

CHESTNUT HEALTH SYSTEMS

SAFETY MANUAL

Table of Contents

INTRODUCTION TO THIS MANUAL	5
STAFF TRAINING.....	7
SAFETY INFORMATION.....	8
SAFETY STRUCTURE	9
SAFETY COMMITTEES	10
DOCUMENTATION – INCIDENT REPORTING	11
SUPERVISOR FOLLOW-UP	12
PATIENT SAFETY EVENT	13
INFECTION AND EXPOSURE CONTROL OBJECTIVES.....	14
INFECTION AND EXPOSURE CONTROL COMMITTEE.....	15
INFECTION CONTROL ANALYSIS AND PLAN	16
INCREASED NUMBER OF INFECTIOUS INDIVIDUALS.....	17
INFECTION AND EXPOSURE CONTROL PRACTICES	18
HIGH RISK INFECTION AND EXPOSURE CONTROL PRACTICES – ENGINEERING CONTROLS.....	19
HIGH RISK INFECTION AND EXPOSURE CONTROL PRACTICES – WORK PRACTICE CONTROLS.....	20
ACCIDENTAL EMPLOYEE NEEDLE/SHARPS STICK OR BLOOD EXPOSURE.....	25
BLOOD – POST EXPOSURE EVALUATION & FOLLOW-UP FOR EMPLOYEES	26
BLOOD – POST EXPOSURE EVALUATION & FOLLOW-UP FOR PATIENTS.....	27
TUBERCULOSIS SKIN TEST – STAFF.....	28
TUBERCULOSIS TEST – PATIENTS	29
TB - POST EXPOSURE EVALUATION & FOLLOW-UP – EMPLOYEES & PATIENTS.....	30
INFLUENZA VACCINATION	31
COVID 19 VACCINATION	32
ENVIRONMENT OF CARE PLAN	33
IMMEDIATE NOTIFICATION OF ENVIRONMENTAL ISSUES	34
SAFETY DATA SHEETS.....	35
BUILDING SECURITY	36
OFFICE SET UP.....	37
INTERVIEW ROOMS DESIGNED FOR VOLATILE SITUATIONS	38
DOOR SWITCH ALARM RESPONSE PROCEDURES	39
ENVIRONMENTAL SUICIDE RISK REDUCTION	40
NURSE CALL BUTTON	41
EYE WASH STATIONS.....	42
NEW SITE SET UP.....	43
PRE-CONSTRUCTION RISK ASSESSMENT.....	44
PEST CONTROL.....	45
BED BUGS.....	46
WATER TEMPERATURE	50
VEHICLE SAFETY	51

VEHICLE ACCIDENT.....	52
MECHANICAL EQUIPMENT	53
ELECTRICAL EQUIPMENT.....	54
GENERATORS	55
UTILITIES.....	56
INSPECTIONS AND TESTING	57
LAUNDRY AND LINEN	58
MOPPING	59
DISINFECTION – PATIENT SLEEPING ROOM.....	60
DISINFECTION – EXAM ROOMS	61
CHILD AREA TOYS.....	62
INTERNAL FOOD SERVICE.....	63
CATERED FOOD	64
REFRIGERATED FOOD STORAGE – PATIENTS.....	65
REFRIGERATED FOOD STORAGE – STAFF.....	66
DISHWASHING – PATIENTS	67
DISHWASHING – STAFF	68
DISPOSAL OF TRASH AND WASTE PRODUCTS	69
EMERGENCY PREPAREDNESS AND RESPONSE PLAN	70
EMERGENCY RESPONSE	71
NOTIFICATION DURING AN EMERGENCY	72
NOTIFICATION DURING AN EMERGENCY – TEXTING.....	73
INCIDENT COMMAND CENTER ACTIVATION PROCEDURES.....	74
CRISIS COMMUNICATIONS	75
ROLES DURING ICC ACTIVATION.....	76
VOLUNTEERS.....	77
INCIDENT COMMAND CENTER COORDINATION	78
INCIDENT COMMAND CENTER LOCATIONS.....	79
FIRE WARNING & SAFETY / LIFE SAFETY CODE	80
FIRE WATCH	82
EARTHQUAKE PREPAREDNESS.....	83
FLOOD PREPAREDNESS	84
WEATHER RADIOS.....	85
SEVERE WEATHER	86
DRIVING IN SEVERE WEATHER.....	88
EMERGENCY SUPPLIES AND WATER	90
EVACUATION / RELOCATION	91
POWER FAILURE – PHONES	92
CIVIL DEFENSE / EMERGENCY MANAGEMENT AGENCIES	94
CLOSED POINT OF DISTRIBUTION (POD).....	95
PANDEMIC.....	96
INTERNAL EMERGENCY PAGING	97
INTERNAL EMERGENCY CODES AND STAFF RESPONSE	98

TEAM APPROACH ROLES.....	100
TESTING OF THE PHONE SYSTEM.....	101
WEAPONS.....	102
ACTIVE SHOOTER PREPAREDNESS	103
DR. LOCK	105
DESIGNATED MEETING SPOTS	107
MISSING/ABDUCTED CHILD/INFANT	108
LOCK DOWN.....	109
LOCK DOWN BUTTON	111
BOMB THREAT	112
STAFF LIVE SAFETY TRAINING	113
RESPONDING TO MEDICAL EMERGENCIES	114
MEDICAL EMERGENCY SUPPLIES	115
Safety Tags	117
NARCAN	118
EXPOSURE TO UNKNOWN POWDERED SUBSTANCES	119
CLIENT BELONGINGS SEARCH PRACTICES.....	120
WORKPLACE VIOLENCE PREVENTION.....	121
SAFETY RELATED ALERTS FOR THE ELECTRONIC MEDICAL RECORD	122
STAFF WORKING IN THE COMMUNITY	123
CLIENT UNDER THE INFLUENCE	125
DISPOSAL OF ALCOHOL/DRUGS/PARAPHERNALIA.....	126
MISSING ADULT	127
SERVICE ANIMALS	128
SAFETY EVENT-STAFF NOTIFICATION OF PROCEDURAL CHANGES.....	129
RECALLS.....	130
ADVERSE DRUG REACTION	131
CONTACTING MEDICAL/SUPERVISORY PERSONNEL.....	132
MEDICAL EMERGENCIES	133
FIRST AID TREATMENT	135
NARCAN PROCEDURE	140
SEIZURE PRECAUTIONS	141
OBSTETRICAL EMERGENCY	142
DIABETIC EMERGENCY	143
HEART ATTACK/STROKE.....	144
ASSESSMENT FOR EMERGENCY MEDICATIONS.....	145
EMERGENCY CONTACT	146
APPENDIX.....	149
Infection/Exposure Control Plan.....	151
WHAT IS AN EXPOSURE.....	187
OSHA BLOODBORNE PATHOGEN STANDARD	188
HEPATITIS B VACCINATION	190
BLOOD EXPOSURE RISK DETERMINATION CLASSIFICATION	191

INFORMATION FOR EMPLOYEE AFTER EXPOSURE	193
IMMEDIATE PROCEDURE FOR EMPLOYEE	198
EXPOSURE TO UNKNOWN POWDERED SUBSTANCE PACKET.....	199
IMMEDIATE PROCEDURE FOR AGENCY CONTRACTED STAFF	205
SOURCE PATIENT	206
<u>BLOOD EXPOSURE PACKET</u>	186
<u>EXPOSURE TO UNKNOWN POWDERED SUBSTANCE PACKET</u>	199

Manual:	Safety Manual
Manual Section:	Introduction
Name:	Introduction
Effective Date:	07/28/21
Policy Cross Reference(s):	SI 10 Safety Program SI 90 Safety Manual SI 100 Total Staff Responsibility for Safety SI 130 General Safety
Citation(s):	EC.01.01.01 IC.01.05.01

INTRODUCTION TO THIS MANUAL

Chestnut Health Systems' Safety Program is built upon the concept of Total Staff Responsibility. This concept calls for each staff member to be aware of their surroundings and to be responsible for safety and infection/exposure control for themselves, patients, visitors and other staff members. Each staff is required to understand and participate in the safety program. All staff should be alert for any potential safety concerns or problems and is responsible to report them, if you see something say something.

This Safety Manual is intended to be a convenient reference for policies and procedures in relation to safety issues and is divided into core sections:

- Infection & Exposure Control
- Environment of Care
- Emergency Preparedness & Response
- Client/Patient, Staff and Visitor Safety
- Response to Urgent/Critical Medical Situation

The policies and procedures in this Manual are applicable to all Chestnut facilities.

The infection and exposure control section details how to prevent exposure and what to do in the event of exposure. It provides information to help protect employees from exposure to bloodborne pathogens, airborne pathogens and other potentially infectious materials. This section contains the exposure control plan which works in conjunction with other safety and infection control policies and procedures. It is also intended to demonstrate compliance with the Occupational and Safety Administration's (OSHA) regulations for employees of healthcare facilities regarding exposure to bloodborne pathogens. It is also designed to demonstrate compliance with the Illinois Substance Use Prevention and Recovery (SUPR) regulations or applicable state regulations.

The environment of care section provides information regarding safety and operational practices related to Chestnut sites and facilities.

The emergency preparedness and response section provide guidance for proactive and reactive response to emergencies.

The client/patient, staff and visitor section provide guidance regarding overall safety for those working, visiting and/or receiving services at Chestnut.

The Response to Urgent/Critical Medical Situation sections provide guidance regarding first aid and other responses to a medical emergency.

All staff are responsible to become familiar with and reference the safety manual as appropriate. If you have any questions regarding the content of this manual, contact your supervisor or the Safety Coordinator.

Manual:	Safety Manual
Manual Section:	Introduction
Name:	Staff Training
Effective Date:	01/01/2018
Policy Cross Reference(s):	SI 130 General Safety
Citation(s):	EC.03.01.01 2060.311 441.184 CMS

STAFF TRAINING

All employees will receive orientation regarding the fundamentals of infection and exposure control, environment of care, and emergency preparedness and response. For staff working in SUPR funded programs, the training shall occur within the first seven days after employment. The training will include information regarding:

- Bloodborne pathogens
- Standard precautions
- Responsibilities of all staff regarding infection control
- Overview of fundamentals of HIV, AIDS, and tuberculosis control

Additionally, clinical staff working in SUPR funded programs shall receive further training and information regarding:

- HIV and AIDS relative to the etiology and transmission of HIV infection and associated risk behaviors
- Symptomatology and clinical progression of HIV infection and AIDS and their relationship to substance use behavior
- Purposes, uses and meaning of available testing and results
- Relapse prevention
- Sensitivity to the issues of an HIV infected patient

Annually, all staff will complete refresher training on various key aspects of the safety manual. Staff will complete this training through the Relias learning management system.

Manual: Safety Manual

Manual Section: Introduction

Name: Safety Information

Effective Date: 01/01/2018

**Policy Cross
Reference(s):**

Citation(s):

SAFETY INFORMATION

Safety information is available to staff via:

- Safety Policy in Chestnut Policy Handbook
- Safety Manual (posted on intranet and in Relias)
- Emergency Procedure Flip Charts
- Program Manuals
- Business Unit Emergency Plans
- Learning and Safety Manager
- Safety Coordinator

Manual:	Safety Manual
Manual Section:	Introduction
Name:	Safety Structure
Effective Date:	01/01/2018
Policy Cross Reference(s):	SI 92 – Safety Structure and Function
Citation(s):	LD.03.09.01

SAFETY STRUCTURE

Responsibility for implementation of the Safety Program is designated as follows:

1. Learning and Safety Manager
2. Safety Coordinator
3. Infection Control Committee
4. Regional Safety Committees

Committee membership for each of the above are listed in the appendix.

Manual:	Safety Manual
Manual Section:	Introduction
Name:	Safety Committees
Effective Date:	01/01/2018
Policy Cross Reference(s):	SI 94 Safety Program Records and Reports
Citation(s):	EM.01.01.01 EC.01.01.01 EC.04.01.01 EC.04.01.03 LD.03.09.01

SAFETY COMMITTEES

The safety committees are multidisciplinary teams which are chaired by the Safety and Learning Manager or Safety Coordinator. The membership shall include regional representatives from various business units. See appendix for assigned individuals.

Functions of the Safety Committees are as follows:

1. Coordinate program safety, infection control, exposure control and risk management activities.
2. Recommend safety practices as needed.
3. Investigate and evaluate incident reports on Safety events.
4. Annually review and update the Safety Manual and environment of care plan.
5. Provide training to staff as assigned.
6. Formulate and supervise the implementation of an active and continuing program of risk identification and management.
7. Report to the Executive Leadership Council on the effectiveness of the Safety Program on a regular basis through the minutes of the Safety Committee and the annual update of the Environment of Care Plans.

Manual:	Safety Manual
Manual Section:	Introduction
Name:	Documentation – Incident Reporting
Effective Date:	01/01/2018
Policy Cross Reference(s):	RM 60 – Incident Reporting SI 100 – Total Staff Responsibility for Safety
Citation(s):	EC.04.01.01 LD.03.09.01

DOCUMENTATION – INCIDENT REPORTING

Incident Reports are an internal mechanism used to document and monitor unusual, dangerous or potentially harmful events as they occur to facilitate the management of a safe and therapeutic environment. As part of the total staff responsibility concept, when an unusual event occurs, staff are required to submit an incident report. This report alerts your supervisor and the Safety Coordinator of a safety concern. Through evaluating incident reports, Chestnut can improve its procedures to ensure a safe and healthy environment. Incident Reports should be submitted by the end of staff's shift.

If the incident involves a fall on site staff should take a picture of the area where the fall occurred. Picture should include any tripping hazard or items that might have been in place to warn of possible concern such as a wet floor sign.

If the incident involves property damage staff should take a picture of the damage and send it with the incident report.

Quality Management staff will work with IT and program leadership to secure video of falls, acts of aggression and theft.

Staff should reference the Chestnut Policy Handbook RM 60 for additional information regarding incident reporting and supervisory follow up.

Incident Report forms are available electronically on the intranet under the safety tab.

Manual:	Safety Manual
Manual Section:	Introduction
Name:	Documentation – Supervisor Follow-Up
Effective Date:	01/01/2024
Policy Cross Reference(s):	RM 60 – Incident Reporting SI 100 – Total Staff Responsibility for Safety
Citation(s):	EC.04.01.01 LD.03.09.01

SUPERVISOR FOLLOW-UP

Supervisor Follow-up Forms are an internal mechanism used to further document details of an incident report. Forms should be filled out after the supervisor has reviewed the incident report and has met with staff and/or clients for follow-up regarding the incident. Some examples of when supervisors should complete this form are:

- ✓ Controlled Count Discrepancies
- ✓ Medication Related Incidents
- ✓ Acts of Aggression
- ✓ Illness
- ✓ Injury

Follow-Up forms should include information on staff retraining as a result of an error, outcomes of incidents where there was an injury or illness requiring medical treatment, ways to mitigate future acts of aggression. Supervisor Follow-Up Forms should be submitted in the same way as Incident Reports.

QM staff may follow up with questions concerning an incident and follow-up to those questions should also be included on the Follow-Up Form.

Manual:	Safety Manual
Manual Section:	Introduction
Name:	Patient Safety Event
Effective Date:	01/01/2018
Policy Cross Reference(s):	RM 15 – Patient Safety Events RM 20 – Sentinel Events RM 60 – Incident Reporting SI 110- Patient Safety
Citation(s):	LD.03.09.01 2060.331 Sentinel Events Chapter (Joint Commission)

PATIENT SAFETY EVENT

The Joint Commission defines a patient safety event as an event, incident, or condition that could have resulted or did result in harm to an individual served. A patient safety event can be, but is not necessarily, the result of a defective system or process design, a system breakdown, equipment failure, or human error. Patient safety events & associated responses include the following:

- **Sentinel Event** – a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches an individual served and results in death, permanent harm or severe temporary harm.
- **Adverse event** – a patient safety event that resulted in harm to an individual served.
- **No-harm event** – a patient safety event that reaches the individual served but does not cause harm.
- **Close call** – a patient safety event that did not reach the individual.
- **Unsafe condition** – a circumstance (other than an individual's own disease, process, or condition) that increases the probability of an adverse event.

An Incident Report must be completed for each patient safety event that occurs. Refer to RM 60.

All Chestnut employees will identify and respond appropriately to all patient safety and sentinel events by referencing and following Risk Management policies RM 15 and RM 20.

Manual:	Safety Manual
Manual Section:	Infection and Exposure Control
Name:	Infection and Exposure Control Objectives
Effective Date:	01/01/2018
Policy Cross Reference(s):	
Citation(s):	IC.01.05.01 IC.03.01.01

INFECTION AND EXPOSURE CONTROL OBJECTIVES

The objectives for infection and exposure control are:

1. To ensure the health of all patients, visitors, and staff while they are on Chestnut premises.
2. To establish preventative policies concerning the environmental control of infection and disease.
3. To establish preventative policies concerning patients and staff who have a communicable disease or infection in order to prevent the spread of disease to other patients and staff.
4. To establish an information and training program to educate staff who have the potential for exposure to blood-borne pathogens and/or airborne pathogens on risk reduction while performing their job duties (see appendix).
5. To establish a post-exposure evaluation and follow-up program for staff who become exposed to blood-borne pathogens or tuberculosis.
6. To promote an influenza education and vaccination program to minimize the transmission of influenza virus in the workplace.
7. To perform an infection control analysis/risk assessment, resulting in an infection control plan.
8. Annually review and update the infection control plan.

Manual:	Safety Manual
Manual Section:	Infection and Exposure Control
Name:	Infection and Exposure Control Committee
Effective Date:	01/01/2018
Policy Cross Reference(s):	
Citation(s):	IC.01.01.01

INFECTION AND EXPOSURE CONTROL COMMITTEE

There is a multidisciplinary Infection and Exposure Control committee, which is chaired by the Learning and Safety Manager or Safety Coordinator. The membership of the Committee shall minimally include regional representatives from the facilities department, Learning and Safety Manager and Safety Coordinator, infection control representatives, health center representative(s), and the Director of Quality and Compliance. See appendix for assigned individuals. In addition to its regularly scheduled meetings some members of the Infection and Exposure Control committee complete semi-annual building walk-throughs to look at risks that could be associated with the environment and infection control.

Manual:	Safety Manual
Manual Section:	Infection and Exposure Control
Name:	Infection Control Analysis and Plan
Effective Date:	05/22/2019
Policy Cross Reference(s):	SI 70 Infection Prevention and Control Plan
Citation(s):	Occupational Health and Safety Administration (OSHA) Standards – Blood Borne Pathogens 1910.1030
	IC.01.04.01
	IC.01.05.01

INFECTION CONTROL ANALYSIS AND PLAN

Chestnut identifies potential infection control issues by engaging in an annual infection control analysis conducted by the Learning and Safety Manager. This analysis reflects all locations where individuals are served. The Learning and Safety Manager, in consultation with the Infection Control Committee is responsible for the annual review of the infection control analysis and subsequent priorities.

The goal of the infection control plan is to identify and reduce the risk of acquiring and transmitting infections among the individuals served, staff, and visitors. Objectives in the plan include monitoring airborne and blood-borne pathogens, hand hygiene, influenza vaccination, infection control competencies, emerging infectious diseases, and building inspections.

The infection control plan will be reviewed and updated annually by the infection control committee and can be found in the appendix of this manual and under the safety tab on the intranet.

Manual: Safety Manual

Manual Section: Infection and Exposure Control

Name: Increased Number of Infectious Individuals

Effective Date:

Policy Cross Reference(s):

Citation(s): IC.01.06.01

INCREASED NUMBER OF INFECTIOUS INDIVIDUALS

Current clinical and epidemiological information is obtained regarding new infections that could cause an increased number of infectious individuals. Critical information is communicated to staff regarding emerging infections.

Chestnut will respond with specific playbook and action plans and will act in accordance with these documents.

Manual:	Safety Manual
Manual Section:	Infection and Exposure Control
Name:	Infection and Exposure Control Practices
Effective Date:	01/01/2018
Policy Cross Reference(s):	SI 20 Staff Responsibilities for Infection/Exposure Control
Citation(s):	IC.01.02.01 IC.01.03.01 IC.02.03.01 441.184 CMS

INFECTION AND EXPOSURE CONTROL PRACTICES

1. All staff shall be oriented during new employee orientation concerning:
 - health and personal hygiene
 - surveillance and infection control measures
 - providing a safe and healthy environment
 - bodily fluid contact (exposure) precautions
2. Staff responsible for admission of residential patients will provide orientation regarding basic infection and exposure control information.
3. It is the responsibility of staff to report unsanitary conditions or inadequate infection and exposure control measures to their supervisor or the Learning and Safety Manager or the Safety Coordinator.
4. Sufficient supplies will be maintained at all sites in support of infection and exposure control measures.
5. Patients and staff will be asked to wear a mask if they are coughing, exhibiting flu like symptoms, or screen/test positive for TB to help prevent the spread of infection. Masks can be found in reception waiting areas.
6. Any staff who is ill may not remain on duty unless approved by their supervisor.

Staff with the following conditions shall not be permitted to administer patient care:

- Skin infections (open draining wounds) until drainage ceases
- Respiratory tract infections
- Active exanthems (widespread rash that is usually accompanied by systemic symptoms such as fever); or
- Enteric (pertaining to the intestine) infections.

Staff with the following conditions shall be limited in patient contact:

- Herpes Simplex
- Poison Ivy

Manual:	Safety Manual
Manual Section:	Infection and Exposure Control
Name:	High Risk Infection and Exposure Control Practices – Engineering Controls
Effective Date:	01/01/2018
Policy Cross Reference(s):	
Citation(s):	IC.01.04.01 IC.02.01.01 IC.02.02.01

HIGH RISK INFECTION AND EXPOSURE CONTROL PRACTICES – ENGINEERING CONTROLS

Engineering controls are in place to minimize the exposure of staff to blood-borne pathogens and other potentially infectious materials and to reduce the risk of infection transmission. All new staff or staff reassigned to new duties are trained and instructed regarding these controls as required by their particular job description by their supervisor.

1. Sharps Containers - Approved "Sharps Containers" that are puncture resistant, red in color, labeled as biohazardous, leak-proof on the sides and bottom, and do not require the employee to reach in by hand.
2. Waste Containers - Plastic lined, leak-proof waste containers are available in exam rooms and labs.
3. Access to Hand Hygiene Supplies - All exam rooms, laboratory areas and residential units will have hand washing facilities. Hand sanitizing stations are located throughout all facilities.
4. Biohazard Labels - Biohazard labels are available for placement on any surfaces that cannot be adequately decontaminated.

Personal Protective Equipment – Disposable gloves, eye protection, face shields, jackets/gowns are available. N95 masks will be made available to Health Center staff as indicated when working with patients with suspected airborne transmitted communicable disease.

