

Kaiser Permanente Hospital North Sacramento Resident Training Manual



KAISER PERMANENTE®



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HOUSESTAFF ORIENTATION GUIDE TO KAISER SACRAMENTO

Welcome to the Kaiser Foundation Hospital, Sacramento. This guide is designed to orient housestaff from UCDMC rotating as interns or residents at the Kaiser Permanente Medical Centers on Morse Avenue. Please refer to the housestaff manual available at housestaff offices at UCDMC for general policies applicable to all rotations. This manual will emphasize those policies that differ at Kaiser Hospitals. The goal of your rotation at Kaiser Permanente is to help you develop the skills, attitude, and knowledge to become a better physician. We hope that your experience here fosters a life-long process of self-directed learning.

THE SYSTEM

Kaiser Permanente is America's leading integrated health care organization. Founded in 1945, it is a nonprofit health plan with headquarters in Oakland, California. Kaiser Permanente serves the health care needs of about eight million members in nine states and Washington, D.C. There are about 3.5 million members in Northern California.

Kaiser Permanente encompasses Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals, and the Permanente Medical Groups, one in each region, and it has an affiliation with Group Health Cooperative based in Seattle, Washington.

Kaiser Permanente aspires to be the world leader in improving health through high-quality, affordable, integrated health care. We are distinguished by our strong social purpose, physician responsibility for clinical care, and enduring cooperation between our health plan and our medical groups.

Kaiser Permanente is a pre-paid health plan with over 600,000 members in the Sacramento area. As a pre-paid health

plan, all members or their employers have paid a monthly premium that entitles them (sometimes with deductibles or co-insurance charges) to most health care needs that they may have. The staff physicians at Kaiser are full-time employees of The Permanente Medical Group. All medicine subspecialties are represented.

The 320-bed North Kaiser Hospital is on Morse Avenue and serves most Kaiser patients in this area. Many of the clinics are located adjacent to the hospital.

Other clinics, containing offices for adult medicine, women's health, ophthalmology, pediatrics, dermatology, and several other departments are located at the Point West Medical Office Building near Cal Expo. Our Downtown Commons Medical Offices (DOCO) located on J Street in Sacramento, has a pharmacy, adult & family medicine, adult psychiatry, behavior health education, child psychiatry, endurance lab, eye services, health education, infusion center, lab, oncology/hematology, pediatrics, physical therapy, radiology, sports medicine, vision, and women's health.

There are clinics in Davis, Folsom, Rancho Cordova and the Fair Oaks Medical Office Building on Fair Oaks Boulevard between Howe and Fulton.

Also, there are three medical offices in or near Roseville, one on Eureka Road, one on Riverside Avenue and one in Lincoln. The hospital in Roseville is located at 1600 Eureka Rd, Roseville, CA 95661.

South Kaiser Hospital is located at 6600 Bruceville Rd, Sacramento, CA 95823.

Occasionally, non-Kaiser patients will be hospitalized at Kaiser hospitals when they present to our ER and their condition does not allow transfer to another hospital.

THE PATIENTS

Part of the uniqueness of working at Kaiser Permanente is our broad range of patients. Sacramento is one of the most culturally and socioeconomically diverse areas in Northern California. This offers a wide range of disease processes and learning opportunities while caring for patients.

GRADUATE MEDICAL EDUCATION OFFICE

The Director of Graduate Medical Education for KP North Valley is Dr. Hillary Campbell, MD, MPH, Contact Information: Hillary.Z.Campbell@kp.org office 916-497-2917. Frances Higoy 916-973-6961 & Monica E Fierro 916-973-6950 are the coordinators.

MEDICAL RECORDS

You are responsible for completing your patient's medical records.

An incomplete record is a record that has not been completed by the physician upon a patient's discharge.

A delinquent record is a record that remains incomplete 14 days after the patient was discharged.

Section 70751(g) of Title 22, California Code of Regulations requires that "medical records be completed promptly and authenticated or signed by a physician, dentist, or podiatrist within two weeks following the patient's discharge."

According to the California Attorney General: "Failure or refusal by a physician to complete or maintain hospital patient records when requested to do so by the hospital constitutes unprofessional conduct under the State Medical Practice Act" (Section. 58, Attorney General, 894-1975).

According to the Medical Staff Rules and Regulations, medical records must be completed within 14 days after the patient's discharge. A resident is not penalized (i.e., suspended) if records are unavailable for completion.

Residents are required to check their KPHC inbox daily for available incomplete or delinquent records. If records are available, residents are required to complete them immediately. Failure to complete available records on a daily basis will start the suspension process, meaning you will be suspended within 14 days for failure to complete incomplete or delinquent medical records.

If you do not fulfill your obligation regarding medical records, recommendation for appropriate disciplinary action will be submitted to the Residency Director at University of California, Davis.

It is your responsibility to complete all available incomplete and delinquent medical records prior to extended vacation, planned sick leave, sabbatical, leave of absence or completion of residency.

If there are available incomplete/delinquent records, they must be completed at the end of your rotation, you will be required to return to the Kaiser Permanente Sacramento to complete these records if dictations or written notes are incomplete. Kaiser Permanente is continuously monitoring your activity in our electronic medical record, Health Connect. Kaiser Permanente will take action if used inappropriately .

WHAT SHOULD BE INCLUDED IN THE MEDICAL RECORDS: A Medical Legal Perspective

Good documentation is important for providing better patient care. Also, it is useful for prevention and defense of a lawsuit by showing the thoroughness of the evaluation and care provided. Principles of documentation include clear and accurate expression, not blaming others, not wrongly admitting fault, not altering records, or using them for obviously defensive purposes, etc. The physician should include only the information necessary for good patient care and which, incidentally, provides the appropriate evidence in the event of litigation. Everything else should be omitted.

The best documentation, from the standpoint of good patient care and of legal defensibility, is concise. Excessive commentary in the records tends to cause the most important information to be lost and discourages other health professionals from taking the time necessary to read it. It also provides a plaintiff's attorney with many more possibilities for misconstruing the meaning of the statements made, finding language which can be interpreted as suggesting fault, or simply confusing the facts that could help defend the case.

The content of any telephone call to or from a family member, which includes information relevant to patient care, should be briefly documented. Clinical judgment must be used to identify those calls that are significant enough to require documentation. Telephone conversations with consultants provide information about patient care, which can show thought processes and can support clinical decisions. Conversations to and from other persons involved in the patient's care, such as, nurses, pharmacists, and therapists also frequently contain significant information, which may be necessary for the defense of a lawsuit.

A discussion with patient and family is the most effective way to convey informed consent information and must be briefly documented in the records. Noting the details of the discussion are not necessary unless there are special factors which affect the risks and require a different or more elaborate than usual disclosure.

Failure to follow instructions given to the patient at the time of discharge from the clinic or hospital is a frequent cause of injury. If the patient denies that adequate discharge instructions were given, the patient's negligence can become the practitioner's liability. Documentation of the types of instructions given may be proof that the patient's conduct was negligent. Harm may result when patients fail to heed warnings such as medication side effects, the importance of follow-up symptoms requiring immediate intervention, serious risks of contraindicated activities, etc. The practitioner's duty is to warn of the seriousness and urgency of foreseeable risks. That this warning was given must be documented.

Objective and factual statements, without criticizing anyone or attacking their competence, should be used to correct errors in the records. An example of an objective correction is: "the previously noted patient history of myocardial infarction should be changed. The patient was hospitalized with chest pain, but no cardiac etiology was confirmed."

Errors must be distinguished from disagreements. Patient's records should not be used as a forum for disagreeing about diagnosis or choice of treatment.

“DO NOT USE” Abbreviation List

Sacramento/Roseville Do Not Use Abbreviation List

Our facility is taking another step in our commitment to patient safety. Many organizations including the Institute for Safe Medical Practice (ISMP) and JCAHO suggest avoiding abbreviations and dose expressions that have led to serious medication errors.

Please help us in this commitment by changing your practice to avoid potentially dangerous abbreviations. Help us eliminate the risk of harming a patient.

