone procedure.

XII. REFERENCES:

A. The Joint Commission: **The Source** March 2017

B. APIC Infection Prevention Manual for Behavioral Health, 2015 3rd Edition.

C. OSHA Bloodborne Pathogens Standard; 1910.1030, Part 1910; Subpart: Z

D. www.osha.gov/oshdoc/directive_pdf/cpl_2-2_69_appd

E. www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html.

XI. ATTACHMENTS

A. OF-SP-17 Exposure Control Plan OSHA Bloodborne Pathogens Attachment A

B. OF-SP-17 Exposure Control Plan OSHA Bloodborne Pathogens Attachment B

C. OF-SP-17 Exposure Control Plan OSHA Bloodborne Pathogens Attachment C

D. OF-SP-17 Exposure Control Plan OSHA Bloodborne Pathogens Attachment D

E. OF-SP-17 Exposure Control Plan OSHA Bloodborne Pathogens Attachment E

NEEDLESTICK, BLOOD OR BODY FLUID EXPOSURE LOG

UNIT: _____ _____ MONTH AND YEAR___ _____ DATE ROUTED TO INFECTION CONTROL OFFICE_ _____

EMPLOYEE NAME PRINT LEGIBLY	EXPOSURE DATE	TIME OF EXPOSURE (Use Military time)	EXPOSURE TYPE	WAS THE NEEDLE OR INSTRUMENT CONTAMINATED WITH BLOOD?	PRECAUTIONS USED	WAS THE AREA CLEANED PROPERLY?	DID YOU REPORT TO YOUR SUPERVISOR AND TO INFECTION CONTROL OFFICE?	DID YOU COMPLETE A C-1 FORM?	SIGNATURE
			☐ DEEP NEEDLESTICK ☐ NEEDLE STICK SCRATCH ☐ BLOOD INGESTION ☐ HUMAN BITE ☐ OPEN WOUND CONTAMINATION ☐ EYE SPLASH ☐ SHARP INSTRUMENT ☐ OTHER	☐ YES ☐ NO	☐ NONE ☐ GLOVES ☐ MASK ☐ GOWN ☐ OTHER	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	

Southern Nevada Adult Mental Health Services
Infection Control Program

NEEDLESTICK, BLOOD OR BODY FLUID EXPOSURE LOG

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY WIDE

SUBJECT: Respiratory Protection Program **NUMBER:** OF-SP-18

EFFECTIVE DATE: 03/2023 **REVIEW DATE:** 03/2025

APPROVED BY:	/s/ Susan Lynch, MBA, CPM Hospital Administrator
SUPERSEDES:	Respiratory Protection Program dated 04/08; 03/10; 01/11; 04/13; 10/15; 10/17; 11/18; 03/21

I. PROTOCOL:

Southern Nevada Adult Mental Health Services (SNAMHS) must fulfill its responsibility to its patients, staff and the community by ensuring that proper safeguards are instituted to identify, and prevent hospital associated airborne transmission/infections.

II. PURPOSE:

The scope of this program is to ensure that all employees required to wear a N95 disposable respirator are protected from respiratory hazards through the proper use of the N95 disposable respirator or appropriate surgical mask if indicated.

When N95 respirator use is required in the workplace, Fit-Testing MUST be performed in accordance with OSHA. However, there may be certain times, when use of the N95 disposable respirator will be required for use by staff and/or patients as a protective measure for hazardous air quality or state of emergency, when declared by the state of local health district, without fit-testing. In such instances, a Fit-Check can be performed to ensure a seal.

III. PROGRAM PROCEDURE:

A. Program Administration:

1. **Southern Nevada Adult Mental Health Services' Infection Control**/Employee Health Program along with the office of Staff Education, will be responsible for the administration of the respiratory protection program and thus is called the Respiratory Program Administrator(s) (RPA).
2. The Infection Control Preventionist will be responsible for monitoring the ongoing and changing needs for respiratory protection.

B. **Program Scope and Application:**

1. The program applies to all employees who could potentially be exposed to airborne respiratory illnesses during:
   a. Normal work operations
   b. During non-routine situations
   c. Emergency situations
2. Some of the types of work activities required to wear the N95 disposable respirator can be but not limited to:
   a. Potential airborne respiratory illness contacts during a client intake
   b. Potential airborne respiratory illness during an admission to RSU
   c. Patient contact
   d. Patient care

C. **Identifying Work Hazards**

1. The N95 disposable respirator selected will be used for respiratory protection from potentially airborne infectious diseases; they do not provide protection from chemical exposure.
2. Through normal working situations employees may have contact with clients/patients who could be infected with a potentially airborne infectious agent such as Mycobacterium tuberculosis or Covid-19.
3. Other examples of potentially airborne infectious diseases that employees may be exposed to in various situations may include:
   a. Severe acute respiratory syndrome (SARS)
   b. Covid-19
   c. Measles
   d. Chicken Pox
   e. Possible novel strains of flu virus when characterized by the local health district as airborne

D. **N95 Disposable Respirator Selection**

1. Only N95 disposable respirators approved by the National Institute for Occupational Safety and Health (NIOSH) will be selected and used.
   a. N95 disposable respirators are available for contact tracing, disease investigation and patient contact/care. (Airborne Precautions).

E. **Medical Evaluation**

1. Persons assigned to tasks that require respiratory protection must be able to perform the tasks while wearing a N95 disposable respirator.
2. The Infection Control Coordinator will distribute the respirator medical questionnaire to employees during the initial fit testing. The employee will return the questionnaire to Infection Control for the employee health MD's review and signature.
3. New employees will fill out the medical questionnaire during the new employee's physical. The examining employee health MD will review the results during the physical. Fit testing will occur after initial assignment to employee's position.

4. If a medical evaluation results in an employee's inability to wear the N95 disposable respirator, the employee will not be allowed to work in conditions requiring respirator use.
5. Re-evaluation will be conducted under these circumstances:
    a. Employee reports physical symptoms that are related to the ability to use a N95 disposable respirator:
        i. Wheezing
        ii. Shortness of breath
        iii. Chest pain, etc.
    b. It is identified that an employee is having a medical problem during the N95 disposable respirator use.
    c. The healthcare professional performing the evaluation determines an employee needs to be re-evaluated and of the evaluation.
    d. A change occurs in the workplace conditions that may result in an increase physiological burden on the employee.
    e. Employee facial size/shape/structure has changed significantly.
6. All examinations and questionnaires are to remain confidential between the employee and the Employee Health Program.
7. Questionnaires will be integrated into the employee's medical file.

F. **Fit Testing**

1. Fit testing will be per manufacturer's recommendations/directions.
2. After the initial fit test, fit tests must be completed at least annually, or more frequently if there is a change in status of the wearer or if the changes model or type of the N95 disposable respirator.
3. Fit tests are conducted to determine that the N95 disposable respirator fits the user adequately and that a good seal can be obtained.
4. Respirators that do not seal do not offer adequate protection.
5. Fit testing is required for tight fitting N95 disposable respirators.
6. Fit tests will be conducted:
    a. Prior to being allowed to wear the N95 disposable respirator
    b. If SNAMHS changes N95 disposable respirator product
    c. If an employee changes weight by 10% or more
    d. If an employee has changes in facial structure or scarring
    e. As OSHA standards require

G. **Proper N95 Disposable Respirator Use General Use**

1. Employees will use their N95 disposable respirators under conditions specified by this program, and in accordance with the training they receive on the use of the selected model.
2. The N95 disposable respirator shall not be used in a manner for which it is not certified by the National Institute for Occupational Safety and Health (NIOSH) or by its manufacturer.

3. All employees shall conduct positive and negative pressure user seal checks each time they wear the N95 disposable respirator.
4. All employees shall leave a potentially contaminated work area to change their N95 disposable respirator if the respirator is impeding their ability to work.

H. **Respiratory Training**

1. Workers will be trained prior to the use of a N95 disposable respirator and thereafter when deemed necessary.
2. Training will include:
   a. Identify hazards, potential exposure to these hazards, and health effects of hazards.
   b. N 95 disposable respirator fit, improper fit, usage, limitations and capabilities, usage, cleaning and storage.
   c. Emergency use if applicable.
   d. Inspection, donning, removal, seal check and trouble shooting.
   e. Explaining respirator program (policies, procedures, OSHA standard, resources).
3. If an employee is faced with an emergent situation that warrants the use of an N95 respirator but has not been fit tested or trained. They may use the mask but sign an OSHA section D document stating that they are fully aware of not having received proper training.

IV. ROLES AND RESPONSIBILITIES

A. Respiratory Program Administrator (RPA)

1. The Respiratory Program Administrator(s) are responsible for administering the respiratory protection program.
2. Duties of the RPA include:
   a. Identify work areas, processes, or tasks that require respiratory protection.
   b. Monitor OSHA policy and standards for changes and make changes to agency's policy.
   c. Select N95 disposable respiratory protection product.
   d. Monitor N95 disposable respirator use to ensure that respirators are used in accordance with their certification.
   e. Distribute and evaluate education/medical questionnaire.
   f. Follow up with MD for questionable information on medical questionnaires.
   g. Arrange for and/or conduct training and fit testing
   h. Ensure proper storage of N95 disposable respirator protection equipment.

B. Program Managers and Supervisors

1. Program Managers and Supervisors (RN IV) are responsible for ensuring that the respiratory protection program is implemented in their particular units and areas.
2. In addition to being knowledgeable about the program requirements for their own protection, Program Managers and Supervisors must also ensure that the program is understood and followed by the employees under their charge.
3. Duties of the Program Managers and Supervisors (RN IV) include:
   a. Knowing the hazards in the area in which they work.
   b. Knowing the N95 disposable respirator that needs to be used.
   c. Ensuring the N95 respirator program and worksite procedures are followed.
   d. Enforcing/encouraging staff to use required N95 disposable respirators if needed.
   e. Ensuring employees receive training and medical evaluations.
   f. Coordinating annual retraining and/or fit testing.
   g. Notifying the Infection Control Coordinator with any problems with the N95 disposable respirator use, or changes in work processes that would impact airborne contaminant levels.
   h. Ensure proper storage of all N95 disposable respirators.

C. Employees

1. Participate in all training
2. Wear the N95 disposable respirator when indicated
3. Maintain equipment.

D. Documentation and Record-keeping

1. An electronic copy of this program can be found in the SNAMHS Policy Manual on the SNAMHS server.

2. The Infection Preventionist will maintain the confidential medical information for all employees covered under the respiratory program.

3. All relevant medical information must be maintained for the duration of the employment of the individual plus thirty (30) years.

V. REFERENCES:

A. OSHA Hospital Respiratory Protection Program Toolkit, Updated April 2022.

https://www.osha.gov/Publications/OSHA3767.pdf

B. Minnesota Department of Health – Infectious Disease Epidemiology, Prevention and Control: Public Health Respiratory Protection Program Template; www.health.state.mn.us

C. University of North Carolina Hospitals; Occupational Health Services

D. OSHA Respiratory Protection Program, Retrieved March 2023. https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.134

VI. ATTACHMENTS:

A. OF-SP-18 Respiratory Protection Program Attachment A

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY WIDE

SUBJECT: Seasonal Influenza Vaccination Program **NUMBER:** OF-SP-19

EFFECTIVE DATE: 08/2021 **REVIEW DATE:** 08/2023

APPROVED BY: /s/ Susan Lynch, MBA, CPM
Hospital Administrator

SUPERSEDES: OF-SP-19 10/08; 03/10; 01/11; 04/13; 10/13; 02/15; 03/15; 03/16; 11/16; 10/17 03/18; 05/20

I. PROTOCOL:

It is the protocol of Southern Nevada Adult Mental Health Services (SNAMHS) to have an annual influenza vaccination program for the prevention and control of seasonal influenza. To maintain a safe and healthy environment for employees, patients, visitors, and the public by using vaccination as a potential means for help in minimizing the spread of influenza.

The Advisory Committee on Immunization Practices recommends vaccinating all persons ≥ 6 months of age. The Association for Professionals in Infection Prevention, the Immunization Action Coalition, the National Foundation for Infectious Diseases and The Centers for Disease Control and Prevention (CDC) all recommend vaccination of all workers in health care settings. The Joint Commission in 2007 approved an infection control standard that requires accredited organizations to offer influenza vaccination to staff, volunteers, and licensed independent practitioners with close patient contact.

II. PURPOSE:

The seasonal influenza program is available to all SNAMHS employees, licensed independent practitioners (LIP), and volunteers. The influenza vaccination program is an essential component of SNAMHS disease prevention programs. Influenza is a cause of substantial morbidity and mortality in the United States (U.S.).

Influenza vaccination is the most effective way primarily to protect against the disease and resultant complications. Vaccination also reduces the risk of transmitting influenza to family members, other patients, and to health care personnel. Vaccination of health care personnel can reduce transmission of influenza to patients, co-workers, visitors, and family members. SNAMHS has made influenza vaccination a priority. The influenza vaccine for seasonal influenza is a safe and cost-effective means for preventing and controlling influenza.

III. DEFINITIONS:

A. Influenza: ("flu") is a mild to severe contagious disease caused by a virus that causes an average of 36,000 deaths each year in the U.S., mostly among the elderly. Influenza spreads from an infected person to the nose and throat of others and can cause fever, sore throat, cough, chills, headache, and muscle aches.

Influenza can lead to pneumonia and can be dangerous for people with heart or breathing conditions.

B. Influenza Season: The time (generally between October and March) when influenza is prevalent in the United States.

C. Influenza Vaccine: A preparation of Influenza viruses (live or inactivated virus), which stimulate the production of specific antibodies when introduced into the body.

D. Personnel: All SNAMHS employees and contracted staff, students, Residents, trainees, and volunteers.

E. Personnel with Client Contact: All personnel who routinely (Nurses, CNAs, MHTs) perform work tasks or intermittently (Maintenance, Food Service Staff, AT staff) are required to wear mask at all times when in-patient care areas or who have contact with their environment in the performance of their duties.

IV. PROCEDURES:

A. General Requirement:

1) The State Health Office prescribes a standing order and protocol for the administration of annual influenza vaccination for DPBH Clinical Services Branch staff.
2) Vaccine will be offered free of charge at various times and locations as soon as the vaccine becomes available. Vaccines will be offered throughout the flu season or our allotment of vaccines has been depleted (whichever occurs first).
3) All individuals covered by this protocol must be immunized within six (6) weeks after the vaccine becomes available to employees.
4) If individuals covered by this protocol are immunized through services other than Employee Health Services (i.e., private physician office, public clinics, or other employers) must provide proof of immunization to Employee Health Services.
    1) Proof of immunization must be provided within six (6) weeks after the vaccine becomes available to SNAMHS employees.
5) Proof of immunization must include:
    1) Name of the individual immunized
    2) Date of the immunization
    3) Immunization type
6) Every year, a log will be maintained documenting how many people (staff, volunteers, and independent licensed contractors) receive the vaccine, as well as the numbers who refused and the reason for declination.
7) All staff shall be provided with information explaining the influenza vaccine, its risks, and the risks versus benefits of vaccination. Documentation must show that specific education was provided, that the staff either received influenza vaccine or did not receive the vaccine, and whether a refusal was due to medical contraindications. Documentation must show that the most current and appropriate education was provided, that the client either received influenza vaccine or did not receive the vaccine, and whether a refusal was due to medical contraindications.

8) The Infection Prevention Practitioner or designated Registered Nurses employed by SNAMHS are authorized to administer influenza vaccine and anaphylaxis treatment agents, including epinephrine for the emergency of treatment of anaphylaxis as set forth below to all agency employees.
9) These nurses are authorized to administer the influenza and anaphylaxis treatment agents only during their employment with SNAMHS.
10) Any Personnel who decline (regardless of reason) to be vaccinated must complete a declination form.
11) Non-Direct Care personnel who decline immunization or are unable to receive immunization and who have patient contact are required to wear a surgical mask when within six (6) feet of a client or when they enter a client area such as a unit, waiting room, exam room, treatment area, reception area or an outpatient clinic area. Direct care Personnel who decline immunization or are unable to receive immunization, must wear a mask continually when in the client area.
The surgical mask must be changed every four (4) hours
12) The exact dates for the requirement to wear respiratory protection will be determined annually, one (1) month after injections are started (generally in September based on the vaccine delivery date) and end March 31st the following calendar year.
13) If a non-immunized SNAMHS employee who has submitted a declination fails to comply with the requirement to wear a mask, they will be subject to progressive corrective action, up to and including termination.

B. **Criteria for Influenza Vaccine for SNAMHS Employees:**

1. All healthcare workers who qualify for vaccination based on CDC recommendations.
2. All persons will be screened for contraindications to influenza vaccine which can include:
   a. Serious allergic reaction to chicken, feathers, eggs, or egg products
   b. Allergies to dry rubber, rubber products or latex
   c. Allergies to thimerosal (a preservative) or gelatin
   d. History of anaphylactic reactions to the influenza vaccination or any vaccination
   e. History of Guillian-Barre Syndrome within six (6) weeks of any influenza vaccination
   f. Illness at the time of inoculation, including acute respiratory infection, other active infection, or serious febrile illness
   g. Acute evolving neurological disorder
   h. Bleeding disorders such as hemophilia or thrombocytopenia
   i. Anticoagulant therapy (e.g., Warfarin)
   j. Use of Theophylline, and Phenytoin

C. **The Infection Preventionist and/or designated Registered Medical Nurse Shall:**

1. Ensure that the potential recipient is assessed for contraindications to immunization.

2. Confirm each recipient of the vaccination has received a copy of the appropriate Vaccine Information Statement and has been informed of the potential side effects and adverse reactions, orally and in writing, before administering the immunization.
3. Confirm that each recipient as completed the Influenza Consent/Declination form prior to the administration of the vaccine.
4. The Infection Preventionist will be responsible for the record of all persons immunized including the recipient's name, date, address of immunization, administering nurse, immunization agent, manufacturer, lot number, expiration date, recommendations for future immunization and standing order and protocol are maintained and reviewed/revised annually. These records will be kept for up to 30 years as part of the employee's health record.
5. The Infection Preventionist will be responsible to maintain a record of all personnel declining the influenza vaccination.
6. Any designated RNs involved in the administration of immunizing agents in accordance with standing order and protocol must be currently certified in CPR by the American Heart Association or an equivalent organization.

D. **Administration of Influenza Vaccine (Multi-dose Vial):**

1. A separate sterile syringe and needle will be used for each injection to prevent a possible transmission of hepatitis viruses, HIV virus or other infectious agent from one person to another.
2. The expiration date of the vaccine will be noted on the vial using an auxiliary label. The expiration date will be 28 days from the date the vial was first opened and used. Any expired vaccine will ***not*** be used.
3. Shake the container vigorously each time before withdrawing vaccine.
4. Never remove the stopper from the container. Moisten the stopper with a sterile alcohol wipe, allowing the antiseptic to act for a few moments.
5. Draw into the syringe 0.5 ml of air.
6. Shake the vaccine container vigorously then pierce the center of the stopper with the sterile needle attached to the syringe. Turn the vial upside down and inject the air from the syringe. Keeping the point of the needle immersed in the vaccine, withdraw immediately into the syringe 0.5 ml vaccine.
7. Primarily: Disinfect the skin at the site of injection (deltoid muscle) with a suitable antiseptic wipe. Inject 0.5 ml of vaccine intramuscular (never IV), aspirating to ensure that the needle has not entered a blood vessel before injection.
8. Secondary: Disinfect the skin at the site of the injection (deltoid muscle) with a suitable antiseptic wipe. Remove bandage from package and apply safe barrier bandage to skin. Make injection through center of bandage and remove. Inject 0.5 ml of vaccine intramuscular (never IV), aspirating to ensure that the needle has not entered a blood vessel before injection. Suggest that this should read aspirating BEFORE injecting.
9. Dispose of safety syringe in appropriate sharps container.
10. All vaccinated persons should be observed for about fifteen (15) minutes after vaccinations.

E. **Alternate Administration Prefilled Syringe:**
1. Use of prefilled syringes to deliver a single dose.
2. Each prefilled syringe will be used once, and then discarded into a puncture resistant container.

F. **Anaphylaxis Reactions**
1. All addresses, clinic areas and units where immunizations are administered will be supplied with anaphylaxis treatment agents and will be equipped with appropriate syringes, needles, and supplies for treatment administration.
2. If a person who received an influenza vaccine develops signs and symptoms consistent with anaphylaxis, (e.g., but not limited to; difficulty in breathing, hives, swelling of face, throat or airway and loss of consciousness), the nurse is to administer one (1) adult dose of EPI-PEN IM or epinephrine 0.3 mg [USP 1:1000, 0.3 ML] subcutaneous and **CALL 911 IMMEDIATELY.**
3. The RN shall ensure that a record of all persons to whom they administered an anaphylaxis treatment agent, including the recipient's name, date, address of administration, administering nurse, anaphylaxis treatment agent, manufacturer, and lot number is kept in the medical record in the person's medical file.
4. The RN shall report to the local emergency medical system or other provider equivalent follow-up care information regarding the administration of the anaphylaxis treatment agent, including when it was administered, the dosage, strength, and route of administration. The nurse shall also report information to the person's primary care provider if one exists unless the patient is unable to communicate the identity of his or her primary care provider.
5. The Infection Preventionist is responsible to report adverse reactions of immunizations to Vaccine Adverse Event Reporting System, (VARES).

G. **Data and Tracking:**

1. The Infection Prevention/Employee Health program will be responsible for tracking seasonal influenza rates.
    a. Rates will be calculated as a percentage
        i. Numerator will be all staff receiving vaccinations.
        ii. Denominator will be all staff within the agency between the start of the flu season and the end of the flu season.
        iii. Declinations will all staff declining the vaccine/all staff within the agency between the start of the flu season and the end of the flu season.
        iv. Declinations will be further calculated based on reason for declination.
    b. Data will be presented to the Infection Prevention Committee and the Executive Leadership Committee annually at the end of each flu season. More frequently if needed and determined by the Administrative Director of the Infection Prevention Program.

V. REFERENCES:

A. Centers for Disease Control "Immunization Recommendations for Health Care Workers"

B. Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices — United States, 2017–18 Influenza Season (https://www.cdc.gov/mmwr/volumes/66/rr/rr6602a1.htm)

C. APIC 2017-18 Summary of Flu Vaccine Recommendations (https://www.cdc.gov/flu/professionals/acip/2017-18summary.htm)

D. CDC, FDA Fact Sheet for Vaccine Information Statements, current year

E. FluLaval™ Full Prescribing Information: Glaxo Smith Kline Pharmaceuticals, 2007-2008

F. Link http://injectsafebandages.com/ Quick reference

II. ATTACHMENTS:

A. OF-SP-19 Seasonal Influenza Vaccination Program Vaccine Consent Form ENGLISH Attachment A

B. OF-SP-19 Influenza Vaccination Program Vaccine Consent - SPANISH Attachment B

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY WIDE

SUBJECT: Outbreak Investigation **NUMBER:** OF-SP-23

EFFECTIVE DATE: 03/2023 **REVIEW DATE:** 03/2025

APPROVED BY: /s/ Susan Lynch, MBA, CPM
Hospital Administrator

SUPERSEDES: 02/11; 04/13; 10/15; 02/16; 06/18; 02/21

I. PROTOCOL:

To establish what protocols to follow in an outbreak investigation.

II. PURPOSE:

To investigate probable outbreaks of infections with the facility, intervening and possibly halting the spread infectious diseases within the hospital.

III. DEFINITIONS:

An outbreak is defined as two (2) or more cases over the usual (endemic) number of cases of healthcare–associated infections, usually produced by the same organism. The time period will vary according to the infection.

IV. PROCEDURE

A. RECOGNITION AND NOTIFICATION

Any personnel recognizing a possible epidemic will immediately report this to the Infection Control and Prevention department through which the facility management and medical director will be notified.

B. PRELIMINARY INVESTIGATION

The Infection Preventionist (IP) and IC Director (and others as assigned), are designated as the investigation coordinators. He or she will review the charts of the involved patients and determine that an epidemic exists. The investigation coordinator, director of IC, and medical director will confer and prepare a preliminary plan of investigation including the following:

1. A working definition of a case will be developed.
2. The presumptive hypotheses for the mode of transmission of the organism and other circumstances will be developed. Procedures for testing the hypotheses will be outlined.

a. The Infection Preventionist will gather and compile data related to the infection(s) as follows:
    i. Conduct case finding (review ongoing surveillance charts of other patients at risk and microbiology reports) to determine whether there have been other cases of the infection.
    ii. Evaluate previous facility experience with the infection.
    iii. Prepare a line listing of cases to include patient, room number, date of admission, date of infection onset, site culture results, and physician.
    iv. Plot number of cases by date of onset (epidemic curve).
    v. Review patient charts of cases and interview involved personnel for various factors that conceivably may have played a role in transmission of an infection, e.g., geographic locations of patients, specific personnel having contact with patients, medications and treatments administered.
    vi. Review various Infection Prevention techniques (hand hygiene, use of PPE, use of standard precautions, etc.) as actually practiced in the facility.
    vii. Maintain surveillance for occurrence of any further infections.
b. The IP will communicate with the lab regarding:
    i. Any need for isolates of the involved organism(s) to be saved for further study (e.g., bio-typing, antimicrobial sensitivity patterns, phage typing, serotyping).
c. The IP will communicate with management regarding:
    i. Whether any environmental and/or personnel cultures are to be taken by whom and by what technique.
    ii. What patient care items suspected of being possible sources of infection may need to be impounded or quarantined.

C. CONTACT TRACING and CASE INVESTIGATION

1. Close contacts are all individuals that were in close proximity to a person with the communicable infectious disease (laboratory-confirmed or clinically diagnosed) for certain amount of time. Duration of exposure and distance vary depending on the infectious disease.

2. Contact tracing is the practice of identifying, notifying, and monitoring individuals who may have had close contact with a person having a confirmed or probable case of an infectious disease as a means of controlling the spread of infection.

3. An infected person can spread the infection starting from several days prior to symptom onset date. Therefore, contact tracing will include close contacts from the presymptomatic period.

4. In case of a communicable disease outbreak, all close contacts among staff, contractors, visitors, and vendors will be informed about their exposure via phone call, email, or in person. The identity of the positive case will be protected. The IP will inform close contacts about their exposure, and will provide infection prevention guidance. Close contacts will be advised to get tested for specific disease if tests are available and if disease is known.

5. Employees who are symptomatic, or test positive for communicable disease, may be asked by their supervisor or IP to immediately leave the premises to prevent further exposure to patients and staff within the facility. In this case, the employee may be required to present a return to work note from their physician before returning to duty stating that they are medically cleared to return and are no longer considered contagious to others.

6. If disease is unknown, symptomatic patients may be placed in medical isolation immediately until infectious disease is ruled out by medical provider and/or testing. Local health authority will be promptly informed as applicable.

7. In case of an outbreak, the facility reserves the right to pause admissions, visitation, client transfers, and treatment groups until outbreak is mitigated and controlled.

8. If the outbreak occurs among patients, staff will be informed of the exposure and will be required to wear adequate PPE, if applicable.

9. All exposed patients will be offered testing (if testing is available), and encouraged to wear PPE, if applicable.

10. Adequate infection prevention information, warning and educational signs will be placed throughout the patient units and entire hospital.

11. Contact information of infection control and local health department will be placed on informational infographics in the lobby and/or other facility entrances.

12. Housekeeping department will be informed about the location of the infectious disease exposure, and will be required to wear adequate PPE while performing cleaning and disinfection at the affected area.

13. If laboratory sample collection is needed, infection control department will communicate with the local public health authority.

D. COMMUNICATIONS

1. The IP will ensure that the following individuals are notified concurrently with the preliminary investigation and advised at reasonable intervals of the progress of the investigation: attending physicians, director of nursing, medical director, administrator, and others as needed.

E. IMMEDIATE CONTROL

1. Reasonable immediate control measures will be put into effect. Such measures might include but are not limited to isolation, quarantine, contact tracing, testing, hospital entrance symptom and body temperature screening, PPE, removal of common suspected sources of personnel from patient contact, or immediate in-service training in certain Infection Prevention techniques.

F. PUBLIC INFORMATION

1. Any questions from the community, uninvolved personnel, or news media are directed to the administrator assigned by the agency, who will act as public information coordinator.

G. ANALYSIS OF DATA

1. The data collected in the preliminary investigation are reviewed by the investigators to determine whether a common source of infection, break in technique, etc., can be implicated as the cause of the epidemic. A preliminary written report will be prepared.
2. If the infectious disease is reportable or emerging, data will be collected and entered into RedCap system, with the assistance of the Office of Public Health Investigations and Epidemiology (OPHIE).

H. FURTHER INVESTIGATION

1. If the cause of the infection is not evident as a result of the above investigation, expert consultation will be sought. Reporting of the potential outbreak will be done to local public health authority (SNHD) as required by law. (See OF-SP-12 for Reportable Diseases.)

I. CONCLUSION OF INVESTIGATION

1. The investigation is continued at least as long as there are cases of the infection occurring above the endemic level.
2. A final written report of the investigation, outlining findings and recommendations, is prepared by the investigation coordinator and issued to the Infection Prevention committee, others participating in the investigation, attending physician(s), director of nursing, and others as needed.

V. REFERENCES:

A. . Transmission-Based Precautions (2016) Last reviewed: January 7, 2016 www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html

B. New Document Guides Hospitals in Responding to Infectious Disease Outbreaks (2017) https://www.infectioncontroltoday.com/view/new-document-guides-hospitals-responding-infectious-disease-outbreaks

C. Outbreak Response and Incident Management: SHEA Guidance and Resources for Healthcare Epidemiologists in United States Acute-Care Hospitals (2017) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7113030/

D. Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007) Last update: July 2019 Page 7 of 206. https://www.cdc.gov/infectioncontrol/pdf/guidelines/isolation-guidelines-H.pdf

E. Interim Guidance on Developing a COVID-19 Case Investigation & Contact Tracing Plan (2022) Last update: July 31, 2020 Page 7 of 13. https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/outbreaks.html

F. OF-SP-12 Reportable Diseases

VI. ATTACHMENT:

A. OF-SP-23 Outbreak Investigation Attachment A

B. OF-SP-23 Outbreak Investigation Attachment B

C. OF-SP-23 Outbreak Investigation Attachment C

D. OF-SP-23 Outbreak Investigation Attachment D

E. OF-SP-23 Outbreak Investigation Attachment E

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY WIDE

SUBJECT: Infection Prevention Surveillance **NUMBER:** OF-SP-27

EFFECTIVE DATE: 04/2023 **REVIEW DATE:** 04/2025

APPROVED BY: /s/ Susan Lynch, MBA, CPM
Hospital Administrator

SUPERSEDES: 04/13; 04/17; 04/19; 04/21

I. PROTOCOL:

It shall be the protocol of Southern Nevada Adult Mental Health Services (SNAMHS) Infection Prevention Program to conduct surveillance.

II. PURPOSE

The purpose of this protocol is to guide the Infection Prevention Program in conducting daily surveillance activities of patient and employee infections to guide prevention activities so appropriate actions/follow-up may be implemented.

III. PROCEDURE:

A. The Infection Preventionist does surveillance of healthcare associated infections by:
   1. Review of culture reports and other pertinent lab data
   2. Nurse consultation and referral
   3. Chart review
   4. Review of the Infection Communication Form, 24-hour report, or morning stand-up meeting
   5. Personal consultation by employees
   6. Follow-up on communicable disease exposure
   7. Review of employee's physical assessments
   8. Maintenance of the employee infection record
   9. Physician consultation
   10. Other

B. Specific definitions of healthcare associated infections shall be used consistently. (See "Definitions")
   Healthcare associated infections shall be reported monthly on the:

   1. Healthcare Associated Infection Summary Report

2. Summary of Infections by Device Days (if used)

3. Surveillance documentation is maintained on the:
   a. Line Listing of Patient Infections
   b. Log of Employee Infections
   c. Infection Surveillance Summary Reports
4. Reporting of infections to the Health Department is done as required by law.

IV. SURVEILLANCE DEFINITIONS:

A. Surveillance definitions published in the APIC Text of Infection Control and Epidemiology. 3rd Edition. Chapter 53: Behavioral Health Washington, DC: APIC: 2009, which is adapted from Surveillance Definitions of Infections in Long-Term Care Facilities: Revisiting the McGeer Criteria, by The University of Chicago Press on behalf of The Society for Healthcare Epidemiology of America

V. REFERENCES:

A. APIC text Surveillance Published October 2, 2014, Revised September 20, 2020

VI. ATTACHMENTS: N/A

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY WIDE

SUBJECT: Infection Prevention Committee **NUMBER:** OF-SP-32

EFFECTIVE DATE: 08/2021 **NEXT REVIEW DATE:** 08/2023

APPROVED BY: /s/ Susan Lynch, MBA, CPM
Hospital Administrator

SUPERSEDES: New; 04/17; 05/19

I. PROTOCOL:

It shall be the protocol of Southern Nevada Adult Mental Health Services (SNAMHS) to adhere to an infection prevention plan which is monitored, evaluated and updated annually by the Infection Prevention Committee.

II. PURPOSE:

To prevent and control health care-associated infections, monitor and evaluate the performance of the infection control program, and, provide guidance and direction to minimize patient and employee risk related to infectious diseases.

III. DEFINITIONS:

1. NHSN: National Healthcare Safety Network: Division of healthcare quality promotion and the Centers for Disease Control and Prevention (CDC).
2. Health Care-Associated Infection (HAI): For the purposes of NHSN surveillance in the acute care setting, the CDC defines an HAI as a localized or systemic condition resulting from an adverse reaction to the presence of an infectious agent(s) or its toxin(s). There must be no evidence that the infection was present or incubating at the time of admission to the acute care setting.

IV. PROCEDURE:

A . Power and Authority

1. The Infection Prevention Committee has the authority to implement any appropriate emergency control measures or investigations when there is a valid reason to believe a danger exists to consumers or personnel.
2. The Infection Prevention Committee may make policy and clinical decisions only when a licensed independent practitioner and a quorum are present.
3. Issues that require expenditures must be approved by the Agency Manager.
4. If there is a conflict with a practitioner that cannot be resolved with the Infection Prevention Committee, the Medical Director will be asked to intervene.

B. Membership and Meetings
    1. Membership of the Infection Prevention includes:
        a. The Infection Prevention Officer who is also the committee chair.
        b. A member who is knowledgeable in epidemiology and infectious disease.
        c. A nursing service representative.
        d. A business office representative.
        e. A housekeeping and laundry service representative.
        f. A dietary service representative.
        g. A QAPI Department representative.
        h. A pharmacy representative.
    2. The Infection Prevention Committee meets quarterly.

C. The Infection Prevention Officer is appointed by the Agency Manager and is responsible for:
    1. Surveillance.
    2. Input into staff education regarding infection control practices.
    3. Employee health pertaining to infection control, including, blood borne pathogen exposure, Tuberculosis screening and immunizations.
    4. The development and implementation of protocols and/or procedures.
    5. Resolving problems related to infection control.
    6. Reporting infection control surveillance and performance improvement
    7. Complying with the Clark County District Health Department Communicable Disease Reporting System.
    8. Annual required reporting of data to the NHSN.
    9. Maintain all documents for a minimum of three (3) years.

D. Surveillance Program
    1. The Infection Prevention Officer monitors:
        a. Laboratory reports for positive cultures from urine or wounds.
        b. Patients receiving antibiotics before and after admission.
            i. Correlation of data with appropriate antibiotic use and surveillance of problem areas.
            ii. Ensures that copies of all antibiotic susceptibility/sensitivity studies are sent to practitioners, pharmacists and nursing staff.
        c. Patient history and physical screening for any infectious disease.
        d. Patient care areas for environmental issues related to infection prevention.
    2. If the medical clinic practitioner or Infection Prevention Officer believes there is an infectious disease outbreak they will:
        a. Determine a method to find the cause of the outbreak, including the causative agent and the source of infection if necessary.
        b. Select the appropriate protocol to keep the infectious disease from spreading.
        c. Seek an outside opinion if necessary.
        d. Determine need to pursue an investigation.
        e. Notify all necessary persons and agencies as needed.
        f. The medical clinic practitioner will write all orders required in connection with any investigation.

3. Cultures
    a. Cultures must be ordered, signed, dated and timed by a practitioner.
    b. The culture specimen may be obtained by a practitioner, a Registered Nurse, or a medical technologist.
    c. Indications for cultures include:
        i. Skin and subcutaneous infections, including, burns, surgical wounds, other wounds, dermatitis, and decubitus ulcers.
        ii. Respiratory infections, including, fever, cough, rales, purulent sputum, sore throat, chills.
        iii. Enteric infections, including, watery or purulent stools.
        iv. Urinary tract infections, including, dysuria, frequency, costovertebral tenderness.
        v. Cervical discharge.
        vi. Penis discharge, canker sores, irritations.
        vii. Eye discharge.

V. REFERENCES:

A. CDC Guidelines for Infection Control: Healthcare Infection Control Practices Advisory Committee (HIPAC) - https://www.cdc.gov/hicpac/.

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY WIDE

SUBJECT: Antimicrobial Stewardship **NUMBER**: OF-SP-34

EFFECTIVE DATE: 02/2023 **NEXT REVIEW DATE:** 02/2025

APPROVED BY: /s/Susan Lynch, MBA, CPM
Hospital Administrator

SUPERSEDES: New; 04/17; 04/19; 04/21

I. PROTOCOL:

SNAMHS will maintain an antimicrobial stewardship program that aligns with Joint Commission Standard MM.09.0101 and addresses antimicrobial stewardship. Antimicrobial stewardship (AMS) can be defined as an ongoing and systematic effort to optimize the use of antimicrobial medicines within a health service organization. The key objectives of these programs include reducing inappropriate antimicrobial use, improving patient care outcomes, and mitigating adverse consequences of antimicrobial use (such as antimicrobial resistance, preventable patient harm and unnecessary costs associated with pharmaceutical expenses and drug-resistant infections).

II. PURPOSE:

SNAMHS establishes a framework for antimicrobial use and management. The purpose of antimicrobial stewardship is to promote the appropriate use of antimicrobials by selecting the appropriate agent, dose, duration, and route of administration in order to improve patient outcomes, while minimizing toxicity and the emergence of antimicrobial resistance. The purpose of the antimicrobial stewardship program is to improve antimicrobial stewardship practices at Rawson Neal Hospital and to monitor outcomes and antimicrobial use (consumption). The purpose of this policy is to ensure the proper and safe use of antimicrobials throughout the Rawson Neal Hospital facility.

III. DEFINITIONS:

1. Antimicrobial Agents: Agents that kill microorganisms or inhibit their growth. Antimicrobial medicines are grouped according to the microorganisms they act primarily against. For example, antimicrobials are used against bacteria and antifungals are used against fungi.

2. Antimicrobial Resistance: The ability of microorganisms to adapt and change when exposed to antimicrobial drugs making the drugs less effective.

3. Antimicrobial Stewardship Committee (ASC): Monitors, advises, and directs the Antimicrobial Stewardship Program.

4. Antimicrobial Stewardship Program (ASP): an ongoing and systematic effort that promotes appropriate use of antimicrobials (including antibiotics), improves patient outcomes, reduces microbial resistance, and decreases the spread of infections caused by multidrug-resistant organisms.

5. Healthcare Associated Infection (HAI): infections that patients get while receiving treatment for medical or surgical conditions.

6. Infection Prevention Committee (ICC).

7. National Health and Safety Network (NHSN): a division of Centers for Disease (CDC).

8. Optimal Antimicrobial Therapy: Selection of an antimicrobial that:

   a. Minimized toxicity and side effects.

   b. Maximizes coverage against most likely pathogens.

   c. Minimizes selection for resistance.

   d. Minimizes selection of pathogenic organism (e.g., Clostridium difficile).

   e. Is prescribed with the correct dose and duration.

9. Sexually Transmitted Infection (STI).

IV. **Infection Prevention Committee**: The Antimicrobial Stewardship Program is coordinated through the Infection Prevention Committee at Rawson Neal Hospital which is a multi-disciplinary workgroup that reports through Pharmacy, Laboratory, Infection Prevention, Physicians and Nursing. It meets quarterly and is charged with the responsibility of promoting optimal antimicrobial utilization.

V. **Objectives of the Antimicrobial Stewardship Program**: This program is designed to improve patient outcomes through optimization of antimicrobial therapy by selection of appropriate antimicrobial dose, route, and duration of treatment. The potential benefits include the following:

- Improve patient safety by decreasing side effects and toxicity

- Support the education of all healthcare providers, patients and families about antimicrobial stewardship practices including antimicrobial resistance and appropriate antimicrobial use
- Minimize the development of antimicrobial resistance by appropriately selecting antimicrobial drugs
- Reduce the rates of hospital-acquired infections
- Control of Clostridium difficile infections and the emergence of multidrug-resistant organisms
- Reduce length of stay and patient-associated hospitalization cost
- Reduce pharmacy expenditures on antimicrobials when this is an available option that still serves the patient.

VI. Key Prescribing Principles

All prescribers at Rawson Neal Hospital are expected to prescribe antimicrobial therapy according to the following key principles:

(i) Therapeutic decisions regarding the prescription of antimicrobials will be based on best available evidence. Empirical antimicrobial therapy (the infective pathogen is not known) or prophylactic therapy (given to prevent acquisition or development of infection) is prescribed according to the following:

- If patient is prescribed antimicrobial therapy and the infective agent is unknown, the prescriber is expected to document their clinical reasoning in the patient's notes, chart, or electronic medical record.
- Where an indication or clinical scenario is not covered, a prescriber may choose antimicrobial therapy based on an appropriate, peer-reviewed source and document this in the medical record of the patient.
- When the infective pathogen is known, antimicrobials are to be prescribed according to microbiology results and antimicrobial susceptibilities, where available.

(ii) Prescribed antimicrobials will be of the narrowest spectrum possible for achieving the intended effect

(iii) Dosage, route, and frequency of prescribed antimicrobials will be appropriate for the individual patient, as well as the site and type of infection

(iv) The duration of antimicrobial therapy will be defined and/or regularly reviewed.

(v) Monotherapy is used in most indications, where clinically appropriate.

VII. Access to Evidence-Based Prescribing Guidelines

The Stanford Antimicrobial Safety and Sustainability Guidebook is available at this link:

https://med.stanford.edu/bugsanddrugs/guidebook.html

VIII. Monitoring of Antimicrobial Usage and Resistance

The infection prevention committee will monitor both the quantity and quality of antimicrobial usage and examine processes associated with antimicrobial prescribing and supply. These methods include (but are not limited to):

1. Antimicrobial utilization will be monitored by the infection prevention committee quarterly
2. Compliance with The Joint Commission Standards and Centers for Medicare and Medicaid Conditions of Participation related to Antimicrobial Stewardship
3. Coordination among all components of the hospital responsible for antimicrobial use and resistance, including, but not limited to, the Infection Prevention and Control Program, the Quality Assessment and Performance Improvement Program, the Medical Staff, Nursing Services, and Pharmacy Services
4. Documentation of the evidence-based use of antimicrobial in all departments and services of the hospital
5. Demonstration of improvements, including sustained improvements, in proper antimicrobial use, such as through reductions in C. difficile infection and antimicrobial resistance in all departments and services of the hospital
6. Adherence to nationally recognized guidelines, as well as best practices, for improving antimicrobial use
7. Development or revision of existing policies, procedures, protocols, and guidelines related to infectious diseases (e.g., restricted antimicrobials, treatment guidelines based on local susceptibilities)
8. Providing recommendations to the Pharmacy and Therapeutics Committee about antimicrobial selection, dose, and duration of therapy
9. Providing ongoing healthcare practitioner education (e.g., newsletters, in-services) regarding antimicrobial stewardship initiatives
10. Educating patients, and their families as needed, regarding the appropriate use of antimicrobial medications
11. Collecting, tracking, and analyzing antimicrobial consumption through days of therapy and defined daily dose.
12. Collecting, tracking, and analyzing resistance patterns
13. Regularly reporting antimicrobial stewardship measures to relevant healthcare practitioners and hospital administration

IX. In accordance with the CDC Core Elements of Hospital Antimicrobial Stewardship Program recommendations, all prescribers are required to perform the following:

Document in the medical record or during order entry the following:

i. Antimicrobial indication
ii. Antimicrobial dose
iii. Duration of antimicrobial therapy
iv. Review appropriateness of any antimicrobials prescribed after 48-72 hours from the initial orders (e.g., antibiotic time out)
v. Competency-based training and education personnel and staff, including medical staff, and, as applicable, personnel providing contracted services in the hospital, on the practical applications of antimicrobial stewardship guidelines, policies, and procedures

X. FDA recommendations on use of fluoroquinolones:

Since the risk of serious effects generally outweighs the benefits for patients with acute bacterial sinusitis, acute exacerbation of chronic bronchitis, and uncomplicated urinary tract infections, the FDA has determined fluoroquinolones should only be prescribed to patients with these conditions who do not have alternative treatment options available.

HIGHLIGHTS OF PRESCRIBING INFORMATION
These highlights do not include all the information needed to use CIPROFLOXACIN INJECTION safely and effectively. See full prescribing information for CIPROFLOXACIN INJECTION.

CIPROFLOXACIN injection, for intravenous infusion.
Initial U.S. Approval: 1990

WARNING: SERIOUS ADVERSE REACTIONS INCLUDING TENDINITIS, TENDON RUPTURE, PERIPHERAL NEUROPATHY, CENTRAL NERVOUS SYSTEM EFFECTS AND EXACERBATION OF MYASTHENIA GRAVIS
See full prescribing information for complete boxed warning.

- **Fluoroquinolones, including Ciprofloxacin Injection (in 5% Dextrose Injection) have been associated with disabling and potentially irreversible serious adverse reactions that have occurred together (5.1), including:**
  - **Tendinitis and tendon rupture (5.2)**
  - **Peripheral neuropathy (5.3)**
  - **Central nervous system effects (5.4)**

  Discontinue Ciprofloxacin Injection immediately and avoid the use of fluoroquinolones, including Ciprofloxacin Injection (in 5% Dextrose Injection), in patients who experience any of these serious adverse reactions (5.1)
- **Fluoroquinolones, including Ciprofloxacin Injection (in 5% Dextrose Injection), may exacerbate muscle weakness in patients with myasthenia gravis. Avoid Ciprofloxacin Injection (in 5% Dextrose Injection) in patients with known history of myasthenia gravis. (5.5)**
- **Because fluoroquinolones, including Ciprofloxacin Injection (in 5% Dextrose Injection), have been associated with serious adverse reactions (5.1 to 5.16), reserve Ciprofloxacin Injection (in 5% Dextrose Injection) for use in patients who have no alternative treatment options for the following indications:**
  - **Acute exacerbation of chronic bronchitis (1.9)**
  - **Acute sinusitis (1.11)**

HIGHLIGHTS OF PRESCRIBING INFORMATION

These highlights do not include all the information needed to use LEVAQUIN® safely and effectively. See full prescribing information for LEVAQUIN®.

LEVAQUIN® (levofloxacin) tablets, for oral use

Initial U.S. Approval: 1996

WARNING: SERIOUS ADVERSE REACTIONS INCLUDING TENDINITIS, TENDON RUPTURE, PERIPHERAL NEUROPATHY, CENTRAL NERVOUS SYSTEM EFFECTS AND EXACERBATION OF MYASTHENIA GRAVIS

See full prescribing information for complete boxed warning.

Fluoroquinolones, including LEVAQUIN®, have been associated with disabling and potentially irreversible serious adverse reactions that have occurred together (5.1), including:

- **Tendinitis and tendon rupture (5.2)**
- **Peripheral neuropathy (5.3)**
- **Central nervous system effects (5.4)**

Discontinue LEVAQUIN® immediately and avoid the use of fluoroquinolones, including LEVAQUIN®, in patients who experience any of these serious adverse reactions (5.1)

Fluoroquinolones, including LEVAQUIN®, may exacerbate muscle weakness in patients with myasthenia gravis. Avoid LEVAQUIN® in patients with a known history of myasthenia gravis *[see Warnings and Precautions (5.5)]*.

Because fluoroquinolones, including LEVAQUIN®, have been associated with serious adverse reactions (5.1-5.15), reserve LEVAQUIN® for use in patients who have no alternative treatment options for the following indications:

- **Uncomplicated urinary tract infection (1.12)**
- **Acute bacterial exacerbation of chronic bronchitis (1.13)**
- **Acute bacterial sinusitis (1.14)**

XI. REFERENCES:

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2. Centers for Disease and Prevention. Core Elements of Hospital Antibiotic Stewardship Programs. http://www.cdc.gov/getsmart/healthcare/implementation/core-elements.html

3. The Joint Commission. https://www.jointcommission.org/assets/1/6/New_Antimicrobial_Stewardship_Standard.pdf
4. The Joint Commission Perspectives, July 2016, Volume 36, Issue 7
5. APIC Text of Infection Control and Epidemiology, Antimicrobial Stewardship Programs, Chapter 122.
6. The Joint Commission website accessed Dec 2022. https://www.jointcommission.org/standards/prepublication-standards/new-and-revised-requirements-addressing-antibiotic-stewardship-for-hospital/
7. Core elements of Antimicrobial Stewardship, CDC website accessed Dec 2022. https://www.cdc.gov/antibiotic-use/core-elements/hospital.html
8. Association for Professionals in Infection Control and Epidemiology**.** https://apic.org/professional-practice/practice-resources/antimicrobial-stewardship/#:~:text=Antimicrobial%20stewardship%20is%20a%20coordinated,caused%20by%20multidrug%2Dresistant%20organisms
9. MacDougall C, Polk RE. Antimicrobial stewardship programs in health care systems. Clin Microbiol Rev. 2005 Oct;18(4):638-56. doi: 10.1128/CMR.18.4.638-656.2005. PMID: 16223951; PMCID: PMC1265911.
10. FDA Drug Safety Communication: https://www.fda.gov/drugs/drug-safety-and-availability/fda-drug-safety-communication-fda-advises-restricting-fluoroquinolone-antibiotic-use-certain

ATTACHMENTS: NA

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY WIDE

SUBJECT: Prevention and Control of Legionella **NUMBER**: OF-SP- 35

EFFECTIVE DATE: 03/2022 **NEXT REVIEW DATE:** 03/2024

APPROVED BY: /s/ Susan Lynch, MBA, CPM
Hospital Administrator

SUPERSEDES: 08/19; 01/20; 03/20

I. PROTOCOL:

This protocol establishes guidelines and process to address prevention and mitigation of risk from legionella exposure in SNAMHS facilities.

II. PURPOSE:

To take every reasonable precaution to protect persons occupying, working, and visiting SNAMHS facilities from exposure to Legionella species that may propagate in water environments in buildings and pose a risk of disease.

III. DEFINITIONS:

Legionella: common aquatic bacteria occurring naturally in freshwater environments. Legionella bacteria become a concern when there are favorable conditions to colonize and grow such as institutional water systems. Legionella are also frequently present in low concentrations in evaporative condenser water (e.g., cooling towers). When healthy individuals are exposed to water mists (aerosols) containing a low concentration of Legionella the health risk is LOW. However, as the concentration increases, the health risk also increases.

Legionnaire's Disease: a serious type of pneumonia caused by bacteria that grows in water sources is called *Legionella pneumophila*. *Legionella pneumophila* is the serotype *(L. pneumophila* serogroup 1*)* that is most commonly pathogenic upon an inhalation of contaminated water (misters, humidifiers, showers, etc.) from building water systems and plumbing fixtures. Legionella will proliferate in water systems held at temperatures between 20ºC and 45ºC.

Dead Legs: are areas of a piping system that rarely see flow, yet are still exposed to process, even if not explicitly cut off. Dead legs are often lines closed by welded caps, flanges, or other fittings. Though they can also take the form of blanked branches, lines with normally closed block valves, lines with one end blanked, pressurized dummy support legs, stagnant control valve bypass piping, spare pump piping, level bridles, relief

valve inlet and outlet header piping, pump trim bypass lines, high-point vents, sample points, drains, bleeders, and instrument connections.

Calorifier: a heat exchanger which heats water indirectly by circulating over a heating coil or multiple coils. The source of heat can be water or steam, heated by an external heat source, contained within a pipe immersed in the water.

IV. PROCEDURE:

A. Infection Prevention and Hospital Facilities will work cooperatively to follow our SNAMHS Water Management Plan that is based on a CDC template.
B. A site survey of water systems will include a list of all associated plant equipment such as calorifiers, boilers and pumps.
C. Schematics in the SNAMHS Water Management Plan should show the configuration of the water system.
D. All taps, outlets, dead legs or other associated components or associated pipework which are not used or are under-used should be fixed or removed.
E. Taps, outlets, and dead legs that cannot be removed should be regularly flushed, monitored for corrosion, isolated, and drained at a minimum of every six (6) months.
F. The facility Manager will perform quarterly sampling to detect *Legionella* (including *L. pneumophila* serogroup 1) of all water sources, taps, outlets, and other components or pipework inclusive of:
    1) Cooling Towers
    2) HVAC plant and ductwork
    3) Hot and Cold-Water Systems
    4) Showers spray heads and faucets
    5) Water fountains
    6) Misters, atomizers, air washers and humidifiers
    7) Ice machines

G. The sample results will be reviewed by:
    1) The Director of Laboratory Services, Infection Control
    2) The Infection Preventionist
    3) The Hospital Administrator
    4) The Medical Director
    5) The Director of Nursing

H. The action in response to *Legionella* colony forming units per mL of water (CFU/mL) in hot and cold-water systems:

Legionella pneumophila **CFU/mL**	***Legionella non-pneumophila serogroup 2-14*** **CFU/mL**	**Risk Level**	**Action**
no growth to <10	<100 CFU/mL	Very low Risk Situation	Maintain normal controls, retest at normal intervals

10-99 CFU/mL	100-999 CFU/mL	Low Risk Situation	Review controls, consider additional measures, examine outlets in detail. Flush system. Retest on at normal intervals. Consider disinfection.
100-999 CFU/mL	1000-5000 CFU/mL	Moderate Risk Situation	Review controls, consider additional measures, examine outlets in detail, disinfect system and flush system. Alert health care staff. Provide bottled drinking water prior to and during disinfection. Schedule an immediate retest of the system.
1000-5000 CFU/mL	>5000 CFU/mL	High Risk Situation	Immediate disinfection of the Cooling Tower and all affected water systems and plumbing is indicated. Alert health care staff. Provide bottled drinking water prior to and during disinfection. Schedule an immediate retest of the system.
>5000 CFU/mL	>10,000 CFU/mL	Very High Risk Situation	Immediate disinfection of the Cooling Tower and all affected water systems and plumbing is indicated. Alert health care staff. Provide bottled drinking water prior to and during disinfection. Schedule an immediate retest of the system. Significant potential for causing an outbreak of Legionnaires disease.

V. REFERENCES:

A. Department of Health and Human Services, Center for Clinical Standards and Quality/Survey & Certification Group, Ref: S&C 17-30-*Hospitals/CAHs/NHs* REVISED 06.09.2017

B. 42 CFR §482.42 for Hospitals

C. Guidelines
Guideline 12—Minimizing the Risk of Legionellosis Associated with Building Water Systems, ASHRAE, Published 2000
www.techstreet.com/ashrae/products/232891 (currently under revision)

D. Legionellosis Guideline: Best Practices for Control of Legionella Cooling Technology Institute, Published 2008 www.cti.org/downloads/WTP-148.pdf

E. ELITE Program: Centers for Disease Control and Prevention and Wisconsin State Laboratory of Hygiene wwwn.cdc.gov/ELITE/Public/EliteHome.aspx

F. Bond water Technologies, Inc. report by John T Dunford, CWT on Ashrae 188-2015

VI. ATTACHMENTS:

A. OF-SP-35 Prevention and Control of Legionella (CDC Legionella Environmental Assessment Form)

B. OF-SP-35 Prevention and Control of Legionella (Water Management Plan) Attachment B

C. OF-SP-35 Prevention and Control of Legionella Attachment C.doc

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY WIDE

SUBJECT: COVID-19 Vaccination Program-Patients **NUMBER:** OF-SP-39

EFFECTIVE DATE: 05/2021 **REVIEW DATE:** 05/2023

APPROVED BY: /s/ Susan Lynch, MBA, CPM
Hospital Administrator

SUPERSEDES: New

I. PROTOCOL:

It is the protocol of Southern Nevada Adult Mental Health Services (SNAMHS) to have a COVID-19 vaccination program for the prevention and control of Coronavirus disease. Rawson Neal Hospital offers the Johnson and Johnson COVID- 19 vaccine to eligible inpatients during their stay or prior to discharge from the hospital.