Manual:	Safety Manual
Manual Section:	Infection and Exposure Control
Name:	High Risk Infection and Exposure Control Practices – Work Practice Controls
Effective Date:	01/01/2018
Policy Cross Reference(s):	
Citation(s):	IC.01.04.01 IC.02.01.01 IC.02.02.01 LS.02.01.30 NPSG.07.01.01

HIGH RISK INFECTION AND EXPOSURE CONTROL PRACTICES – WORK PRACTICE CONTROLS

Work practice controls are in place to minimize the exposure of staff to blood-borne pathogens and other potentially infectious materials and to reduce the risk of infection transmission. All new staff or staff reassigned to new duties are trained and instructed by their supervisor regarding these controls as required by their particular job description.

Standard Precautions - Staff shall consider all individuals as potentially infected with Hepatitis B virus (HBV), Hepatitis C virus (HCV) and/or Human Immunodeficiency Virus (HIV) and shall take Standard precautions in relation to blood, other bodily fluids containing visible blood, semen and vaginal secretions, tissues. While urine, feces, vomit, and nasal secretions are not considered potentially infectious unless they contain blood, staff should take Standard precautions and practice appropriate work place procedures to avoid contact with these bodily fluids as well.

Extraordinary care must be taken to avoid accidental wounds from sharp instruments contaminated with potentially infectious material and to avoid contact of open skin lesions with bodily fluids of patients. Safe methods of removing the needle from the syringe or other devices are necessary to protect employees from injury. This procedure must be carried out close to a [sharps container](#), and the needle must be discarded immediately. **NEVER** disassemble an exposed, used needle with your bare hands. If the needle has to be disassembled from the barrel or syringe, re-sheath using a one-hand scoop technique as explained below. Do not recap needles unless required. Dispose of needles in the appropriate sharps receptacle. Should exposure to blood products occur, the employee should follow the post-exposure procedures as stated in the post-exposure section of this manual.

One-hand scoop technique

1. Leave the needle cap on the surface and guide the tip of the used needle tip into it using only one hand. Clean the surface with disinfectant afterward to avoid leaving blood.
2. Place the needle cap against a firm upright surface with its opening towards you, and place the used needle tip into it.
3. Lift the needle and syringe vertically and, once the tip is covered, use the other hand to fix the cap into place.

Medical quality grade gloves should be worn anytime contact with blood or bodily secretions/excretions, including urine, may occur. Gloves must be worn only once and discarded appropriately. Gloves should

be removed without exposing skin to the outside of the glove. In situations where gloves are not readily available, utilize plastic trash can liners as an emergency barrier.

Hands should be washed thoroughly after handling anything suspected of being contaminated. Wash hands after removing gloves. Wash hands before eating. Keep hands away from mouth and face while working. Use lotion to prevent chapping and cracking of hands, however, avoid using lotions that contain petroleum as this can degrade the latex in gloves.

Clean blood, urine, vomit or other spills promptly with soap and water and a cleaning solution that is EPA approved to kill Hepatitis-B, Hepatitis-C virus and HIV virus or a solution of 1 part bleach to 10 parts water (wear gloves while cleaning). Use double plastic bags to dispose of cleaning materials. Flush fluid waste down toilet. Cleaning materials (paper towels, towels, etc) are considered contaminated waste only if fluid will drip from them when squeezed. If cleaning materials appear to be contaminated, they should be discarded in the hazardous waste receptacles. Clean with soap/water, then, sterilize reusable equipment which was in contact with mucous membranes, blood, secretions, or excretions.

Aprons/coats, etc. are available to be worn when clothing is likely to come in contact with blood, excretions, or secretions. Staff shall remove all potentially contaminated personal protective equipment prior to leaving their work areas and either decontaminate it or place it in the appropriate receptacle for decontamination or disposal.

Linens or personal protective cloth gowns or jackets contaminated with blood shall be machine laundered by Chestnut in hot water with detergent and dried on high in dryer. Staff are prohibited from removing contaminated personal protective equipment from the facility.

Staff shall exercise caution when providing emergency help to avoid exposure to bodily fluids. Gloves and plastic airways that are included in the first aid kits should be used. Chemical Disinfectants which are EPA approved disinfectants, effective against most bacteria and viruses, including HIV and tuberculosis should be used.

If a centrifuge is used, the lid must be kept closed.

Urine Specimen Collection - The infection risk from urine is extremely low unless the urine contains blood. However, to protect staff, all urine specimens are to be treated as if they are biohazardous.

Staff should use closed specimen containers when testing permits. Staff should always wear gloves when handling the specimens.

Staff should carefully follow written urine collection procedures designed for that particular kind of specimen collection (observed, unobserved). Reference Medical Manual.

Hand Hygiene - Practicing proper hand hygiene is a simple yet effective way to prevent the spread of pathogens and infections in health care settings. Chestnut will reinforce hand hygiene as a fundamental infection prevention and control strategy among its workforces. All staff will complete periodic training on hand hygiene in our Relias learning management system ("LMS"). In addition, signage on proper hand hygiene will be conspicuously placed in appropriate areas within all Chestnut sites. Proper hand hygiene includes the use of alcohol-based hand rub ("ABHR") or handwashing with soap and water.

Staff shall wash their hands following the World Health Organization (WHO) Guidelines prior to and directly after administering any physical care to patients (examples of physical care include contact with the patient's intact skin as when taking a pulse and performing a physical examination).

Staff performing nursing procedures or working with medication will be observed at least annually washing their hands and the results of the observation will be documented in Relias.

When hands are visibly dirty or soiled with blood or other body fluids, wash hands with soap and water as soon as possible. If hands are not visibly soiled or soap and water is not immediately available, an alcohol-based hand sanitizer may be used for decontaminating hands. Antimicrobial wipes are a last alternative when soap and water or alcohol-based sanitizer are not available.

- If washing hands with soap and water wash your hands using these points:
 - Wet hands with water
 - Apply enough soap to cover all hand surfaces
 - Rub hands:
 - palm to palm
 - right palm over left back of hand with interlaced fingers and vice versa
 - palm to palm with fingers interlaced
 - back of fingers to opposing palm with fingers interlocked
 - rotational rubbing of left thumb clasped in right palm and vice versa
 - rotational rubbing backwards and forwards with clasped fingers of right hand in left palm and vice versa
 - Rinse hands with water
 - Dry hands thoroughly
 - Use towel to turn off faucet
- This whole process should take 40-60 seconds.
- If using an alcohol-based hand rub, rub your hands using these points:
 - Apply a palm full of the product in a cupped hand, covering all hand surfaces.
 - Rub hands:
 - palm to palm
 - right palm over left back of hand with interlaced fingers and vice versa
 - palm to palm with fingers interlaced
 - back of fingers to opposing palm with fingers interlocked
 - rotational rubbing of left thumb clasped in right palm and vice versa
 - rotational rubbing backwards and forwards with clasped fingers of right hand in left palm and vice versa.
 - Once dry your hands are safe.
- This whole process should take 20-30 seconds.

If sanitizer is stored in refillable containers the expiration date will be added each time the container is refilled.

Alcohol-based hand rubs (ABHR) are stored and handled in accordance with NFPA 101-2012: 8.7.3.1, unless all of the following conditions are met:

- Corridor is at least six feet wide
- ABHR does not exceed 95% alcohol
- Maximum individual dispenser capacity is 0.32 gallon of fluid (0.53 gallon in suites) or 18 ounces of NFPA
- Level 1—classified aerosols
- Dispensers have a minimum of four feet of horizontal spacing between them
- Dispensers are not installed within one inch of an ignition source
- If floor is carpeted, the building is fully sprinkler protected
- Operation of the dispenser complies with NFPA 101-2012: 18/19.3.2.6(11)
- ABHR is protected against inappropriate access
- Not more than an aggregate of 10 gallons of fluid or 135 ounces of aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room
- Storing more than five gallons of fluid in a single smoke compartment complies with NFPA 30

Staff Expectations:

1. Perform hand hygiene frequently throughout your workday. Minimally, staff are expected to do so at the following times:
 - Immediately upon entry into any Chestnut site
 - Prior to and after temperature monitoring or use of Chestnut-provided infrared thermometers
 - Before and after every face-to-face patient interaction
 - When entering any occupied group or meeting room
 - When exiting any occupied group or meeting room
 - Before and after disinfecting personal workspaces or common areas
 - As is customary, such as after using the restroom, before and after eating, and after coughing or sneezing
2. Eating, Drinking, Smoking, Applying Cosmetics, and Handling Contact Lenses - Eating, drinking, smoking, applying cosmetics, and handling contact lenses are prohibited in any work area where there is any risk of occupational exposure to potentially infectious materials. The use of hand lotions is not considered applying cosmetics.
3. Storage of Food and Drink - The storage of food and drink is prohibited in places where potentially infectious materials are kept. This applies to labs, refrigerators, freezers, shelves, cabinets, and countertops. The storage of food and drink is prohibited in refrigerators and freezers where medications are kept.
4. Leak Proof Containers - Leakproof containers are to be used for all specimens sent to the lab.
5. Splashing - All procedures involving blood or other infectious materials should be completed in a way to minimize splashing, spraying, or other actions generating droplets of these materials.
6. Personal Protective Equipment - All new staff or staff reassigned to new duties are trained and instructed regarding work practice controls and the use of personal protective equipment as required by their particular job description by their supervisor.

Disposable nitrile gloves are available to use in situations where contact with potentially infectious materials may be reasonably anticipated. Eye protection/face shield devices are available for use in examination rooms. Eye/face protection shall be worn in all situations where there is a reasonable possibility of splashes, sprays, splatters, or droplets of infectious materials occurring.

Protective jackets or gowns are available for use in examination rooms. Protective body clothing shall be worn when body exposure to blood or other infectious materials is anticipated.

Staff with jobs considered to be of potential high exposure risk will be eligible for evaluation for an N95 mask. Staff will undergo an OSHA respirator medical evaluation and if medically cleared will be fit tested and issued an N95 mask. Nitrile Gloves, masks, and goggles are available for staff that may come in contact with Fentanyl or other drugs to prevent exposure.

7. Disposal of Protective Equipment – After use, all potentially contaminated personal protective equipment should be placed in the appropriate receptacle for decontamination or disposal.
8. Disinfection of Medical Equipment, Devices and Supplies - Low level disinfection is to be performed between each patient use for items such as stethoscopes and blood glucose meters.
9. Housekeeping Practices - The Facilities Manager in consultation with the Learning and Safety Manager and Infection Control representatives is responsible for establishing the cleaning and decontamination schedule and assuring that it is appropriately carried out.
 - All staff will be provided with disposable gloves to be worn whenever hand contact with potentially infectious materials may be reasonably anticipated.
 - All equipment and surfaces are cleaned and decontaminated after any contact with blood or other potentially infectious materials.

- All trash containers and other receptacles intended for use routinely are inspected, cleaned, and decontaminated as soon as possible if visibly contaminated.
 - Broken glass is to be picked up using mechanical means such as a dustpan and brush or other appropriate tool. Broken glass should never be picked up with bare hands.
 - Linen contaminated with blood shall be machine laundered in hot water with detergent and dried on high heat setting in the dryer.
10. Regulated Waste and Similar Materials- Chestnut contracts for the disposal of contaminated waste.
- Contaminated needles and bandages that are saturated to the point of releasing blood and other potentially infectious materials are discarded in containers that are:
 - Closeable
 - Puncture Resistant (if appropriate)
 - Leak proof
 - Red in color or marked with biohazard warning labels
 - Containers for this waste are placed in locations as close as possible to the source of the waste.
 - Containers are maintained upright and not allowed to overfill.
 - Containers are dated when waste is placed in them.
 - Whenever containers are moved from one area to another, the containers are closed and placed within a second container if leakage is possible.
 - Staff that are utilizing biohazard containers are required to complete a Regulated Medical Waste training on proper use.
11. Handling, Storage and Disposal of Sharps, Needles, and Disposable Medical Equipment -
Extraordinary care must be taken to avoid accidental wounds from sharp instruments contaminated with potentially infectious material and to avoid contact of open skin lesions with bodily fluids of patients or staff. Do not recap needles or sharps. Safety needles should be used unless there are extenuating circumstances.

Sharp objects should not be left unsecured in areas where patients have access (i.e. unit counter, unlocked drawers).

Use caution when reaching into patient belongings to avoid undetected sharps.

All injectable devices and sharps (IM injectable devices, TB and insulin needles and syringes, and blood sugar monitoring lancets) and disposable medical equipment shall be disposed of immediately after use in a sharps container. If a sharp object should become contaminated with blood or bodily fluids, it should be appropriately disinfected or disposed. In the event that a needle is found in the regular trash it should not be removed, instead the entire bag of trash should be treated as a biohazard.

If staff should become exposed to blood or bodily fluids as a result of handling sharps or needles, the post-exposure procedures should be immediately implemented. Packets can be found on the intranet under the safety tab.

Manual:	Safety Manual
Manual Section:	Infection and Exposure Control
Name:	Accidental Employee Needle/Sharps Stick Or Blood Exposure
Effective Date:	01/01/2018
Policy Cross Reference(s):	SI 80 Accidental Employee Needle Stick or Blood Exposure
Citation(s):	IC.03.03.01 IC.02.03.01 OSHA 1904.8 - Recording criteria for needlestick and sharps injuries

ACCIDENTAL EMPLOYEE NEEDLE/SHARPS STICK OR BLOOD EXPOSURE

Per the Center for Disease Control, "An exposure that might place Health Care Providers at risk for Hepatitis B Virus (HBV), Hepatitis C Virus (HCV), or HIV infection is defined as percutaneous injury (e.g., a needlestick or cut with a sharp object), contact of mucous membranes, or contact of skin (especially when the exposed skin is chapped, abraded, or afflicted with dermatitis or when the contact is prolonged or involves an extensive area) with blood, tissues, or other potentially infectious body fluids. These fluids include a) semen, vaginal secretions, breast milk or any other body fluid visibly contaminated with blood, because these substances have been implicated in the transmission of HIV infection; b) cerebrospinal fluid, synovial fluid, pleural fluid, peritoneal fluid, pericardial fluid, and amniotic fluid, because the risk of transmission of HIV from these fluids has not yet been determined; ..."

"Feces, nasal secretions, saliva, sputum, sweat, tears, urine, and vomitus are not considered potentially infectious unless they contain blood. The risk for transmission of HBV, HCV, and HIV infection from these fluids and materials is extremely low." The above quote from MMWR, Recommendations and Reports, "Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposure to HBV, HCV, and HIV and Recommendations for Post-Exposure Prophylaxis, June 29, 2001, Vol. 50, No. RR-11.

Should a staff or patient be exposed to blood either via a used needle/sharp or via a spill/splatter of another individual's blood onto an open wound or mucous membrane (eye, mouth, etc.), the following procedure should be followed:

- The site should be immediately and thoroughly washed
- Apply a gauze dressing to stop the bleeding
- The exposure is to be immediately reported to supervisor on duty or designee
- If staff exposure, within 1 hour after the incident, the employee must see a health care professional for a post-exposure evaluation (see below). If Agency contracted staff, the staff should follow the procedures of the employer.
- A Chestnut Incident Report is to be completed prior to the end of the staff's shift during which the exposure occurred.

Chestnut has guidelines and preferred providers for employees who require a post-exposure evaluation. The Blood Exposure Packet which contains information and forms regarding the post-exposure evaluation are included in the Appendix of this Safety Manual, on the intranet under the Safety tab, and in the first aid backpacks.

Manual:	Safety Manual
Manual Section:	Infection and Exposure Control
Name:	Blood – Post Exposure Evaluation & Follow- Up For Employees
Effective Date:	01/01/2018
Policy Cross Reference(s):	
Citation(s):	IC.02.03.01 OSHA 1904.8 - Recording criteria for needlestick and sharps injuries

BLOOD – POST EXPOSURE EVALUATION & FOLLOW-UP FOR EMPLOYEES

The Blood Exposure Packet contains two sets of documents:

Employee Forms/Documents

- Employee Medical Information (to be completed by employee and taken to health care provider)
- Information sheet regarding OSHA Bloodborne Pathogen standard
- Information sheet regarding *Morbidity and Mortality Weekly Bulletin* guidelines on managing blood exposures and recommendations for post-exposure prophylaxis
- Incident Report

Occupational Health Provider Documents

- Instructional sheet regarding billing and post-exposure evaluation
- A copy of Chestnut's Blood Exposure Risk Categories (see appendix)

A list of occupational health care providers can be found on the intranet under the Human Resources tab, Supervisor Tools, Occupational Health.

Within **1 hour** after the incident, the employee must see a health care professional for a post-exposure evaluation. The employee should take the Blood Exposure Packet with them and provide this to the health care professional. The post-exposure evaluation will consist of an evaluation of the exposure incident, and if known and available, information regarding the source patient's Hepatitis B and HIV status will be given to the health care professional completing the post-exposure evaluation. The name of the source patient must be kept confidential. With the employee's consent, a blood sample will be collected and tested for HIV, Hepatitis B and Hepatitis C. If the employee consents to the blood collection but not for HIV antibody testing, the sample will be preserved for 90 days and the employee can consent to the test within that time period. The results of this baseline test will remain with health care professional (and will not be provided to Chestnut). The health care professional should provide post-test counseling and post-exposure prophylaxis if indicated. All diagnosis and test results remain confidential between the occupational health provider and employee.

Manual: Safety Manual

Manual Section: Infection and Exposure Control

Name: Blood – Post Exposure Evaluation & Follow-Up for Patients

Effective Date: 01/01/2018

**Policy Cross
Reference(s):**

Citation(s):

BLOOD – POST EXPOSURE EVALUATION & FOLLOW-UP FOR PATIENTS

Should a patient experience an accidental needle stick or blood exposure, the patient should follow-up with their healthcare provider.

Manual:	Safety Manual
Manual Section:	Infection and Exposure Control
Name:	Tuberculosis Skin Test – Staff
Effective Date:	01/01/2018
Policy Cross Reference(s):	SI 45 - Tuberculosis Infection Control – Employees and Volunteers
Citation(s):	IC.02.03.01 2060.415

TUBERCULOSIS SKIN TEST – STAFF

As part of its Infection Control Plan, Chestnut screens staff and volunteers for potential Tuberculosis infection prior to beginning employment based on the “Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005” published by the Center for Disease Control (CDC). Based on an assessment using CDC guidelines, Chestnut facilities are considered “low risk” which means the facilities are settings in which persons with TB disease are not expected to be encountered, and, therefore, exposure to Mycobacterium tuberculosis (TB) is unlikely.

Chestnut uses two methods of screening for Tuberculosis infection. The method used for the individual employee depends upon the employee’s job description which involves direct face-to-face patient contact and/or the employee’s history of positive TB skin tests.

Staff should consult Policy Handbook - SI 45 Tuberculosis Infection Control – Employees and Volunteers for specific guidance regarding TB testing policies and required documentation specific to time of hire, annual, and pregnancy.

Manual:	Safety Manual
Manual Section:	Infection and Exposure Control
Name:	Tuberculosis Test - Patients
Effective Date:	01/01/2018
Policy Cross Reference(s):	SI 46 Tuberculosis Infection Control – Patients
Citation(s):	2060.415

TUBERCULOSIS TEST – PATIENTS

All non-residential patients that receive face-to-face clinical services are evaluated for signs and symptoms of active Tuberculosis during their initial evaluation by the clinician conducting the evaluation. When indicated, patients should be referred to their personal physician, local health department or to Chestnut nursing staff to obtain medical clearance prior to beginning treatment.

All patients receiving the following services will be evaluated for symptoms of active TB and past exposure to Tuberculosis upon admission, but no later than 7 calendar days after admission:

- Residential – Substance Use
- Residential - Crisis
- Supervised Housing
- Detoxification

Staff should consult Policy Handbook - SI 46 Tuberculosis Infection Control – Patients for specific guidance regarding TB testing policies and required documentation specific to Chestnut patients.

Manual: Safety Manual

Manual Section: Infection and Exposure Control

Name: TB – Post Exposure Evaluation & Follow-up – Employees & Patients

Effective Date: 01/01/2018

Policy Cross Reference(s):

Citation(s):

TB - POST EXPOSURE EVALUATION & FOLLOW-UP – EMPLOYEES & PATIENTS

When it is determined that an employee(s) or patient(s) has been exposed to active TB, it is necessary that appropriate evaluation and follow-up occur.

In cases where information can be obtained regarding the potentially infected persons TB test results, actions will be taken based on those results. If unable to obtain results, the following process is to be taken.

A baseline must be established for each exposed individual. If the exposed individual has had a TB test within the last 3 months prior to exposure, it is not necessary that the individual be retested, and that most recent test shall serve as the baseline. If the individual has not had a TB test within the last 3 months, the individual should have a 1 step TB test. This test shall serve as the baseline.

Individuals should be re-tested at 6 months post-exposure. The 6-month test will be compared to the baseline test. Actions taken are dependent on these results.

The Medical Director will be consulted as determined necessary regarding incidents of potential exposure and the need for post-exposure evaluation and follow-up.

Staff who are not Chestnut employees (i.e. staff from temporary agencies) should follow the post exposure procedures as determined by the employer.

Manual:	Safety Manual
Manual Section:	Infection and Exposure Control
Name:	Influenza Vaccination
Effective Date:	01/01/2018
Policy Cross Reference(s):	
Citation(s):	IC.02.04.01

INFLUENZA VACCINATION

Influenza vaccination for staff is an ongoing safety concern for healthcare providers. Unvaccinated individuals who become infected are contagious at least one day before any signs or symptoms of influenza appear and therefore these individuals can infect others without knowing they are contagious.

Chestnut emphasizes increased safety for its patients by decreasing their exposure to the influenza virus while receiving care. One way to improve safety for patients is for Chestnut's staff to receive the influenza vaccination annually.

According to the US Department of Health and Human Services, vaccination is an effective preventive measure against influenza and can prevent many illnesses, deaths, and losses in productivity. The CDC conducts studies each year to determine how well the influenza (flu) vaccine protects against flu illness. While vaccine effective can vary, recent studies show that flu vaccination reduces the risk of flu illness by between 40% and 60% among the overall population during seasons when most circulating flu viruses are well-matched to the flu vaccine.

Chestnut has established an annual influenza vaccine program to facilitate staff receiving the influenza vaccine. Chestnut will educate staff about the vaccine, non-vaccine control and prevention measures, and the diagnosis, transmission and impact of influenza.

Chestnut acknowledges that knowledge, attitudes, and perceptions about influenza and influenza vaccination vary. It will strive to provide its staff with basic knowledge regarding influenza and the vaccine.

As part of its infection control plan, Chestnut sets a goal of improving influenza vaccination rates and will strive to incrementally increase vaccination rates amongst its staff. See appendix for previous year vaccination rates. Chestnut will annually collect data from staff on who received the influenza vaccination (onsite/offsite) and review the reason given by staff for declining the influenza vaccination. The total number of staff that received the vaccination will be compared to the total number of staff to obtain the percentage of staff that received vaccination. The designated Safety Coordinator is responsible to provide annual influenza vaccination rate data to leadership.