Abbreviation/Expression	Intended Meaning	Misinterpretation	Correction
U or u	unit	May be read as a zero (0) or a four (4), causing a 10-fold overdose or greater (4U seen as "40" or 4u seen as "44").	"Unit" has no acceptable abbreviation. Use "unit".
IU	international unit	May be misread as IV (intravenous).	Use "international units."
QD	Once daily	May be misread as OD.	Use "once daily"
QOD	Once every other day	May be misread as OD or QID.	Use "once every other day"
Trailing zero: Zero after decimal point (1.0)	1 mg	May be misread as 10 mg if the decimal point is not seen.	Do not use terminal zeros for doses expressed in whole numbers.
Lack of a leading zero: No zero before decimal dose (.5 mg)	0.5 mg	May be misread as 5 mg.	Always use zero before a decimal when the dose is less than a whole unit.
MS	Morphine sulfate	May be misread as Magnesium sulfate	Always use "morphine"
M _{SO} 4	Morphine sulfate	May be misread as Magnesium sulfate	Always use "morphine"
MgSO ₄	Magnes. Sulfate	May be misread as Morphine sulfate	Always use "magnesium"

- **SMART PRESCRIBING TIPS:**

1. Write legibly.
2. Date, Time and Sign all orders
3. Do not write frequency range orders.
4. All "PRN" orders must be qualified.

Report all Adverse Drug Reactions to the **ADR HOTLINE** at **8-426-3636**.

Report all Med Safety Issues to the **Med Safety HOTLINE** at **8-432-4242**.

Approved by the HIM Committee and Medication Safety Committee

Approved by the Executive Committee

Approved by the Pharmacy and Therapeutics Committee

INFECTION PREVENTION and CONTROL

The Infection Control Department provides consultation for inpatient care. Program guidelines and policies are based on sound epidemiologic principles from CDC, California Department of Health, the Joint Commission and OSHA regulations.

Infection Control follows trends within the hospital, such as central line infections, specific surgical site infections, along with rates of infection for MRSA, VRE, and C. Difficile.

1. Occupational Exposure to Blood Borne Pathogens

Occupational exposure to Blood Borne Pathogens is considered when blood or body fluid containing blood, or OPIMs (other potentially infectious material which includes amniotic fluid, vaginal secretions, semen, saliva during a dental procedure, synovial/pericardial, and peritoneal/pleural fluid), comes into contact with non-intact skin or mucous membranes.

If exposed, immediately:

- a. Wash the affected area with soap and water. If a mucous membrane exposure occurs, flush with water for a minimum of 15 minutes.
- b. Seek medical evaluation as soon as possible (preferably within 2 hours). Employee Health Services is available Monday through Friday, 8:30am to 5pm. After hours and weekends the Emergency Department will provide evaluation.
- c. Report the incident to U.C.D., (or other appropriate) Employee Health Department.
- d. Per California law, the individual with the exposure cannot directly consent the source patient for HIV testing. Another medical provider/Infection Control Coordinator must perform this request.

Post-exposure prophylaxis (PEP) may be recommended. These recommendations should be implemented in consultation with persons having expertise in anti-retroviral therapy and HIV transmission. If indicated, PEP should be initiated promptly, preferably within 1-2 hours post-exposure (PEP is based on current CDC recommendations).

2. OSHA Mandated Sharps Safety Devices

OSHA standards require the use of sharp safety devices. Our facilities provide safety needles, scalpels and peripheral IV catheters. The law requires that the safety mechanism be activated immediately after use and before disposing of the sharp into a sharp's container.

Dispose of sharps in the appropriate sharp's container. Many injuries have occurred when sharps have been left on instrument trays following procedures (i.e., central line insertions) or when improperly disposed of in waste containers.

3. National Kaiser Vascular Access Device Guidelines

Kaiser guidelines for central vascular devices call for:

- a. Use of full barrier precautions for insertion of central lines including sterile gloves, sterile gown, mask, cap, and sterile sheet drape.
- b. Chlorhexidine impregnated central line catheters for high-risk patients. The faculty has chosen to use these catheters for all patients requiring central lines (not available in PICC, arterial and dialysis catheters).
- c. 2% Chlorhexidine prep is used for skin preparation prior to insertion of central, PICC and peripheral IV's and must be allowed to dry completely for maximum effectiveness prior to beginning the procedure. Fanning to dry is not recommended by the manufacturer.
- d. Utilize an impregnated insertion site patch (Biopatch) over the insertion site for all central lines, including arterial, dialysis and PICC.
- e. Adhesive anchoring device (i.e., Statlock) is recommended instead of suturing for all central lines in order to decrease risk of site infection. Avoid suturing, which increases the risk of a central line infection.
- f. Avoid use of jugular and femoral lines if possible due to their higher risk of infection.
- g. Be sure to document all central line insertion in the Central Line Insertion Navigator.

4. Standard Precautions and Hand Hygiene

- a. Standard Precautions are to be used in the care of all patients by treating all body substances as potentially infectious.
- b. Patient Safety Goal 7a: "Comply with current World Health Organization (WHO) Hand Hygiene Guidelines or Centers for Disease Control and Prevention (CDC) hand hygiene guidelines." Kaiser Permanente complies with WHO hand hygiene guidelines.
- c. Artificial nails are not allowed for health care workers (including medical students and residents) engaged in direct patient care
- d. Soap and Water
 1. Before touching a patient
 2. Before clean/antiseptic procedures
 3. After body fluid exposure risk
 4. After touching a patient
 5. After touching patient surroundings
- e. Alcohol Hand Degermer
 1. When hands are not visibly soiled
 2. Before and after patient contact
 3. After contact with any contaminated item
 4. Before and after removing gloves
 5. *Provided near the doorway of each patient room*
 6. Can be used 10-12 times between hand washing with soap and water

5. Personal Protective Equipment (PPE) - found in designated locations in patient care areas
 - a. Gloves-should be used whenever hands may become contaminated with blood/body fluids, when doing invasive procedures or when touching non-intact skin or mucous membranes.
 - b. Gowns-should be worn when performing activities that may generate splashes or sprays of blood or body fluids or cause soiling of clothing.
 - c. Masks-should be used when performing activities that may generate splashes or sprays of blood or body substances.

6. **CDC Transmission-Based Special Isolation Precautions are used in our facilities**
 - **Please refer to Table #1 pg. 12**

7. Senate Bill 1058
 - a. Requires MRSA screening within 24 hours for patients who meet the screening criteria.
 - b. Screening Criteria: Transfer from skilled nursing facility, admit to ICU, discharge from acute care facility within the past 30 days, all dialysis patients and those meeting these criteria and having inpatient surgery.
 - c. A patient is EXCLUDED if they have previously tested positive for MRSA.
 - d. Attending physician MUST inform the patient or family of positive results and document the notification in the progress note as soon as possible.

8. Communicable Disease Reporting:
 - a. California Code Title 17 sets the requirements for reporting communicable disease.
 - b. The Medical Board regulation allows the County Health Department to report physicians for failure to report communicable diseases or failure to report in a timely manner. The Medical Board will issue a citation and fine depending on the severity of the offense (\$250- \$2500).
 - c. Laboratories are required to report certain reportable diseases, but this report does not include all the diseases that physicians are required to report.
 - d. You will notice the statement "Department of Public Health will be notified, Reportable Disease - Please complete CMR form."
 - e. Laboratory reporting is not adequate in most situations. Laboratory reporting does not give the onset date, medication, etc. Therefore, to ensure completeness of reporting, physicians must report all reportable diseases.

9. Methods for Communicable Disease Reporting:
 - a. Reports required immediately or within one day (See Title 17)
 1. The Infection Control Department may be contacted to answer questions regarding reporting requirements during regular business hours or go to <http://www.kaisersac.com/clinical/infection/index.htm> for the Infection Control policy on Reportable Diseases (Policy #3.1).

KNOWLEDGE APPLIED

2. Call the County Health Department where the patient resides.
3. Call through county communications if you do not have the county's emergency number for evenings, weekends and holidays.

b. Non-urgent reports or all other diseases/conditions should be reported by FAX, telephone, or mail within seven calendar days of identification.

Mandatory disease reporting:

1. AIDS/HIV
2. Hepatitis A, B, C
3. Measles (report immediately)
4. Salmonella, Shigella, and other enteric pathogens
5. Sexually transmitted diseases
6. TB or suspicious TB

10. Communicable Disease Exposure Protocol

If you feel that you have had unprotected exposure to communicable disease while providing care or in the community, please notify your Chief Resident who will reach out to Infectious Disease/Infection Prevention to investigate and determine if there has been an exposure.