II. PURPOSE:

To maintain a safe and healthy environment for our patients by reducing their potential risk of being afflicted by the Corona Virus and thereby spreading it while in the hospital and throughout the community once discharged.

III. DEFINITIONS:

A. COVID-19: Coronavirus disease 2019, the virus that causes COVID-19 is designated severe acute respiratory syndrome coronavirus 2 (SARS-COV-2). It is predominantly a respiratory illness that can affect other organs. People with COVID-19 have reported a wide range of symptoms, ranging from mild symptoms to severe illness. Symptoms may appear 2 to 14 days after exposure to virus. Symptoms may include fever or chills; cough; shortness of breath; fatigue; muscle and body aches; headache; new loss of taste or smell; sore throat; congestion or runny nose; nausea or vomiting; diarrhea.

B. COVID- 19 vaccine: (Adenovirus Vector/Janssen): Promotes active immunity against COVID-19 caused by SARS-CoV-2 virus. The adenovirus vector in the vaccine is a recombinant, replication-incompetent adenovirus vector that expresses the SARS-CoV-2 spike (S) antigen without virus propagation. The vaccine then elicits an immune response to the S antigen, which contributes to protection against COVID-19 disease. The Janssen vaccine contains a human adenovirus type 26 (Ad26) vector.

C. Fact Sheet Jansen COVID-19 Vaccine

IV. PROCEDURES:

A. The authorized prescriber shall be responsible to discuss the COVID vaccine with the patients, including its risks and the risks versus benefits of vaccination before writing an order for a patient assessed to be a suitable candidate for the COVID vaccine and who is in agreement with receiving the vaccination.

B. The order shall be written to include the route of administration and dose to be administered.

C. The authorized prescriber will also write as part of their order, that "the patient consented to the COVID Vaccine." If the patient declined, they will note, "patient declined the COVID vaccine."

D. The nurse at the time of administration of the COVID vaccine will provide each patient with the attached Jansen information sheet and SNAMHS vaccination consent form. (available on every unit). **Please be sure that when you document in AVATAR that you have administered the COVID shot, that you also indicate that the Vaccine information sheet and SNAMHS vaccination consent form were provided to the patient prior to administration. Nursing staff will also document vaccination administration in WEBIZ.**

E. If at the time of administration, the patient has "changed his/her mind" or is refusing. The nurse will document in the nursing notes, that the patient has now declined receiving the vaccine.

V. REFERENCES:

A. Fact Sheet for Healthcare Providers Administering Vaccine (Vaccination Providers). Janssen COVID-19 Vaccine, Dated April 23, 2021.

B. COVID-19 Vaccine Information. Department of Health and Human Services Nevada Division of Public and Behavioral Health. COVID Vaccine (nv.gov). Accessed May 4, 2021.

C. Janssen COVID-19 Vaccine (Johnson & Johnson): Standing Orders for Administering Vaccine to Persons 18 Years of Age and Older (cdc.gov). Accessed May 4, 2021.

IV. ATTACHMENTS:

A. OF-SP-39 COVID-19 Vaccination Program-Patients Attachment A
B. OF-SP-39 COVID-19 Vaccination Program-Patients Attachment B

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: NURSING DEPARTMENT

SUBJECT: BinaxNOW Antigen Test **NUMBER:** II-53

EFFECTIVE DATE: 1/22 **REVISION DATE:** 1/24

APPROVED BY: /s/ Earl Farinas, BSN
Director of Nursing II

SUPERSEDES: New

I. PURPOSE:

To establish guidelines and proper procedures for collecting, handling, and testing patients with COVID symptoms using the BinaxNOW COVID-19 Ag Card antigen. This is a qualitative detection of nucleocapsid protein antigen from SARS-CoV-2 in direct anterior nasal (nares) swabs from individuals suspected of COVID-19 by their healthcare provider within the first seven days of symptom onset.

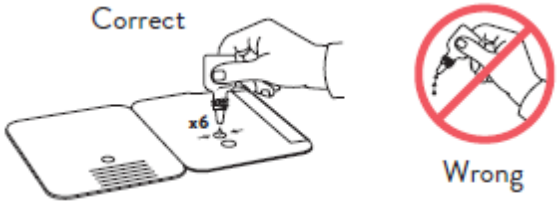
II. DEFINITION:

BinaxNOW COVID-19 Ag Card is a rapid lateral flow immunoassay for the qualitative detection and diagnosis of SARS-CoV-2 directly from nasal swabs, without viral transport media. The BinaxNOW COVID-19 Ag Card Kit contains all components required to carry out an assay for SARS-CoV-2. The BinaxNOW COVID-19 Ag Card is intended for use by medical professionals who are proficient in performing rapid lateral flow tests.

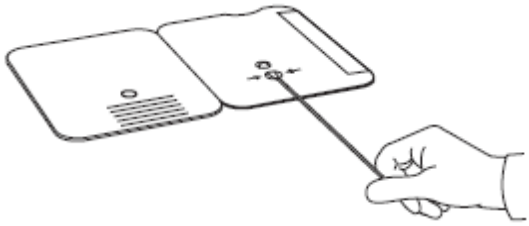
III. PROCEDURE:

1. Only trained staff may collect and test patients using the BinaxNow, after an order for SARS-CoV-2 RNA (COVID-19) test is established by or obtained from medical staff.
2. Guidelines in obtaining, acknowledging orders, medical staff orders, and documentation standards are followed per hospital policy.
3. Verify by using two individual identifiers per hospital policy.
4. Explain before the procedure.
   a. **Assemble supplies needed:**
      Test cards
      Extraction reagent
      Nasal Swabs
      Gloves
      Face shield or protective shield
      Timer

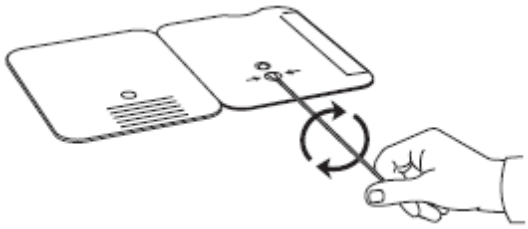
5. Specimen collection **(**Follow Universal Precautions and treat all specimens as potentially hazardous. Assure appropriate swab kit is utilized).
6. Perform hand hygiene.
7. Don PPE (mask, face shield, gloves, and gown).
8. Remove the patient's mask if applicable to perform the procedure and replace it when complete.
9. Have the patient use a tissue to gently clean the nasal passage before a swab is taken as appropriate.
10. **Testing External QualityControl (QC)**
    a. **Follow instructions for external controls.** Hold Extraction Reagent bottle vertically. Hovering ½ inch above the TOP HOLE,slowly adds **8 DROPS** to the **TOP HOLE** of the swab well. DO NOT touch the card with the dropper tip while dispensing.
    b. Insert the (+) or (-) control swab into **BOTTOM HOLE** and firmly push upwards so that the swab tip is visible in the **TOP HOLE.**
    c. Rotate (twirl) swab shaft 3 times CLOCKWISE (to the right). Do not remove swab.
    d. Peel off adhesive liner from the right edge of the test card. Close and securely seal the card.
    e. Read result in the window 15 minutes after closing the card. It is important to read the result promptly at 15 minutes, and not before. Resutls should not be read after 30 minutes.
11. **Anterior Nasal (Nares) Swab**
    a. Only the swab provided in the kit is to be used for nasal swab collection
    To collect a nasal swab sample, carefully insert the entire absorbent tip of the swab usually ½ to ¾ of an inch (1 to 1.5 cm) into the nostril. Firmly sample the nasal wall by rotating the swab in a circular path against the nasal wall **5 times** or **more for a total of 15 seconds**, then slowly remove from the nostril. Using the same swab, **repeat sample collection in the other nostril.**
12. **Test Procedure**
    a. Open the test card prior to use and lay it flat.
    b. Hold Extraction Reagent bottle vertically. Hovering ½ inch above the TOP HOLE, slowly add 6 DROPS to the TOP HOLE of the swab well. DO NOT touch the card with the dropper tip while dispensing.



    c. Insert sample into BOTTOM HOLE and firmly push upwards so that the swab tip is visible in the TOP HOLE.

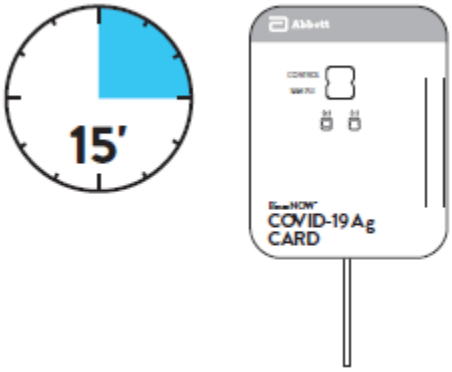


d. Rotate (twirl) swab shaft 3 times CLOCKWISE (to the right). Do not remove swab.



Note: *False negative results can occur if the sample swab is not rotated (twirled) prior to closing the card.*

e. Peel off adhesive liner from the right edge of the test card. Close and securely seal the card. Read result in the window 15 minutes after closing the card. In order to ensure proper test performance, it is important to read the result promptly at 15 minutes, and not before. Results should not be read after 30 minutes.



Note1: *False negative results can occur if test results are read before 15 minutes.*

Note 2: When reading test results, tilt the card to reduce glare on the result window if necessary. Individuals with color-impaired vision may not be able to adequately interpret test results. If indicated, may verify colorblindness by visiting the link:

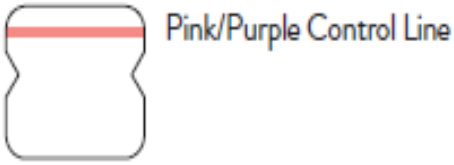
https://enchroma.com/pages/test?gclid=CjwKCAiAzrWOBhBjEiwAq85QZ5x36o

EPMXfLo1ZBx6FshvYfdgIbxp5Pk8FJQOi4pyTQL9XwfO_h-xoCXPAQAvD_BwE

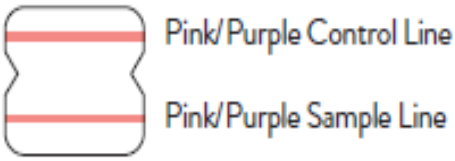
13. Remove PPE, discard in the biohazard bin, including the swab kit and test card.
14. Perform hand hygiene.
15. Document as indicated.

IV. **Result Interpretation**

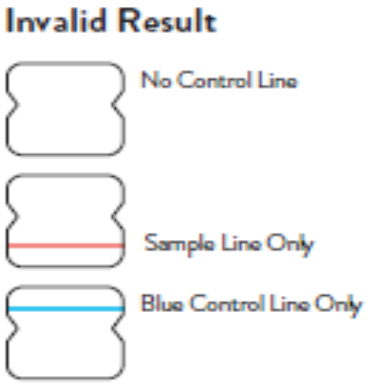
1. ***Note:*** In an untested BinaxNOW COVID-19 Ag Card there will be a blue line present at the Control Line position. In a valid, tested device, the blue line washes away and a pink/purple line appears, confirming that the sample has flowed through the test strip and the reagents are working. If the blue line is not present at the Control Line position prior to running the test, do not use and discard the test card.
2. **Negative:** A negative specimen will give a single pink/purple colored Control Line in the top half of the window, indicating a negative result. This Control Line means that the detection part of the test was done correctly, but no COVID-19 antigen was detected.



3. **Positive:** A positive specimen will give two pink/purple-colored lines. This means that COVID-19 antigen was detected. Specimens with low levels of antigen may give a faint Sample Line. Any visible pink/purple colored line is positive.



4. **Invalid:** If no lines are seen, if just the Sample Line is seen, or the Blue Control Line remains blue, the assay is invalid. Invalid tests should be repeated.



V. REFERENCES

1. DPBH Laboratory Department Document 213 – BinaxNOW COVID 19 ag Card
2. U.S Food and Drug Administraiton (2022, January 4). *BINAXNOW COVID-19 AG CARD (PN 195-000) – Instructions for use.*https://www.fda.gov/media/141570/download.

VI. ATTACHMENTS: N/A

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCYWIDE

SUBJECT: Patient Identifier **NUMBER:** PF-CC-55

EFFECTIVE DATE: 01/2023 **REVIEW DATE:** 01/2025

APPROVED BY: /s/ Susan Lynch, MBA, CPM
Hospital Administrator

SUPERSEDES: 02/12; 04/12; 08/14; 01/15; 01/17; 01/19; 01/21

I. POLICY:

It shall be the protocol of SNAMHS to ensure two patient identifiers are completed for all services or treatments.

II. PURPOSE:

To utilize a structured process of two identifiers to reliably identify the patient as the individual for whom service or treatment is intended and to match the service or treatment to that individual.

III. DEFINITIONS: N/A

IV. PROCEDURE:

A. Two (2) identifiers will be required anytime the patient is receiving services or treatment and are not limited to medication administration, but including check-in for medication clinic and therapy appointments, prescription refill, Telehealth services, etc.

B. Each medical record will have two (2) of the following identifiers available:

1. Picture
2. Patient's full name (First and Last) to include any alias
3. Patient's date of birth date

C. Prior to treatment and/or services rendered, the staff is required to ask the patient to state full name (First and Last) with the medical record available for verification.

D. Compare the patient to the picture in the medical record to reliably identify the patient as the individual for whom the service or treatment is intended.

Recognition of the patient by the direct service provider can also be used in combination with one of the identifiers listed under section B.

E. If a picture is not available or does not appear to match the person, the **staff is required** to ask the patient to state date of birth with the medical record available for verification.

V. REFERENCES: N/A

VI. ATTACHMENTS: N/A

DIVISION OF MENTAL HEALTH AND DEVELOPMENTAL SERVICES
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: NURSING DEPARTMENT

SUBJECT: Outpatient Direct Admits to Rawson Neal **NUMBER:** II-2

EFFECTIVE DATE: 06/22 **REVISION DATE:** 06/24

APPROVED BY: /s/ Earl Farinas
Director of Nursing II

SUPERSEDES: 5/11, 10/15, 11/17, 01/19, 01/20

I. PURPOSE:

To establish a process to directly admit outpatient clinic clients to Rawson Neal Hospital.

II. PROCEDURE:

A. All clients currently open and in active treatment for an outpatient episode are eligible for direct admission to the hospital without being diverted to the closest local emergency room for medical clearance.

B. Clients who have been identified as appropriate for an involuntary admission and are approved for admission to Rawson Neal must receive a brief screening by the referring outpatient psychiatrist, advanced practice registered nurse, physician's assistant, or registered nurse. Mental Health Crisis Hold will be initiated before transporting the client.

C. Outpatient clinic staff will contact the admission department for bed availability. The admission department will offer the bed to the outpatient clinic client when available and notify the Rawson Neal Unit to save the bed.

D. Outpatient clinic nurse will give a nurse-to nurse report to the admission department of the directly admitted client.

E. The following pieces of information will be reported to the admission department prior to transport or admitting the clients:

1. Outpatient Programs – Medication Clinic, Service Coordination, AOT, PACT, etcetera

2. Sending Licensed Independent Practitioner

3. Mental Health Crisis Hold (complete page 1 and certification ofMental Health Crisis Hold)

4. Patient name
5. Date of birth (DOB)
6. Gender
7. Chief complaints that warrant hospitalization
8. Axis III diagnosis/Medicare Conditions
9. Vital signs
10. Current medications
11. Allergies
12. Special needs (example, HR for fall)
13. Any Insurance

Follow-Up Report: Outpatient Clinic =Staff will send the following documents via email or fax: 702 486-7158 or x 67158.

- Diagnoses
- Any previous psych evaluations (AVATAR) or current psych evaluation
- Medication List
- Allergies
- H&P (if any)
- COVID screening questionnaires

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F. Transportation arrangements are arranged by Outpatient clinic staff via AMR or personal escorting the client to Rawson Neal Hospital.

G. Following the client's arrival at Rawson Neal Hospital, unit staff will proceed with the standard intake process following the "intake protocol process".

H. Any outpatient staff who brings a client for admission without prior approval or pre-arranging transport will be denied access until all appropriate approvals are obtained from the administration.

I. The Admissions Department will consult with the SNAMHS Primary Care Medical Staff for any clients with medical concerns and notify the Medical Director of Rawson Neal for admission appropriateness.

J. If the client is not approved by the Primary Care Medical Staff and the Medical Director due to being medically unstable, unit staff will initiate the patient's transfer following the COBRA protocol.

III. REFERENCES: II-15 COBRA and Escort of an Inpatient to Emergency Room

IV. ATTACHMANETS: N/A

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: NURSING DEPARTMENT

SUBJECT: Post Incarceration Direct Admits **NUMBER:** II-3

EFFECTIVE DATE: 06/22 **REVISION DATE:** 06/24

APPROVED BY: /s/ Earl Farinas, RN
Director of Nursing II

SUPERSEDES: 07/11, 10/15, 11/17, 01/19, 01/20

I. PURPOSE:

To establish a process to directly admit post-incarceration Mental Health Crisis Hold (MHCH)directly from correctional facilities

II. PROCEDURE:

A. All inmates who are currently incarcerated and identified by correctional facility mental health providers to be a danger to self or others and have been deemed appropriate for involuntary admission are eligible for direct admission without first being directed to the closest local emergency room for medical clearance.

B. Any inmate identified as appropriate for an involuntary admission must receive no less than a brief screening from the clinic psychiatrist, advanced practice registered nurse or a physician's assistant, or registered nurse who will initiate the Mental Health Crisis Hold process and approve a direct admission.

C. Rawson Neal requires the following documentation:

1. Face Sheet or Basic demographics (name, DOB, address, gender)
2. Patient Profile Summary (if any)
3. Most recent labs (if any)
4. Medication (MARS if available)
5. Allergies
6. History and Physical
7. Psychiatric Evaluation
8. Mental Health Progress Notes
9. PPD status / CXR
10. Diagnostic Test (if any)
11. HCG (required for females, 50 years old and below)
12. Mental Health Crisis Hold completed including medical portion **to be completed 24 hours prior to transfer**
13. Pending charges and detainer (if any)
14. COVID test result (if any)
15. COVID screening questionnaires
16. Reports on ADL's, use of assistive devices, behavior etcetera

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D. The Admissions Department will ensure that all documents have been received prior to admission via e-mail or fax to 702-486-7158. The correctional facility can contact the Admission Department for referrals via email or phone, contact numbers: 702-486-7148, 702-486-0740, 702-486-7065.

E. Admission Staff will add the client to the crisis wait list once the referral information (Mental Health Crisis Hold, Evaluations etcetera) is received and complete the admission form (aka Golden Rod)

F. Admissions Department will consult with the SNAMHS Primary Care Medical Staff for any clients with medical concerns and notify the Medical Director of Rawson Neal Hospital, if necessary, of admission appropriateness.

G. If the client has a detainer of probation officer, the admission department will write the information in the Golden Rod and forward the information to the appropriate staff in the unit as such: a psychiatrist, nurse and social worker.

H. Admission staff will coordinate with the correctional facility via phone or e-mail for the transport schedule and determine the arrival date and time. Transportation arrangements are arranged by the correctional facility.

I. Following the client's arrival, staff will proceed with the standard intake process following the Intake Protocol.

III. REFERENCES: N/A

IV. ATTACHMENTS: N/A

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
NURSING DEPARTMENT

SUBJECT: Transportation of Inpatients **NUMBER:** II- 04

EFFECTIVE DATE: 04/2022 **REVISION DATE:** 04/2024

APPROVED BY: /s/ Earl Farinas
Director of Nursing

SUPERSEDES: 11/02, 10/15, 03/17, 04/18, 01/19, 01/20, 11/20

I. PURPOSE:

To safely transport patients to pre-arranged appointments in the community and to Mental Health Court.

A. Main Hospital

1. Utilize the emergency bay outside C-Pod for all patient transports.

II. DEFINITIONS:

Physical Intervention: Any action that involves use of physical restraint to gain control of a client/situation. Crisis Prevention Institute (CPI) control techniques will always be used first. Physical Intervention is only to be used as a last resort and will always be the minimum amount necessary to gain control of a client or situation

III. PROCEDURE:

A. COMMUNITY APPOINTMENTS

1. Registered Nurse / Designee

a. Complete the Inpatient Transportation Request form. Place a copy with the Kardex, and on the medical board.

b. The unit charge nurse or designee will email copies of the following to the unit manager or designee:

1. Copy of the completed Transportation Request Form
2. Medical staff's order for transport
3. Most recent Elopement Risk Assessment report

4. Nursing Progress notes from the past 72 hours

c. The unit manager or designee will review all attachments for completeness and accuracy and forward the email to the Medical Director and Hospital Administrator.

d. All non-emergent off campus appointments will require approval from the Medical Director and Hospital Administrator prior to transport.

e. Send completed Transportation Request form, signed by the Unit Manager, to the Staffing Office and to Transportation (Supply Department) via e-mail.

f. Prior to the departure of the patient, verify appointment.

2. Registered Nurse

a. Prior to the departure of the patient, assess the patient and report pertinent clinical information to the staff who will accompany the patient.

b. Send appropriate and requested clinical information regarding the patient with the patient to the appointment.

c. Document findings in a progress note.

d. Upon patient's return to the unit, review and follow up on any medical instructions and complete a progress note that includes documentation of the patient's condition on return and any issues associated with appointment.

3. Staffing Office

a. Arrange staff coverage for transport along with driver. (the Registered Nurse in conjunction with doctor's order will determines the number of staff who needs to accompany the patient to the appointment).

4. Transportation (Supply Department)

a. Plan to drive transport vehicle for all pre-arranged community appointments.

b. May leave and pick up staff and patient after the appointment is completed.

5. Staff Accompanying Patient

a. Carry a hospital issued cell phone and telephone numbers.

b. Walk directly beside or behind the patient maintaining close proximity to ensure the patients safety during transport.

c. Remain with the patient during appointment.

d. Crisis Prevention Institute (CPI) verbal techniques shall be used by staff to redirect patients who are attempting to elope during an off-campus transport

e. If the patient elopes, immediately notify the unit Registered Nurse. The nurse will then notify

- Metro
- Primary physician or designee
- PN IV/designee
- Notify family if indicated and or legally indicated.
- Treatment Team members
- Complete incident report

6. Registered Nurse

a. Prior to the departure of the patient, assess the patient and report pertinent clinical information to the MHT staff who will accompany the patient.

b. Complete progress note.

IV. REFERENCES:

II-01 Vehicle Use for Transport

V. ATTACHMENT:

A. II-04 Transportation Of Inpatients - Attachment A

INPATIENT TRANSPORTATION REQUEST

Date of Request: _____

Patient Name: _____

Unit: _____

Date and Day of Transport: _____

Appointment Time: _____

Appointment Location: _____

Number of Staff Needed: _____

Staff Name Requesting: _____

Specific Instructions: _____

Purpose: ☐OB ☐ORTHO ☐GI ☐RESP ☐CARDIAC ☐DENTAL ☐NEURO ☐OTHER: _____

THE PORTION BELOW IS FILLED OUT BY THE PN IV AFTER COMPLETION. THE ORIGINAL IS TO BE PLACED IN THE TRANSPORT BINDER LOCATED IN THE PN IV OFFICE. A COPY IS TO BE PLACED IN THE KARDEX.

Date Request Received: _____

Documents emailed to Hospital Administrator and Medical Director for Review:

☐ **Copy of Inpatient Transportation Request** ☐ **Medical Staff Order for Transport**

☐ **Most current Elopement Risk Assessment**

☐ **Nursing Progress Notes from the past 72 hours**

Approval Received for Transport from Hospital Administrator and Medical Director ☐ **YES**

PN IV Signature: _____

Copy of Request Placed in the Transport Binder ☐ **YES**

Comments: _____

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
NURSING DEPARTMENT

SUBJECT: Physician/Patient Transfers **NUMBER:** II - 05

EFFECTIVE DATE: 05/23 **REVISION DATE:** 5/25

APPROVED BY: /s/ Earl Farinas, BSN, RN
Director of Nursing II

SUPERSEDES: 04/05, 12/17, 1/18, 01/19, 11/19, 07/20, 02/23

I. PURPOSE:

To best promote the quality of services and continuity of care when transferring a patient from one hospital unit to another and/or from one Physician to another. Room assignments upon patient admission and/or a patient transfer are based upon room availability and ensure non-discrimination in those assignments. Room assignments are not based on race, religion, age, or financial status.

II. PROCEDURE:

A. Nurse acknowledges Physician order for transfer, informs patient unless otherwise specified by the physician and documents the notification in the Progress Notes.

B. Nurse notifies assigned Mental Health Technician (MHT) of transfer. The nurse will communicate to the technician any information pertinent to the safety and well-being of the patient during transfer.

C. The nurse completes the New Admission Report and faxes it to the receiving unit. The nurse calls receiving unit and reports to the accepting unit nurse the estimated time of transfer.

D. Nurse and MHT complete patient Transfer Checklist.

E. The nurse completes Progress Note prior to patient transferring off the unit/transferring to another Physician.

F. Patient's belongings and valuables are checked prior to transfer by MHT or nurse against Inventory of Personal Effects sheet.

G. The accepting unit re-checks patient's belongings and valuables to validate accuracy using the Inventory of Personal Effects sheet. Upon completion, both patient and staff sign the sheet.

H. Any patients moving/transferring between any SNAMHS buildings will be escorted by two (2) clinical staff members. These staff members are to walk directly beside or behind the patient maintaining close proximity in an effort to ensure safe arrival to the location.

I. The transferring Physician shall document the transfer of care/services to the specified Physician and reviews the list of current medications available in the eMAR. For patient's transferring to another Agency program, the transferring Physician shall complete the documentation on a new prescription.

J. Any difficulties in achieving the above should be reported to the PN III or PN IV.

III. REFERENCES: III-01 Nursing Medication Administration Process

IV. ATTACHMENTS: N/A

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: Nursing Department

SUBJECT: Inpatient Admission Procedure **NUMBER:** II-08

EFFECTIVE DATE: 02/23 **NEXT REVIEW DATE:** 02/25

APPROVED BY: /s/ Earl Farinas, BSN, RN
Director of Nursing

SUPERSEDES: 11/02, 3/14, 5/15, 10/15, 7/16, 3/17, 1/18, 4/18, 1/19, 09/19, 01/20, 9/20,11/20, 03/21, 04/21, 06/21

I. POLICY: To provide for a standardized and consistent process for admitting patients to inpatient units.

II. PURPOSE:
To identify the specific elements involved in the admission procedure and staff members responsible for compliance and to ensure room assignments ensures non-discrimination.

III. PROCEDURE:

A. PRE ADMISSION

1. PN DUTIES

a. Check fax(s) received from sending agency/facility for a complete and accurate Legal 2000R/certification or petition and review the paperwork for outstanding legal/medical issues.

b. Fill out Facility Information and IP/ER area of form.

c. Psychiatrist will review all faxes and will make one of two decisions: refer to MD for medical consultation or admit.

d. Obtain most recent scanned medical records from server. Include: discharge summary, recent inpatient discharge summary, inpatient MARs and psychiatric evaluation.

e. If referred to MD, Psychiatrist will fill out section referring to MD in Admission Acceptance Information area on form and initial and date.

f. MD will review medical issues and will fill out section OK to Accept in Admission Acceptance Information area on form and sign and date.

g. After MD has accepted patient for admission, Psychiatrist will fill out OK to Accept in Admission Acceptance Information area on form and sign and date.

h. The Corresponding Information area on the Pending Clients form is to be utilized for any and all correspondence that occurs as it relates to the designated patient. Examples are but not limited to lab results, discovery of prior history, missing Legal 2000R, specific individuals notified, etc.

i. Psychiatrist enters admission orders. If unavailable Psychiatrist will be called and nurse will receive telephone admitting orders.

i. Admit

ii. Vital signs

iii. Observation

iv. Diet

v. Patio privileges

j. Patient Arrival Information is to be entered on form upon arrival.

k. If the patient has not arrived within one (1) hour after being accepted, call the facility and document in Corresponding Information area on form.

B. ADMISSION (refer to Admission Checklist, attachment A)

1. PN DUTIES

a. Complete Quick Screen in ambulance bay and confirm Legal Status - Legal 2000/petition date and time.

b. Update Shift Movement Log sheet.

c. Complete Admission Checklist Fungal Infection form, COVID-19 screening, and the Monkeypox Screening.

d. Initiate TST Screening/Documentation form.

e. Place applicable alert sticker(s) on front of chart (Allergies, Legal Guardian, Pregnant, Fall Risk, Red Risk, Anticoagulant Therapy).

f. Obtain Physician Admitting orders.

g. Complete Kardex file.

h. Personal (Home) medications logged and stored (if necessary).

i. AVATAR: Nurse's Assessment, Fall Risk with fall risk assessment tool attached, Allergies & Hypersensitivities, AIMS, Inpatient progress note, Treatment plan, Mental Status.

j. Complete the Columbia-Suicide Severity Rating scale screening form. (attachment D).

k. Elopement risk assessment form initiated. (PF-CC-08 attachment A).

l. Medication reconciliation log reviewed/placed on psych board.(OF-MOI-60 attachment A).

m. Confirm patient consents including Advance Directive signed and placed under Legal tab.

n. Complete medical consult (if necessary).

o. Medication Consents signed (if applicable).

p. Place Client ID report (patient picture) in Red Binder.

2. MHT DUTIES

a. Take admission photograph, date, place inside of the patient's chart, and import into AVATAR.

b. Complete patient safety check with RN/Co-sign Admission checklist fungal infection form.

c. Orient patient to room and unit.

d. Complete room assignment.

e. Service Application Worksheet, Consents, Advance Directive, and Patient Identification completed and filed in chart.

f. AVATAR: Admission including bed assignment, Import Client Picture, Client Wristband Report, Legal Status, Diagnosis, Attending Practitioner, Vitals Entry form, Admission Authorization, Consent for Admissions, Consent to Photograph.

g. Complete Patient Safety Plan sheet and place in Kardex.

h. Photocopy identification cards including picture ID and place in chart.

i. Take vital signs, height, weight, and enter into Avatar Vitals Entry Form.

j. Inventory property and valuables, sign, file, and place in storage.

k. Valuables and home medications given to nurse.

l. Monitor Board and SBAR updated.

C. TRANSFER: Transferring Unit (refer to Patient Transfer - Transferring Unit Checklist)

1. PN DUTIES

a. Verify physician's order for transfer is current (7 days).

b. Verify current legal status.

c. Update Shift Movement log.

d. Update Unit census board.

e. Place Client ID report, medication consents, TST form, and Kardex in chart.

f. Transfer patient with non-Pyxis medications (from med room/cart), (i.e. inhalers, eye drops).

g. Secure property and valuables from safe and storage.

h. AVATAR: Inpatient progress note.

i. Fax or call report to inpatient unit nurse.

2. MHT DUTIES

a. Property sheet signed by sending staff, receiving staff and patient.

b. Transfer patient with property/valuables/medications/chart.

c. Notify Housekeeping to clean room.

d. Update monitor board and SBAR.

D. TRANSFER: Receiving Unit (refer to Patient Transfer - Receiving Unit Checklist – attachment C)

1. PN DUTIES:

   a. Patient Safety Check (when patient is received)

   b. Verify Legal status (Voluntary, Legal 2000, PPP, Court Petition).

   c. Verify labs – Complete requisition.

   d. Verify Medication Consents signed.

   e. Verify TST Screening/Documentation form.

   f. Update Kardex.

   g. Update unit census board.

   h. Store non-Pyxis medications in med cart/med room (if applicable).

   i. Secure patient's valuables in safe.

   j. Elopement risk assessment form updated.

   k. Medication reconciliation log in chart.

   l. AVATAR: Treatment plan updated, Nurse's assessment updated (if applicable), Fall Risk with fall risk assessment tool attached (OT referral, if applicable), Inpatient progress note.

2. MHT DUTIES

   a. Complete patient safety check with the accepting nurse.

   b. Orient patient to unit and room.

   c. Take vital signs and enter into Avatar Vitals Entry Form.

   d. Complete room assignment.

   e. Store property and valuables per protocol.

   f. Update monitor board and SBAR updated.

IV. REFERENCES:

The Columbia Lighthouse Project. (n.d.). https://cssrs.columbia.edu/

V. ATTACHMENTS:

A. II-08 Inpatient Admissions Procedure Attachment A

B. II-08 Inpatient Admission Procedure Attachment B

C. II-08 Inpatient Admission Procedure Attachment C

D. II-08 Columbia-Suicide Severity Rating scale screening form Attachment D

E. PF-CC-86 Elopement Risk Attachment A

F. OF-MOI-60 Medication Reconciliation Attachment A

Patient Admission Checklist

PATIENT NAME/MR#: _____ UNIT: _____

PN

Initial

_____ Legal status confirmed (Mental Health Crisis Packet, Petition, Voluntary, PPP)
_____ Admission Checklist Fungal Infection form completed
_____ Coronavirus (Covid-19) Screening check-off list completed
_____ Columbia-Suicide Severity Rating Scale (CSSRS) form completed
_____ Medication Reconciliation log reviewed/placed on psych board
_____ TST Screening/Documentation form initiated
_____ Shift Movement Log & Unit census board updated
_____ Placed applicable alert sticker(s) on the front of the chart (Allergies, Guardian, Pregnant, Fall Risk, Red Risk, Anti-coagulant)
_____ Physician admission orders obtained and acknowledged
_____ Medication consent(s) signed (if applicable)
_____ Kardex completed
_____ Client ID report (patient picture) placed in Red Binder
_____ Patient's Personal Medication Inventory Sheet (Home Medications) completed and stored (if applicable)
_____ Patient's label placed in the psychiatric board for psychiatric evaluation, and medical board for History and Physical
_____Psychology Consult Request (PCR) (Red risk, aggression). Place pt name in the PCR book

AVATAR forms:

_____ Allergies & Hypersensitivities
_____ Treatment Plan (include any applicable Secondary Problem/s)
_____ Nurse's Assessment with Fall Risk Assessment Tool attached
_____AIMS
_____ Mental Status
_____Inpatient Progress Note
_____Elopement Risk

PN PRINT NAME: _____ DATE: _____
PN SIGNATURE: _____ TIME: _____

MHT

Initial

_____ Admission photograph taken, dated, placed inside patient's chart, and imported into AVATAR
_____ Safety check completed with RN/Co-signed Admission checklist fungal infection form
_____ Service Application Worksheet, Patient Identification Forms, and Safety Plan completed and filed in chart/Kardex
_____ Patient oriented to room and unit
_____ Property and valuables inventoried, signed, filed, and stored per protocol
_____ Monitor board and SBAR updated

AVATAR forms:

_____ Admission including bed assignment (No blanks)
_____ Import Client Picture
_____ Client Wristband Report (Print and give to RN)
_____ Consents completed (Admission Authorization, Consent for Admission, Consent to Photograph)
_____ Legal Status
_____ Diagnosis (from the Golden Rod)
_____ Vitals Entry form
_____ Attending Practitioner

MHT PRINT NAME: _____ DATE: _____
MHT SIGNATURE: _____ TIME: _____

Revised November 2022

Patient Transfer – Transferring Unit Checklist

PATIENT NAME/MR#: _____ UNIT: _____

PN

Initial
_____ Verified physician's order for transfer is current
_____ Current legal status verified
_____ Shift Movement log updated
_____ Unit census board updated
_____ Client ID report (patient picture), medication consents, TST form, and Kardex placed in chart
_____ All non-Pyxis medications transferred with patient (if applicable)
_____ Patient's property and valuables secured from safe and storage
_____ Incident Report, Seclusion & Restraint, or Allegation of Abuse endorsed (if applicable)
_____ Psychology consult (PBSP request) completed (if applicable)
_____ Psychology consult (Red Risk Protocol) completed (if applicable)
_____ OT consult (Fall Risk) completed (if applicable); Date completed: _____
_____ Report called to receiving unit Nurse: _____ Time: _____

AVATAR forms:
_____ **Inpatient Progress Note**

PN (NAME/SIGNATURE): _____DATE/TIME: _____

CHARGE PN (NAME/ SIGNATURE: _____DATE/TIME: _____

MHT

Initial
_____ Property sheet signed by sending staff, receiving staff, and patient prior to transfer
_____ Property/Valuables/Medications/Chart transferred with the patient
_____ Housekeeping notified to clean the room
_____ Monitor board and SBAR updated

MHT (NAME/SIGNATURE): _____DATE/TIME: _____

LEAD MHT (NAME/ SIGNATURE): _____DATE/ TIME: _____

Patient Transfer – Receiving Unit Checklist

PATIENT NAME/MR#: _____ UNIT: _____

PN

Initial

____ Patient Safety Check
____ Current legal status verified
____ Verified medication consents signed
____ Verified labs–completed requisition
____ Verified TST Screening/Documentation
____ Client wristband report, medication consents, and TST form placed in Red binder
____ Kardex updated
____ Unit census board updated
____ Patient's property and valuables placed in safe storage
____ All non-Pyxis medications stored (if applicable)
____ Placed on psychiatric board (new patient)
____ Patient Transfer – Transferring Unit Checklist (PN) Reviewed/Verified for Accuracy

AVATAR:

____ **Treatment Plan updated, include/update any secondary problems**
____ **Nurse's Assessment update (if applicable)**
____ **Fall Risk with fall risk assessment tool attached (OT referral, if applicable)**
____ **Inpatient Progress Note**

PN (NAME/SIGNATURE): _____DATE/TIME: _____

CHARGE PN (NAME/SIGNATURE): _____ DATE/TIME: _____

MHT

Initial

____ Patient safety check completed with the nurse.
____ Patient oriented to room and unit
____ Vital signs completed and entered into Avatar Vitals Entry Form, inform nurse to approve on their "To do list", then complete Review To Do Item on your "To do list"
____ Room assignment completed
____ Patient data entered into Avatar
____ Property and valuables stored per protocol
____ Monitor board and SBAR updated
____ Patient Transfer – Transferring Unit Checklist (MHT) Reviewed/Verified for Accuracy

MHT (NAME/SIGNATURE): _____DATE/TIME: _____

LEAD MHT (NAME/SIGNATURE): _____DATE/TIME: _____

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: NURSING

SUBJECT: Patient Property **NUMBER:** II-09

EFFECTIVE DATE: 09/22 **NEXT REVIEW DATE:** 09/24

APPROVED BY: /s/ Earl Farinas, RN
Director of Nursing II

SUPERSEDES: 11/02, 7/14, 10/15, 8/17, 01/18, 5/18, 04/19, 5/19, 01/20, 06/22

I. PURPOSE:

To establish procedures for the handling of patients' belongings.

II. DEFINITION:

A. The Inventory of Personal Effects form is to be used for any and all items brought in by the patient upon admission.

B. The Valuables for Deposit in Unit Safe form is to be used for any and all items deposited in the unit safe.

C. The Safe Deposit Record form is used to record deposits and withdrawals.

D. The Safe Deposit Record / Count is used to count the valuable envelopes in the safe every shift.

III. PROCEDURE:

A. ADMISSION

1. Upon admission, the patient will be questioned regarding belongings, including but not limited to, cash, checks, negotiable paper, important documents, credit cards, rare coins, jewelry, and firearms.

2. The only property items a patient is allowed access to are hygiene products that are not sharp and in non-glass containers, three changes of clothing and one pair of shoes. The treatment team shall approve patient access to items stored in safe and/or storage area. Such items may include but are not limited to wedding rings, rosaries, jewelry, money, etc.

3. When clients are admitted to the hospital with perishable food items, pharmaceutical products or alcohol the following protocol will be followed:

    a. Prescribed medications will be sent to the pharmacy with a physician order to either hold for discharge or to destroy.

b. With a physician order, Nursing staff may pick up held medications for release on discharge and return them to the client.

c. Open bottles of alcohol brought in by a client on admission will be disposed of.

d. All perishable food items will be disposed of.

4. After explaining the protocol to patient possessions, these items will be labeled, placed in a plastic bag using the zip ties, and stored in the appropriate area, such as the patient storage room. Unless otherwise specified, the plastic bag will not be opened until after the discharge has taken place.

5. Two (2) staff members will jointly inventory any remaining items upon patient's arrival on the unit. Inventory will be completed in a secure area..

   a. Patients are not allowed to keep sharps, aerosols, keys, matches, or lighters (this list is not all inclusive). These items will be locked up on the unit after an Inventory of Personal Effects has been completed.

   b. Any item(s) that nursing staff have added or taken from a patient will be identified on an Inventory of Personal Effects Form.

6. Upon inventory of personal property, identification cards, credit cards are discovered to have a name other than the patient being admitted, Las Vegas Metropolitan police Department (LVMPD) are to be notified. These articles will not be returned to the patient. Do not inventory on patient property sheet, or make note that articles were discovered and turned over to the police. In accordance with HIPPA, the patient who is in possession of these articles will not be divulged to police. The articles will be placed in an envelope with no further information given.

   a. Treatment Team shall be informed.

   b. The situation should be documented in the medical record.

7. The Inventory of Personal Effects form will be completed, signed, and dated.

8. The Valuables for Deposit in Unit Safe form will be completed, signed, and dated.

9. Should a patient have more than $1000, cash, the cash will be routed to the Office of the Hospital Administrator's Safe.

   a. The cash is routed during normal business hours.

   b. The Charge Nurse is responsible for the safety of the monies until it is routed to the Office of the Hospital Administrator Safe.

c. The chain of custody must be documented by each involved Charge Nurse until the monies are routed to the Office of the Hospital Administrator.

d. The patient at the time of discharge during normal business hours may collect all property including monies and valuables.

e. The patient monies may be routed to the Charge Nurse for anticipated after hours discharge. The Charge Nurse will obtain a signed, dated receipt at the time of departure.

f. The Charge Nurse may coordinate for the patient to pick up the monies Monday through Friday 8am-5pm in the Office of the Hospital Administrator.

10. If the patient has cash less than $1,000, a separate envelope for valuables will be designated for cash only. A preprinted label signed and dated by two staff members will be used to seal the envelope, and it will be deposited in the unit safe.

11. The following should be noted with respect to each item recorded:

a. Cash – total amount and the denominations of all bills and coins.

b. Checks – amount of each check, who issued check and serial numbers.

c. Credit Cards – company and the last four digits of the account.

d. Rare Coins – coins that the patient specifically identifies as “rare coins.”

e. Securities – company, face amounts and account number.

f. Other Valuable Documents – description of each, i.e., bus tickets, food stamps, pawn tickets.

g. Jewelry – an approximate description of the color of the metal and the color of the stone. Do not describe the metal as “gold” or “silver”, or the stones as “diamonds” or “rubies”. Include any visible brand names.

Examples:

i. Yellow metal ring with red stone.

ii. White metal neck chain.

iii. White metal wristwatch with 12 small clear stones located around the watch, TIMEX.

iv. Yellow metal bracelet with ID tag with 1 clear stone (small).

12. The valuable items will be placed in the Valuables for Deposit Envelope and placed in the unit safe, refer to agency protocol OF-PI-25 Personal Property.
    a. The unit Charge Nurse will hold the key to the safe.
    b. The safe will be under a double lock system. Two (2) staff must be present when the safe is open.
    c. The Charge Nurse and/or staff admitting the patient (MHT or staff nurse) on the Pod will deposit the valuables in the safe and both will sign the log under deposits.

13. The valuable envelopes in the safe will be counted every shift. Results will be recorded on Safe Deposit Record / Count Sheet located in the unit safe book.
    a. Envelopes will be counted by oncoming and off going shift charge nurses, timed, dated and signed by both parties.
    b. Reconciliation count will be recorded on the Safe Deposit Record / Count sheet.
    c. All discrepancies will be investigated and reported to the House Supervisor and Nurse Administrator On-Call immediately and an Incident Report will be filled out.

14. Firearms are to be given to the Nursing Supervisor or House Supervisor after a description has been documented on the Valuables for Deposit in Unit Safe Form.
    a. The Nursing Supervisor or House Supervisor will give the firearm(s) to the Las Vegas Metropolitan Police Department.
    b. The Las Vegas Metropolitan Police Department will provide a receipt that will be attached to the patient's Inventory of Personal Effects Form.
    c. At discharge, the patient will be given the Police Department receipt.

15. Sharps will be inventoried on the Inventory of Personal Effects form and then stored in the safe. <u>This includes unused razors which should be placed in a separate envelope marked "Caution – Sharps inside" with a red marker and attached to other envelopes for the same patient. Used razors should be discarded in a sharps container.</u>

16. All other items are to be stored in containers on the unit or in the storage room.

17. Empty space on the forms should be crossed out at the time of completion. No subsequent additions or deletions should be made. If circumstances change, new forms will be initiated.

18. Items that the patient will keep on their person or in their room will be listed on the Inventory of Personal Effects form.
    a. The patient will be asked to sign this form and it will be kept in the patient's chart.
    b. The Patient Property forms will be kept in the patient's medical record.

19. Containers, such as suitcases and boxes may be stored after inventoried.
    a. Excess items that the patient does not need easy access to will be stored in the proper storage area.
    b. Each box or suitcase must be labeled with the patient's first and last name, ID number and the date the box or suitcase was stored.

20. SNAMHS is not responsible for property that the patient has on their person or access to. It is the responsibility of the patient for the safekeeping of these items.

21. It is the responsibility of the Charge Nurse or designee to remedy any problems with the admission of Patient Property.

B. DISCHARGE

1. When items listed on the Inventory of Personal Effects form are returned to the patient, the patient and staff will sign, date and time the bottom section, acknowledging the patient has received their property.

2. At discharge, all valuable items will be returned to the patient.
    a. The Charge Nurse and/or staff discharging the patient (MHT or staff nurse) on the unit will remove the valuables from the safe and both will sign the log under withdrawals.
    b. The patient and both staff will sign, date and time the Valuables for Deposit in Unit Safe Form acknowledging the patient has received their belongings.

3. If any patient belongings have been damaged destroyed, lost, etc., this should be described in detail on the appropriate Patient Property Form. In addition, an Incident Report must be completed.

4. If a patient is discharged and family is not available to take the patients property, the property will be held in safekeeping. Record will be kept in the Safe Deposit Record / Count sheet located in the unit safe book.

5. Any property brought in by a patient that is suspected of being stolen are to be given to the Nursing Supervisor or House Supervisor after a description has been documented on the Valuables for Deposit in Unit Safe Form.

    d. The Nursing Supervisor or House Supervisor will give the property to the Las Vegas Metropolitan Police Department.

    e. The Las Vegas Metropolitan Police Department will provide a receipt that will be attached to the patient's Inventory of Personal Effects Form.

    f. At discharge, the patient will be given the Las Vegas Metropolitan Police Department receipt.

6. If the patient is not available to sign the property forms the discharge shift will be responsible for stating this on the forms.

7. It is the responsibility of the Charge Nurse or designee to remedy any problems with the return of Patient Property within three weeks of discharge. Unclaimed patient property may not be accumulated on the units and is to be accounted for.

C. TRANSFER

1. All patient property is to be signed off on the Inventory of Personal Effects Form by sending unit staff. The date, time, and destination must be included.

2. A staff person from the receiving unit is to check property given against property listed with staff from the sending unit, the receiving unit will initial each item, and document same on Inventory of Personal Effects Form including date, time, and staff signature.

    a. Cash envelopes will be counted by transferring and receiving unit charge nurses, timed, dated and signed by both parties.

    b. Reconciliation count will be recorded on the Safe Deposit Record / Count sheet.

    c. All discrepancies will be investigated and reported to the House Supervisor and Nurse Administrator On-Call immediately and an Incident Report will be filled out.

3. The property must be stored in the receiving unit property room.
Note: If there is a discrepancy between what is present versus recorded, the receiving unit staff must notify the nursing supervisor.

4. Upon transfer of a patient, two staff will transfer valuables to the safe. The valuable items will be placed in the valuable for deposit envelope and placed in the unit safe.

    a. The Charge Nurse for the shift will hold the key to the safe.

    b. The safe will be under a double lock system. Two staff must be present when the safe is open.

    c. The Charge Nurse and/or staff admitting the patient (MHT or staff nurse) on the unit will deposit the valuables in the safe and both will sign the log under deposits.

5. It is the responsibility of the Charge Nurse or designee to remedy any problems with the transfer of Patient Property.

D. PROPERTY STORAGE

1. All property must be bagged and dated with the first and last name of the patient and the patient ID# (use chart labels if available).

2. Property is to be placed in the patient's assigned bin. If property will not fit into the assigned bin place the property in the storage room bagged and dated with the first and last name of the patient and the patient ID# (use chart labels if available).

3. Perishable food items will be disposed of.

4. Make a note on the card on the outside of the assigned bin that there is property located in the storage room and note the number of items (bags, boxes, etc.).

5. When property is removed the patient's label must also be removed and shredded.

6. If property is left behind by a patient, a label indicating the first and last name of the patient and the discharge date must be attached. The Social Worker/Charge Nurse will attempt to try and contact the patient or family.

7. For personal property worth more than $100 left on discharge, the Social Worker shall notify the former patient or the patient's legal representative in writing by certified mail, that personal property remains in the custody of the facility.

    a. The property must be held in safekeeping in the unit for the patient for a period of one year from the date of discharge.

    b. If upon the expiration of the one year period no claim has been made, another notice must be sent to the person or the person's

legal representative, stating the fact that personal property remains in the custody of the facility, and specifying that the property will be disposed of if not claimed within 15 business days.

c. After 15 business days of the second notification {one (1) year and 15 days}, the property may be considered unclaimed property.

d. The Hospital Administrator will be notified and will determine disposition of the property.

8. The property storage room is to be kept clean and orderly.

IV. REFERENCE:

1. OF-PI-04 SNAMHS Incident and/or Accident Reports
2. OF-PI- 25 Personal Property
3. NRS 433.538, 433.539, 433.541, 433.542, 433.543 Safekeeping of Client's Money and Other Personal Property

V. ATTACHMENTS:

A. OF-PI-25 Personal Property Safe Deposit Record Attachment A
B. OF-PI-25 Personal Property Inventory of Personal Effects Attachment B
C. OF-PI-25 Personal Property Valuables Deposited in Unit Safe Attachment C
D. OF-PI-25 Personal Property Transfer Documentation Attachment D

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: NURSING DEPARTMENT

SUBJECT: Admissions from Lakes Crossing, Stein, and C-POD

NUMBER: II-11

EFFECTIVE DATE: 06/22

NEXT REVIEW DATE: 06/24

APPROVED BY: /s/ Earl Farinas, RN
Director of Nursing II

SUPERSEDES: 12/05, 10/15, 11/17, 01/19, 1/20

I. PURPOSE:

Clients will be admitted through interagency: Rawson-Neal hospital from Stein, C-Pod, and Lake Crossing Center (LCC) is coordinated with staff members at Rawson-Neal hospital under applicable laws and statue for an effective continuum of care and services.

II. PROCEDURE:

A. LCC (Lake crossing Center), Stein, and C-pod facility shall refer any individual to Rawson-Neal hospital/SNAMHS for services as such:

1. An individual with mental health diagnosis.
2. An individual with a current court order for civil and release.

B. Only Individuals with a court order, administrative transfer and are approved for admission to SNAMHS that warrants inpatient psychiatric treatment, such as gravely disabled mentally ill clients, who currently present a danger to himself, herself, or others, are eligible for admission to the Rawson Neal hospital at SNAMHS.

C. LCC, Stein, and C-pod forensic staff will contact the Rawson-Neal admission department for the referrals and provide the following information to the admission department when an inpatient placement is requested via fax or e-mail.

Legal documents needed:
Court Order (Civil released)
Petition Filed copy (Completed by transferring facilities)
Arrest Report (if any)
Criminal complaint (if any)

Medical documents needed:
Suicide Evaluation (if any)
Psychology or Psychiatry Consult/Evaluation (if any)
History & Physical / Physical Assessment
Medication Administration List (Current & Previous medications list)
LABS (UDS, CBC, BMP, ETOH/BAL - if any)
HCG (a must-have for females if less than 50 y/o.)
PPD step 1 or CXR (if any)
COVID Test Result (if any)
COVID Screening Questionnaires

D. LCC, Stein, and C-pod forensic staff shall fax the Medical Clearance Form and the appropriate documents needed for admission as stated above in section E to the Admission office: Fax number is (702) 486-7158. Admission office direct phone lines: (702) 486-7064, (702) 486-7148 and (702) 486-0740.

E. Admission staff will add the client to the crisis wait list once the referral information (Court Order, Evaluations, etc.) is received and complete the admission form (AKA Goldenrod).

F. A nurse-to-nurse report must be done before transferring the clients to Rawson-Neal.

G. The psychiatrist from transferring facility is to contact the agency director or designee for a report.

H. Rawson-Neal Psychiatrist will review the client's document for admission appropriateness to the facility.

I. Admission Department will consult with the SNAMHS medical doctors and APRN for any clients with medical concerns and notify the Medical Director of Rawson-Neal admission for admission appropriateness. The reviewing medical staff must sign the medical portion of the Goldenrod. If such treatment is required, appropriate medical care will be coordinated prior to transport and admission to the Rawson-Neal hospital.

J. Admission staff will coordinate with LCC, Stein, and C-pod team via phone or e-mail for the transport schedule and determine the arrival date and time.

K. Bed will be saved in the inpatient unit the night before the client's transport schedule date. Admission staff will notify Unit PN III, PN IV, and house supervisor via e-mail for the bed save of LCC, Stein, and C-pod Unit admits.

IV. **REFERENCE:**

N/A

V. **ATTACHMENTS:**

N/A

EDIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
NURSING DEPARTMENT

SUBJECT: Patient Identification Procedure **NUMBER: II-18**

EFFECTIVE DATE: 06/22 **NEXT REVIEW DATE:** 06/24

APPROVED BY: /s/ Earl Farinas, Director of Nursing II

SUPERSEDES: New,1/03,1/14, 11/15, 11/17, 01/19, 01/20

I. PURPOSE:

To utilize a structured process including two client identifiers in order to reliably identify the patient as the individual for whom service or treatment is intended and to match the service or treatment to that individual.

II. PROCEDURE:

A. ADMISSION:

1. Take a photograph of each patient, upon arrival to hospital.
2. Insert one (1) photo in the Patient Identification form.
3. Upload the patient's photograph into the electronic health record (EHR), via AVATAR form Import Client Picture.
4. Place the patient's photograph on all identifying documents, such as but not limited to the SBAR, monitor board, Kardex, and patient data board.
5. Place one (1) photograph in the EMAR Binder.
6. If the patient is transferred to a receiving unit, send photos (as a part of the medical record).
7. If a patient refuses to be photographed, complete a denial of rights so the picture may be taken.

B. DISCHARGE:

1. Take a photograph of each patient, upon discharge.
2. Place the discharge photograph in the chart, with the admission photo. All photographs should be labeled with MR#, client's name and date taken.

C. ALL STAFF

1. Utilize two identifiers for each patient whenever treatment or service is provided.

   a. Compare the patient to the picture to reliably identify the patient as the individual for whom the service or treatment is intended.

   b. Ask the patient their name and date of birth (DOB)

2. Match the service or treatment to that individual.

D. CONSENT FOR PLACING NAME ON DATA BOARD

1. Upon arrival to hospital each patient will be provided with a consent form authorizing SNAMHS to print his/her full fist name and last initial on the patient data board.

2. If the patient refuses to sign the consent form, his/her initials only will be utilized on the data board.

III. REFERENCES: N/A

IV. ATTACHMENTS:

A. II-18 Patient Identification Consent Form Attachment A

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: NURSING DEPARTMENT

SUBJECT: Contraband/Searches **NUMBER:** II-22

EFFECTIVE DATE: 02/23 **REVISION DATE:** 02/25

APPROVED BY: /s/ Earl Farinas, BSN, RN
Director of Nursing II

SUPERSEDES: 10/03, 10/15, 11/17, 01/18, 01/19, 01/20, 06/22

I. PURPOSE:

To reduce the occurrence of contraband being brought onto the patient care units and to provide a therapeutic environment for patients while protecting their privacy and dignity, as well as safety to patients, staff and others.

II. DEFINITIONS:

Contraband:
Includes, but is not limited to:
Legal and illegal chemical substances, weapons or potentially harmful objects, such as aerosol containers, glass containers, razor blades, matches, lighters, pocket knives, knitting needles, crochet hooks, metal fingernail files, glue, hair spray, scissors, hair coloring, sewing needles or pins, medications of any type, appliances with cord, coat hangers, pencils (including "golf" pencils), plastic bags, shoe laces, belts, scarves and drawstrings.

Personal Toiletries:
Makeup, hairbrushes, combs and contact solutions: These items shall be stored in a designated area in the patient storage room and the patient may use them while under staff supervision. No items are to be used by patients in glass containers.