Manual:	Safety Manual
Manual Section:	Infection and Exposure Control
Name:	COVID 19 Vaccination
Effective Date:	
Policy Cross Reference(s):	
Citation(s):	IC.02.04.01

COVID 19 VACCINATION

Chestnut will **not** require staff to be vaccinated against COVID-19. Chestnut encourages staff to educate themselves regarding vaccination and to consider vaccination as a means to protect their own health and the health of patients/clients, family, and community members. See Covid Playbook for current Chestnut guidelines.

Manual:	Safety Manual
Manual Section:	Environment of Care
Name:	Environment of Care Plan
Effective Date:	05/22/2019
Policy Cross Reference(s):	
Citation(s):	EC.02.01.01 EC.04.01.01 EM.03.01.03

ENVIRONMENT OF CARE PLAN

The goal of the environment of care plan is to maintain safe facilities so that all individuals served, all staff, and all visitors may comfortably utilize Chestnut facilities, free from concern about their safety. Objectives of the plan include monitoring incident reporting, building evaluation, staff competencies, monitoring fire and phone safety features, and evaluating safety drills. The environment of care plan will be reviewed annually and can be found in the appendix of this manual and under the safety tab on the intranet.

Manual:	Safety Manual
Manual Section:	Environment of Care
Name:	Immediate Notification of Environmental Issues – Incident Reporting/Support Tickets
Effective Date:	05/22/2019
Policy Cross Reference(s):	RM 60 – Incident Reporting SI 270 Facilities Maintenance
Citation(s):	EC.02.01.01

IMMEDIATE NOTIFICATION OF ENVIRONMENTAL ISSUES

INCIDENT REPORTING SUPPORT TICKETS

When an issue involving the environment occurs staff should complete a support ticket. If the situation involves an immediate safety concern such as ice in a parking lot, broken equipment, etc. facility staff, including notification of the Regional Facility Manager, should be contacted directly. Facility staff will document steps taken to correct environmental issues.

Manual:	Safety Manual
Manual Section:	Environment of Care
Name:	Safety Data Sheets
Effective Date:	01/01/2018
Policy Cross Reference(s):	SI 230 Safety Data Sheets
Citation(s):	EC.02.02.01 OSHA The Hazard Communication Standard (HCS) (29 CFR 1910.1200(g))

SAFETY DATA SHEETS

Safety Data Sheets (SDS) communicate the hazardous aspects of chemicals that may be used at Chestnut. Electronic versions of SDS sheets are maintained alphabetically on the W drive in the SDS folder.

Should there be an accidental exposure to a chemical, the SDS sheet can be consulted to identify any special precautions or treatment necessary. Notify the purchasing staff if an SDS Sheet is not present on the w drive. New SDS sheets should be forwarded to the Safety Coordinator. The Safety Coordinator will scan to the W drive.

Staff are not permitted to bring in chemicals (i.e. cleaning, art supplies, air fresheners) without prior approval of the Facility Manager. If the Facility Manager approves the product, staff should notify purchasing staff to obtain a SDS sheet for the product. Staff can use their own personal products like hand cream or hand sanitizers, these products should be stored so that they cannot be accessed by patients.

Manual:	Safety Manual
Manual Section:	Environment of Care
Name:	Building Security
Effective Date:	01/01/2018
Policy Cross Reference(s):	
Citation(s):	EC.02.01.01

BUILDING SECURITY

All Chestnut staff are issued a photo ID badge which is expected to be displayed while in Chestnut facilities. If an individual is discovered in the facility without a Chestnut ID, staff are to assume they are a visitor and escort them accordingly. If for any reason an individual does not have access to his/her identification badge the individual must obtain a temporary badge from designated staff. Badges are to be returned per the direction of designated staff.

Some Chestnut facilities are equipped with alarm systems. Staff should be oriented by their supervisor if their duties include alarming or disarming the system. If staff are unable to alarm or disarm an alarm system, facilities staff should be immediately contacted. If this occurs after regular business hours, staff should contact the designated or on-call facilities worker and/or supervisor.

If a staff person enters a residential building after regular business hours and is not typically scheduled to work, he/she should inform staff on duty on the units of their presence in the building. These procedures are important to assure that all staff are evacuated in the case of an emergency and as a courtesy to the unit staff, so they are aware of authorized individuals being in the building.

In residential facilities, a staff member on each shift during non-business hours should conduct a patrol of the building to observe any unusual occurrences, unlocked doors, lights left on or unauthorized individuals in the building. An Incident Report should document these occurrences.

Manual:	Safety Manual
Manual Section:	Environment of Care
Name:	Office Set Up
Effective Date:	
Policy Cross Reference(s):	
Citation(s):	HRM.01.05.01

OFFICE SET UP

When setting up an office staff should be mindful about the placement of furniture. Staff should take precautions to avoid trapping themselves in an office in case a situation were to become volatile. Staff should also consider items that are left within reach to ensure that those items cannot be used as a weapon.

Manual: Safety Manual

Manual Section: Environment of Care

Name: Interview Rooms Designed for Volatile Situations

Effective Date: 05/22/2019

Policy Cross Reference(s):

Citation(s):

INTERVIEW ROOMS DESIGNED FOR VOLATILE SITUATIONS

Certain rooms have been designed in a way to enhance safety for staff while meeting with patients when there is reason to believe that the person may become volatile during their visit (i.e. hospitalization, payee/money issues, history of aggression, crisis intervention interaction).

These rooms are designed to have minimal furniture that is situated in a way so that exits are unobstructed.

If the facility does not have a designated room, staff should if possible, utilize a group room or other space that has two ways of egress.

Other safety practices that staff may utilize when meeting with a potentially volatile individual is, to tell another staff member when the meeting is scheduled and leave the door cracked open. The second staff member can be on alert for changing situations in your office

Manual: Safety Manual

Manual Section: Environment of Care

Name: Door Switch Alarm Response Procedures

Effective Date: 10/1/21

Policy Cross Reference(s):

Citation(s):

DOOR SWITCH ALARM RESPONSE PROCEDURES

The Door Switch alarm system will notify staff that a self-harm event may be or has taken place. Alarms are installed on both the main bedroom door and bathroom doors in the handicap rooms on residential units. When a door switch is activated, an alarm will sound and a blue strobe light will be activated at the affected room.

1. When the alarm sounds look for an activated blue strobe light above one of the handicap room doors. If the strobe is not on in the unit that you occupy, check the other unit.
2. Immediately go to the indicated room/s and assist the client attempting self-harm.
3. Initiate applicable first aid or suicide risk assessment procedures.
4. Call 911 if emergency medical treatment is needed.
5. When the client is safe and being attended to, silence the alarm by entering the silence code into the keyboard. After entering the code the key pad should read, "THE DOOR SWITCH SYSTEM ENABLED" If it does not, reenter the code again.
6. Make all necessary event notifications as outlined in the program procedures manual and complete an incident report.
7. Submit a maintenance work order to have the alarm tested to ensure the system is reset and in proper operations after a self-harm event.
8. If the alarm was a result of a false alarm, follow the program procedures as you would for any misconduct. Such behavior may result in damage to the door switch and must immediately be addressed.

Manual: Safety Manual

Manual Section: Environment of Care

Name: Environmental Suicide Risk Reduction

Effective Date: 05/22/2019

Policy Cross Reference(s):

Citation(s): NPSG.15.01.01

ENVIRONMENTAL SUICIDE RISK REDUCTION

As part of the suicide prevention initiative all residential units will be inspected semi-annually for environmental suicide risks. Items deemed to be a risk will be discussed during committee meetings with key leadership staff. When immediate risks are identified, the following will occur:

- Notification of the Learning and Safety Manager and Safety Coordinator,
- Completion of incident report,
- Immediate mitigation of the risk, or if risk cannot be immediately mitigated, then interim steps will be taken to ensure patient safety (i.e. room closure).
- The Learning and Safety Manager and Safety Coordinator will monitor progress towards full mitigation of identified risks.

As part of this risk assessment certain items have been deemed as restricted from residential use.

Restricted items are as follow:

Crisis/Detox Units

Plastic trash bags in areas that are not visible at all times.

Razors (kept with staff and given to clients with approval to use)

Corded items such as alarm clocks, lamps, or radios

When using a hospital bed with a cord the cord should be zip-tied.

Manual:	Safety Manual
Manual Section:	Environment of Care
Name:	Nurse Call Button
Effective Date:	05/22/2019
Policy Cross Reference(s):	
Citation(s):	

NURSE CALL BUTTON

In facilities that contain a nurse call button the Nursing Coordinator will coordinate the testing of button on a monthly basis. Documentation of testing will be stored by the Safety Coordinator. The form for documenting this test can be found in the appendix of this manual and under the safety tab on the intranet.

Manual: Safety Manual

Manual Section: Environment of Care

Name: Eye Wash Stations

Effective Date: 05/22/2019

Policy Cross Reference(s):

Citation(s):

EYE WASH STATIONS

Emergency eye wash stations use a steady stream of water to flush irritants from the eyes to treat and prevent eye injuries.

Eye wash stations that are connected to sinks will be tested on a weekly basis by the facilities department or nursing staff to ensure they are in proper working order. Documentation of testing will be stored by the Safety Coordinator. The form for documenting this test for Behavioral Health programs can be found in the appendix of this manual and under the safety tab on the intranet. In the Health Center equipment tags serve to document this test.

Manual:	Safety Manual
Manual Section:	Environment of Care
Name:	New Site Set Up
Effective Date:	06/24/20
Policy Cross Reference(s):	
Citation(s):	LS.01.01.01

NEW SITE SET UP

The Safety Coordinator will send the following items for new sites:

- Emergency Procedures
- Safety Flip Chart
- First Aid Kit
- Template for business unit specific safety plan for the Director to complete

The Safety Coordinator will work with site staff to designate a fire meeting location, tornado shelter, and designated meeting location for Dr. Lock and Active Shooter. The Safety Coordinator and facility staff will work together to create and post a map including evacuation routes for the building.

Ensure that staff have an analog phone if needed during a power failure or cell phone.

The Facility Director, or designee will ensure that facility licensing paperwork (Schedule C and architect approval for SUPR and Plumbing and Electrical clearance for DMH) along with the Statement of Conditions for Joint Commission is complete for all new facilities.

Designated QM staff will complete required paperwork to add a site to SUPR, DMH, and Joint Commission.

Manual: Safety Manual

Manual Section: Environment of Care

Name: Pre-Construction Risk Assessment

Effective Date:

Policy Cross Reference(s):

Citation(s): EC.02.06.05
LS.01.02.01

PRE-CONSTRUCTION RISK ASSESSMENT

When planning for demolition, construction, renovation, or general maintenance, a pre-construction risk assessment for air quality requirements, infection control, utility requirements, noise, vibration, and other hazards that affect care, treatment, and services is completed by facilities staff. The Pre-Construction Risk Assessment can be found in the appendix of this manual and under the safety tab on the intranet. The completed assessment should be given to the QM department for storage.

When Life Safety Code items are identified during periods of construction the following is completed as deemed necessary by the Facilities Director and Safety Coordinator:

- Post Signage identifying the location of alternative exits to everyone affected.
- Inspect exits in affected areas on a daily basis.
- Provide temporary but equivalent fire alarm and detection systems for use when a fire system is impaired.
- Provide additional firefighting equipment.
- Use temporary construction partitions that are smoke-tight or made of noncombustible or limited-combustible material that will not contribute to the development or spread of fire.
- Increase surveillance of buildings, grounds, and equipment, giving special attention to construction and storage areas.
- Enforce storage, housekeeping, and debris-removal practices that reduce the building's flammable and combustible fire load to the lowest feasible level.
- Provide additional training to staff on the use of firefighting equipment.
- Conduct one addition fire drill per quarter.
- Inspect and test temporary systems monthly.
- Conduct education to promote awareness of building deficiencies, construction hazards, and temporary measures implemented to maintain fire safety.

Manual: Safety Manual

Manual Section: Environment of Care

Name: Pest Control

Effective Date: 08/01/2018

**Policy Cross
Reference(s):**

Citation(s):

PEST CONTROL

Chestnut contracts with a professional pest control company for ongoing, routinely scheduled pest control maintenance services for all sites and more frequently when a pest control issue is identified.

Manual: Safety Manual

Manual Section: Environment of Care

Name: Bed Bugs

Effective Date: 05/22/2019

Policy Cross Reference(s):

Citation(s):

BED BUGS

Chestnut maintains preventative and reactive procedures relating to bed bugs for outpatient, community based, housing, health center, and residential services.

For outpatient and health center patients being seen in a Chestnut facility

If at any point a client reports that they have recent exposure to bed bugs, staff should offer the bed bug informational sheet found on the intranet under the safety tab or in the appendix of this manual. Clients should be asked not to bring bags or purses on site. If possible, staff should meet with clients in a room with hard surface floor and plastic chairs. After the meeting staff should do a close inspection of the room and immediately speak to facilities staff to notify them of the room that was being used and where the client was sitting, label the chair that needs to be cleaned. If a bug is noticed, it should be retrieved, if possible, placed in a sealed container and given to facilities staff.

Facilities staff may offer other possible interventions on a case-by-case basis.

Cleaning schedule for OP and health center areas affected by bed bugs:

- Vacuum floors or offices
- Steam clean office space (floor, chairs, couches) as needed
- Spray office space (floor, chairs, and couches) as needed
- Re-inspect every other day for 10 days. Facilities staff will call the contractor for needed pest removal.

When seeing patients in the community:

To reduce the risk of picking up bed bugs while working in the community staff should

1. Bring as little as possible by not carrying bags or personal belongings.
2. Sit on a hard chair, away from the wall if possible.
3. After leaving the residence, carefully shake out clothing before entering your vehicle. Consider bringing a change of clothes and shoes for working in the field, change clothes at work and keep the field clothes and shoes in a sealed bag for laundering. When washing clothing use the highest water temperature setting possible and dry on high heat. If you will be helping a client clean an infested area wear a Tyvek suit. Discard the suit by changing immediately and sealing it in a plastic bag before discarding in an outside trash can. Tyvek suits are available from the purchasing department.

For residential patients:

New residential patients should be educated about preventing and controlling bed bugs. This education includes cooperating with staff during inspections, knowing the signs of bed bugs, promptly reporting suspected bed bugs, which may include obtaining a bug for verification, and procedures that patients are expected to follow if bed bugs are found. Patients will also be educated on the number of items that can be brought on to residential units. Patients bringing in more items than allowed will have their items double bagged and sealed and placed into storage while they are receiving services. These items will be returned to the client upon discharge. All appropriate items that are allowed on the unit should be placed in a hotbox or dryer to be treated prior to coming on the unit. If there is a delay in treating client belongings, they should be bagged, sealed and stored until such time that they are treated. Clients will be provided clothing in the interim of receipt of their items.

Cleaning schedule for residential areas affected by bed bugs:

- Vacuum floors
- Spray space as needed, preferably when clients are off the unit
- Launder all bedding
- Have clients bag and treat their laundry by either using the dryer or hot box
- Place bed bug trap in room
- Re-inspect every other day for 10 days. Facilities staff will call the contractor for needed pest removal.

For housing patients:

New Housing Patients:

New patients should be educated about preventing and controlling bed bugs. This education includes cooperating with staff during inspections, knowing the signs of bed bugs, promptly reporting suspected bed bugs, which may include obtaining a bug for verification, and procedures that patients are expected to follow if bed bugs are found. Patients will also be educated on how to maintain a clutter free apartment.

Upon admission, clothing and linens should be washed and dried on high heat for at least 30 minutes. In the event that this cannot be done immediately, items should be placed in double plastic bags and sealed until laundry can be completed.

Furniture should be inspected for bed bugs before being put into an apartment by facilities or housing staff. If bed bugs are found, items should be vacuumed or steam cleaned. Mattresses and box springs should be covered in bed bug proof vinyl coverings. Furniture such as couches and chairs should be steam cleaned if possible. Mattresses and fabric furniture with bed bugs will not be allowed in the apartment, until cleared as being insect-free by a Facility staff. Tenants may be asked to pay for the cost of treatment to personal furniture that is infested. Mattresses that are supplied by Chestnut will be staff check mattresses which are made to help reduce the likelihood of infestation.

Prevention:

Housing Staff:

During monthly apartment inspections staff should evaluate apartments for cleanliness and clutter. If a client's apartment is in need of cleaning/decluttering staff should work with patients on a weekly basis until the issue is resolved. This information is documented on the monthly apartment inspection form.

Monthly during community meetings staff should discuss ways to prevent bed bugs.

Facilities Staff:

Facilities staff will inspect apartments owned by Chestnut for bed bugs and document findings on their monthly apartment inspection form.

If Bedbugs are reported:

Housing Staff:

Contact facilities staff by completing a work request and emailing your supervisor and regional facilities manager immediately. If possible, obtain a bug in a secure container for inspection.

Facilities Staff:

Facilities staff will contact a professional pest management service on the same or next business day. A professional inspection of the infested area will be scheduled at the first available time. Facilities staff will communicate with housing staff regarding the date and time of inspection.

Recommendations from the pest control agency should be documented.

If Bedbugs are confirmed:

Housing staff:

Housing staff will help patients clean and prepare for recommended treatment as prescribed by the contractor (see room preparation checklist found on the intranet under the safety tab or in the appendix of this manual).

The Room Preparation checklist will be followed each day by housing staff and submitted to their supervisor.

Items that need to be discarded will be placed in the back of a Chestnut truck or trailer so that it can be disposed of in a dumpster at a main Chestnut office. This is to help prevent other patients from taking in infested items.

Facilities Staff:

Facilities staff will help direct staff with items that need to be completed before treatment. This information will be documented and kept on site.

All Staff:

To reduce the risk of picking up bed bugs while working in an affected area, staff are to wear a Tyvek suit. Discard the suit by changing immediately and seal the suit in a plastic bag before discarding in an outside dumpster.

Day Before Treatment:

Housing Staff:

Housing staff should work with client to launder an outfit that can be kept in the office.

During Treatment:

Housing Staff:

Housing staff will assist client in completing all of their laundry. Laundry should be emptied from bags and laundered on the hottest setting possible for at least 30 minutes. Used bags should be placed in an outside trash can at the laundromat if possible. Once laundry is complete it should be placed into NEW sealed plastic bags.

When returning to the office have client change into the outfit that was left there the day before and launder the outfit that they are currently wearing.

All Staff:

All staff should work together to treat items that can be placed in the hot box.

Post Treatment:

Facilities staff and housing staff:

Inspect the apartment no less than weekly for three months. This should be documented on your monthly apartment inspection form. If more bugs are found during inspection, the pest management service will be contacted and recommendations will be followed as stated above. If no bugs are found at the end of three months then the routine monthly inspection will be reinstated.

Housing Staff:

Consider creating a tenet agreement for patients as necessary. See examples in appendix and under the safety tab on the intranet.

Transporting Housing Clients with known bed bugs

When possible have client place a change of clothing into the dryer and dry on highest setting for at least 30 minutes. Immediately place clothing into a sealed Ziploc bag and place in the bathtub. Client should change into clothing just prior to leaving with Chestnut staff.

Transporting Clients that report bed bugs

Facilities staff should be notified after client has been transported so that they can spray the vehicle with approved bed bug spray upon return to the facility.

Manual:	Safety Manual
Manual Section:	Environment of Care
Name:	Water Temperature
Effective Date:	01/01/2018
Policy Cross Reference(s):	SI 310 Water Supply
Citation(s):	

WATER TEMPERATURE

Preferred hot water temperature should be between 110 -115 degrees and never exceed 120 degrees at the outlet.

Manual:	Safety Manual
Manual Section:	Environment of Care
Name:	Vehicle Safety
Effective Date:	01/01/2018
Policy Cross Reference(s):	SI 170 Vehicle Safety
Citation(s):	

VEHICLE SAFETY

Only staff who have been approved by Chestnut's automobile insurance carrier and who have a valid government issued driver's license may transport patients. Any staff transporting a patient shall do so with the prior approval of the supervisor.

Staff must be approved prior to driving company vehicles/mobile units and/or transporting patients. Human Resources will provide instructions regarding this process. Facilities staff or your supervisor will provide orientation to procedures and/or competency check related to the use of company vehicles or mobile units. Additionally, staff are assigned training via the learning management system.

Chestnut staff should abide by all State laws and Chestnut policies regarding driving vehicles when driving company vehicles and/or transporting patients in personal vehicles. Fees incurred due to driving violations are the financial responsibility of the driver. All Chestnut staff and passengers should properly use the vehicle's safety belt when driving company vehicles and when using personal vehicles for company use. Children will be secured in an age-appropriate car/booster seat.

There is an expectation for compliance with Chestnut rules and instructions regarding proper conduct during transportation. Staff are not expected to transport individuals who refuse to be secured and who do not comply with the requests of the driver.

Before the vehicle is put into motion the driver is responsible to account for all passengers and that doors are securely shut.

Manual:	Safety Manual
Manual Section:	Environment of Care
Name:	Vehicle Accident
Effective Date:	01/01/2018
Policy Cross Reference(s):	SI 170 Vehicle Safety
Citation(s):	

VEHICLE ACCIDENT

In the event of a vehicle accident, staff involved should:

- Attend to the medical needs of individuals involved and call Emergency Medical Services, as needed.
- Call police for the purpose of making/gaining a police report.
- Notify supervisor.
- Notify Human Resources.
- Complete an incident report and attach police report.
- Parents/guardians of an adolescent patient or adult patient with guardian who is in the vehicle at the time of the accident are to be notified as soon as possible following the accident. Documentation of the accident and the procedures followed should be documented in each patient's medical record, as well as any known injuries or medical refusal.

When the accident occurs in a Chestnut vehicle, staff should also follow the written accident procedures attached to the insurance card located in the vehicle glove compartment. This requires completion of a separate accident report form which is to be forwarded to the Regional Facilities Manager.

Manual:	Safety Manual
Manual Section:	Environment of Care
Name:	Mechanical Equipment
Effective Date:	01/01/2018
Policy Cross Reference(s):	SI 260 Utility Systems
Citation(s):	EC.01.01.01 EC.02.05.01 441.184 CMS

MECHANICAL EQUIPMENT

Facilities staff are responsible to perform and/or arrange for operation and/or repair of mechanical equipment. No staff are to attempt to operate or repair any mechanical device unless specifically trained to do so.

In the event of an emergency involving a mechanical malfunction, staff should turn off the malfunctioning equipment and immediately contact the Facilities staff and/or supervisor.

It is the responsibility of all staff to report to Facilities personnel the presence of any hazardous situation relating to the repair or use of Chestnut's mechanical devices.