If it is determined that you have had an exposure to active TB, meningococcal disease, pertussis, scabies, varicella, or COVID19 you will be notified and advised of appropriate follow-up.

Exposure is defined as follows:

- a. **Active pulmonary or laryngeal TB** - when proper isolation precautions were not implemented (i.e. N95 respirator mask or PAPR and negative pressure room).
- b. **COVID19 (no aerosol generating procedure)**– If >15 minutes of exposure within 6 feet of an unmasked patient and caregiver is without mask and and/or face shield.
- c. **COVID19 (with aerosol generating procedure)** – Any amount of time in the patient room without respirator (N95, PAPR, Elastomeric Respirator) and face shield.
- d. **Meningococcal disease** - close, face-to-face unprotected (without the use of a mask) contact with patient's oropharyngeal secretions, prior to patient having at least 24 hours treatment with an appropriate antibiotic.
- e. **Pertussis** - close face-to-face unprotected (without the use of a mask) contact with patient.
- f. **Scabies** - skin-to-skin contact, highest risk being crusted Norwegian Scabies. **Varicella** - non-immune person being in the general area of a patient with active Varicella

11. Infectious Disease/Infection Control Department Resources:

The on-call Infectious Disease Physician can be reached by:

- Pager 8-426-5595
- Sacramento Page Operator at X5288

HIV/AIDS Information Line

- Call ID Physician On-Call through operator services

HIV Specialty Clinic is provided for:

- Newly diagnosed/New health plan member with HIV infection
- Any member with HIV infection who requests an ID consult

Infection Control Managers, Coordinators, and Support Personnel

Sacramento/Davis/Fair Oaks/Point West

Infection Prevention and Control Hotline: 916-973-GERM (4376)

- Julie Roberts, RN, BSN, CIC, Quality Director
 - Phone: 916-973-76345 (8-426)
- Amanda R. Berling, BSN, RN, CIC, HACP-IC, Quality Nurse Consultant, Infection Prevention
 - Phone: 916-973-6106 (8-426)
- Angelique Tjen-A-Looi, MD, Chief of Infectious Diseases
 - Phone: 916-973-5230 (8-426)

Roseville/Folsom/Rancho Cordova

Infection Prevention and Control Hotline: 916-784-4930

Department Email: ROS-IP-Team@kp.org

- John Belko, RN, BSN, CIC, Infection Prevention Manager
 - Phone: 916-784-4880
- Deidre Jones, RN, PHN, MSN, MPH, CIC, Infection Prevention Quality
 - Consultant Office: 916-784-4882
 - Cell: 279-900-7926
- Katherine E. Sisco, RN, Infection Prevention Quality Consultant Office
 - Phone: 916-784-4881

Please refer to our Infection Prevention page for most up to date information:
https://kaisersac.kp.org/infection_sac/home/contact-us/

TRANSMISSION-BASED SPECIAL ISOLATION PRECAUTIONS

	AIRBORNE PRECAUTIONS	DROPLET PRECAUTIONS	CONTACT PRECAUTIONS	CONTACT PLUS PRECAUTIONS	NEUTROPENC PRECAUTIONS
Diseases	<ul style="list-style-type: none"> • TB, known or suspected • Measles (Rubeola) • Chickenpox (Varicella) • Disseminate d Herpes Zoster • Smallpox • COVID19/ SARS(with Aerosol Generating Procedure) 	<ul style="list-style-type: none"> • Meningococcal Disease • Pertussis • Acute Influenza • Mumps • Diphtheria • Rubella • Strep pharyngitis (until 24hrs. after treatment) 	<ul style="list-style-type: none"> • MRSA, VRE , ESBL and other multi-drug resistant organisms • RSV (Respiratory Syncytial Virus) • Impetigo • Pediculosis, Scabies until 24hrs. after treatment • Major wounds -when unable to contain drainage with dressing • Chickenpox, SARS, Smallpox (in addition to Airborne) 	<ul style="list-style-type: none"> • C.difficile • Diarrhea of unknown origin 	<ul style="list-style-type: none"> • Immuno-suppressed • Absolute neutrophil count <500
Private Room	Yes	Yes	Yes - preferred but may be cohorted – contact IC.	Yes - preferred but may be cohorted - contact IC.	Yes
Negative Pressure	Yes. Contact Engineering to verify negative pressure upon admission to room.	No	No	No	No. May use Positive Pressure room - only in PEDS.
Closed Door	Yes	No	No	No	Yes
Hand Hygiene	Yes , when entering and leaving room, and when likely contaminated.	Yes , when entering and leaving room, and when likely contaminated.	Yes , when entering and leaving room.	Yes, when entering and leaving room – use soap, water to wash out	Yes , when entering and leaving room.
Gloves	Yes , when contact with blood or body secretions is likely	Yes , when contact with blood or body secretions is likely	Yes , when entering room, regardless of contact with blood or body secretions.	Yes , when entering room, regardless of contact with blood or body secretion.	Yes , when contact with blood or body secretions is likely

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	AIRBORNE PRECAUTIONS	DROPLET PRECAUTIONS	CONTACT PRECAUTIONS	CONTACT PLUS PRECAUTIONS	NEUTROPENC PRECAUTIONS
Mask	Yes , N95 or HEPA respirator.	Yes , surgical mask when within 3 feet of patient.	No, unless splashing is likely or when close to coughing patient.	No, unless splashing is likely or when close to coughing patient.	No, unless ordered by MD.
Gown	Yes , when clothing may become contaminated with blood or body secretions.	Yes , when clothing may become contaminated with blood or body secretions.	Yes , when entering room, regardless of contact with blood or body secretions	Yes , when entering room, regardless of contact with blood or body secretions	NO, unless contamination of clothing is likely.
Equipment	Disinfect equipment when soiled with blood or body fluids.	Disinfect equipment when soiled with blood or body fluids.	Dedicate BP cuff, stethoscope, glucose monitor, thermometer and wheelchair or walker to patient room when possible. Disinfect all equipment when removed from patient room.	Dedicate BP cuff, stethoscope, glucose monitor, thermometer and wheelchair or walker to patient room when possible. Disinfect all equipment when removed from patient room with bleach.	Disinfect equipment when soiled with blood or body fluids.
Trans- portation	Patient should wear surgical mask.	Patient should wear surgical mask.	Patient to have clean gown and clean linen on bed. Drainage contained by dressing. Patient may ambulate in hall for PT. No PPE must be worn by staff unless contamination or splash with blood and body fluids are likely.	Patient to have clean gown and clean linen on bed. Drainage contained by dressing. Patient may ambulate in hall for PT. No PPE must be worn by staff unless contamination or splash with blood and body fluids are likely.	Consult with MD. Patient to mask if around other persons.

KNOWLEDGE APPLIED

	AIRBORNE PRECAUTIONS	DROPLET PRECAUTIONS	CONTACT PRECAUTIONS	CONTACT PLUS PRECAUTIONS	NEUTROPENC PRECAUTIONS
Who may D/C pre-cautions?	MD, Infection Control Coordinator (TB: unable to d/c until ruled out or 3 negative consecutive smears)	MD, Infection Control Coordinator (Bacterial Meningitis- until 24hrs of appropriate antibiotic)	Infection Control Coordinator or Infectious Disease physician. (VRE and MRSA – for duration of hospitalization. Pediculosis and Scabies – until 24 hours after effective treatment).	Infection Control Coordinator or Infectious Disease physician. (Precautions will remain in place for 3 months within last positive C.difficile toxin).	MD
Visitors	Mask Hand washing before entering and leaving room	Mask , if within 3 feet of patient. Hand washing before entering and leaving room.	Gloves and Gown while in the patient room. Hand washing before entering and leaving room.	Gloves and Gown while in the patient room. Hand washing before entering and leaving room (must use soap and water to wash out).	Evaluate visitors for communicable illness and wash hands before entering and leaving room.