Jewelry:
Jewelry is not to be worn unless approved by the Treatment Team. Patient may not wear jewelry which may be used as a weapon. Examples of jewelry that may be worn are, but not limited to: small non dangling earrings, thin chains having the ability to break under pressure, rings having no large or sharp pointed areas.

III. PROCEDURE:

Nursing staff have the responsibility for searching patients and their property upon admission, transfer to another unit, after passes or ground privileges, and when there is reasonable cause to suspect that chemical substances, weapons or harmful objects are present on the patient care unit. A Denial of Rights is filed in the event a patient refuses compliance with any search that is requested of him or her. In addition, room searches will be conducted on day and evening

shifts to ensure that contraband items are not present. On the night shift, a visual observation of the room will be done upon rounds. Emphasis on looking on window seals and under nightstands.

A. Person Search

1. Search the clothing being worn, including turning pockets inside out and inspection of cuffs.
2. Search wallets change purses and purses.

B. Body Search

1. A body search upon admission is conducted by staff, and when it is deemed necessary for the safety and welfare of the patient, other patients, and staff.
2. This search is done with two (2) staff members of the same sex as the patient. One staff does the search, which requires removing all clothing and carefully searching seams, the other staff observes.
3. The body search will be done on the receiving unit with one staff from the sending unit and one staff from the receiving unit.

C. Internal Body Search

1. An internal body search is a search of anal, and or pelvic area when there is a strong suspicion of contraband stored there which could be a danger to the safety of the patient, other patients, or staff.
2. Only a physician can do an internal body search. There must be one staff person present with the physician. This staff person must be the same sex as the patient.

D. Baggage Search

1. Look through all items the patient brings with them to the unit, including luggage, carrying case, overnight bag, paper/plastic sacks, boxes and other varied containers before delivering to storage area.

E. Environmental Rounds

1. Environmental Rounds will be conducted by two staff members once a day on both the day and evening shift to ensure that no contraband items are present (either new items or possibly those missed on earlier searches). On the night shift, a visual observation of the room will be done upon rounds.

2. Searching patient rooms will include:
    a. Removing patient’s belongings from their cubicle. Staff will return their belongings following the search.
    b. Looking into trash containers.
    c. Looking under the bed and the mattress; this may include removing and inspecting the bedding with staff and/or patient remaking the bed.

d. Inspection of window ledges, torn screens, other areas of property damage. Damage is to be reported for prompt repair to the maintenance department.

e. Patient will be present for room search unless he/she refuses.

3. Day Room

a. Looking in chair crevices and on top of pictures. Anywhere an item may be secreted.

F. Disposition of Unauthorized Substance/Harmful Unidentified

1. Unauthorized substances, unidentified pills, liquids, are sent to the pharmacy. When the pharmacy is closed, contraband substances are locked in the unit narcotic cabinet for safekeeping until the pharmacy opens.

2. Harmful objects, knives, sharps, are bagged and stored in the safe. Items are returned to the patient at discharge at the discretion of the treatment team.

G. Nursing staff on each patient care unit are responsible for informing patients on admission about items that are not allowed in their rooms or on their person.

H. All items brought in by visitors will be searched prior to being given to the patient.

1. If more clothing arrives than can be stored, the patient will be given the choice of which clothes to return to the visitor.

I. If a visitor attempts to provide a patient with contraband, the physician will be informed. Notify the nursing supervisor or unit nurse immediately. The physician will decide if a Denial of Rights for future visits by this specific visitor needs to be initiated.

J. Documentation

1. All belongings with the patient are to be documented on the “Inventory of Personal Effects” as well as “Valuables for Deposit in Safe” forms.

2. All items brought in for the patient by a visitor are to be documented on the “Inventory of Personal Effects” as well as “Valuables for Deposit in Safe” forms.

3. Contraband

a. Items found on searches that are not allowed on the patient care unit will be stored in the designated areas until the patient is discharged.

b. Nursing staff will do a progress note detailing the contraband.

c. The physician will be informed if the contraband is a substance that could have been used or ingested for appropriate disposition.

4. Any item that belongs to a patient that leaves SNAMHS (i.e., is sent out with a family member or visitor) must be documented on the “Inventory of Personal Effects” as well as “Valuables for Deposit in Safe” forms.

5. The patient will be informed of any Denial of Rights initiated by the physician.

6. A facility incident report is to be initiated when contraband is found.

7. Make sure patient signs the property list before leaving the unit upon discharge
8. Use Tort Form when valuables cannot be located at time of discharge.

IV. REFERENCES:

1. OF-PI-25 Personal Property
2. II-09 Patient Property

V. ATTACHMENTS: N/A

SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
STANDARD AGENCY POLICY AND PROCEDURE
SCOPE: INPATIENT SERVICES

SUBJECT: Hospital Admission/Discharge Criteria **NUMBER:** PF-AST-04

EFFECTIVE DATE: 04/2023 **REVIEW DATE**: 04/2025

APPROVED BY: /s/ Susan Lynch, MBA, CPM
Hospital Administrator

SUPERSEDES: 3/27/02; 03/01/07; 10/07; 02/12; 04/12; 03/17; 03/19; 04/21

I. PROTOCOL:

It shall be the protocol of Southern Nevada Adult Mental Health Services (SNAMHS) that all inpatient admissions be based on established criteria. These criteria are consistent with the ability of the agency to deliver necessary psychiatric inpatient care for each person. To assist staff in making informed decisions about established admissions criteria determinations, a Client Alert List will be utilized by approved admissions staff members and this list shall be used as a clinical communication tool.

II. PURPOSE:

The purpose of this protocol is to identify the SNAMHS inpatient admission and discharge criteria.

III. DEFINITIONS: N/A

IV. PROCEDURE:

Admission Criteria

A. Patients admitted to SNAMHS inpatient services shall have a DSM-5-TRcondition as their primary diagnosis. Exceptions to this rule can be made upon approval of the Medical Director, Administration, or in cases of court ordered admissions.

B. Patients should have acute psychiatric symptomatology requiring inpatient level of care.

C. Admitted patients shall not be intoxicated (blood alcohol level less than 0.1 mgm % and serum Lithium level less than 1.5 meq/l) and have no anticipated need for detoxification.

D. Admitted patients shall be on involuntary psychiatric status (i.e. Legal 2000, under petition for or already under court commitment, brought in legally under a Personal Protective Petition [PPP, formerly known as District Attorney Petition or

DAP], or court ordered for inpatient competency restoration) or as a voluntary patient who requests/accepts psychiatric evaluation and treatment.

E. Admitted patients shall have required COBRA documentation and/or copies of the patient's medical and legal information provided by the transferring facility.

F. The Client Alert List shall be located on the SNAMHS server as a folder. The folder shall include an Excel file titled "Client Alert List."

G. Authorized staff can add a patient's name to the list by submitting an email request to the Mobile Crisis Team's administrative assistant (AA) and copying to the Medical Director, the Director of Psychology, and the Mobile Crisis Team Director. The request should contain the patient's: name, social security number, date of birth and the diagnosis that support them being added to the list.

H. Admissions staff shall review, access, and utilize this list after receiving an update from the Mobile Crisis Team's AA.

I. All SNAMHS outpatient and inpatient staff shall have access to the Client Alert List folder to assist them in providing informed effective and efficient services for the populations we serve.

Exclusion Criteria

Note: Exclusion criteria cannot list all instances of patients who may be excluded from admission. Rather, exclusions may be made based on statutes and regulations, and on the general principle of capacity to treat the patient. That is, patients may not be admitted when the SNAMHS facility does not have the capacity to treat them, as allowed by applicable state and federal law.

J. Altered consciousness, most instances of delirium due to medical causes (unless it is determined that the delirium can be safely treated on a psychiatric unit), coma or significant catatonia resembling coma, or significant neurocognitive disorder.

K. Expected need for urgent/acute medical re-evaluation/treatment such as indicated by laboratory findings requiring significant medical evaluation or treatment in a medical hospital setting.

L. Patients requiring skilled or intermediate nursing care.

M. Incomplete medical detoxification or evidence of acute intoxication.

N. Serum lithium levels exceeding a patient's, previously established, toxic blood level or greater than 1.5 meq/L.

O. Unstable, life threatening or significantly disabling physical conditions accompanying and complicating psychiatric management.

P. Neuroleptic Malignant Syndrome or other severe physical symptoms of neuromuscular reactions to medications.

Q. Anorexia Nervosa or other eating disorders associated with precarious physical condition requiring inpatient medical services.

R. Primary diagnosis of any substance use, abuse, or dependency, or in need of detoxification and/or with a blood alcohol level in excess of 0.1 mgm %.
Complicated pregnancy.

S. Blood sugar > 200 (must be approved by primary care).

T. The presence of a severe active communicable disease as described in

DBPH Policy CD 4.56.

1) The presence of any other communicable illness (e.g., acute influenza, open sores, parasitic/pediculosis infestations which would infect other patients, etc.) which cannot be appropriately managed in the psychiatric setting or pose a risk to other patients in a psychiatric milieu.

U. A requirement for opioid maintenance therapy unless the opioid maintenance can be provided directly to the patient by another treatment agency licensed for such therapy.

V. The requirements for management of severe pain which require a significant number of narcotics daily such that the patient cannot be appropriate monitored in a psychiatric setting.

W. The requirements for medications or treatments which cannot practically or legally be provided at SNAMHS.

X. Patients who require significant assistance with activities of daily living.

Other Diagnostic Considerations

A. The following Diagnoses shall not be utilized as the primary diagnosis for admitting individuals to inpatient services:

1. Alcohol Use Disorder,
2. Substance Abuse Disorder,
3. Adjustment Disorder,
4. Malingering,
5. Personality Disorder
6. Academic Problem,
7. Acculturation Problem,
8. Age Related Cognitive Decline,
9. Autism Spectrum Disorder,
10. Major and Minor Neurocognitive disorders
11. Intellectual and/or Developmental Disabilities (Individuals cooperatively served by DPBH agencies shall have the permission of the Medical Director)
12. V-codes in general for primary diagnosis.
13. These diagnoses may, however, be utilized if secondary to another acceptable primary DSM-5-TR diagnosis

Discharge Criteria:

A. At the time of a patient's discharge from Rawson Neal, the attending Medical Staff shall have determined that the patient is no longer a danger to him/herself or others and can function with ability to care for self with or without identified supports in a less restrictive environment.

B. Patients discharged from SNAMHS Inpatient Forensic Services will be returned to the Committing County Detention Center, to the Civil Hospital, or to the community as determined by the Courts.

V. REFERENCES:

A. DPBH Policy SP 4.18 Criteria and Process for Consumer Admission
B. DPBH Policy SP 4.43 Coordination of Services for Persons with Dual Diagnosis
C. DBPH Policy CD 4.56 Communicable Infectious Disease Policy

VI. ATTACHMENTS:

A. PF-AST-04 Admission Discharge Criteria Attachment A

B. PF-AST-04 Admission Discharge Criteria Application for Voluntary Admission Attachment B

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY WIDE

SUBJECT: Secure Transportation of Client Charts **NUMBER:** OF-MOI-05

EFFECTIVE DATE: 07/2022 **REVIEW DATE:** 07/2024

APPROVED BY: /s/ Susan Lynch, MBA, CPM
Hospital Administrator

SUPERSEDES: OF-MOI-05, dated 09/03; 09/08; 03/09; 05/11; 12/13; 01/16; 01/18; 07/20

I. PROTOCOL:

Southern Nevada Adult Mental Health Services (SNAMHS) transports client Protected Health Information (PHI) known as Medical Records in a consistent, secure, safe and organized fashion.

II. PURPOSE:

To safeguard paper form PHI during transportation of patients' charts from loss, destruction or stolen information.

III. DEFINITIONS: N/A

IV. PROCEDURES:

A. Transportation of client protected Medical Records between, Inpatient, Outpatient Services, Health Information Services (HIS).

B. Transportation of client medical records between inpatient units and HIS:

1. Each unit shall safeguard all previous day discharged clients' charts in a safe and protected area in the nursing station. These charts are picked up Monday-Friday by the HIS staff utilizing the Avatar Discharge Log Sheet as tools for check out.
2. All 'loose' filings for charts are to be given to the HIS employee.
3. HIS may return to the units if it is missing (loose) patients' forms (for filing and completion).
4. The HIS department shall send one of its employees, during the regular working hours for HIS, to each of the units to retrieve the discharged charts.

5. The HIS staff member shall retain a copy of the completed Discharge Log Sheet.

C. Transportation of Client Medical Records between clinic sites:

1. Check chart(s) out in Avatar-Alias.
2. The site shall log all of their charts needing to be transported to the HIS department on the Transportation Log Sheet and place the chart and log in a locked satchel. Matching keys are available in each HIS department.
3. The Agency courier shall pick up the records and transport them to the designated site.
4. The HIS staff member at the site shall complete their section of the Transportation Log Sheet when they confirm they have received the chart.
5. The HIS staff member will return a copy of the completed Transportation Log Sheet to the respective units for their records.
6. On an emergency basis, any SNAMHS employee can transport chart(s) between sites. A transportation log sheet is then signed that they have the possession of the chart and the site will call the sender by phone confirming receipt of chart.

D. It is the responsibility of all employees to adhere to Agency policies. All employees shall report observed violations of this policy to his/her supervisor through the chain of command. Failure to report is subject to progressive disciplinary action.

V. REFERENCES:

A. Joint Commission Accreditation Manuals for Hospital, Behavioral Healthcare and Laboratory; Current edition; Management of Information

B. Health Insurance Portability and Accountability Act (HIPAA), CFR, 42.

C. SNAMHS P&P: OF-MOI-24

VI. ATTACHMENTS:

A. OF-MOI-05 Secure Transportation of Client Charts Attachment A

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY WIDE

SUBJECT: Psychiatric Discharge Summary **NUMBER:** OF-MOI-12

EFFECTIVE DATE: 04/2023 **REVIEW DATE:** 04/2025

APPROVED BY: /s/Susan Lynch, MBA, CPM
Hospital Administrator

SUPERSEDES: 10/13; 02/18; 02/19; 04/21

I. PROTOCOL:

It shall be the protocol of Southern Nevada Adult Mental Health Services that a Hospital Discharge Summary be completed for every patient discharged.

II. PURPOSE:

The purpose of this policy is to ensure that a patient's discharge summary report is completed within 30 days of patient discharge.

The Discharge Summary is a clinical resume and communication tool. Documentation should be brief and meaningful without sacrificing essential facts, and thoroughly describe observations and other pertinent information.

III. DEFINITIONS:

Medical record, chart, patient's record, documentation, form maybe used interchangeably; all reference the legal documentation as defined by CMS, TJC and Nevada NRS.

IV. PROCEDURE:

A. The Hospital Discharge Summary must be completed in its entirety and entered in the electronic medical record, Avatar.

B. Discharge documentation must include:
   1. Reason for hospital presentation
   2. Course of hospital stay
   3. Allergies
   4. Condition at the time of discharge,
      DSM5-TR diagnoses must be completed upon discharge, including substance abuse, personality disorders and medical issues if present.
   5. Discharge plan describing
      a. Disposition
      b. Diet
      c. Activity

d. All discharge medications
e. Psychiatric follow up
f. Drug and alcohol treatment
g. Medical follow up
h. Access to emergency services

V. REFERENCES:

A. Current TJC Standards
B. CMS Standards for Psychiatric Facilities.
C. DPBH Policy IMRT 2.1 Basic Documentation Guidelines for Medical Records Documentation
D. IMRT 2.1 Basic Documentation Guidelines for Medical Records -Medical Record Documentation Timeline Table

VI. ATTACHMENTS:

A. OF-MOI-12 Psychiatric Discharge Template Attachment A

DIVISION OF PUBLIC AND BEHAVIORAL
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: HOSPITAL SOCIAL SERVICES

SUBJECT: SW-03 - Treatment Plan Procedure

EFFECTIVE DATE: 06/2022 REVIEW DATE: 06/2024

APPROVED BY: /s/ Dr. Aaron Bomer, PSY.D. LCSW
Director, Social Services

SUPERCEDES: Treatment Plan Procedure dated 8/07, 10/21/08, 2/2010, 2/2012, 4/2013, 01/2015, 2/2017, 4/2020

I. PROCEDURE

It shall be the procedure of Southern Nevada Adult Mental Health Services Hospital Social Services to develop, implement and coordinate treatment planning for all clients.

II. PURPOSE

It shall be the purpose of the Hospital Social Services Department to have treatment plan to identify problems, establish goals/objectives and interventions specific to each clients' needs. The plan shall provide a roadmap in the provision of care that guides treatment. It is based on comprehensive assessments and integrates the Multidisciplinary collaboration from admission to discharge.

III. PROTOCOL

A. Social Work Plan of Care in the RSU
   1. Social Workers shall develop and document a suggested plan of care, which is documented in the Psychosocial Needs tab, under the High Risk Psychosocial Problem comments section of the Psychosocial Assessment.
   2. The Social Work shall propose interventions targeted to specific patient needs.
   3. Specific goals, objectives, interventions and persons responsible for specific interventions shall be identified by the treatment team.
      a. Documentation shall include the presenting problem.
      b. Documentation shall include the plan of care of the psychiatrist/APN and the social work.
      c. Documentation shall indicate review with the client.
      d. Documentation shall include the social worker's name & the date.

B. Social Work Inpatient Treatment Plan
   1. Social Workers shall complete the Avatar Treatment Plan including all related tabs for problems, goals, objectives, services, intervention and identify the social worker within

72 hours of admission for each client. The Master Treatment Plan is reviewed with the Treatment Team members and client.

2. The Interdisciplinary Treatment Team consisting of the attending medical staff, social worker and adjunct discipline(s) shall meet with the individual to document the plan of care, assessment and update the electronic Treatment Plan to formulate the Interdisciplinary Master Treatment Plan in the electronic medical record by day seven (7) of the individual's admission. Should the individual be discharged prior to day seven (7), the initial treatment plan shall be finalized.
3. Each discipline attending the team meeting and the client shall sign the treatment plan.
4. Individual treatment plans shall be updated by the social worker, at least, every 7 days from the development of the Master Treatment Plan. The team members shall discuss with the client the updated treatment plan. Social Workers coordinate the Treatment Team, and the psychiatrist/APN is the Treatment Team Leader.
5. The social worker shall update the electronic treatment plan.
6. The Treatment Plan shall be finalized by the social worker within 24 hours of discharge. If the social worker is unavailable, the Treatment Plan shall be finalized by the discharging nurse.

IV. REFERENCES:

A. Nevada Revised Statutes 433; 433.224; 433.484; 433.494

B. Center for Medicare and Medicaid Services (CMS) regulations for Psychiatric Hospitals; §482.61

C. Joint Commission CAMH and CAMBHC; current edition; Provision of Care; Treatment and Services chapter

D. Division MHDS Radplus Avatar Clinician's Workstation Resource Guide; Current edition

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: HOSPITAL SOCIAL SERVICES

SUBJECT: SW-04 - Psychosocial Assessment

EFFECTIVE DATE: 06/2022 REVIEW DATE: 06/2024

APPROVED BY: /s/Aaron Bomer, PSY.D, LCSW
Director of Social Services

SUPERCEDES: Psychosocial Assessment of Clients dated 8/2007, 10/2008, 2/2010, 2/2012, 4/2013, 9/2013, 10/2013, 3/2014, 01/2015, 2/2017, 2/2018, 4/2020

I. POLICY

It shall be the procedure of Southern Nevada Adult Mental Health Services Hospital Social Services to provide a directive to all Social Workers that defines elements, time frames, and documentation requirements for completion of individualized psychosocial assessments, electronically, using AVATAR and the tool labeled Psychosocial Assessment for each client.

II. PURPOSE

It shall be the purpose of the Hospital Social Services Department to have a psychosocial assessment which identifies the client's current baseline social functioning and documents the strength and deficits on which the client's treatment interventions and discharge plans are formulated. The Psychosocial Assessment shall enhance the quality of care for the client identifying presenting problems and conditions, previous treatment, diagnosis and interventions. As an informational tool the Psychosocial Assessment shall identify needs and discharge plans including follow up care and implementation of the plan.

III. DEFINITIONS

A. Medical Record is defined as the combination of hard copy forms and computer entered data.
B. Electronic Medical Record is defined as those elements of the client's medical record that are data entered into a computer rather than hand written on a form. This includes all the elements and programs used to capture client information.
C. AVATAR Program Management (PM) and Clinical Work Station (CWS) is defined as the computer software programs that enable clinicians statewide to document treatment.
D. **Initial** is defined as the active Psychosocial Assessment. The assessment will be completed within 48 hours of admission to RSU. It shall be updated on each episode of admission.

IV. PROCEDURE

The Social Worker shall interview the client within 48 hours of the admission and complete the Psychosocial Assessment in AVATAR. The Social Worker will complete the full Psychosocial Assessment within 48 hours of admission and finalize the assessment. If the information on initial psychosocial assessment is unobtainable due to acute psychosis, patient unwillingness to cooperate, or patient the patient is a poor historian, etc, the psychosocial assessment shall be finalized within the 72 hours, with documentation attesting to the patient's status. Additional information will be added by the Social Worker in the weekly progress note. If the AVATAR system has a major downtime, Social Workers shall hand write Psychosocial Assessments until such time as the data can be entered into the electronic medical record. Within one business day of Avatar coming back online, the Social Worker shall enter the information on the Psychosocial Assessment. If the downtime exceeds 48 hours, the hardcopy will be sufficient for documentation purposes and is to be placed in the patient's chart. When AVATAR is back online, the social worker shall write a brief note stating the psychosocial assessment is in the file

The RSU Social Worker shall complete and document the psychosocial assessment including the following areas:

A. **Identifying Information Tab:** This tab contains two pages and is the basic demographics for the client including language/need for an interpreter, religion/spirituality.

B. **Emergency Contacts Tab:** This tab is one page and identifies client's contacts in the community and how they can be reached. It also identifies the current release of information available including the expiration dates of these releases. Completed in RSU. Review and updated as needed by Inpatient by adding additional consents to medical records.

C. **Problems/Support Tab:** This tab includes the presenting concerns box for narrative. Information in this tab should include reason for Legal 2000, client's account of precipitating events leading up to admission, and information from family, significant others, and service providers who are part of client's support system, about the presenting concern, history and the social worker's name and the date. Social Worker will gather this information from all necessary sources, as Releases of Information are provided. The social worker shall include their name and the date to their narrative in the Presenting Concerns text box. Completed in RSU.

D. **Social History Tab:** This tab contains five pages and provides information about adult relationships, marital status and sexual orientation as well as living situation. Detail on living situation is integral to discharge planning and arranging for community resources and services. Homelessness is identified in this tab. Information about client's children is identified, and if they have special needs, or who is providing care and supervision. This tab identifies if the client feels they are in danger of or suffering from abuse or neglect and alerts the social worker to mandated reporting issues of abuse and neglect, as well as safety needs to be provided for at discharge.

E. **Family History Tab:** This tab contains four pages and documents family history, parental and sibling relationships, developmental concerns, traumatic events, history of abuse or abusing others, losses, divorce, deaths, significant illnesses or injuries. Completed by RSU Social Worker.

F. **Education Vocation Tab:** This tab contains six pages and addresses educational level, academic performance and school related behavior and activities, employment history, current employment status and whether receiving SSI/SSDI. Military service and discharge status, identifying possible veteran's benefits and services available to client at discharge. Financial resources and needs are also addressed, including a listing of psychosocial needs that will require attention during treatment or discharge planning process.

G. **Substance Use Tab:** This tab contains two pages and includes recent use of substances identifying pattern of use for evaluation of dual diagnosis treatment needs.

H. **Addictions Tab:** This tab contains three pages and includes previous treatment for substance dependence, and if treatment was court ordered. Family history of substance abuse issues is addressed and client's history of participation in peer to peer recovery programs. Completed by RSU Social Worker.

I. **Legal Problems Tab:** Contains four pages and identifies convictions and sentencing, parole or probation, alerting the Social Worker to possible legal complications. Identifies payee or legal guardian, power of attorney, with contact information. Legal Guardian of the client can approve client's medication and should be actively involved in client's treatment as soon as possible.

J. **Strengths and Opportunities Tab:** Contains four pages and addresses barriers to learning, preferred learning methods and educational needs, ability to learn and readiness for specific programs, which will help formulate discharge plans.

K. **Psychosocial Needs Tab:** Contains three pages and identifies psychiatric and medical needs, substance abuse needs, financial and housing needs, high risk psychological, any out of state discharge and destination, living arrangements at discharge, giving a clear picture of needs and community resources arranged to meet those needs problems. The social worker shall include their name and the date to their narrative in the High Risk Psychological Problems Comments text box. This is completed by RSU Social Worker.

L. **Discharge Appointments Tab:** Contains one page and is entitled **Recommendations** of the who, what, when and where of appointments arranged for client prior to discharge, to be arranged in conjunction with client to ensure their understanding of commitment to follow up after discharge for medication, counseling and other community resource needs. Completed in RSU. The clinician shall use all available resources to gather information about client prior to hospitalization, prior psychosocial history of client, treatment needs for psychiatric, medical and substance abuse. The social worker shall review all previous SNAMHS records for additional insight into clients needs. The RSU Social Worker is responsible for reviewing RSU psychosocial information, and developing, information that was obtained at that level of care. In addition, obtaining historical information relevant to ongoing care is a focus for

RSU Social Worker. The following are important elements of the discharge recommendations:

a. The RSU Social Worker shall document collaboration of the plan of care on page 2 of Psychosocial Needs, under problem comments. This shall include involvement of the psychiatrist/APN, nurse, social worker and client, in problem identification and coordination of services.
b. For RSU dispositions to the community, the psychosocial needs section and discharge appointment section of the psychosocial assessment shall confirm the level of discharge planning implemented from the RSU. These sections for clients admitted to impatient services shall serve as initial plans to be refined and updated in the initial Treatment Plan and Progress Notes within 72 hours of admission, and ongoing at least every 7 days.
c. On the day following the psychosocial assessment, RSU Social Workers shall enter a Progress Note. This shall be in the DAP format. The note shall focus on disposition and/or any updated information. The note shall serve as a follow up/transfer or discharge note depending on the plan for the client.
d. When a client has returned to the RSU within 30 days or less of discharge from the RSU or inpatient, the Social Worker shall include in the Psychosocial Assessment the presenting problem and the reason for rapid readmission.
e. The Social Worker shall specify steps for discharge to occur including barriers to discharge and the anticipated social worker role in treatment and discharge planning, estimating dates tasks shall be completed. The Treatment Plan shall be updated weekly (every 7 days) showing progress toward goals and changes in interventions. Progress Notes shall identify specific contacts made, verification or changes in each week regarding the discharge plan, psychoeducational interventions, barriers to discharge and progress on specific tasks. All progress notation shall be in the DAP format.
f. Social workers shall collaborate with Interdisciplinary Team members with regard to assessments, plans of care, treatment interventions and disposition.
g. The psychosocial assessment shall contain a recommendations tab entitled "Recommendations" and include individualized client specific recommendations from the information gathered from the assessment.

V. REFERENCES:

A. CMS Interpretive Guidelines, current edition
B. Joint Commission Standards
C. Utilization Review Program Policy

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCYWIDE

SUBJECT: Discharge Planning and Interdisciplinary Continuity of Care Plan

NUMBER: PF-COC-18

EFFECTIVE DATE: 03/2021

REVIEW DATE: 03/2023

APPROVED BY: /s/ Susan Lynch, MBA, CPM
SNAMHS Hospital Administrator

SUPERCEDES: New Policy, 3/18, 06/18

I. PROCEDURE

It shall be the protocol of the SNAMHS to provide discharge planning to all clients. Discharge planning starts on admission.

II. PURPOSE

The purpose of discharge planning is to identify and describe the services and support systems that are appropriate to meet the client's needs.

III. PROTOCOL FOR DISCHARGE PLANNING

1. The Treatment Team, consisting of but not limited to the Social worker, nurse, and psychiatrist, will conduct a comprehensive multiphase assessment, including an interview with the client, to determine the client's discharge needs including, if necessary, transfer to another facility. The client will be an active participant in this process and will be encouraged to make their needs known.

2. The Treatment Team may also include the activities therapist, mental health technician and psychologist involved in the client's care, and shall document the process of discharge planning, as well as the specific steps to be completed by the time of discharge, which may include:

    - A thorough exploration with the client, family members, significant others, friends, roommates, guardians and intra-agency and inter-agency supports, of available housing and other outpatient services, including programs and support systems to help meet the client's needs upon discharge.
    - Confirmed housing, documented by the Social worker and/or Psychiatric Caseworker.
    - Creating a working discharge plan, within 72 hours of admission, as part of the Inpatient Treatment Plan.

    Every seven (7) days, the Treatment Team shall document in AVATAR its progress and steps taken toward an effective discharge for each client,

including notation of client progress towards readiness for discharge. Additionally, Treatment Team shall document barriers to discharge. In the event the client refuses to allow collateral contact to assist in discharge planning, the Treatment Team shall document attempts, refusal, and efforts to gather information from the patient.

1. Family/significant others shall be invited, as soon as possible, with consent from client, to Treatment Team meetings to participate in the client's treatment and discharge planning.

2. The Social worker and/or Psychiatric Caseworker shall clearly identify to the client the Medication Clinic to which the client will be referred for medication management. Available outpatient counseling shall also be discussed.

3. Individuals with Medicare benefits, private insurance and/or Medicaid benefits will be notified of the option to select participating providers; the Social worker will assist in facilitating services with the identified provider. In the event the selected provider is not available, the Social worker will discuss with client and/or client's family (as appropriate), alternate providers.

4. Outpatient appointments should be scheduled within one but not greater than two weeks from discharge. If the appointment is further than one week, the treating provider will provide a sufficient supply of medications and refills at discharge.

5. A release of information (ROI) authorizing the release of the provider's discharge summary shall be obtained prior to discharge for clients with psychiatric providers outside of SNAMHS.

6. A list of home health agencies and skilled nursing facilities shall be maintained in the department and provided, along with a list of participating Medicare home health agencies, to clients/guardians (families as appropriate) in the client's geographic area; these lists will be accessible online. Clients enrolled in managed care organizations will be provided a list of managed care contracted home health agencies or skilled nursing facilities according to treatment needs.

7. The Social worker shall provide the list to client and shall document any financial interest between the hospital and the home health agency.

8. The client shall be provided with a copy of the Discharge Instructions (Aftercare Plan), including scheduled appointments, and instructions for how the client can access the services.

9. The original signature copy of the Discharge Instructions is to be placed in the medical record and a copy given to the client.

10. Court-committed clients shall be discharged on conditional discharge. The Social worker shall contact HIS Department and inform the identified staff who completes court committed discharges to initiate the one-page leave form for Medical Director or designee to sign. The signed conditional release form shall be given to HIS for filing in Family Court prior to discharge.

11. When the social worker obtains information that client has an appointed legal guardian, the legal guardian must be advised to provide the necessary guardianship documentation.

12. The SSAP Patient Needs tab will be utilized for ongoing reassessment to assess the patient's needs to be addressed and barriers to successful discharge. Patients will be assessed at admission, the admission SW will complete the Initial Patient Needs tab to identify those needs and barriers, should the patient be discharged from the Rapid Stabilization Unit (RSU), the RSU SW will complete the patient need discharge tab. In the event the patient is discharged from the inpatient unit, the SW will complete a Patient Needs Review tab (90) days post admission and complete the Patient Needs Discharge tab upon discharge. There will be a random audit of closed medical records from readmitted patients to determine preventable readmissions.

13. Prior to patient discharge, the Social worker shall initiate the Interdisciplinary Continuity of Care (ICOC) plan and place the initiated plan on the top of the client's medical chart on the unit.

    A. The Social worker shall obtain a Release of Information from the patient to contact outside providers and arrange for the transfer of pertinent information to outside providers. Prior to the client's discharge or transfer, the Social worker shall provide the next of care providers with:
        - Reason for patient discharge or transfer
        - Client's psychosocial status
        - Summary of care, treatment and services provided to the client
        - Client's progress toward goals
        - List of community resources or referrals made or provided to the client.

    B. Social worker shall educate the patient with respect to the Affordable Healthcare Act (ACA) and educate the patient on enrollment process prior to discharge if the patient is not currently enrolled.
        1. The social worker shall document the name, time, and date of the exchange of information in the client's discharge summary, and fax the aftercare plan and Intra-agency checklist, if applicable, to the next of care provider.

        2. Social worker shall provide the client with outpatient appointment date, time, and location, and verify that the

client has transportation to and from their appointments. Social worker shall provide the client with the ICOC plan at discharge detailing the appointment information, as well as an appointment slip for inter-agency referrals only.

3. All members of the Treatment Team shall write a discharge summary based on their department procedures. This summary shall include:

- Complete description of referrals to treatment and community resources including date(s) and times, addresses, directions to service providers and phone numbers, if available.
- Community Resource Guide will be given to all discharging clients by Social worker.
- Description of community-based housing arrangements and prior communication and exchange of information.
- Economic/financial status of application for social security benefits, Medicaid, and Clark County rent voucher.
- Brief description of family and significant others' involvement with client's discharge, anticipated problems after discharge and suggested resources and interventions.
- Documented transportation resources provided, i.e. day bus pass, or taxi voucher. Transportation must be consistent with and limited to the Patient Transportation Policy.
- Any out of state transportation arrangements must be approved in conformance with Client Transportation Back to Home Community policy PF-COC-07, effective 10/10/2014, which is to be signed by the Hospital Administrator.
- Brief bio-psychosocial description of status of client on day of discharge.
- Appointment times, location, and verification that the client has transportation to and from their appointments.
- The treating medical staff shall complete the Hospital Discharge Summary (HDS) in accordance with OF-MOI-12: Psychiatric Discharge Summary.

4. The Social worker shall document:

- Client's participation in, and understanding of, the Aftercare Plan.
- Next of care provider contact, and whether the provider has accepted the patient for care.
- Dates and times of each contact with family, friends and all other individuals involved in client's discharge planning
- All contacts and referrals with intra agency and community programs.
- Weekly progress notes

- Barriers to progress
- Follow up appointments
- Available community services and resources, including but not limited to home health agency/skilled nursing facilities, transportation, and housing resources.
- Date and time the list of these resources was presented to and reviewed with client prior to discharge.

5. In addition to a discharge progress note, Social workers shall complete the Social Services Aftercare Plan or "SSAP" (date and core measure tab) in Avatar, and document that client's family, guardian, significant other, etc. have been educated about client's aftercare plan.

    a. When a client is transferred to a medical facility in the community, and the Social worker has <u>previously</u> established a clinical working relationship with the patient during the current episode, the SNAMHS Social worker shall:
        - Initiate contact within 24 hours of the transfer with the Social worker responsible for discharge planning at the receiving facility.
        - Inform their Social Work counterpart of the legal status and the discharge plan i.e. rehabilitation, nursing home etc.
        - Make appropriate collateral contact the next business day, in the event the client is sent to a medical facility outside of normal business hours for the Social Work Dept.

    b. If the client is discharged from inpatient status following the requisite 24-hour period, the SNAMHS Social worker shall then complete the Interdisciplinary Continuity of Care Plan (**check off the appropriate box for a COBRA discharge on the form),** complete the discharge summary and/SSAP.

    c. If the Social worker has NOT established a clinical working relationship with the patient and has not had contact with the patient during the current episode, the Social worker will not be responsible for completing the ICOC. The Social Services Director/Associate Director will complete the ICOC form for the purposes of continuity of documentation. This will include only the following:
        - Client demographics
        - Name of hospital to which client was sent, and
        - Supervisor's signature.

    d. If the client is incarcerated following their inpatient episode and the Social worker has previously established a professional working relationship with the patient during the

current episode, the Social worker shall complete the Interdisciplinary Continuity of Care plan, discharge summary and SSAP.

e. In the event that the patient is incarcerated outside of normal business hours for the Social Work department and the Social worker has previously established a professional working relationship with the client, the Interdisciplinary Continuity of Care Plan (**check off the appropriate box labeled "other" on the ICOC form, and write on the line "incarcerated")**, discharge summary/SSAP shall be completed on the next business day.

V. REFERENCES:

A. TJC, Elements of Performance, PC.04.01.01, PC.04.01.03, RI.01.02.01.
B. CMS Standards §482.61(e): Discharge Planning and Discharge Summary

VI. ATTACHMENTS:

A. PF-COC-18 Discharge Planning and Continuity of Care Plan ICOC Check List Attachment A

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY WIDE

SUBJECT: Personal Property **NUMBER:** OF-PI-25

EFFECTIVE DATE: 07/2021 **REVIEW DATE:** 07/2023

APPROVED BY: /s/ Susan Lynch, MBA, CPM
Hospital Administrator/SNAMHS Appointing Authority

SUPERSEDES: OF-PI-25 dated 04/03; 04/07;2/10, 12/11, 8/15; 12/16; 06/17; 06/19

I. PROTOCOL:

SNAMHS shall have protocols and procedures in place to ensure client personal property items are inventoried, stored and returned. SNAMHS shall have defined protocols to ensure internal and external review whenever clients are missing items, to locate the missing items and or reimburse for such items.

II. PURPOSE:

The purpose of this protocol shall be to define SNAMHS procedures should a client report of missing items from personal property inventory.

III. DEFINITIONS:

Hospital: as used in this protocol, is defined as In-Patient Hospital sites at Rawson Neal and Stein.

Personal Property: as used in this protocol, is defined as items stored by SNAMHS or items kept by the individual while the individual are in SNAMHS hospital.

IV. PROCEDURES:

A. All complaints of missing personal property shall be investigated and SNAMHS employees shall complete all attempts to locate missing items and return them to the individual.

B. All complaints of missing personal property shall be reported to the House Supervisor and he/she shall report such to the On-Call Administrator.

C. Should a hospitalized individual communicate that they are missing personal property, the SNAMHS employee shall immediately report such to the Charge Nurse. The Charge Nurse shall:

1. Assign a Mental Health Technician to assist the individual to search for

the item and review the personal property inventory sheet (Attachment A) to ensure the item is identified.

2. Report to the nurse supervisor, if the item is not found within 30 minutes.
   a. The Nurse Supervisor shall ensure that a SNAMHS Internal Incident Form (OF-PI-04) ***(No employee shall ever give a copy of the form to anyone other than his/her supervisor or to the Office of Performance Improvement.)*** is completed and is reported to the Director of Nursing.
   b. The Nurse Supervisor shall obtain the Personal Property Inventory Form.
3. Assign a Mental Health Technician to encourage and assist the individual to complete a "Compliments - Concerns" Form (Employees shall never give a copy of the form to anyone other than his/her supervisor or to the Office of Performance Improvement.)
4. Ensure an appropriate thorough progress notation is written. (No employee shall reference an incident or concerns form in a progress note.)
5. Offer the opportunity to the individual to complete a Tort Claim and inform the client that this is a legal process that usually takes a month or longer. Inpatient discharge cannot be delayed due to the processing of the claim.
6. Assist the client to have his/her safety needs met by securing replacement items from agency supplies, donations, etc. while the claim is being processed or to ensure safety, or to facilitate discharge.
7. When clients are admitted to the hospital with perishable food items, pharmaceutical products or alcohol the following protocol will be followed:
   a. Perishable food items will be sealed with heavy tape if possible, if not possible the perishable item is disposed of.
   b. Prescribed medications will be sent to the pharmacy with a physician order to either hold for discharge or to destroy.
   c. Nursing staff may pick of held medications for release on discharge and return them to the client with a physician order.
   d. Open bottles of alcohol brought in by a client on admission will be disposed of.

D. Should a non-hospitalized individual communicate that they are missing personal property, that was lost while the patient was in the hospital, Stein and or the Rapid Stabilization Unit, the SNAMHS employee shall:

1. Report the communication to the Director of Nursing.
2. Complete a SNAMHS Internal Incident Form (Employees shall never give a copy of the form to anyone other than his/her supervisor or to the Office

of Performance Improvement).

3. Assist the individual to complete a "Compliments – Concerns" Form (No employee shall ever give a copy of the form to anyone other than his/her supervisor or to the Office of Quality Assurance Performance Improvement.)

4. The individual assigned to follow up investigation shall offer the individual the opportunity to complete a Tort Claim.
   a. The TORT Claim process must be independently submitted to the TORT Claims Office.

V. REFERENCES:

A. NRS 433
B. NRS 197.160
C. CAMH; current edition
D. OF-PI-04 SNAMHS Incident and/or Accident Reports
E. PF-RRE-03 Consumer Family Complaints and Grievances

VI. ATTACHMENTS:

A. OF-PI-25 Personal Property Safe Deposit Record Attachment A
B. OF-PI-25 Personal Property Inventory of Personal Effects Attachment B
C. OF-PI-25 Personal Property Valuables Deposited in Unit Safe Attachment C
D. OF-PI-25 Personal Property Transfer Documentation Attachment D

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: Medical Staff

SUBJECT: Post Discharge Follow-up Phone Calls Procedure **NUMBER:** 01-134

EFFECTIVE DATE: 04/2023 **NEXT REVIEW DATE:** 04/2025

APPROVED BY: /s/ Leo Gallofin, MD
Agency Medical Director

SUPERSEDES: New, 03/17, 01/19

I. PROTOCOL:
Southern Nevada Adult Mental Health Services has a vested interest in ensuring that patients discharged from inpatient maintain continuity of care through continued treatment in our outpatient clinics.

II. PURPOSE:
The following procedure is to provide for reinforced information to patients after discharge about follow-up appointments, medication compliance, answer clinical questions they may have, and increase the likelihood of compliance with outpatient follow-up. Available evidence indicates that successful follow-up phone contact with discharged patients' results in decreased 30-day readmission rates.

III. **DEFINITIONS:**
Avatar - Electronic Medical Record

IV. **PROCEDURE:**

a. A list of discharged patients from Rawson Neal Psychiatric Hospital is generated via Avatar using the "detail of discharge by program SQL" form.

b. A list of patient phone numbers and outpatient follow-up appointment dates are obtained through the interdisciplinary continuity of care form (ICOC) located either in Avatar or as a hard copy form.

c. Desginated Staff will attempt to contact the discharged patients within one (1) week of discharge. If contact is successful, nursing will remind the patient of their appointment time, and be provided the opportunity to answer questions regarding medication compliance, their inpatient stay at Rawson Neal Psychiatric Hospital, and current health status.

d. All calls to patients, will be documented in a data entry spreadsheet. The data will be maintained by the Medical Administration's Nursing Staff.

e. Designated Staff shall attempt to contact 100% of all discharged patients with a working phone number.

V. REFERENCES: N/A

VI. ATTACHMENTS: Data Entry Spreadsheet

01-134 Post Discharge Follow-up Phone Calls Procedure Data Entry Spreadsheet Example Attachment A

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: HOSPITAL WIDE

SUBJECT: Interhospital Patient Transfers and COBRA Compliance

NUMBER: PF-COC-02

EFFECTIVE DATE: 01/2022

REVIEW DATE: 01/2024

APPROVED BY: /s/ Susan Lynch, MBA, CPM
Hospital Administrator

SUPERSEDES: 04/04; 10/04; 03/06; 06/10; 05/11; 03/14; 01/17; 02/19; 02/21

I. PROTOCOL:

It is the protocol of the Southern Nevada Adult Mental Health Services (SNAMHS) that all patient transfers to other acute care facilities shall be in conformance with applicable regulations and requirements. This shall include pre-transfer information sharing and authorization to transfer from the receiving hospital, provision of proper patient transport, and completion of required forms for necessary documentation. In the event of a life-threatening medical emergency, patient treatment needs shall be met first. SNAMHS employees shall stabilize the patient for transfer to the extent possible and congruent with hospital scope of responsibility. Documentation for the emergency patient transfer shall be provided as soon as practical.

II. PURPOSE:

The purpose of this protocol is to ensure that SNAMHS is in compliance with the State and Federal regulations as mandated by Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) when receiving or transferring patients. SNAMHS provides acute inpatient psychiatric care.

III. DEFINITIONS:

A. Determine the need for a Mental Health Tech (MHT) escort. RN will inform Medical Staff about the patient's latest elopement risk status prior to transfer. Medical Staff shall be involved in MHT escort decision. Assigned staff competency and staff gender will be at the discretion of the shift supervisor which will be dependent upon patient situation and clinical judgment. Any conditional release inpatients, any 1:1 observation, or any patient deemed at risk for safety, containment or medical stability must be accompanied by at least one (1) MHT staff.

B. A PNIII or House Supervisor will determine if more than one MHT is needed and discuss arrangements with the shift supervisor.

C. Prior to transfer, the patient's assigned nurse will utilize the transfer SBAR sheet as a guide when completing hand-off communication, via telephone, with the accepting facility's nursing staff.

D. The patient's property will be sent with the patient during transfer. The property bag will remain with the MHT staff escort until such time and only if the patient becomes officially admitted to the accepting facility.

E. A copy of legal status and/or original emergency application for admission is to be sent with the patient.

F. The MHT will ride in the ambulance if emergency transport is needed.

G. The MHT will remain with the patient until it is determined if the patient is to return to SNAMHS or be admitted to the hospital. If an over-lap of shifts occurs, the MHT will contact the shift supervisor and staffing department to arrange coverage.

A. The MHT is to remain with the patient until disposition is made – either admission to medical facility or discharge back to SNAMHS. While on COBRA escort assignment, the staff member should be able to visually observe the patient at all times and be able to intercede immediately if necessary to maintain the patient's safety. The staff escort will remain at a distance of no more than 8 feet from the patient.

H. The MHT staff escort will communicate the patient's legal status and elopement risk level with ER staff to ensure that all precautions are taken to prevent the risk of patient elopement. Staff shall use CPI verbal redirection techniques to prevent patient escape or elopement while on off campus transport.

I. The Charge Nurse or House Supervisor will contact receiving facility (hospital) within two (2) hours to determine patient status and disposition.

J. If the patient is to return to SNAMHS, the MHT will accompany the patient back to SNAMHS. If the patient is admitted to the medical facility, the MHT will remain with the patient until he/she is admitted to that facility.

K. Upon admission to the medical facility, the shift supervisor will notify the medical hospital administrator or on-call administrator of the SNAMHS patient's admission to their facility and state the patient's current legal status.

L. Document in the medical record the name of the administrator notified, date and time.

M. Prior to the return of a patient from another facility where they have received emergency medical care, there needs to be phone contact between the sending facility and SNAMHS with medical physician involvement when required to

confirm that SNAMHS is able to provide ongoing follow-up medical care recommended by the other facility.

N. Prior to the return of a patient that has been admitted to a medical facility back to SNAMHS, the social worker from SNAMHS needs to communicate with the social worker from the medical facility to determine discharge date. The medical physician involvement needs to occur to determine follow-up medical needs.

O. Prior to the return of a patient from another facility where they have received medical care, either on an emergency basis or as an in-patient medical patient, all pertinent material form the other facility needs to be received at SNAMHS by fax which includes the most current medical diagnosis, current medications prescribed with current dosing, and time frames, discharge instructions and/or summary, laboratory findings, H&P, Medication Administration Record, operative reports, and all follow up medical care recommendations.

P. Returning COBRA patients from a treating facility providing inpatient or emergency care require a full readmission. Patients returning to SNAMHS within sixty (60) hours do not require a repeat full psychiatric evaluation by physician.

Q. Returning SNAMHS inpatient who has been COBRA to other medical facilities may be directly admitted to inpatient status upon return.

R. The term “emergency medical condition” means:

1. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
    a. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
    b. Serious impairment to bodily functions.
    c. Serious dysfunction of any bodily organ or part.

S. The term “stabilized” means, with respect to an emergency medical condition described in paragraph (A) (1), that no material deterioration of the condition is likely, within reasonable medical probability, to result from or during the transfer of the individual from a facility, or, with respect to an emergency medical condition described in paragraph (A) (2), that the woman has delivered (including the placenta).

T. The term “Cobra” stands for Consolidated Omnibus Budget Reconciliation Act of 1985. COBRA requires most employers with group health plans to offer employees the opportunity to continue temporarily their group health care coverage under their employer’s plan if their coverage otherwise would cease due to termination, layoff, or other change in employment status (referred to as “qualifying events”).

U. The term "EMTALA" stands for The Emergency Medical Treatment and Active Labor Act. It is a statute which governs when and how a patient may be:

1. Refused treatment
2. Transferred from one hospital to another when he is in an unstable medical condition.

V. The term "transfer" means the movement of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, either directly or indirectly, with) the hospital, but does not include the movement of a patient who:

1. Has been declared dead.
2. Left the facility without the permission of any such person.
3. Was a regular approved physician discharge.

W. Regular discharges, AMA's, AWOL's, or discharges based on patient death do not require completion of the COBRA forms. All transfers to another acute care facility do require COBRA compliance.

IV. PROCEDURES:

CONSUMER TRANSFER FORM (COBRA):

The Patient Transport Form is to be used anytime a patient from SNAMHS is transferred to another facility including, but not limited to, acute care medical facility for inpatient or emergency department care, skilled nursing facility.

1. PATIENT INFORMATION SECTION:

   a. Enter patient identification in the lower right-hand corner by using a patient label from chart.
   b. Enter patient name, social security number, sex, address, telephone number and date of birth, Insurance Plan or check the box if No Insurance. Enter next of kin, relationship and phone number. Enter Guardian name (if applicable). Enter name of who notified next of kin/guardian.

2. TRANSFER INFORMATION SECTION:

   a. Enter reason for transfer
   b. Enter name of receiving facility
   c. Enter Date facility notified, and Time facility notified
   d. Enter name of the receiving physician and name of person accepting patient
   e. Enter the name of the person receiving your verbal report.

f. Check Yes box if copy of chart sent with patient, check No box if not.

3. PHYSICIAN CERTIFICATION SECTION:

a. The physician is responsible to provide benefits/risks to complete this section.
b. Physician signature is to be completed if the physician is available. If the physician is not available, it must be signed within forty-eight (48) hours after giving the order.
c. If the physician is not available, the Registered Nurse shall obtain the benefits/risks from the physician, and document this, along with the physician who gave the transfer order and date and time of such order.
d. The original of this form goes in the patient's SNAMHS medical record and the copy accompanies the patient to the receiving facility.
e. Enter the patient's name.
f. Enter the name of the person receiving telephone Order.
g. Enter the name of the Physician sending the Telephone order. Enter Date and Time.
h. Physician will sign Date and time
i. RN will "Note" order, date and time

4. MODE OF TRANSPORTATION SECTION:

a. Check the box that applies to the form of transportation
b. Check the box that applies to the patient property disposition.

5. PATIENT CLINICAL DATA:

a. Enter known allergies
b. Enter Psychiatric diagnosis
c. Enter medical diagnosis,
d. Enter physical limitations.
e. Enter general condition
f. Enter any significant psychiatric information or special conditions/considerations involving the patient.
g. Enter current vital signs. Vital signs shall always be taken on patients, prior to transfer.
h. Enter any other information that may influence care

6. MEDICATION SECTION:

a. Enter current medications, dose, frequency and last dose. All medications the patient is receiving should be entered.

7. CONSENT TO TRANSFER SECTION:

    a. Patient will write their name
    b. Patient will check any restriction for the release of any information
    c. Patient/Guardian will sign then date and time
    d. Witness will sign date and time.

8. REFUSAL OF SERVICES SECTION:

    a. Patient will write their name
    b. Patient/Guardian will sign then date and time
    c. Witness will sign date and time.
    d. When a patient refuses to sign a CONSENT TO TRANSFER, the patient must make this statement to two (2) staff members that he/she verbally agrees with the transfer. It must be documented on the Consent to Transfer form that the patient verbally agrees but refuses to sign; and both witnesses need to sign the form.
    e. When a patient refuses a medically necessary transfer, and the physician believes the transfer should take place:

        1. If a patient is a voluntary patient, an emergency application for admissions may be initiated, and the patient transferred to the acute care hospital for medical clearance. If the patient refuses to sign the form note this in the patient signature section and send the papers needed.
        2. Send a copy of the emergency application for admission.
        3. If the patient has been committed to SNAMHS a Denial of Rights may be done, provided the medical necessity for the transfer to an acute care hospital is documented by the patient's physician on the Denial of Rights form.
        4. On the Physician's Consent to Transfer in the patient signature section, staff can write "patient refused to sign but transfer is medically indicated".

9. The original of this form goes in the patient's SNAMHS medical record and the copy accompanies the patient to the receiving facility.

10. PHOTOCOPYING THE CHART:

    a. The patient must have signed the form Consent to Transfer and Release of Information prior to copying information in the chart.
    b. Copy the pages requested.

c. Each page must be stamped with the Medical Records "Disclosure Stamp", using red ink. The individual making the copy must indicate on the blank line in red ink, who the page is being released to.

Sample of stamp: "This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulation (42 CFR Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains: or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose."

11. PATIENT TRANSFERS TO OTHER HOSPITALS:

SNAMHS provides treatment to patients requiring acute psychiatric care. It does not have the capacity to provide acute medical care and has only limited medical emergency response capacity. In the event that a psychiatrist's patient requires acute medical treatment or emergency medical/surgical intervention, the patient shall be transferred to a designated treatment resource. Patient transfers from SNAMHS to other hospitals shall comply with the applicable COBRA requirements, regulatory requirements, and SNAMHS protocol.

V. REFERENCES:

A. COBRA (Consolidated Omnibus Budget Reconciliation Act): T.42 U.S.C., 1395dd., and N.R.S., 439b.410

B. EMTALA Write Out Act

C. Reference EMTALA Policy

D. SNAMHS Nursing Procedure II-15 COBRA and Escort of a patient to Emergency Room.

VI. ATTACHMENTS:

A. PF-COC-02 Interhospital Patient Transfers and COBRA Compliance Attachment A

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
NURSING DEPARTMENT

SUBJECT: Development Needs and Competency Assessment **NUMBER:** I-05

EFFECTIVE DATE: 06/22 **REVISION DATE**: 06/24

APPROVED BY: /s/ Earl Farinas, RN__
Director of Nursing II

SUPERSEDES: 03/03, 10/15, 11/17, 01/19, 6/20

I. PURPOSE:

To ensure that all members of the nursing staff are competent to fulfill their assigned responsibilities throughout their tenure with Southern Nevada Adult Mental Health Services.

II. PROCEDURE:

GENERAL CONSIDERATION**:**

A. Staff Licensed by the State Board of Nursing, without restriction, shall qualify the Nurse as competent for all duties approved by the Board.

1. Each Nurse will achieve 30 Continuing Education Hours (CEH) every 2 years in approved job-related education.

B. Mental Health Technician

1. Certification as a Mental Health Technician in accordance with the provision of NAC 433.110.

2. Promotion to MHT II required 1-year experience or the equivalent of MHT I, completion of 5 credits that must include 101 and 125, and approval of appointing authority. Promotion to MHT III requires 1-year experience or equivalent of MHT II, completion of all classes, and approval of appointing authority.

C. Assessment of competence begins prior to employment and at defined intervals throughout the individual's association with the agency.

D. Evaluations are objective assessments of the individual's performance in delivering client care services in accordance with client needs.

E. Pre-Employment: Applications are screened and assessed according to the following criteria:

1. Does the individual meet educational requirements?
2. Does the individual have appropriate licensure/certification?
3. Does the individual have related job experience?
4. Does the individual display the personal characteristics needed for this position?

F. Employment Interviews: All employees in the Nursing Department are interviewed by the appropriate individuals. During the employment interview the following criteria are assessed:

1. Education
2. Experience
3. Ability to assimilate and apply knowledge
4. Communication skills

G. Employment References: Each individual seeking employment submits the names of three individuals who are familiar with the individual or work performance (not personal references) and are asked to provide information on the following:
1. Quality/Quantity of work performed
2. Attitude
3. Ability to accept criticism
4. Attendance
5. Cooperation/Team Player
6. Dependability

B. Orientation: Individuals hired for the Nursing Department are given a four to six-week orientation. During the orientation period the following process is followed:

1. Nursing Education trains and coordinates unit orientation for new hires and ongoing education and training.
2. Unit-specific orientation is the responsibility of the unit staff who provides the documentation of completion to the Nursing Education department.
3. Respective PN IVs give feedback to the Director of Nursing and Nursing Education regarding competency, attitude, and degree of acclimation (comfort level) achieved by the individual, as needed.
4. Based on feedback from the PN IV, PN III and Nursing Education, the Director of Nursing may extend orientation beyond the standard two-week cycle on the unit when necessary.

C. Probationary Period: All employees complete a Probationary Period of employment. Feedback from respective PN IV and PN III is solicited during this time regarding the performance of the individual. Probationary Periods guidelines are contained in the State Administrative Manual (SAM).