Manual:	Safety Manual
Manual Section:	Environment of Care
Name:	Electrical Equipment
Effective Date:	01/01/2018
Policy Cross Reference(s):	SI 260 Utility Systems
Citation(s):	LS.02.01.70 441.184 CMS

ELECTRICAL EQUIPMENT

As part of the total responsibility concept, all staff are responsible for reporting to facilities any observed electrical hazards or potentially hazardous situations.

Operating instructions and training on specific electrical equipment are given to staff who have responsibility for the operation of the equipment or the supervision of its use. Staff who have not received specific training in the use of electrical equipment are not allowed to operate such equipment.

Portable space heating devices, where the heating elements do not exceed 212 degrees Fahrenheit, may be permitted in staff and non-sleeping patient areas. Such heating devices may only be issued by facilities staff; individual employees are not permitted to bring their own devices into the facility. Staff desiring a heater should request this from facilities staff that will evaluate the need.

Facilities staff have the responsibility of ensuring that all personal electrical equipment (staff or patient) brought to a facility is in good operating condition and does not have frayed or broken electrical cords or plugs. A maintenance request via the intranet should be made for this purpose. If items are found satisfactory for use, they will be tagged as such.

The use of appliances in staff offices is prohibited without the approval of the facilities department.

The use of extension cords or multiple outlet adapters must receive prior approval of the facilities staff before being used.

Manual:	Safety Manual
Manual Section:	Environment of Care
Name:	Generators
Effective Date:	01/01/2018
Policy Cross Reference(s):	SI 260 Utility Systems
Citation(s):	EC.02.05.03 EC.02.05.07 441.184 CMS

GENERATORS

Generators will be tested per Joint Commission requirements on a monthly basis. Documentation of generator load tests will be stored by the facilities department.

Manual:	Safety Manual
Manual Section:	Environment of Care
Name:	Utilities
Effective Date:	01/01/2018
Policy Cross Reference(s):	SI 260 Utility Systems
Citation(s):	EC.01.01.01 EC.02.05.01 441.184 CMS

UTILITIES

Information regarding emergency utility shut off is in the Appendix section of this Safety Manual.

Manual: Safety Manual

Manual Section: Environment of Care

Name: Inspections and testing

Effective Date:

Policy Cross Reference(s):

Citation(s): EC.02.05.07

INSPECTIONS AND TESTING

Facilities staff complete a monthly inspection of all Chestnut buildings. This inspection includes looking for risks related to the environment of care and life safety. As part of this inspection a functional test of emergency and exit lights are tested for 30 seconds,

Annually a functional test of battery-powered lights is completed for 1 ½ hours.

Documentation of inspections and tests can be found in the facility specific binder that is stored by the facilities department. At least semi-annually these binders will be inspected by the Safety Coordinator.

Manual:	Safety Manual
Manual Section:	Environment of Care
Name:	Laundry and Linen
Effective Date:	01/01/2018
Policy Cross Reference(s):	
Citation(s):	2060.305

LAUNDRY AND LINEN

All laundry and linen are to be handled using the following procedure:

1. Staff members should use Standard precautions and follow proper handwashing procedures while handling linens.
2. Soiled linens are collected in such a manner as to avoid germs scattering into the environment.
3. Saturated linens are to be placed in a leak proof container to transport to laundry.
4. Soiled linens are to be sorted, laundered and stored only in designated areas and should be stored separately from clean linen.
5. All linens (both soiled and clean) should be handled as little as possible.
6. Clean linens should be stored in a way to prevent contamination such as in a cabinet or covered bin.
7. Trash cans in laundry areas should have a lid.
8. Items such as brooms and dustpans should not be stored in the laundry area.
9. Dryer vents should be cleaned out after each use.
10. Facilities staff should check dryer exhaust vents monthly to ensure that the area behind the dryer is clean and the vent is correctly attached to the dryer.

Manual: Safety Manual

Manual Section: Environment of Care

Name: Mopping

Effective Date:

**Policy Cross
Reference(s):**

Citation(s):

MOPPING

Any time staff or clients mop the floor with either a mop or a wet jet device a wet floor sign should be placed in the area until area is determined to be completely dry.

Manual: Safety Manual

Manual Section: Environment of Care

Name: Disinfection – Patient Sleeping Room

Effective Date: 01/01/2018

Policy Cross Reference(s):

Citation(s):

DISINFECTION – PATIENT SLEEPING ROOM

Facilities staff will typically be responsible for disinfection of sleeping rooms and will follow the procedures outlined in the environmental services cleaning guide. If Facilities staff is unavailable, program staff may be required to do so.

All patient rooms are to be disinfected prior to occupation by another patient using the following procedure:

1. Strip bed following laundry and linen procedure.
2. Empty waste cans and spray with appropriate chemical disinfectant:
 - Neutral Disinfectant Cleaner
 - Q&A Cleaner
 - Other commercial disinfectants approved by facilities
4. Spray with disinfectant and wipe down the following:
 - Mattress
 - Plastic Pillow Covers
 - Closet shelf
 - Bed
 - Dresser Drawers
 - Desk (if empty)
5. Move bed and vacuum/sweep under and around.
6. Clean bathroom and spray stool and sink with disinfectant and wipe clean.
7. Signage is posted on the bed when it has been disinfected.

Manual: Safety Manual

Manual Section: Environment of Care

Name: Disinfection – Exam Rooms

Effective Date: 01/01/2018

**Policy Cross
Reference(s):**

Citation(s):

DISINFECTION – EXAM ROOMS

The clinical space where patients are seen will have all contacted surfaces wiped down after each use. In addition, facilities staff or contracted vendors will typically be responsible for disinfection of exam rooms after hours and will follow the procedures outlined in the environmental services cleaning guide.

Manual: Safety Manual

Manual Section: Environment of Care

Name: Child Area Toys

Effective Date:

**Policy Cross
Reference(s):**

Citation(s):

CHILD AREA TOYS

In areas where toys are made available for children, they should be age appropriate, in good repair, easily cleanable, and should not pose a choking risk. Toys in the waiting area should be cleaned by facilities staff when cleaning other waiting room items. Toys located in offices should be cleaned by staff that are working with children at the end of the session.

Manual:	Safety Manual
Manual Section:	Environment of Care
Name:	Internal Food Service
Effective Date:	01/01/2018
Policy Cross Reference(s):	
Citation(s):	Illinois Food Code 750.203

INTERNAL FOOD SERVICE

Each facility that has a food permit shall have one full-time staff member that is a Certified Food Sanitation Manager. In addition, housing and residential programs that periodically cook with clients shall have one staff member that is involved in the food preparation trained as a Certified Food Sanitation Manager. Staff serving as the Certified Food Sanitation Manager should have their certificates uploaded to Relias.

As required by local health departments, all staff that handle food should complete Food Handler training (posted in the Relias Learning Management system) before handling food. This training will be documented by completing a quiz. Quizzes will be reviewed by the Safety Coordinator and uploaded to Relias.

All staff should follow the rules set forth in the food handler training.

At least semi-annually a Certified Food Sanitation Manager will inspect food preparation areas to ensure proper food handling and storage procedures.

Manual: Safety Manual

Manual Section: Environment of Care

Name: Catered Food

Effective Date: 01/01/2018

Policy Cross Reference(s):

Citation(s):

CATERED FOOD

Food provided by a caterer shall be inspected by Chestnut staff upon arrival to Chestnut's facility. This inspection should include the internal temperature (of potentially hazardous foods), a general count (if items can be counted) and assurance that all ordered food has been received. If the food is not provided as ordered, an incident report should be completed.

Staff should take the internal temperature of potentially hazardous food using a proper food thermometer. "Potentially hazardous food" means any food that consists in whole or in part of milk or milk products, eggs, meat, poultry, fish, shellfish, edible crustacea, or other ingredients, including synthetic ingredients, in a form capable of supporting rapid and progressive growth of infectious or toxigenic microorganisms". Staff should use the following procedures:

1. Clean the thermometer.
2. Insert the thermometer through the foil or plastic covering and into the food. For foods like vegetables in liquid, the temperature of the liquid can be taken if it is difficult to insert the thermometer into the food item.
3. If the temperature reads outside of the acceptable range of 136° or greater for hot foods or 40° or below for cold foods, the temperature should be retaken to assure accuracy.
4. A unit supervisor should be contacted to decide whether to accept any potentially hazardous food with the temperature outside of the acceptable range.
5. If the temperature of the food is outside of the expected range upon delivery and the food has been placed in a food warmer, microwaved or refrigerator prior to serving, the temperature should be retaken and recorded prior to serving.
6. Documentation: The temperatures should be documented on the Catered Meals Quality Control Documentation form (these forms should be sent to the Safety Coordinator at the end of each month). If the food was not acceptable to serve due to temperature concern, an incident report should be completed by the staff.

Manual: Safety Manual

Manual Section: Environment of Care

Name: Refrigerated Food Storage – Patients

Effective Date: 01/01/2018

Policy Cross Reference(s):

Citation(s):

REFRIGERATED FOOD STORAGE – PATIENTS

All food stored for patients in the refrigerator must be properly wrapped and labeled for storage. Any food that is not labeled or is not properly wrapped should be immediately discarded.

Meals saved for patients should be labeled with the patient's first name and date and time food is placed in storage. This food should be discarded after 72 hours.

Bulk lunch meat should be removed from the original packages on the day of arrival and reasonable amounts of meat placed in freezer zip-lock bags, dated and stored in the freezer. The staff member that removes the lunch meat from the freezer should take the package with the oldest date out to be used, write the date that the bag is placed in the refrigerator on the bag. The lunch meat in this bag must be eaten or discarded within 7 days from being placed in the refrigerator.

Bulk items that need to be moved from their original container into a new container shall be labeled with the expiration date. Containers should be washed before placing new food into them even if it will be the same type of food item.

There should be no open containers in the refrigerator or freezer. Drinks must be stored in a closed pitcher.

Manual: Safety Manual

Manual Section: Environment of Care

Name: Refrigerated Food Storage – Staff

Effective Date: 01/01/2018

**Policy Cross
Reference(s):**

Citation(s):

REFRIGERATED FOOD STORAGE – STAFF

All food stored for staff in the refrigerator must be properly wrapped and labeled (name and date) for storage. Facilities staff will routinely clean refrigerators and freezers and will dispose of food that is not properly stored or that has expired.

Manual: Safety Manual
Manual Section: Environment of Care
Name; Dishwashing – Patients
Effective Date: 01/01/2018
Policy Cross Reference(s):
Citation(s):

DISHWASHING – PATIENTS

Hand Washing

All hand washing of dishes and utensils shall be completed using the following procedures:

1. Dishes are washed and rinsed in hot water.
2. Dishes are dipped for one minute in a mixture of $\frac{1}{4}$ cup bleach to 5 gallons of hot water and then rinsed
3. Drying dishes with cloths is not considered sanitary by the health department and is prohibited. Dishes are drain dried.
4. Always wash hands before putting clean dishes away.

Automatic Dishwasher

Use of the automatic dishwasher may be substituted for washing by hand. The automatic dishwasher should be used per the manufacturer's instructions.

Manual: Safety Manual

Manual Section: Environment of Care

Name: Dishwashing – Staff

Effective Date: 01/01/2018

**Policy Cross
Reference(s):**

Citation(s):

DISHWASHING – STAFF

All staff are required to wash dishes used for personal use. Unwashed dishes and utensils should not be left in the sink.

Manual: Safety Manual

Manual Section: Environment of Care

Name: Disposal of Trash and Waste Products

Effective Date: 01/01/2018

Policy Cross Reference(s):

Citation(s):

DISPOSAL OF TRASH AND WASTE PRODUCTS

All trash and waste products shall be disposed of using the following procedures:

1. All trash should be properly bagged and not exposed to the environment.
2. Per food service regulations, trash cans in kitchen/food prep areas should have lids.
3. Trash cans in kitchen/food preparation areas should be cleaned regularly and any time when visibly soiled.
4. Trash should not be carried through hallways without a protective covering and assurance that the bag is not leaking.
5. Use liner bags and seal them securely before removing them from the premises.
6. Trash should be transported to the proper garbage removal zone outside.

Manual:	Safety Manual
Manual Section:	Emergency Preparedness and Response
Name:	Emergency Preparedness and Response
Effective Date:	01/01/2018
Policy Cross Reference(s):	SI 300 Emergency Preparedness and Management
Citation(s):	EM.01.01.01 EM.02.01.01 2060.305 132.65 2060.305 441.184 CMS

EMERGENCY PREPAREDNESS AND RESPONSE PLAN

Chestnut has established and maintains emergency preparedness and response procedures designed to understand and manage the consequences of emergencies that may disrupt Chestnut's ability to provide services. The purpose is to provide organizational structure so that programs and business units can effectively prepare and respond to emergencies.

Emergency preparedness and response procedures are designed to coordinate Chestnut's communications, resources, assets, safety, security, staff responsibilities, and clinical and support activities during an emergency. The emergency preparedness and response section provides guidance for proactive and reactive response to emergencies.

Emergency procedure flip charts are maintained at each facility. The flip charts are intended to provide a quick reference guide to staff during emergencies.

Each program/business unit develops and maintains an emergency response plan specific to its operations. The Safety Coordinator is responsible for monitoring the status of Business Unit Emergency plan updates.

When indicated, Chestnut utilizes an Incident Command (IC) system which is an "all hazards" approach and provides a general response capability that is flexible to address a range of emergencies of different duration, scale and cause. Large scale emergency responses will be coordinated with local emergency management agencies.

Chestnut identifies potential emergencies that could affect demand for its services or its ability to provide those services by engaging in an annual hazard vulnerability analysis (HVA) conducted by the Learning and Safety Manager and Safety Coordinator. The HVA reflects all locations where individuals are served. The Learning and Safety Manager and Safety Coordinator are responsible for the annual review of the HVA and subsequent drills are prioritized accordingly.

Manual:	Safety Manual
Manual Section:	Emergency Preparedness and Response
Name:	Emergency Response
Effective Date:	05/22/2019
Policy Cross Reference(s):	
Citation(s):	EM.02.01.01 EM.02.02.07

EMERGENCY RESPONSE

In the event of an emergency, the staff on duty will take necessary actions to ensure the immediate well-being of individuals served and others present.

Staff will follow the program/business unit's specific emergency response plan. Your supervisor will advise you of the location of these plans. The plans provide practical guidance on immediate actions and management contact information.

When the emergency cannot be effectively managed at the program/business unit level, the Incident Command (IC) system will be activated.

Manual:	Safety Manual
Manual Section:	Emergency Preparedness and Response
Name:	Notification During An Emergency
Effective Date:	01/01/2018
Policy Cross Reference(s):	
Citation(s):	EM.02.01.01 EM.02.02.01

NOTIFICATION DURING AN EMERGENCY

Staff on duty will take necessary actions to ensure the immediate well-being of individuals present, including calling emergency personnel if determined necessary.

Once staff become aware of an emergency, staff should notify one of the following starting with a program supervisor and continuing until someone is reached. Once someone is reached, they will determine the need to notify others:

- 1) Program or Site Supervisor
- 2) Program or Site Director
- 3) Vice President of Integrated Care
- 4) Corporate Facilities Manager
- 5) Chief Operating Officer

Staff initially responding to the emergency may involve program, safety, and/or facilities staff as determined necessary. If staff involved in initially responding to the emergency determine that the incident requires the coordination of staff for continued action, an Incident Command Center can be initiated. Activation of the ICC shall be determined by any of the above mentioned staff, their designee, Learning and Safety Manager or Safety Coordinator.

If a staff person is working off-site or has not yet arrived at work for regularly scheduled work duties and is aware of a potential disaster situation at his/her work area, staff should contact the immediate supervisor. Staff should not assume that he/she should not come to work. If the entire facility is to be closed, this announcement will be made via local or social media for clients and through the texting platform system for staff. Chestnut may announce the canceling of clinical services, but that does not automatically mean that a facility will be closed.

Emergency notifications may be sent using email list serves that exist within Microsoft Outlook and/or the texting platform. The emergency notification system **is** intended for various uses, including but not limited to: Notification of building closings, building issues, weather emergencies, road closures impacting staff ability to reach work, etc.

Manual:	Safety Manual
Manual Section:	Emergency Preparedness and Response
Name:	Notification During An Emergency – Texting
Effective Date:	01/01/2018
Policy Cross Reference(s):	
Citation(s):	EM.02.01.01 EM.02.02.01

NOTIFICATION DURING AN EMERGENCY – TEXTING

All Chestnut owned cell phones have been set up with the designated texting platform for emergency notifications. Staff may opt in or out to receive text on their personal cell phones. Staff wishing to sign up for the texting platform should sign up by clicking on the QR code under the safety tab on the intranet or text the word join to (737) 282-7760.

Contact the Director of Marketing and Communications, Director of Quality and Compliance, Regional Vice President of Integrated Care, Learning and Safety Manager, or Safety Coordinator to initiate a text alert request.

Manual:	Safety Manual
Manual Section:	Emergency Preparedness and Response
Name:	Incident Command Center Activation Procedures
Effective Date:	01/01/2018
Policy Cross Reference(s):	
Citation(s):	EM.02.01.01

INCIDENT COMMAND CENTER ACTIVATION PROCEDURES

When notified of an emergency that requires intervention beyond what can be managed by the program, the Incident Command Center (ICC) may be activated by making an announcement that an incident has occurred and provide directions to available staff to go to the Incident Command Center. The announcement will include the location of the ICC.

Manual:	Safety Manual
Manual Section:	Emergency Preparedness and Response
Name:	Crisis Communication
Effective Date:	01/01/2018
Policy Cross Reference(s):	
Citation(s):	EM.02.02.01 441.184 CMS

CRISIS COMMUNICATIONS

The Crisis Communications plan should be enacted in the event of:

- A mass casualty incident at any Chestnut facility
- The evacuation or closure of any Chestnut facility for reasons listed in this Safety Manual or for any other reason
- Suspected or confirmed criminal activity involving any Chestnut staff member, client, or patient and relating to Chestnut property, business dealings, or programs
- Any incident or circumstance that has the potential to draw news media attention or public scrutiny

Crisis Communications work should be coordinated with the Incident Commander and other key staff if the ICC is activated. If ICC is not activated, such work will be coordinated among Marketing and Communications staff, members of corporate leadership (CEO, CFO, COO, CCO, and the involved or impacted program or service line director. Because crisis situations can happen outside regular business hours, the key staff named in this policy will have each other's cell phone or other emergency contact information programmed into their cell phones.

In the event of any of the situations outlined above, the Marketing and Communications Director should be contacted along with staff listed in the Safety Manual section, "Notification During an Emergency."

In coordination with staff members listed here, the Marketing and Communications staff will write messaging for internal (staff, Board of Directors) and external (news media, referral sources, partner agencies, government agencies, funders, patient/client families, etc.) audiences; determine communication channels; determine frequency of communications; and either act as media spokesperson or appoint a designee. Hard copy templates for media advisories, internal email, and social media posts are contained in ICC boxes at CR and SR locations. Electronic copies can be found here: W:/Marketing/Crisis.

Manual: Safety Manual

Manual Section: Emergency Preparedness and Response

Name: Roles During ICC Activation

Effective Date: 01/01/2018

Policy Cross Reference(s):

Citation(s):

ROLES DURING ICC ACTIVATION

Incident Commander

The Incident Commander shall be determined at the time of incident and is the person in charge. The Incident Commander can be anyone with competency to make decisions and act under pressure.

The Incident Commander will identify the initial scope of the incident given the information available. Initially, assigning tactical resources and overseeing operations will be under the direct supervision of the Incident Commander. The Incident Commander may delegate authority for performance of certain activities to others.

As an incident becomes more complex, a new Incident Commander may be assigned. Prior to the change of an Incident Commander, there will be a full briefing to the incoming Incident Commander and notification will be made regarding the change in command.

Recorder

This person is responsible for writing and updating all information that is posted in the Incident Command Center. The Incident Commander assigns this position to a specific staff member.

Runner

This person is responsible for a variety of tasks including getting status sheets from staff making phone calls and bringing them in to the recorder. The runner is also responsible for periodically briefing reception on what is happening in the Command Center. The Incident Commander assigns this position to a specific staff member.

Other Staff

Staff should remain in the ICC until assignments are made. Staff will be released by the Incident Commander or designee if there is not an assignment. If staff is given an assignment and cannot complete the task, he/she should advise the person assigned to lead the task so the duty may be reassigned if necessary. Staff from other locations may be called to assist as determined by the Incident Commander.

Manual:	Safety Manual
Manual Section:	Emergency Preparedness and Response
Name:	Volunteers
Effective Date:	11/13/2019
Policy Cross Reference(s):	
Citation(s):	441.184 CMS

VOLUNTEERS

During an emergency, facilities may need to accept volunteer support from individuals with varying levels of skills and training that are working in other Chestnut programs in the Central and Southern Region.

Volunteers should only perform services within their scope of practice and training. Any necessary privileging and credentialing will occur before volunteers perform any service.

In the event of an emergency occurring after hours off duty staff will be contacted using the emergency phone chain to report to the facility. If more volunteers are needed staff working at other locations will be contacted using the emergency phone chain or text notification system.

Volunteers will follow the directions given by the Incident Commander.

Manual: Safety Manual

Manual Section: Emergency Preparedness and Response

Name: Incident Command Center Coordination

Effective Date: 01/01/2018

Policy Cross Reference(s):

Citation(s):

INCIDENT COMMAND CENTER COORDINATION

The organization of the ICC is built around 5 major activities:

1. Command – Directed by the Incident Commander who is the person in charge. Sets objectives and priorities, has overall responsibility at the incident or event. Delegates authority for performance of tasks; maximizes the response effort while using resources efficiently.
2. Planning – Develops the action plan to accomplish the objectives set by Command. Collects, evaluates, disseminates and uses information. Maintains resource status.
3. Operations – Implements the action plan. Directs resources. Informs Incident Commander of situation and resource status within operations.
4. Logistics – Provides support to meet incident needs, provides resources (personnel, facilities, services and materials) needed to support the incident.
5. Finance – Monitors and records costs related to incident. Keeps receipts.

Manual: Safety Manual

Manual Section: Emergency Preparedness and Response

Name: Incident Command Center Locations

Effective Date: 01/01/2018

Policy Cross Reference(s):

Citation(s):

INCIDENT COMMAND CENTER LOCATIONS

Central Region

The location of supplies and support staff at King Drive make it the preferred location for the ICC. The facilities at Crossroads will be used as a secondary location, as appropriate. Locations will have a clearly labeled ICC box that contains forms and reference documents needed for the ICC. Staff should be familiar with the location of the ICC box in building in which you work.

Facility	ICC Box location
1003 Martin Luther King	Basement, conference center, K1, under table
702 West Chestnut	Meeting Room 207
Crossroads, 448 Wiley Dr.	Large training room, back closet

Southern Region

The location of supplies and support staff at Northgate make it the preferred location for the ICC. The facilities at Belleville or Maryville will be used as secondary locations, as appropriate.