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HAND HYGIENE

Hand hygiene most important step one can make to prevent the spread of infection. Transmission of health care associated pathogens from one patient to another can occur via the hands of health care workers. Hand antisepsis following the World Health Organization's (WHO) guidelines can reduce the incidence of healthcare associated infections.

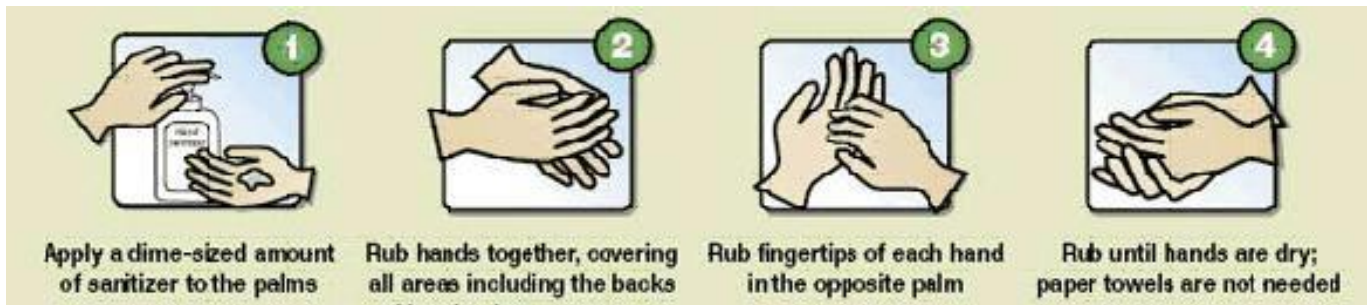
BEFORE PATIENT CONTACT	When: Clean your hands before touching a patient when approaching him or her. Why: To protect the patient against harmful germs carried on your hands.
BEFORE AN ASEPTIC TASK	When: Clean your hands immediately before any aseptic task. Why: To protect the patient against harmful germs, including the patient's own germs, entering his or her body.
AFTER BODY FLUID EXPOSURE RISK	When: Clean your hands immediately after an exposure to body fluids (and after glove removal). Why: To protect yourself and the healthcare environment from harmful patient germs.
AFTER PATIENT CONTACT	When: Clean your hands after touching a patient and his or her immediate surroundings when leaving. Why: To protect yourself and the healthcare environment from harmful potential germs.
AFTER CONTACT WITH PATIENT SURROUNDINGS	When: Clean your hands after touching any object or furniture in the patient's immediate surroundings, when leaving – even without touching the patient. Why: To protect yourself and the healthcare environment from harmful patient germs.

How to Wash Your Hands Correctly

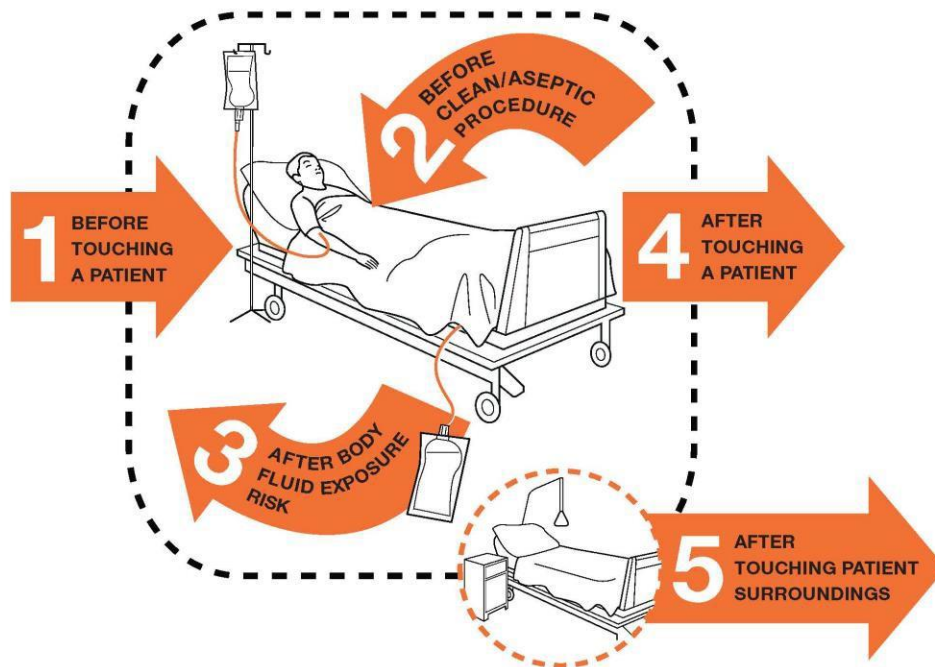
Hand wash when hands are visibly soiled



Alcohol sanitizer for routine cleaning when hands are NOT visibly soiled



Your 5 Moments for Hand Hygiene



1	BEFORE TOUCHING A PATIENT	WHEN?	Clean your hands before touching a patient when approaching him/her.
		WHY?	To protect the patient against harmful germs carried on your hands.
2	BEFORE CLEAN/ASEPTIC PROCEDURE	WHEN?	Clean your hands immediately before performing a clean/aseptic procedure.
		WHY?	To protect the patient against harmful germs, including the patient's own, from entering his/her body.
3	AFTER BODY FLUID EXPOSURE RISK	WHEN?	Clean your hands immediately after an exposure risk to body fluids (and after glove removal).
		WHY?	To protect yourself and the health-care environment from harmful patient germs.
4	AFTER TOUCHING A PATIENT	WHEN?	Clean your hands after touching a patient and her/his immediate surroundings, when leaving the patient's side.
		WHY?	To protect yourself and the health-care environment from harmful patient germs.
5	AFTER TOUCHING PATIENT SURROUNDINGS	WHEN?	Clean your hands after touching any object or furniture in the patient's immediate surroundings, when leaving – even if the patient has not been touched.
		WHY?	To protect yourself and the health-care environment from harmful patient germs.



World Health Organization

Patient Safety

A World Alliance for Safer Health Care

SAVE LIVES

Clean Your Hands

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SIGNING UP/SIGNING OUT

Upon arrival for each rotation at Kaiser, you must sign in at the Residency office, 916-973-6961, or at orientation. You must sign out on Medical Records on your last day of the rotation.

FRINGE BENEFITS

MEAL POLICY

To obtain meals, please use SOGO Card. SOGO Card will be issued by the Residency Program Administrator. Please follow instructions on how to obtain the card. SOGO Card is to be kept by trainee until the end of residency. Each block roster will allocate funds as such: 1 week =\$56; 2 weeks=\$112; 3-4 weeks+ =\$225. Cards will be automatically reloaded before each block begins. If your card is lost, contact the GME Office.

Cafeteria purchases cap at a \$50 daily limit. Please do not wait until the last day of rotation to utilize your meal funds - as this is abusing the meal privilege and cafe inventory.

A UC Davis ID badge is required to confirm identity. This is for theft protection.

Cafeteria Hours:

Roseville Cafeteria - Monday-Friday 7:00am to 3:00pm and closed Saturday and Sunday.

Sacramento Cafeteria - Monday-Friday 7:00am to 2:00pm and closed Saturday and Sunday.

Sacramento Coffee Cart - Monday-Sunday 7:00am to 2:00pm.

If you need a meal after regular cafeteria hours or on holidays, you may call the hospital operator and ask for the house supervisor. The house supervisor can let you in the kitchen where extra patient meals are stored in refrigerator #2. There is a log on the refrigerator please sign it with your name.

An on-call meal allotment is not provided for medical students or outpatient residents.

PARKING

Residents/Students will be allowed to park in the physicians' lot. Each resident/student must provide complete information to register their vehicle. Vehicle registration and access card pick-up is to be completed at the Security Office located in the small office just outside the Commons Building. Upon termination in the Residency Program/Student rotation, the card should be returned to the security office.

Residents/students may not park in the "Consulting Physicians" parking spaces in the lot.

When leaving the facility after dark, you may call X6168 and have the operator send a page to the security guard to meet you to escort you to your car.

LIBRARY

Completely virtual, the kpLibraries serve as a primary source of information for physicians, nurses, allied health care professionals, and other employees of the Sacramento Valley service area.