D. Continued Employment: Upon completion of the Probationary Period, the PN IV and PN III assess competency by, but are not limited to, the following factors:
1. Attendance at Unit educational programs designed to increase staff's knowledge and skills for the specific client population.
2. Oral or written feedback received from the staff working directly with the individual.

3. Feedback from the Training Coordinator as staff complete the following:
   a. Annual Competency Assessment.
   b. Cardiopulmonary Resuscitation: All licensed nursing staff (RNs, and MHTs) who are involved in direct nursing care are required to maintain CPR Certification.
   c. Mandatory in-services and training such as but not limited to:
      Fire Extinguisher Training – every 2 years
      Sexual Harassment Prevention – every 2 years
      Pharmacy Annual in Service – every year
      Defensive Driving – every 4 years
      CPI -every 2 years and every year for a refresher
      Nursing skills competency – every year
   d. Audits of clinical documentation to ensure documentation compliance.
   e. Direct observation of staff in the performance of their duties (direct client care).
   f. Attendance at Continuing Education workshops/in-services which are offered outside of the agency.
   g. Client complaints or compliments submitted.
   h. Disciplinary actions.
   i. Yearly performance appraisal reviews completed by the PN IV, PN III, and or MHT IV.
   j. Specific goals and objectives are designated when need dictates.

III. REFERENCES: NAC 433.110

IV. ATTACHMENTS: N/A

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
NURSING DEPARTMENT

SUBJECT: Re-Assignment of Nursing Staff Related to Allegations of Abuse or Neglect of Patients

NUMBER: I-06

EFFECTIVE DATE: 06/22

REVISION DATE: 06/24

APPROVED BY: /s/ Earl Farinas, RN__
Director of Nursing II

SUPERSEDES: 04/05, 10/15, 11/17, 01/19, 01/20

I. PURPOSE:

To take immediate steps to protect patients in the event of allegations of abusive or neglectful treatment by nursing staff.

II. PROCEDURE:

A. EMPLOYEE

1. Notify RN Supervisor (Nurse Manager, Charge Nurse, House Supervisor) of any suspected allegations of abuse or neglect within one hour of such suspicion.

B. RN SUPERVISOR (NURSE MANAGER, CHARGE NURSE, HOUSE SUPERVISOR)

1. Notify the Director of Nursing/designee of suspected allegations of abuse or neglect within one hour.

2. As directed, obtain detailed written statements from staff members and/or patients; forward statements to Director of Nursing/designee.

C. DIRECTOR OF NURSING/designee

1. Take all necessary action to provide for patient welfare and safety.

2. Report allegations to Hospital Administrator/designee.

3. Direct RN Supervisor to obtain written statements as necessary to support decision making process regarding reassignment.

4. Review written statements.

5. Coordinate any staff reassignment related to allegations of patient abuse with Human Resources Director/designee.

D. HOSPITAL ADMINISTRATOR/designee

1. Coordinate decision regarding reassignment of staff.

2. Review written statements.

3. Initiate internal or external investigation as indicated.

III. REFERENCES: N/A

IV. ATTACHMENTS: N/A

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: NURSING DEPARTMENT

SUBJECT: Medical Staff 's Boards **NUMBER:** II-37

EFFECTIVE DATE: 06/22 **REVISION DATE:** 06/24

APPROVED BY: /s/ Earl Farinas, RN
Director of Nursing II

SUPERSEDES: 10/05, 10/15, 03/17, 01/19, 01/20

I. PURPOSE:

To establish a process to notify Psychiatry and Primary Care Medical Staff of Clinical needs of inpatient patients. This process shall incorporate a follow up monitoring component to enhance the delivery of services.

II. PROCEDURE:

The Medical Staff Boards shall be comprised of three components: A) Primary care– Medical/History & Physical Medical Board and B) –Psychiatric Board. There shall be two separate Medical Staff Boards on each unit, one for psychiatric clinical needs and one for medical clinical needs.

A. HISTORY AND PHYSICAL

1. Upon patient admission to the RSU, the admitting staff shall place the patient's name via AVATAR entry on the Bed Availability Report and indicate on the Primary Care Medical Board that an H&P needs to be completed.

2. After completing the H&Ps in Avatar, the Primary Care Medical Staff shall initial and date the list next to each entry indicating that the H&P has been completed. If the H&P cannot be performed due to patient refusal, the charge nurse shall note the refusal on the Primary Care medical board for the patient to be seen the next day, and make a progress note entry. The Primary Care Medical Staff shall write an order to repeat the attempt to perform the H&P. That entry shall remain on the daily pages of the board until complete.

3. If the patient is transferred with an incomplete H&P, the RSU Primary Care Medical Staff shall notify the Inpatient Medical Staff of the incomplete H&P and the RSU nurse shall notify the unit nurse of the incomplete H&P. The Primary Care Medical staff shall write an order to "place H&P on medical board daily until completed," and documentation shall reflect daily attempts to complete the H&P.

4. If a patient comes to RSU after the Primary Care Medical Staff has left for the day, AND if that patient is admitted to inpatient status BEFORE the Primary Care Medical Staff return to duty, the RSU nurse transferring the patient shall tell the unit nurse in the verbal report that the H&P has not been done. The inpatient unit nurse shall enter the incomplete H&P on the Primary Care Medical Board the incomplete H&P shall be noted on the Transfer and Admission checklists, and the attending physician shall include in the transfer orders an order to notify the inpatient medical doctor of the incomplete H&P.

5. When the Primary Care Medical Staff has finished the H&Ps for the day, the H&P list shall be retained by the charge nurse. The Medical Director and Director of Nursing shall be notified of all non-compliance.

B. PRIMARY CARE MEDICAL BOARD

1. Any medical needs voiced by a patient or identified by the nursing staff <u>that require follow-up</u>, including medication renewal/prn needs, shall be placed on the Psychiatric Board (Attachment A) by the unit staff nurse. Examples include but are not limited to headache, sore throat, diarrhea, constipation, etc. If the Psychiatric provider finds it necessary for the Primary Care Medical Staff to evaluate and treat, a consult will be ordered, referring to Primary Care Medical Staff

2. When the attending Psychiatrist writes an order for a medical consult, the order shall be transcribed and placed onto the Primary Care Medical Board.

3. What entries should be written on the Primary Care Medical Board (attachment B):

   a) All Diabetic Issues

   b) All Hypertension Issues

   c) All Cardiac Issues

   d) All Seizures

   e) All Labs/Imaging Results for Review

   f) All Medical Medications for Review/Renewal

   g) Coumadin/Blood Thinner Management

   <u>Important:</u> Call Medical for Acute Medical Issues and Initiate Doctor Blue for Emergencies.

4. Entries on the Medical Board must include brief details of why the patient needs to be seen. (Incorrect: “assess left leg.” Correct: “assess cut on upper left thigh.”)

5. The nurse entering information on the Primary Care Medical Board is responsible to assure that the entries are legibly written and that it is clear which patient the entry pertains to.

6. ALL entries MUST be signed by the nurse who places them on the Medical Board. The nurse shall complete the Date/Nurses Name (print legibly) column.

7. When the inpatient Primary Care Medical Staff is notified by the RSU Primary Care Medical Staff of an inpatient admission with an incomplete H&P, he/she shall give an order to "place H&P on medical board daily until completed."

8. The inpatient Primary Care Medical Staff shall document daily attempts to do the H&P in the patient's medical record until completed.

9. The Primary Care Medical Staff shall review the Primary Care Medical Board daily to identify clinical needs. Upon seeing a patient, the Primary Care Medical Staff shall complete the "MD Initial and Date" column on the board. **This indicates that the patient was seen, orders were written if indicated and documentation was completed in the medical record.**

C. PSYCHIATRIC BOARD

1. Any psychiatric needs voiced by the patient or identified by the unit nursing staff that require follow-up, including medication renewal/prn needs, shall be placed on the Psychiatric Board (Attachment B) by the unit staff nurse

2. The Psychiatrists shall consult the Psychiatric Board daily to identify clinical needs. Upon seeing a patient, the psychiatrist shall complete the "MD Initial and Date" column on the board. This indicates that the patient was seen, orders were written if indicated and documentation was completed in the medical record

D. MEDICAL BOARD FORM (Primary Care and Psychiatric)

1. All psychiatric and medical patient's clinical needs shall be recorded on the appropriate Medical Board, i.e., Psychiatric or Primary Care.

2. Seven (7) pages for each week shall be CLIPPED (not stapled) together – one page per day - with the day, date and unit indicated on each page. The Sunday night shift shall be responsible for maintaining three weeks of daily pages on the board, one group each for the previous, current and upcoming weeks. As the pages are removed from the boards, they shall be given to the PN III who shall retain them on the unit in a designated place.

3. Clinical needs that arise after the appropriate physician has left the unit for the day must be entered on the form for the following day.

4. Records from the H&P list and from the inpatient medical boards shall be retained for three months in the unit nursing file cabinet.

III. REFERENCES: N/A

IV. ATTACHMENTS:

A. II-37 Physician's Board Psychiatric Attachment A

B. II-37 Physician's Board Medical Attachment B

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: HOSPITAL WIDE

SUBJECT: Patient Observation **NUMBER:** PF-CC-88

EFFECTIVE DATE: 01/2022 **NEXT REVIEW DATE:** 01/2024

APPROVED BY: /s/ Susan Lynch, MBA, CPM
Hospital Administrator

SUPERSEDES: New

I. PROTOCOL:

SNAMHS believes in providing a safe, secure, and healthy environment, and is committed to the development of comprehensive services for the population that we serve.

II. PURPOSE:

The purpose of this procedure is to provide standards and guidelines for the assignment of appropriate observation levels for patients admitted to the inpatient floor in order to reduce risk and support their safety and define staff roles and responsibilities in how patients are monitored based on their level of observation and care.

III. DEFINITIONS:

A. Categories of Observation

1. 1:1 Observation: is an observation order in which a designated staff member is assigned to monitor one patient within line of sight and within 8 feet of the patient or as designated by medical staff at all times allowing immediate intervention to maintain the safety of the patient and unit.

2. Special Precautions: are written as an additional order to Q 5-minute observation or 1:1 observation. Special precaution orders include but is not limited to:
    - Supervision of patients in the use of sharps
    - Limited access to some areas of the unit per nursing staff discretion
    - Supervision of patients during bathroom use
    - Contraband searches of patients, patient property and/or their rooms when ordered by medical staff
    - No blankets, towels, sheets, or any items that may be a risk to the patients during bathroom use

- Activity participation will be limited to the unit unless evaluated and cleared by medical staff for off unit groups and activities.
- Assigning a designated staff member to accompany patients during COBRA or off unit referrals in addition to ambulance and/or rescue staff.

3. 5, 15-minute observation: observation order in which patients are visually observed by a designated staff member at the ordered interval either every 5 or 15 minutes.
4. Routine observation: observation level in which patients are visually observed every 30 minutes.

5. Red Risk Protocol: orders consisting of suicide prevention measures and 1:1 level of observation for patients identified as moderate or high risk for suicide.

B. Designated Staff for Conducting Patient Observation: are Mental Health Technicians (MHT), Registered Nurses (RN), and Contract/Agency nursing staff who have completed their orientation, training, and competency on patient observation.

IV. PROCEDURE:

A. ASSESSMENT

1. The Registered Nurse will assess the patient on admission and on an ongoing basis throughout the patient's admission regarding their level of risk and observation needs. If the nursing assessment indicates a change in the observation level, the Registered Nurse will notify Medical Staff and get an order for the appropriate level of observation based on the assessment and level of risk.
2. Inpatient staff will observe and document the location and behavior of all patients regardless of the observation level ordered. Monitoring requires assigned staff to conduct physical rounds of the unit and make visual observation at all times based on the level of observation ordered.

B. ROLES AND RESPONSIBILITIES:

1. Staff assigned to the monitor board is responsible for the following:
    - Conduct walking rounds during their assigned times, visually observe and monitor the patients at their assigned intervals.
    - Document the level of observation on the monitor board form including patient behavior and location
    - Should not engage in any activities that could distract them from performing patient observation checks. Examples include but not limited to computer work, pill pass, discharge or admit a patient, pass snacks, pass linen, or go behind the desk to make routine phone calls**.**
    - <u>May</u> open the bathroom door, talk with a patient, or assist in a life/death emergency on the unit.

- Should never leave the monitor board unattended.
- Will immediately report any changes in the patient's condition, mood, and activity level or concerns that may affect the observation level to the Charge Nurse or designee.
- Will intervene immediately in the event of any patient safety issue.

2. Medical Staff will be responsible for the following:
    - Provide orders for the initiation, discontinuation, or changes to the level of observation.
    - Entering the level of observation orders in eMAR. The level of observation orders will include the following information: type of observation, indication and/or any special instructions.
    - Notify the Medical Director of all orders for 1:1 Observation.
    - Complete a progress note when discontinuing or changing the level of observation which will include but not limited to patient's current mental status and reason(s) for discontinuing or changing the level of observation.
    - Co-signing all telephone orders within 48 hours.

3. Charge Nurse or Designee will be responsible for the following:
    - Assigning qualified nursing staff members for monitoring every shift.
    - Ensuring that staff assigned to the monitor board will not be provided with other duties and responsibilities.
    - Notifying all staff members of patients' level of observation and of any special restrictions.
    - Advise visitors (family, friends, or significant others) the patient is being observed under the Special Observation status. Provide explanation for implementation of Special Observation status only with the patient's prior consent.
    - Conduct a thorough search of the patient's clothing, personal belongings, and room to detect and secure any potentially dangerous objects or items.
    - Conduct additional searches based on reasonable concern or suspicion of possibility of patient harm.
    - Conduct searches that minimize amount of disruption to the patient's roommate(s) and property.
    - Allow patient to participate in off unit activities based on observation level to include physician order.
    - Ensuring that the patients' level of observation and surveillance are not interrupted by shift change, staff member breaks, meals, patient participation in therapy or leisure activities, during disturbances or incidents or during visiting hours.
    - Providing report and update about patient status whenever assigned staff member is replaced/relieved.

4. Registered Nurse will be responsible for the following:
    - Assessing the patient on admission and on ongoing basis regarding their level of risk and observation needs.
    - Obtaining medical staff order for the appropriate level of observation based on the patient's assessment and safety risks identified.
    - Informing the patient of the reasons for the level of observation ordered.
    - Monitoring and ensuring observation precautions are carried out by assigned staff.
    - Completing a progress note which will include but not limited to exact time the level of observation was implemented, patient behavior, rationale for the level of observation including restrictions and other pertinent information.
    - Notifying Medical Staff member of any patient behavior that indicates the need to review or change the current level of observation ordered.

C. LEVELS OF OBSERVATION

1. ROUTINE 30-MINUTE OBSERVATION
    - Assigned staff will conduct walking rounds and visually observe patients on routine observation at a minimum of every 30 minutes including visiting hours and any unit activities.
    - The location and behavior(s) of each patient on routine observation must be documented on the Monitor Board form at a minimum of every 30 minutes. Observation times should not be pre-entered prior to visualization of each patient.
    - The assigned staff member must see the patient to verify their location with the following exception: When patients are escorted off the unit to attend an off-unit activity the appropriate code is placed on the monitor board.
    - Patients who are sleeping will need to have their breathing status verified during the rounds.
    - Staff assigned to the monitor board will carry the observation flow with them during the duration of their assignment.
    - Assigned staff will check bathrooms and patient rooms every 30 minutes for environmental safety, ligature risks, anchor point, contrabands, and patient activity including safety checks on fall risk patients, taking note of hydration/toileting needs, environmental safety issues, and other patient needs. The corresponding bathroom and safety check boxes must be initialed after every inspection.

- The assigned staff member will report any irregularities or concerns to the Charge Nurse or designee immediately.
- Upon completion of an assigned rounds period, assigned staff are responsible for transferring the rounds clipboard directly to the next scheduled assigned staff.

2. 15-MINUTE LEVEL OF OBSERVATION
    - Assigned staff will conduct walking rounds and visually observe patients at a minimum of every 15 minutes including visiting hours and any unit activities.
    - The location and behavior(\s) of each patient on 15-minute observation must be documented on the Monitor Board form at a minimum of every 15 minutes. Observation times should not be pre-entered prior to visualization of each patient.
    - The assigned staff member must see the patient to verify their location with the following exception: When patients are escorted off the unit to attend an off-unit activity the appropriate code is placed on the monitor board.
    - Patients who are sleeping will need to have their breathing status verified during the rounds.
    - The assigned staff member will report any irregularities or concerns to the Charge Nurse or designee immediately.
    - Staff assigned to the monitor board will carry the observation flow with them during the duration of their assignment.
    - Upon completion of an assigned rounds period, assigned staff are responsible for transferring the rounds clipboard directly to the next scheduled assigned staff.

3. 5-MINUTE LEVEL OF OBSERVATION
    - Assigned staff will conduct walking rounds and visually observe patients at a minimum of every 5 minutes including visiting hours and any unit activities.
    - The location and behavior(s) of each patient on 5-minute observation must be documented on the Monitor Board form at a minimum of every 5 minutes. Observation times should not be pre-entered prior to visualization of each patient.
    - The assigned staff member must see the patient to verify their location with the following exception: When patients are escorted off the unit to attend an off-unit activity the appropriate code is placed on the monitor board.
    - Patients who are sleeping will need to have their breathing status verified during the rounds.
    - The assigned staff member will report any irregularities or concerns to the Charge Nurse or designee immediately.

- Staff assigned to the monitor board will carry the observation flow with them during the duration of their assignment.
- Upon completion of an assigned rounds period, assigned staff are responsible for transferring the rounds clipboard directly to the next scheduled assigned staff.

4. 1:1 LEVEL OF OBSERVATION
    - One staff will be assigned to monitor one patient on a 1:1 level of observation continuously without interruption and must always accompany the patient including when the patient is showering, toileting, dressing, when assisting with activities of daily living or when sleeping.
    - Assigned staff must ensure that the patient is within an arms-length to 8 feet, as long as it is safe to do so, or as determined by the Medical Staff maintaining close proximity to react and intervene if needed.
    - The location and behavior of each patient on 1:1 observation must be documented on the Monitor Board form and should not be pre-entered prior to visualization of each patient.
    - Patients on 1:1 level of observation will not be allowed to take blankets, towels, sheets, or any items that may cause harm into the bathroom.
    - During shift change rounds and when providing hand-off, the patient on 1:1 level of observation will be observed by both the outgoing and incoming staff. Both staff members will document the status of the client and co-sign the last 15-minute check sheet (for shift ending) on the 1:1 observation sheet on all shifts. Charge nurse will ensure this is being completed.
    - All staff members assigned to a 1:1 level of observation will ensure their initials and signature are documented on the same form.
    - Patients on a 1:1 level of observation may only leave the unit for emergency treatment and under a physician's order.
    - Assigned staff will have no other duties while monitoring the patients on a 1:1 level of observation.
    - 1:1 observation level order will be reviewed at least every 24 hours by the Medical Staff.
    - Staff assigned to monitor patients on 1:1 level of observation will be assigned not longer than two hours at a time.

5. RED RISK PROTOCOL
    - Patients on red risk protocol will be placed on a 1:1 level of observation and will be monitored continuously without interruption.
    - Assigned staff must accompany the patients at all times including

when showering, dressing, toileting, and activities of daily living if needed.

- Assigned staff must ensure that the patient is within an arms-length to 8 feet, as long as it is safe to do so, or as determined by the Medical Staff maintaining close proximity to react and intervene if needed.
- The location and behavior of each patient on 1:1 observation must be documented on the Monitor Board form and should not be pre-entered prior to visualization of each patient.
- Off unit activities and privileges for patients on red risk will be determined by medical staff.
- Clients on Red Risk will be evaluated by the Medical staff within 24 hours of giving the order.
- The need to continue or discontinue Red Risk Protocol will be reassessed daily by medical staff in consultation with the Treatment team

D. CARE PLANNING AND DOCUMENTATION:

1. For Off Unit and Treatment Mall Groups:

   - Staff will assist patients to sign the off-unit log sheet before leaving the unit for a group or activity and will be escorted to the appropriate location for the group or activity session.
   - Staff must ensure patients sign the sign-in sheet at the beginning of each group or activity then sign out and be escorted to the next group or assigned unit.

2. For Breathing Status Verification:
   - Visually observe patient and verify breathing status either through verbal acknowledgement or observation of chest rising and falling with each respiration. Flashlights will be utilized if unable to clearly visualize respiration status.
   - With the flashlight on, shine the light on the side of the mattress so the patient's chest movement can be seen. If unable to observe breathing movement re-position the light on a different part of the mattress, moving either up or down the side. If possible, do not shine the flashlight on the patients face.
   - Any abnormalities need to be reported to the Charge Nurse and documented in the progress note.

3. All monitoring will be conducted on time. Assigned staff unable to complete their responsibilities should notify the charge nurse or designee so another staff member can be assigned.

4. Errors on the monitor board shall be corrected with a single line drawn through the error and initialed.

5. In case of fire alarm, the assigned staff will take their monitor board to the evacuation area and conduct a complete count of all assigned patients.

6. The Charge Nurse will review the monitor board for completion and accuracy to ensure optimal care. Errors will be discussed immediately with the assigned staff to promote reinforcement of the importance of patient observation.

7. The Charge Nurse or Designee will review the monitor board and sign as the reviewing nurse at the top of the form on a routine basis before the monitor board is complete and filed.

8. Failure to conduct the monitor board correctly may result in corrective action.

9. Completed monitor boards are kept on file on the pod for the calendar year. The Unit Secretary or designee will send to storage off site at the end of each calendar year.

10. For patient safety incidents requiring a tool for cutting, a cutting tool can be accessed in the emergency cart located in the unit medication room.

E. Any difficulty in achieving the above procedure should be reported to the Unit Nurse Manager for mitigation and follow-up.

V. REFERENCES:

1. Montana State Hospital Policy and Procedure TX-34
2. Hertfordshire Partnership Safe and Supportive Observations Policy
3. NHS Policy for Clinical Observation of Patients with Mental Health Problems

VI. ATTACHMENTS: N/A

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: NURSING DEPARTMENT PROCEDURE

SUBJECT: Documentation Standards **NUMBER:** IV-05

EFFECTIVE DATE: 04/23 **NEXT REVIEW DATE:** 04/25

APPROVED BY: /s/ Earl Farinas, RN
Director of Nursing II

SUPERSEDES: 4/03, 7/14, 10/15, 3/16, 4/16, 11/16, 12/16, 5/17, 11/17, 02/18, 01/19,05/19, 07/19, 01/20, 07/21, 07/22, 08/22

I. PURPOSE:

To define inpatient nursing staff documentation expectations.

II. PROCEDURE / NURSES:

A. ASSESSMENT / REASSESSMENT

a. Complete an initial nursing assessment and document in the Electronic Medical Record (EMR) within eight (8) hours of patient arrival to the hospital.
b. Reassess each patient at least every shift, after unit transfers, and as indicated by changes in the patient's condition, and completes a follow-up Nursing Assessment in Avatar.
c. Heparin and Insulin (high alert drugs) must be checked by two (2) nurses for accuracy of dosage before administering, and documentation of both nurse's signatures on eMAR.
d. All telephone orders via order entry are validated by the physician within 48 hours.
e. A red sticker labeled ALLERGIES will be placed on the front of every chart. All reported allergies from source documents (H & P, Nurse Intake assessment, Psychiatric evaluation, Avatar Allergies and Hypersensitivities tab, MAR, Kardex) will be written on this sticker. If there are no documented allergies NKA (no known allergies) will be written on this sticker.
f. A yellow sticker labeled GUARDIAN will be placed on the front of every chart, for those patients with documentation indicating Legal Guardianship.
g. A pink sticker labeled PREGNANT will be placed on the front of every chart, for those patients with positive HCG and/or labs indicating pregnancy.
h. An orange sticker labeled FALL alert will be placed on the client chart, MAR, and Kardex and an orange dot will be placed on the

monitor board sheets, fall risk written on the SBAR sheets and a fall "leaf" magnet placed on the patient's door to identify the client as a fall risk.

i. A red dot will be placed on the monitor board sheets and front of the chart for any patient that is placed on red risk protocol.

j. An alert sticker labeled ANTICOAGULANT will be placed on the front of every chart, for those patients on anticoagulant therapy.

k. Chart audits:
The nursing chart audit shall be completed weekly in EPOD and GPOD. The audit form is in the SNAMHS share>Nursing>Unit Forms folder. The RSU nursing chart audit shall be conducted when transferred to the inpatient unit.

B. PROGRESS NOTES

1. Utilize DAP as a standardized progress note format.
D - Data - includes subjective and objective information
A - Assessment/Conclusion - only RNs can perform an assessment
P - Plan - Strategy for relieving the problem, relate the data and assessment to the treatment plan.
2. The Electronic medical record has a functionality to save progress notes until it is ready for submission. This allows for subsequent entries to the progress note to reflect any change in patient's condition, additional assessment and/or any interventions provided by staff.
3. Complete an initial progress note within the shift of patient admission.
4. Include patient's presentation on admission, patient's stated reason for admission and overall mental status/condition, statements and/or reasons for admission by family or by others, preferable verbatim and identify informant(s).
5. Assess for medical problems as per patient history and prior documentation indicating pre-existing medical condition(s), place on medical board, include in DAP progress note, and list as a secondary problem within the Treatment Plan after medical doctor has prescribed treatment for patient.
6. Address patient's ability to describe problems, stressors and/or situations experienced prior to hospitalization.
7. Describe current and observed behavior.
8. Complete a progress note that includes the following:
   a. Initial assessment/intervention/plan at the beginning of the shift; subsequent assessment/intervention/plan at the end of the shift and assessment/intervention/plan at any time during the shift as needed
   b. PRN medication given with the effectiveness of the medication
   c. Changes in observation
   d. Status of the "target symptoms" presented by patient on admission
   e. Information about behaviors during shift
   f. Report of signs of possible side effect of medications by patient
   g. Nursing interventions as listed in the treatment plan
   h. Attach progress note to treatment plan

9. In addition, progress notes should reflect patient admission, transfers, discharge; in the event of a change in patient's condition (medical or behavioral); in the event of other interventions such as the use seclusion and/or restraints or manual holds.
10. Complete a progress note at discharge that addresses patient's understanding of an agreement with discharge plan, medication management plan and plan for follow up care.
11. DAP progress notes shall start by typing the shift such as 7p-7:30a; 7a-7:30p; 3p-11:30p; 11p-7:30a; 7a-3:30p. The staff is expected to document the following: 3 entries for 12-hour shift, 2 for 8-hour shift, and chart by exception for 4 hours shift. The guidelines for the chart by exception (CBE) are as follows: incident report, COBRA, seclusion, a restraint, red risk, admission, transfer, discharge, 1:1, or every 5 minutes observation.

C. TREATMENT PLAN

1. After completion of the initial nurse assessment, initiate the multi-disciplinary Treatment Plan by listing the patient's problem (s), problem statement reflecting signs & symptoms, long term and short-term objectives, and interventions.
2. Document the date and time of initial Treatment Plan creation within the Plan Description box.
3. Review the Treatment Plan and update every 7 days or as needed based on changes in patient behavior and progress with treatment.

D. ELECTRONIC MEDICATION ADMINISTRATION RECORD (eMAR)

1. Document all medication administered (including routine medications, STAT medications, NOW and PRN medications on the eMAR (the nurse administering the medication MUST be the nurse documenting medication administration on the eMAR.
2. Assess medication effectiveness within 60 minutes of administration and document effectiveness on the eMAR. Update progress note with the effectiveness of the medication
3. Document pain assessment and reassessment (use numerical or faces scale) on the eMAR and update progress note. Include documentation regarding pain location (example: proximal, distal, medial or lateral), pattern (example: time of onset, duration, persistence or intervals without pain), intensity (patient rates pain), quality (example: crushing, dull, heavy, sharp or jabbing).

E. NEUROLOGICAL VITAL SIGNS CHECK SHEET

1. Complete neurological vital signs as ordered or as required by policy with change in neurological functioning.
2. Evaluate patient's level of consciousness, pupillary activity and level of orientation to person, place, time and situation.

F. ABNORMAL INVOLUNTARY MOVEMENT SCALE (AIMS) DOCUMENTATION

Complete AIMS examination upon admission and then every Sunday, which then regulates to every 7 days, and at discharge. AIMS must be updated when there is a change in a patient's condition and or when a medication has been given for extrapyramidal symptoms (EPS).

G. MEDICATION RECONCILIATION LOG

Complete as outlined in the Medication Reconciliation Log policy.

H. INTERDISCIPLINARY CONTINUITY OF CARE (ICOC) DISCHARGE INSTRUCTIONS

1. The electronic form, ICOC document is the collaboration between the RN and the Social Worker during patient discharge.
2. A. Medication Reconciliation is completed by the RN
3. B. Two (2) copies of the completed form is printed and distributed, one to the patient and one, electronically signed by the patient is filed in the chart.
4. The ICOC document includes the following data:
    a. Medication prescribed for the patient and the education provided to the patient including discharge medication handouts.
    b. Any special care needs of the patient.
    c. Outpatient clinic appointments, including but not limited to address and phone numbers.
5. Validate patients' understanding and obtain patients' signature as documentation of understanding and agreement with discharge plan/instructions.
6. Provide Drug information/Medication handouts.
7. Document discharge instructions provide to the patient in the progress note in the Electronic Medical Record.

I. SBAR

1. Utilize SBAR as a standardized Hand off communication tool.
    S – Situation - Clearly and ***briefly*** define the situation.
    B – Background - Provide clear, relevant background information that relates to the situation.
    A – Assessment - A statement of your professional conclusion.
    R – Recommendation – Provide recommendations/suggestions of what to do next for the plan of care.
2. Information to be included on the SBAR data sheet: room number, patient photo, patient first name and last initial, age, gender, medical record number, admit date, attending physician, social worker, legal status, observation level, diagnosis, history of victimization, history of assaultive, anger/aggression risk, assessments, recommendation, allergies, diet order, food allergies.
3. Psychiatrist will notify RN of the patient's anger/aggression risk, either low risk, moderate risk, or high risk and make level of observation orders.

The nursing staff is responsible for documenting the risk level on the SBAR and communicating with the treatment team.

4. Nursing staff will update patient information on SBAR data sheet as needed anytime per shift.

III. PROCEDURE / MHTS:

A. SBAR

RN will provide patient information to the MHT and the MHT will input data into the SBAR data sheet as needed anytime per shift.

B. PROGRESS NOTES

Complete a progress note when instructed by the nurse or as indicated by policy, utilizing the standard format below:

D - Data - includes subjective and objective information
P - Plan - Strategy for relieving the problem

C. VITAL SIGNS, MEALS, WEIGHTS

1. Complete vital signs for all patients shall be taken and documented daily including but not limited to temperature, pulse, respiration, blood pressure, and pulse oximetry. The assignment of vital signs may be divided between the day shift and the evening shift.
2. All meals, including breakfast, lunch, dinner, and snacks, are documented in Avatar before midnight by the night shift.
3. Weekly weights shall be taken every Saturday and documented in Avatar.

IV. DOCUMENTATION OF ERRORS:

A. Employees are prohibited from destroying any document associated with patient care without :
   1. Receiving specific permission from the PN IV and;
   2. Reporting and completing an incident report.

B. All official documents associated with patient care shall comply with medical record documentation standards.

C. Errors shall be identified with one line strike through, error written and initials.

D. The following actions are prohibited on all documents associated with patient care:
   1. Use of white out
   2. Darkening over an error (i.e. to turn a 1 into a 2)
   3. Using multiple lines or markers to black out errors; and/or
   4. Use of tape to add to or replace.

V. DOCUMENTATION FOR LATE ENTRIES IN THE ELECTRONIC MEDICAL RECORD:

A. Documentation should be completed by the end of each shift. If a late entry is necessary, please follow below process. Late Entries: The rationale is that what is not documented was not done.

B. Documentation for late entry in the Electronic Medical Records is to compensate for an omitted original entry.
   1. Create a new entry in Electronic Medical Record and distinctly identify the entry as “late entry”
   2. Enter the current date and time

C. Addendum: An addendum is used to provide information that was not available at the time of the original entry.
   1) Locate original entry in the Electronic Medical Record and click append
   2) Append original notes ONLY
   3) Complete as soon as possible.

VI. REFERENCES: N/A

VII. ATTACHMENTS: N/A

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: NURSING DEPARTMENT

SUBJECT: Kardex **NUMBER:** IV-07

EFFECTIVE DATE: 06/22 **REVISION DATE:** 06/24

APPROVED BY: /s/ Earl Farinas, RN__
Director of Nursing II

SUPERSEDES: 10/05, 10/15, 12/16, 02/17, 02/18, 01/19, 06/19, 01/20

I. PURPOSE:

To establish a process for documenting vital patient information (personal and medical) in a consolidated and concise manner for the purpose of communicating patient specific information to members of the patient care team. The Kardex shall be utilized in every change of shift report.

II. PROCEDURE:

A. Upon admission the Kardex will be initiated by the PN or AA.

B. Information on the Kardex is obtained from the Nurse Assessment, Physician's Electronic Order Entry, Service Application, prior medical records, and/or any additional documentation containing vital information. This may include allergies, specific behaviors, prior patient situations, or specific patient preferences.

C. Kardex must be updated and completed prior to transfer.

D. Upon acknowledging the Physician's Electronic Orders, any nursing and physician treatments are noted on the Kardex.

E. When a physician's electronic order involves transportation of the patient, a copy of the Inpatient Transportation Request form shall be placed in the Kardex upon transcription and completion of the order.

F. Upon treatment being discontinued or completed, the item is highlighted with a date and initials noted.

G. The Patient Personal Safety Plan is in the Kardex and is initiated by the Mental Health Technician on admission. The plan is to be completed in the Treatment Team meeting and documented in the treatment plan. Continue to attempt if patient refuses, date time and signature.

H. The Group Therapy listing shall be completed based upon the decision from the Treatment Team and documented in the treatment plan.

I. The Kardex is a permanent part of the medical record. Upon admission to inpatient services the Kardex will be sent to the unit with the patient.

III. REFERENCE: NA

IV. ATTACHMENTS:

A. IV-07 Kardex Attachment A
B. IV-07 Kardex Attachment Stein B

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
NURSING DEPARTMENT

SUBJECT: Evaluating Contract Nursing and CNA Staff **NUMBER:** VI-09

EFFECTIVE DATE: 06/22 **NEXT REVIEW DATE:** 06/24

APPROVED BY: /s/ Earl Farinas, RN
Director of Nursing II

SUPERSEDES: 08/13, 10/15, 9/16, 11/16, 11/17, 1/19, 5/20

I. PURPOSE:

To provide adequate evaluation and supervision of the clinical activities of non-employee nursing personnel, including Registered Nurses and Certified Nursing Assistants.

II. PROCEDURE:

A. The "Performance Evaluation of Contract Staff" form will be completed by the Charge Nurse of each shift for the contract Registered Nurses and Certified Nurse Assistants for the first three months and 320 hours of floor time worked.

B. After completion of the evaluation form, the Charge Nurse will deliver the form to the unit's PN IV (Nurse Manager) for review and signature.

C. Suppose the performance evaluation form is within the acceptable rating scale of the employee performance. In that case, it can be filed in the agency employee folder or scanned into the SNAMHS share drive where their employee folder is located.

D. Suppose the contract employee's performance is not within the acceptable rating scale of the employee performance. In that case, additional action is required by the PN IV (Nurse Manager) and the Director of Nursing to evaluate the issue and plan for resolution.

E. The action plan will be documented on the performance evaluation form

F. A copy of the performance evaluation will be sent to the employment agency for review.

III. REFERENCES: N/A

IV. ATTACHMENT:

A. VI-09 Evaluating Contract Nursing and CNA Staff - Attachment A

B. VI-09 Evaluating Contract Nursing and RN Staff - Attachment B

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
NURSING DEPARTMENT

SUBJECT: Contract Employee Orientation for Nursing Department **NUMBER: VI-14**

EFFECTIVE DATE: 6/2021 **REVISION DATE:** 06/23

APPROVED BY: **/s/** Earl Farinas
Director of Nursing II

S**UPERSEDES:** 10/16, 12/17, 01/19, 2/19

I. PURPOSE:

The purpose is to establish a procedure for providing a complete and thorough orientation for non-employee nursing personnel, including Registered Nurses and Certified Nursing Assistants.

II. PROCEDURE:

A. Nursing Department orientation for agency personnel is accomplished from five days to twenty-one days, pending on the title and experience.

1) Five days for certified nurse assistant.

2) Fourteen days for a registered nurse with experience.

3) Twenty-one days for a new graduate registered nurse.

B. Orientation shall include an agency tour, introductions to supervisors, review of policy and nursing procedures, including but not limited to electronic health record assessments and documentation, medication process, unit orientation, and other information relative to the division/agency organization.

C. Orientation is provided by and verified by Nursing Education. The orientation record form identifies the description of the orientation, the date the training was given, and the names of those providing the training. Both the employee and the individual providing the training will sign off on the orientation record, indicating that the employee agrees that they understand and have had their questions answered.

D. Training

1. CPI training is required before unit orientation and then a CPI refresher annually after that.

2. All other training required by division/agency including but not limited to the fire extinguisher, KnowBe4, Sexual Harassment, HIPAA, Security Training,

3. Access to electronic medical record (Avatar) windows account, state email, and policy tech will be disabled after 30 days without any activities. After that, a designee will contact the IT department to enable the account.

4. Nursing Education shall review the training records for any RN/CNA reinstated to return to work to determine training needs.

E. Medical Record Deficiencies

1. The medical record, which includes Electronic Medical Record (Avatar) and paper medical record deficiencies, including unit deficiencies, must be corrected within 72 hours of notification. Any staff not in compliance with the procedure and repeated non-compliance to the 72-hour rule will be removed from the active list and will be reviewed to determine reinstatement.

F. Timesheets

1. Timesheet requires two supervisor signatures for each shift worked. The timesheet needs to be signed by a supervisor at the beginning and end of the shift.

III. REFERENCE:

A. Nursing Department Orientation Record

B. Registered Nurse - Unit Orientation Record

C. Mental Health Technician - Unit Orientation Record

IV. ATTACHMENTS: N/A

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: Statewide

SUBJECT: All Medical Staff Procedures **NUMBER:** SWMS 01-114

EFFECTIVE DATE: 04/2023 **NEXT REVIEW DATE:** 04/2025

APPROVED BY: /s/ Leon Ravin, MD
Statewide Medical Director

SUPERSEDES: 01/17, 1/19, 01/21

I. PURPOSE:

Medical Staff has a directive to ensure a consistent quality of care as directed by policy and procedure.

II. PURPOSE:

To establish procedures for all Medical Staff.

III. PROCEDURE:

1. All documentation in the medical record will be clearly legible.
2. All progress notes will be documented in the electronic medical record.
   a) When the electronic medical record is unavailable, the Medical Staff member will complete a hard copy progress note.
   b) The Medical Staff member will document in the electronic medical record, "See hard copy note", as soon as the electronic medical record is available.
3. All treatment planning will be documented in the electronic medical record.
4. All LOCUS assessments will be documented according to agency policy.
5. All progress notes written by Medical Staff will contain documentation of suicidal and homicidal ideation.
6. All Medical Staff performing completing psychiatric evaluations will ensure proper mental status assessment and documentation. The following areas require assessment and documentation:
   a) Appearance
   b) Demeanor/Behavior/Psychomotor activity
   c) Mood
   d) Affect
   e) Speech
   f) Thought Process
   g) Thought content with at minimum assessment for the presence of SI/HI/aggressive ideation and delusional thoughts (including pertinent negative finding)

h) Cognitive functioning
    i. Level of consciousness
    ii. Orientation
    iii. Memory/concentration with indication how you have arrived at your conclusions (i.e. performing standardized test or judging accordingly to history data presentation)
    iv. Insight (substantiated)
    v. Judgement (substantiated)
    vi. Impulse (substantiated)
    vii. Description of patient's strengths and assets

7. All mental health status updates shall be documented in the electronic medical record.
8. All Medical Staff shall assess for early warning signs of a charge or deterioration in a patient's condition during their clinical evaluation. This may include at time of initial evaluation (initial psychiatric evaluation or history and physical), subsequent encounters (treatment team session, medical consultation, clinic follow up), or other clinical situations where a physician is rendering treatment and services to a patient.
    a. Early warning signs may include but are not limited to:
        i. Neurological: dizziness, syncope, lightheadedness, weakness, numbness or tingling.
        ii. Cardiac: chest discomfort, pain or discomfort in arms, back, neck, or jaw, shortness of breath, sweats, or nausea.
        iii. Pulmonary: shortness of breath, wheezing, tachypnea
        iv. Gastrointestinal: sudden onset abdominal pain or discomfort, nausea, vomiting
        v. Metabolic/nutritional: blood sugar greater than 450 or less than 60 or refusal to eat at least three consecutive meals.
        vi. The above warning signs may also be accompanied by changes in vital signs (ex. Pulse greater than 100 BPM, SBP greater than 150, DMP less than 90, temperature greater than 100 degrees Fahrenheit). Refer to Policy PF-CC-50: Medical Management of Acute Psychiatric Patients for additional details regarding vital signs monitoring.
    b. Medical Staff shall make further decisions regarding patient care, which may include:
        i. continued treatment within the facility
        ii. Primary Care consultation for additional management
        iii. or transfer to an outside emergency department or medical center if the patient's needs exceed the facility's capacity to treat.

IV. PROCEDURE FOR ACCEPTING PATIENTS FROM THE EMERGENCY ROOM:

1. All admissions will be ordered by the Medical Staff
2. If a medical problem is present as well as a mental illness, Medical Staff can request a review by primary care and will approve or deny the admission based on the nature of the medical illness.
3. The primary care Medical Staff is to be contacted as soon as a medical issue is raised so that they can contact the emergency room and assess the medical issue relative to admission.
4. Medical Staff are to delay admission until all laboratory studies that they deem necessary are obtained, and the results are completely transmitted to the facility for review.
5. Both the psychiatrist and the primary care medical staff are directed to delay admission until they are satisfied that the patient's condition is stable enough to warrant transfer.
6. If the medical illness significantly affects a patient's ADLs, the Medical Staff will consult with the DON or their designee to determine if the facility is capable of providing care.
7. All entries to the Golden Rod related to admission, denial of admission, and delay in admission are to be dated, timed, and have the Medical Staff reasons for action are to be fully described.
8. No patient is to be denied admission for medical reasons without contact between the admitting Medical Staff and transferring physician.
9. No patient is to be denied admission to the facility for non-psychiatric reasons without contact between the facility Medical Staff and the transferring physician.
10. SNAMHS is not obligated to receive a patient if we cannot safely ensure our facilities can provide adequate medical management.
11. Safety contracts are not to be used as part of a risk assessment. If present, they must clearly be identified as a therapeutic tool and not part of the risk assessment.

V. REFERENCES:

1. IMRT 2.1 Basic Documentation Guidelines for Medical Records
2. SP 4.18 Criteria and Process for Consumer Admission

VI. ATTACHMENTS: N/A

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
NURSING AND LABORATORY DEPARTMENTS

NUMBER: II-44 Nursing
1001 Laboratory

SUBJECT: Quest Diagnostic Laboratory Ordering, Patient Sample Labeling and Phlebotomy Procedures.

NEXT REVIEW DATE: 6/2024

EFFECTIVE DATE: 06/22

APPROVED BY: /s/ Deborah Keil
Medical Director of Laboratory Services

/s/Earl Farinas, RN__
Director of Nursing II

SUPERSEDES: 11/17, 02/18, 4/18, 12/18, 06/20

I. PURPOSE:

To ensure accurate and timely collection and reporting of laboratory procedures.

PROCEDURE:

A. An order is written stating designated lab work to be drawn. Order will state specific date and time that the lab work needs to be drawn.

B. Quest Diagnostic and/or in-house test form are utilized to fill out patient data, test, date, time, diagnosis and provider. Do not borrow Lab Requisition forms from other units. The units are account specific, and results will be delivered to that specific unit. Outpatient requisitions are also separate. Should a patient be discharged and follow up labs are ordered, on discharge patient is referred to the outpatient clinic.

a. How to fill Quest Diagnostics requisition form

1. Complete the Quest Diagnostics requisition form
2. Check **My Account** for billing and add ordering physician name (complete name)
3. Attach patient sticker (with name and MR#), fill in DOB, SEX
4. Check the appropriate orders/tests
5. For tests/orders not included in the requisition form, handwrite the test/orders along with the appropriate **Test Code** (test codes can be seen in Quantum Portal, open Care360.com, hover mouse towards for *Physicians & Hospitals*, select *Test Center*, then on the search box type the *Test/Order* and *click Go,* then select the appropriate Test/Code)

C. The designated RN will take the completed requisition and place in the "Lab" Binder which is located on each unit.

a. When collecting urine, swabs or other biological patient samples, the date and time of collection, source of specimen (for cultures or biological samples) initials of the person that collected, the name of the patient, and the medical records number must be on the container and must match the time of collection and other identification data on the on the ordering requisition.

b. A Quest collection kit will be provided for urines. Use large cup for urine collection. Using provided pipet and appropriate PPE, transfer urine to the conical tubes provided as soon as the urine is collected. Timing is important. Immediate transfer to conical tubes is necessary for reflex culture and urinalysis.

c. Specimen containers must NOT be prelabeled and must be labeled in front of the patient after the patient verifies that the name on the label is correct.

d. If identifiers do not match, laboratory should reject the specimen and request a recollection. Laboratory personnel cannot order or cancel tests, but we can advise on the process.

D. The laboratory assistant, technician or technologist will look at "Lab Binder" and perform draws from those requisitions.

E. Only approved STAT order tests may be placed for STAT. See attachment A for the approved STAT test order list.

F. Add on tests: When a doctor wants to add on a test to a previously collected specimen call Quest Client Services (866-MYQUEST). They will send "Verbal and Add-On Test confirmation form" which you will complete and fax signed/completed form to designated number listed.

G. STAT 24/7

STAT Courier

- Testing is available seven days a week, 24 hours a day
  In-house phlebotomist STAT testing (Mon-Fri) 5:30 am – 2 pm; (Saturdays) 5:30 am – 9:30 am; (Sundays) CLOSED. Use Quest on weekends when In-house phlebotomist is not on site.
- Turnaround time on Quest STAT testing is a maximum of 4 hours from the time the STAT call is received to releasing results
- Please mark STAT on the requisition, place the requisition and specimen in the Red Stat bag
- Call the logistic department for the STAT pick up – (866) 697-8378 – say "PICK-UP"

- Place stat sample in the Quest box, outside the front entrance doors of Rawson Neal Hospital.
- House Supervisor for evening/nights will draw for any STAT draw. Draw phlebotomy kit is available in the laboratory for the house supervisor performing phlebotomy. It is located near the draw chair in the laboratory, specifically by the bench in front of the bankers boxes in front of the bathroom.
- A key for the laboratory will be available to the House Supervisor.

H. Urine Collection

- Separate requisition will be made
- At that time, enter time of collection of the urine.
- Ensure the urine is properly labeled with patient full name, date and time of collection, initials of the person that collected, and medical records number.
- Specimen containers must NOT be prelabeled and must be labeled in front of the patient after the patient verifies that the name on the label is correct.
- The sample will be rejected by lab if the specimen is not correctly labeled. A Quest collection kit will be provided for urines. Use large cup for urine collection. Using provided pipet and appropriate PPE, transfer urine to the conical tubes provided as soon as the urine is collected. Timing is important. Immediate transfer to conical tubes is necessary for reflex culture and urinalysis.
- Refer to Quest Diagnostic Specimen Collection & Transport Guide for proper urine collection. Only a nurse will process urine into collection tube. This is to be done in the soiled linen room.

I. Urine drug screen, urine pregnancy, and stool occult blood are tests run in-house.

- The Quest Lab requisition form is available in all the units.
- All patient samples must be properly labeled with patient full name, date and time of collection, source of specimen, initials of the person that collected, and medical records number.
- Specimen containers must NOT be prelabeled and must be labeled in front of the patient after the patient verifies that the name on the label is correct.

J. Transfer of patient from RSU to other units: If patient has a lab ordered from RSU and was not collected, the transferring nurse will insure the Kardex is accurate for labs completed and due. The transferring nurse will also endorse to the receiving nurse and send the lab requisition for labs that were not

completed. The receiving nurse will then complete a new requisition for the receiving unit and place in Lab Binder to be drawn.

- If a patient had a Quest lab test collected in RSU, and was not resulted yet, the receiving nurse will print out the result from Quest Quanum.

K. In the event a client on the inpatient units refuses to have blood drawn, the laboratory technician will inform the charge nurse of the refusal and will ask the nurse to sign off the printed form confirming the rejection. Laboratory keeps a record of refusals. In the progress notes, the charge nurse must document the refusal in the electronic medical record, inform the next shift, and then keep the requisition in the Lab Binder to try again.

L. To ensure patient safety and personnel safety, an MHT or Nurse is required to remain within 5 feet or less of the laboratory phlebotomist during the phlebotomy. The laboratory phlebotomist will not draw the blood without these safety precautions. When an MHT or nurse is not available, the phlebotomist will request help from the charge nurse or house supervisor. If staff are not available to assist the phlebotomist, the phlebotomist will immediately contact both the Director of Nursing/Designee and the Medical Laboratory Director.

M. Routine phlebotomy rounds are conducted by a Quest phlebotomist, laboratory assistant, technician or technologist on all inpatient units during morning rounds, at 9 am for DOR, and for noon/afternoon rounds daily Monday through Friday. Weekdays - Routine lab draws from 5 am – 1 pm (including Quanteferon, DOR, and refusals) Saturdays – Routine lab draw from 5 am - 7 am SUNDAY CLOSED.

Off Hours Lab draw

- Weekdays after 1 pm
- Saturdays after 7 am
- Sundays or some Holidays all day. Email from Lab to DON and nursing supervisors will indicate which Holidays there is no laboratory service.
- Call House Supervisor to perform blood draws during off hours

N. The nurse on the unit must review, initial and date the Quest lab results then place it on the Physician's Board and Medical Board for physician review. The physician review is validated by dating and initialing the lab report.

O. It is the ordering physician's responsibility to check the Physician's Board on a daily basis.

P. When nursing learns of panic values through Quest Diagnostic he/she shall call the Medical Physician or Psychiatrist, depending on who ordered the test. Any and all panic and stat values will be telephoned to the unit by Quest Diagnostic, and a STAT lab printout will be faxed to the unit. Panic and stat values will be reported to the Physician IMMEDIATELY by nursing. The nurse who received the call will date and time when the call was received and sign the STAT lab printout. A second nurse will date, time, and sign STAT lab printout IMMEDIATELY**.** A progress note will be entered for lab notification as follow up.

Q. For the telephone reporting of panic and stat values and other diagnostic tests that require a response, verify the complete order or test by having the person receiving the order or test result "Read Back" the order or test result.

R. Discharges/Outpatient Lab

- Instruct UNINSURED patients to go to Rawson Neal for an outpatient lab draw
- UNINSURED patients will use Lab requisition form that has the "Outpatient" account number (written OUTPATIENT on the lab requisition form)
- INSURED patients may go to any of the 22 Quest phlebotomy sites in Las Vegas. They will be given a different requisition than those uninsured.

S. Laboratory Staff (Phlebotomist)

1. The phlebotomist will adhere to National Patient Safety Goals.
2. Education/in-service training will be the responsibility of the Medical Director of Laboratory Services.
3. Upon entering the unit, the 2 patient identifiers from any of the following will be used, patient name, picture, date of birth, confirmation of identification from a unit nurse or mental health technician for identification purposes
4. The phlebotomist must be accompanied by a unit staff member during client blood draw.

II. **REFERENCES: N/A**

III. **ATTACHMENT:**

II-44 Quest Diagnostic Laboratory Ordering, Patient Sample Labeling and Phlebotomy Procedures. Attachment A II-44 Quest Diagnostic Laboratory Ordering, Patient Sample Labeling and Phlebotomy Procedures.Attachment B

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
NURSING DEPARTMENT

SUBJECT: Inpatient Nursing Staffing Plan **NUMBER:** I-03

EFFECTIVE DATE: 12/22 **REVISION DATE:** 12/24

APPROVED BY: /s/ Earl Farinas, RN
Director of Nursing II

SUPERSEDES: 01/03, 10/15, 8/16, 11/16, 1/17, 2/17, 6/17, 07/17, 08/18, 01/19,02/19, 5/19, 8/20

I. PURPOSE:

To ensure that a sufficient number of qualified and competent staff are available to provide care, treatment and services for the adult acute psychiatric patients that have been medically cleared in a medical hospital.

DEFINITIONS:

A. Tier 1 Staffing Plan

B. Tier 2 Staffing Plan

C. Tier 3 Staffing Plan

D. The hospital consists of one Inpatient Unit and a Rapid Stabilization Unit (RSU). RSU can consist of up to a total of 20 adult acute psychiatric patient beds single occupancy and the remaining G Pod can consist of up to a total of 34 adult psychiatric patient beds. The maximum census of the hospital will not exceed 54 adult psychiatric patient beds.

II. PROCEDURE:

A. Nursing Administration/Clinical Leadership develops a Staffing Plan for inpatient nursing units based on the patient care needs of the patient population and the number of patients. The Staffing Plan is presented to the quarterly Staffing Committee.

B. Nursing Administration/Clinical Leadership updates the Staffing Plan as indicated/needed and posts the updated version on the server.

C. Changes may occur in the size or function of any pod as a result of infection control, acuity, special observation, closed bed, seclusion and restraint, availability of personnel, or administration mandates. If acuity needs changed, the agency will make every effort to meet nursing staffing needs.

D. The Staffing Office will begin with the Tier 1 Staffing Plan. The Staffing Office/House Supervisor will notify Administration/ Nurse Administrator On-Call when Tier 2 or Tier 3 Staffing Plans need to be initiated.

III. REFERENCE:

a. II - 08 Admission Procedures

b. II - 05 Physician/Patient Transfers

c. II - 27 Discharge

d. PF-AST-04 Admission/Discharge Criteria

e. VI - 13 Staff Work Assignments/Scheduling

f. III - 01 Nursing Medication Administration Process

g. I - 02 Nursing Organizational Plan

h. III - 02 Emergency Cart

i. IV - 03 Patient Observation

j. PF-RRE-02 Seclusion and Restraint

IV. ATTACHMENTS:

a. I-03 Inpatient Staffing Plan Tier 1 Attachment A

b. I-03 Inpatient Staffing Plan Tier 2 Attachment B

c. I-03 Inpatient Staffing Plan Tier 3 Attachment C

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: NURSING

SUBJECT: Visiting **NUMBER:** II-12

EFFECTIVE DATE: 05/23 **REVISION DATE:** 05/25

APPROVED BY: /s/ Earl Farinas, BSN, RN
Director of Nursing II

SUPERSEDES: 01/03, 10/15, 11/17, 01/18, 01/19, 01/20, 06/22, 08/22

I. PURPOSE:

To provide guidelines for visitors and visiting hours at Rawson Neal Psychiatric Hospital.

II. POLICY

A. Visiting hours are from 1930 (7:30 pm) to 2030 (8:30 pm) in the Main Hospital Building. Visitors may enter the Front Lobby prior to 1930 (7:30 pm) in preparation for visiting hours.

B. Visiting hours are posted at the entrance of each building.

C. Visitors must be at least 14 years of age.

D. Two visitors per patient are allowed at any time. The treatment team or registered nurse may make exceptions to this restriction based on individualized patient needs.

E. The treatment team with a physician's order may arrange for alternative visiting hours based on individualized patient needs and will document alternative visiting hours as part of the treatment plan.

F. The treatment team may deny visitor admission to ensure patient safety and well-being. When visitors are denied, a treatment team member addresses the restriction in a progress note and on the treatment plan.

G. Conduct that threatens, intimidates, or coerces another staff member, a customer, or a member of the public at any time will not be tolerated. Individuals who commit acts of workplace violence will be subject to disciplinary action (if a state employee), may be removed from the premises, and/or subject to criminal actions by the Attorney General.

H. Individuals with respiratory disease or overt signs or symptoms of communicable disease are not permitted to visit.

III. PROCEDURE (Main Hospital Building):

A. VISITORS RECEPTION DESK STAFF/SCREENING STAFF

1. Prepare the Reception Desk at 1915 (7:15 pm) on scheduled visiting day. Security Guard will go to Front Lobby area to assist with visitor check in and exit.

2. Greet visitors; identify patient that visitor wishes to see; verify patient's location and willingness to receive visitor(s). Review daily *No Visitor List*.