Facility	ICC Box location
Northgate, 50 Industrial Dr.	Training Room
Belleville, 12 N. 64 th St.	Downstairs, training room
Maryville, 2148 Vadalabene	Large training room

Manual:	Safety Manual
Manual Section:	Emergency Preparedness and Response
Name:	Fire Warning & Safety / Life Safety Code
Effective Date:	01/01/2018
Policy Cross Reference(s):	SI 280 Fire Safety
Citation(s):	EC.01.01.01 EC.02.03.01 EC.02.03.03 EC.02.03.05 LS.01.02.01 LS.02.01.34 LS.02.01.35 LS.02.01.70 LS.04.02.30 132.65 2060.305 441.184 CMS

FIRE WARNING & SAFETY / LIFE SAFETY CODE

Building/Mobile Unit Evacuation Procedures

Building/mobile unit evacuation procedures are prominently posted throughout the buildings. Evacuation of all occupants has the highest priority in case of fire. If the building contains a fire alarm system pull the alarm, evacuate the building, and call 911. Specific evacuation procedures describing staff responsibilities in the evacuation process are maintained in program procedure manuals.

Fire Extinguishment

Fire extinguishers are located throughout all buildings/mobile units. Staff are only to attempt to extinguish a fire if it appears confinable and does not place their safety at risk.

Evacuation Drill Schedule

Buildings which offer housing or residential care will conduct bimonthly (not less than six times per year) fire drills in each building designed as a residential board and care facility, with at least two annual drills conducted during the dead of night (1:00 am-4:00 am) when individuals served are sleeping. These drills include actual evacuation of all residents. Outpatient, ambulatory care and business only occupied buildings will conduct evacuation drills and/or actually evacuate due to an emergency at least annually.

Following the drill or evacuation, any staff responsible for conducting drills and evacuations will forward documentation to the Safety Coordinator. The Safety Coordinator will maintain documentation of all drills and evacuations.

Maintenance & Inspection of Fire Alarm and Carbon Monoxide Systems

Facilities staff are responsible for preventive maintenance and inspection of fire alarm and carbon monoxide systems. Staff are responsible to report any concerns with any systems and complete associated documentation.

In coordination with the Safety Coordinator, facilities will test alarm in outpatient, ambulatory care and business only occupied buildings, during each quarter that a drill is not conducted. The testing will occur outside of business hours.

External Inspection of Facilities

Facilities and safety staff will coordinate with local fire department jurisdictions for such inspections as determined by the local authority requirements. If a local authority presents for an inspection, Facilities staff should be contacted.

Furnishings & Equipment

All furniture, bedding, curtains, decorations and other equipment purchased by Chestnut for use in Chestnut facilities or mobile units are reviewed by the Purchasing, Facilities and/or Safety departments regarding fire safety features.

Maintenance & Inspection of Furnishings & Equipment

Prior to any electrical equipment being installed or utilized by patients or staff, the Facilities department is responsible to inspect and tag the equipment. Staff should send a maintenance request for such inspections.

When a fire alarm system is out of service more than 4 out of 24 hours or a sprinkler system is out of service more than 10 hours in a 24-hour period in an occupied building the fire department should be contacted, and a fire watch will be initiated.

Manual: Safety Manual

Manual Section: Emergency Preparedness and Response

Name: Fire Watch

Effective Date:

Policy Cross Reference(s):

Citation(s): LS.01.02.01

FIRE WATCH

A fire watch consists of one or more staff charged with maintaining life safety by patrolling all areas of a facility affected by an impairment or other fire watch condition. If smoke, fire, or other abnormal conditions are spotted, the fire watcher must immediately contact emergency personnel, alert building occupants, and help evacuate the building.

The main responsibilities of a fire watch include:

- Searching diligently for fires
- Immediately addressing any hazards that are discovered
- Controlling fire ignition sources
- Making sure there's adequate means of egress and removing any obstructions
- Making sure other alarm systems are functioning properly
- Standing ready to contact the local fire department
- Standing ready to extinguish any fires using a portable fire extinguisher or hose
- Alerting occupants to hazardous conditions that require evacuation
- Documenting patrols at least once every hour

Fire watch patrols should systematically cover the impacted area every hour, documenting their findings at the completion of each round. The fire watch form is located in the appendix and can be found on the intranet safety section under the forms tab. Completed forms should be sent to the Learning and Safety Manager or the Safety Coordinator for storage.

Manual: Safety Manual

Manual Section: Emergency Preparedness and Response

Name: Earthquake Preparedness

Effective Date: 01/01/2018

Policy Cross Reference(s):

Citation(s):

EARTHQUAKE PREPAREDNESS

If inside the building

- Keep Calm. Do not run or panic.
- Remain where you are.
- Drop to the ground. Take cover by getting under a sturdy desk or table and **hold on** to it until the shaking stops. If there isn't a table or desk near you, cover your face and head with your arms and crouch in an inside corner of the building. Stay away from windows or objects that are likely to fall.
- Do not use elevators.
- Staff involved in service to individuals with an auditory, visual, or physical impairment are responsible for assisting them in locating adequate shelter.

If outside of the building

- Stay away from overhead electric wires, poles, or anything else that might shake loose and fall.
- Watch for downed electric wires.

Driving During an Earthquake

- If an earthquake occurs while you're driving, slow down, look for an open area to stop and pull over as soon as it is safe to do so
- Avoid parking near or under bridges, overpasses, signs, building overhangs, power lines, trees, or any other hazard that might fall onto your car
- Turn off the engine, set the parking brake and stay seat-belted in your car until the earthquake is over
- If a power line falls on your vehicle, stay inside and wait until an emergency worker removes the wire. Only leave your vehicle if staying inside poses an immediate threat to the welfare of you or your passengers.

Following an earthquake

- Report any damage/injuries to your supervisor and the regional facility manager; complete an incident report.
- If you are trained in CPR and First Aid help with any injured individuals.
- If the Incident Command Center is activated, follow the directions of the incident Commander

Manual: Safety Manual

Manual Section: Emergency Preparedness and Response

Name: Flood Preparedness

Effective Date: 01/01/2018

Policy Cross Reference(s):

Citation(s):

FLOOD PREPAREDNESS

In the event that a facility or mobile unit becomes inaccessible, arrangements for continuing services in other locations will be made as follows:

- In the event of a flood warning the disaster notification process located in the procedure section of the disaster manual should be followed.
- The CEO or designee will determine if relocation actions are necessary.
- Instructions from the local Civil Defense Agency will be followed.

If evacuation and relocation are deemed necessary, each program should follow the instructions of the CEO or designee.

Manual: Safety Manual

Manual Section: Emergency Preparedness and Response

Name: Weather Radios

Effective Date: 06/24/20

**Policy Cross
Reference(s):**

Citation(s):

WEATHER RADIOS

Each Chestnut facility and Residential Unit should have at least one weather radio. Batteries should be changed in the radio semi-annually at time change. In the event that the radio is not working properly complete an incident report and request a new radio from purchasing immediately. In the event that a site is unable to receive notification from weather radio due to signal strength, an alternate method will be implemented, such as an alert via a cell phone application.

Manual: Safety Manual

Manual Section: Emergency Preparedness and Response

Name: Severe Weather

Effective Date: 01/01/2018

Policy Cross Reference(s):

Citation(s):

SEVERE WEATHER

Tornado Preparedness

Chestnut facilities are equipped with weather radios that broadcast automatically when threatening weather conditions (i.e., tornado, high winds, snow, ice) exist in the immediate geographical area. Designated staff are responsible for monitoring weather radios and to alert patients, visitors and other staff about the alert. (Designated staff include reception staff during normal business hours and residential staff after business hours.) During times of ominous weather conditions, staff should have heightened awareness of the potential need to seek shelter, even when an alert has not been issued.

When a weather alert is broadcast, response procedures will be implemented.

- A tornado watch is issued when conditions are conducive to the formation of tornadoes.
- A tornado warning is issued when a tornado has been spotted in the immediate area and people should seek shelter immediately.

Tornado Warning

During a tornado warning the designated staff in residential, ambulatory care and business only occupied buildings are responsible for informing all staff, patients, and visitors of the tornado warning by making the following announcement:

“Attention staff a tornado warning has been issued for the (city). All occupants of this building should immediately seek shelter in the designated emergency shelter areas.” REPEAT

The preferred “safe” locations are the first-floor interior areas or basement of the building. The receptionist on duty is responsible for bringing the visitor’s list to the shelter area for a count of all visitors known to be in the office. Reception will post instructions for individuals entering the facility after others have retreated to shelter area.

All staff should accompany any patients to the appropriate shelter areas. The staff immediately involved with visually, auditorily, or physically handicapped individuals are responsible for assisting them to designated tornado shelter areas. Designated residential staff are responsible for a count of all individuals on a unit.

Portable radios should be taken to the shelter areas, as well as flashlights. Monitoring the radio for the end of the warning is necessary to determine when to resume normal activities. Individuals should not leave shelter areas until an all clear is given by designated staff. While individuals in Chestnut facilities are encouraged to take internal shelter, individuals may choose to leave the facility.

Snow/Ice

As soon as inclement weather is forecast residential/housing staff will be reminded to double check their emergency supplies and to contact purchasing within 1 day of any items that need to be restocked. Purchasing will send requested supplies as soon as they can safely obtain them.

Parking Lots

Facilities staff will coordinate the cleaning of parking lots. There will be designated parking spaces so that lots can be cleared in the most effective manner possible.

Staff will be sent an email indicating where to park in the event of inclement weather.

Chestnut Sites

Facilities staff will inspect sites daily in the morning and before they leave for hazards, such as ice that has reformed after being cleaned.

Ice melt will be left in central locations so that any staff members can put it out if they notice a problem during non-facilities hours.

Facilities staff will barricade areas that are exceptional trouble spots until they are safe to enter. Staff should not pass the barricade unless it is an emergency.

Staff should follow Immediate Notification of Environmental Issues – Incident Reporting/Support Tickets section of this manual when environmental issues are noted.

Manual: Safety Manual

Manual Section: Emergency Preparedness and Response

Name: Driving in Severe Weather

Effective Date: 01/01/2018

Policy Cross Reference(s):

Citation(s):

DRIVING IN SEVERE WEATHER

Flash Flooding

If you are in the car and a flash flood is imminent or occurring, try to stay calm and remember these tips from [Ready.gov](https://www.ready.gov):

Don't drive around barricades: If you come across a barrier blocking a flooded road, do not drive around it. Instead, back up and find an alternate route.

Avoid driving on bridges over fast-moving water: Floodwater can wash out a bridge with little or no warning. If water is moving quickly under a bridge, avoid driving over the bridge.

Avoid driving through floodwater: Driving through floodwater is dangerous, as it only takes 12 inches of water to for a small sedan or SUV to float, says the NWS. You should also avoid driving through large puddles. They may look more shallow than they are, and can disguise hazards such as a washed-out road or sharp debris.

Stay in your vehicle if you're surrounded by fast-moving water: Unless water is rising inside your vehicle, do not exit the vehicle when you're surrounded by quickly-moving floodwater. If water is rising inside your vehicle, exit the car and get onto the roof.

If you're ever in doubt about you or your family's safety during a flood, remember to [turn around, don't drown](#), says the National Weather Service.

Flash floods can happen suddenly and without warning. By planning ahead and remembering these flood safety tips, you and your family can be better prepared if a flash flood affects your area. Staff should also be cautious when parking vehicles not to park them in an area prone to flooding.

Tornado Warning

If the Tornado Is Far Enough Away:

If you can see the tornado in the distance, National Oceanic Atmospheric Administration (NOAA) recommends changing course and driving toward a sturdy shelter as soon as you are able. They recommend truck stops, convenience stores, restaurants, and even walk-in coolers. Once you are inside, go to the basement, a cellar, or a hallway or room without windows in the center of the house.

It is possible to try to get out of the tornado's path, NOAA says, and you may be able to stop and allow the tornado to pass, depending on where it is and how you're positioned. If you can see the tornado far in the distance and can determine its movement, drive at a right angle to that movement. So, if it's heading east, drive to the south.

If the Tornado Threat Is Immediate:

If the tornado is imminent and you are forced to stay in your car, the NWS recommends [keeping your seat belt on](#) and making sure your head is covered, below your windshield and windows to protect it from glass. The Red Cross recommends covering your head with a blanket, if you have one in the car.

“Highway overpasses are [NOT tornado shelters](#), and these should be avoided,” NOAA road safety guidelines state. “Ditches, culverts and ravines should be used only as an absolute last resort. You will be exposed to flying debris, rain and hail, lightning and extreme wind.”

Manual:	Safety Manual
Manual Section:	Emergency Preparedness and Response
Name:	Emergency Supplies and Water
Effective Date:	01/01/2018
Policy Cross Reference(s):	SI 310 Water Supply
Citation(s):	EM.02.02.03 441.184 CMS

EMERGENCY SUPPLIES AND WATER

The Facilities and Safety departments will coordinate to ensure proper and adequate emergency supplies and water for each facility.

If deemed necessary, emergency supplies may be moved to a more secure location and monitored directly by the facilities and purchasing department in order to facilitate tracking and ensure availability of product based on the program with the highest degree of need.

Food supplies are maintained as determined appropriate for each facility and its programs.

Emergency water supplies are used in the event that the public water supply becomes contaminated. Water supplies are maintained at each facility and may be re-allocated to other facilities as indicated by the emergency. Each residential facility shall maintain at least three gallons per person of drinkable water for each anticipated person who will need water in an emergency (to include all residential patients and scheduled staff on duty).

Emergency supplies stored at other facilities will be utilized as necessary. If the Incident Command is activated, matters such as transportation and purchasing of supplies will be managed through that process.

Manual:	Safety Manual
Manual Section:	Emergency Preparedness and Response
Name:	Evacuation / Relocation
Effective Date:	01/01/2018
Policy Cross Reference(s):	
Citation(s):	EM.02.02.07 EM.02.02.11 441.184 CMS

EVACUATION / RELOCATION

Evacuation

A building should be evacuated when:

- fire alarm sounds unexpectedly,
- there is a strong odor of gas, or
- the building is damaged and it is unsafe to remain.

Relocation – Residential Programs

In the event a facility becomes uninhabitable and an immediate need for relocation exists, staff should follow the plan as outlined in the program/business unit specific emergency response plan. When patients are required to be relocated staff will track where patients are sent. The patient tracking form is located in the appendix of this manual and under the safety tab on the intranet. Only the CEO or designee shall make decisions regarding long-term relocation of services.

Central Region

Bloomington adult patients will be transferred to outpatient status if residency allows, or be housed at the Home Sweet Home Mission per agreement.

Southern Region

Southern Region Crisis Residential/Detox patients as well as both the Men's/Women's Substance Use Residential Units will be relocated to Northgate for short-term housing if residency allows. If residency doesn't allow or relocation is needed for an extended period of time, patients will be moved to other residential programs that have openings.

All housing patients from Madison and St. Clair County will be moved to other housing sites that have openings or off-site with collaterals, as appropriate.

Detoxification patients will be evaluated for medical stability and if appropriate relocated to another treatment provider. If medically unstable, patient will be referred to hospital.

Relocation – Outpatient Services

When the need for relocation has been determined by management, outpatient staff from the affected facility will meet the morning of the next business day at the facility or other determined location for an emergency staffing to review the needs of patients and discuss the resumption of services. The Incident Command will be utilized as appropriate. Outpatient services shall be continued by using available space in other facilities, rescheduling services, or conducting services in the patient's home or via telephone or approved videoconference.

Manual: Safety Manual

Manual Section: Emergency Preparedness and Response

Name: Power Failure – Phones

Effective Date: 01/01/2018

Policy Cross Reference(s):

Citation(s): EM.02.02.01

POWER FAILURE – PHONES

In the event of a power failure, the multi-line Cisco phone system has battery backup power supply so the phones are operable for a limited time. In the Central Region, Cisco phones are connected through servers which are backed up by a generator. Therefore, Cisco phones in Central Region will typically remain operable during power failures. In the Southern Region, Cisco phones will be operable for a limited time (approximately one hour at satellite sites and should remain operable at the Northgate facility as it is backed up by a generator).

In the event of inoperability of Cisco phones, there are single line phones available in each facility that are not dependent upon power. A traditional single line phone is a basic phone, similar to telephones that one might find in their own homes, made up of a handset and base with a keypad. Outgoing calls can be made from these phones either directly connected or connected to a fax machine.

Specific single line phone numbers listed below are designated for incoming calls, and supervisors are expected to have these phone numbers available in their back up procedures. Incoming calls to these phone lines cannot be transferred to another phone.

Chestnut and/or personal cell phones can be used as available.

Central Region

The main phone number (309) 827-6026 is answered in the Central Region Reception areas. If the power is out and the battery backup power is no longer available incoming phone calls to this number will not be able to be answered. There are single line phones available (see below for location).

Staff answering the single line phone may need to take a message for another building if necessary.

King Drive Building Location	Phone Number
Fax machine King 1 – 2 nd floor	309-820-1386
Men's Unit	309-820-3685
Women's Unit	309-820-3682

Southern Region

Staff should connect the fax machine line to an analog phone

Location	Fax/Phone Number
Granite City Fax machine	618-877-9526 administration

	618-877-2215 crisis
Maryville Fax machine	618. 288.2278 reception 618-288-3371 medical records
Oakmont	618-797-2088 Apt #4
Mainstay	618-452-2832
Fairview Heights	618-239-6490
Belleville Fax machine	618-397-4368 medical records
<i>Madison</i>	<i>618-877-7209 CMR</i> <i>618-877-7431 CRI</i>
<i>Hillsboro</i>	<i>No fax line, use cell phone</i>

Manual:	Safety Manual
Manual Section:	Emergency Preparedness and Response
Name:	Civil Defense / Emergency Management Agencies
Effective Date:	01/01/2018
Policy Cross Reference(s):	
Citation(s):	EM.01.01.01 2060.305 441.184 CMS

CIVIL DEFENSE / EMERGENCY MANAGEMENT AGENCIES

In the event of a disaster which affects community functioning for which an emergency management agency is given jurisdiction, Chestnut will follow instructions from that agency.

Chestnut is prepared to cooperate with the Red Cross and local health departments in the event of a community-wide disaster to the extent that cooperation does not compromise the safety or confidentiality of patients.

Chestnut will partner with local health departments to participate in community disaster drills that they have planned. These drills can include notification drills up to a full-scale event.

Manual:	Safety Manual
Manual Section:	Emergency Preparedness and Response
Name:	Closed Point of Distribution (POD)
Effective Date:	05/22/2019
Policy Cross Reference(s):	
Citation(s):	EM.01.01.01

CLOSED POINT OF DISTRIBUTION (POD)

Chestnut maintains Memorandums of Understanding (“MOU”) with local health departments to be a closed POD in the event of a biological or pandemic event.

Activation of the POD will be determined by the local health departments. Procedures for activating and running the closed POD can be found in the Closed POD Plan Manual.

Manual:	Safety Manual
Manual Section:	Emergency Preparedness and Response
Name:	Pandemic
Effective Date:	05/22/2019
Policy Cross Reference(s):	
Citation(s):	IC.01.06.01 IC.02.03.01

PANDEMIC

In the event of a pandemic Chestnut will utilize action plans to respond to the event. These action plans are designed in consultation with WHO, CDC, Federal and Local Government, Funding Agencies, and Chestnut's Medical Director(s). Due to the variableness of the pandemic, these action plans are intended to be disease specific to help ensure staff, client, patient, and visitor safety and are geared to help prevent the spread of infection. Action plans may address the following, but not limited to, self-monitoring, use of PPE, guidelines for when to stay home and when to work, social distancing, and environmental cleaning. Staff training related to the procedures listed in the action plan will be placed in Relias and will be assigned to all staff as appropriate.

Important infection prevention and control information should be available to staff, individuals served, and their families. Precautions need to be taken consistent with the setting, services, and individuals served (including, where necessary, using personal protective equipment such as gloves and masks); and any infection that spreads within the organization should be investigated. All staff should observe good hand hygiene practices and respiratory etiquette. This will reduce risks from hand-to-hand spread, as well as when handling pens, door handles, toys, assistive devices, and other items. Cleaning and disinfecting surfaces and common items, such as tabletops and keyboards, will further minimize infection risks.

Staff and clients should be screened for exposure to infectious disease when workplace contact with infections is possible.

Manual: Safety Manual

Manual Section: Emergency Preparedness and Response

Name: Internal Emergency Paging

Effective Date: 01/01/2018

Policy Cross Reference(s): SI 305 Emergency Code Alerts and Staff Response

Citation(s): EM.02.02.01

INTERNAL EMERGENCY PAGING

Paging

Chestnut staff have the ability to notify others of an emergency situation and as appropriate request assistance by issuing an emergency code alert. These codes can be issued through the paging system or verbally when paging is not available. Any staff member can issue the page. When a page is issued at a building with on duty receptionist and it safe to do so, staff initiating the page should notify reception. As available and appropriate, an email should be sent to the entire building as a follow up to the paged code.

Paging codes for facilities are as follows.

Central Region	Southern Region
MLK 1: *681#	Northgate: *5250
MLK 2: *682#	64 th Street: *6200
All King Drive: *684#	Maryville: *6300
702: *889	

Additionally, paging codes are printed and should be kept with staff badges and contained within posted Emergency Procedure flip charts.

When the emergency situation is over staff should page "all clear" to alert other staff that it is now safe to enter the designated area.

Manual: Safety Manual

Manual Section: Emergency Preparedness and Response

Name: Internal Emergency Codes and Staff Response

Effective Date: 05/22/2019

Policy Cross Reference(s): SI 305 Emergency Code Alerts and Staff Response

Citation(s):

INTERNAL EMERGENCY CODES AND STAFF RESPONSE

Available Chestnut staff are expected to respond to an emergency code, operating within the constraints of their role and training. Those that do not have proper training for specific tasks should not engage in these activities. Non-trained staff should avoid the announced area until further notice. When responding to an emergency page, staff must keep in mind the trauma informed care (TIC) principles and promote a sense of safety, calming, and de-escalation for patients, visitors and staff. Staff should page "all clear" once the emergency is over.

Emergency Code For Behavioral Incident

"Paging Dr. Armstrong to _____ (area announced)":

A behavioral incident requiring additional staff intervention is occurring in this area. Staff trained on de-escalation techniques should respond.

Clinical staff will take the lead in behavioral incidents following the team approach and utilizing role assignments.

Emergency Code For Potentially Dangerous Situation

"Paging Dr. Lock to _____ (area announced)":

A dangerous situation or a possibly dangerous person is in this area of the building. Staff should assess for safety. Staff should remain in their work area, move to a more secure area, or flee the building.