NCAL kpLibrarians provide:

- Expert literature searches to locate reliable, current evidence
- 24/7 Access to electronic information resources
- Point-of-care tools, clinical and business databases, and medical mobile apps
- Access to articles and resources outside of KP
- Training classes and webinars to enhance employees' information skills
- Resources for education and professional development

You can reach us at:

Email: ask@kplibraries.libanswers.com

Website: <http://kplibraries.libanswers.com>

Text: 510-228-4237

SCRUBS POLICY

At Kaiser Permanente, we are committed to provide an excellent training environment with highest professional standards to practice patient-centered medicine for all residents and medical students. We also want to provide a secure and safe environment for you, our hospital staff, and our patients.

Your compliance is needed to strictly adhere to the North Valley operating room's etiquette and scrub policy. Please pay extra attention to the following:

- ❖ Foam in and out as required
- ❖ Do not wear scrubs outside of the building
- ❖ Hair and mustaches must be covered
- ❖ Face mask must be worn and already tied prior to enter the operating room


Any resident or medical student identified by the Staff/Quality Department for not adhering to the OR etiquette/scrub policy will be disciplined, possible suspension of OR privilege, and a disciplinary letter from our office will be sent to your institution.

Preop: Surgical Attire


Our responsibility

- Only use hospital laundered scrub, home laundered scrubs not allowed
- Wear jacket in the OR
- Remove jackets outside the OR before scrubbing to minimize air flow in the OR
- Wear shoe covers if your shoes don't 'live' in the hospital

STOP before passing GO





- ✗1. Hair showing
- ✗2. T-shirt showing
- ✗3. Hip packs
- ✗4. Open cover jacket
- ✗5. White coat
- ✗6. Mask hanging around neck
- ✗7. Watches, jewelry
- ✗8. Nail polish
- ✗9. Street shoes (no covers)
- ✗10. Scrub shirt not tucked into scrub pants
- ✗11. Badges on lanyard or fabric badge holder





- ✓1. Hair covered (including sideburns)
- ✓2. Cover jackets closed
- ✓3. Sleeves rolled down
- ✓4. Mask is on or off (not hanging)
- ✓5. Scrub shirts tucked in
- ✓6. No visible street clothes
- ✓7. Badges showing (not lanyard)
- ✓8. No white coat
- ✓9. No jewelry or nail polish
- ✓10. Street shoes covered with CLEAN shoe covers

OR ETIQUETTE


OR Etiquette

Talking Point/Guideline/Requirement	Source (Policy/Guideline)
<p>Hand Hygiene is required:</p> <ul style="list-style-type: none"> • Prior to entering a patient or procedure room regardless of contact with the patient or environment • Upon exiting the patient or procedure room regardless of contact with the patient or environment • Before touching a patient or before donning gloves, gown, or <u>other</u> PPE • Before clean/aseptic procedures • After body fluid exposure/risk or after doffing gloves, gown, or <u>other</u> PPE • After touching a patient • After touching patient surroundings <p>Scenarios:</p> <ul style="list-style-type: none"> • If I am going into the OR to check on the patient, and do not plan to touch anything, do I have to clean my hands before going into the OR? Yes. • If I am going to put on a pair of regular gloves to help position the patient, and I cleaned my hands upon entering the OR, do I have to clean my hands again before donning gloves? Yes, if you touched anything. If you did not touch anything, your hands are still clean and you can don gloves without potential contamination. If you touched anything, you must clean your hands again prior to donning gloves. • I have gloves on and just helped position the patient. I am exiting the OR to scrub. Do I have to clean my hands upon exit of the OR? Yes, if you touch something between doffing gloves and exiting the OR (such as the door handle). If you use your elbow to open the door, and you proceed directly to the sink to scrub, you do not have to clean your hands between doffing gloves and going to the sink. • I am in the OR, and I am working on the computer or adjusting equipment. I cleaned my hands upon entry to the OR. Now I need to don gloves to help position the patient. Do I have to clean my hands again prior to donning gloves? Yes. Your hands are contaminated by touching the environment and must be cleaned prior to donning gloves. • I am seeing patients on the floor. Do I have to clean my hands before going in the patient room to talk to the patient? Yes. • I am done seeing the patient and am going to the next patient room. Do I need to clean my hands upon exiting the room even if I did not touch anything? Yes. • I just cleaned my hands leaving a patient room, and I am going to the next patient room. Do I need to clean my hands again before I go into the next room? No, unless you touched something before going into the next room. 	<p>Policy: Hand Hygiene NCAL Regional Policy</p> <p> Hand Hygiene Policy_SSC.pdf</p> <p>References:</p> <ul style="list-style-type: none"> • HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force, MMWR Oct 25, 2002 • AORN Recommended practices for hand hygiene in the perioperative setting, 2015 • KP Human Resources Policy Number CA.HR.5.02 • Journal of Hospital Infection Control, Volume 67, 2007 • WHO (World Health Organization) 5 Moments for Hand Hygiene <p> Your_5_Moments_For_Hand_Hygiene_P</p>

KNOWLEDGE APPLIED

<p>Surgical Attire: Appropriate surgical attire consists of the following elements:</p> <ul style="list-style-type: none"> • Hospital issued Gray Scrubs (top and bottom) • Hospital issued cover jacket completely buttoned/snapped to the top when in restricted areas (OR, SPD) or areas with sterile supplies. • Bouffant to cover hair, cloth hats, and skull caps; <u>bouffants</u> do not have to be removed when exiting the OR area. • Shoe covers: <ul style="list-style-type: none"> ◦ Shoe covers should be worn in the OR/restricted areas if shoes are not dedicated facility shoes or if gross contamination can reasonably be anticipated. ◦ Soiled shoe covers should always be removed. ◦ New/clean shoe covers may be worn outside the OR/restricted area over dedicated facility shoes only. <p>Additional elements:</p> <ul style="list-style-type: none"> • All hair must be covered: chest, head, ears, and facial hair, including sideburns, beards, and hairlines • All personal clothing must be covered, <u>ie</u> undershirts, cloth hats, or skull caps • All shirts must be tucked in • NO visual jewelry (must be covered by surgical attire) • NO rings allowed under sterile gloves • For non-scrubbed staff, rings must be covered by non-sterile gloves • Do not wear off campus/outdoors or take home 	<p>Policy: Surgical Attire NCAL Regional Policy</p> <p> SurgicalAttirePolicy.pdf</p> <p>References:</p> <ul style="list-style-type: none"> • OSHA – Occupational foot protection, 2012 • OSHA – Bloodborne pathogens, 2012 • AORN, Perioperative Standards, 2015 • AORN, Recommended practices for prevention of transmissible infections, 2013
<p>Masks:</p> <ul style="list-style-type: none"> • Surgical mask will be worn and secure (no hand holding) upon entry to the OR room when sterile supplies/equipment are opened and during procedure • Masks will be worn at the scrub sink area <u>when personnel</u> are scrubbing • Mask must be changed with each patient surgery and whenever it becomes soiled and/or before leaving the OR department • Mask cannot hang from neck or ears 	
<p>Time Out:</p> <ul style="list-style-type: none"> • Required for each patient and for each procedure (if multiple) • All team members must be present in the OR and must actively participate in the Time Out, and must acknowledge their agreement with all elements of the Time Out 	<p>Policy: Universal Protocol (NCAL)</p> <p> Universal Protocol_S5C.pdf</p> <p>References:</p>

KNOWLEDGE APPLIED

	<ul style="list-style-type: none"> • AORN, Perioperative Standards, 2015 • The Joint Commission Accreditation Standards, 2015 • World Health Organization Surgical Safety Checklist • AHRQ – Surgical Safety • Patient Safety in Surgery Journal Universal Protocol
<p>Safety Stop:</p> <ul style="list-style-type: none"> • Encouraged of all staff when safety issues identified • Any staff can call a Safety Stop. • Safety Stop is non-punitive. 	<p>Policy: Safety Stop Policy</p>  <p>Safety Stop Policy.pdf</p>
<p>Enforced traffic control practices protects personnel, patients, supplies and equipment from potential sources of cross-contamination</p> <ul style="list-style-type: none"> • Keep doors closed • Limit traffic in and out • Eliminate unnecessary activity • Eliminate unnecessary personnel 	

APPENDIX A – FACILITY EMERGENCY CODES

Facility operators are responsible for calling/dispatching codes/alerts from the code button on phone. This button by-passes all calls and is answered immediately by a hospital operator. All emergency calls should be placed using this button and **NO EMERGENCY** should ever be called by dialing “0”.