3. Provide a copy of written *Visitor Rules* to each visitor (English and Spanish versions are available on the server); offer to clarify the *Visitor Rules* as indicated/needed.

4. Request visitors to empty pockets and instruct visitors to leave personal items/bags/purses/contraband in the car.

5. The Security Guard will use a metal detector wand on all visitors entering the building.

6. Instruct visitors that hospital staff must clear any items prior to giving them to patients.

7. Assist visitors to complete information label (client name, visitor name, relation, address, phone and date) and place the label on the visitor sign-in sheet (available on the server).

8. Give the visitor a completed disposable name badge that is marked as "VISITOR" (available on the server). Visitor's badges will be turned in after the visitation is completed.

B. PSYCHIATRIC NURSE III / CHARGE NURSE:

1. Restrict visitors if the unit or patient acuity is such that visitor safety could be in question.

C. MENTAL HEALTH TECHNICIAN IV / DESIGNEE

1. Address visiting hours and process at Community Group; develop daily list of patients who do not wish to receive visitors (*No Visitor List*).

2. Assign Mental Health Technician (MHT) staff member from each POD to act as a "runner" between visiting Unit location and Reception Desk each scheduled visiting day to facilitate visitor escort. Send *No Visitor List* to Visitors Reception Desk Staff with assigned MHT.

3. Assign a staff member to the visiting room during visiting hours.

D. MENTAL HEALTH TECHNICIAN STAFF

1. Take *No Visitor List* to Visitors Reception Desk Staff each evening at 1915 (7:15 pm).

2. Inspect any items visitors wish to provide to patients prior to giving to patient (visitors may bring personal items or clothing for patients; staff must inspect items prior to giving to patients).

3. Reinforce that visitors may not bring food, candy, gum etc. onto unit(s).

4. Limit visitors to visiting room.

5 Request visitors to inform nursing staff of any concerns about patient's behavior, i.e., expressed suicide or homicide ideation.

6. Escort visitors to the unit.

7. Upon conclusion of visit/visiting hours, escort the visitor back to the Main Lobby/Reception Desk.

IV. REFERENCES: Policy OF-EC-11 Workplace Violence

V. ATTACHMENTS:

A. II-12 Visiting Visitor Rules Attachment A

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
NURSING DEPARTMENT

SUBJECT: COBRA and Escort of an Inpatient to Emergency Room

NUMBER: II-15

EFFECTIVE DATE: 01/2022

REVIEW DATE: 01/2024

APPROVED BY: /s/ Earl Farinas, RN
Director of Nursing II

SUPERSEDES: 07/03; 10/15; 12/16; 01/18; 01/19; 01/20

I. PURPOSE:

To define the procedure for staff when the psychiatric continuity of care has been interrupted due to receiving medical care in another facility through the medical emergency rooms and/or medical inpatient admission.

To assure that both behavioral and medical care be resumed without negative consequences when a patient is hospitalized in another facility for medical management during a period of psychiatric inpatient care.

II. DEFINITION:

Another facility means either a Medical Hospital Emergency Room, a Medical Hospital Emergency Department, or a Medical Hospital Unit.

III. PROCEDURE:

A. RN will inform Medical Staff about the patient's latest elopement risk status prior to transfer. The decision to escort a patient must be made in consultation with the medical staff, charge nurse, and house supervisor A

B. COBRA transport. Any conditional release inpatients, for instance 1:1 observation, patient deemed at risk for safety, containment or medical stability must be accompanied by at least (1) MHT staff

C. Follow COBRA procedure. A copy of legal status or original Legal 2000R is to be sent with the patient.

D. Prior to transfer, the patient's assigned nurse will utilize the transfer SBAR sheet as a guide when completing hand-off communication, via telephone, with the accepting facility's nursing staff.

E. The patient's property will be sent with the patient during transfer. The property bag will remain with the MHT staff escort until such time and only if the patient becomes officially admitted to the accepting facility.

F. The MHT will ride in ambulance if emergency transport is needed.

G. The MHT will remain with the patient until it is determined if the patient is to return to SNAMHS or be admitted to the hospital. If an over-lap of shifts occurs, the MHT will contact the shift supervisor and staffing department to arrange coverage.

H. The MHT is to remain with the patient until disposition is made – either admission to medical facility or discharge back to SNAMHS. While on COBRA escort assignment, the staff member should be able to visually observe the patient at all times and be able to intercede immediately if necessary, to maintain the patient's safety. The staff escort will remain at a distance of no more than 8 feet from the patient.

I. The MHT staff escort will communicate the patient's legal status and elopement risk level with ER staff to ensure that all precautions are taken to prevent the risk of patient elopement. Staff shall use CPI verbal redirection techniques to prevent patient escape or elopement while on off campus transport. Charge Nurse or House Supervisor will contact receiving facility (hospital) within (2) two hours to determine patient status and disposition.

J. If the patient is to return to SNAMHS, the MHT will accompany the patient back to SNAMHS if clearance is provided by a Nurse. If the patient is admitted to the medical facility, the MHT will remain with the patient until he/she has an admit order admitting to medical facility.

K. Upon admission to the medical facility, the shift supervisor will notify the medical hospital administrator or on-call Nurse Administrator of the SNAMHS patient's admission to their facility and state the patient's current legal status.

L. Document in the medical record the name of the administrator notified, date and time.

M. Prior to the return of a patient from another facility where they have received emergency medical care, there needs to be phone contact between the sending facility and SNAMHS with medical physician involvement when required to confirm that SNAMHS is able to provide ongoing follow-up medical care recommended by the other facility. A doctor's order must be received for return of patient to facility that includes current medication and treatment.

N. Prior to the return of a patient that has been admitted to a medical facility back to SNAMHS, the social worker from SNAMHS needs to communicate with the social worker from the medical facility to determine discharge date. The medical physician involvement needs to occur to determine follow-up medical needs.

O. Prior to the return of a patient from another facility where they have received medical care, either on an emergency basis or as an in-patient medical patient, all pertinent material from the other facility needs to be received at SNAMHS by fax which includes the most current medical diagnosis, current medications prescribed with current dosing, and time frames, discharge instructions and/or summary, laboratory findings, H&P, Medication Administration Record, operative reports, and all follow up medical care recommendations.

P. Returning COBRA patients from a treating facility providing inpatient or emergency care require a full readmission. Patients returning to SNAMHS within (60) sixty hours do not require a repeat full psychiatric evaluation by physician.

Q. Returning SNAMHS inpatient who has been COBRA to other medical facilities may be directly admitted to inpatient status upon return.

IV. REFERENCES: N/A

V. ATTACHMENTS: N/A

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: NURSING DEPARTMENT

SUBJECT: Escort and/or Supervision – Mealtimes **NUMBER:** II-16

EFFECTIVE DATE: 06/22 **REVISION DATE:** 06/24

APPROVED BY: /s/ Earl Farinas, RN__
Director of Nursing II

SUPERSEDES: 08/03, 10/15, 12/16, 1/18, 01/19, 01/20

I. PURPOSE:

To establish procedure of recording each patient's intake every shift and reporting insufficient intake to the charge nurse and to ensure patient safety during mealtimes.

II. PROCEDURE:

A. Escort to/from Dining Room

1. Assign staff members to accompany patients to the Dining Room. Include at least one Registered Nurse from each pod.

2. The mealtimes for each hospital unit shall be posted on the daily schedule at each unit. Patients shall be notified of approaching mealtimes by Nursing Staff far enough in advance to give patients the opportunity to adequately wash or sanitize their hands prior to eating each meal.

3. Identify patients who are leaving the unit(s) to go to the Dining Room and maintain patient surveillance/observation while the patients are off the unit(s).

4. The assigned staff member will place the appropriate code on the monitor board documenting which patients left the unit to go to the Dining Room.

5. All patients who have Dining Room privileges shall be escorted to the hospital Dining Room by Nursing Staff. Position at least one staff member at the front of the patient group and one staff member at the end of the patient group when leaving the unit(s) to go to the Dining Room.

6. Maintain door security when entering or exiting the unit(s).

B. Meal Distribution

1. Nursing Staff shall provide a written copy of the DAILY DIET ORDER FORM to Foodservice Personnel and shall escort patients who have dietary needs through the serving line to ensure Foodservice Personnel are aware of the

patients' dietary modifications and that those needs are provided to that patient. At least two patient identifiers are to be used.

2. Patients who do not have Dining Room privileges shall be provided their meals on the patient unit. Nursing Staff will indicate on the DAILY DIET ORDER FORM any patient remaining on the unit requiring dietary modifications so that the Foodservice Personnel may label the modified meal.

3. Patients shall be notified of the arrival of meals on the units by Nursing Staff. Nursing Staff shall distribute each labeled meal to the appropriate patient using at least two patient identifiers. Patients on regular diets shall receive an unlabeled meal. Meals may be held in reserve on the unit for 30 minutes and then be discarded if not consumed. Food and beverages from patient meals may not be stored in patient refrigerators or brought to unauthorized locations.

4. Food and beverage items are restricted to designated areas. Patients may not transport food and beverages from the Dining Room. Food and beverages brought to the unit from Foodservice Personnel or Supply Technicians are to be stored in either the nourishment station of the patient refrigerators as directed.

C. <u>During Mealtimes</u>

1. Minimize personal conversation while monitoring patients during mealtimes in the Dining Room so that patients may be assisted as needed in procuring a meal. Nursing Staff might facilitate pro-social dining and conversation, proper disposal of uneaten foods and beverages, and cleanliness of tables. Nursing Staff shall monitor patients in the serving, dining and outdoor areas throughout the mealtime.

2. Observe disposal of plastic ware and ensure patients do not bring plastic ware back to the unit(s). Food and beverages from patient meals and snacks may not be stored in patient rooms.

3. Patients may refuse to eat any or all of the food without fear of reprisal.

4. Report any percentage less than 50% to the Charge Nurse.

5. Maintain visual surveillance of the entire outdoor courtyard while patients are eating by assigning staff to monitor all areas during this time.

6. Patients are not to be sharing their food with other patients.

III. REFERENCES: IV-03 Patient Observation

IV. ATTACHMENTS: II-16 Escort and or Supervision -Meal Times Attachment A

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: NURSING DEPARTMENT

SUBJECT: Nursing Staff Responsibilities in Medical Emergency

NUMBER: II-17

EFFECTIVE DATE: 06/23

REVISION DATE: 06/25

APPROVED BY: /s/ Earl Farina, BSN, RN
Director of Nursing II

SUPERSEDES: 08/03, 10/15, 3/17, 01/181 01/19, 01/20, 08/20

I. PURPOSE:

To define inpatient nursing staff roles/responsibilities in a medical emergency (Dr. Blue) including:

A. Medical emergency response team members and roles (the emergency response team provides care to patients in the event of a medical emergency. There are four team members: Team Leader, Recorder and Two RN Team Members).

B. Support staff roles.

C. For easy accessibility the emergency carts are strategically located in the medication room on each pod. The Automated External Defibrillator (AED's) are located on the emergency carts.

D. All Pods are to respond with pre-assigned designated staff members with the exception of the forensic unit staff.

E. Emergency telephone number to announce codes:

1. Rawson-Neal Hospital pager intercom: dial #694.

F. Emergency Supplies/Cart:

1. A standardized uniform cart for emergency supplies is kept on each Pod.

2. Supply Technicians restock the cart after use.

II. PROCEDURE:

Emergency Response Team:

A. Charge Nurses on each unit will assign a designated staff member to respond to Dr. Blue at the start of each shift.

1. Alternate staff members will be assigned in the event the primary designated staff member chosen to respond is on break.

2. Both the primary designated staff member and the alternate designated staff member chosen by the Charge Nurse will be documented on the assignment sheets.

B. Team Leader Responsibility at the Start of the Code (RN or MD):

3. Organize team members and assign team roles.

4. Designate support staff to activate emergency response (call Dr. Blue).

5. Designate support staff to call 911.

6. Ensure responding staff bring an emergency cart, accu-chek, pulse oximeter and oxygen tank.

7. Assign staff to wait at entrance to escort both 911 and Fire Department.

8. Assign staff members to start oxygen at 2L via nasal cannula for pulse oximetry reading less than 92%.

9. Assign team members to obtain accu-chek if patient is symptomatic.

10. Direct staff to administer emergency medications as ordered.

11. Monitor team performance and patient response.

C. Recorder (RN, MHT, or AA):

1. Utilize Dr. Blue recording sheet.

2. Focus on recording only.

3. Provide Dr. Blue recording sheet copy to 911 and file original in patient's medical record.

D. RN Team Member #1 (usually RN assigned to patient):

1. Obtain and announce complete vital signs and task completion.

2. Start oxygen at 2L via nasal cannula as directed.

3. Perform CPR.

4. Administer emergency medication as ordered.

5. Provide verbal report to 911 staff; remain with patient until patient leaves via ambulance.

6. Review Dr. Blue recording sheet and complete progress note.

E. RN Team Member #2:

1. Obtain accu-chek as directed.

2. Perform CPR.

3. Support RN Team Member #1 as needed.

F. House Supervisor:

1. Ensure team members complete assigned duties.

2. Perform crowd control.

3. Facilitate attending physician notification.

4. Assess the effect on other patients and assign support staff as needed.

5. Facilitate completion of COBRA paperwork.

6. House Supervisor, PN IV, or Charge Nurse will complete an Incident Report.

G. Retrieving AED recue report information:

1. Attach a USB cable from the AED to a desktop or laptop computer. Obtain AED cable from the supply department.

2. Install the AED manager software on your desktop or laptop computer by going to www.cardiacscience.com. Follow instructions provided in the link provided: https://www.youtube.com/watch?v=jxWJphwRuZs.

3. Download the data of the event and forward it to the Director of Nursing.

III. REFERENCES: N/A

IV. ATTACHMENT:

A. II-17 Nursing Staff Responsibilities in Medical Emergency - Dr. Blue Recording Sheet - Attachment A

B. II-17 Nursing Staff Responsibilities in Medical Emergency - Dr. Blue Unit Responder Sheet - Attachment B

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: NURSING DEPARTMENT

SUBJECT: Security in the Inpatient Unit **NUMBER:** II-19

EFFECTIVE DATE: 6/22 **REVISION DATE:** 6/24

APPROVED BY: /s/ Earl Farinas
Director of Nursing II

SUPERSEDES: 08/03, 10/15, 4/17. 01/18, 01/19, 1/20

I. PURPOSE:

Establish security regulations for the unit as adequate precautions are taken to ensure a safe and secure environment in the unit.

II. PROCEDURE:

1. KEYS

   a) Each employee is issued keys for use and is accountable for their keys throughout employment. The set of keys is to be on the person at all times.

   b) The charge nurse is responsible for the unit set of keys and must be in their possession at all times.

   c) Keys are never to be given to the patient or other non-authorized persons.

2. MEDICATIONS AND MEDICATION ROOM

   a) Medication Room is locked when not in use.

   b) Medications will not be left unattended.

   c) Needles and syringes are always under the control or possession of the registered nurse.

   d) Non-licensed personnel must be supervised in the medication room at all times.

3. POTENTIALLY DANGEROUS OBJECTS

a) Razors, scissors, etc. belonging to clients are inventoried, labeled as sharps, and placed in the safe.

b) Patients are supervised while using potentially dangerous objects.

c) Electrical appliances will not be used in the patient's bedrooms.

4. MISCELLANEOUS

a) Cleaning equipment and supplies are kept locked when not in use.

b) Staff is present when patients are in public areas of the unit.

c) Patients must always be escorted by the staff from one location to another.

5. Security of the inpatient unit is the reasonability of all staff.

a) Staff will monitor entrances and exits of the unit.

b) MHTs will check with RNs before any patient leaves the unit.

c) All patients will be listed on the monitor board and monitored per observation level ordered by the attending physician/designee by a staff member.

d) MHT assigned to the monitor board will also check doors during rounds to ensure they are adequately and appropriately locked.

III. REFERENCES:

II-09 Patient Property

III. ATTACHMENTS: N/A

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: NURSING DEPARTMENT

SUBJECT: Patient Bathroom Security **NUMBER:** II-41

EFFECTIVE DATE: 06/22 **REVISION DATE:** 06/24

APPROVED BY: /s/ Earl Farinas, RN
Director of Nursing II

SUPERSEDES: 09/06, 10/15, 04/17, 01/19, 01/20

I. PURPOSE:

To provide for safety and security in the patient bathroom areas.

II. PROCEDURE:

A. BATHROOM SURVEILLANCE

1. Assign staff to bathroom(s) observation every shift.

2. Maintain locked bathroom door(s) when bathroom(s) are not in use on all the units (bathrooms in Main Hospital Building close automatically).

3. Upon request, unlock the bathroom door for the patient.

4. Inspect the bathroom for safety and security before the patient enters.

5. Encourage appropriate personal hygiene including washing hands.

6. Inspect the bathroom for safety and security after the patient leaves.

7. For patients on Special Observation monitor the patient continuously from the doorway for safety, security and privacy until the patient leaves the bathroom. Keep the main bathroom door ajar and the bathroom stall door partially open for all patients requiring 1:1 Observation. Remain in attendance just outside of the stall door. Patients must be monitored continuously.

8. Check bathroom(s) every hour for environmental safety and patient activity. Initial corresponding area of the monitor board form to indicate completed bathroom check.

9. Notify Mental Health Technician IV and Psychiatric Nurse III / Charge Nurse of any unusual patient activity and document as appropriate in patient's medical record.

III. REFERENCES: N/A

IV. ATTACHMENTS: N/A

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY

SUBJECT: Sentinel Events **NUMBER:** OF-PI-28

EFFECTIVE DATE: 03/2023 **REVIEW DATE:** 03/2025

APPROVED BY: /s/ Susan Lynch, MBA, CPM
Hospital Administrator

SUPERSEDES: OF-PI-28 dated 09/03; 01/05; 07/08; 08/09; 01/10; 02/12; 10/14; 02/15; 01/17; 03/19; 03/21

I. PROTOCOL:

A. It is the protocol of SNAMHS that all Sentinel Events, as defined by the criteria in this policy, shall be reported to the Agency Administrator or designee within one (1) hour. Sentinel Events shall be investigated, and a determination made if the event meets criteria of a Sentinel Event.

B. SNAMHS shall have a Sentinel Event process to manage, investigate and appropriately report Sentinel Events.

C. SNAMHS is committed to improving the quality of client care. The occurrence of a Sentinel Event identifies an opportunity for improvement. A performance Root Cause Analysis (RCA) shall be conducted to intensively assess root cause of the event and identify opportunities for improvement.

II. PURPOSE:

The purpose of this policy is to:

A. Have a positive impact in improving client care, treatment, and services and preventing Sentinel Events.

B. Focus the attention of SNAMHS' leaders and personnel on investigating the causes that may have contributed to the event, and on improving the organization's systems and processes to enhance organizational resiliency from similar events in the future.

C. Increase the general knowledge about Sentinel Events, their causes, and strategies for prevention.

D. Ensure SNAMHS complies with reporting requirements for Sentinel Events according to NRS 439.835 and for the accrediting bodies of the Bureau of Health Care Quality and Compliance the Nevada State Division of Health, the Center for

Medicare and Medicaid Services and The Joint Commission. (Attachment A – Reporting Requirements Reference Sheet).

E. Participate in a nation-wide effort of reporting Sentinel Events based on the NQF-endorsed list of Serious Reportable Events in Healthcare. The efforts are expected to result in a uniform public reporting database used "to drive systematic national improvements in client safety based on what is learned. (NQF, 2011:1)"

III. DEFINITION:

A. Sentinel Event is defined as Product or Device events, Client Protection Events, Care Management Events, Environmental Events, or Potential Criminal Events. Such events are called "Sentinel" because they signal the need for immediate investigation and interventions to enhance staff and client safety.

B. Serious injury is defined as an event that can result in death, loss of a body part, disability, loss of bodily function, or require major intervention for correction (e.g. higher level of care, surgery).

C. Sexual abuse (including rape) as a sentinel event is defined as unwanted intimate touching of any kind especially the breasts, buttocks, or perineal area, forced observation of masturbation and/or sexually explicit images including pornography, text messages, or social media nonconsensual sexual contact involving a client and another client, staff member or other perpetrator while being treated or on the premises of the hospital, including oral, vaginal, or anal penetration, or fondling of a patient's sex organ(s) by another individual's hand, sex organ, or object. Sexual contact is also considered nonconsensual in the following situations:

a. When the client lacks the cognitive ability to consent even though appearing to want the contact to occur.

b. When the client does not want the contact to occur

c. A client's apparent consent to engage in sexual activity is not valid if it is obtained from the individual lacking the capacity to consent, or consent is obtained through intimidation, coercion, or fear, whether it is expressed by the individual or suspected by staff. Any forced, coerced, or extorted sexual activity with an individual, regardless of the existence of a preexisting or current sexual relationship, is considered to be sexual abuse.

D. Sexual assault is defined as subjecting a client or staff to sexual penetration or forces the consumer or staff to make sexual penetration on themselves or another against the will of the victim or under conditions in which the perpetrator knows or should know that the victim is mentally or physically incapable of resisting or understanding the nature of the perpetrator's conduct. Including but not limited to sexual assault or battery such as rape, sodomy and coerced partial or complete

nudity.

E. An event is reportable if it actually results in:

1. Product or Device Events
   a. Client death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting.
   b. Client death or serious injury associated with the use or function of a device in client care, in which the device is used or functions other than as intended. (Misuse Error)
   c. Client death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting.
2. Client Protection Events
   a. Discharge or release of a client/resident of any age, who is unable to make decisions, to other than an authorized person.
   b. Death or serious injury associated with client elopement.
   c. Client suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting.
   d. Fall resulting in any of the following: any fracture, surgery, casting or traction, required consult/management or comfort care for a neurological or internal injury or a patient with coagulopathy who receives blood products as a result of the fall, or death or permanent harm as a result of injuries sustained from the fall.
3. Care Management Events
   a. Client death or serious injury associated with a medication error. (errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
   b. Client death or serious injury associated with a fall while being cared for in a healthcare setting.
   c. Any Stage 3, Stage 4, or unstageable pressure ulcers acquired after admission/presentation to a healthcare setting.
   d. Client death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen.
   e. Client death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results.
4. Environmental Events
   a. Client or staff death or serious injury associated with an electric shock in the course of a client care process in a healthcare setting.
   b. Any incident in which systems designated for oxygen to be delivered to a client contains no gas, the wrong gas, or are contaminated by toxic substances.
   c. Client or staff death or serious injury associated with a burn incurred from any source in the course of a client care process in a healthcare setting.

d. Client death or serious injury associated with the use of physical restraints while being cared for in a healthcare setting.

5. Potential Criminal Events
   a. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.
   b. Abduction of a client/resident of any age.
   c. Sexual abuse/assault on a client, staff member, licensed independent practitioner, visitor, or vendor within or on the grounds of a healthcare setting.
   d. Death, or serious injury of a client, staff member, licensed independent practitioner, visitor, or vendor resulting from a physical assault (i.e. battery) that occurs within or on the grounds of a healthcare setting.

F. ***Patient Safety Officer*** as used in this policy references NRS. 439.815 means a person who is designated as such by a medical facility pursuant to NRS 439.870.

G. ***Root Cause Analysis*** is a formal process for identifying causal factors that contribute to an event associated with adverse outcomes or near miss/close call situations.

IV. PROCEDURE:

A. When a SNAMHS employee is aware of a Sentinel Event, as defined in this policy, he/she shall follow the Nevada Division of Public and Behavioral Health incident reporting procedures and report the incident to his/her supervisor immediately, but no later than one (1) hour.

B. When agency staff become aware of incidents that could have resulted in any of the outcomes described in Section III, they must notify their supervisor within one (1) hour of knowledge of the incident and follow normal incident reporting requirements.

C. In the normal incident reporting or tracking process, the Agency Administrator, and the Patient Safety Officer or the Director of Quality Assurance and Performance Improvement shall identify potential Sentinel Events.

1. Potential Sentinel Events shall be reviewed for determination by the Agency Administrator and the Patient Safety Officer or the Director of Quality Assurance and Performance Improvement.
2. Incidents identified as meeting the Sentinel Event criteria as defined in this policy shall be investigated by a duly appointed team using Root Cause Analysis.
3. Incidents not determined to be a Sentinel Event shall be reviewed per Division policy A-5.2.

D. Once the incident has been determined to meet the Sentinel Event criteria per this policy:

1. The Agency Administrator and the Patient Safety Officer or the Director of Quality Assurance & Performance Improvement shall determine to which licensing and accreditation bodies the event shall be reported to.
    a. Sentinel Events shall be reported in compliance with:
        i. The Nevada State Division of Public and Behavioral Health per NRS 439.
        ii. The Joint Commission per the Accreditation Reporting Requirements chapter and Sentinel Event Self Reporting policy.
        iii. Deaths of clients while in seclusion or restraint or within 24 hours of such must also be reported to the Centers for Medicare and Medicaid Services (CMS) via telephone no later than close of business the next CMS business day and followed by FAX notification.
        iv. Occupational Safety and Health Administration for employee related events.
    b. The Sentinel Event shall be reported. Attachment A shall be used as a reference.

E. Once the incident has been determined to meet Sentinel Event criteria by the Patient Safety Officer, the Patient Safety Office notifies the Medical Director who will then appoint a Root Cause Analysis lead facilitator.

F. The Lead Facilitator will appoint a team consisting of

1. Staff who were involved in the care of the client.
2. Multidisciplinary team, including: Physician, nurse, SW, Psychologist, and other appropriate personnel.
3. Representatives of Leadership.
4. Due to the unpredictable nature of an RCA, members of the RCA team and their supervisors shall understand that these meetings take priority over usual business, and the written report must be completed within 15 working days.
5. Those assigned to the RCA must communicate to their supervisors that they have been assigned to an RCA and this assignment is high priority.

G. Agency Administrator Responsibilities (within the first 24 hours of the determination):

1. Ensure reporting requirements are determined and initiated.
2. Designate a representative, per NRS 439.855, for the notification of clients involved in the Sentinel Event, who shall provide notice of that fact to each client and/or client guardian within seven (7) days of becoming

aware of the event.

3. Ensure that SNAMHS is doing everything possible to provide follow up care / services / debriefing to ensure the best possible outcomes for involved clients, family members, employees, and any other identified parties.
4. Ensure all parties in the event receive appropriate information to avoid miscommunications.
    a. Appoint an agency spokesperson familiar to the client and family members to provide updates as needed. Communication will occur within seven (7) days of identification of Sentinel Event. This will be done with the Patient Safety Officer or the Director of Quality Assurance and Performance Improvement
    b. Keep members of the facility Leadership informed.
5.
6. Ensure that all pertinent documentation and data is collected and safely secured with the Patient Safety Officer or designee. Instruct the Director of Health Information Services to secure the medical record and all other evidence.
7. Consult with the Deputy Attorney General and other resources as needed.
8. Maintain confidentiality surrounding the event and the client.

Root Cause Analysis Team Responsibilities

1. The team shall:
    a. Meet as necessary.
    b. Interview involved parties.
    c. Obtain written statements.
    d. Determine root cause, risk elimination and reduction interventions.
        i. If the failure of a piece of equipment is involved in the incident, the Sentinel Event Team, through the Agency Administrator and Patient Safety Officer shall submit the appropriate reports to the Food and Drug Administration, Bureau of Licensure and Certification and manufacturer within ten (10) days of the incident.
        ii. The team shall preserve the equipment in its last used state and have a qualified vendor review the equipment.
2. The team shall submit a written report to the Executive Medical Committee for review and approval.
3. The Medical Director or designee submits the final RCA report to the Agency Administrator with the recommendations for an action plan and prioritize action(s) to follow up on final recommendations. The Agency Administrator will assign Action Plan responsibilities to appropriate personnel.
    a. The Agency Performance Improvement Director or designee shall monitor completion of all areas identified for action and submit a

final report to the Agency Administrator and Leadership Team.

b. The Agency Administrator shall submit evidence of the completed plan to the Administrator of the Division of Public and Behavioral Health and the Statewide Medical Director.

H. The Agency Administrator shall forward the root cause analysis to the Division of Public and Behavioral Health.

1. All reports shall be submitted and approved prior to routing to the accreditation body.

2. All corrective action plans and measures of success shall be documented and filed for retention with the Sentinel Event document in the Office of Performance Improvement.

I. The Sentinel Event, root cause analysis and follow up risk reduction plans shall be filed and secured in the Performance Improvement office per Records of Retention.

J. A Sentinel Event summary report shall be submitted to the Nevada State Division of Public and Behavioral Health annually per NRS 439.835.

V. REFERENCES:

A. NRS 439: Health and Safety of Clients at Certain Medical Facilities
B. NRS 449 Medical Related Facilities
C. NRS 439.835
D. DPBH Policy CRR 1.13 Sentinel Events
E. SNAMHS Policy OF-PI-02, Incident Investigations
F. SNAMHS Policy OF-PI-04, Serious Incidents: Internal Tracking and Data Analysis
G. SNAMHS Policy OF-PI-29 Patient Safety Plan
H. The Joint Commission, CAMH Accreditation Reporting Requirements Chapter current edition
I. State of Nevada Division of PBHS and SNAMHS Records of Retention.
J. National Quality Forum Serious Reportable Events in Healthcare- 2011 Update

VI. ATTACHMENTS:

A. OF-PI-28 Sentinel Events Attachment A

DIVISION OF PUBLIC AND BEHAVIORAL HEATLH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
NURSING DEPARTMENT

SUBJECT: Sexual Contact, Physical Contact and/or Assault Between Hospitalized Patients or Patient Allegation of Abuse

NUMBER: II - 07

EFFECTIVE DATE: 03/22

REVISION DATE: 03/24

APPROVED BY: /s/ Earl Farinas, RN__
Director of Nursing II

SUPERSEDES: 02/07, 10/15, 11/17, 01/18, 01/19, 1/20, 11/21

I. PURPOSE:

The purpose of this procedure is to prevent abuse or neglect of clients receiving services and to provide procedures for reporting, investigating, and following up when an allegation of client abuse or neglect is made, or when other information is received indicating that client abuse or neglect may have occurred.

II. DEFINITIONS

Abuse: is any willful and unjustified infliction of pain, injury or mental anguish upon a person served by a SNAMHS or contract staff. Abuse includes but is not limited to:

A. *Sexual*. *Assault*: a person who subjects another person to sexual penetration, or who forces another to make a sexual penetration on themselves or another, against the will of the victim or under conditions in which the perpetrator knows or should know that the victim is mentally or physically incapable of resisting or understanding the nature of his or her conduct which includes but not limited to oral, vaginal, or anal penetration or fondling of the person's sex organ(s) by another individual. To meet the sentinel event criteria, one of the following must be present:

- Any staff-witnessed sexual contact as described above.
- Admission by the perpetrator that sexual contact, as described above, occurred on the facility's premises.
- Sufficient clinical evidence obtained by the facility to support allegations of sexual contact.

Examples of sexual abuse include but not limited to: rape, sexual assault, sexual exploitation, sexually degrading language or gestures, sexual molestation, attempts to engage a person in sexual conduct, intimate touching or fondling, encouraging a person

to sexually touch a staff member, other clients, or herself/himself, exposing one's sexual parts to a person, and encouraging a person to expose his/her sexual parts to others.

B. *Physical Abuse*: is the infliction of pain or injury on a person. Physical abuse could also include serious or unexplained injury, inappropriate physical or chemical restraint, medication abuse (over or under medicating), deprivation of food, shelter, clothing, or services which are necessary to maintain the physical or mental health of a person. Permitting any of the acts described above also is considered abuse. Examples of physical abuse include but are not limited to any act that cause physical pain or injury to the client, hitting, slapping, kicking, shoving, and hair pulling. An allegation of physical abuse may be substantiated without observable injury.

C. *Verbal Abuse:* Examples of verbal abuse include but are not limited to verbal intimidation or coercion of a person without redeeming purpose, name-calling, cursing, mocking, swearing, ridiculing, yelling, or using words or gestures that frighten, humiliate, intimidate, threaten, or insult the person.

D. *Emotional/Psychological Abuse:* is threatening, controlling, or socially isolating the person, disregarding the needs of these individuals, or harming, damaging, or destroying any property of the person, including, without limitation, pets. Examples include but are not limited to actions or utterances that cause mental anguish such as making obscene gestures, or using other non-verbal gestures that frighten, humiliate, intimidate, threaten, or insult the person, harassment, and threats of punishment or deprivation.

E. *Abandonment:* The desertion of a client by a staff member who has the responsibility for providing care and resulting in harm or the risk of harm occurring to the client.

F. *Excessive Force:* The use of excessive force when placing a client in physical restraints or seclusion.

G. Use of physical, chemical, or mechanical restraints, or use of seclusion in violation of state and federal law.

H. *Exploitation:* is any illegal or improper use of a client's funds, property, or assets resulting in monetary, personal, or other benefit, gain, or profit for the perpetrator, or resulting in monetary, personal, or property loss by the consumer. Examples include but not limited to borrowing a client's money, taking a client's medication, accepting, or coercing gifts from clients, a client doing work for staff with or without compensation, and etcetera.

I. *Neglect:* is any act or omission to act that causes injury or mental anguish to a client or that places the client at risk of injury whether due to indifference, carelessness, or intention. Neglect includes but is not limited to:

    1) Failure to establish or carry out an appropriate plan of treatment for which the client has consented, failure to follow agency policies and procedures,
    2) Failure to provide for basic needs, failure to provide a safe environment, failure to respond to aggression between clients or client engaging in self abusive behavior, and
    3) Failure to act to stop the abuse as defined above.

Mandated Reporter: Any person required by law, NRS 200.50935, subsection 3, to report

when they have reasonable cause to believe that a vulnerable or older person has been abused, neglected, exploited, isolated or abandoned. This includes any physician, resident, intern, professional nurse, physician assistant, psychiatrist, psychologist, alcohol and drug abuse counselor, music therapist, licensed dietitian, social worker, hospital administrator, manager, volunteer, any personnel of a hospital, anyone providing services to a vulnerable population, or any employee of the Department of Health and Human Services (DHHS).

Older person: a person who is 60 years or older.

Staff: is any SNAMHS contract service provider staff, employee, or volunteer, unless stated otherwise.
Supervisor: is any SNAMHS contract service provider supervisor, unless otherwise stated.

Vulnerable Person: a person 18 years and older who suffers from a condition of physical or mental incapacitation due to developmental disability, organic brain damage or mental illness and/or has one or more physical or mental limitations that restrict the ability of the person to perform the normal activities of daily living.

II. PROCEDURE:

Staff Training: All staff will participate in required training related to abuse and neglect at the time of orientation and annually, including but not limited to the following:

1. What constitutes abuse and neglect
2. Staff behaviors that may lead to abuse and neglect
3. Prevention, identification, and intervention techniques
4. Procedure for reporting suspected abuse and neglect including mandatory reporter definition.
5. Indicators of abuse or neglect including clients who report abuse, staff who witness threats, abusive or neglectful behavior or violence toward the client, assessing clients for signs and symptoms, and documenting physical findings, verbal reports and actions taken.

A. Reporting suspected abuse and neglect:

1. Any staff member who knows or have reasonable cause to believe that abuse, neglect, sexual assault, exploitation or abandonment of any client, staff or other individual has occurred will immediately notify the PN III/Charge Nurse. The PN III/Charge Nurse will report to PN IV/UNIT MANAGER or Designee, who will report within one hour to Hospital Administrator/Designee. Voice recorded messages or email do not meet the reporting requirement. All items on the Nursing Checklist for all allegations of abuse/Neglect (Attachment A) will be completed by PN III/Charge Nurse. When there is a House Supervisor assigned, the House Supervisor will complete CHECK LIST FOR ALLEGATIONS OF ABUSE/NEGLECT FOR HOUSE SUPERVISOR.

    i. Take all appropriate and feasible steps necessary to ensure the safety and

protect the client, staff or other individual.

ii. Complete nurses' assessment of alleged victim to check for any injury. Provide first aid as needed. Photos to be taken if applicable.

2. Immediately copy Monitor Board and Assignment Sheet.

3. Complete an Incident Report (per OF-PI-04 Incident and Accident Reports).

4. Obtain witness statements

5. Notify Guardian if applicable

6. Person to person notification of House Supervisor, Nurse Administrator, Hospital Administrator, Psychiatrist, and Internist within one hour.

7. Obtain post-exposure lab work, if applicable

8. Patient offered Grievances-Concerns Form per PF-RRE-03

9. Notify victim of their right to file a police report, Call Capitol Police and obtain police event number.

10. If any SNAMHS staff member knows or has reasonable cause to believe that abuse, sexual assault, neglect, exploitation, isolation, or abandonment of a client, staff or any other individual has occurred the staff or agency shall report the allegation to law enforcement agency within the following required timeframes:

a. As soon as reasonably practicable but not later than 24 hours after knowledge of the incident and will include but not limited to: any allegation of abuse, neglect, exploitation, isolation, or abandonment, of any client or individual that occurred within the agency's programs when abuse or neglect is suspected. If known or reasonable cause to believe sexual assault has occurred, consult with doctor and COBRA to UMC for evaluation, if order to do so is received.

b. Notify psychologist to determine counseling needs.

III. The Nurse Manager/PN IV is responsible for review and verification that all items on the Nursing Check List for Allegations of Abuse are completed and documented.

IV. REFERENCE:

1. Division DPBH Policy CRR 1.2 Prohibition of Abuse or Neglect of Consumers and Reporting Requirements
2. SNAMHS Nursing Department Procedure II-07 Allegations of Abuse/Neglect
3. NNAMHS Policy and Procedure NN-RI-01 Consumer Abuse and Neglect
4. The University of Toledo Rehabilitation Services Department Policy 3364-137-IR-06 Abuse and/or Neglect of Patients
5. Montana State Hospital Policy and Procedure TX-17 Allegations of Abuse or Neglect
6. NRS 200.50935 Report of abuse, neglect, exploitation, isolation, or abandonment of vulnerable person; voluntary and mandatory reports; investigation; penalty.
7. NRS 630,633
8. LDS Abuse and Neglect Policy Number 76.3
9. Aurora Health Care Abuse, Neglect, or Harassment of patients in Hospitals Policy Number 259
10. SNAMHS Policy PF-RRE-22

V. ATTACHMENTS:

A. II-07 Sexual, Physical Contact and or Assault Between Hospitalized Patients or Patient Allegation of Abuse Attachment A

B. II-07 Sexual Contact, Physical Contact and/or Assault Between Hospitalized Patients or Patient Allegation of Abuse Attachment B

C. II-07 Sexual Contact, Physical Contact and/or Assault Between Hospitalized Patients or Patient Allegation of Abuse Attachment C

II-07 Sexual, Physical Contact and or Assault Between Hospitalized Patients or Patient Allegation of Abuse Attachment A

NURSING CHECK LIST FOR ALLEGATIONS OF ABUSE/NEGLECT

Date and Time of Event: _____

DESCRIPTION	YES	NO	If no explain
Immediately report within one hour			
Take action to immediately protect patients and employees			
Immediately copy Monitor Board: (to include 1:1, 2:1)			
Immediately copy Assignment Sheet			
Complete Incident Report			
Complete Progress Note (Document safe environment provided to patient in the medical record Nursing note in chart/Avatar)			
Complete Nursing Assessment			
Patient complaint form offered if applicable			
Capitol Police at (702) 486-2935 was called on abuse, neglect, or sexual assault incidents involving patients 18 years old and under 60 years old within one hour or as soon as reasonably practicable but not later than 24 hours after knowledge of the incident.			
NV Elder Protective Services at (702) 486-6930 was called for abuse, neglect or sexual assault incidents involving patients 60 years old and above within one hour or as soon as reasonably practicable but not later than 24 hours after knowledge of the incident.			
Police report and event number obtained. Police event number #_____			
Necessary Personnel actions are completed. (Any allegation of abuse/neglect involving an employee, the supervisor has the authority to make the immediate decision to remove the employee from the situation. They must be re-assigned to non-patient care, to do paperwork with constant direct supervision or can be asked to leave the premises on administrative leave to return the following day for assignment.)			
COBRA to hospital/sexual assault evaluation			
Notification of House Supervisor (person to person contact & F/U e-mail)			
Notification of Nurse Administrator On-Call (person to person contact & F/U e-mail)			
Notification of Hospital Administrator (person to person contact & F/U e-mail for Sentinel Events)			
Notification of legal guardian if applicable & family with patient's consent			
Witness statements from **ALL** staff present on the unit at the time of the incident. This includes any staff from other disciplines or departments. (Statements are to include name and position of employee/patient; exactly what *individual* was doing at time of event and exactly where individual was on/off the unit, identification of who talked to individual to obtain statement and when, and any activities observed or pertinent). Witnesses are to be separated until statements are written.			
Photos of injuries (photos should be taken of complaining part of injuries whether visible or not).			
Social Services counseling (If not available or not business hours, e-mail).			
Medical board review/ follow up treatment			

NAME: _____

FILE NO: _____

Attending Psychiatrist notified (If not available, or after business hours e-mail, and place on psychiatric board).			
On Call Psychiatrist notified (during designated hours that Attending Psychiatrist is not available).			
Exposure lab work: HIV, Hepatitis			

_____ _____ _____

Reporting Nurse Signature DATE: TIME

_____ _____ _____

House Supervisor Signature DATE TIME

_____ _____ _____

PN IV Signature: DATE TIME

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY WIDE

SUBJECT: Seclusion or Restraint of Patients - Civil **NUMBER:** PF-RRE-02

EFFECTIVE DATE: 10/2021 **REVIEW DATE:** 10/2023

APPROVED BY: /s/ Susan Lynch, MBA, CPM
Hospital Administrator

SUPERSEDES: PF-RRE-02 10/05; 06/07; 03/09; 08/09; 06/10; 07/10; 02/11; 3/12; 09/13; 10/13; 04/14; 12/14; 02/15; 03/15; 06/15; 10/15; 07/16; 08/16; 08/17; 01/18; 11/18; 03/19; 01/20

I. PROTOCOL:

A. It is the protocol of Southern Nevada Adult Mental Health Services (SNAMHS) that all patients/clients be treated and managed in the least restrictive manner consistent with their clinical status and needs and that seclusion or restraint be used only in an emergency to insure safety of the patient/client and others and when less restrictive interventions have been determined to be ineffective to protect the patient/client or others from harm.

B. The decision to use seclusion or restraint is not driven by diagnosis. It is driven by an individual assessment that indicates that a less intrusive measure poses a greater risk of harm to self or others than the risk of using a seclusion or restraint.

C. The patient/client has the right to be free from seclusion or restraints of any form that are imposed as a means of coercion, discipline, convenience, or retaliation by staff.

D. Seclusion or restraint events shall be terminated when the behaviors that necessitated the seclusion or restraint order are no longer in evidence and documented.

II. PURPOSE:

The purpose of this directive is to describe the principles to be applied when using seclusion or restraint, required safety procedures, necessary documentation, specifications for medical staff orders, and the review process that shall be followed for SNAMHS.

III. DEFINITIONS:

A. ***Positive Behavioral Support Plan:*** a specialized part of the treatment plan that is written for an individual client to provide specific, consistent interventions that are positive in focus to eliminate or reduce the frequency of one or more maladaptive

behaviors and/or self-defeating behaviors via reinforcement and the implementation of one or more adaptive coping skills and/or pro social behaviors.

B. ***Restraint:*** the direct application of physical force to a patient/client, with or without the patient's/client's consent to restrict his/her freedom of movement.

1. ***Physical force/physical intervention*** may be human, mechanical devices or a combination of the two.

2. A ***physical restraint***, pursuant to NRS 433.5476 and NRS 449.774, means the use of physical contact to limit a person's movement or hold a person immobile.

3. A ***mechanical restraint***, pursuant to NRS 433.547 and NRS 449.772, means the use of devices, including, without limitation, mittens, straps and restraint chairs to limit a person's movement or hold a person immobile.

4. A ***chemical restraint***, pursuant to NRS 388.476 means the administration of drugs to a person for the specific and exclusive purpose of controlling an acute or episodic behavior that places the person or others at a risk of harm when less restrictive alternative intervention techniques have failed to limit or control the behavior.

   a. The term does not include the administration of drugs prescribed by a physician, physician assistant or advanced practice registered nurse as standard treatment for the mental or physical condition of the person.

   b. When a patient/client is given medication without previously signing written medication consent, a Denial of Rights for Written Consent to Medical Treatment will be initiated.

   Chemical Restraint (The Joint Commission), a drug or medication when it is used as a restriction to manage the patient's/client's behavior or restrict the patient's/client freedom of movement and is not a standard treatment or dosage for the patient's/client's condition.

C. ***Seclusion:*** The involuntary confinement of a patient/client in a locked room (or unlocked with employee used to prevent exit) or a specific area from which the patient/client is physically prevented from leaving.

1. Seclusion does not include confinement on a locked unit or ward, where the patient/client is with others. Seclusion is not just confining an individual to an area, but separating him or her from others.
2. Seclusion may only be used for the management of violent behaviors towards others or to prevent self-injurious behavior.

D. ***Emergency,*** pursuant to NRS 433.5466 and NRS 449.770, means a situation in which immediate intervention is necessary to protect the physical safety of a person or others from an immediate threat of physical injury or to protect against an immediate threat of severe property damage. It may be an unanticipated situation where the patient's/client's behavior is violent or aggressive.

E. ***Time Out:*** Allowing the patient/client to voluntarily be alone in an unlocked room for 30 minutes or less for quiet time and to promote a calming effect so they may return to the therapeutic milieu. Time out is not seclusion. Individuals may not be forced or coerced to go to voluntary time out. Staff shall not use physical force for a patient/client to enter time out.

F. ***Mental Health Technician*** (MHT): A person professionally qualified in the field of Mental Health as defined by NRS 433.209.

G. ***Patient/Client:*** Patient/Client means a person who consults or is examined or interviewed by a psychologist for purposes of diagnosis or treatment as defined by NRS 641.0245.

H. ***Acuity:*** is based on close observation levels, census, patient diagnoses, co-occurring conditions, and developmental functioning.

I. Qualified Registered Nurse (QRN): is a registered nurse who received training to provide the 1-hour-face-to-face evaluation of patients in seclusion or restraint.

IV. PROCEDURES:

A. All patients/clients are to be treated and managed in the least restrictive manner consistent with their clinical status and needs and that seclusion or restraint be used only in an emergency to insure safety of the patient/client and others and when less restrictive interventions have been determined to be ineffective to protect the patient/client or others from harm.

B. Principles Governing the Use of Seclusion or Restraint – This section of the policy and procedure include the principles for initiating and/or providing care for patients/clients in seclusion or restraint.

1. Training: All staff that have direct patient/client contact shall have ongoing education and training in the proper and safe use of seclusion, restraint application and techniques and alternative methods for handling behavior, symptoms, and situations that traditionally have been treated through the use of restraints or seclusion on a yearly basis Direct care personnel permitted to employ manual restraint, physical restraint, seclusion, and mechanical support are those who have successfully completed the approved training

and/or are certified. Other uncertified personnel who may be present should immediately help redirect other patients/clients and remove themselves from the confrontation scene.

2. Staff responsible for implementing this policy includes all clinical, administrative and treatment staff.

3. All clinical staff: Medical Staff, Social Worker, Psychologist, Allied Health Services (AHS), and Nursing Staff on the unit at the time of the occurrence shall be assigned by the RN to assume the following duties, these duties may include, but are not limited to:
   a. Answering telephone
   b. Removing patients to a safe area.
   c. Initiate impromptu group.
   d. Monitor patients for routine observation checks.
   e. If during mealtime, assist with trays.

4. The use of seclusion or restraint shall require clinical justification. So as to reduce and eliminate confusion, medical staff shall clarify physicians' orders for both emergency medications used as a chemical restraint and emergency medications used to treat the underlying psychiatric condition in addition to the immediate behaviors.

   a. When a medication is used to treat the underlying psychiatric condition in addition to the immediate behaviors, the physician shall check the appropriate seclusion or restraint box.
   b. If the patient did not consent to the use of such medications, a denial of rights shall be initiated.

5. Only authorized restraint materials shall be used by clinical personnel, who have demonstrated competencies. The following types of restraints are authorized: mittens, straps and restraint chairs to limit a person's movement or hold a person immobile.

6. Seclusion or restraint shall be used in such a manner as not to cause any undue physical discomfort, harm, or pain, and shall not be employed as punishment or for the convenience of staff.

7. Seclusion or restraint shall be utilized only in cases of emergency and imminent danger and when other less restrictive methods have failed. Alternatives shall be tried and documented prior to the use of seclusion or restraint.

8. Clinical staff shall make all efforts to preserve the privacy, safety, human dignity, and the physical and emotional comfort of the patient at all times. A staff of the same gender shall participate and/or observe in all physical interventions when patient/client is in non-common areas (i.e. restrooms, shower, or bedroom).

9. Upon initiation of the seclusion or restraint event, clinical staff shall notify the patient's/client's family or legal guardian of the seclusion or restraint event unless the patient/client or family have waived notification or place specific parameters on the notification specifying timeframes for notification.

10. The duration of the seclusion or restraint episode shall be the shortest time possible to reasonably assure the safety and protection of the patient/client and the safety of others.

11. At the onset of seclusion or restraint and throughout the course of the procedure, the patient/client shall be given a clear explanation of the reason(s) for using seclusion or restraint, the monitoring procedure, the desired outcome, and the criteria the patient/client shall meet in order for the episode to be terminated. The explanation given and the patient/client response shall be documented in the progress note.

12. An approved restraint chair may be used to safely transport the patient/client.

13. A room designated for use as seclusion or restraint shall be designed and maintained to preserve the safety, privacy, human dignity, and the physical and emotional comfort of the patient/client.

14. The initial assessment of each patient/client at the time of admission shall include attempts to obtain information that may help minimize the use of restraint or seclusion and any historical information that may indicate that the use of seclusion or restraint may result in greater psychological trauma and is clinically contraindicated.

    1. The initial assessment shall include medications used to treat the underlying psychiatric condition and associated behaviors.
    2. Patients/clients are to consent to the use of such medications.
    3. The comprehensive assessment should include a physical assessment to identify medical problems that may be causing behavior changes in the patient. (Example: temperature elevations, hypoxia, hypoglycemia, electrolyte imbalances, drug interactions, and drug side effects may cause confusions, agitation, and combative behaviors)

15. A patient/client and staff debriefing shall be conducted after each incident. If staff cannot conduct a debriefing following the completion of the incident, the delay will be documented and the debriefing will be conducted as soon as possible.

C. Safety Procedures – This section of the policy and procedure includes safety procedures for initiating and/or providing care for patients/clients in seclusion or restraint.

1. Patients/clients who are requiring seclusion or restraint will be placed on a higher level of observation and acuity level. The physical design of each unit allows temporary coverage for the higher acuity level of care. The staffing assignments/ratios will be adjusted as follows:

a. One MHT for one patient (1:1)
b. Two MHT's for every one patient (2:1)

2. Do not endanger yourself or your others, if additional personnel are likely to be needed, call for assistance prior to attempting restraint procedures. Accomplish placement in seclusion or restraint in the safest manner possible and identify staff involved in the electronic medical record.
3. Avoid applying any pressure to or obstructing the airway, or affixing limb restraints that inhibit distal circulation.
4. NEVER mechanically restrain a patient/client in the prone position; it becomes impossible to monitor and/or protect the airway.
5. Explain to the patient/client why they are being restrained.
6. Patients/clients shall be searched, prior to the placement in seclusion or restraint, and all items other than clothing shall be removed.
7. The staffing department and house supervisor will be notified.
8. No physical or mechanical restraint or body positioning of a patient/client shall place excessive pressure on the chest or back of the patient/client or inhibit or impede the patient's/client's ability to breathe and shall be in compliance with approved CPI techniques.
9. Patients/clients are to be restrained in a manner to minimize potential medical complications. Staff shall be aware of the possibility of patient/client injury in the application and/or utilization of restraints. This includes, but is not limited to, the danger of aspiration of vomitus, impaired circulation and/or respiration, and damage to nerves and skin breakdown.
10. Staff shall consider the potential negative impact if seclusion or restraints are likely to occur in those patients/clients with a history of trauma such as physical or sexual abuse and be particularly sensitive to the needs of these patients.
11. Nursing will maintain a file of Kardex, which will contain the following information on each patient/client admitted to the inpatient unit: patient/client name, age, diagnosis, medical problems and history of trauma or abuse.
    a. This information will be provided to and utilized by direct care staff involved in episodes of secluding or restraining any individuals to assure that staff are aware of relevant medical and psychiatric history.
12. Patients/clients in restraint will be on constant one-to-one (1:1), uninterrupted observation, which includes face-to-face evaluation.
13. The condition of the restrained patient/client shall be continually assessed, monitored and re-evaluated. Frequency of monitoring shall be made on an individual basis, reflecting consideration of the patient's /client's medical needs and health status. The rationale for this decision as to the needed frequency of assessment/monitoring shall be documented in the medical record.
    a. The patient/client in seclusion or restraint will have his/her vital signs taken and documented at a minimum of every fifteen (15) minutes

for the first hour then every hour thereafter and any concerns will be referred to the medical staff by the RN.

b. At a minimum of every 15 minutes the MHT staff will document their ongoing continual review of the patient's/client's hydration needs, level of distress and agitation, mental status, cognitive functioning, skin integrity, position, circulation, respiration, and safety. Any observed changes or problems will be referred to the medical staff by the RN.

c. Any changes in gait or coordination shall be documented and referred to the medical staff by the RN.

d. Staff will offer the patient/client fluids, toileting and comfort measures every fifteen (15) minutes. Meals and snacks will be offered at regular times. Staff will assist with the patient washing of hands after toileting before meals and as needed. Any exception to the above procedures shall be clinically justified and noted in the medical record.

e. Range of motion and movement of limbs will be provided for a minimum of ten (10) minutes and at least every sixty (60) minutes to maintain adequate circulation.

   i. Relief from mechanical restraint will occur as long as it is deemed to be safe. If patient/client has not regained sufficient control of his/herself to be considered safe, this shall be documented in the progress note.

   ii. During relief periods, the staff shall insure proper positioning of the patient/client and provide movement of limbs as necessary.

f. No matter how long the prescribed treatment order allows, the seclusion or restraint will be terminated when the behaviors that necessitated the seclusion or restraint order are no longer in evidence and the behavioral release criteria are attained.

   i. If the patient/client is falling asleep or falls asleep an immediate assessment of the patient/client and the release criteria will be made.

   ii. Patients/clients who are sleeping in seclusion or restraint shall be evaluated and removed from seclusion or restraint if they meet release criteria.

g. In the event of any emergency requiring unit evacuation (including drills), the patient/client shall be removed from seclusion or restraint, and staff will stay with the patient/client on a 1:1 basis.

h. The Treatment Team shall collaborate with the patient/client to identify personal alternatives that can be used rather than seclusion or restraint.

14. Charge Nurse will assess the staffing levels based on census and unit acuity at the beginning of every shift and as needed. The charge nurse will notify the House Supervisor or Unit Manager of acuity and census changes.

D. Reporting Requirements – SNAMHS employees shall report all deaths or serious injury associated with seclusion or restraint directly to the Patient Safety Officer and the Hospital Administrator/Designee.

Per Policy OF-PI-04 SNAMHS Incident and/or Accident Reports, all incident reports shall be verbally reported through the appropriate chain of command to the Nursing Director and Agency Director or designee within one (1) hour of knowledge of the incident. **Voice to voice contact shall be made** during normal business hours. If the incident occurs after hours or on the weekend contact must be made with the Nursing Administrator on call within (1) hour of knowledge of the incident. Nursing Administrator on call will follow up with a written report on next scheduled working shift by 9 am. In the event of a suspicious death or sentinel event, the Agency Administrator/Designee is to be contacted by phone.

For all incidents meeting the criteria for sentinel events, the Patient Safety Officer shall be notified within 24 hours and report as required with direction from the Agency Administrator to the Bureau of Health Care Quality and Compliance, the Nevada State Division of Health and The Joint Commission for Healthcare Organization within fourteen (14) days.

1. Employees shall report a death or serious injury to the Hospital Administrator/Designee immediately but no later than one hour after the death.

2. Employees shall document in the patient's /client's medical record the date and time the death was reported to the Hospital Administrator.

3. SNAMHS employees shall report:
    a. Each death that occurs while a patient/client is in restraint or seclusion; and
    b. Each death that occurs within 24 hours after the patient/client has been removed from restraint or seclusion.
    c. Refer to OF-PI-28

4. The Charge Nurse shall submit an incident report for any patient/client that is in seclusion or restraint continuously for more than 8 hours and any patient/client that has had three or more seclusions or restraints in a week.