Staff remaining in the building should secure the area by locking doors and remain as quiet as possible. If safe, staff should call 911.

Emergency Code For Active Shooter Situation

"Active Shooter is in _____ (area announced)":

A person with a firearm is at the facility. Staff should assess for safety. Staff should remain in their work area, move to a more secure area, or flee the building and go to the designated meeting spot.

Staff remaining in the building should secure the area by locking doors and remain as quiet as possible. If safe, staff should call 911.

Code For Medical Emergency

"All CPR Certified staff report to _____ (area announced)":

A medical emergency is occurring in this area. Staff certified in CPR should respond. Other staff should avoid this area until further notice.

Emergency Code For Incident Command Activation

"The Incident Command Center is now operating at _____"

This alerts all staff of the location of the Incident Command center. Available staff should report to the command center.

Following the issuance of any emergency code alert, an “All Clear” announcement will be made verbally and where available via paging and email. With this announcement, staff activity may resume as usual.

Emergency Code for Missing/Abducted Child/Infant

“Code Pink _____ A child/infant has gone missing (announce information about the missing infant/child: gender, ethnicity, age, and description of clothing).”

All Clear Emergency Code

The emergency requiring a response is over.

Manual: Safety Manual

Manual Section: Emergency Preparedness and Response

Name: Team Approach Roles

Effective Date: 05/22/2019

Policy Cross Reference(s):

Citation(s):

TEAM APPROACH ROLES

Team approach roles may depend upon how many people are available and the needs of the situation. A person may need to be in multiple roles, if that can happen safely.

- Team Leader – delegates responsibilities for team members.
- Client support – responsible for direct communication with clients in crisis.
- Runner – secures equipment or supplies; meets first responders.
- Communicator – communicates with external emergency personnel (911) and internal personnel with any needs and updates regarding the situation.
- Recorder – records time and information about the response (i.e. time 911 called); ensures completion of incident reports; progress notes etc.
- Client Liaison –assists in evacuation, if necessary, perform brief counseling if needed, request additional assistance when indicated.
- Administrative Liaison – coordinates with appropriate directors and human resources and pulls records as needed.

Manual: Safety Manual

Manual Section: Emergency Preparedness and Response

Name: Testing of Phone System

Effective Date: 05/22/2019

**Policy Cross
Reference(s):**

Citation(s):

TESTING OF THE PHONE SYSTEM

Safety and IT staff will coordinate the testing of emergency features on CISCO phones. These tests will be done as needed. The form for documenting the test can be found in the appendix of this manual. Documentation of testing will be stored by the Safety Coordinator. If staff have concerns about their phones not working properly, they should contact IT and should not test their phones on their own.

Manual: Safety Manual

Manual Section: Emergency Preparedness and Response

Name: Weapons

Effective Date: 05/22/2019

Policy Cross Reference(s): PP 355 No Weapons

Citation(s):

WEAPONS

For the safety of Chestnut clients, guests, and staff, Chestnut prohibits the use or possession of firearms and/or other weapons of any type while on Chestnut premises, with the exception of law enforcement. Weapons include firearms, explosives, knives and other dangerous items that could cause harm to individuals. Appropriate signage will be posted at the main entrances to all facilities describing the premises as weapon-free.

If an individual presents with a weapon leading to a situation which is deemed an emergency, call 911 immediately and follow Dr. Lock or Active Shooter procedures.

In an outpatient or housing setting, if the situation is not deemed an emergency, staff should:

- Inform the individual that weapons are not allowed
- Advise the individual that the weapon must be removed from the premises
- If individual refuses to cooperate, call law enforcement.

In a residential setting, if the situation is not deemed an emergency, staff should:

- Inform the individual that weapons are not allowed
- Advise the individual that the weapon must be removed from the premises. Assist the client to determine if there is someone who can possess the weapon while he/she is in treatment
- At the discretion of the program director, small pocketknives may be kept in locked storage while the client is in treatment.
- If individual refuses to cooperate, call law enforcement.

In the event that staff must handle the firearm it should be handled this way:

- Carefully take the firearm by the grip with your finger off and away from the trigger pointing the firearm in a safe direction.
- Place the firearm on a surface inside a locked office.
- Ask the consumer for any ammunition they may have.
- Place the ammunition in a different locked office
- Inform the client that they may speak to the police department about retrieving the weapon.

Any time a weapon is brought into a facility, a supervisor should be contacted and staff should complete an incident report.

Manual: Safety Manual

Manual Section: Emergency Preparedness and Response

Name: Active Shooter Preparedness

Effective Date: 01/01/2018

Policy Cross Reference(s):

Citation(s):

ACTIVE SHOOTER PREPAREDNESS

The “**Active Shooter**” emergency code alerts staff that there is a potentially dangerous individual with a gun in the building. For the safety of others, the alert is announced. The potentially dangerous person may be a patient, a patient’s family member, a visitor, a current or former employee or a person unknown to staff.

The Department of Homeland Security defines an active shooter as “an individual actively engaged in killing or attempting to kill people in a confined and populated area: in most cases, active shooters use firearm(s) and there is no pattern or method to their selection of victims”.

The “Active Shooter” announcement may be made via the paging system (if the paging system is available) but could also be announced via text, email or verbally. The announcement may be made by any staff member at any time. As the situation develops, updates will be provided via additional alert notifications.

When you hear the “Active Shooter” announcement or if you hear the actions of an active shooter, you should consider the safety of yourself and patients or visitors in your care. Staff should **not** assume that the passport doors will prevent the individual from accessing areas of the building. Quickly determine the most reasonable way to protect your life – Run, Hide, or as a last resort, Fight.

Run (Flee): If you feel it is in your best interest to flee, go to the nearest exit and once outside, run to the designated meeting spot. Discourage others from entering the building you just left. If you decide to flee, take action regardless of whether others agree to follow. Do not stop to take personal items. Do not attempt to move wounded people. Keep your hands visible and follow the directions of the police. Do not stop until you are safely away from the area of the threat. Once you feel safe, call law enforcement and REPORT what you have seen and heard.

Hide (Lock Down): If you feel it is in your best interest to seek shelter, look for a space that you can barricade yourself in – a room with a lockable door. If possible, place a heavy object in front of door. Stay quiet and avoid drawing attention to yourself; turn off lights, silence your phone and turn off radios. Remain there until the “All Clear” announcement or follow any instructions from the police.

Fight (Take Action Against the Active Shooter): Homeland Security recommends fighting as a last resort, and only when your life is in imminent danger, You can attempt to disrupt and/or incapacitate the active shooter by:

- Acting as aggressively as possible against him/her
- Throwing items and improvising weapons
- Yelling
- Committing to your actions

You should also contact 911: Remain calm when calling. If you cannot speak, leave the line open and allow the dispatcher to listen. If you are able to talk, communicate the location of the

aggressive individual(s), the number of aggressive individuals, describe the individual(s), describe the weapons, and relay information about potential number of victims.

When the police arrive at the facility, it is important to cooperate and act appropriately for your safety. Follow these guidelines (you may need to coach patients or visitors to follow these guidelines):

- Remain calm and follow the officer's instructions.
- Put down any items in your hands and raise your hands up, with fingers spread.
- Keep your hands visible at all times.
- Avoid making quick movements toward the officer, or trying to hold onto the officer.
- Avoid pointing, screaming or yelling.
- Do not stop to ask for directions from the officers when evacuating, just proceed in the direction from which officers are entering the premises.

Manual: Safety Manual

Manual Section: Emergency Preparedness and Response

Name: Dr. Lock

Effective Date: 01/01/2018

Policy Cross Reference(s):

Citation(s):

DR. LOCK

The “**Dr. Lock**” emergency code alerts staff that there is a potentially dangerous individual with a weapon, other than a gun, in the building. For the safety of others, the alert is announced. The potentially dangerous person may be a patient, a patient’s family member, a visitor, a current or former employee or a person unknown to staff.

The “Dr. Lock” announcement may be made via the paging system (if the paging system is available) but could also be announced via text, email or verbally. The announcement may be made by any staff member at any time. As the situation develops, updates will be provided via additional alert notifications.

When you hear the “Dr. Lock” announcement you should consider the safety of yourself and patients or visitors in your care. Staff should **not** assume that the passport doors will prevent the individual from accessing areas of the building. Quickly determine the most reasonable way to protect your life – Run, Hide, or as a last resort, Fight.

Run (Flee): If you feel it is in your best interest to flee, go to the nearest exit and once outside, run to the designated meeting spot. Discourage others from entering the building you just left. If you decide to flee, take action regardless of whether others agree to follow. Do not stop to take personal items. Do not attempt to move wounded people. Keep your hands visible and follow the directions of the police. Do not stop until you are safely away from the area of the threat. Once you feel safe, call law enforcement and REPORT what you have seen and heard.

Hide (Lock Down): If you feel it is in your best interest to seek shelter, look for a space that you can barricade yourself in – a room with a lockable door. If possible, place a heavy object in front of door. Stay quiet and avoid drawing attention to yourself; turn off lights, silence your phone and turn off radios. Remain there until the “All Clear” announcement or follow any instructions from the police.

Fight (Take Action Against the Individual): Homeland Security recommends fighting as a last resort, and only when your life is in imminent danger, You can attempt to disrupt and/or incapacitate the active shooter by:

- Acting as aggressively as possible against him/her
- Throwing items and improvising weapons
- Yelling
- Committing to your actions

You should also contact 911: Remain calm when calling. If you cannot speak, leave the line open and allow the dispatcher to listen. If you are able to talk, communicate the location of the aggressive individual(s), the number of aggressive individuals, describe the individual(s), describe the weapons, and relay information about potential number of victims.

When the police arrive at the facility, it is important to cooperate and act appropriately for your safety. Follow these guidelines (you may need to coach patients or visitors to follow these guidelines):

- Remain calm and follow the officer's instructions.
- Put down any items in your hands and raise your hands up, with fingers spread.
- Keep your hands visible at all times.
- Avoid making quick movements toward the officer, or trying to hold onto the officer.
- Avoid pointing, screaming or yelling.
- Do not stop to ask for directions from the officers when evacuating, just proceed in the direction from which officers are entering the premises.

Manual: Safety Manual

Manual Section: Emergency Preparedness and Response

Name: Designated Meeting Spots

Effective Date: 01/01/2018

Policy Cross Reference(s):

Citation(s):

DESIGNATED MEETING SPOTS

The locations listed below have been deemed meeting spots in the event of an Active Shooter or Dr. Lock incident. To see an ariel view of these locations please refer to the appendix.

Southern Region	Central Region
Northgate – Far end of the extra parking lot behind Northgate II	702 – behind 720 (west side)
Madison – Police Department	720 – behind 702 (Mason Street side / east side)
Mainstay – Community Care Center	Martin Luther King – on the North side of GCB
Oakmont – Laundromat	Glenn Covert Building – left (East side) of MLK1
Collinsville – Uptown Hair Studio	Crossroads – Movie theater
Fairview – Grace Church	Chicago – Parking lot to the left of the building at the back by trees
Belleville - Laundromat	Oregon – Across the street at the back of the parking lot
Maryville – Behind the shed	
Hillsboro – Far side of parking lot behind the building	

Manual: Safety Manual

Manual Section: Emergency Preparedness and Response

Name: Missing/Abducted Child/Infant

Effective Date:

Policy Cross Reference(s):

Citation(s):

MISSING/ABDUCTED CHILD/INFANT

If a staff member becomes aware of a missing child/infant on or from Chestnut premises, they should page using the emergency code procedures for code pink.

Upon hearing the page all staff should have a heightened awareness of potentially suspicious people.

Available staff should immediately go to the front desk where they will use the team approach to cover exits and begin looking for the missing child/infant. Staff should be alert on their way to the area for child/infant meeting the description that was paged.

The team lead will designate staff to:

- Cover all exits, including emergency exits (maps available in pink folders at reception)
- Search sections of the building
- Check parking lots
- Call 911
- Stay with parent/guardian of missing child
- Review camera footage

All calls, including media inquiries, regarding the missing child/infant will be referred to the Marketing and Communication Manager.

Individuals should be encouraged not to leave the building until the police arrive.

- Inform the individual that an emergency has occurred and that it is necessary for the individual to wait for police clearance before they exit the building.
- If the individual refuses to remain for the police, monitor from a safe distance, taking note of physical description, direction of travel, and vehicles involved.

The team lead will determine when the All Clear, Code will be issued.

Manual: Safety Manual

Manual Section: Emergency Preparedness and Response

Name: Lock Down

Effective Date:

Policy Cross Reference(s):

Citation(s):

LOCK DOWN

PURPOSE:

To establish guidelines for the lockdown of a Chestnut Health Systems facility in the event of an emergency in which a lockdown of the site would be required and/or necessitated, as a safety measure to protect staff and/or visitors.

POLICY:

The ability to lockdown a Chestnut Health Systems facility is of primary importance to control access to a facility during an emergency. Establishing a secure perimeter and maintaining a secure interior environment are key elements in controlling and maintaining safety within a facility. During a total lockdown, all exterior doors are secured, restricting entry to the facility.

Situations calling for the lockdown of a facility include, but are not limited to, external environmental incidents such as criminal activity or civil disturbance within the immediate area of a facility when the perpetrator(s) are not in police custody, or a situation where a Chestnut Health Systems facility or staff has been targeted and in immediate danger.

Staff within a Chestnut facility should remain in the building and shelter in place, staying away from windows and doors. Badge card readers should remain active as normal to restrict access. Staff should not leave the building unless it is unsafe to remain inside.

PROCEDURE:

Any staff being made aware of a situation described above should immediately notify management staff. Management staff will utilize every available means of communication including, but not limited to, using the facilities paging system, email, phone calling, TEAMS notification and, texting platform, to warn of an immediate danger that would necessitate a lockdown scenario, using the template below. Staff will contact a member of the Executive Leadership Council and/or QM Team to apprise of the situation.

Sustained lockdown will be contemplated and authorized by a member of the Executive Leadership Council and/or QM Team. Only members of the Executive Leadership Council and/or QM Team can authorize lifting a lockdown after an all-clear determination has been made.

When the decision is made to lockdown a facility, staff should immediately secure all exterior doors until the lockdown is lifted. The badge access system will remain active during a lockdown.

Sample notification in the event of a lockdown:

- Attention staff, Chestnut has been made aware of a threat. Due to this threat the building will immediately be placed on lockdown until an all clear is given. Please secure all exterior doors and request that no one exits the building. Everyone should position themselves inside the

building, avoiding windows and exterior doors, taking care to ensure the safety of staff and our patients.

Manual: **Safety Manual**

Manual Section: **Emergency Preparedness and Response**

Name: **Lock Down Button**

Effective Date:

**Policy Cross
Reference(s):**

Citation(s):

LOCK DOWN BUTTON

The 702 facility is designed with a lock down button that is in reception. This button is designed to lock all exterior doors quickly. Staff should utilize this button if it is determined that the Lock down procedures need to be followed. This button should NOT be pushed for an internal incident as it will slow first responder time to assist in an emergency.

Manual: **Safety Manual**

Manual Section: **Emergency Preparedness and Response**

Name: **Bomb Threat**

Effective Date: **06/24/2020**

**Policy Cross
Reference(s):**

Citation(s):

BOMB THREAT

If you receive a telephone bomb threat:

- Remain calm.
- Try to prolong the conversation and get as much information as possible.
- If possible, involve a second staff member to assist with calling 911.
- Note what you hear. Are there background noises, such as music, voices, or cars?
- How does the caller's voice sound? Any accent? What gender? What age? Any unusual words or phrases?
- Does the caller seem to know about Chestnut? How is the bomb's location described? Does the caller use a person's name? Does the caller give his/her name?
- Do not hang up.

When the call is over, complete a bomb threat checklist immediately. The checklist can be found in the appendix or on the intranet in the safety section under the forms tab.

- Dial 911 and report a bomb threat.
 - Give the operator all the information you collected on the checklist.
 - Identify yourself, giving your name, address, and phone number.
- Notify your supervisor immediately.
- Stand by for further instructions.
- If it is deemed necessary to evacuate, you will be notified by your supervisor or the overhead paging system. Evacuate via the primary route for your area, or by the alternate route if directed.

If you discover a bomb or suspicious item:

- Leave it untouched and secure the area until the police arrive.
- Call 911 and report a suspicious item. You may be asked to assist in a search because you are familiar with the area. If so directed, evacuate your area via the primary route for your area or by the alternate route if directed.

Manual:	Safety Manual
Manual Section:	Emergency Preparedness and Response
Name:	Staff Live Safety Training
Effective Date:	05/22/2019
Policy Cross Reference(s):	SI 140 First Aid and Medical Emergencies
Citation(s):	

STAFF LIVE SAFETY TRAINING

All staff will be trained in de-escalation via the Relias Learning Management System. In some programs additional training in CPI will also be required. All Medical, Residential, Housing, Community Based, and Facilities staff will be required to take CPR training within the first year of employment and refresher trainings as required. Staff working in other programs will be assigned first aid training through the Relias Learning Management System at the discretion of their program director.

Manual:	Safety Manual
Manual Section:	Emergency Preparedness and Response
Name:	Responding to Medical Emergencies
Effective Date:	05/22/2019
Policy Cross Reference(s):	SI 140 First Aid and Medical Emergencies
Citation(s):	

RESPONDING TO MEDICAL EMERGENCIES

Chestnut staff are expected to respond to medical emergencies, operating within the constraints of their role and training. Those that do not have proper training for specific tasks should not engage in these activities.

When a medical emergency occurs staff should assess the situation and utilize their CPR/First aid training and call 911. Follow the instructions of 911 personnel. Complete the Medical Emergency Tracking Form in real time during the medical emergency. Complete an incident report for all medical related emergencies.

Manual:	Safety Manual
Manual Section:	Emergency Preparedness and Response
Name:	Medical Emergency Supplies
Effective Date:	6/1/22
Policy Cross Reference(s):	SI 140 First Aid and Medical Emergencies
Citation(s):	2060.413 441.184 CMS

MEDICAL EMERGENCY SUPPLIES

Chestnut maintains medical emergency supplies.

Red First Aid Grab and Go bag are provided at all sites. Red First aid kits are provided in company owned vehicles that are used for transporting clients, and staff that use their personal vehicles to transport patients are given a mini first aid kit. Supervisors should notify the Safety Coordinator if they have a staff that needs a kit for their personal vehicle.

Red First Aid Grab and Go bags are backpacks that are placed around each site and will be found either hanging on the wall, on top of refrigerators, or in an identified cabinet.

Most items are found in the main compartment, that is secured by a red tab. This is placed to help make staff aware that the bag has been entered and needs the contents inventoried. In this compartment, the follow can be found:

- Narcan can be found in a red case along with gloves and a mask inside the main, secured compartment of the Red First Aid Grab and Go Bags. Please note that Narcan is not kept in the vehicle first aid kits due to temperature holding requirements.
- Clipboard-used to document events on the Medical Emergency Tracking Form.
- Bag Valve Mask-this is a CPR tool that you are trained on in your CPR training classes.
- Band-Aids -Band-Aids are found in the main compartment and also in the easily accessible, black mesh front pocket. The black mesh front pocket lets users obtain Band-Aids without entering the main, secured compartment.
- other items include: eye wash, aspirin, gauze and pads in a variety of sizes, tape, elastic bandage, triangle wrap, emergency blanket, iodine swabs, gloves, burn cream, triple antibiotic ointment, ice pack, small spill kit, absorbing powder, alcohol pads, scissors, and blood exposure packet.

These bags' main compartment is sealed, using a red, plastic "zip" tag. PLEASE BE SURE NOT TO OVER TIGHTEN THEM.

- removing tag that is not overtightened-you may "pull" the loop apart, placing your fingers within the circle, dislodging the white, inner locking piece and removing the zip tie to enter the main compartment
- removing tag that may be overtightened-you may use a door key as a tool to "cut" the tag on the plastic portion that is not "teethed"



Automated External Defibrillators (AEDs) are maintained at 702, 720, MLK, Glen Covert Building, Northgate, Maryville, Belleville, Crossroads, Chicago, Oregon, and the CFHC mobile units.

Emergency carts are maintained at Health Center and CR Male Residential Unit.

Each First Aid Grab and Go Kit will be checked monthly by the Learning and Safety Manager or the Safety Coordinator with the exception of Hillsboro. For the Hillsboro, Chicago, and Oregon sites the Safety Coordinator will work with the office manager or designated staff to check the kit monthly. Red First Aid kits for agency vehicles should be checked monthly by the facilities staff when doing their routine vehicle inspection.

- If it is sealed, the assigned staff member will initial and date the tag to indicate it was checked. For Hillsboro, Chicago, and Oregon sites the designated staff person checking the kit should send a picture of the initialed tag to the Safety Coordinator.
- If it is not sealed, the assigned staff member should notify the Safety Coordinator with a list of the missing items. The Safety Coordinator or designee will replace the missing items and reseal the kit.

The Safety Coordinator will keep a master list of all expiration dates for items in the first aid kits and will monitor items to be replaced before the expiration date occurs.

Manual:	Safety Manual
Manual Section:	Emergency Preparedness and Response
Name:	Safety Tags
Effective Date:	6/1/22
Policy Cross Reference(s):	SI 140 First Aid and Medical Emergencies
Citation(s):	2060.413 441.184 CMS

SAFETY TAGS

Various safety and medical equipment are equipped with inspection tags. These supplies should be inspected according to the equipment schedule and the tag should be initialed and dated after inspection. Any items found to not to be working correctly should be reported immediately to the Nurse Manager and Safety Coordinator.

Manual:	Safety Manual
Manual Section:	Emergency Preparedness and Response
Name:	Narcan
Effective Date:	05/22/2019
Policy Cross Reference(s):	SI 140 First Aid and Medical Emergencies
Citation(s):	

NARCAN

Narcan is available for administration at all facilities.

All first aid kits contain four doses of Narcan.

In the Health Center and Central Region Male Unit Narcan is kept in the emergency cart.

Northgate and Belleville have designated group rooms with clear lock boxes that contain Narcan. The code to get into the lock box is 9111.

Housing sites have an additional box of Narcan for each client with a substance abuse diagnosis that is kept in the medication cabinet and is checked monthly by the Safety Coordinator.

Staff working in the community that take Narcan with them should note the following: Narcan should be stored at room temperature between 59 to 77 degrees Fahrenheit with excursions permitted up to 104 degrees Fahrenheit. Narcan should not be frozen and should be protected from light.

Maryville, Belleville, Northgate, and 702 have a designated locked drawer where staff can obtain Narcan to give to clients. These drawers are checked monthly by Prevention staff to ensure that the drawers are well stocked and that there are no expired boxes.

For sites that have Narcan vending machines available, Narcan is available by retrieving a token from staff for the machine. The machine is checked monthly by Prevention staff to ensure that the machine is well stocked and that there are no expired boxes.

Narcan administration training can be found in Relias and is mandated for all staff.