If a code/alert button is not available on the phone, please dial the following extension:

- Sacramento – ext. 8-426-2222
- Roseville – ext. 8-514-4111

Operator Services monitors various facility alarms and contacts appropriate personnel to respond to the issue such as fire alarms, panic alarms, and power supply alarms.

Emergency calls may include but not limited to:



APPENDIX B – NEEDLESTICK AND INJURY PROTOCOL

Needle Stick Injury

Because of the potential need for early prophylaxis, residents and medical students should seek medical care as soon as possible after the exposure.

Do not go to UC Davis.

M-F 8:30AM-5PM: Immediately notify Employee Health (EH) Triage Line: (916) 973-6454

Outside of EH business hours: Go to the Emergency Department (ED)

You will need to provide the source patient and sharp device details per the BBPE Data Form.

Occupational Health Location:

Sacramento Office

2016 Morse Ave.
(916) 973-5499
Mon – Fri | 8:30am – 5:00pm

Roseville Office

Eureka MOB2-1st Floor
(916) 784-6455
Mon – Fri | 8:15am – 4:45pm

The source patient must be evaluated and verbally consent to the source patient testing. The physician in charge of the patient's care or designee, manager, supervisor, charge person must obtain consent. The resident/medical student involved in the exposure may not evaluate the source patient or ask the source for consent.

Resident/medical student should report the incident to the KP Rotation Coordinator, KP Program Director, KP Graduate Medical Education office, and the affiliated school as soon as possible.

Resident/medical students without a KP medical record number will need to have Occupational Health call Member Services or Emergency Department, to provide the resident/medical student with a KP number to administer services.

Follow-up in the Occupational Health Department will be necessary in all cases for completion of Hepatitis B and HIV protocols while the resident/medical student is working at the Kaiser facility. Billing will be listed as KFH. Ultimately bills will need to be suppressed as part of GME reciprocal agreement with Housestaff.

HOUSESTAFF:

- **Sponsored Podiatry Residents** – are KP employees. Treat as own KP employee. Residents have Kaiser medical/liability coverage.
- **Visiting Residents/Medical Students** – receive initial evaluation and treatment at KP. Follow-up care will be completed at the individual's home facility.
- **UC Davis Housestaff** – Initial treatment at Kaiser Permanente. Follow-up treatment at UC Davis Employee Health - 734-7585 (24- h o u r line).

Please contact the Sacramento GME Office with questions:

Monica Fierro 916-973-6950 Or Gina Mazzuchi 916-973-6961

APPENDIX C – PATIENT IDENTIFICATION, VERIFICATION, SITE MARKING POLICY & PROCEDURE

PATIENT IDENTIFICATION, VERIFICATION, SITE MARKING POLICY & PROCEDURE

I. PURPOSE and SCOPE

Patient identification, final verification, and site marking will be consistent throughout the Medical Center/Medical Office.

- To ensure that identification of the correct patient, procedure, anatomic side and/or site, level, equipment, position, and implant is conducted in all locations throughout the service area, where operative and other procedures are performed that expose patients to harm.
- Locations include, all licensed hospital settings including the operating room, emergency room, imaging, and other procedure rooms; and outpatient ambulatory settings including endoscopy and other procedure rooms and surgical rooms.
- Most procedures that involve puncture or invasion of the skin, or insertion of an instrument or foreign material into the body, including but not limited to, percutaneous aspirations, biopsies, cardiac and vascular catheterizations, and endoscopies are within the scope of this policy.
- Certain routine “minor” procedures such as venipuncture, peripheral IV-line placement, insertion of nasogastric tube or Foley catheter insertion are excluded.

II. POLICY STATEMENT

The physician, staff members most closely associated with the procedure and to the extent possible the patient (or legally designated representative), are responsible for the following:

- Pre-operative (Pre-Procedural) Verification Process: Correctly identify the patient, relevant documents, procedure, surgical side/site and as applicable the need for special equipment or implant information with expiration dates. Ensure all information is consistent regarding the patient, procedure and side/site and that missing information or discrepancies are addressed before starting the procedure.
 - Mark the side/site of the procedure or surgery as appropriate. For procedures involving right/left distinction, multiple structures (such as fingers and toes), or multiple levels (as in spinal procedures), the intended site must be marked such that the mark will be visible after the patient has been prepped and draped.
 - Time Out or "Briefing" for final verification of the patient, procedure and side/site, position and as applicable, implants or special equipment will take place in the operating room, procedure room or other location before the surgery/procedure begins. The final verification will include active communication and agreement with all members of the of the surgical procedure team including: the physician, anesthesia practitioner, the circulating RN, and the scrub technician/nurse. The Time Out will be consistently initiated by a designated member of the team, and conducted in a fail-safe mode, i.e., the procedure is not started until any questions or concerns are resolved.
1. If imaging studies are required to determine operative side/site in procedures such as urology, orthopedic, or neurosurgery, the procedure must not commence until the practitioner has verified the imaging findings. In cases where a prosthesis, implant, or special equipment is to be used, verification of the device or equipment will take place prior to the start of the procedure.

III. PROCEDURE

A. Preoperative (Preprocedural) Verification Process should occur as applicable: Verification of the correct person, procedure and side/site will occur:

1. At the time the surgery/procedure is scheduled.
2. At the time of admission/registration/check-in.
3. Anytime the responsibility for care of the patient is transferred to another caregiver.
4. With the patient involved, awake and aware, if possible (or with the legally designated representative).
5. Prior to patient leaving preoperative area or entering the procedure/surgical room.
 - a. Verification of the patient, consented procedure and surgical procedure side/site must be accomplished by:
 - Patient interview
 - Review of the consent
 - Physician's orders
 - History and Physical
 - b. Procedure/surgery schedule as available.
 - c. Using a preoperative verification checklist, ensure availability and consistency of the following, prior to the start of the procedure:
 - a. Relevant documentation (e.g., H&P, laboratory and other diagnostic tests, and consent).
 - b. Relevant images properly labeled and displayed.
 - c. Any required implants and special equipment.
 - d. Utilizing the consent, the responsible staff will:
 - a. Check the patient's armband for name and medical record number.
 - b. Verify patient identity by utilizing the armband, consent, and patient's acknowledgment of identity.
 - c. Ask the patient to indicate the operative procedure side/site verbally and physically.
 - d. If the patient is non-English speaking, interpretive services shall be provided.
 - e. For outpatient procedures when patients do not have armbands, identification of the patient must be verified by other means such as:
 - a. Ask the patient to state their name versus asking them to confirm their name.
 - b. Verify picture ID, name, and patient medical record number.
 - c. Ask a family member or companion to identify a child or elderly person by name.

B. Marking the Operative Side/Site

1. Make the mark at or near the incision side/site. DO NOT mark any non-operative side/site unless necessary for some other aspect of care.
2. The mark will be unambiguous (e.g., use initials, "YES," or a line representing the proposed incision; DO NOT use "X)."
3. The mark will be positioned to be visible after the patient is prepped and draped.
4. The mark will be made using a marker sufficiently permanent to remain visible after completion of the skin prep.
5. The method of marking and type of mark will be consistent throughout the medical center as discussed above.
6. At a minimum, mark all cases involving laterality, multiple structures (fingers, toes, and lesions), or multiple levels (spine).
Note: In addition to pre-operative skin marking of the general spinal region, special intra-operative radiographic techniques are used for marking the exact vertebral level).
7. The person performing the procedure should do the side/site marking. If the person performing the procedure did not mark the site, he/she must confirm that the correct site was marked.

KNOWLEDGE APPLIED

8. Marking should take place with the patient involved, awake and aware, if possible, (or with the patient's legal surrogate).
9. Final verification of the side/site mark will take place during the "Time Out."
10. Documentation of the side/site verification by the patient/representative and the surgical team will be present on the operative record.
11. Patients who refuse side/site marking will be informed of the risks associated without marking and will be documented in the medical record.