5. The Charge Nurse shall submit an incident report for any patient/client that is in seclusion or restraint that has serious injury or death within 24 hours.

6. The Charge Nurse shall ensure a psychological consult has been completed for any patient/client that is in seclusion or restraint, and that a Positive Behavioral Support Plan has been initiated if indicated.

7. A Psychology Consult Request form will be emailed to the Psychology Department following each episode of seclusion and restraint.

E. Nursing/Functions – The nursing staff is responsible for the direct CPI interventions.

1. A RN shall be notified immediately if a patient/client exhibits threatening or harmful behavior. The emergency use of seclusion or restraints requires an RN assessment of whether an emergency situation exists.
    a. The RN assessment will include and be documented in the electronic medical record whether alternatives to the use of seclusion or restraint to include information obtained from the Safety Plan were adequately attempted or considered including, but not limited to:
        i. Patient's/client's verbalization of feelings
        ii. Verbal reassurance/redirection given to patient/client
        iii. 1:1 interaction for the patient/client with staff
        iv. Redirection in stimuli
        v. Environmental changes for the patient/client
        vi. Limit setting
        vii. Time Out offered to the patient/client
        viii. Medication offered to the patient/client
2. Upon determination by an RN that seclusion or restraint is necessary, a medical staff order is obtained.
3. Medical Staff to seclude or restrain:
    a. Medical Staff Orders should be written on the Seclusion and Restraint Order Form no more than fifteen (15) minutes after employment of these measures. Telephone orders to a staff RN are acceptable and shall be cosigned by the medical staff when the face-to-face assessment is conducted. The RN shall record the details of the incident on the Seclusion and Restraint Order Form and place the form in sequence in the order section of the patient's medical record.
    b. No application of restraint or seclusion shall occur without a Division of Public and Behavioral Health medical staff's order, stating the reason for use.
    c. The order will include the method of seclusion or restraint to be utilized and the clinical reason for seclusion or restraint (e.g. danger to self or others).
    d. Restraint or seclusion orders shall not be written as PRN orders.
    e. The medical staff shall perform a face-to-face evaluation within one (1) hour of the initiation of the episode/intervention regardless of the duration of the seclusion or restraint. All seclusion and restraint orders including manual restraint requires face-to-face evaluation. With Medical Director or designee authorization, if a medical staff is not immediately available or during the hours of 9:00 pm -8:00 am Monday through Friday and 5:00 pm – 8:00 am on Saturday, Sunday and Holidays, a Qualified Registered Nurse (QRN) who received training on face-to-face evaluation, will conduct the 1-hour-face-to-face evaluation of patients in seclusion or restraint and will consult

with the Medical Director or designee responsible for the care of the patient/client as soon as possible.

f. Restraint/seclusion orders are time limited and are valid for no longer than eight (8) consecutive hours.
    i. The original order is only good for a maximum of four (4) hours and the continuation order (which shall be included in the original order) is only good for four (4) hours; this is a total of eight (8) hours maximum for one order.
    ii. Nursing staff may request additional medical staff face-to-face assessments based on the patient's condition.
    iii. If, the seclusion and restraint order exceeds 8 hours, the medical staff shall conduct and document a second face-to-face, patient assessment within one (1) hour.
    iv. If restraints or seclusion are discontinued prior to the expiration of the original order, a new order shall be obtained prior to reinitiating seclusion or reapplying the restraints and the requirements restart.
    v. The PN IV/designee shall be notified within one (1) hour of all applications and removals of restraints and/or seclusions.
    vi. The PN IV/designee will assume responsibility for delegation of tasks to other clinicians on the unit during the episode of seclusion or restraint. The PN will oversee and coordinate the actions of the response team.

4. The RN shall document the clinical rationale for the use of seclusion or restraint in the progress note. This documentation shall include but is not limited to:
    a. An appraisal of the patient's/client's behavior and clinical justification necessitating the use of seclusion or restraint. The justification shall clearly specify the nature of the dangerous behavior. The use of seclusion or restraint may not be based on past history, criminal behavior, convictions or commitment status.
    b. The treatment techniques tried attempting to quiet or control the patient's/client's behavior prior to using seclusion or restraint (e.g., administration of medication, counseling, quiet time).
    c. The reason for the use of seclusion or restraint and the criteria for termination of seclusion or restraint.
    d. Explanation of the criteria for termination of seclusion or restraint to the patient/client, including the behavior that will determine their readiness for release from seclusion or restraint.
    e. A description of interventions implemented to assist the patient/client in meeting the release criteria.
    f. A summary of the patient's/client's current physical assessment, including vital signs.

5. The patient/client shall be continuously assessed, monitored and re-evaluated as to the need for seclusion or restraint. This review and assessment will be documented within one (1) hour following the initiation of seclusion or restraint and every two hours, anytime there is a change in the patient's/client's physical status and at shift change by the RN coming on duty. The review will address the following:
    a. Mental status and behaviors patient/client is exhibiting at the moment justifying continuation of seclusion or restraint.
    b. Why less restrictive alternatives are not appropriate.
    c. The patient's/client's physical condition will be documented on flow sheet every 15 minutes until such time as the seclusion and restraint order is discontinued.
    d. If there is risk for potential injury, restraints shall be readjusted, repositioned, padded, or removed if necessary.
    e. If there is evidence of actual injury, the appropriate medical staff shall be notified, proper treatment initiated including readjustment, repositioning, padding or removal of restraints and/or any other medical treatment that may be necessary. Complete documentation in the medical record is required.
    f. Review with patient/client criteria necessary for release from seclusion or restraint and any additional counseling and/or education needed.
6. The action recorded on the seclusion and restraint order form will be considered an emergency plan of care with the release criteria established as the immediate goals for the patient/client to accomplish. Seclusion or restraint events shall be identified in the treatment plan.
7. If a patient remains in seclusion or restraint when a nursing shift ends, the RN going off duty and the RN coming on duty shall assess the patient/client together. The joint assessment shall be documented in the progress note.
8. All progress notes and observation and monitoring report entries on each patient/client shall be consistent and sequential in the medical record.
9. When the patient/client is released from seclusion or restraint a Nurse and MHT staff shall meet with the patient/client to conduct a debriefing for the purpose of:
    a. Assisting the patient/client to develop an understanding of the precipitants, which may have evoked the behaviors necessitating the use of seclusion or restraint and discussing the patient's/client's perception and observation of the episode.
    b. Providing feed back to the staff.
    c. Assisting the patient/client to develop appropriate coping mechanisms or alternate behaviors that could be effectively utilized

should similar situations/emotions/thoughts present themselves again.

d. Developing and documenting a specific plan of interventions for inclusion in the comprehensive individualized Treatment Plan, with the intent to avert future need for seclusion or restraint.

10. The Nurse shall document the patient/client debriefing interview process and the patient's/client's response in the patient's/ client's electronic medical record and in the NRI event.

11. The RN shall, at the time of the seclusion/restraint, provide the MHT staff assigned the one to one information relating to the medical needs and medications that may be affected by seclusion/restraint.

12. The RN shall conduct a debriefing with staff regarding the seclusion and restraint event and document in the electronic medical record and the NRI event.

13. The RN shall ensure the information is communicated in the shift-to- shift report until such time as the seclusion or restraint is added to the treatment plan and discussed by the treatment team.
    a. Seclusion and Restraint status shall be included on the S-Bar
    b. Seclusion and Restraint status should be included on the patient/client report sheet.
    c. Seclusion and Restraint information reported shall include the precipitating events, the time started the time for four (4) hour evaluation and the eight (8) hour maximum time limit.

14. The Treatment Team shall meet the next business day to review the event and ensure the seclusion or restraint is documented in the treatment plan. Discussion and documentation shall focus on the areas including but not limited to: behaviors leading up to the seclusion/restraint implementation, changes in treatment plan interventions, appropriateness of actions taken and injury noted.

F. Medical Staff Functions – This section describes Medical Staff procedures for initiating and/or providing care for patients/clients in seclusion or restraint.

1. Medical Staff is responsible for ordering initiation or discontinuation of seclusion and restraints.
2. Medical Staff shall conduct the face-to-face assessment for all seclusions and restraints including manual restraints, mechanical restraints and chemical restraints within one (1) hour. If a medical staff is not immediately available or during the hours of 9:00 pm -8:00 am Monday through Friday and 5:00 pm – 8:00 am on Saturday, Sunday and Holidays, a Qualified Registered Nurse (QRN) who received training on face-to-face evaluation, will conduct the 1-hour-face-to-face evaluation of patients in seclusion or restraint and will consult with the Medical Director or designee responsible for the care of the patient/client as soon as possible.

3. The Medical Staff's assessment and documentation shall include a minimum of:
    a. Clinical reason for seclusion or restraint, which includes an assessment of risks and benefits to patient/client.
    b. The type of external control (e.g., seclusion, seclusion and restraint).
    c. An appraisal of the patient's/client's behavior necessitating the use of seclusion or restraint. The justification shall clearly specify the nature of the dangerous behavior.
    d. Alternative interventions attempted.
    e. Treatment recommendations.
    f. Medical or other contraindications to seclusion or restraint.
    g. The maximum length of time seclusion or restraints is to be employed.
    h. A statement of the desired behavior for discontinuation for seclusion or restraint.

4. Only upon completion of a face-to-face clinical assessment by the medical staff or the Qualified Registered Nurse, may the patient/client be secluded or restrained beyond one (1) hour. The medical staff order will include the length of time (up to four hours) and the method of seclusion or restraint to be utilized. The medical staff will be contacted for any continuation of the order for seclusion or restraint.

5. If a patient/client who is restrained for aggressiveness or violence quickly recovers and is released from seclusion and restraints before the face to face assessment, the Medical Staff or the Qualified Registered Nurse, shall still see the patient/client face-to-face to perform the assessment.

6. The Medical Staff or the Qualified Registered Nurse, is responsible for all seclusion/restraint assessment, evaluations to be conducted in person. Prior to administering the seclusion or restraint, the on – Call Medical Staff member is to review with the nurse all medications administered within the last 24 hours. All seclusion and restraints shall be documented in the hand off communication. The treating physician will be consulted as soon as possible if the treating physician did not order the seclusion or restraint.

7. Continuation of seclusion or restraint may be ordered for an additional four (4) hours.

8. Continuation of seclusion or restraint beyond eight (8) hours requires a new face-to-face assessment by the medical staff a new order, progress note as outlined above and an incident report.

9. All progress notes and observation report entries on each patient shall be consistent and sequential in the medical record.

10. The physician is responsible to coordinate a Treatment Team meeting within 24 hours of the implementation of the seclusion/restraint or within

the next business day. Review of the treatment plan to include the intervention for seclusion or restraint shall be completed.

G. Additional Procedures for Monitoring Seclusion or restraint

1. When the patient/client remains in restraint and seclusion for more than eight (8) hours, or experiences more than three separate episodes of restraint or seclusion within a week, the Agency Administration and clinical leadership shall be notified within one (1) hour and an incident report shall be completed.

2. For episodes, more than eight (8) hours, daily administrative review and clinical rationale to continue seclusion or restraint shall be provided by a non-treating Psychiatrist or designee of the Medical Director and an incident report shall be completed.

3. The Treatment Team shall meet with the patient/client for the purpose of exploring and developing, an understanding of the precipitant which may have evoked the behaviors necessitating the use of the restrictive technique(s).
   a. Exploring with the patient/client to develop appropriate coping mechanisms or alternate behaviors that could be effectively utilized if similar situations/emotions/thoughts recur.
   b. Assisting to identify stress reduction methods and teaching identification of antecedent trigger events which may cause stress.

4. Using admission forms, treatment plans, and any other agency forms when discussing what precipitating event occurred that led to an initiation of seclusion or restraint and what changes need to occur that would lessen future occurrences.

5. Developing and documenting a plan to reduce or eliminate the need for restrictive techniques for inclusion in the Treatment Plan, the team member shall document the debriefing process in the progress notes. Documentation of the new intervention(s) to be used shall be included in the Treatment Plan.

6. All events of seclusion or restraint shall be reported to the Nurse Manager or the Nursing House Supervisor who reports to the Director of Nursing. The Nurse Manager and House supervisor shall ensure the event is completely documented in AVATAR and in the medical record.

7. All denial of rights including those associated with seclusion or restraints will be reported to the Nevada State Division of Public and Behavioral Health.

8. Executive and Medical staff shall include the review of seclusion and restraint data. The retained data will be saved in the facility performance improvement program.
   a. The data shall be systematically aggregated and analyzed on an ongoing basis.
   b. Ongoing efforts to reduce the utilization of seclusion or restraint shall be employed by each facility.
   c. The Hospital Administrator/Designee and Medical Director shall include the review of the Seclusion and Restraint data in their report to the LGB.
9. The Hospital Administrator/Designee is responsible for assuring that ongoing documentation and monitoring of patients placed in seclusion or restraint is maintained.

V. REFERENCES:

A. Division of Public and Behavioral Health policy on Denial of Patient Rights
B. NRS 433A
C. NRS 439
D. NRS 449
E. NRS 388.476
F. NRS 641.0245 "Patient" defined.
G. CMS Conditions of Participation for Psychiatric Hospitals: Patient Rights
H. The Joint Commission CAMH, Current Edition
I. 42 CFR 482.13(g) Deaths Associated with the Use of Restraints or Seclusions
J. SNAMHS Agency Policy OF-PI-28: Sentinel Events
K. SNAMHS Agency Policy OF-MHR-21: Training and Education Policy
L. SNAMHS Nursing Procedure IV – 04 Special Observation of Patients
M. FF-SP-02 Transporting Forensic Clients
N. SNAMHS Agency Policy IV-11

VI. ATTACHMENTS:

A. PF-RRE-02 Seclusion and Restraint Attachment A
B. PF-CC-78 Inpatient Psychology Consult Request Form Attachment A
C. I-03 Inpatient Staffing Plan Tier 1 Attachment A
D. I-03 Inpatient Staffing Plan Tier 2 Attachment B
E. I-03 Inpatient Staffing Plan Tier 3 Attachment C
F. PF-RRE-02 Seclusion and Restraint Attachment F Observation Check Form (Days)
G. PF-RRE-02 Seclusion and Restraint Attachment G Observation Check Form (Swings)
H. PF-RRE-02 Seclusion and Restraint Attachment H Observation Check Form (Nights)

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY WIDE

SUBJECT: Qualified Registered Nurse (QRN) **NUMBER:** **IV-11**

EFFECTIVE DATE: 06/2022 **NEXT REVIEW DATE:** 06/2024

APPROVED BY: Leo Gallofin, MD

Agency Medical Director

SUPERSEDES: New; 06/20

I. PURPOSE:

To identify and define the QRN One Hour Face to Face Evaluation responsibility and procedure for One Hour Face to Face Evaluation

II. DEFINITIONS:

A. Qualified Registered Nurse (QRN): A Registered Nurse who has received training to provide the 1-hour face-to-face evaluation of patients in seclusion or restraint.

B. Restraint: Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely. Examples include use of mittens, straps, restraint chairs, handcuffs, belly chains, jumpsuits, four-point restraints or use of physical contact to limit a person's movement or hold a person immobile.

C. Chemical Restraint:

1. **NRS 433.5456 "Chemical restraint"** means the administration of drugs to a person for the specific and exclusive purpose of controlling an acute or episodic behavior that places the person or others at a risk of harm when less restrictive alternative intervention techniques have failed to limit or control the behavior. The term does not include the administration of drugs prescribed by a physician, physician assistant or advanced practice registered nurse as standard treatment for the mental or physical condition of the person.

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CMS §482.13(e) (1) - A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's

condition. Drugs that are used as part of a patient/client's standard medical or psychiatric treatment and are administered within the standard dosage for the patient/client's condition is not considered a chemical restraint.

D. Seclusion: The involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior.

III. PROCEDURE:

A. QRN Training requirements

1. QRNs shall have training to demonstrate they are qualified to conduct a physical and behavioral assessment of the patient that addresses: the patient's immediate situation, the patient's reaction to the intervention, the patient's medical and behavioral condition, and the need to continue or terminate the restraint or seclusion. Training shall consist of:

    a. Taking the "Restraints and Seclusion Training for Qualified Registered Nursing (QRN)" course and scoring at least 90% on the QRN training course quiz.

B. Other QRN requirements

1. See attachment B: "Competency/ Training Checklist For Qualified Registered Nurse One Hour Face to Face Evaluation" for additional QRN requirements

C. One Hour Face to Face Evaluation

1. The QRN will conduct the face-to-face evaluation during the hours of 9:00pm-8:00 am Monday through Friday and 5:00 pm-8:00 am on Saturday, Sunday and Holidays, including any other time when medical staff is not immediately available with Medical Director or designee authorization.

2. The QRN must perform a face-to-face evaluation within one (1) hour of the initiation of the seclusion and/or restraint. Orders for seclusion or restraint must be obtained from Medical Staff no later than 15 minutes after initiation of the event.

3. The QRN conducting the face-to-face assessment shall document findings on the Seclusion and Restraint One Hour Face to Face Evaluation Form. Sections of the Evaluation form may be completed by other staff on behalf of the QRN. Staff completing documentation on the Evaluation Form on behalf of the QRN shall initial and date the sections they complete. The

QRN shall consult the Medical Staff who is responsible for the care of the patient soon as possible after the completion of the 1-hour face-to-face evaluation.

a. This consultation should include, at a minimum, a discussion of the findings of the 1-hour face-to-face evaluation, the need for other interventions or treatments, and the need to continue or discontinue the use of restraint or seclusion.

b. If at any time during the face-to-face assessment concerns about the patient's safety or medical condition arise then Medical Staff will be contacted immediately.

c. The consulting Medical Staff shall determine release criteria.

4. If a patient who is restrained or secluded is released before the QRN arrives to perform the assessment, the QRN must still complete the face-to-face assessment and consult with Medical Staff.

5. Any seclusion or restraint lasting 8 hours or longer must have a face-to-face assessment completed in person by Medical Staff.

    a. In addition, if at any time during a seclusion/restraint event the nursing or the medical staff determines that the patient's condition dictates the necessity of a face to face evaluation by the medical staff, such evaluation must be completed within one hour from the moment when the decision of the necessity of such evaluation has been made.

6. The restrained or secluded patient shall be continually assessed, monitored and re-evaluated according to procedures set forth in PF-RRE-02: Seclusion or Restraint of Patients until release. Follow-up documentation shall be entered into Avatar progress notes.

7. Medical Staff shall be notified once a patient is released from seclusion or restraint. No additional order is required for discontinuation.

8. Medical Staff must examine the patient within 24 hours following the initiation of the seclusion or restraint, review and sign the completed QRN assessment form.

REFERENCES:

A. PF-RRE-02: Seclusion and Restraint

B. OF- MHR-21: Training and Education

C. NRS 433.547, 433.5476: “Mechanical Restraint” and “Physical Restraint” defined

D. CMS §482.13(e) (1): “Restraint” defined

E. NRS 433.5456: “Chemical restraint” defined

F. CMS §482.13(e)(1)(ii): “Seclusion” defined

IV. ATTACHMENTS:

A. IV-11 Qualified Registered Nurse (QRN) Attachment A. QRN Seclusion and Restraint One Hour Face to Face Evaluation Form

B. IV-11 Qualified Registered Nurse (QRN) Attachment B Competency/ Training Checklist For Qualified Registered Nurse One Hour Face to Face Evaluation

Competency/ Training Checklist

For Qualified Registered Nurse One Hour Face to Face Evaluation

Name: Title: Employee #:

Tasks Completed:

☐ QRN is a PN II (or equivalent contractor), III or IV

☐ QRN is current with all SNAMHS Mandatory Training

☐ QRN is current with Nevada Nursing License

☐ QRN is current with CPR Certification

☐ QRN is knowledgeable and understands the following policies:

- Policy OF- MHR-21/ Training and Education
- Policy PF-RRE-02/ Seclusion or Restraint of patients

☐ QRN has completed and passed Written Exam with a score of not less than 90%

Date:

(Once completed, this form is to be turned into to the Training Department to be placed in employee's file)

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY WIDE

SUBJECT: Fall Prevention **NUMBER:** PF-CC-51

EFFECTIVE DATE: 04/2023 **REVIEW DATE:** 04/2025

APPROVED BY: /s/ Susan Lynch, MBA, CPM
Hospital Administrator

SUPERSEDES: PF-CC-51 dated 07/10; 04/12; 01/14; 02/16; 09/16; 06/17; 06/19; 11/19; 11/22

I. PROTOCOL:

. It is the protocol of Southern Nevada Adult Mental Health to provide the highest quality care for all the clients admitted to the hospital, prevent client falls and injury, manage and identify risks, ensure a safe environment, and implement an effective fall prevention program which will involve all staff and other health professionals.

II. PURPOSE:

To establish a mechanism of identifying clients who are at risks for falls utilizing an evidenced based fall risk assessment tool

To establish a comprehensive standard of care for the initiation of safety measures and implementing an effective fall prevention program

Provide ongoing assessment of clients who are identified as a fall risk and maintaining a safe environment for all clients admitted to the hospital

III. DEFINITIONS:

Fall: is a sudden, unintentional descent with or without injuries to the patient, including falls where a patient lands or rests on the floor, other surface areas, another person, or an object whether assisted or unassisted. It can also be related to fainting or environmental reasons. National Data Base of Nursing Quality Indicators (NDNQI March 2012).

Edmonson Psychiatric Fall Risk Assessment Tool (EPFRAT): an assessment tool utilized to predict the likelihood of a patient falling by reviewing history of falls, ambulatory aids, gait, transfers, and mental status.

Conditions contributing to falls or risk for falls include the following but not limited to neurological disorders such as epilepsy, Alzheimer's disease and other related Dementia's, cerebrovascular disease, and Parkinson's disease. Traumatic brain injury, sleep deprivation, malnutrition, and side effects from anti-psychotic medication.

Durable Medical Equipment (DME): Medical equipment that can withstand repeated use. The equipment includes but not limited to wheelchairs, shower chairs, and walkers.

Americans with Disabilities Act (ADA) Compliant Bathrooms: Bathrooms that meet the ADA's Standards for Accessible Design requirements for buildings or facilities to be physically accessible to people with disabilities.

IV. PROCEDURES:

A. Clinical Assessment and Care:

1. All clients will be assessed for falls:

    a. On admission
    b. During transfer to a different unit
    c. When there is a change in the client's condition such as but not limited to: changes in orientation or alertness, changes in balance or gait, complaints of increasing pain during ambulation, or increased requests for as needed pain medications for lower extremity or hip pain.
    d. Following a fall
    e. Weekly

2. Clients will be assessed utilizing the Edmonson Psychiatric Fall Risk Assessment Tool (EPFRAT). A total score of 61 or greater indicates a fall risk and fall precautions shall be initiated.

3. If the client's condition/EPFRAT score changes, fall precautions may be initiated or discontinued at the discretion of the attending physician or internal medicine provider.

4. Upon identifying a client as a fall risk, the following procedures are to be completed:

    a. Notify attending provider and internal medicine provider. Obtain an order for fall precautions and occupational therapy services referral.
    b. Initiate fall prevention strategies such as: fall risk indicators, change in observation as indicated by their status, client education including provision of fall prevention education leaflet and fall prevention occupational therapy plan, staff communication to minimize the client's risk of falling.

d. Document all fall prevention strategies in the medical record, and update treatment plan. Information will include, but not limited to description of the client's behavior and status, interventions implemented, client's response, level of observation, frequency of staff contact, and maintenance of protocol until discontinued.

e. Communicate fall risk among staff utilizing the SBAR sheet during the beginning and end of shift report.

f. Visual indicators such as fall alert stickers will be placed on the client's chart, monitor board, and Kardex to alert staff that close monitoring is indicated. Orange dots will be placed on the on the monitor board sheets, and SBAR sheets to identify the client as a fall risk. An orange leaf will be placed above the door of the client's room.

g. Client's level of observation will be increased at an appropriate frequency as indicated by their status and as ordered by the attending provider or internal medicine provider

h. Provide visual and verbal education to client regarding fall preventive measures such as: rising slowly when getting in and out of bed, asking for help or assistance when needed, medications that can increase risks for falls or pose a threat to safety, and wearing appropriate footwear.

i. Perform safety checks to assess the client's toileting and hydration needs, pain level, personal items such as eyeglasses, footwear, etc. are within reach or easy access, and that the client's room is free of clutter and floors are dry. These checks are to be completed hourly during rounds.

j. Any medications that predispose clients to falls such as: anti-hypertensive, diuretics, benzodiazepines, psychotropic medications, anti-convulsant, and etcetera, shall be monitored or evaluated. The RN will collaborate with treatment team regarding effectiveness of fall prevention strategies and change of status within a client.

5. All clients admitted to the facility will be provided with terry cloth non-skid footwear. Nursing staff will monitor, provide education and encouragement to identified fall risk clients about the importance of wearing non-skid footwear while ambulating to prevent falls.
6. Hospital-issued slippers are provided to all admitted clients for use only During showering.

7. Clients using assistive devices for ambulation including but not limited to wheelchairs will be on 1:1 staff observation when utilizing the assigned American with Disabilities Act (ADA) compliant bathrooms for toileting and personal hygiene activities.

8. All falls will be documented and reported in the medical record.

9. Assessment and treatment will be decided in collaboration with both the client and treatment team to prevent repeated falls or falls resulting in an injury.

10. All falls will be tracked and trended using the accident/incident monthly reporting by the Patient Safety Officer. Data will be analyzed for total number of falls, patterns, trends, causal factors, and will be utilized to improve treatment plans and presented to the Patient Safety Committee, Executive Medical staff, Executive Leadership and quarterly to the Local Governing Board.

B. Post Fall Evaluation and Care:

1. When a client falls or is found on the floor:

a. Do not move the client until a full head to toe assessment has been conducted by an RN or clinical staff.
b. Do not place anything under the head. Immobilize and maintain proper alignment of the neck area if head or neck pain is reported or suspected.
c. Notify the RN or clinical staff immediately.

2. The Registered Nursing Staff will:

a. Assess the environment and any immediate danger to all involved.
b. Assess circulation, airway and breathing, and complete the head to toe assessment and assess for any injuries.
c.
c. Check vital sign.
d. Assess for pain or difficulty weight bearing if no injury is apparent.
e. Perform neurological assessment
1. If the fall was unwitnessed
2. If the fall was witnessed and staff observed the client hit his or her head on any surface during the fall
3. If RN assessment indicates any injury to the patient's head.
f. Notify the Attending Psychiatrist and Medical Staff for follow up care.
g. Notify the family per client's consent, or the client's power of attorney/Legal Guardian if applicable.
h. Transfer to a higher level of care i.e. emergency department, if the client meets criteria for emergent care,

i. For clients who were not transferred or are waiting to be transferred to a higher level of care, assess client every hour for the first four (4) hours and then every four (4) hours for 24 hours. Observe for delirium and new or worsening symptoms such as: confusion, headache, amnesia, vomiting or change in the level of consciousness, and unrelieved pain.

j. Complete an incident report documenting all the contributing factors that led to the incident.

k. Document the following in the progress notes: date and time of the incident, location of the incident, whether the fall was witnessed or unwitnessed, completed assessments, interventions carried out and if the client was transferred to a higher level of care.

V. REFERENCE:

A. Nursing Procedure Seizure Precautions II-13

B. The Joint Commission Provision of Care Chapter, current Hospital accreditation manual

VI. ATTACHMENTS:

A. PF-CC-51 Fall Prevention Attachment A

B. PF-CC-51 Fall Prevention Attachment B

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY WIDE

SUBJECT: Elopement **NUMBER:** PF-CC-86

EFFECTIVE DATE: 01/2022 **REVIEW DATE:** 01/2024

APPROVED BY: /s/ Susan Lynch, MBA, CPM
Hospital Administrator

SUPERSEDES: 12/20

I. POLICY:

It shall be the protocol of Southern Nevada Adult Mental Health Services (SNAMHS) to provide an established process for the assessment of risk and the prevention, reporting, investigation and review of each episode of inpatient elopement.

II. PURPOSE:

To establish a mechanism for identifying clients who are at risk for elopement using an elopement risk assessment tool.

To establish individualized prevention plans for each client identified as an elopement risk based on risk level.

To provide ongoing assessment for all clients and maintain a safe environment for all clients admitted to the hospital.

III. DEFINITIONS:

A. Elopement – when a consumer leaves a 24-hour facility or custody of 24-hour staff, without authorization from medical staff

B. Elopement Risk Assessment – an assessment tool, utilized to determine the likelihood that a patient will leave a 24-hour facility or custody of 24-hour staff without authorization, through review of factors including but not limited to elopement history, mental status, observed behaviors and statement of intent.

C. Medical Staff - include physicians, advance practice registered nurses and physician's assistants who are licensed, credentialed and privileged to perform patient care duties within their scope of practice for Southern Nevada Adult Mental Health Services.

D. Crisis Prevention Institute (CPI) Training - a trauma-sensitive, person-centered focus on alternatives to restraints and is a required certification for specific positions and/or staff.

IV. PROCEDURE:

A. Clinical Assessment and Care:

1. All clients admitted to the facility will be assessed using the Elopement Risk Assessment form (Attachment A):

   a. On admission

   b. On transfer to a different unit

   c. Weekly, on Sundays

B. Upon identifying a client as a high elopement risk, the following procedures are to be completed:

1. Nursing staff will notify the attending medical staff and obtain an order for High Elopement Risk Protocol which will include but is not limited to:

   a. The patient's level of observation as determined appropriate by the attending medical staff

   b. The patient's off unit privileges as determined appropriate by the attending medical staff.

2. After acknowledging the order on Avatar e-MAR, the patient's assigned registered nurse staff will:

   a. Communicate the patient's high elopement risk status by updating the SBAR sheets, Kardex, monitor board and placing an alert sticker on the patient's chart

   b. Report the patient's high elopement risk status through verbal shift change reports

   c. Place High Elopement Risk signs on the unit double doors

   d. Document elopement prevention strategies on daily progress notes entered into the electronic medical record

   e. Update the treatment plan.

C. Elopement event and notification

1. If a patient is observed by staff actively attempting to elope:

   a. Staff will use verbal commands, ventilation of feelings, 1:1 interaction and other less restrictive means to redirect the patient.

b. CPI approved physical intervention techniques may be used to prevent escape or elopement within the facility when the client is within reasonable proximity, with no loss of line of sight and when less restrictive techniques have been attempted but failed pursuant to DPBH Policy FS 4.62.

2. If a patient's location cannot be determined during regular staff rounds, a thorough search of his/her/their last known environment will be completed.

3. If the patient is not found within his/her/their last known environment, the registered nurse will immediately notify the unit program manager or house supervisor and the attending medical staff or medical staff on call.

4. The unit program manager or house supervisor will assign staff members who will be part of the search party and will assign areas of the hospital to be covered by each one.

5. Any non-direct care staff member who locates the patient within the hospital building will report the patient's location to the unit to ensure that sufficient number of Crisis Prevention Institute (CPI) trained staff members can safely respond.

6. If the patient is not found within the facility, termination of the search will be at the discretion of the unit program manager or house supervisor

   a. Registered nurse will notify the Las Vegas Metropolitan Police Department (LVMPD) regarding the elopement and provide a physical description of the eloped client including but not limited to the patient's sex, clothing, height and weight, hair color and name. LVMPD will be informed regarding any person in the community toward whom the patient had been known to make any verbal or physical threat.

   b. Registered nurse will notify the patient's legal guardian if any and the patient's family if release of information consent was provided for them by the patient.

7. If the patient is found within the inpatient facility, the registered nurse will complete a head to toe assessment to check for any injuries and a full body search to check for any contraband.

8. The registered nurse will update the attending medical staff or medical staff on call regarding the patient's status.

D. For off campus scheduled appointments or emergency transport (COBRA)

1. All non-emergent off campus appointments will be reviewed for approval by the Medical Director and Hospital Administrator prior to transport.

2. For emergency transfer to higher level of care (COBRA) of patients who are identified as high elopement risk, the medical staff will determine the number of staff members that will be assigned to escort the patient during transport.

3. High elopement risk status will be communicated by the patient's assigned nurse to the accepting facility staff (receiving facility RN or provider) prior to the patient's transfer.

4. Prior to the departure of the patient, the registered nurse will assess the patient and report any pertinent clinical information to the staff member/s who will escort the patient. RN will inform Medical Staff about the patient's latest elopement risk status prior to transfer.

5. Staff accompanying the patient will carry a hospital issued cell phone and a copy of the patient's identification sheet for any emergencies.

6. Staff accompanying the patient should be able to visually observe the patient at all times and be able to intercede immediately if necessary to maintain the patient's safety. The staff escort will remain at a distance of no more than 8 feet from the patient.

7. If the patient is observed by staff actively attempting to elope:

    a. Crisis Prevention Institute (CPI) verbal techniques shall be used by staff to redirect patients who are attempting to elope during an off-campus transport.

    b. Staff accompanying the patient will immediately report the attempted elopement to the registered nurse.

8. If the patient was able to successfully elope during transport:

    a. MHT staff member will immediately notify the patient's assigned Registered Nurse who will notify the unit charge nurse regarding the elopement.

    b. Registered nurse will immediately notify the Las Vegas Metropolitan Police Department regarding the elopement and provide a physical description of the patient including but not limited to the patient's sex, clothing, height and weight and hair color. Registered nurse will document the LVMPD Case Number in the patient's medical record.

    c. Registered nurse will notify the patient's attending medical staff or medical staff on call, the unit program manager or house

supervisor and the patient's legal guardian, if any and/or the patient's family if release of information consent was provided for them by the patient.

E. Investigation of Elopement Episodes:

1. Registered nurse will complete an incident report related to the elopement within 1 hour from discovering the elopement. Incident report will be completed and routed as per Policy OF-PI-04 Incident and/or Accident Reports.

2. Unit program manager or house supervisor will conduct a debriefing with all staff involved in the elopement within one (1) working day which will be documented.

3. An environmental risk assessment will be completed using the SNAMHS Risk Assessment Form (Attachment B) immediately and in no case more than one (1) day following an elopement episode.

4. All elopement episodes will undergo a formal Root Cause Analysis Process per DPBH Policy CRR 1.14.

5. All elopements will be reported to division using an SIR form and reporting time frames as required by Division Policy CRR.014, within (1) one business day of discovery.

6. Elopements will be reported to the Sentinel Event Registry if there is a serious injury or death related to the elopement.

F. All employees shall be apprised of this policy and educated in its implication within ten (10) days of hire. All direct-care employees must receive annual training on elopement risk assessment and prevention. Communication between care providers is regarded as paramount and shall be emphasized in training. All training must be documented in the employees' personnel training files.

V. REFERENCES:

A. DPBH Policy CRR 1.5 Management of Civil Inpatient Elopement Episodes

B. DPBH CRR .014 Risk Management and Reporting Serious Incidents Policy

C. DPBH Policy FS 4.62 Client Aggressive Behavior Management Intervention Continuum

D. DPBH Policy CRR 1.14 Root Cause Analysis

E. SNAMHS Policy OF-PI-04 Incident and/or Accident Reports

F. SNAMHS Nursing Procedure II-04 Transportation of Inpatients

VI. ATTACHMENTS

A. PF-CC-86 Elopement Risk Attachment A

B. PF-CC-86 Elopement Risk Attachment B

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: HOSPITAL WIDE

SUBJECT: Civil Hospital Sexual Assault/Abuse **NUMBER:** PF-CC-89

EFFECTIVE DATE: 05/2023 **REVIEW DATE:** 05/2025

APPROVED BY: /s/ Susan Lynch, MBA, CPM
Hospital Administrator

SUPERSEDES: New

I. POLICY:

Southern Nevada Adult Mental Health Services (SNAMHS) is committed to protecting the health and safety of patients and maintaining a supportive environment which guards patients' dignity and rights against sexual abuse, sexual harassment, sexually transmitted diseases and unwanted pregnancies.

II. PURPOSE:

To establish a process for identifying patients with history of or actual observed sexually inappropriate or sexually assaultive behaviors and using various levels of observation and appropriate behavior management interventions to address such behaviors.

To establish processes to educate patients regarding rules on appropriate unit conduct and safety measures developed to protect patients, staff and visitors from sexual exploitation, assault or abuse.

To provide a mechanism for reporting and observed incidents of sexually assaultive or sexually inappropriate behavior involving patients.

III. DEFINITIONS:

Sexual Assault (NRS 200.364): A person is guilty of sexual assault if the person subjects another person to sexual penetration, or forces another person to make a sexual penetration on themselves or another, or on a beast, against the will of the victim or under conditions in which the perpetrator knows or should know that the victim is mentally or physically incapable of resisting or understanding the nature of the perpetrator's conduct.

Sexual Abuse as a sentinel event is defined as unwanted intimate touching of any kind especially the breasts, buttocks, or perineal area, forced observation of masturbation and/or sexually explicit images including pornography, text messages, or social media nonconsensual sexual contact involving a client and another client, staff member or other perpetrator while being treated or on the premises of the hospital., including oral, vaginal, or anal penetration or fondling of a patient's sex organ(s) by another individual's hand, sex organ or object. Sexual contact is also considered nonconsensual in the following situations: (1) When the client lacks the cognitive ability to consent even though appearing to want the contact to occur, (2) When the client does not want the contact to occur (Joint Commission, 2023).

IV. PROCEDURE:

A. Clinical Assessment and Observation:

1. All patients admitted to Rawson-Neal Hospital will be assessed for history of sexually inappropriate or sexually assaultive behavior during admission through the following:

    a. Review of pre-admission documentation including but not limited to transferring facility's progress notes and psychiatric evaluation, criminal charges reports and arrest reports for documented history of sexual assaultive or sexually inappropriate behavior.

    b. Review of documented history of sexually inappropriate or sexually assaultive behavior from previous SNAMHS inpatient admissions as recorded on the AVATAR electronic medical record system.

2. Nursing staff will continuously monitor all patients for sexually inappropriate behaviors using the unit monitor boards.

    a. MHT staff holding the monitor boards will notify the assigned Registered Nurse and/or Charge Nurse if any patient is observed exhibiting sexually inappropriate or sexually assaultive behaviors including but not limited to the following: verbalizing sexual propositions, exposing private areas such as genitals, buttocks and breasts, disrobing and/or masturbating in common areas in the unit, unwanted hugging/ kissing/ touching of other patients or staff.

b. The registered nurse will notify Medical Staff if any of these behaviors, or others not listed but are deemed by staff to be sexually inappropriate, are observed.

B. Sexualized Behavior Risk Protocol

1. Upon determination that a patient has a documented history of sexually inappropriate or sexually assaultive behavior and/or observed or reported involvement in sexually inappropriate behavior or sexually assaultive incidents in the unit, medical staff may order to initiate the Sexualized Behavior Risk Protocol (SBRP) if indicated. SBRP includes but is not limited to the following steps:

   a. Complete a Psychology Consult Request (PCR) and provide details of the patient's behavior that warranted initiation of the SBRP.

   b. Place visual identifier on the outside part of the client's chart, monitor board, the unit white boards and SBAR sheets.

   c. Communicate the client's high risk for sexually inappropriate behavior status during shift-to-shift report and Treatment Team Meeting.

   d. Update the treatment plan to reflect the client's identified risk.

   e. Maintain observation as determined by Medical Staff.

   f. Off unit activities and privileges as determined by Medical Staff.

2. The need to continue or discontinue SBRP will be assessed during treatment team meetings and documented in the progress notes tab in AVATAR. Documentation will include the following:

   a. A justification of the rationale to continue or discontinue SBRP.

   b. Other relevant information that supports risk determination.

3. A medical staff face-to-face evaluation and an order in Avatar are required to discontinue the SBRP. The treatment plan will be updated to reflect the order.

4. Once Medical Staff determines that the patient no longer meets the criteria for SBRP, the following will be completed:

   a. Remove the visual identifier from the patient's chart, SBAR sheet, monitor board, and unit whiteboards.

   b. Update the treatment plan to reflect the patient's current level of risk and orders received.

   c. Document in progress note any information supporting the patient's current level of risk, education provided, and provider notification and orders received.

C. Client Treatment and Care

1. All patients admitted to Rawson Neal Hospital will be provided education on the rules against sexually inappropriate or sexually assaultive behavior while admitted in the hospital facility.

2. All patients admitted to Rawson Neal Hospital will be provided education on addressing sexual impulses, practices to protect selves from sexual exploitation or abuse, sexually transmitted diseases, and unwanted pregnancy.

3. Patient education will be provided during treatment team meeting, community groups, treatment mall groups and on daily interactions with staff.

4. For patients with identified history of or known incidents of sexually inappropriate or sexually assaultive behavior:

   a. The treatment team is responsible for incorporating appropriate goals, objectives, and interventions in the treatment plan to address identified history of or known incidents of sexually inappropriate or sexually assaultive behavior.

   b. The treatment team will address, as indicated, clinical interventions for patients who have been identified with history of or known incidents of sexually inappropriate or sexually assaultive behavior.

c. Patients' referral to active treatment groups will be representative of goals identified in the treatment plan.

D. Incident Reporting and Follow-Up Care

1. Any staff member who knows or have reasonable cause to believe that sexual assault of any patient, staff or other individual has occurred will take all appropriate and feasible steps necessary to ensure the safety and protection of the client, staff or other individual involved in the suspected or actual incident.
2. If it is known or there is reasonable cause to believe that sexual assault or sexual contact has occurred involving patients, medical staff will be notified immediately for consultation regarding follow up medical evaluation and/or treatment as indicated.
3. Upon determination that sexual assault or sexual abuse has occurred, the allegation of abuse process, as described in PF-RRE-22 Abuse and Neglect Protocol will be initiated and completed within the required time frames indicated in the policy.
4. OF-PI-28 Sentinel Events policy will be followed regarding required sentinel event reporting.
5. PF-RRE-22 Abuse and Neglect policy will be followed regarding required reporting to law enforcement.

II. REFERENCE:

A. The Joint Commission Manual of Hospital: PC.01.02.03 (2023)

B. OF-PI-28 Sentinel Events Policy

C. PF-RRE-22 Abuse and Neglect Protocol

III. ATTACHMENT:

A. PF-CC-89 Civil Hospital Sexual Assault/Abuse Attachment A: Sexual Assault/Abuse Prevention Patient Education

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY WIDE

SUBJECT: Safety Management Plan **NUMBER:** OF-EM-00

EFFECTIVE DATE: 08/2022 **REVIEW DATE:** 08/2024

APPROVED BY: /s/ Susan Lynch, MBA, CPM
Hospital Administrator

SUPERSEDES: Policy OF-EC 01 dated 06/0900,04/09/06 and 11/06,11/08; 04/11; 06/13; 06/15; 01/16; 01/17; 05/18; 05/19; 08/20

I. PROTOCOL:

It is the protocol of the Southern Nevada Adult Mental Health Services (SNAMHS) to provide a physical environment free of hazards and manage staff, client and visitor activities to reduce the risk of injuries.

II. PURPOSE:

This protocol establishes the requirements for developing the SNAMHS Safety Management Plan and defining the method for implementation. The scope of this plan is to establish an agency-wide safety plan including authorities and responsibilities. This plan is applicable to all departments and sites within the SNAMHS Agency.

III. DEFINITIONS: N/A

IV. PROCEDURE:

A. Maintaining and supervising grounds and equipment:
   1) Grounds will be maintained and supervised by the Maintenance Department. A contracted vendor may provide lawn maintenance services.
   2) Maintaining of equipment to ensure reliability, minimize risks and reduce failures is the responsibility of the Maintenance Department.
   3) Offsite SNAMHS building leases include maintenance and supervision of grounds.

B. Conducting risk assessment that proactively evaluates the impact of building, grounds equipment, occupants and internal physical systems on client and public safety:
   1) All clinic sites shall be inspected monthly by the Clinic Director or designee using the SNAMHS Environmental Health and Safety Checklist.

C. Examining safety issues by appropriate representatives:
   1) The Environment of Care Team (EOCT) is an ongoing team comprised of members from administration, clinical services and support services.

2) This team meets at minimum monthly to examine and discuss safety issues that impact the facility.

D. Reporting and investigating all incidents of property damage, occupational illness and patient, personal or visitor injury:
1) All incidents of these types are to be reported in accordance with agency policy pertaining to incident / accident reporting procedures.
2) The Environment of Care Team reviews these incident / accident reports.

E. Ongoing hazard surveillance and product safety recalls:
1) It is the responsibility of each staff member of SNAMHS to report any hazardous situation of which they may become aware.
2) Hazard surveillance reports are made to the Maintenance Department.
3) Hazards are to be reported immediately via telephone and a completed Maintenance Repair / Work Request form is to be submitted to maintenance in accordance with agency policy following the verbal report.
4) Maintenance will investigate the hazard, assess the situation and take corrective action as necessary.
5) The Maintenance Department will also inspect, test and maintain critical operating components as described in the Utility Systems Management Plan; see agency policy OF-EM-05.
6) Product safety recalls are to be reported to Maintenance and the Supply Department.

F. Appointing a qualified individual for oversight of safety management:
1) The Safety Officer is responsible to oversee development, implementation and monitoring of safety management.
2) The Safety Officer will work in concert with the Environment of Care Team.

G. Maintenance Department regarding safety issues:
1) Identified individuals who may intervene whenever conditions pose an immediate threat to life, health, or threaten to damage equipment or buildings:
2) If at any time any level of management staff believes there is a need for immediate evacuation, they shall implement such evacuation immediately.
3) The staff shall immediately advise all personnel by broadcasting the appropriate code on the paging system.
4) The staff member will also notify the Agency Manager or designee of the condition and the Agency Manager will make a final determination regarding the situation.
5) For any other type of disruption, the staff will contact the Maintenance Department and apprise them of the situation, following the procedures outlined in the Utility Systems Management plan.

H. Orientation and Education:

1. General Safety Processes:
   a. The staff of SNAMHS is required to participate in ongoing general safety education and training as required by position.
   b. This training includes but is not limited to Standard Precautions, CPR (if required),

c. Conflict Prevention and Response Nonviolent Crisis Intervention (CPI) Training
d. Fire Extinguisher Training,
e. Defensive Driving, etc.

2. Area Specific Safety:
   a. Staff are trained in safety specific to their area of work.
   b. Each staff member will receive training in fire procedures and any other training deemed necessary for their area of work.
3. Specific Job-Related Hazards:
   a. Specific job-related hazards are identified and staff members complete training specific to the hazard.
   b. This shall be documented in departmental orientation and forwarded to the SNAMHS Training Office.
4. New Employee Orientation and Continuing Education:
   a. Each new employee is required to participate in a new employee orientation that includes safety orientation.
   b. Thereafter, all employees are required to participate in regularly scheduled general safety training as part of continuing education.

I. Performance Standards:
1. Monitoring and Inspection:
   a. It is the responsibility of each staff member to report any hazardous situation of which they may become aware.
   b. Any staff member specifically assigned monitoring / inspection duty is required to do so.
2. Inspections: Monthly inspections using the Environmental Health and Safety Check List; see agency policy OF-EC-04.
3. Reporting of Incidents:
   a. Each staff member is required to report any disruptions, utility failures, injuries, accidents, etc.
   b. Reporting shall be done in accordance with agency policy pertaining to incident / accident reporting procedures and management plans that address safety, security, hazardous materials, emergency preparedness and life safety.
4. Inspection, Preventive Maintenance and Testing:
   a. All equipment is inspected and tested in accordance with state law and as described in the Utility Systems Management Plan, see agency policy OF-EM-05.

J. Safety Policies and Procedures:
1. Each safety policy / procedure is reviewed, updated, practiced and enforced.
   a. All SNAMHS staff are required to review policy as assigned through Policy Tech.
   b. Emergency Management Policies are reviewed annually.
   c. All other policies are reviewed every 24 months.

K. Policy Review:
1. The Environment of Care Team reviews this policy every two (2) years to

evaluate its objectives, scope, performance and effectiveness and recommends revision,

2. The Executive Leadership Team reviews and approves.

V. REFERENCES:

A. The Joint Commission Standards-CAMH, CAMLAB, and CAMBHC; Chapter of Environment of Care (EC), current edition
B. OSHA Standards (current)
C. SNAMHS Agency Policy OF-EC-04; Health and Safety Inspections
D. SNAMHS Agency Policy OF-EM-05; Utility Systems Management Plan
E. DPBH Policy CRR .014 Risk Management and Reporting Serious Incidents Policy

VI. ATTACHMENTS: N/A

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY WIDE

SUBJECT: Employee Safety, Health, and Environmental Concerns **NUMBER:** OF-EC-03

EFFECTIVE DATE: 05/2021 **REVIEW DATE:** 05/2023

APPROVED BY: /s/ Susan Lynch, MBA, CPM
Hospital Administrator

SUPERSEDES: 06/02; 01/08; 01/10, 03/10, 04/12; 04/14; 05/16; 06/18; 05/19

I. PROTOCOL:

SNAMHS establishes a protocol for employees to identify and report their safety, health and/or environmental concerns.

II. PURPOSE:

This protocol is to identify steps to be taken to resolve employee concerns pertaining to unsafe working or environmental conditions and responsibility for eliminating hazards (NRS618.383).

III. DEFINITIONS: N/A

IV. PROCEDURES:

A. All employees are responsible for notifying their immediate supervisor about conditions that compromises the quality of SNAMHS' Mission or they believe to be a safety, health, and/or environmental hazard.
   1) Notification may be submitted on the Employee Safety, Health and/or Environmental Concern Advisement Form (see attachment A) that is available through site administration and the SNAMHS server.
   2) The employee may also submit any environmental concerns via the Compliments and Complaints form as outlined in OF-LDR-12, *Employee Compliments, Complaints, and Suggestions.*

B. In a timely manner, but no longer than one (1) hour after receiving notice of potential hazard, the supervisor shall determine if an imminent danger (or risk) of serious harm is present.
   1) If, in the supervisor's judgment, an eminent danger does exist, at risk activities shall be stopped and the area secured until the supervisor determines that it is prudent (safe) to proceed with normal or modified activities.
   2) Notification to the Safety Officer and completion of a work order will be completed.

C. When imminent danger of serious harm does not exist, the supervisor shall initiate any necessary steps to assure an injury free activity is maintained.

D. The concerned employee shall be periodically advised regarding scheduled remedial actions.
E. If in the concerned employees' opinion or additional action is needed to protect patients, staff, or visitors, they should notify administration, the Safety Officer, or the Patient Safety Officer.
   1) Every employee also has the right to file a complaint with the State of Nevada Division of Industrial Relations.
F. Supervisors shall forward the advisement form, related dispositions, and/or correspondences electronically to the Safety Officer for central filing.
G. Supervisors shall ensure employees are not penalized for complying with the provisions of this policy.

V. REFERENCES:

A. Employee Compliments Complaints and Suggestions (OF-LDR-12)
B. Employee Compliments, Complaints or Suggestions Form (OF-LDR-12 Attachment A)
C. Health and Safety Inspections (OF-EC-04)
D. Safety Program (OF-EC-02)
E. Safety Management Plan (OF-EC-01)
F. The Joint Commission; CAMH; Management of the Environment of Care
G. NRS 618.383

VI. ATTACHMENTS:

A. OF-EC-03 Employee Safety, Health and Environmental Concerns Attachment A
B. OF-EC-03 Employee Safety, Health and Environmental Concerns What is a Maintenance Emergency Attachment B
C. 2023 Patient Safety Plan

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY WIDE

SUBJECT: Emergency Codes: Use of Public Announcement System

NUMBER: OF-EC-08

EFFECTIVE DATE: 01/2022

REVIEW DATE: 01/2024

APPROVED BY: /s/ Susan Lynch, MBA, CPM, Hospital Administrator; Ellen Richardson-Adams, CPM, Outpatient Administrator

SUPERSEDES: 03/02; 09/04; 01/05; 10/06; 04/08; 09/09; 12/10; 08/11; 10/11; 12/11; 04/13; 01/14; 12/15; 01/18; 01/20

I. POLICY:

It is the protocol of Southern Nevada Adult Mental Health Services (SNAMHS) to provide guidelines to employees on the use of the Public Announcement (PA) System.

II. PURPOSE:

A. To implement an efficient emergency communication system that provides a timely response.

B. The PA system is only used:

1. To alert employees to provide assistance in case of emergency.
2. To make special announcements.
3. To page an individual when unable to reach him/her through regular channels.

III. DEFINITION:

Emergency – Defined in this policy, any detrimental behavior, anticipation of such behavior, or a situation that requires immediate action.

IV. PROCEDURE:

A. On Call Medical Staff must surrender their cell phones when entering Forensic Service units. Staff must call the forensic units to reach those physicians.

B. Utilization of the Public Announcement System

1. In an emergency use the PA system:

a. For building 1 call "#690" with the code and the location of the assistance needed.
b. For Bldg. 2 call "#690" with the code and location of assistance first and announce the code in Bldg. 2, then call "#691" with the code and the location of assistance needed. Note: this will allow staff in Bldg. 1 to respond to Bldg. 2 as quickly as possible.
c. For the Rawson Neal Hospital call "#694" with the code and the location of the assistance needed.
d. For Human Resources (HR) – Jones Facility "#693".
e. For Stein Hospital (Bldg. 3) call "#698"; Direct dial to control room (702-486-6505)
f. For Building 3A and outpatient clinic sites other than West Charleston, if overhead paging system(s) is available, follow procedure. If paging system is not available, emergency code and location will be announced verbally.

2. Designated employees to respond to emergencies:
   a. For the Rawson Neal Hospital, the unit nurse will designate an employee for the emergency as needed.
   b. For buildings 1 and 2 all supervisory personnel or as directed by supervisory personnel.
   c. Forensic Unit staff assigned to the Stein Hospital will respond to emergencies units **within the Stein Hospital only**.
   d. Forensic Unit Staff assigned to the C-POD at the Rawson Neal Hospital will not respond to emergencies off of the C-POD.

3. Fire Emergency:
   a. Access PA system, announce "CODE RED" (The term fire is also permissible) and give location of fire.
   b. Respondents to this code are all staff in the building.
   c. Prepare clients and employees for immediate evacuation as per policy. Delegate an employee to telephone 9-911 immediately to alert fire department of emergency. Clinical professional staff will assist nursing and technician staff with clients.
   d. Within the Rawson-Neal hospital the use of the special handheld microphones located at each nurse's station in each individual unit is strictly used to override the fire systems for emergency communications only. All unit employees have keys to access.

4. Medical Emergency:
   a. Access PA system, announce "**DOCTOR BLUE**" in the event of a medical emergency and give location. Respondents to this code are any physicians in the building, nursing supervisors and any RN who can safely leave his or her assigned area to assist in the emergency. Delegate an employee to telephone 9-911 to obtain paramedic assistance for the medical emergency.

5. Potentially Assaultive Behavior Emergency:

a. Access PA system, announce "**CODE 1**" (Show of Force) in the event that there is support needed on the unit or in the event of a physical management in progress and there is an "immediate" danger to an employee, client, contractor and/or visitor. Give location where assistance is needed. Respondents to this code are assigned representatives from each unit and or departments.

b. Announce "**CODE 3**" (External Threat), **do not give a specific location**, in the event that a potential threat has been made against an employee, client, contractor and/or visitor from outside the agency, i.e. a threat made by phone or e-mail. Notify security and Capitol Police. When "CODE 3" is announced, staff shall ensure office and meeting room doors are shut and locked. Security shall ensure all doors, other than main entrances, are locked. All visitors to buildings shall be directed to use main entrances only. Staff may use other entrances if they possess keys to do so and are wearing a SNAMHS Identification Badge. Should staff observe an individual without a badge attempting to enter a building through any door, other than a main entrance, they are to notify security immediately. STAFF IS NOT REQUIRED TO RESPOND TO ANY SPECIFIC LOCATION.

6. Potential Weapon Emergency:

a. Access the PA system, announce "**CODE 45**" in the event a weapon will be used, and give exact location. Then request assistance. Dial 9-911, identify yourself as an employee of Southern Nevada Adult Mental Health Services, describe the situation that is occurring and give the exact location of the facility. Respondents include administrators, supervisors, department heads and other personnel as identified to prepare clients and employees for evacuation. Everyone else shall keep employees and clients away from involved area. ***See section C and D below.***

7. Internal / External disaster (Including Potential Bomb Threat):

a. Access PA system, announce "**CODE 77**" in the event of any internal or external disaster, i.e., flood, earthquake.

b. In the event of a potential bomb threat and or detection of a suspicious letter or package, immediately report the incident to your department's supervisor. Supervisor will contact the Agency Safety Officer, Agency Director, Medical Director, and/or designee. Give location if available. It shall be the discretion of the Agency Director or designee as to whether or not to call 911, evacuate the area, and/or to appoint staff members to assist officers / investigators with the search. If Agency Director or alternate deems it necessary to call 911, they will access the PA system, announce **"BRAVO"**, give the location of the threat, and call 911. Respondents include all personnel, who are to prepare clients and

employees for immediate evacuation of affected area(s) as per policy.