Manual: Safety Manual

Manual Section: Emergency Preparedness and Response

Name: Exposure to Unknown Powdered Substance

Effective Date: 05/22/2019

Policy Cross Reference(s): SI 85 Exposure to Unknown Powdered Substances

Citation(s):

EXPOSURE TO UNKNOWN POWDERED SUBSTANCES

While performing a task when exposure to drug powders is possible, standard precautions for dealing with suspicious substances should be implemented. Staff should take the following precautions related to unknown powdered substances:

- Avoid direct contact with the substance
- Wear personal protective equipment (PPE) including gloves, properly fitted respiratory protection, and safety eyewear
- Wash your hands with **soap and water** often and after handling suspicious substances or packages; do not use any sort of hand sanitizer
- Use proper decontamination and notification procedures for contaminated equipment or clothing

If an overdose is suspected, Naloxone (i.e. Narcan Nasal Spray) is safe and counteracts the effects of an opioid overdose including fentanyl and other synthetic opioids.

- **DON'T** delay. Administer naloxone, if you suspect an overdose. Administer additional doses if necessary
- Call immediately for emergency medical assistance
- If naloxone is not available, provide rescue breathing or life-saving efforts until emergency services arrive

If exposure is suspected (without overdose), the employee must seek post exposure evaluation immediately after the incident. The employee should access the suspicious substance exposure packet located within the Safety page of the intranet or in the appendix of this manual. The packet provides needed instructions, forms and information. Staff not employed by Chestnut and working per a contract should follow the procedures of the employer.

The staff or supervisor must document the exposure event on an incident report which is to be completed prior to the end of the shift during which the event occurred.

Manual: Safety Manual

Manual Section: Client/Patient, Staff and Visitor Safety

Name: Client Search Practices – Belongings and Person

Effective Date: 04/23/2021

Policy Cross Reference(s):

Citation(s):

CLIENT BELONGINGS SEARCH PRACTICES

The following Patient Belongings Search practices are applicable to all clients that are being admitting into any residential program.

1. Don a pair of Nitrile gloves.
2. Don a pair of puncture resistant gloves for the duration of this practice.
3. Ask client if there are any known sharp items in belongings, such as broken glass, needles, or drug paraphernalia.
4. Use a transparent plastic tote prepared to receive the items to be searched.
5. If the client is able, have him/her to remove all items from their bag(s) into the tote.
6. If a client is unable, staff should empty the belongings into the tote.
7. Staff should not reach into the bag.
8. When going through items in the tote staff should use a ruler or pencil to separate items before sticking their hand in the tote.
9. Items should be handled one at a time. Items not allowed on the residential unit will be disposed of properly or placed in storage.
10. If any needles or inappropriate sharps are found staff should immediately dispose of them in a sharps container.

Client Person Search Practices

Some programs have procedures related to person searches. Staff should refer to the appropriate Program Manual regarding the use and implementation of such procedures.

Manual:	Safety Manual
Manual Section:	Client/Patient, Staff and Visitor Safety
Name:	Workplace Violence Prevention
Effective Date:	05/22/2019
Policy Cross Reference(s):	RM 60 Incident Reporting RM 65 Incident Review SI 320 Workplace Violence Prevention
Citation(s):	HRM.01.05.01 EC.02.01.01 EC.04.01.01

WORKPLACE VIOLENCE PREVENTION

The CDC and the National Institute for Occupational Safety and Health define workplace violence as “violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty.”

The U.S. Department of Labor defines workplace violence as an action (verbal, written, or physical aggression) which is intended to control or cause, or is capable of causing, death or serious bodily injury to oneself or others, or damage to property. Workplace violence includes abusive behavior toward authority, intimidating or harassing behavior, and threats. Staff should report any aggressive physical or verbal behavior to a supervisor and via an incident report. All incidents undergo various levels of review as per RM 65 Incident Review. Data is aggregated and reviewed for trends.

Incidents of violence, assault, threats and intimidation will be treated seriously and will be promptly investigated to determine an action plan for the safety of staff, clients and visitors. Actions plans will be communicated to staff.

Annually the Learning and Safety Manager and Safety Coordinator will perform a Workplace Violence Assessment for each facility. This information along with incident trends will be shared with the appropriate safety committees.

Manual: Safety Manual

Manual Section: Client/Patient, Staff and Visitor Safety

Name: Safety Related Alerts for the Electronic Medical Record

Effective Date: 05/22/2019

Policy Cross Reference(s):

Citation(s):

SAFETY RELATED ALERTS FOR THE ELECTRONIC MEDICAL RECORD

Alerts will be created in the electronic medical record following the medical records alert procedures for the following items:

Aggression:	For patients that have displayed aggression to staff or other patients while on site.
Special needs:	List items such as service animal, hearing impaired, etc.
Schedule Conflicts:	List conflicts with other patients for example domestic violence situations do not schedule on the same day.
TB:	Patients suspected to have active TB.
Recreation Status:	List if recreation status is restricted.
Password:	List password used for patients on residential unit.
Client Names	For known clients with the same or similar names, to avoid a patient safety concern
Separated Clients	Clients who have been separated from Chestnut and are ineligible for services
Service/Therapy Animal	Documentation on file
Infection Control Risk	For patients that test positive to COVID.
Suicide risk	Residential only-Patients with moderate or high suicide risk

Manual: Safety Manual

Manual Section: Client/Patient, Staff and Visitor Safety

Name: Staff Working in the Community

Effective Date: 05/22/2019

Policy Cross Reference(s):

Citation(s):

STAFF WORKING IN THE COMMUNITY

Staff working in the community have unique safety risks. Prior to each visit staff should observe and consider the following:

Environmental factors

- Do you have a complete and exact address to avoid appearing lost or confused?
- Does the neighborhood pose risks for violence?
- Is the visit scheduled at a time of day that is more risky than other times?
- Are there other factors that may pose a risk for violence or danger?

Client's living space

- Does accessing the space require the use of an elevator or stairs?
- Are common spaces well-lit and clean?
- Are exits easily accessible?
- Who is likely to be in the house during visit?
- Is/are the client, family members, or friends of the client known to engage in criminal or dangerous activities in the home?
- Is there an increased risk of disease, infection, or pests in the home?
- Is the family known to have weapons?

Proposed work activities

- Will staff engage in high-risk activities during the visit (for example delivering unwelcome information)

Risk due to client's condition

- Does the client have an active substance use problem?
- Does the client have a mental health disorder, particularly untreated?
- Does the client have a history of or frequent violence or threatening behavior?
- Is client at risk of infectious disease?

Worker vulnerability

- Working Alone
- Visible physical conditions that may increase vulnerability (pregnancy, disabilities)
- Lack of experience
- Appearing timid, vulnerable, lost, or confused
- Lax attitude and/or overconfidence
- Worker bias or stereotyping that causes over or under reaction to safety threats
- Attire (jewelry, high-heels)

- Lack of safety plan

Condition of emergency equipment that may be needed

- Vehicle in good repair and working condition
- Mobile device fully charged and has reception
- Emergency phone numbers available

Discussion with your supervisor regarding the issue of safety should take place prior to the first home visit. When a safety risk is identified, a plan must be created and adapted as necessary to address concerns. This may include meeting in a community location such as a library or meeting in the office.

Prior to leaving the office:

- Ensure that your schedule is updated to reflect clients, places and times
- Consider prior safety discussions and information from prior visits
- If on a community-based crisis outreach, contact police

During the visit:

- Be present in a location where exits are unobstructed.
- If sitting, sit on a hard chair, if possible, hard chairs are easier to get out of than cushioned ones, and pose less exposure to items, such as bed bugs.
- Be present with your back to a wall so that no one can sneak up behind you.
- Keep mobile device readily accessible.

If at any time during the visit the situation becomes volatile, conclude the visit.

Manual: Safety Manual

Manual Section: Client/Patient, Staff and Visitor Safety

Name: Client Under the Influence

Effective Date: 05/22/2019

Policy Cross Reference(s): Behavioral Health Programs - Physical Health Manual – Client Under The Influence

Citation(s):

CLIENT UNDER THE INFLUENCE

When any client is thought to be under the influence of alcohol or other substances, staff will question the client regarding use and will assess observed clinical symptoms and level of impairment with consideration for, but not limited to these factors:

• Orientation	• Perception and comprehension
• Sensory response	• Reaction time
• Visual acuity	• Sensory-motor coordination
• Balance	• Consciousness
• Emotional state	• Speech

If a client appears to be under the influence of alcohol, staff will also ask client to submit to a breathalyzer test. If client refuses breathalyzer, advise him/her that intended service will not be provided. If client agrees to breathalyzer, a trained staff will administer the breathalyzer test. Intended service provision subsequent to the breathalyzer result will be at the discretion of staff.

Based on observation and breathalyzer results, as applicable, staff may determine the need for medically trained staff to assist in intervening with the client. On-site medical staff will assist as appropriate and available. If a client shows signs of physical distress, staff will call 911.

As necessary, staff will assist in arranging safe transportation for clients known or suspected to be under the influence (i.e. transport by a family member/friend, cab).

If the individual has driven to Chestnut and refuses safe transportation, staff will advise the client that police will be called should he/she choose to drive. If a call to the police is necessary, staff may not disclose that the individual is a client, just that you believe he/she is driving while under the influence. Provide any available information about the vehicle description, location or license plate. Notify your supervisor.

In housing programs in which client medications are monitored, also refer to the Medical Manual for the procedure related to medication self-administration for clients suspected to be under the influence.

Document relevant clinical information in the client's medical record. Complete an incident report for incidents involving clients under the influence.

Manual: Safety Manual

Manual Section: Client/Patient, Staff and Visitor Safety

Name: Disposal of Alcohol/Drugs/Paraphernalia

Effective Date: 05/22/2019

**Policy Cross
Reference(s):**

Citation(s):

DISPOSAL OF ALCOHOL/DRUGS/PARAPHERNALIA

When negligible amounts of alcohol/drugs/paraphernalia is discovered on site, two staff shall be involved in disposal.

- Wear Personal Protective Equipment
- Use Detera bags to dispose of drugs.
- Alcohol is emptied into a toilet and flushed away.
- Paraphernalia should be rendered unusable whenever possible and double bagged.
- Dispose of bagged material in outside dumpster.
- Document in clients' record.
- Notify your supervisor.
- Complete an incident report.

When a larger quantity of drugs or significant paraphernalia is discovered call the police and follow their instructions. If they advise to dispose, follow the procedure above. If the police indicate that they will pick up the drugs have the police officer sign our incident report form.

Manual:	Safety Manual
Manual Section:	Client/Patient, Staff and Visitor Safety
Name:	Missing Adult
Effective Date:	05/22/2019
Policy Cross Reference(s):	
Citation(s):	

MISSING ADULT

If a staff member suspects a patient or visitor is missing, the supervisor on duty should be alerted immediately.

Procedure

The Supervisor or Designee will complete the missing person checklist, which can be found in the appendix of this manual and under the safety tab on the intranet, and ensure all actions are recorded including time of action and person completing the action.

Manual:	Safety Manual
Manual Section:	Client/Patient, Staff and Visitor Safety
Name:	Service Animals
Effective Date:	05/22/2019
Policy Cross Reference(s):	SI 250 Services Animals and Pets
Citation(s):	

SERVICE ANIMALS

For safety reasons, pets and other animals are not allowed inside of ambulatory, outpatient or residential facilities, with the exception of service animals for persons with a disability and certified therapy animals. Refer to policy SI 250.

Ensure that staff communicate the presence of service animals at each handoff throughout the visit.

Staff should not touch, pet, feed, play with, or otherwise distract the service animal from its work. If staff need to engage with the service animal, they should ask the handler for permission and guidance first.

Staff should wash their hands using soap and water before and after interacting with a service animal.

Clean and disinfect any contaminated surfaces using standard cleaning procedures.

Ensure proper disposal of animal waste if a service animal urinates or defecates.

Manual: Safety Manual

Manual Section: Client/Patient, Staff and Visitor Safety

Name: Safety Event – Staff Notification of Procedural Changes

Effective Date: 05/22/2019

**Policy Cross
Reference(s):**

Citation(s):

SAFETY EVENT-STAFF NOTIFICATION OF PROCEDURAL CHANGES

During the course of business, it may be necessary to change procedures due to a potential safety risk. These changes will be sent out to staff via an all-staff email and will be placed in Relias. This information will be assigned to all current staff and new staff until the procedural changes can be updated in the proper manual.

Manual:	Safety Manual
Manual Section:	Client/Patient, Staff and Visitor Safety
Name:	Recalls
Effective Date:	06/24/20
Policy Cross Reference(s):	SI 130 General Safety
Citation(s):	EC.02.01.01

RECALLS

The Learning and Safety Manager and the Safety Coordinator will subscribe to email services to monitor the FDA, CDC, and Consumer Product Safety Commission for all product recalls. . Additionally, a copy of any recall notification received directly by any Chestnut staff person (i.e. a medical professional, administrator or purchasing staff) will be forwarded to the Safety Coordinator.

The Learning and Safety Manager or Safety Coordinator will forward all medication, medical device or medical equipment recall information to the All-MedicalRecalls@chestnut.org distribution list. The Safety Coordinator will be responsible for ensuring that distribution lists are current and accurate.

All other recalls will be forwarded to the Regional Facilities Managers, IT, and Purchasing Manager. The Business Manager, Nursing Coordinators, Facilities and Purchasing staff will notify the Learning and Safety Manager and Safety Coordinator of actions taken as a result of the recall.

The Learning and Safety Manager will keep a binder of all products recalls along with actions taken relating to the recall.

Manual: Safety Manual

Manual Section: Response to Urgent/Critical Medical Situation

Name: Adverse Drug Reaction

Effective Date:

Policy Cross Reference(s):

Citation(s): MM.06.01.01
MM.07.01.01
MM.07.01.03

ADVERSE DRUG REACTION

Any serious adverse side effects will be reported to the provider and documented in the client's chart.

Clients receiving medication on-site will be monitored for any signs of adverse side effects at the time of administration of any new medications.

Potentially serious adverse drug reactions include:

1. Dyspnea (difficulty breathing) and tightness of the chest.
2. Shortness of breath.
3. Urinary retention.
4. Sudden infection (especially while on Clozapine).
5. Rash, welts, or itching.
6. Fever over 101⁰ F.
7. Sudden visual disturbances.

In the event of an adverse drug reaction:

1. Call for CPR certified staff. Chestnut staff are expected to respond to medical emergencies, operating within the constraints of their role and training. Those that do not have proper training for specific tasks should not engage in these activities.
2. Bring an emergency cart, AED, and First Aid Kit to the location.
3. In the event that the client is in distress, dial 911.
4. Monitor vitals and start CPR as needed.
5. Keep clients comfortable until help arrives.
6. If a client refuses external medical treatment have them complete the Informed refusal form.
7. Stop medication immediately.
8. The provider will be notified. All orders are to be carried out promptly to provide for the safety and well-being of the client.
9. Call the pharmacy to notify them of unexpected drug reactions and obtain the name of the drug manufacturer. (Authorization from the client may be necessary.)
10. For severe adverse drug reactions, provider shall call U.S. Food and Drug Administration Med Watch (24-hour service) 800-332-1088 to report problem with drug.
11. Provider (or designee) shall call drug manufacturer (number in front of PDR) to report problem with drug.
12. Document in the client's medical record.
13. Complete an incident report.

Manual: **Safety Manual**

Manual Section: **Response to Urgent/Critical Medical Situation**

Name: **Contacting Medical/Supervisory Personnel**

Effective Date:

**Policy Cross
Reference(s):**

Citation(s):

CONTACTING MEDICAL/SUPERVISORY PERSONNEL

A nurse should be contacted when a client's medical condition cannot be safely managed by non-medical staff. However, in some circumstances, contacting emergency medical services (911) is the more appropriate action.

The following list of symptoms serve as a guide to help staff decide whether or not to call medical personnel. Staff should consult with medical personnel or supervisor (on-site or on-call) for the following reasons:

- Fever of 101 degrees or higher.
- Nausea and vomiting—projectile (forceful) vomiting or inability to keep any food or liquid down.
- Diarrhea—not responding to anti-diarrheal medication which can result in dehydration, which may result in extreme thirst, reduced or no urine output. Passing blood in stool.
- Low blood sugar readings that do not respond to carbs or glucose gel.

Manual: Safety Manual

Manual Section: Response to Urgent/Critical Medical Situation

Name: Medical Emergencies

Effective Date:

Policy Cross Reference(s):

Citation(s):

MEDICAL EMERGENCIES

Chestnut is not a medical emergency care facility but will respond within its capacity to medical emergencies. A Medical Emergency exists when a client/staff exhibits the sudden onset of 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 placing the client's health in serious jeopardy.

Staff should call 911 emergency personnel including, but not limited to the following situations:

- a. Any symptom for which the staff feels emergency care is needed.
- b. Any suspected overdose.
- c. Tremors/shakes/seizures
 - First reported seizure;
 - Client is in ASAM level III residential;
 - Client is in detoxification services;
 - There was observed trauma, possible injury such as injury to head, back or neck or blunt abdominal injury;
 - More than one seizure without regaining consciousness.
- d. Unconsciousness
- e. Unexplained shortness of breath
- f. Rash, accompanied by shortness of breath. Client may state, "I feel like my throat is closing up."
- g. Possible fracture, head trauma or chest trauma, or inability to use any extremity after trauma. Any visible bony parts bulging through skin. DO NOT MOVE- CALL 911.
- h. Erratic, uncontrollable behavior.
- i. Chest pain.
- j. Choking
- k. Facial paralysis, difficulty with speech, numbness, visual problems.
- l. Severe or persistent vomiting
- m. Blood sugar above/below recommended reading. (See Monitoring Blood Sugar Levels)
- n. Signs of heat related emergencies.
- o. Signs of hypothermia.

Procedure

1. Call for CPR certified staff. Utilize the team approach. Chestnut staff are expected to respond to medical emergencies, operating within the constraints of their role and training. Those that do not have proper training for specific tasks should not engage in these activities.
2. Bring emergency cart, AED, and First Aid Kit to the location.
3. Call 911 and follow EMS instructions.
4. Monitor vitals and start CPR as needed.
5. Keep client comfortable until help arrives. In the event of falls, suspected falls, or other possible trauma do not move the client unless the client is in danger of additional significant harm.

6. If a client refuses external medical treatment have them complete the Informed refusal form.
7. Call Poison Control, in the event of overdose or suspected overdose. (1-800-942-5969) This is not for when Narcan is used.
8. Call and notify Chestnut provider and supervisors.
9. Document in the client's medical record.
10. Complete an Incident Report.

Information to Provide 911 Responders

- Client name
- Birth date
- Allergies
- Current medications
- Last noted vital signs
- Last food/liquid intake
- Any loss of consciousness
- Emergency contact person

Manual: **Safety Manual**

Manual Section: **Response to Urgent/Critical Medical Situation**

Name: **First Aid Treatment**

Effective Date:

**Policy Cross
Reference(s):**

Citation(s):

FIRST AID TREATMENT

All staff monitoring clients are to be trained in basic first aid procedures. First aid kits are maintained at all facilities. Call 911 as warranted by the situation. If a client refuses external medical treatment have them complete the Informed refusal form.

CPR

1. Check the client for responsiveness.
2. Check the client's pulse and breathing. Slide two fingers to the side of the trachea (windpipe) just beneath the jaw. Feel for a pulse while watching the chest for chest rise to determine if the client is breathing. Check for pulse and breathing simultaneously for at least 5 but no more than 10 seconds. If there is no pulse and no **normal** breathing, call 911 and begin CPR. If an AED is available, send someone to get the AED. Note: Gasping and gurgling are NOT normal breathing and should be treated the same as having no breath.
3. Begin with compressions and press hard and fast on the center of the chest, midpoint between the nipples at the lower half of the sternum (breastbone). Compress at a rate of 100-120 compressions per minute and allow the chest to fully recoil (return to neutral position) between compressions.
 - a. For adults (puberty through older adulthood), compress to a depth of at least 2 inches. Deliver 30 compressions before giving 2 breaths.
 - b. For children (age 1 to puberty), compress at a depth of approximately 2 inches. For a single rescuer, deliver 30 compressions before giving 2 breaths. For 2 rescuers or more, deliver 15 compressions before giving 2 breaths.
 - c. For infants (less than 1 year old), compress at a depth of approximately 1 ½ inches. For a single rescuer, deliver 30 compressions before giving 2 breaths. For 2 rescuers or more, deliver 15 compressions before giving 2 breaths.
4. To deliver 2 breaths, select your barrier device (CPR face shield, pocket mask, ambu bag). Perform a head-tilt, chin-lift. Deliver 2 breaths, giving each breath over 1 second. Watch for chest rise and deliver just enough air to see visible chest rise. Do NOT overly ventilate. Resume chest compressions in less than 10 seconds.
5. Continue cycles of CPR until advanced help arrives. If more than 1 rescuer is present, switch compressor/ventilator roles every 2 minutes, or sooner if fatigued.
6. If an AED is available, turn on the AED as soon as possible and follow the prompts on the AED. Follow the diagrams on the pads for placement of the pads on the client.

Rescue Breathing

1. If your client is unresponsive, isn't breathing normally, but has a pulse, call 911 and begin rescue breathing.
2. For adults, give 1 breath every 6 seconds. Give each breath over 1 second and watch for chest rise. Do not overinflate the lungs; only give enough air to see visible chest rise. Continue rescue

breaths until EMS arrives. Check for a pulse every 2 minutes. If the client no longer has a pulse, begin CPR.

3. For infants and children, give 1 breath every 2-3 seconds. Give each breath over 1 second and watch for chest rise. Do not overinflate the lungs; only give enough air to see visible chest rise. Continue rescue breaths until EMS arrives. Check for a pulse every 2 minutes. If the client no longer has a pulse (or for infants, if their pulse is less than 60 beats per minute), begin CPR.

Eye Injuries

1. Rinse eyes exposed to chemicals immediately with copious amounts of tap water, normal saline, or commercially available eye irrigation solution, for at least 15 minutes.
2. Review Safety Data Sheets (SDS) for the chemical (located on the W drive).
3. Contact local poison control or seek help from a medical provider or 911 if needed.

Penetrating Object or Eyeball Out of Socket

1. Position client on back.
2. Do not remove object that has entered the eyeball.
3. Stabilize object and wrap both object and eye.
4. Call 911.

Nose Injuries

1. Lean client forward with chin on chest.
2. Pinch Nose.
3. Apply ice pack to bridge of nose.
4. Contacting Nursing Supervisor or call 911 as necessary.

Possible Spinal Injuries

1. Place your hands on either side of client's head and hold it still.
2. Client should be encouraged not to move until help arrives.
3. If face-down and the airway is blocked, use the log-roll maneuver to turn the over.
4. Call 911.