C. Site Marking Exceptions:

1. Emergent/urgent cases when not prudent.
2. Single organ cases (e.g., C-section, cardiac surgery).
3. Interventional cases for which the catheter/instrument insertion side/site is not predetermined (e.g., cardiac catheterization).
4. Teeth - BUT indicate operative tooth name(s) on documentation OR mark the operative tooth (teeth) on the dental radiographs or dental diagram.
5. Premature infants, for whom the mark may cause a permanent tattoo.
6. The individual doing the procedure is in continuous attendance with the patient, from the time of the decision to do the procedure and consent from the patient, through the conduct of the procedure. (The requirement for a "time out" final verification still applies).

D. "Time Out" is the final verification of the patient, procedure, and site immediately before starting the procedure.

The "Time Out" will be conducted in the location where the procedure will be done, just before starting the procedure. It must involve the entire operative team, use active communication, (unassisted procedures require a brief pause), reconcile all differences, and be documented, such as in a checklist and must include:

- Correct patient identity
- Correct side and site
- Agreement on the procedure to be done
- Correct patient position
- Availability of correct implants
- Any special equipment or special requirements.

In the operating/procedure room, verification of patient, procedure and site/site will be made with the surgeon, anesthesia practitioner, circulating nurse, and scrub staff member if applicable immediately prior to the procedure. In the event a discrepancy is identified, no one will proceed until any questions or concerns are resolved.

- Any discrepancies noted concerning the consent, history and physical, surgeon's orders, surgery scheduling or patient's verbal identification or operative site/site will be documented. Calls to appropriate parties, including the surgeon, will be attempted to correct the discrepancies.
- Side/site will NOT be marked UNTIL all discrepancies are rectified.

E. Documentation

- Documentation of the patient, the operative plan, procedure verification and marking of the side/site will be found in the electronic record in the Intraoperative Log. See Intraoperative Log: Guidelines for Documentation Policy.
- Documentation in the outpatient care and other settings will be found in the electronic record in the Procedural Sedation Navigator, see Procedural Sedation Policy and Documentation Guidelines.

F. General Issues

1. Procedures for non-OR settings including bedside procedures. Site marking must be done for any procedure that involves laterality, multiple structures, or levels (even if the procedure takes place outside of an OR).
2. Unassisted procedures (one person, often at the bedside): A brief pause should occur to confirm the correct patient, procedure, and site. Exception: The individual doing the procedure is in continuous attendance with the patient, from the

KNOWLEDGE APPLIED

time of the decision to do the procedure and consent from the patient, through the conduct of the procedure. (The requirement for a “time out” final verification still applies).

3. All "mistakes" from a surgical marker will be removed from the skin and corrected prior to patient arriving in the procedure/surgical suite.
4. All marking should be removed prior to the application of steri-strips, surgical dressings, or casts at the conclusion of surgery.

APPENDIX D -PRINTED MATERIAL PROTOCOL

NEW REQUIREMENT

All printed materials must be shredded



Desktop PHI bin, left, can be used to collect ALL paper for transport to locked collection bins.

Kaiser Permanente remains committed to strictly following the law and our own established policies when it comes to proper disposal of regulated waste. To further these efforts, KP is enacting a policy:










All printed materials of any kind (including handwritten notes), whether clinical, administrative, or business related, are to be placed in confidential waste bins. No printed material is to be disposed of in regular trash or in recycling bins.

Anyone who generates PHI or business paper is responsible for bringing it to a common locked PHI console in your department, unless an alternate workflow agreement has been established.

Please contact your local building manager or Support Services Administrator if you need assistance in understanding your facility's paper waste removal processes.

APPENDIX E – WASTE MANAGEMENT

Waste Management – Patient Care Areas*






Confidential Waste	Medical Waste	Medical Waste
<p>PHI/Confidential Documents</p>  <p>Place all paper, DVDs, or CDs into a container that has been designated by your facility for secure destruction through shredding.</p> <p>All Paper Includes:</p> <ul style="list-style-type: none"> • All paper documents (hand written or printed) • After visit summary (AVS) • Care-related faxes • Check-in/Payment receipts • Claims and billing records • Dietary tickets • Encounter lists/ Appt. logs • Medical records • Medical referral forms • Member coverage and benefits information • Patient menus • Patient print out stickers • Patient safety engineering work orders • Pharmaceutical prescription forms • Patient care documents/Medication lists • Patient questionnaires • Post-It sticky notes • Test orders or result printouts • Vendor contracts • Visit notes • Patient wrist bands 	<p>Biohazardous/Red Bag Waste</p>  <p>Disposable items with any recognizable dry caked blood or any visible fluid blood and/or otherwise potentially infectious body fluids.</p> <ul style="list-style-type: none"> ▪ Band-Aids and gauze with any visible fluid blood or recognizable dry caked blood ▪ Used wound cleaning swab and gauze ▪ Chux pads or surgical towels with blood ▪ Blood transfusion bags and/or tubing ▪ Catheters or feeding tubes ▪ Used speculums with batteries removed ▪ Specimen bags or any item labeled with a "Biohazard" symbol ...even if empty! <p>➔ Place in a red bag waste container labeled with a Biohazard symbol AND lined with a Red Bag.</p> <p>Pathology Waste</p>  <p>Human specimens or tissues removed from a minor procedure, surgery, or autopsy.</p> <ul style="list-style-type: none"> ▪ Skin tags, bone fragments, tissue, fat, surgery specimens or tissues, limbs, other organs, and placentas. <p>➔ Place in a container labeled with the words "Path" or "Pathology Waste," "Incinerate Only," AND a Biohazard symbol</p> <p>Suction Canisters</p>  <p>Blood or body fluid waste that is contained inside of flexible or rigid walled containers.</p> <ul style="list-style-type: none"> ➔ Place used empty suction canisters into biohazard/red bag waste container ➔ Place flexible walled suction canisters containing blood and body fluid without solidifier into a biohazard/red bag waste container. ➔ Place rigid walled or flexible walled suction canisters containing blood and body fluid with solidifier canisters in a Pathology Waste "Incinerate Only" container. <p>Trace Chemotherapy</p>  <p>All materials from the production or administration of chemotherapy agents. Must not have free flowing liquids that will readily pour out</p> <ul style="list-style-type: none"> ➔ Place into a yellow container labeled "Chemo" or "Chemotherapy Waste," "Incinerate Only," AND a Biohazard symbol ➔ See EH&S Department for arsenic trioxide waste disposal 	<p>Pharmaceutical Waste Also called Co-mingled Sharps and Pharmaceutical Waste</p>  <p>OR</p>  <p>All non-RCRA hazardous waste pharmaceuticals, prescription or Over-the-Counter (OTC) products</p> <ul style="list-style-type: none"> ▪ IV bags/tubing set containing saline or medications even if empty! ▪ Empty and Partially full injectable medication vials ▪ Loose pills and tablets ▪ Medicinal patches and lollipops ▪ Lubricants, gels, and creams ▪ Nebulizers with any pourable liquid ▪ Live and attenuated vaccine without preservative ▪ Personal care products, soaps, shampoos, toothpaste ▪ Anything that is a sharps waste; Syringes with or without needles. Including flush or feeding syringes ▪ Small items (e.g. cotton ball or 2x2) with fluid or dry blood (where red bag not available) <p>➔ Place in a blue or blue lidded container labeled with the words "Incinerate Only," AND a Biohazard symbol</p> <p>Sharps Waste</p>  <p>OR</p>  <p>Items capable of puncturing or cutting the skin and that are contaminated or not with blood or potentially infectious body fluids</p> <ul style="list-style-type: none"> ▪ Needles, syringes with or without needles attached, scalpel blades, guide wires, blood vials <p>➔ Place in a red or blue container labeled with a Biohazard symbol; red container must say "sharps", blue container must say "incinerate only"</p>





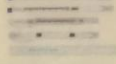










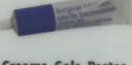



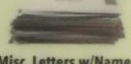
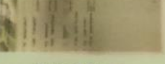






* For any waste questions, contact your Safety Operations Leader, Environmental Health and Safety Leader or Compliance Officer.

KNOWLEDGE APPLIED

CHOOSE THE RIGHT BIN

Emergency and Urgent Care Departments
Audits show these items were disposed of incorrectly. See below for the correct bins.