8. Accreditation Surveyors on Campus:
   a. Access the PA system, announce "**CODE 6161**" in the event accreditation surveyors from the Joint Commission (Accreditation of Healthcare Organizations), Center for Medicare and Medicaid Services (CMS) or the Bureau of Healthcare Quality and Compliance (BHCQC) are on campus conducting a survey; give location of surveyors. This will ensure all employees present are informed and prepared for the survey in progress.

9. Locking Systems throughout Rawson-Neal Hospital Inoperable:
   a. Maintenance employee is to call "**CODE YELLOW**" in the event that locking systems are inoperable due to service or failure of the system. All employees are to monitor electric-lock doors to ensure security of hospital and monitoring of clients.

10. Fire protection system inoperable – Fire Watch Initiated:
Maintenance employees are to call "**CODE BLACK**" in the event the fire alarm system is inoperable for more than 4 hours during any 24-hour period. A fire watch will be initiated. All staff shall monitor electric-lock doors to ensure security of hospital and monitoring of clients.

   b. a. Maintenance department will conduct a 24-hour campus fire watch, for both fire alarm systems and fire sprinkler systems. Where a fire alarm system is out of service for more than 4 hours in a 24-hour period, or a fire sprinkler system is out of service for more than 10 hours, the Administrator shall be notified, and the building evacuated, or an approved fire watch shall be provided until the fire alarm system or fire sprinkler system has been returned to service.

   c. A fire watch requires staff trained in fire prevention to continuously walk the affected areas.

      i. Rawson Neal Hospital: One staff dedicated to Fire Watch shall make rounds on both A and B sides continuously.

      ii. Stein Hospital: One staff per patient occupied floor

      iii. Building 3A, and Outpatient Clinics: One staff per clinic while occupied.

2. All Clear:
   a. Access the PA system, announce "**CODE GREEN - ALL CLEAR**" in the event the emergency has been declared safe by respondents to the emergency.

B. Responsibilities:

1. Any staff member observing or having knowledge of an emergency that involves clients, staff, visitors and/or anyone who is within the buildings or on the grounds of SNAMHS, including clinic sites, will immediately, and without delay, summon assistance.
2. It is the responsibility of department heads and/or immediate supervisors to educate subordinate staff on all emergency codes and access of the PA system.
3. It is the responsibility of all SNAMHS staff to biannually review this policy.
4. It is the responsibility of all supervisors to ensure that all direct-care, clinical, and designated personnel are trained in therapeutic techniques used in the Non-violence crisis intervention training (CPI)
5. All actions of staff in such emergencies shall be under the complete management and control of the identified supervisor, the clinical department head, or senior staff members present.
6. The goal of such intervention and assistance shall always be the protection of the client, staff, and others.
7. As required, staff assisting in the emergency may assist in the movement of the client from one location on site to another for services. Should physical intervention be required, clinical staff involved in direct care shall be utilized and will employ minimally restrictive, approved techniques of intervention. Only staff trained in the use CPART B may apply these.
8. All direct-care, clinical, and designated personnel will receive in-service training and testing in CPI the Non-violence crisis intervention training (CPI). Inpatient nursing staff and Mental Health Technicians must recertify annually in the Non-violence crisis intervention training (CPI).
9. Drills to facilitate the utilization and application of approved techniques will occur regularly through training.
10. It is the responsibility of the Environment of Care (EOC) Chairperson or designee to inform the Agency Director, Medical Director, Director of Nursing, front desk receptionist, and other key personnel before an emergency drill is executed.
11. It is the responsibility of each Area Manager, Department/Program Supervisor and Site Manager, or acting Supervisor(s) to ensure that the SNAMHS Emergency Code Log in the Monthly Safety Report form (OF-EC-35 Life Safety Plan Attachment D or Attachment C) is filled out correctly when an emergency code is called in their area or department.
    a. The Emergency Code Log in the Monthly Safety Report shall be submitted electronically to the chair of EOC and coped to the EOC Recording Secretary on the first day of the following month.

12. It is the responsibility of the Human Resources Department to ensure that all staff is equipped with a laminated emergency code card designating code names, definitions, and command center and paging numbers, as detailed in Attachment A of this policy.

C. Preface each emergency announcement with the word "**CODE**". Identify the location and call the code twice.

1. In the event a situation requires members of the public to understand the code for life safety reasons, SNAMHS employees shall use normal language to give instructions "**CODE RED.**"

2. **Plain English announcements may be used as needed to facilitate immediate response.**

3. In the event a situation requires members of the work environment or the public to understand and comply with the code for life safety reasons, SNAMHS employees shall repeat the code and instructions every two to three minutes until compliance is reached.

D. Evacuation of Lobby in Building 1:

1. In the event the client lobby of Building 1 is to be evacuated for life safety reasons personnel and contracted security shall assist with the following:
   a. Direct staff, consumers, and members of the public from the waiting area to the employee lounge of Building 1.
   b. Lock the door once staff and other individuals are safely inside.

2. SNAMHS employees in the area shall assist with escorting consumers and individuals from the public to the evacuation area of the computer room.

3. Each member of Leadership shall assess his or her immediate situation and potential to evacuate to the Administrative Suite at Rawson Neal Hospital and:
   a. Locate themselves in the conference or training room as the situation permits.
   b. Bring his or her cellular telephone if the situation permits.
   c. Once a member of Leadership arrives at the Administrative Suite, he or she shall announce on both public address systems, "**THE COMMAND CENTER IS STAFFED**" repeating the announcement twice on each paging system.
   d. Contact other buildings on campus without PA system access to communicate the situation.
   e. Contact other agencies on campus if the situation indicates such.

E. The **Command Center** for SNAMHS shall be the Administrative Suite in Rawson Neal Hospital, including the training and conference rooms. If the Administrative Suite is unavailable, information as to location of Command Center will be disseminated,

II. REFERENCES:

A. The Joint Commission; CAMH; Management of the Environment of Care (EC)

B. SNAMHS policies OF-EC-30 and OF-EC-35

III. ATTACHMENTS:

A. OF-EC-08 Emergency Codes Use of Public Announcement System Attachment A

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: HOSPITAL WIDE

SUBJECT: Hazardous Materials, SDS & Waste Management Plan **NUMBER:** OF-EC-25

EFFECTIVE DATE: 01/2022 **REVIEW DATE:** 01/2024

APPROVED BY: /s/ Susan Lynch MBA, CPM
Hospital Administrator

SUPERSEDES: 06/00; 03/02; 04/04; 03/07; 11/09; 02/10; 03/12; 05/13; 01/15; 07/15; 06/18; 11/19

I. PROTOCOL:

It shall be the protocol of SNAMHS to provide a safe physical environment with managed control of hazardous materials and waste and ensure staff are aware of what hazards exist in their work environment.

II. PURPOSE:

A. To protect staff, clients, visitors, and students from the hazards that may be associated with chemical products and provide information on hazardous materials in the work environment.

B. To identify, manage, and dispose of hazardous materials and wastes in a manner that presents no danger to staff, clients, visitors, or students in accordance with all local, state, and federal laws and regulations. It is further the intent to observe standards proposed to maintain a clean and healthful environment.

III. DEFINITIONS:

A. Currently there are two (2) ways a material is classified by the Environmental Protection Agency (EPA) as hazardous. The first is its presence on a list of material published by the EPA. The second is by the properties of the material in question. Any material that meets any one or more of the following definitions must be classified as hazardous:

1. IGNITABLE: If the material has a flash point of less than 60° C (144° F).
2. CORROSIVE: The pH is less than 2.0 or greater than 12.5 or corrodes steel at the rate of 6.35mm or more per year.
3. REACTIVE: The material is unstable, capable of detonating, readily

undergoes violent changes, reacts violently with water, or forms potentially explosive mixtures with water.

4. TOXIC: A chemical falling within any of the following categories:
   a. A chemical that has a median lethal dose (LD) of more than 50 milligrams per kilogram, but not more than 500 milligrams per kilogram of body weight when administered orally to albino rats weighing between 200 and 300 grams each.
   b. A chemical that has a median lethal concentration (LC) in air of more than 200 parts per million, but not more than 2,000 parts per million by volume of gas or vapor, or more than two milligrams per liter, but not more than 20 milligrams per liter of mist, fume, or dust, when administered by continuous inhalation for one hour (or less if death occurs within one hour) to albino rats weighing between 200 and 300 grams each.
5. EXPOSURE or EXPOSED: Subjected to a hazardous chemical through any route of entry (inhalation, ingestion, skin contact, or absorption, etc.) and includes potential (e.g., accidental, or possible) exposure.
6. HAZARD WARNING: Any words, pictures, symbols, or combination thereof appearing on a label or other appropriate form of warning which conveys the hazards of the chemical(s) in the container(s).
7. HAZARDOUS CHEMICAL: Any chemical that is a physical or health hazard.
8. HEALTH HAZARD: A chemical for which there is statistically significant evidence based on at least one study conducted in accordance with established scientific principles that acute or chronic health effects may occur in exposed employees. The term (health hazard) includes chemicals which are carcinogens, toxic or highly toxic agents, reproductive toxins, irritants, corrosives, sensitizers, hematotoxin, nephrostomies, neurotoxin agents which act on hematopoietic system and agents which damage the lungs, skin, eyes, or mucous membranes.

B. Safety Data Sheet (SDS): The Safety Data Sheet (SDS) is the primary instrument for transmitting detailed hazard information about hazardous chemicals in use at SNAMHS. The SDS contains specific information regarding particular products including identification of hazards, composition of ingredients, first-aid measures, fire-fighting measures, accidental release measures, handling and storage, exposure controls/personal protection, physical and chemical properties, stability/reactivity, toxicological information, ecological information, disposal considerations, transport information, regulatory information, and “other” information. The SDS reflects recent labeling requirements implemented by the Occupational Safety and Health Administration’s alignment with the GHS (Globally Harmonized System) created by the United Nations as the new Hazards Communication 2012 Standard.

C. Trade Name vs. Generic Name: A trade name is that name which a manufacturer sells a product under while the generic name is what the product is for. Example, laundry detergent is the generic name while “Tide”, “Cheer”, and “Wisk” are

manufacturers' trade names.

D. Industrial Products: Industrial products are those products that are not readily available to the general population or those products that are packaged differently for industrial use as opposed to consumer use. Example: floor wax in quart or half gallon containers purchased at a supermarket would be a consumer product; the same wax purchased from a maintenance supply firm in a five - (5) gallon container would be considered an industrial product because the five - (5) gallon container is not readily available to the general population.

E. Consumer Products: Consumer products are products that are readily available to the general population as found in supermarkets, hardware, and department stores and in general are packaged for household or family use. Example: laundry soap packaged in up to ten - (10) pound containers is considered a consumer product; the same laundry soap packaged in a 55-gallon drum would be considered an industrial product.

F. Infectious Wastes:

1. Disposable equipment, instruments, and fomites from the rooms of clients who are suspected to have or been diagnosed as having a communicable disease and must be isolated.
2. Laboratory wastes, including pathological specimens (i.e., all tissues, specimens of blood elements, excreta and secretions obtained from patients or laboratory animals) and disposable fomites (any substance that may harbor or transmit pathogenic organisms) attendant thereto.
3. Surgical pathologic specimens and disposable materials from the clinic areas.
4. Waste materials derived in whole or in part from: Cultures and stocks of infectious agents and associated biologicals.

G. Pathological Wastes:

1. Contaminated animal carcasses and body parts.
2. Contaminated sharps.
3. Human blood and blood products.
4. Contaminated by-product waste such as, but not limited to, dressings, bedding, swabs, pads and gloves, invasive disposable equipment.

H. Hazardous Pharmaceutical Wastes:

1. Any pharmaceutical waste in the form of a solid, liquid, or gas that can pose substantial hazard to human health or the environment when not properly managed.
2. A non-viable pharmaceutical that exhibits a characteristic as described in 40 CFR Part 261, Subpart C or is listed hazardous waste pursuant to 40 CFR Part 261, Subpart D.

I. Institutional Solid Waste: Solid waste originating from public or private educational, health care, correctional and research facilities.

IV. PROCEDURE:

A. SNAMHS' Environment of Care (EC) Committee or its designee shall ensure the following procedure is operational:

1. Establish, support, and maintain a hazardous material and waste management plan.
2. Establish a plan for selection, handling, storing, use and disposal of hazardous materials from receipt, through use, from generation to final disposal with a record trail to follow.
3. Establish written criteria in accordance with applicable law and regulation, to identify, evaluate and inventory hazardous materials and wastes used or generated by each department.
4. Manage chemical wastes and regulated medical or infectious wastes, including sharps.
5. Educate and monitor personnel who manage or regularly have contact with hazardous materials and waste i.e., staff, students, (including residents) and volunteers.
6. Provide adequate and appropriate space and equipment for the safe handling and storage of hazardous materials and waste.
7. Report and investigate all hazardous material or waste spills and exposures or other incidents that involve patients, visitors, staff, or property.
8. Annual evaluation of the objectives, scope, performance and effectiveness of the documented hazardous materials and waste management plan.
9. Every two (2) years evaluate policies and procedures on hazardous material waste management.

B. Hazard Communication:

1. At the time of initial employment, all SNAMHS' employees shall have immediate access to Safety Data Sheets, labeling systems and types of materials present. Information shall include the following:
   a. Specific potential hazards present in the workplace;
   b. Personal protective devices and their use;
   c. Procedures in the event of a hazardous spill or exposure.
2. Records of the initial training and any subsequent training must be kept a minimum of thirty (30) years. After an employee leaves SNAMHS, the records shall be forwarded to the SNAMHS Personnel Office to be maintained by the Department of Personnel in Carson City, Nevada.
3. Records of employee exposure to any hazardous materials must be kept for a minimum thirty (30) years after employment. This includes physical

examinations as well as results of laboratory tests on samples from employees. These records shall be forwarded to the SNAMHS Personnel Office to be maintained by the Department of Personnel in Carson City, Nevada.

4. Contractors that perform services at SNAMHS shall be informed of potentially hazardous materials in the work environment to which they may be exposed. If warranted, they shall be informed by SNAMHS' EC Committee or its designee of measures to decrease the possibility of exposure, the location of SDS sheets on file and the procedures they are to follow in the event of a spill or exposure.

5. Contractors performing services at SNAMHS must provide similar information to the SNAMHS EC Committee concerning potentially hazardous materials they bring to the facility.

C. Safety Data Sheet:

1. A Safety Data Sheet must be on file for each product that appears on the Product Inventory List. Products shall not be released for use until the SDS is on file.
2. Safety Data Sheets may be found in the Supply Department's program manual under the section marked SDS. The Safety Data Sheets are arranged in alphabetical order according to product trade name as found in the product and listed on the product Inventory List.
3. SDS can also be found on the agency server under the folder "SDS".
4. No Safety Data Sheets may be added or removed from the program manual without acceptance by the EC Committee.
5. Exception: SDS is pulled for reference during a medical emergency.
6. The Purchasing Department is to include a statement on all purchase orders to the effect that the purchase order shall not be considered complete unless an SDS is on file or accompanies the shipment.
7. The individual who checks incoming orders shall ascertain that the SDS has accompanied the order.
8. If an SDS is missing from a product received and is not on file at SNAMHS, the Supply Department shall call the vendor that day and request an SDS be faxed or emailed immediately. The order shall not be distributed until the Supply Department has an SDS on file.
9. The Supply Department is responsible for the completeness and accuracy of the SDS program.
10. The Supply Department shall enter the SDS received into the Master File. The Master File shall be the one used to determine if the SDS is available at SNAMHS.
11. If a department has a SDS on file, but it is not in the Master File, it shall

not be considered in existence until a copy is place in the Master File.

12. When the Supply Department receives a new SDS or a revised SDS, they are responsible to distribute this to all Department Heads within two (2) business days. It is the responsibility of the Department Heads to educate all of their staff within four (4) business days.

13. The Supply Department shall keep an index of all SDS on file. The index shall include the title of the SDS and the effective date. This index shall be distributed to all Department Heads no less than on an annual basis.

D. Hazardous Materials Procedures:

1. Each Department Head of SNAMHS shall be responsible for the proper handling and disposal of all hazardous materials in their department in accordance with SNAMHS protocols.

2. All efforts shall be made to minimize hazardous waste. Hazardous materials or materials which result in hazardous waste upon disposal shall be reviewed at the time of request for purchase by the Purchasing Department. Substitution may be made of items that are hazardous or have hazardous waste by-products.

3. The Supply Department shall designate products as industrial or consumer products.

4. All chemicals must be received by the Purchasing Department according to the following criteria:
   a. SDS sheets must accompany materials or already be on file.
   b. Careful inspection of material to assure correct delivery.
   c. Inspect containers for damage, leakage, etc. If leakage is noted, DO NOT ACCEPT SHIPMENT. If it is necessary to clean up such a spill, inform the transporter, the Purchasing Department Supervisor, and the Environmental Safety Officer immediately.
   d. Attach the appropriate label per the National Fire Protection Agency (NFPA 400 & NFPA 704) after it is determined that the material shall not have to be sent back to the manufacturer.
   e. Purchasing shall maintain a master list of all hazardous materials received at SNAMHS and the list shall be cross-referenced by NFPA category.

5. The Accounting office shall forward to the Supply Department a copy of all transactions involving the purchase of chemical products before those products are released for use. The Supply Department shall classify the products and ensure Safety Data Sheets are on file for each product.

6. Employees are restricted from purchasing chemical products that fall under the Industrial Product Definition. Employees may purchase over the counter consumer items from supermarkets, hardware, and department stores only.

7. Labeling of hazardous materials is required to inform employees of the

nature of the materials they handle and to assure they are handled properly. SNAMHS shall comply with NFPA 400 & NFPA 407 and other applicable codes.

a. This system uses a diamond-shaped label containing four smaller diamonds with colors identifying the hazard category and numbers identifying hazardous properties. The definitions of the colors and the numbers are as follows:

BLUE - HEALTH HAZARD
4 - DEADLY
3 - EXTREME DANGER
2 - HAZARDOUS
1 - SLIGHTLY HAZARDOUS
0 - NORMAL MATERIAL

RED - FLAMMABILITY
4 - EXTREMELY DANGEROUS
3 - HAZARDOUS
2 - WARNING
1 - MUST BE PREHEATED TO BURN
0 - SHALL NOT BURN

YELLOW - REACTIVITY
4 -EXTREMELY DANGEROUS
3 - DANGEROUS
2 - HAZARDOUS
1 - CAUTION
0 - NORMALLY STABLE

WHITE - SPECIFIC HAZARD
OX OXIDIZER
ACID ACID
ALKALI
CORROSIVE
A. WATER REACTIVE
RADIATION HAZARD

* Manufacturers of hazardous material may use a different labeling system.

b. SNAMHS requires that a proper label be attached to all hazardous materials. Where no label is provided by the manufacturer or the label is unclear, the NFPA labels should be used. In addition, if it is necessary to decant or reconstitute the hazardous chemical into another container, the information from the manufacturers label shall be affixed to the NFPA label and placed on the container. The information necessary to fill out the diamond label is generally provided in the SDS sheets.

c. When necessary, NFPA labels shall be provided with the shipment of hazardous materials by the warehouse. The transfer of information to the individual containers is the responsibility of the

department opening the box.

d. When using cleaning agents in trigger spray bottles, the bottles are to be precisely marked as to what they contain including the products primary and its brand.

8. Any department having hazardous materials must notify the Facility Manager immediately for proper storage to ensure safety of staff members and clients. The following procedures shall be strictly adhered to by those departments:
   a. Hazardous materials must be properly identified and stored in secure areas, in accordance with label instructions.
   b. Store only in an area designated for chemical storage. Items in breakable containers must be stored low to the ground, protected as much as possible from being damaged.
   c. Reactive materials must be segregated. (Example: Ammonia must not be stored next to or above Chlorine).
   d. Custodial rooms and cabinets used by housekeeping personnel for storage of cleaning materials shall remain locked at all times.
   e. Leaving keys in storage room or storage cabinet locks is strictly prohibited.
   f. All chemicals shall be kept and stored in their original containers with product labels legible and intact.

9. CAUTION shall be taken to ensure appropriate usage and handling of Hazardous Materials:
   a. Always follow manufacturer's directions and recommendations when using any cleaning product including the use of body protective apparel.
   b. Keep the quantities to a minimum.
   c. Do not pour out, or otherwise use more than necessary.
   d. Instructions for handling materials located on the SDS must be followed at all times. If you do not know how to handle a particular item or there is no SDS, you must contact your supervisor before proceeding.
   e. Do not mix any cleaning agents together. Some mixtures may produce hazardous gasses or violent reactions. For example: Chlorine bleach mixed with vinegar, toilet bowl cleaner or ammonia shall produce chlorine dioxide, which is extremely toxic. On the other hand, cleaning agents such as disinfectants are rendered useless when mixed with deodorants, detergents and other cleaning agents that have opposite electrical charges.
   f. Cleaning supplies used by housekeeping personnel range from very mild, light-duty cleaners to toxic, heavy-duty compounds and acids. It is the responsibility of each employee to know the type of cleaning agent they are using, its correct use, and what specific items it is used for.
   g. Use only the specific amount and type of cleaner for a particular job. Be aware that excessive quantities or the wrong type of cleaner may cause skin problems, respiratory problems, eye, and

throat irritation, slipping, fires or surface deterioration.

10. Chemical products whether they are classified as industrial, or consumer products may not be transferred from their original containers to other containers without written authorization from the Facility Manager.
    a. Industrial products may not be transferred from their original container to a different container that bears the label or printed information about another product on the container even if the products are the same generically.
    b. When the product in an original manufacturer's container is used up, the container must be discarded and cannot be used for any other purpose unless it is to fill the container back up with the same product.
    c. Products may not be transferred from one container to another or different container that has previously held a different product. For example, mouthwash may not be transferred to a container that previously held shampoo.
    d. The facility provides unlabeled spray bottles for the purpose of making product transfers. These bottles may be obtained through the Supply Department.
    e. *Industrial Products* - If approved in writing by the Facility Manager, the new container into which the chemical product is transferred must be labeled with the trade name of the product, identity of the hazardous chemical(s), the appropriate hazard warning and name of the manufacturer or distributor.
    f. *Consumer Products* - If approved in writing by the Facility Manager, the new container must be labeled with the generic name of the product. Example, Scope mouthwash would be labeled "mouthwash."
    g. If a product is transferred to a portable container and used immediately by the employee making the transfer, no label is required.
    h. Germicidal bleach (Sodium Hypochlorite) is generally designated as a laundry brightener, deodorizer, sanitizer, and disinfectant, and may be transferred from its original container with approval from the Facility Manager and Infection Control Preventionist. Follow manufacturer's labeling for specific use and seek prior authorization from the Infection Control Specialist before application Additionally, the empty bleach container must be triple rinsed and discarded and may not be refilled or adapted for any other use.

E. Hazardous Material Spills: (Refer to Attachment A)

1. In the event of a hazardous substance spill, the following procedures shall be used:
    a. The individual noticing the spill shall isolate the area of the spill and notify his/her supervisor regardless of the quantity involved.
    b. The supervisor shall ensure all necessary measures are taken to

reduce and/or control the amount of spillage. The Supervisor or Department Head shall contact the Facility Maintenance Help Desk during normal business hours (702-486-6069), or the After-Hours Emergency Maintenance Technician immediately (702-574-4036), inform him/her of the *Hazardous Material* Spill, and give the location (See Appendix A). Upon arrival, the Maintenance Technician or Housekeeping Technician shall assess the situation and take the appropriate action.

c. Be prepared, if possible, to give information about the material involved, have the appropriate SDS available for Maintenance and Housekeeping staff and any other agency response personnel.
d. Employees exposed to a hazardous substance shall report to their supervisor for evaluation and any necessary action for further treatment shall be provided.
e. Identify the chemical before attempting to contain or cleanup any hazardous chemical spill.
f. Follow the established procedure provided in the SDS for cleanup of chemical spills or leaks.
g. A Spill Kit shall be readily available in the Housekeeping Department for the purpose of containing and removing a hazardous material spill. The "Spill Kit" shall contain the following items:
    i. Absorbents
    ii. Surgical Masks
    iii. Plastic Bags and Containers
    iv. Head Covers
    v. Nitrile Gloves
    vi. Isolation Gowns
    vii. Goggles
    viii. Impervious Shoe Covers
    ix. Wet-Vac
k. The "Spill Kit" shall be routinely checked to see that all required materials are present and in usable condition.
l. The plumbed eyewash and/or shower stations will be cleaned and tested weekly by the Maintenance Department. Documentation will be kept at specific station sites and with the Maintenance Department (Attachment B).
m. Ensure adequate ventilation of the area if there is no fire present.
n. Evacuate all personnel from the area if necessary.
o. Extinguish all flames if a fire occurs. Set off fire alarm and dial 9-911.
p. Fill out the proper Incident Report form and if a personal injury occurred, complete a C - 1 Employers Compensation form.

2. It is the responsibility of every employee to report spills or other problems to his/her immediate supervisor.
    a. If you have a serious emergency and have to call (911), or the spill extends outside the facility or could reach surface waters, the

Hospital Administrator or designee shall be notified along with the Facility Manager, and they shall immediately call the National Response Center (1-800-424-8802) and give them the information they ask for.

b. Any person who fails to report a hazardous materials incident may be subject to a fine, a jail sentence and the cost of repairing any damage, even if the facility was not the single or main cause of the damage.

c. ***IN ANY SITUATION*** involving a hazardous material, an Incident Report must be filled out and sent to the Hospital Administrator and Quality Improvement within 24 hours by the Department Head.

d. In addition, the Facility Manager or designee must do a follow-up investigation within 24 hours and report at the next Environment of Care Team Meeting.

Disposal of Hazardous Materials and or Waste:

3. For materials in your department that meet the definition of Hazardous Waste, you must notify the Facility Manager for proper disposal. The following procedures shall be strictly adhered to:

a. A complete inventory of all materials considered hazardous or mixed with hazardous materials to be disposed of, is to be provided by the department.

b. Hazardous material must be accurately identified, preferably in original containers.

c. The container must be free of obvious damage, corrosion, deterioration, and not leaking.

d. The Department Head shall notify the Custodial Department, who will pick up and transport the hazardous waste material to the appropriate storage area.

e. The container shall be clearly marked by the Department Head in two (2) places (HAZARDOUS WASTE) and dated.

f. If the container is not full, the quantity must be determined and noted on the container.

g. Hazardous waste must be stored in containers suitable for the type of waste generated, as determined by the Environmental Safety Officer.

h. Hazardous waste MUST NOT be mixed so as to cause a reaction, fire, or leak.

i. DO NOT MIX hazardous waste with non-hazardous materials. This creates a large amount of hazardous waste, since it shall all be classified as hazardous.

j. The Facility Manager or designee(s) shall monitor stored hazardous waste. The storage of hazardous waste must not exceed 180 (one hundred eighty) days or 270 (two hundred seventy) days if the disposal facility is over 200 (two hundred) miles away.

k. Additional requirements are that the hazardous waste generator

must have an EPA identification number if the quantity exceeds 60kg (26 pounds).

l. Storage containers for hazardous wastes shall be inspected weekly for integrity. If any damage or other problems are found, the material must be placed into another container.

4. Transportation of hazardous wastes should be arranged through the Inpatient and Outpatient Safety Officers or the Clinic Site Managers:
   a. Clinic Site Managers shall be responsible for calling the designated waste management facility at least quarterly, or as needed, for waste disposal.
   b. Call the following based on the location of the clinic or Hospital:
      i. Las Vegas Metropolitan Area: Republic Services, (702) 735-5151.
      ii. Laughlin: Republic Services, (1-800) 752-8719
      iii. Mesquite: Virgin Valley Disposal, (702) 346-5396
   c. Individual departments are not to contact haulers or other agencies.
   d. All transport of these materials must comply with the Department of Transportation (DOT) and any other applicable regulations.
   e. Hazardous material shall be properly packaged and identified. Material must be marked (HAZARDOUS WASTE) and dated when the container is first filled. The container content is to be clearly labeled. An SDS sheet is to be attached in a plastic enclosure.
   f. The Purchasing Department or designee shall contact the hauler and designated waste management facility to verify that they have US – EPA identification numbers. Additionally, verify they have the necessary permits and insurance.
   g. A Uniform Hazardous Waste manifest form shall be obtained by the Environmental Safety Officer or designee who shall complete the appropriate section for the material generator.
   h. The waste manifest must be filed and kept on record for 30 years in the Purchasing Department.
   i. Within thirty (30) days of shipping, a signed returned copy of the manifest should arrive from the waste management facility.
   j. If the manifest is not received in thirty days, the Purchasing Department or designee shall follow up and determine the reason.
   k. The file must include a copy of the Purchase Order for the transport and management services.
   l. Liability does not end once the material has been moved from the facility.

F. Chemical Ingestion by Client:
All staff shall know the correct procedure to follow if a client ingests a chemical and shall respond immediately if a client ingests a chemical. This refers to any substance used in a chemical process (includes all cleaning substances).

1. Procedure:

a. Prevent patient from further ingestion, if possible, calling for help as appropriate.
b. Isolate the chemical container.
c. Contact unit nurse or unit manager or call 911 if a nurse cannot be located.
d. Locate appropriate Safety Data Sheet (SDS) to determine appropriate treatment for the ingested chemical.
e. Send a copy of the SDS with the patient if transported to an emergency room.

2. Responsibilities:
   a. Employee Involved: Responsible for isolating area and denying entry.
   b. Department Head: (If spill is identified) responsible for proper clean up and/or management of the spill or release utilizing SDS. Provide list of individuals in area at time of spill/release.
   c. Reporting: Information shall be reported verbally immediately through the chain of command and in writing, per OF-PI-04 SNAMHS Incident and/or Accident Reports.
   d. Facility Manager: Shall be notified if spill cannot be identified.
   e. Employee Health: Shall treat injured parties pursuant to recommendations on SDS.

G. Performance Standards:

1. Performance standards may address staff hazardous materials and waste management knowledge and skill, level of participation in materials and waste management activities, monitoring, inspection and corrective action, and incident / injury report procedures. Full participation is expected for those who handle or come in contact with hazardous material / waste, such as maintenance, housekeeping, nursing, and direct care staff.

2. It is mandatory that staff members report any hazardous material / waste incidents, following guidelines outlined in this policy.

3. SNAMHS has established performance standards that assist hazardous materials and waste programs in safely controlling hazardous materials and wastes in the environment of care, including:
   a. The proper procedures and precautions for selecting, handling, storing using and disposing of hazardous materials and wastes.
   b. The proper emergency procedures during a hazardous materials and waste spill or exposure.
   c. The health hazards associated with mishandling hazardous materials and waste in their departments.
   d SNAMHS processes for reporting hazardous material and waste spills or exposures.

4. Annual Review
   a. The purpose of the annual environmental review is to ensure compliance with this policy and applicable OSHA, State and

Federal rules and regulations.

b. The review is a function of the Environment of Care Team and should be conducted by individuals knowledgeable of this policy and applicable OSHA, State and Federal rules and regulations.

c. This policy shall be reviewed every two (2) years by the Leadership Executive Team and the Environment of Care Team to evaluate objectives, scope, performance, and effectiveness.

5. Performance Improvement Monitoring: Hazardous materials and waste issues are reported and monitored through the Environment of Care Team meetings.

6. Training:

a. New employees shall be oriented to the location and content of the Infection Control policies during orientation.
The SNAMHS Housekeeping and Maintenance orientation and education component pertaining to hazardous materials and waste addresses:

i. The proper precautions in selecting, handling, storing, using, and disposing of hazardous materials and waste for those personnel who manage and/or come into contact with hazardous materials and waste.

ii. The proper emergency procedure during a hazardous material / waste spill / exposure for staff that manages or comes in contact with hazardous materials and waste.

iii. The health hazards associated with mishandling hazardous materials and waste within their departments or services for staff that manages or comes in contact with hazardous materials and waste.

b. Housekeeping staff shall be trained by their supervisor regarding the selecting, handling, storing, using, and disposing of hazardous materials and waste.

c. Direct care staff shall be trained annually in the handling and disposing of hazardous waste by the Nursing Department.

d. Emergency procedures for hazardous material and waste spills or exposure

e. Health hazards of mishandling hazardous materials and waste shall be explained to appropriate staff by the Facility Manager and the Nursing Department.

V. REFERENCES:

A. The Joint Commission; CAMH; Environment of Care (EC); Current edition

B. Occupational Safety and Health Administration Hazard Communication Standard (OSHA) 29CFR 1910.1200

C. Code of Federal Regulations. (Protection of the Environment) 40CFR 261-Identification and Listing of Hazardous Waste

D, Code of Federal Regulations. (Hazardous Material Regulations). HMR; 49 CFR Parts 171-180

E. OF-EC-01 & 02: Safety Plan and Program

F. OF-EC-08: Emergency Codes and Use of PA System

G. OF-PI-04: SNAMHS Incident and/or Accident Reports

VI. ATTACHMENTS:

A. OF-EC-25 Hazardous Materials SDS and Waste Management Attachment A

B. OF-EC-25 Hazardous Materials SDS and Waste Management Attachment B

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY WIDE

SUBJECT: Fire, Emergency and Disaster Plan **NUMBER:** OF-EC-30

EFFECTIVE DATE: 09/2022 **REVIEW DATE:** 09/2024

APPROVED BY: /s/Susan Lynch, MBA, CPM
Hospital Administrator

SUPERSEDES: 103 #2, #3, EOC #9, OF-EOC-30 dated 6/1/00, OF-EOC-35 dated 6/9/02 and OF-EC-30 dated 04/01/05, 12/01/06; 09/09; 12/11; 10/13; 03/14; 05/16; 05/18; 09/18; 09/20

I. PROTOCOL:

SNAMHS maintains a safe environment for employees, volunteers, visitors and clients and responds promptly and effectively to an emergency or disaster situation.

All SNAMHS programs / buildings shall have a fire and emergency evacuation plan that identifies responsibilities of personnel and includes a building diagram with pre-determined evacuation routes clearly identified.

II. PURPOSE:

A. The purpose of this protocol is to ensure proper response by SNAMHS personnel in the event of a fire or other emergency.

B. This protocol is also intended to provide a guideline for the handling of any external / internal disaster occurrences that may require a coordinated emergency response involving Southern Nevada Adult Mental Health Services (SNAMHS), Desert Regional Center (DRC) and Division of Child and Family Services (DCFS).

III. DEFINITION:

A. EMERGENCIES may be natural or man-made and may include (but are not limited to) fire / smoke, bomb threat, thunderstorms, hazardous chemical spills, hostage situations, and environmental issues. Emergency response may be required during either presidential- or gubernatorial-declared disasters.

B. Emergency Management (NRS 414.035) means the preparation for and carrying out of all emergency functions, other than for which military forces are primarily responsible.

C. DISASTER (NRS 414.0335) is an occurrence or threatened occurrence; natural or man-made which in the determination of the governor, the assistance of the Federal

Government is needed. Disaster may significantly disrupt the environment of care, such as damage to the building(s) and grounds due to severe windstorms, thunderstorms, tornadoes, or earthquakes. A disaster also includes events that disrupt care and treatment, such as loss of utilities (power, water, telephones, internet, etc.) due to floods, civil disturbances, accidents, or emergencies within the organization or in the surrounding community.

D. COMMAND CENTER (CC) is the control center for all activity during an emergency or disaster. All requests for additional help or resources shall come through the CC. The CC is in the Administrative Suite including the Training and Conference Rooms in Rawson Neal Hospital. In the event the Administrative Suite is not available, the Hospital Administrator or Designee shall designate an alternate area. The Command Center for DRC is in their Administration Building, and the Command Center for DCFS is in their Administration Building in co-operation with SNAMHS Command Center.

IV. PROCEDURE:

A. General Evacuation plan for fire or other emergency situations. (Also see program / site specific evacuation plans)

1. The decision to evacuate any building / unit preferably shall be made by the Agency Director or Medical Director or their designees. Depending on the urgency of the situation, however, unit physicians, nursing supervisors, or program managers shall assume the responsibility for ordering evacuation while the proper authorities are being advised of the situation. This decision chain applies during the workweek, weekends, and holidays.
2. Medical records, Red Binder and Kardex shall be moved with the clients if possible. Medication carts shall be moved to the Pharmacy, or another location designated by the Command Center, and shall remain under continuous control of a Pharmacist, Physician or Registered Nurse.
3. One person from each hospital unit and department shall be designated as responsible for keeping a record of all clients and personnel, in order to ascertain that all were evacuated and where they are located. That record should be made available to the Command Center as soon as possible so that families might be reassured about the safety and status of family member(s) in the hospital or in outpatient programs.
4. Evacuation by means of stairways is required unless it is specifically determined by the Maintenance Department that use of elevators is safe. Routinely, expect to evacuate downward.

B. Temporary shelter for clients

1. In the event it becomes necessary to evacuate one or more SNAMHS hospital units for safety reasons, alternate temporary shelter shall be determined by the Hospital Administrator or Designee. Patients and staff will be moved laterally to the nearest unit, provided that that unit is safe.

2. The Agency Directors for SNAMHS, DRC, and DCFS shall meet to designate available shelter space for use on an emergency basis.
3. The Hospital Administrator and Safety Officer shall maintain information to ensure it is immediately available to the Command Center for use as needed.

C. The Safety Officer and the Environment of Care Team (EOCT) shall:

1. Ensure the Fire, Emergency and Disaster Plan is reviewed annually and updated as needed.
2. Ensure that all buildings, including off site locations, have a floor plan that identifies evacuation routes.
3. Ensure that all program / department areas have a site-specific emergency evacuation plan.
4. Ensure that fire drills are conducted quarterly, and other emergency management plan drills are conducted at each site annually and biannually at the hospital. Actual activation of an emergency management plan drill may be utilized in lieu of a drill.
5. Ensure that disaster drills are conducted annually.
6. Collect and evaluate information regarding incident / accident, monitoring and training reports.
7. Take corrective action as needed to correct deficits.

D. Maintenance Department shall:

1. Inspect and test the fire alarm systems monthly.
2. Ensure that the contracted vendor inspects the fire detection systems (transmits fire alarm to the local alarm company) monthly.
3. Ensure that the contracted vendor inspects, tests, and maintains all automatic fire-extinguishing systems in accordance with all required periodicities, i.e., quarterly, semi-annual, and annual.
4. Inspect portable fire extinguishers on a monthly basis. A contracted vendor conducts annual servicing.

E. Department Heads shall:

1. Review program / department or site-specific fire and emergency evacuation plans on an annual basis and report to the EOCT any changes made to the previous plan.
2. As part of orientation, provide instruction to all new employees, volunteers and students regarding the fire, emergency and disaster plan procedures as well as any program / department or site-specific evacuation plans.
3. Provide annual training to current employees regarding the fire, emergency and disaster plan procedures as well as any program / department or site-

specific evacuation plans.

4. Ensure that all staff and volunteers are aware of evacuation routes and relocation sites.
5. Ensure employees are trained every two (2) years in fire prevention and use of portable fire extinguishers.
6. Maintain at their workplace and at home a current list of their employees' home telephone numbers.

F. Employees shall:

1. Keep current on his or her function during a fire, emergency or disaster situation and be familiar with the functions of other personnel.
2. Know the location of fire alarm pull stations, portable fire extinguishers, and relocation sites.
3. Report any fire protection deficiency, failure or user error to the Maintenance Department / management personnel.
4. Participate in emergency drills and mock disaster exercises.

V. REFERENCES:

A. Joint Commission; CAMH; Environment of Care-Emergency Preparedness (EC)

B. Quick Reference: Emergency Procedures Flip Chart dated 06/2016

C. Agency policy OF-EC-08 Emergency Codes: Use of PA System

D. Agency Policy OF-EC-35 Life Safety Plan

E. OSHA

F. SNAMHS Emergency Operations Plan (EOP)

G. OF-EM-02 SNAMHS Campus Lockdown

H. DPBH Clinical Services Policy A 4.1 Mail Room and Mail Handling Safety

VI. ATTACHMENTS:

A. OF-EC-30 Fire, Emergency and Disaster Plan Attachment A

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY WIDE

SUBJECT: Management and Care of Medical Equipment **NUMBER:** OF-EC-47

EFFECTIVE DATE: 03/2022 **REVIEW DATE:** 03/2024

APPROVED BY: /s/ Susan Lynch, MBA, CPM
Hospital Administrator

SUPERSEDES: 09/14; 09/16; 11/17; 01/20

I. PROTOCOL:

It is protocol to provide management and care of medical equipment.

II. PURPOSE:

To ensure the medical equipment utilized for patient care services is in working condition**.**

III. DEFINITIONS:

A. Definition of medical equipment includes, but is not limited to the following:

1. Weight scales, thermometers, sphygmomanometers, AED (Automated External Defibrillator), EKG (electrocardiograph machine), stethoscopes, wheelchairs, pulse oximeters, otoscopes, oxygen tanks and suction machines.

IV. PROCEDURES:

A. The agency Supply Department or designee will:

1. Maintain a current list of all medical equipment utilized for patient care services inclusive of the frequency and due dates of required maintenance and/or calibration.
2. Schedule maintenance and/or calibration with the designated state approved vendor.
3. Insure that all AEDs are maintained annually and as per manufacturer recommendation.
    a. The SNAMHS Supply Department group e-mail address is registered with the AED Superstore to automatically receive

manufacturer's notices of recalls and updates. In the event of a recall or update the AEDs will be updated per the manufacturer's recommendations through an approved state vendor.

4. Insure that all in use and stored medical equipment is maintained and calibrated as required annually and as needed. The result of the calibration will be documented and filed in a binder located in the supply department office.
5. Insure that all medical equipment is updated with a sticker or tag documenting the date maintenance and/or calibration was performed.
6. Insure that all patient care equipment is tested for compliance with previously specified minimum safety and/or performance standards before being used for the first time for patient care. The results of this testing will be documented and filed in a binder located in the supply department office.
7. Submit a medical equipment maintenance/calibration annual report to the Director of Nursing and Hospital Administrator, or designee.
8. Communicate timely with the Director of Nursing and Hospital Administrator, or designee regarding the repair or needed replacement of any non-working equipment.

B. Supply Technician, Nursing staff, or designee will:

1. Perform daily, monthly, and annual AED maintenance as per manufacturer recommendation and document on the Daily AED Maintenance Check Log (Attachment A), Monthly AED Maintenance Check Log (Attachment B) and Annual AED Maintenance Check Log (Attachment C).
2. Utilize SDS approved low-level disinfectant wipes to clean all medical equipment in active use daily.
3. Insure the "For Sanitary Reasons" sign is strategically located near the weight scale and insure that footwear is worn during weight scale use. (Attachment D).
4. Remove any non-working medical equipment from active use, label it out of order, and contact supply technician or designee to replace and remove the non-working equipment from the patient care area.

C. Emergency clinical intervention and back-up plan for failure of medical equipment:

1. If the Automated External Defibrillator is unavailable, becomes disabled or is otherwise non-functional, staff will, in accordance with the guidelines established by the American Heart Association, continue with CPR (chest compressions; breaths).

V. REFERENCES:

A. SNAMHS Policy: OF-EC-02 Safety Program
B. SNAMHS Policy: OF-EC-40 Utility Systems Management Plan
C. SNAMHS Policy: OF-SP-03 Infection Control Program Overview
D. SNAMHS Policy: OF-SP-05 Standard Precautions (Universal Precautions)

VI. ATTACHMENTS:

A. OF-EC-47 Management of Medical Equipment Attachment A
B. OF-EC-47 Management of Medical Equipment Attachment B
C. OF-EC-47 Management of Medical Equipment Attachment C
D. OF-EC-47 Management of Medical Equipment Attachment D

Monthly AED Check Log

Month/Year: _____

☐ 1. Open the AED lid

☐ 2. Wait for the AED to indicate status:

- Observe the change of the **Status Indicator** to **RED.**
- After approximately 5 seconds, verify that the **Status Indicator** returns to **GREEN.** Open the AED lid

☐ 3. Check the expiration date on the electrodes _____ *(MM/DD/YYYY)*

☐ 4. Follow the voice prompts

☐ 5. Follow the voice prompts

☐ 6. Close the lid and confirm that **Status Indicator** remains **GREEN.**

☐ 7. If any of the above checks fail contact the SNAMHS supply department immediately.

Checked by: Print full name: _____

Signature: _____

Date: _____ *(MM/DD/YYYY)*

Annual AED Check Log

Month/Year: _____

- ☐ 1. Open the AED lid
- ☐ 2. Remove the pads.
- ☐ 3. Close the lid.
- ☐ 4. Confirm that the **Status Indicator turns** to **RED**.
- ☐ 5. Open the lid and confirm that the **PAD** indicator is lit.
- ☐ 6. Reconnect the pads and close the lid**.**
- ☐ 7. Make sure the expiration date on the pad is visible through the clear window of the lid.
- ☐ 8. Check the expiration date of the pads; if expired, replace them.
    - Note the expiration date: _____ *(MM/DD/YYYY)*
- ☐ 9. Check to make sure the **Status Indicator** is **GREEN.** If the pads are not installed properly, the **PAD** indicator will illuminate; call SNAMHS supply department for assistance.
- ☐ 10. Open the lid and confirm that no diagnostic indicators are lit.
- ☐ 11. Check the pads packaging and integrity.
- ☐ 12. Close the lid.

Checked by: Print full name: _____

Signature: _____

Date: _____ *(MM/DD/YYYY)*

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY WIDE

SUBJECT: Construction Safety and Security **NUMBER:** OF-EC-43

EFFECTIVE DATE: 08/2021 **REVIEW DATE:** 08/2023

APPROVED BY: /s/ Susan Lynch, MBA, CPM
Hospital Administrator

SUPERSEDES: OF-EC-43 dated 11/00; 11/02; 03/05 and OF-EC-12 dated 05/06; 08/09; 03/10; 03/12; 12/13; 12/16; 05/19

I. PROTOCOL:

It shall be the protocol of SNAMHS to ensure the safety, health and security of facilities and clients, staff, and the public therein during construction, repair and/or renovation which may affect safety, security and/or health including potential allergen risks.

No repairs, renovations or construction may occur without the prior written approval of the Facility Manager, Hospital Administrator and/or Agency Director or their designees.

Further, it is the protocol of SNAMHS to ensure that all staff is advised of impacts of any work-related activities prior to commencement of such activities. This protocol extends to all clinic sites whose site managers are the designees of the agency director.

II. PURPOSE:

To ensure all staff are advised of proposed repair, renovation, construction and or potential allergen risks prior to commencement and that staff is involved in the planning of any related adjustments, which will ensure uninterrupted care in a healthy, safe, and secure environment.

III. DEFINITIONS:

A. Emergency Repair: The restoration of failed, malfunctioning, or damaged equipment, systems or facilities to their intended function or design condition. Warrants an immediate response to mitigate threat to life, property, assets, the environment, or security. It could also impact the mission of SNAMHS if not remedied.

B. Repair: The patching, restoration, or painting of materials, elements, equipment, or fixtures for maintaining such materials, elements, equipment, or fixtures in good or sound condition.

C. Renovation: The replacement in kind, strengthening, or upgrading of building elements, materials, equipment, or fixtures, that does not result in a reconfiguration of the building spaces within.

D. Modification: The reconfiguration of any space; the addition, relocation, or elimination of any door or window; the addition or elimination of load-bearing elements; the reconfiguration or extension of any system; or the installation of any additional equipment.

E. Reconstruction: The reconfiguration of a space that affects an exit or a corridor shared by more than one occupant space; or the reconfiguration of a space such that the rehabilitation work area is not permitted to be occupied because existing means of egress and fire protection systems, or their equivalent, are not in place or continuously maintained.

F. Construction: refers to work that creates, composes, or builds a new structure or asset. The structure or asset was previously non-existent, making new construction work different from renovation work.

IV. PROCEDURES:

A. The approved construction, renovation, and repair plan and impact statement shall be forwarded to the Agency Manager for review and approval.
   1. If the Agency Manager r disapproves the plan or impact statement, he/she shall immediately contact the Facility Manager for clarification and further action.

B. As detailed in agency protocol OF-EC-46, prior to initiation of construction, renovation or emergency repair, a short-term program of specific safety guidelines and requirements will be implemented when either Life Safety Code deficiencies or interruptions cannot be immediately corrected or when renovation, construction, or alteration work on SNAMHS buildings or grounds requires that standard safety systems and mechanisms are temporarily disabled.

C. At least three (3) days prior to work commencement, the Facility Manager or designee shall forward a Maintenance / Housekeeping Department Work Notification form (Attachment A) to Supervisors and SNAMHS Department Heads responsible for the area where the work is going to take place.
   1. In the event of an emergency, the Facility Manager shall notify the specific work area supervisor in person and shall notify all involved persons via the public address system. During this public announcement, individuals shall be instructed to contact his/her supervisor immediately if there are special needs.

D. Department supervisors shall ensure all affected staff and/or volunteers on all shifts are notified of the activities, impact, and plans.

1. All affected areas (e.g., hospital unit, building, site office, etc.) shall receive and post a copy of the completed Maintenance / Housekeeping Department Work Notification Form prior to the beginning of the activity.

E. SNAMHS employees requiring special accommodations that will be affected by the repair, renovation, or construction, shall immediately notify his/her supervisor upon receipt of work notification.

F. SNAMHS employees and/or volunteers shall be responsible for notifying their supervisor of their need or desire to not be exposed to potential allergens at least one (1) day prior to the date work is to begin.

G. Supervisors and Department Heads shall be responsible for arranging an alternative work environment for any employee and/or volunteer under their supervision for the period in which the maintenance/repair work will take place.

H. Pest control shall be done monthly in building interiors or more frequently by request.

1. Pest control shall be done weekly along the perimeters of all buildings.

2. The Maintenance Department Work Notification form (Attachment A) will not be distributed for regularly scheduled pest control but will be distributed for all maintenance activity that poses an allergen risk done by special request or on an emergency basis.

I. Any contracted service provider or staff member executing repairs, renovation and/or construction shall be briefed by assigned maintenance staff as to specific procedures regarding security and safety.

J. Maintenance staff or assigned Contract Monitors shall monitor for completion of all repairs, renovations and/or construction.

V. REFERENCES:

A. The Joint Commission; CAMH and CAMBHC; Management of Information (IM), TJC Elements of Performance for Leadership 3.90 – Current edition
B. The Joint Commission Comprehensive Accreditation Manual, Accreditation Requirements, Environment of Care – Current Edition
C. CMS Manual for Psychiatric Hospitals – current edition
D. SNAMHS Interim Life Safety protocol OF-EC-46
E. NAC 449
F. After Hours Emergency Contact Number 702-574-4036
G. NFPA 101 (Current Edition) Life Safety Code

VI. ATTACHMENTS:

A. OF-EC-43 Construction Safety and Security Attachment A

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY WIDE

SUBJECT: Interim Life Safety Plan **NUMBER:** OF-EC-46

EFFECTIVE DATE: 08/2022 **REVIEW DATE:** 08/2024

APPROVED BY: /s/ Susan Lynch, MBA, CPM
Hospital Administrator

SUPERSEDES: 05/13; 01/14; 04/16; 06/18; 08/20

I. PROTOCOL:

SNAMHS maintains a safe environment for employees, volunteers, visitors and clients when either Life Safety Code deficiencies cannot be immediately corrected or as part of planned construction, renovation, or alteration projects that require the temporary disabling of standard safety mechanisms or systems.

II. PURPOSE:

This protocol provides a short-term program of specific safety guidelines and requirements when either Life Safety Code deficiencies or interruptions cannot be immediately corrected or when renovation, construction, alteration work on SNAMHS buildings or grounds requires that standard safety systems and mechanisms are temporarily disabled.

The requirements indicated in this plan will apply to all facility patients, temporary and/or permanent staff including medical staff, construction project staff, temporary or permanent volunteers, and visitors.

This Interim Life Safety Plan may be also implemented in the event existing conditions pose hazards that conflict with the requirements of the NFPA 101 Life Safety Code.

III. DEFINITIONS:

A. External Service Providers and Contractors: Licensed or certified individuals or organizations which provide ongoing or short-term service during construction, renovation or alteration projects.

B. Life Safety Components: Any individual mechanism or system that, when activated or operational, is designed to provide immediate protection to patients, staff, volunteers and others during critical disaster events. Examples include but

are not limited to fire exits, fire doors, the fire alarm system and automatic sprinkler systems.

C. Building Life Safety System: The combination of all individual Life Safety components for a designated building.

D. Pre-Construction Risk Assessment: A comprehensive evaluation of the risks and effects associated with proposed construction, renovation or alteration activities completed and approved prior to the commencement of construction. This assessment documents potential effects on the Building Life Safety System as well as the individual Life Safety components.

E. Interim Life Safety Measures: Specific health and safety procedures that are implemented on a time-limited, non-permanent basis to ensure the ongoing provision of protection to a building's occupants when construction, alteration, or renovation activities are being conducted. Examples can include maps detailing alternate exit signs and pathways to specific egress locations, fire protection systems, fire extinguishers, smoke barriers and fire alarm systems.

F. Deactivations: The process of temporarily disabling a fire protection system or utility service in order to perform required work.

G. Fire Watch: A specific plan used to monitor an area for excessive combustible or flammable material build-up, early detection of fire and identification of potential ignition sources.

H. "Hot Work" permits: Permits that are requested by External Service Providers and Contractors which allow for work activities to be completed in designated buildings or locations and which specifically involve ignition sources (i.e., welding, cutting, soldering, etc). Permits must be obtained before the work starts and shall be posted at the site of work. See BOF standard operating procedure "Hot Work Permitting Procedures."

IV. PROCEDURES:

A. External Service Providers and Contractors shall, prior to construction, coordinate with SNAMHS' Maintenance Facility Supervisor to:

1. Complete an initial "walk-through" ("Pre-Construction Risk Assessment") of designated work areas and identify / plan for any safety issues that may impact on SNAMHS' operations. Examples of items to be evaluated include obstruction of exits and egress, accumulation of debris or materials which could increase the combustible load, effect of ignition sources on the location, etc.

2. Communicate required Interim Life Safety Measures to project personnel and SNAMHS staff before construction, alteration, or renovation activities begin. This includes providing temporary signage, acceptable route changes, and notification of Interim Life Safety Measures to occupants.

3. Perform and document pre-construction and follow up risk assessments for any construction, alteration, or renovation activities.

4. Identify any Interim Life Safety Measures required for approval of a deactivation.

5. Request deactivations as required by the project activities.

6. Provide direction for duration and location of a required fire watch.

7. Ensure appropriate “hot work” permits are issued and available at the site of work.

8. Audit areas with active “hot work” permits and ensure all required safety precautions are being followed.

9. Regularly evaluate construction sites for additional Interim Life Safety Measures which might be required as the construction progresses.

10. Post Interim Life Safety Measures notices in buildings and provide additional training where appropriate.

11. Review and ensure safe and appropriate implementation of all deactivations.

12. Provide notification to SNAMHS employees of all work that may disable Life Safety components or otherwise impact on the Building Life Safety System.

B. The Maintenance Facility Manager will, for all construction, renovation or alteration activities:

1. Maintain documentation of all permits, contracts, assessments and identified project events.

2. Maintain documentation for all deactivations. Information will include, at the minimum, time, date, and person requesting deactivation.

3. Coordinate staff to implement fire watches when a fire watch has been mandated.

4. Monitor all fire protection system alarms.

5. In the event of an alarm:
   a. Verify the source of the alarm.
   b. Verify the location of the event causing the alarm.
   c. Contact the appropriate fire department if not completed already.

6. Notify the appropriate, respective fire department when a Life Safety feature is disabled for more than four (4) hours during a twenty-four (24) hour period in an occupied building.

7. Ensure that all communication and needed documentation (including permits) with External Service Providers and Contractors has been completed and available.

8. Review and record required daily Interim Life Safety Measures reports from External Service Providers and Contractors.