Hazardous	Biohazardous	Sharps/Pharmaceutical Comingle Containers	Shred/PHI	Universal
 <p>Unopened Skin Preps Prevantics®, Chloraprep™</p>  <p>Unopened Skin Preps Iodine prep pads & swabsticks Tincture of benzoin</p>  <p>RCRA Pharmaceutical Products Lindane/selenium shampoo, silver creams, creams/gels with alcohol</p>  <p>Cleaning/Disinfectant Chemicals Containers with residual fluid of bleach, OxyCide™, hard-sided sani-wipes, CaviWipes™</p>  <p>Sterile Skin Markers and Procedure Site Marking Pens</p>  <p>Flammable Items Hand sanitizer, barrier film, tissue adhesive, hemocult developer</p>	 <p>Angiocatheter Tubing with Blood</p>  <p>Recognizable Visible Blood Items with wet or dry blood, bandages, gauze, tissues, paper towels, cotton swabs, Band-Aids, sponges, chux pads</p>  <p>Speculums (Without batteries) that have come in contact with blood or body fluids</p>  <p>Wet Povidone-Iodine (Betadine) Chucks, cotton balls, swabs, gauze</p>  <p>Suction Canisters With blood or body fluids</p>  <p>Vomit Bag/Basin Vomit with or without blood</p>	 <p>Angiocatheter - IV Start Kit Used or unused</p>  <p>Blood/Specimen Vial Used, unused, containing fluids</p>  <p>Syringes/Needles/Sharps All types - glide needles, injection, feeding, flush, blunt, etc.</p>  <p>Creams, Gels, Pastes, Lotions, Lubricant Jelly (non-RCRA hazardous waste items)</p>  <p>Medication Vials, pens, prefilled syringes, pills/tablets (non-RCRA hazardous waste)</p>  <p>Nebulizer - Not Empty Residual fluid</p>  <p>IV Bag and Tubing Empty, not empty</p>	 <p>Misc. Letters w/Name, MRN etc. Order list for patient with exam info</p>  <p>Patient Menu Dietary ticket w/ PHI</p>  <p>Office Paper & Sticky Notes Computer generated or handwritten</p>  <p>Patient Printout Sticker Patient labels</p>  <p>Patient Wristband</p>  <p>Empty Patient Belonging Bag With patient name, room number, date</p>	 <p>Batteries All types (AAA-D) including button cell</p>  <p>All Electronic Devices that contain an on/off switch, regardless if it is powered by a battery or cord for wall outlet</p>

WHEN IN DOUBT...

This chart does not represent a complete list of waste items – only those most commonly discarded incorrectly in these departments.

Never place medical waste, hazardous waste, universal waste, or PHI in a regular trash container. If you are in doubt of the correct container for any waste, ask your supervisor, Safety Operations or EH&S Departments

SAP Safety Action Plans

All KP sponsored trainees are required to complete the training in KP Learn

- COVID-19 Training
- Slip, Trip and Fall Prevention
- OSHA Clinical Safety Training for California (Hospital and MOBs) (includes EOC_Waste_PWV) 2023



This training should not be used to meet OSHA compliance. For OSHA compliance training, please take the appropriate course on KP Learn.

Contact NEHS-Communications@kp.org with any questions.

What is a **Safety Stop**?

- A Safety Stop is when an employee stops the task at hand and says that they will only continue once an imminent risk to the safety of our patients and/or co-workers is fixed.
- It is the policy of Kaiser Permanente that safety stops should occur without fear of repercussions to employees who call the safety stop.

When to use a **SAFETY STOP**

A **Safety Stop** is required if anyone:

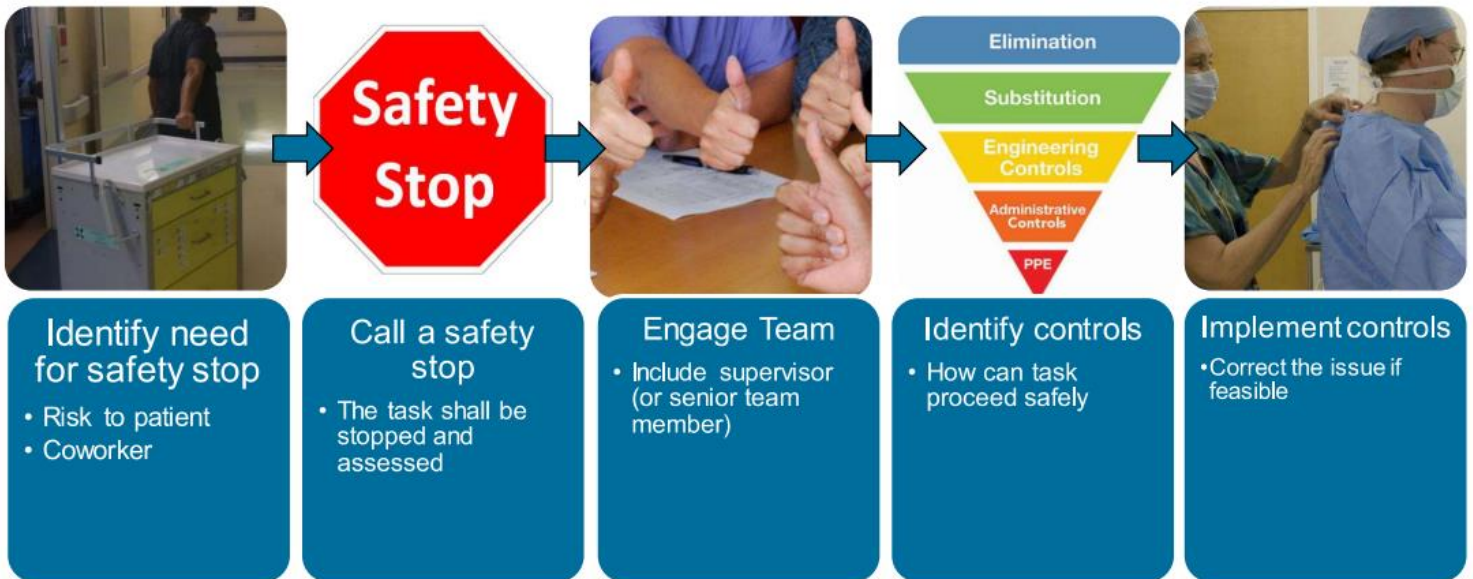
- Determines an unsafe condition exists.
- Is about to engage in an at-risk behavior.
- Is about to engage in an unsafe practice or process.
- Is about to use unfamiliar equipment or equipment that is not working properly.

How to proceed when a SAFETY STOP is called

- The work task being performed shall be stopped and assessed.
- The employee, who called the Safety Stop, will immediately engage with other members of their team/department, including their immediate supervisor.
- If the supervisor is not available engage the next most senior Kaiser Permanente representative to have a conversation about the concern.
- Identify what controls are needed to proceed safely.
- Take actions to implement the controls or to correct the issue if feasible.

Calling a safety stop helps us realize the vision of a workplace free from harm!

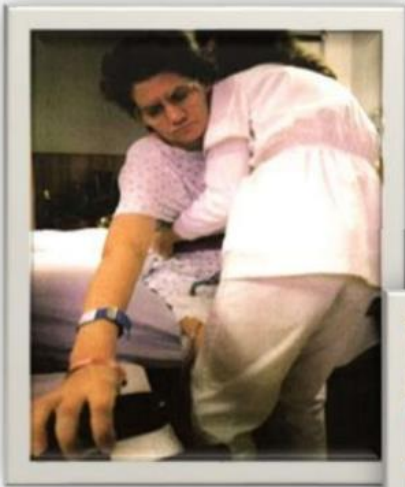
How to proceed when a SAFETY STOP is called



Calling a safety stop helps us realize the vision of a workplace free from harm!

Examples of When to Call a SAFETY STOP

What's wrong with these pictures?



Did you call a
Safety Stop on
all of them?



What to do when a SAFETY STOP is ignored

We hope that this will never happen, but if your SAFETY STOP goes unanswered:

- Make sure your co-worker heard you call the stop
- Re-enforce your concern by repeating the stop
- Where there is a disagreement always stop and reassess
- Remove yourself from the hazard if possible
- Escalate