C. External Service Providers and Contractors shall be exclusively responsible to:

1. Ensure persons performing work implement and maintain the required Interim Life Safety Measures procedures and inspections or suspend work until life safety code measure can be maintained.
2. Respond to the Maintenance Facility Supervisor when contacted about fire alarm signals, fire watches, and other items as appropriate.
3. Submit required daily Interim Life Safety Measures reports to the Maintenance Facility Supervisor.
4. Notify the Maintenance Facility Supervisor to suspend work if the fire watch cannot be maintained to include system deactivation.
5. Post completed Interim Life Safety Measures at the main entrance at the construction site with evidence of daily inspection.
6. Audit Interim Life Safety Measures daily reports on an ongoing basis.

D. The Pre-Construction Risk Assessment will:

1. Be completed before all construction, renovation, or alteration activities which may adversely affect the Life Safety components of a building or adversely affect building occupants (e.g. noise, vibration, other environmental effects) begins.
2. Be completed every time a building's fire suppression or detection system is expected to be out of service for any duration during a twenty-four (24) hour period for a planned outage.
3. Be completed any time there is significant compromise of one or more Life Safety components of a building.
4. Determine which Interim Life Safety Measures are required for an area.
5. Outline the necessary steps to be taken for the person performing work to comply with the requirements set during the risk assessment.
6. Be posted at the work site in order to validate required Interim Life Safety Measures are being implemented.

E. Interim Life Safety Measures: Are identified and applied as required by the Pre-Construction Risk Assessment (any duration) and may include, but are not limited to the following:

1. Education of building occupants on construction activities affecting their work area.
2. Daily surveillance to ensure unobstructed exits.
3. Daily surveillance to ensure emergency forces access.

4. Daily surveillance to ensure that the appropriate type and quantities of fire suppression devices are on hand.
5. Assurance that dust partitions are constructed as "smoke tight" and of non-combustible or limited combustible materials (i.e., drywall, fire resistant plywood, or metal partitions).
6. Storage and housekeeping practices which require the prompt removal of accumulations of combustible flammable debris and supplies.
7. Compliance with "hot work" practices.
8. Monthly testing of temporary fire alarm, detection, and suppression systems (projects of more than one (1) month duration).
9. Fire exit drills conducted twice quarterly (projects of more than one (1) month duration)—these may be "table-top" educational drills.
10. Scheduling work to minimize impact to occupants.
11. Any other appropriate measures as determined by External Service Providers and Contractors.

F. Fire Watch and Fire Department Notification:

1. Shall be required when any of the following systems have been impaired for more than the maximum allowable time:
    a. The fire alarm system (four hours).
    b. Automatic Sprinkler system (ten hours).
2. A Fire Watch shall survey the construction area and will:
    a. Follow the established surveillance schedule.
    b. Survey every room in the affected area for:
        i. Excessive build-up of combustibles (e.g., trash).
        ii. Potential ignition sources.
        iii. Improper work practices which may result in a fire.

G. Specific criteria used to evaluate construction deficiencies or potential hazards and to determine when and to what extent risk of safety may occur related to a particular construction project, phase of construction, or deficiency may include but not be limited to construction activities that:

1. Alter or compromise integrity of exit access, exit or exit discharge features.
2. Significantly compromise integrity of the building's features such as fire barriers, smoke barriers, floor slabs, corridor walls, etc.
3. Impairment of the building's fire alarm, fire detection or fire suppression systems.
4. Involvement of temporary sources of ignition such as cutting, welding, and plumber's torch operations.
5. Presence of large quantities of combustible materials and debris.

V. REFERENCES:

A. Joint Commission CAMH for Hospitals Life Safety (LS) Standard LS.01.02.01 EP 2

B. Agency policy OF-EC-30 Fire, Emergency and Disaster Plan

C. Agency Policy OF-EC-01 Safety Plan

D. Agency Policy OF-EC-35 Life Safety Management Plan

VI. ATTACHMENTS: N/A

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY WIDE

SUBJECT: Health and Safety Inspections **NUMBER:** OF-EC-04

EFFECTIVE DATE: 02/2023 **REVIEW DATE:** 02/2025

APPROVED BY: /s/Susan Lynch, MBA, CPM
Hospital Administrator

SUPERSEDES: OF-EC-04 dated 06/09/00; 02/01/02; 04/09/06; 11/06; 11/08; 03/09; 05/12; 01/14; 02/15; 02/17; 09/18; 12/20

I. PROTOCOL:

It is the protocol of SNAMHS to continuously monitor the Environment of Care (EOC) to ensure the highest level of safety on SNAMHS facilities.

II. PURPOSE:

To establish rigorous health and safety inspections in SNAMHS facilities to ensure the highest level of safety for SNAMHS patients, staff and visitors. Each employee of the organization performs a dedicated and critical role in ensuring patient and employee safety. All employees are responsible for monitoring the environment and patient care systems for actual and potential safety hazards and are responsible for bringing those concerns to the Patient Safety Officer or the Safety Committee.

III. DEFINITIONS:

A. EOC shall mean Environment of Care.

IV. PROCEDURE:

A. Supervisory Personnel and Managers: Supervisors and managers shall ensure that all personnel under their direction obtain and maintain knowledge and awareness of their functions relating to health and safety and the inspections conducted by the Environment of Care Team.

B. Staff are responsible to review the content of this policy and all attachments. To assist in providing knowledge and familiarity of health and safety inspections, supervisors and managers shall review the content of this policy with their personnel on as appropriate. Further, supervisors and managers shall insure it is easily available to personnel for review at their convenience.

C. Non-Supervisory Personnel: Every employee, volunteer worker, student trainee and contracted agency personnel has an individual responsibility to keep current on his or her particular function and to be familiar with the functions of other personnel relating to health and safety inspection procedures.

D. Procedures relating to health and safety inspections are comprised of (3) three components as follows:

1. Staff cooperation, Functions and Responsibilities
2. Inspections
3. Inspection results

E. Staff Cooperation, Functions and Responsibilities

1. Staff of the facility shall be familiar with the components of the Environmental Health and Safety Inspection Checklist. This is necessary to keep the work environment in a safe condition.
2. All staff are responsible to correct, or report to be corrected, any safety issue they find throughout their work period.
3. Safety hazards should be corrected or reported for correction as soon as the hazard is recognized.
4. Staff, if unable to correct the hazard themselves, must report the hazard immediately to the Maintenance Department/Safety Officer or Patient Safety Officer via telephone and work order.

F. Facility Inspection

1. A facility risk assessment shall be conducted at least annually.
2. A health and safety inspection shall be conducted at least monthly and more frequently if needed or directed.
3. The facility risk assessment and the monthly health and safety inspections inspection shall be conducted by the Safety Officer, Patient Safety Officer, Infection Control Preventionist, Nursing representative, Housekeeping Supervisor, and member(s) of the EOC Team or designee(s).
4. The inspection team shall utilize the Environmental Health and Safety Inspection Checklist.
5. Building staff shall cooperate with all aspects of this inspection including any corrective action needed upon receipt of Notice of Noncompliance (see Attachment B).

G. Inspection Results

1. After the risk assessment and health and safety inspections, the inspection results shall be forwarded to the EOC Recording Secretary for review by the Environment of Care Committee and to the Patient Safety Officers.

2. If immediate action is required, the Safety Officer will initiate that action and the report will be submitted to the EOC committee.
3. These results shall be reviewed, and hazards reported. Reported hazards must be corrected in a timely manner.
4. The results will also be discussed in the next monthly EOC Team meeting.

V. REFERENCES:

A. The Joint Commission Standards CAMH, CAMBHC and CAMLAB; Chapter of Environment of Care (EC)

B. OSHA

VI. ATTACHMENTS:

A. OF-EC-04 Health and Safety Inspections Attachment A

B. OF-EC-04 Health and Safety Inspections Attachment B

CHECKLIST FOR ENVIRONMENT OF CARE ROUNDS

ENVIRONMENT OF CARE/LIFE SAFETY

UNIT CLEANLINESS	YES	NO	COMMENTS
Hallways are free of clutter			
Floors, walls, nursing station counters clean and free of clutter			
Patient and staff bathrooms are well cleaned, including sinks, toilets, and showers. Paper products and soap are well-stocked			
Staff monitors patients during rounds and telephone use. Phones have no anchor points or other safety hazards.			
Floor finish and edges are in good condition. Flooring has no loose tiles or carpet imperfections			
Paints and wall coverings are in good repair			
Lighting fixtures are all in good repair and operational			
Unit ceiling tiles are intact with no evidence of roof or plumbing leaks			
Nursing unit sinks and areas under the sinks are drip free, no evidence of plumbing leaks, molds, stains or damage, and is clear of supplies and other items			
Unit trash bins are not full, uncluttered and padlocked.			
Air vents, televisions, and furniture are clean and properly dusted			
Fire doors are intact, unobstructed, and releases freely			
All exits are marked, illuminated, and unobstructed			
Sprinklers have no dust build-up, paint overspray, rust or corrosion, verdigris observed			

CHECKLIST FOR ENVIRONMENT OF CARE ROUNDS

ENVIRONMENT OF CARE/LIFE SAFETY

UNIT CLEANLINESS	YES	NO	COMMENTS
Fire evacuation maps are properly placed and are updated to reflect egress limitations			
All fire extinguishers are inspected monthly and annually with dates of inspection, and services are current			
Access to fire alarm annunciation panel, pull stations, override switches, and fire extinguishers are unobstructed			
Means of egress (hallways) unobstructed			
All electrical panels, outlets, switches, and cords are covered correctly and in working order			
Power strips approved for use are not piggybacked.			
SDS binder is current			
Eye wash solutions are not expired			
Patient care equipment has inspection and preventive maintenance stickers indicating last inspection date and name of inspector			
Handwashing and disinfecting products are available			
Patient food refrigerators are clean and in proper working order			
Staff are disinfecting drinking fountains and patient telephones			
Laundry rooms are kept locked when not in use or are monitored by staff when in use.			
All staff displays an authorized photo identification card			
Staff assigned to the board are observed conducting rounds			

CHECKLIST FOR ENVIRONMENT OF CARE ROUNDS

ENVIRONMENT OF CARE/LIFE SAFETY

MEDICATION ROOMS	YES	NO	COMMENTS
Medication room is locked, and only authorized staff have access			
No open single use vials			
Open multi-use vials, medications, or solutions, are dated and expiration dates documented			
Expired meds, meds for pharmacy return, discharge meds, and patient's own medications are managed and stored properly			
No expired medications or supplies noted			
Counters are clean, clutter free, and nothing stored on floor			
Look-alike, sound-alike form posted			
Do not use abbreviations form posted			
Sharps container not full			
No pre-drawn syringes or medications			
Ice machines are clean and in proper working order			
Crash cart is clean, neat, and locked			
Crash cart inspection checklist completed, no expired medications or supplies, and is fully stocked.			
Medication cabinet is clean, and medications stored properly.			
Refrigerator temperature is within 36-46 degrees, temperature checks are completed and logged.			
Has adequate stock of PPE			

CHECKLIST FOR ENVIRONMENT OF CARE ROUNDS

ENVIRONMENT OF CARE/LIFE SAFETY

MEDICATION CARTS			
All doors/drawers locked when not in use			
Pill crushers/splitters are clean			
All opened multi-dose vials, medications, or solutions are dated and the expiration dates are documented			
Medication cart is clean and clutter free			
No pre-drawn syringes or medications			
PATIENT ROOMS			
Patient rooms are clean and uncluttered			
No medications, food, snacks or unlabeled items at bedside			
No extra linens or supplies around the room			
No attachment points on furniture parts or doors, all screws are tamper-resistant			
Mounted fixture such as sprinkler heads/ventilation covers have no attachment points that can be used for self-harm			
Light fixtures securely mounted with tamper resistant screws and has non-breakable lenses, all are working			
Mattress is clean, no rips, holes or offensive odors.			
Furniture, paint and wall coverings are in good repair, flooring has no loose tiles			
Ceiling intact with no evidence of roof or plumbing leaks, sprinkler head is clean.			

CHECKLIST FOR ENVIRONMENT OF CARE ROUNDS

ENVIRONMENT OF CARE/LIFE SAFETY

PATIENT BATHROOMS			
Light fixtures securely mounted with tamper resistant screws and has non-breakable lenses, all are working			
No medications, food, snacks or unlabeled items			
Mounted fixture such as sprinkler heads/ventilation covers have no attachment points that can be used for self-harm			
Ceiling intact with no evidence of roof or plumbing leaks, sprinkler head is clean.			
Toilet paper holders free of all anchor points			
Sinks securely mounted to the wall, plumbing fixtures concealed and secured.			
Shower curtains will tear away if a load of 5 pound or more is applied			
HOUSEKEEPING CLOSET			
Clean and clutter free and locked at all times			
Chemicals properly labeled and clean			
Chemical spill kit present			
All items on top of the shelf are at least 18 inches below the sprinkler head			
CLEAN UTILITY ROOM			
All shelves and cart for clean supplies are covered			
Clean utility door closed/locked			

CHECKLIST FOR ENVIRONMENT OF CARE ROUNDS

ENVIRONMENT OF CARE/LIFE SAFETY

CLEAN UTILITY ROOM			
The room is clean and clutter free, no boxes on floor			
No dirty supplies stored in clean utility room			
Clean linens are properly stored			
SOILED UTILITY ROOM			
No clean items are stored in soiled utility room			
Clean and clutter free, no boxes on floor, nothing stored under the sink			
Storage bins are not blocking the exit doors			
Sinks are drip free, clean, and no evidence of plumbing issue. Drains are not clogged			
Garbage, and hazardous waste receptacles are labeled, covered, and not overflowing			
Soiled linens are properly stored			
Specimen refrigerators are identified with a biohazard label			
Specimen refrigerator temperature checks are completed and documented on log.			
LACTATION ROOM/INFECTION CONTROL OFFICE			
The room is clean, clutter free, and no boxes on the floor			
Nothing stored under sink			
Ceiling tiles intact with no evidence of roof or plumbing leaks			
Furniture, paint and wall coverings are in good repair, flooring has no loose tiles			

Lactation room refrigerator is clean and in proper working order, Refrigerator temperature is within 36-46 degrees			
All electrical panels, outlets, switches, and cords are covered correctly and in working order, has no gaps or broken panels			
Appliance are plugged directly to the wall and not on power strips or extension cords			
STAFF OFFICES			
Doors are not wedged open with unapproved devices			
All items on top of the shelves are at least 18 inches below the sprinkler head			
All appliances have been inspected, approved for use, labeled and plugged directly to the wall.			
Appliances are not plugged to a power strip or extension cord			
Portable space heaters are tagged, has a built-in tip-over protection and high temperature limiting features			
No boxes on the floor and office is clean and uncluttered.			
Wall decorations are kept to a minimum and paper hangings are placed in a sheet protector			

Completed by:

Site/building:

Date completed:

SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES

Monthly Environment of Care and Life Safety Report (OF-EC-04)

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY WIDE

SUBJECT: Storage of Oxygen Tanks **NUMBER:** OF-EC-05

EFFECTIVE DATE: 08/2021 **REVIEW DATE:** 08/2023

APPROVED BY: /s/ Susan Lynch, MBA, CPM
Hospital Administrator

SUPERSEDES: OF-EC-05 dated 03/02; 04/06; 01/09; 07/11; 01/14; 01/18; 06/19

I. PROTOCOL:

SNAMHS ensures that the use, storage, transport, and maintenance of oxygen tanks are in compliance with state and federal regulations.

II. PURPOSE:

The purpose of this protocol is to ensure that individuals are informed of the presence of oxygen tanks and adhere to oxygen tank storage regulations.

III. DEFINITIONS: N/A

IV. PROCEDURES:

A. Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases or oxygen are used or stored and in any other hazardous location.
   1. All areas in which oxygen tanks are stored shall indicate oxygen storage and have a “NO SMOKING NO OPEN FLAMES” sign posted on the door.
   2. Employees may not store oxygen tanks in unmarked areas.
   3. Any oxygen tank that is empty, empty (with gauge) 500 psi or less, or partially full (without gauge) would be considered empty and must be separated from other oxygen tanks and marked individually as empty. (If there is a rack or cart designated for empty, the cart or rack could be labeled as the designation for the empty tanks.
   4. Full and partially full (with gauge, and 501 psi or greater) cylinders not yet depleted are permitted to be stored together.
   5. The total allowable amount of 300 cubic feet
   6. Oxygen tanks will be secured, always labeled and/or mounted on authorized carts.

7. Operating instructions shall be maintained at the site of oxygen tank storage.

B. If an oxygen tank must be used or temporarily located in an unmarked area, employees are to post the attached "NO SMOKING NO OPEN FLAMES" (Attachment A) sign on the compartment/room door.

1. Should a SNAMHS employee observe that an oxygen tank is present, and the employee is not able to locate an approved sign, he/she shall notify his/her supervisor immediately.

2. The supervisor shall take necessary steps to post the approved sign. Signs are available as an attachment to SNAMHS policy manuals and/or from maintenance staff.

V. REFERENCES:

A. National Fire Protection Association (NFPA) 99-2012, 11.6.5.2 and 11.6.5.3
B. Occupational Safety & Health Administration (OSHA) Standard 1910.104

VI. ATTACHMENTS:

A. OF-EC-05 Storage of Oxygen Tanks Attachment A

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: HOSPITAL WIDE

SUBJECT: Inpatient Facilities Life Safety Drawings **NUMBER:** OF-EC-48

EFFECTIVE DATE: 12/2021 **REVIEW DATE:** 12/2023

APPROVED BY: /s/ Susan Lynch, MBA, CPM
Hospital Administrator

SUPERSEDES: 02/15; 02/19; 11/19

I. PROTOCOL:

Southern Nevada Adult Mental Health Services (SNAMHS) maintains life safety drawings (maps) of the SNAMHS Inpatient Facilities.

II. PURPOSE:

To identify and maintain SNAMHS Life Safety Drawings to establish locations of essential inpatient building components.

III. DEFINITIONS: N/A

IV. PROCEDURES:

A. Develop and maintain Life Safety Drawings to comply with federal and state statutes.

B. Review and update the Life Safety Drawings at least annually and as needed based on capital improvements.

C. At a minimum, the following components will be included on the Life Safety Drawings.
   1. Fire Wall and Fire Door Locations and Ratings
   2. Designated Smoke Compartments
   3. Hazardous Storage Area locations

V. REFERENCES:

A. The Joint Commission Comprehensive Accreditation Manual; Accreditation Requirements, Environment of Care, current edition.

VI. ATTACHMENTS:

A. OF-EC-48 Inpatient Facilities Life Safety Drawings Attachment A Fire Emergency Map Rawson Neal

B. OF-EC-48 Inpatient Facilities Life Safety Drawings Attachment B Life Safety Map Rawson Neal

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY WIDE

SUBJECT: Civil Security Camera System **NUMBER:** OF-EC-53

EFFECTIVE DATE: 06/2021 **NEXT REVIEW DATE:** 06/2023

APPROVED BY: /s/ Susan Lynch, MBA, CPM
Hospital Administrator

SUPERSEDES: 06/19

I. PROTOCOL:

To increase safety and security of Clients and Staff, video camera technology will be used.

II. PURPOSE:

This protocol provides guidance regarding the use of video camera technology in certain clinical areas.

III. DEFINITIONS: N/A

IV. PROCEDURE:

A. Video Camera technology will be used to monitor common areas, including observation and seclusion rooms, day rooms, corridors and hallways, visiting rooms, and/or group rooms.

B. The use of video camera technology is not meant to supplant client supervision, rather it is intended to supplement and enhance safety and well-being for clients and staff.

C. The use of video camera technology records images for security and administrative purposes.

D. The use of video camera records will be used for educational purposes for training and improved performance for staff providing direct care to clients.

E. These recordings may be used to investigate abuse or neglect of clients and may be;
   1. preserved for investigative purposes;
   2. used to report to law enforcement agencies; and
   3. preserved in the incident report file.

F. Video camera system technology is not to be placed in individual rooms (except those designated for special observation), bathrooms, or shower areas.

G. The video camera technology includes a recording feature with archival capacity.
   1. Video is automatically retained for up to 14 days. This provides the opportunity to review images after a reportable incident, if/when a complaint is made, and/or for other clinical and administrative purposes, including training and quality improvement.

2. Copies of records from the archived data may be made and stored separately when authorized or when litigation or any other legal or disciplinary action is anticipated, pending, or ongoing.

H. Access to video recordings will be limited to designated staff members.

I. Authorized staff members will have the capability to pull recordings upon request.
   1. Other staff are prohibited from tampering with or disabling video camera system technology unless the staff member has been granted access by the Agency Manager.
   2. Any staff not assigned responsibility for maintaining the video camera system technology that is caught tampering with and/or disabling the video camera system may be disciplined, up to and including termination.

J. Access to viewing video camera system technology is limited to DPBH Deputy Administrator, Hospital Administrator, Agency Director, and authorized staff.
   1. Anyone requesting review of or access to video camera system records must obtain authorization from the DPBH Clinical Services Deputy Administrator and/or Agency Manager.
   2. Requests must be made in writing.

K. Videos involving incidents of the following events will be retained until all related incidents or investigations are closed: escape and allegations of patient abuse/neglect by a staff member.
   1. An Incident Report must be completed in these situations.
   2. An email will be sent, in addition to the incident report, to the authorized staff requesting video be saved for any of these incidents or others when video could be beneficial.

L. Video recordings and incident reports will not be referenced in Avatar documentation and/or included in a patient chart.

M. Video recordings are considered to contain confidential information and are not to be viewed or shared with clients or staff members.

N. Staff that are within range of the video camera system have no expectation of privacy regarding any of their activities that are recorded.

O. All images and records may be used in investigations and/or complaints and with respect to disciplinary action.

P. Video recordings may be shared with law enforcement with approval from the Hospital Administrator. Additionally, a subpoena may be requested prior to sharing with law enforcement.

V. REFERENCES:

A. SP 4.08 Civil Security Camera System

VI. ATTACHMENTS: N/A

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY WIDE

SUBJECT: Campus Lock Down **NUMBER:** OF-EM-02

EFFECTIVE DATE: 07/2021 **NEXT REVIEW DATE:** 07/2023

APPROVED BY: /s/Susan Lynch, MBA, CPM
Hospital Administrator/SNAMHS Appointing Authority

SUPERSEDES: New; 10/16; 08/17; 08/19; 09/19; 04/20; 12/20

I. PROTOCL:

SNAMHS will provide a safe environment for staff, consumers, and visitors by responding promptly and effectively to any incident or threat.

II. PURPOSE:

To reduce the risk of injury or danger to staff, consumers, and visitors by minimizing accessibility to campus during an internal or external threat or incident.

III. DEFINITIONS:

Lockdown: a procedure which is initiated to secure the campus against any internal or external threat or incident and to provide for the safety and welfare of consumers, staff and the public; to protect state property; to maintain or restore order on campus.

Incidents that may require a lockdown include a bomb threat, threats of harm to employees or clients, person(s) armed with firearm or weapon on campus property, gunshots directed at or near campus, police incidents involving dangerous person(s) on or adjacent to campus, intruders, hazardous chemical spills, gas leaks, electrical conditions, disasters close to campus. These examples are not absolute or all-inclusive but reflects the type of situation that may require a lockdown.

Threat: any expression by any individual(s) of an intention to harm, inflict pain, or injury against any consumer, staff, or the facility.

IV. PROCEDURE:

A. Any SNAMHS employee who receives, hears, or observes a threat should notify their Supervisor immediately.
B. If the employee receives the information via telephone call, they will:
    1. Listen carefully for any background noises, such as music, voices, crying baby, motors running, church bells, aircraft or any other noises which might give even a remote clue as to the origin of the call.
    2. Note any distinguishing characteristics of the caller's voice, such as sex, speech impediments, lisps, accents, dialects, or slurs. Try to determine the approximate age and the attitude of the caller. Try to determine if the caller is intoxicated.
    3. Note if the caller indicates any knowledge of the facility by descriptions of locations and names of buildings.

C. Voice-to-voice notification will be made by staff who first becomes aware of the incident to immediate supervisor responsible for the unit. The supervisor will then communicate through their chain of command to the next administrative level to include the SNAMHS Safety Officer

    1. The Hospital Administrator or designee will make the decision for a campus lockdown, possibly with input from the local law enforcement or fire department or similar community agencies.
    2. If the Hospital Administrator/designee or Safety Officer/designee is not available, and a decision must be made immediately, the Nursing Shift Supervisor or designee will decide to provide for the immediate safety of consumers and staff.
    3. At the direction of the Hospital Administrator or designee, a code 3 (three) will be announced.
    4. The Hospital Administrator or designee will notify DPBH Administration (OF-EM-04 Emergency Notification) through their chain of command to the next administrative level.
    5. 5.4. The Hospital Administrator or designee will send an alert to employees via Everbridge Communicator advising them of a threat on campus, by contacting the Public Health Preparedness Program Contact. Employees who are "off-site" at the time of the threat should not return to campus unless specifically directed to do so or an "all clear" is posted.
    6. All doors and windows in each building will be closed and locked and blinds pulled closed if possible. One designated means of egress as designated by the Agency Administrator or designee will remain unlocked.
    7. Office doors will be closed, and hallway traffic minimized.
    8. The campus lockdown will be announced through an overhead page in every building affected, group paging system and an e-mail sent to everyone at SNAMHS. A location will be given as appropriate and if available. If possible, signage will be placed on entry doors that indicate "Lockdown", "Code 3", or "Do Not Enter".

9. If a building search is warranted, some police will stay with staff at the building exits while the remainder will accompany the Hospital Administrator and/or Safety Officer on a tour of the SNAMHS buildings and grounds.
10. Outpatient Services will secure doors and ask consumers to remain inside. Consumers wishing to leave will be advised of the threat and directed to an exit the furthest away from the threat.
11. If indicated, the Facility Safety Officer or designee will notify staff if they need to begin preparations for evacuation.
12. The "all clear" will be given by the Hospital Administrator or designee.
13. The Facility Safety Officer will submit an After-Action Report and conduct a debriefing post event to evaluate strengths and weaknesses identified during the event.

V. REFERENCES:

A. NN-EC-12
B. OF-EM-04 Emergency Notification Protocol
C. OF-EC-08 Emergency Codes: Use of Public Announcement System
D. Employee Code Card

VI. ATTACHMENTS: N/A

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: AGENCY WIDE

SUBJECT: Life Safety Management Plan **NUMBER:** OF-EM-35

EFFECTIVE DATE: 09/2021 **REVIEW DATE:** 09/2023

APPROVED BY: /s/ Susan Lynch, MBA, CPM
Hospital Administrator

SUPERSEDES: 06/00; 06/02; 09/06; 05/08; 06/10; 12/10; 05/12; 06/13; 01/14; 03/15; 09/16; 05 07/17; 05/19; 09/20

I. PROTOCOL:

It is the protocol of Southern Nevada Adult Mental Health Services (SNAMHS) to provide safe and proper care coupled with a nurturing environment. This plan provides a safe and supportive physical environment free of fire, smoke and other hazards and dangers. This plan addresses fire/life issues concerning all buildings, grounds, clients, staff, and visitors.

II. PURPOSE:

A. SNAMHS Fire Prevention Procedure is designed to establish common, effective procedures on Fire and Fire Prevention within all agency-owned buildings and leased site offices.

B. The Life Safety Management Plan is designed to establish common, effective procedures on fire and fire prevention to be utilized. The purpose is to provide a fire-safe environment of care to protect clients, personnel, visitors, and property.

III. DEFINITIONS:

A. *Charge Nurse* shall mean Psychiatric Nurse (PN) IV or III, or the most senior nurse currently working in each work shift.
B. *Code Red* shall mean a fire emergency announcement.
C. *Code Green* shall mean "All Clear," indicating that an emergency code called prior has ended.
D. *Hospital* and *Inpatient Hospital* shall mean the Rawson-Neal Psychiatric Hospital.
E. *MHT* shall mean mental health technician.
F. *Senior Administrator on duty* shall be designated by the following on-duty officers in descending order:
    1. SNAMHS Administrator
    2. Medical Director

3. Outpatient Administrator
4. Director of Nursing II
5. Director of Nursing I
6. Clinic Site Director
7. Hospital Nursing (House) Supervisor
8. Community Services Director

G. Sites, and site offices shall mean as of the effective date of this policy the:
   1. Administrative offices and maintenance service buildings, which include:
      a. 1321 S. Jones site office containing the Human Resources Training, and Payroll departments
      b. West Charleston Campus Buildings 1, 2, 3, 4, 5, 6, and 6A
      c. 1650 Community College Dr., Rawson Neal Hospital
   2. Urban outpatient clinics in the Las Vegas metropolitan area, which include:
      a. East Las Vegas
      b. West Charleston Campus Buildings 1 & 2
   3. Southern Rural Outpatient Clinics, which are located:
      a. Laughlin
      b. Mesquite

IV. PROCEDURES:

A. STAFF RESPONSIBILITIES

1. For all sites:
   a. Department Heads and Supervisors shall ensure that all personnel under their direction obtain and maintain a thorough knowledge of their functions relating to fire and fire prevention procedures.
   b. Department heads and supervisors shall complete the following on the first working day of staff's employment and minimum annually thereafter:
      i. Review contents of this policy and staff's responsibility to locate the policy for future reference (SNAMHS Policy/Procedure Folder on Server)
      ii. Provide orientation on the first working day on the following:

      iii. The nearest fire extinguisher(s)
      iv. The evacuation route from their work area
      v. The designated evacuation meeting area
      vi. A mode of communication for drills specific to each work site
      vii. If applicable, the public-address system, the fire annunciator system, and the fire alarm pull station
      viii. In addition to orientation, departments and supervisors shall ensure that employees are proficient in handling fire

emergency procedures which includes training via the following methods at minimum:
(i) SNAMHS Annual Training Exam Packet
(ii) Fire Extinguisher Training (refresher required every two (2) years)
(iii) Annual site-specific disaster drills

c. Non-supervisory personnel: Every SNAMHS employee, volunteer worker, student trainee and contracted agency personnel has an individual responsibility to keep current on his/her function and to be familiar with the functions of other personnel relating to fire and fire prevention procedures.

d. Annually, the local fire department will inspect the leased or agency-owned structures to ensure buildings are maintained in accordance with current NFPA's (National Fire Protection Association) Life Safety Code®. Deficiencies are to be reported to the Business Office and corrective action is completed by the Maintenance Department.

e. Inspecting, testing, and maintenance of fire protection systems.
   i. If there is an installed fire protection system (i.e., a system with fire sprinklers, and/or fire alarm control panel), staff will ensure they are in working order, and that any problems will be addressed to Maintenance and/or the leased building owner.

f. Any fire protection deficiency, failure, or user error is to be immediately reported to the Maintenance Department. The staff member reporting the incident will follow the instructions of the Maintenance Department until the staff member is relieved of duty.

2. For Rawson-Neal Psychiatric Inpatient Hospital:

a. In addition to the life safety responsibilities applicable for all sites, supervisors and department heads stationed at the Rawson-Neal Psychiatric Hospital are responsible for these following items for staff also working at the hospital:
   i. Providing a key (PS3) to be used for fire pull stations and cabinets containing fire annunciator panels.
   ii. Providing orientation on the first working day to hospital staff on the following:
   iii. The nearest fire pull station to workstation and how to use the system
   iv. The nearest fire extinguisher and how to access if in lock box
   v. The nearest electromagnetic lock override system (as applicable) to include location of master door key (MDK) and how to use the system's override and reset functions.
   vi. The public-address system and fire annunciator system

b. The charge nurse for each shift in each hospital unit on duty and department head or designee of Community Services,

Administration, Allied Therapies, Laboratory, HIS and Pharmacy assumes the duties of Fire Monitor. In this capacity, the Fire Monitor is responsible for the following:

i. Each time a fire (real or drill) occurs, the charge nurse and department head/designee (as applicable) shall ensure a Monthly Safety Report (OF-EC-35 Attachment C) is completed and submitted to the Patient Safety Officer by the 5th day of the following month.

ii. The Patient Safety Officer will track to ensure all drills are received for each shift quarterly and forwarded to the Facility Manager or designee.

iii. Put into effect procedures for combating an actual fire.

B. MAINTENANCE RESPONSIBILITIES

1. Duties for all sites:

a. Develop, implement, and revise SNAMHS life safety policies that comply with federal and state statutes.

b. Conduct quarterly fire protection system inspections of SNAMHS facilities to ensure compliance with all applicable fire codes.

c. Conduct monthly fire alarm communicator testing to ensure signal transmission and receipt by central monitoring contracted vendor.

d. Conduct semi-annual hardware testing to ensure functionality of audible and visual signaling devices and proper operation of electromagnetically controlled doors.

e. Inspection, testing, and maintenance of fire protection systems will also be conducted annually by a contracted vendor to ensure the reliability of the device and monitored for compliance by the Maintenance Department.

f. Coordinate, with the Environment of Care Committee and the Patient Safety Officer to prepare and distribute completed fire-related activity reports.

g. Coordinate fire related activities with local, state, and other fire regulatory agencies.

h. Inspect portable fire extinguishers monthly. A contracted vendor will perform detailed annual servicing/inspections of fire extinguishers.

i. Ensure that the contracted vendor inspects the fire detection systems and tests transmission of fire alarm to the local alarm company monthly.

j. Ensure that the contracted vendor inspects, tests, and maintains all automatic fire sprinkler systems annually.

2. 24-Hour Fire Watch for Rawson-Neal Psychiatric Hospital

a. Three positions have been dedicated within the maintenance department for the sole purpose of conducting a 24-hour fire watch, for both the fire alarm systems and fire sprinkler systems. Staff occupying these positions has been fully trained on the

procedures of the 24-hour fire watch including but not limited to: fire extinguisher procedures, procedures for reporting an emergency, evacuation procedures, knowledge of the building and the various rooms contained within the building, and fire awareness and recognition of obvious hazards. The three dedicated staff positions are the Facility Manager I, Maintenance Repair Worker III, and Maintenance Repair Specialist I.

b. Conduct a fire watch when the fire alarm and/or sprinkler system is temporarily shut down or inoperable more than 4 hours for reasons including maintenance, periodic inspection, renovation, or demolition work. The areas that are affected by the shutdown or inoperable system will be covered until the system has been repaired, tested, and placed back into service.

c. Fire watch will consist of a minimum of two (2) hour physical rounds/on-site inspections of the affected areas in and/or around the perimeter of the building by qualified staff in order to detect any signs of smoke, fire or any other life safety hazards including any areas without fire protection. These inspections will be documented on the 24-hour fire watch log form (see Attachment L) until the system is fully operational. A fire protection system impairment notice will be posted at the affected area(s) and will be removed once the fire watch has been discontinued.

d. The 24-hour fire-watch log will be maintained and filed in the Maintenance Department's office. The fire log will include but not limited to the following: date of the fire watch, building involved in the fire watch, time fire watch began, time that the hourly check of each area was conducted, record and emergencies or other significant incidents, the date and time the fire watch ended, the total length of the fire watch and the signature of the staff performing the fire watch.

e. The Facility Supervisor must notify the Administrator or designee, the local fire department, and the Bureau of Health Care Quality and Compliance (BHCQC) when a fire watch has been initiated and again upon its completion.

3. Testing Frequency

a. Testing of emergency back-up equipment will be completed in accordance with the Environment of Care and Life Safety Check list (Attachment J).

C. **RAWSON-NEAL PSYCHIATRIC HOSPITAL**

In addition to the duties applicable for all sites:

Conduct fire drills once per quarter, per shift, and per building. Drills will include simulations in which individuals must evacuate to different smoke compartments and drills in which individuals must evacuate to the community.

a. Ensure that evacuation routes from each area of the hospital are posted in each corridor leading to the exterior.
b. Submit quarterly fire drill reports to the Environment of Care Committee for review.

D. COMPLIANCE AND REPORTING

1. All issues regarding fire/life safety are included in the Security Management Plan (OF-EC-20) and the Utility Systems Management Plan (OF-EM-05.
2. Life Safety Code Compliance: SNAMHS currently complies with all life safety codes. Construction decisions and code compliance is the responsibility of the Public Works Division for the State of Nevada.
3. Interim Life Safety Measures: In the event of new construction interim life safety measures will be enforced from project to completion.
4. Fire/Life Safety Issues Reports: Any staff noting noncompliance with fire plans, policies or procedures should report immediately to the EOC committee, supervisor/department head, security, facility manager, and site director.
5. PI Monitoring: Fire/life safety issues are reported at regularly scheduled Environment of Care Team meetings.
6. Safety Checklist, Rawson Neal: Maintenance and Performance Improvement will conduct quarterly fire safety checklists at the Rawson-Neal Psychiatric Hospital
7. Information, Collection, Evaluation: Information collected and evaluation regarding fire/life safety include but is not limited to:
   a. Injury/Incident Report
   b. Monthly Safety Reports
   c. Quarterly Environmental Health and Safety Report (OF-EC-04, Attachment A)
   d. Rawson-Neal Quarterly Fire Safety Checklist
   e. Related information/matrixes, monitoring activities
   f. Fire / life safety training
8. Performance Standards: Performance standards may address staff fire / life safety knowledge and skill level of participation in fire/life safety activities. It may also address monitoring, inspection, corrective action, use of space, replenishment of supplies, and management of staff, preventative maintenance, and testing of applicable equipment.
9. Evaluation: The Fire/Life Safety Program is evaluated annually including related reports, PI monitoring activities, and aggregate of incident/injury.
10. The facility manager or designee will be responsible for maintaining documentation of compliance with all items in the Environment of Care and Life Safety Check list (Attachment J).

V. REFERENCES:

A. The Joint Commission Comprehensive Accreditation Manual; Accreditation Requirements, Environment of Care (current Edition)
B. National Fire Protection Association (NFPA) Current Edition *Life Safety Code*
C. Nursing Procedure V-02 Fire Alarm / Evacuation of Patients
D. SNAMHS POLICY OF-EC-04: Health and Safety Inspections
E. SNAMHS POLICY OF-EC-08: Emergency Codes
F. SNAMHS POLICY OF-EC-20: Security Management Plan, Building Security State Property Control, and Trespass
G. SNAMHS POLICY OF-EC-40: Utility Systems Management Plan

VI. ATTACHMENTS:

A. OF-EM-35 Life Safety Management Plan - Attachment A - Inpatient Evacuation and Fire Drill Procedures
B. OF-EM-35 Life Safety Management Plan - Attachment B - Admin & Site Offices Evacuation & Fire Drill Proc
C. OF-EM-35 Life Safety Management Plan - Attachment C - Inpatient Quarterly Safety Report
D. OF-EM-35 Life Safety Management Plan - Attachment D - Outpatient Quarterly Safety Report
E. OF-EM-35 Life Safety Management Plan - Attachment E - 24-Hour Fire Watch Map
F. OF-EM-35 Life Safety Management Plan - Attachment F - Fire Compartment Evacuation Map
G. OF-EM-35 Life Safety Management Plan - Attachment G - Override Switch Locations
H. OF-EM-35 Life Safety Management Plan - Attachment H - Rawson-Neal Quarterly Fire Safety Checklist
I. OF-EM-35 Life Safety Management Plan - Attachment I - 911 Emergency
J. OF-EM-35 Life Safety Management Plan Life Safety Check List Attachment J
K. OF-EM-35 Life Safety Management Plan Rawson Neal Fire Drill Matrix Attachment K
L. OF-EM-35 Life Safety Management Plan - Attachment L- Fire Watch Checklist and Log
M. OF-EM-35 Life Safety Management Plan - Attachment M Out of Service Sign

Month: (The month the checklist is pertaining to)	
Date Completed: (The completion date of the entire report)	

RAWSON NEAL EXTERIOR DOORS

A1	A2	A3	A4	A6	B2	B5	B6	C1	C4	C5	C8	B20	D12	E2	F2	F5	G12	H2		
Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/A ☐	Y ☐ N ☐ N/a ☐	Y ☐ N ☐ N/A ☐		

Additional Comments:		

Follow up actions taken for areas identified with "NO":

Date:_____

Follow up actions taken:

RAWSON NEAL OVERRIDE SYSTEM RANDOM CHECK (MINIMUM 1 STAFF PER UNIT)

Unit A&B Override	Unit C Override	Unit D Override	Unit E Override	Unit F Override	Unit G Override	Unit H Override	Date Completed:	Completed By:
Y☐N☐N/A☐	Y☐N☐N/A ☐	Y☐N☐N/A☐	Y☐N☐N/A☐	Y☐N☐N/A☐	Y☐N☐N/A☐	Y☐N☐N/A☐		

Additional Comments:

Follow up actions taken for areas identified with "NO":

Date:________________

Follow up actions taken:

RAWSON NEAL STAFF PS3 KEY RANDOM CHECK (MINIMUM 4 STAFF PER UNIT)								
Unit A	Unit B	Unit C	Unit D	Unit E	Unit F	Unit G	Unit H	Date Completed:
Y☐N☐N/A☐ Y☐N☐N/A☐ Y☐N☐N/A☐ Y☐N☐N/A☐	Y☐N☐N/A☐ Y☐N☐N/A☐ Y☐N☐N/A☐ Y☐N☐N/A☐	Y☐N☐N/A☐ Y☐N☐N/A☐ Y☐N☐N/A☐ Y☐N☐N/A☐	Y☐N☐N/A☐ Y☐N☐N/A☐ Y☐N☐N/A☐ Y☐N☐N/A☐	Y☐N☐N/A☐ Y☐N☐N/A☐ Y☐N☐N/A☐ Y☐N☐N/A☐	Y☐N☐N/A☐ Y☐N☐N/A☐ Y☐N☐N/A☐ Y☐N☐N/A☐	Y☐N☐N/A☐ Y☐N☐N/A☐ Y☐N☐N/A☐ Y☐N☐N/A☐	Y☐N☐N/A☐ Y☐N☐N/A☐ Y☐N☐N/A☐ Y☐N☐N/A☐	 Completed By:

Additional Comments:

Follow up actions taken for areas identified with "NO":

Date:________________

Follow up actions taken:

RAWSON NEAL FIRE PULL STATION LOCATION RANDOM CHECK (MINIMUM 1 STAFF PER UNIT)								
Unit A	Unit B	Unit C	Unit D	Unit E	Unit F	Unit G	Unit H	Date Completed:
Y☐N☐N/A☐	Y☐N☐N/A☐	Y☐N☐N/A☐	Y☐N☐N/A☐	Y☐N☐N/A☐	Y☐N☐N/A☐	Y☐N☐N/A☐	Y☐N☐N/A☐	 Completed By:

Additional Comments:
Follow up actions taken for areas identified with “NO”:
Date:________________ **Follow up actions taken:**

RAWSON NEAL FIRE EXTINGUISHER LOCATION RANDOM CHECK (MINIMUM 1 STAFF PER UNIT)								
Unit A	Unit B	Unit C	Unit D	Unit E	Unit F	Unit G	Unit H	Date Completed:
Y☐N☐N/A☐	Y☐N☐N/A☐	Y☐N☐N/A☐	Y☐N☐N/A☐	Y☐N☐N/A☐	Y☐N☐N/A☐	Y☐N☐N/A☐	Y☐N☐N/A☐	Completed By:

Additional Comments:
Follow up actions taken for areas identified with “NO”:
Date:________________ **Follow up actions taken:**

RAWSON NEAL STAFF IDENTIFICATION BADGE RANDOM CHECK (MINIMUM 4 STAFF PER UNIT)								
Unit A	Unit B	Unit C	Unit D	Unit E	Unit F	Unit G	Unit H	Date Completed:
Y☐N☐N/A☐ Y☐N☐N/A☐ Y☐N☐N/A☐ Y☐N☐N/A☐	Y☐N☐N/A☐ Y☐N☐N/A☐ Y☐N☐N/A☐ Y☐N☐N/A☐	Y☐N☐N/A☐ Y☐N☐N/A☐ Y☐N☐N/A☐ Y☐N☐N/A☐	Y☐N☐N/A☐ Y☐N☐N/A☐ Y☐N☐N/A☐ Y☐N☐N/A☐	Y☐N☐N/A☐ Y☐N☐N/A☐ Y☐N☐N/A☐ Y☐N☐N/A☐	Y☐N☐N/A☐ Y☐N☐N/A☐ Y☐N☐N/A☐ Y☐N☐N/A☐	Y☐N☐N/A☐ Y☐N☐N/A☐ Y☐N☐N/A☐ Y☐N☐N/A☐	Y☐N☐N/A☐ Y☐N☐N/A☐ Y☐N☐N/A☐ Y☐N☐N/A☐	Completed By:

Additional Comments:

Follow up actions taken for areas identified with "NO":
Date:_____ **Follow up actions taken:**

Signature of staff completing form: _____

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
SCOPE: NURSING DEPARTMENT

SUBJECT: Emergency Cart **NUMBER:** III-02

EFFECTIVE DATE: 06/22 **NEXT REVIEW DATE:** 06/24

APPROVED BY: /s/ Earl Farinas, RN
Director of Nursing II

SUPERSEDES: 4/13, 6/15, 7/15, 10/15, 11/17, 7/18, 1/19, 1/20, 3/21,6/21, 7/21

I. PURPOSE:

To delineate the location, contents, methods of use, procedures, and steps involved in delivering emergency services (CPR/AED and choking) to Southern Nevada Adult Mental Health Services – Inpatient Units.

Healthcare Provider CPR training is required every two years for all clinical and direct care staff.

II. DEFINITION:

Emergency Cart - The emergency cart is a wheeled cabinet that contains the resuscitation equipment that is medically reasonably needed to deliver emergency services (CPR/AED and choking) while awaiting the arrival of emergency medical response teams.

III. PROCEDURE:

A. Cart Locations:

1. Emergency carts are located in the medication rooms on every unit.

2. The nursing staff is responsible for ensuring that carts are kept in their designated locations.

B. Checking the Cart:

1. The night shift nurse will check the cart's contents weekly at a minimum using the Emergency Cart Checklist and re-stock as needed. In addition, the night shift nurse checks the operation of equipment, i.e., AED, including the expiration pads. Notify the Supply department of any needed replacement, as necessary.

2. Cart supplies can be obtained through the Supply Department.

3. The carts will be cleaned every Wednesday by the night shift nurse.

4. The Emergency Cart Check List shall be forwarded to the Nursing Department for retention after completion.

C. Cart Contents:

1. The cart will contain reasonably needed supplies for CPR/AED and other emergency supplies listed on the emergency cart checklist (see attached A).

2. Each cart will be uniform, with the same supplies kept in the same place on the cart.

3. AED's are located on all units. They can be found on all units on the emergency cart.

4. Refer to the Emergency Cart Check List for a complete listing of supplies and content of the cart.

D. When Cart is Used:

1. The supplies used will be re-stocked.

IV. REFERENCES: N/A

V. ATTACHMENT:

A. III-02 Emergency Cart Checklist Attachment A

EMERGENCY CART CHECK LIST

SUPPLY DESCRIPTION	QUAN	EXPIRATION DATE IF APPLICABLE	PRESENT AND WORKING	PRESENT AND WORKING	PRESENT AND WORKING	PRESENT AND WORKING
ABD Pad	1					
Ace Bandage, 2 inch	2	N/A				
AED w/1pk of pads	1					
Aspirin 81 mg chewable	10					
Blood Pressure Cuff	1	N/A				
Cardiac Board	1	N/A				
CPR Rescue Barriers	4	N/A				
Disposable Bag-Mask Resuscitator	1	N/A				
Disposable razor	1	N/A				
EpiPen	2					
Eye Patch	2					
Extension Cord	1	N/A				
Flashlight	1	N/A				
Gauze 4” x 4”	12					
Glucagon Emergency kit	1					
Kerlix Roll	2					
Laerdal Pocket Mouth-to-Mouth Resuscitator	1	N/A				
Narcan (Nasal Spray)	1					
Nitrostat 0.4 mg	1					
Oral Airway	3	N/A				
Oxygen Mask with Connecting Tube	2					
Oxygen Nasal Cannula	3					
Oxygen Tank	1	N/A				
Oxygen Tank On-Off Valve	1	N/A				
Oxygen Wrench	1	N/A				
Paper Tape	2	N/A				
Pull tab locks	2-10	N/A				
Pulse Oximeter	1	N/A				
Rescue Tool	1	N/A				
Scissors and alcohol wipes (in plastic bag)	1					
Sterile Gloves, Medium and Large	1 ea					
Stethoscope	1	N/A				
Suction Connecting Tube, 6 feet	2					
Suction Machine	1	N/A				
Yankauer Suction Tube	3					
The night shift nurse checks, re-stocks and cleans the cart weekly (at a minimum). Completed check lists are to be forwarded to the Nurse Manager of each pod for retention.			Signature _____ Date _____	Signature _____ Date _____	Signature _____ Date _____	Signature _____ Date _____

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
SOUTHERN NEVADA ADULT MENTAL HEALTH SERVICES
INPATIENT NURSING

SUBJECT: Refrigerators and Freezers **NUMBER:** VII-06

EFFECTIVE DATE: 06/2021 **NEXT REVIEW DATE:** 06/23

APPROVED BY: /s/ Earl Farinas, RN, Director of Nursing II

SUPERSEDES: 12/2003, 02/2015, 10/2015, 12/2016,01/19, 01/20, 4/21

I. PURPOSE:

a. To ensure medications, specimens and food are never co-mingled in a single refrigerator and/or freezer.

b. To ensure all refrigerators and freezers are cleaned and sanitized.

c. To ensure the temperatures of all refrigerators and freezers kept in an acceptable temperature range.

d. To ensure the integrity of all medications, specimens and food stored in refrigerators and freezers.

II. SPECIAL INSTRUCTIONS:

A. Patient/client food or beverages, staff food or beverages, medications and/or specimens cannot be co-mingled in a single refrigerator or freezer. A separate refrigerator freezer must be designated.

B. Designated medication refrigerators are for patient/client medications only. The medication refrigerator will be marked clearly by a sign posted clearly on the door (attachment E).

C. Designated specimen refrigerators are for specimens only. The specimen refrigerator will be marked clearly by a sign posted on the door (attachment D).

D. Designated refrigerators freezers for patient/client food and beverages are for patient/client food and beverages only. The patient/client refrigerator will be marked clearly by a sign posted on the door (attachment C).

E. Designated staff refrigerators are for staff food and beverage items only. The staff refrigerator will be marked clearly by a sign (attachment A).

F. The acceptable temperature range for patient/client food or beverages, staff food or beverages refrigerators is 41 degrees Fahrenheit or less.

G. The acceptable temperature range for freezers must be 5 degrees Fahrenheit or cooler.

III. PROCEDURE:

A. INPATIENT SERVICES:

1. The medication nurse on all three shifts is responsible for checking and documenting the temperature of the medication refrigerator, as well as the cleanliness of the refrigerator.

2. Documentation of the medication refrigerator temperature will be entered on the Medical Equipment Inventory and Narcotic Check Sheet (attachment B). The sheet is kept in the Narcotic Count Book and is to be completed at the time of the shift narcotic count.

- The refrigerator used for the storage of medications shall have its temperature maintained between 36- and 46-degrees F. The temperature of the refrigerator shall be checked at each shift change and recorded on the Refrigerator Temperature Log.
    a. If the refrigerator temperature is out of range, adjust the thermostat and move the medication to the nearest medication refrigerator.
    b. Medication may be returned to that refrigerator when the temperature returns to “in range” parameters.
    c. If the temperature does not return to “in range” parameters notify Pharmacy for a STAT repair.

3. The night shift nurse will be responsible for cleaning the medication refrigerator on an as needed basis (attachment E).

4. The night shift charge nurse or designee is responsible for checking and documenting the temperature of the specimen refrigerator. The biohazard temperature should range 35.6 to 46.4 F. The temperatures will be documented on the Temperature Log (attachment D). The logs are to be kept on the outside of the refrigerator doors and the temperature documented nightly. The night shift charge nurse or designee is responsible for cleaning the specimen refrigerators every Sunday. If the refrigerator temperature is not within the acceptable range the Maintenance Department will be notified immediately. A maintenance work order request is completed and submitted for completion of repairs.

5. The night shift charge nurse or designee is responsible for checking and documenting the temperature of the patient/client refrigerator and freezer. The temperatures will be documented on the Temperature Log (attachment C). The logs are to be kept on the outside of the refrigerator doors and the temperature documented nightly. The night shift nurse or designee is responsible for cleaning patient/client refrigerators every Sunday. If the refrigerator temperature is not within the acceptable range the Maintenance Department will be notified immediately. A maintenance work order request is completed and submitted for completion of repairs.

6. The night shift charge nurse or designee is responsible for checking and documenting the temperature of the staff refrigerator` and freezer. The temperatures will be documented on the Temperature Log (attachment A). The night shift is responsible for cleaning the staff refrigerators each week on Sunday night using mild soap and water. Every Sunday night the staff refrigerators will be emptied with all food items being discarded. Personal staff refrigerator must have a sign on it clearly stating staff only (attachment F).)

7. Completed Temperature Logs for refrigerators are to be sent by the AA, to each Unit Manager or designee of that assigned unit no later than the 5th of the following month. The AA will also place a new log each month on the outside of the refrigerator door. The Unit Manager or designee will forward the completed refrigerator logs to the Infection Control Department.

8. The Infection Control will review the logs and keep on file for the Joint Commission review period of three years. Any discrepancies will be reported to the Pharmacy, Maintenance, and or Director of Nursing.

9. If there is a problem with the client/patient Medication Refrigerator or thermometer, the pharmacy should be contacted before maintenance, and the pharmacy can determine if maintenance needs to be contacted.

10. Staff will notify the Maintenance Department if there are any problems with the operation of the Client/patient refrigerators or freezers. A Maintenance work order request is completed and submitted for completion of repairs.

IV. REFERENCE:

A. FDA Food Code 3-501.16

B. NRS 439.200, 446.940

C. NAC 639.527

D. NAC 446.178

V. ATTACHMENTS:

A. VII-06 Attachment A Refrigerator Temperature and Cleaning Staff Break Room

B. VII-06 Refigerators and Freezers Medical Equipment and Narcotocs Inventory Check Sheet Attachment B

C. VII-06 Attachment C Client Refrig. Sign and Temp Log

D. VII-06 Attachment D BIO SIGN and Temp Log

E. VII-06 Refrigerator Temperature and Cleaning Medication Room Attachment E

F. VII-06 Attachment F Staff Personal Refrigerator Sign

STAFF REFRIGERATOR ONLY

Refrigerator Temperature and Cleaning Log

Unit: ____ Month: _____ Year: _____

DATE	REF. TEMP. (°F)	FREEZER TEMP. (°F)	TEMPS. WITHIN RANGE (Y/N)	REF. CLEAN (Y/N)	ACTION TAKEN (Ex. Maintenance notified, Work order requested, Cleaned ref., or N/A)	CHARGE NURSE/DESIGNEE (Print Name)

STAFF BREAK ROOM REFRIGERATOR CLEANING LOG (EVERY SUNDAY)	Date: Signature:	Date: Signature:
	Date: Signature:	Date: Signature:

Please notify Maintenance if refrigerator temperature is above 41 °F OR freezer temperature is above 5°F.

UNIT MANAGER (NAME/SIGNATURE): _____ DATE REVIEWED: _____

CLIENTS REFRIGERATOR ONLY

Refrigerator Temperature and Cleaning Log

Unit: ____ Month: _____ Year: _____

DATE	REF. TEMP. (°F)	FREEZER TEMP. (°F)	TEMPS. WITHIN RANGE (Y/N)	REF. CLEAN (Y/N)	ACTION TAKEN (Ex. Maintenance notified, Work order requested, Cleaned ref., or N/A)	CHARGE NURSE/DESIGNEE (Print Name)

CLIENTS REFRIGERATOR CLEANING LOG (EVERY SUNDAY)	Date: Signature:	Date: Signature:
	Date: Signature:	Date: Signature:

Please notify Maintenance if refrigerator temperature is above 41 °F OR freezer temperature is above 5°F.

UNIT MANAGER (NAME/SIGNATURE): _____ DATE REVIEWED: _____

BIOHAZARD REFRIGERATOR ONLY

Refrigerator Temperature and Cleaning Log

Unit: ____ Month: _____ Year: _____

DATE	REF. TEMP. (°F)	TEMP. WITHIN RANGE (Y/N)	REF. CLEAN (Y/N)	ACTION TAKEN (Ex. Maintenance notified, Work order requested, Cleaned ref., or N/A)	CHARGE NURSE/DESIGNEE (Print Name)

BIOHAZARD REFRIGERATOR CLEANING LOG (EVERY SUNDAY)	**Date:** **Signature:**	**Date:** **Signature:**
	Date: **Signature:**	**Date:** **Signature:**

Please notify Maintenance if refrigerator temperature is not between 35.6 to 46.4 °F.

UNIT MANAGER (NAME/SIGNATURE): _____ DATE REVIEWED: _____