Suspected Broken Bones

1. Have the client sit or lie down.
2. Splint the joints above and below the injured area.
3. Discourage touching or moving the fracture.
4. Do not move the client without instructions from medical personnel.
5. Stay with the client and reassure them.
6. Utilize chain of command and call 911 if necessary.

Burns

1. Remove flame or smother flame with blanket or roll client on the floor.
2. Do not remove burned clothing.
3. Flush with tepid/lukewarm water.
4. If burned over large area of body, cover with a clean sheet.
5. If feet are not burned, elevate legs 6 to 8 inches.
6. Call 911.

Bleeding

1. Apply dressing to the wound.
2. Apply direct pressure (wear gloves, or as a last resort, utilize any available waterproof barrier).
3. Elevate the bleeding body part above the heartline if there is no fracture.
4. Call 911.

Shock

Symptoms indicative of shock include cool and clammy skin, pale skin, rapid pulse and breathing, blue/gray tinge to lips and/or fingernails, nausea/vomiting, dilated pupils, weakness or fatigue, dizziness or fainting, and potential change in mental status.

1. Monitor breathing.

2. Elevate legs about 12 inches, if no head or neck injury.
3. Keep client lying flat If suspected head or neck injury.
4. Maintain the client's body heat. On a cold day cover with a blanket.
5. Call 911.

Heat Related

1. Heat Cramps

Symptoms of heat cramps include muscle pain or spasms and heavy sweating during intense exercise. Have the client:

- a. Stop physical activity and move to a cool place
- b. Drink water or a sports drink
- c. Wait for cramps to go away before doing any more physical activity.
- d. Get medical help right away if:
 - i. Cramps last longer than 1 hour.
 - ii. The client is on a low-sodium diet
 - iii. The client has heart problems.

2. Heat Exhaustion

Symptoms of heat exhaustion include heavy sweating, cold/pale/clammy skin, a fast and weak pulse, nausea or vomiting, muscle cramps, tiredness or weakness, dizziness, headache, and fainting (passing out). Have the client:

- a. Move client to a cool area.
- b. Loosen tight or constricting clothing.
- c. Put cool, wet cloths on their body or take a cool bath.
- d. Sip water.
- e. Get medical help right away if:
 - i. Throwing up
 - ii. Symptoms get worse
 - iii. Symptoms last longer than 1 hour.

3. Heat Stroke

Symptoms of heat stroke include a high body temperature (103F or higher), hot/red/dry or damp/clammy skin, a fast and strong pulse, headache, dizziness, nausea, confusion, and loss of consciousness (passing out).

- a. Call 911 right away. Heat stroke is a medical emergency.
- b. Move the client to a cool area.
- c. Help lower the client's temperature with cool cloths or a cool bath.
- d. Do not give the person anything to drink.

Cold Related

1. Hypothermia

Hypothermia is a medical emergency. Symptoms of hypothermia include shivering, exhaustion or feeling very tired, confusion, fumbling hands, memory loss, slurred speech, and drowsiness. If you notice these signs, check the client's temperature. Call 911 immediately for a temperature below 95°F. If medical help isn't available right away:

- a. Get the client to a warm room or shelter.
- b. Remove any wet clothing the client is wearing.
- c. Warm the center of the client's body – chest, neck, head, and groin – using an electric blanket, if available. You can also use skin-to-skin contact under loose, dry layers of blankets, clothing, towels, or sheets.
- d. Warm drinks can help increase body temperature if the client is conscious.
- e. After body temperature has increased, keep the client dry and wrap their body, including their head and neck, in a warm blanket.
- f. If the person does not have a pulse or normal breathing, begin CPR and continue CPR until emergency help becomes available.

2. Frostbite

Redness or pain in the skin is an indication that the client should get out of the cold and protect any exposed skin. Signs of frostbite include a white or grayish-yellow area of skin, skin that feels unusually firm or waxy, and numbness. If immediate medical care is unavailable, do the following:

- a. Check for signs of hypothermia – hypothermia is the more serious condition. Follow the guidance for hypothermia if signs are present.
- b. Get the client into a warm room as soon as possible.
- c. Unless absolutely necessary, tell the client to not walk on feet or toes that show signs of frostbite as this increases damage.
- d. Do not rub the frostbitten area. This can cause more damage.
- e. Put areas affected by frostbite in warm (not hot) water. The temperature should be comfortable to the touch for unaffected parts of the body.
- f. If warm water is unavailable, warm the affected area using body heat from a different part of the body.
- g. Frostbite should be checked by a healthcare provider as soon as possible.

Poisoning

1. If chemical is used for cleaning, refer to the SDS binder located on the W drive and follow directions.
2. Call Poison Control. (1-800-942-5969)
3. Monitor breathing.
4. Call 911.

Unconsciousness

1. Call the client or tap them to see if they are asleep.
2. If no response, call 911. Check breathing and pulse. Slide two fingers to the side of the trachea (windpipe) just beneath the jaw. Feel for a pulse while watching the chest for chest rise to determine if the client is breathing. Check for pulse and breathing simultaneously for at least 5 but no more than 10 seconds.
3. If there is no pulse and no **normal** breathing, call 911 and begin CPR. If an AED is available, send someone to get the AED. Note: Gasping and gurgling are NOT normal breathing and should be treated the same as having no breath.
4. If the client has a pulse but no normal breathing, begin rescue breathing.
5. If there is a pulse and normal breathing, turn the client to the left side to prevent choking if the client vomits, and recheck the pulse and breathing at least every 2 minutes while waiting for EMS to arrive.
6. If an opioid overdose is suspected, follow Narcan procedure.

Choking

1. Ask the client if they need help.
2. If the client is coughing, encourage them to continue to cough.
3. If the client is wheezing, perform the Heimlich maneuver by:
 - a. Adults/Children
 - i. Stand behind the client with your chest to the client's back.
 - ii. Place your arms around the client.
 - iii. Place a closed fist just above the belly button and place your other hand over the top of that fist.
 - iv. Swiftly provide 5 abdominal thrusts upward towards the client's chest.
 - v. Repeat until the object is dislodged, or the client loses consciousness.
 - vi. If the client loses consciousness call 911 and begin CPR.
 - b. Infants
 - i. Hold the infant face down, angled towards the ground with their head closest to the floor. (Be careful not to block airway)
 - ii. Perform 5 forceful back slaps.
 - iii. Carefully turn baby over continuing to have them angled towards the ground with their head closest to the floor and perform 5 chest compressions using 2 fingertips.
 - iv. Continue rotating between back slaps and chest compressions until the object is dislodged or the baby loses consciousness.

- v. If the baby loses consciousness begin CPR.
 - vi. Call 911.
- 4. Any time the Heimlich maneuver is performed the client should go to the hospital to be evaluated.

Drug Overdose

1. Amphetamine Overdose (Speed) – A Stimulant
 - a. Call 911.
 - b. Attempt to keep client calm.
 - c. The client will be very hyperactive at first with a very high pulse rate, which will eventually level off at a steady, fast rate after several hours.
2. Barbiturates overdose (Downers) – A Depressant Overdose is extremely dangerous – IMMEDIATE NEED FOR HOSPITAL SERVICES.
 - a. Call 911.
 - b. If client is unconscious, stay with him/her until medical help arrives.
 - c. If client is conscious, follow these steps:
 - i. Try to keep client awake.
 - ii. Do not give client food or drink.
 - iii. Keep client on side to reduce aspiration risk.
3. Opioid overdose – Refer to Narcan procedure.

Manual: Safety Manual

Manual Section: Response to Urgent/Critical Medical Situation

Name: Narcan Procedure

Effective Date:

Policy Cross Reference(s):

Citation(s):

NARCAN PROCEDURE

Chestnut is not a medical emergency care facility but will respond within its capacity to suspected opioid overdose.

DURING AN OVERDOSE EVENT

1. Check for signs of an overdose:
 - a. No Response when spoken to or when gently shaken
 - b. Pin-Point Pupils
 - c. Slow or Shallow breathing / Making gurgling sounds
 - d. Lips/Fingernails turning blue or gray
 - e. Skin is clammy or pale
2. Call 911.
3. Obtain Narcan kit found in the first aid kit or from the emergency cart or medication cabinet, if available. Obtain an AED in case it is needed later. If another person is available, send that person to get the AED.
4. Administer Narcan
 - a. Position client on his/her back.
 - b. Gently tilt the person's head back.
 - c. Insert the Narcan into one nostril.
 - d. Press the plunger firmly into one nostril. You will feel a click.
5. Monitor the client's pulse. If at any point the client has no pulse and no normal breathing, begin CPR until EMS arrives. If the client has a pulse but no normal breathing, begin rescue breaths until EMS arrives, checking every 2 minutes to make sure the client still has a pulse.
6. If no response after 2-3 minutes administer another dose of Narcan in the opposite nostril.
7. Continue administration of Narcan every 2-3 minutes, alternating nostrils, until EMS arrives or client responds.
8. If client refuses medical transportation complete the informed refusal consent.

AFTER AN OVERDOSE EVENT

1. As soon as possible, but prior to end of work shift, complete an Incident Report & NARCAN State Grant Form (if Narcan from First Aid Kit was used).
2. Email Notification within 24hrs:
 - a. Regional Manager; Medical Director; Director of Program (if current client); Your Supervisor

Further review of the incident will occur as per RM 65. Follow other program specific procedures as outlined in program manuals.

Manual: **Safety Manual**

Manual Section: **Response to Urgent/Critical Medical Situation**

Name: **Seizure Precautions**

Effective Date:

**Policy Cross
Reference(s):**

Citation(s):

SEIZURE PRECAUTIONS

Staff will take precautions to prevent injuries if a client has a seizure.

1. If a client has a seizure:
 - a. Ease client to ground, if possible, and stay with them.
 - b. Position client on side.
 - c. Keep a calm and reassuring attitude.
 - d. Protect the client from injury and loosen tight clothing around client's neck and waist.
 - e. Call 911, if
 - First reported seizure;
 - Client is in ASAM level III residential;
 - Client is in detoxification services;
 - There was observed trauma, possible injury such as injury to head, back or neck or blunt abdominal injury;
 - More than one seizure without regaining consciousness.
 - f. Implement internal emergency code – CPR Certified Staff to assist in response.
 - g. If the client stops breathing start CPR.
 - h. Call Chestnut provider, if applicable.
 - i. Document in progress notes:
 - Duration of seizure.
 - Type of movement observed.
 - Was the client unresponsive and for how long?
 - Did the client stop breathing and for how long?
 - Did the client have more than one seizure?
 - Was there any observed trauma, possible injury such as injury to head, back or neck or blunt abdominal injury?
 - Complete Incident Report.

Don't

1. Don't restrain the client.
2. Don't try to put anything in the client's mouth, including your fingers.

Manual: Safety Manual

Manual Section: Response to Urgent/Critical Medical Situation

Name: Obstetrical Emergency

Effective Date:

Policy Cross Reference(s):

Citation(s):

OBSTETRICAL EMERGENCY

Staff will properly respond to obstetrical medical emergency.

1. When a client reports warning signs of a possible problem with pregnancy, the client should not be on her feet and should be placed in a reclining position.
2. Staff will assist the client in notifying her obstetrician.
3. Call 911.

Warning Signs of Possible Problem with Pregnancy

1. Bleeding or spotting blood from the vaginal area.
2. Cramping or severe abdominal pain.
3. Clear fluid leaking from the vaginal area.
4. Excessive vomiting and unable to retain fluids.

Other Symptoms

1. Temperature over 100°F.
2. Severe headaches.
3. Sudden decrease in urination.
4. Severe nausea and/or vomiting (continue sips of water).
5. Puffiness to face or eyes.
6. If patterns of movement differ from the normal pattern.
7. Significant increase in blood pressure.

Manual: Safety Manual

Manual Section: Response to Urgent/Critical Medical Situation

Name: Diabetic Emergency

Effective Date:

**Policy Cross
Reference(s):**

Citation(s):

DIABETIC EMERGENCY

Staff will properly respond to diabetic medical emergency.

If the client is unconscious or having a seizure, first call 911.

1. For a blood sugar reading below 55, or if the client has a blood sugar reading below 69 and has lost consciousness, administer glucose injection found in emergency cart, if available.
2. For low blood sugar between 55-69, have the client consume 15 grams of carbs and recheck their blood sugar in 15 minutes. If the blood sugar is still below 70, repeat this process and have the client consume 15 additional grams of carbs and recheck blood sugar in 15 minutes. Repeat this process until the client's blood sugar is 70 or more, then have the client eat a nutritious meal or snack. The following items have 15 grams of carbs:
 - a. 4 ounces (or $\frac{1}{2}$ cup) of juice or regular soda.
 - b. 1 tablespoon of sugar, honey, or syrup.
 - c. Hard candies, jellybeans, or gumdrops (see nutritional label for how much to eat for 15 grams).
 - d. 1 dose of glucose gel (if available in emergency carts or first aid bags).

Manual: Safety Manual

Manual Section: Response to Urgent/Critical Medical Situation

Name: Heart Attack/Stroke

Effective Date:

Policy Cross Reference(s):

Citation(s):

HEART ATTACK/STROKE

Staff will properly respond to heart attack/stroke medical emergency.

If someone is having a heart attack or stroke, follow medical emergency procedures section of this manual.

Heart Attack Symptoms

Symptoms of a heart attack vary, but common symptoms are:

- Severe pain/pressure in chest or upper body (back, shoulder blades, left arm, and neck);
- Nausea or vomiting;
- Dizziness;
- Shortness of breath or light-headedness;
- A person may look pale, ashen or have bluish skin.
- A person does not have to be unconscious to be experiencing a heart attack.

Many people deny or ignore the symptoms they experience.

Stroke Symptoms

The following are warning signs of a stroke, although not all signs occur in every stroke. Do not ignore the symptoms even if they go away.

- Sudden numbness or weakness of the face, arm, or leg, especially on one side of the body;
- Sudden confusion, trouble speaking or understanding;
- Sudden trouble seeing in one or both eyes;
- Sudden trouble walking, dizziness, loss of balance or coordination;
- Sudden, severe headache with no known cause.

F.A.S.T

Facial drooping

Arm weakness

Speech slurred

Time – contact 911 immediately.

Manual: Safety Manual

Manual Section: Response to Urgent/Critical Medical Situation

Name: Assessment for Emergency Medications

Effective Date:

Policy Cross Reference(s):

Citation(s): MM.03.01.03

ASSESSMENT FOR EMERGENCY MEDICATIONS

Chestnut medical staff will abide by the following procedures for use of Emergency Medications.

1. An accurate history of medication, food, seasonal and insect allergies shall be obtained and recorded in the client's record at each medication related encounter and with each admission.
2. Specific focus shall be made regarding any history of prior allergic reactions, including relative severity, frequency and when such reactions occurred, shall also be recorded in the client record. Additional information shall be noted regarding prior interventions, including the use of Epi-pens.
3. If a client enters a residential or housing program and has a potential need of an emergency medication such as Epi-pens, the client or guardian/parent will bring the medication for use at admission. If unavailable, attempts should be made to obtain emergency medication through prescribers.
4. If your program is housed in a facility co-located with Chestnut Family Health Center, emergency medications may be available through the health center.

Manual: **Safety Manual**

Manual Section: **Response to Urgent/Critical Medical Situation**

Name: **Emergency Contact**

Effective Date:

**Policy Cross
Reference(s):**

Citation(s):

EMERGENCY CONTACT

Staff will take appropriate actions following a medical emergency.

1. Notify client's emergency contact.
2. Staff will follow-up with the emergency provider(s) to check the status of the client referred for emergency services.
3. Notification of the client's family, in addition to the emergency contact, shall be made as soon as possible and appropriate per program requirements and with a valid release.
4. Notification to the emergency contact should be documented in the client's medical record.
5. An Incident Report form shall be completed.

APPENDIX:
Infection Control Committee Members 2024

Director of Quality and Compliance

Learning and Safety Manager

Safety Coordinator

Vice President of Integrated Care

CFHC Provider

CFHC Behavioral Health Coordinator

CFHC Business Manager

Mobile Unit Coordinator

Integrated Wellness Clinical Director

Integrated Health Coordinator

Medical Assistant Coordinator

Infection Control Nurse

Facilities Managers

Chestnut Family Health Center Nurse Manager

Behavioral Health Programs Nurse Coordinator and Residential Unit Coordinators

Safety Committee Members 2024

Central Region	Heather Towell Dietra Kulicke Carrie Anderson Bryan Hinman Kelly Luckey Matt Mollenhauer Stephanie Paxton Pam Kouri Thomas Brown Austin Howald Sherise Kirvan Jessica Barnes Nadia Klekamp Tim Cramer Brady Hudson Amanda Musson Tamarra Likens Erica Quick Bekime Branch
Chestnut Family Health Center	Heather Towell Dietra Kulicke Amy Gibbar Jessica Barnes Brady Hudson Stephanie Paxton Chantel Bailey Pam Kouri Kathi Morris Jennifer Fouts Erica Quick Jennifer Evens Molly McVey Emma Melvin Katrina Cordova Bekime Branch Kirsten Waters
Southern Region	Heather Towel Brent Cummins Julie Brugger Terri Klawonn Chris Norton Emma Melvin Jennifer Holtgrewe Donna Nahlik Linda Dunham Amy Gibbar Cara Moellenhoff

APPENDIX

Systems Failure

Failure of:	What to Expect:	Who to Contact:	Responsibility of User:
Computer System	System Down	IT Program Supervisor	Proceed with program downtime procedures
Total Failure of Electrical Power	Failure of all electrical systems.	Facilities Manager Program Supervisor	Utilize flashlights, emergency phones, and take action to provide continuity of care which may involve starting the ICC. Use offices with windows (may need to be prioritized between programs), use group rooms with emergency lighting/windows, if possible, utilize outdoor space for sessions.
Elevators Out of Service	Movement between floors of a building will be by stairwell.	Facilities Manager Program Supervisor	Review the fire evacuation plans.
Elevators Stopped Between Floors	People may be trapped in the elevator for an extended period of time.	Facilities Manager Program Supervisor	Keep verbal contact with those in elevator and let them know that help is on the way.
Fire Alarm System	Fire alarms may not sound. In areas equipped with sprinklers, they are available as long as water is accessible.	Facilities Manager Program Supervisor	Institute a fire watch (hourly inspections documented on the fire watch form), minimize fire hazards, use phone/runner to report fires.
Sprinkler System	Sprinkler system is out of service.	Facilities Manager	Institute a fire watch (hourly inspections documented on the fire watch form), minimize fire hazards, use phone/runner to report fires.
Sewer Stoppage	Drains backing up.	Facilities Manager Program Supervisor	Do not flush toilets. Do not use water.
Telephones	Complete lack of telephone service.	IT Program Supervisor	Use cellular phones and/or emergency phones per the safety manual.
Water	Sinks, toilets, sprinkler systems, and other sources of running water are inoperative.	Facilities Manager Program Supervisor	Institute a fire watch, conserve water, use bottled water for drinking, and turn off water in sinks.
Water (Water Becomes Undrinkable)	Tap water unsafe to drink and ice from ice machine is unsafe for consumption	Facilities Manager Program Supervisor	Use bottled water, Place "Do not drink" signs on all drinking fountains and sinks and "do not use" signs on ice machines. Flush lines when water service is restored.
Ventilation	No ventilation, heating or cooling.	Facilities Manager Program Supervisor	Open windows, obtain blankets or fans (if needed), and restrict use of

			odorous/hazardous materials.
Water leak	Puddles of water due to problem with plumbing	Facilities Manager Program Supervisor	Turn off water at marked valve. If you are unsure of where the valve is look at maps in appendix of safety manual.
Gas leak	Sulfuric, rotten egg odor	Facilities Manager Program Supervisor	Contact the gas company and evacuate staff and patients to a safe area. Turn off gas at marked valve. If you are unsure of where the valve is look at maps in appendix of safety manual.

Infection/Exposure Control Plan

Chestnut Family Health Center (CFHC) – 702
February 2024

Infection Control

Goal: To identify and reduce the risks of acquiring and transmitting infections among the individuals served, staff and visitors.

1. All CFHC staff will demonstrate Safety and Infection Control Competencies annually with the initial demonstration occurring prior to providing patient care. This competency includes hand hygiene, routine cleaning and disinfecting, appropriate use of PPE, and regulated medical waste disposal.
2. All CFHC staff will complete training on hand hygiene as part of their annual Safety/Infection Control Training with the initial completion occurring prior to providing patient care. Training scores will be monitored in the regional infection control meeting. The training will be updated if a pattern of low scores is detected. In addition, additional live training may take place when a pattern is noted.
3. A member of the Infection Control Committee or designee will conduct monthly inspections of CFHC facilities to assure hand sanitizer, soap, and other cleaning supplies being utilized are clearly marked with expiration date of the solution and not identified as expired upon inspection.
4. A member of the Infection Control Committee will complete monthly ATP testing on designated items in the health center. Results will be reported in the infection control meeting.
5. When disposing of regulated medical waste, including needles, staff will follow written guidelines in the Safety Manual. Regulated medical waste packed for transport will not be stored in the facility for more than 90 calendar days.
6. The Annual Airborne Risk Assessment will be conducted annually, and the results will be reported to the Infection Control Committee. The Infection Control Committee will make recommendations for appropriate procedural changes or other interventions.
7. The Annual Infection Control Risk Assessment – site specific – will be conducted annually by the Safety Manager or designee and reviewed by the Infection Control Committee.
8. Any conversion of a staff TB test from negative to positive will be reported to the Infection Control Committee. The Infection Control Committee will make recommendations for appropriate procedural changes or other interventions.
9. Exposures or potential exposures to blood or blood products documented on an Incident Report form will be monitored by the Infection Control Committee. The Infection Control Committee will make recommendations for appropriate procedural changes or other interventions.
10. All CFHC staff will be offered an annual influenza immunization during the designated influenza season (September – April). The percentage of CFHC staff/interns that obtain an influenza immunization (either at Chestnut or elsewhere) will be monitored and reported to the Infection Control Committee.
11. CFHC nursing leadership will monitor the number of patients that obtained an influenza immunization between September 1 and April 30th of each year (immunization could have been provided by Chestnut or by another entity but is documented in the patient's medical record). CFHC nursing leadership is responsible to provide data to Infection Control Committee.
12. CFHC nursing leadership will monitor the number of patients that obtained a COVID -19 immunization (immunization could have been provided by Chestnut or by another entity but is documented in the patient's medical record). CFHC nursing leadership is responsible to provide data to Infection Control Committee.
13. A review of the Illinois COVID-19 Surveillance Report and Illinois Influenza Surveillance Report will be conducted by the Nurse Coordinator or designee and reported to the Infection Control Committee.
14. The CFHC Nurse Coordinator or designee will monitor the number of patients diagnosed by Chestnut Family Health Center with influenza/Covid and report to the Infection Control Committee.

15. CFHC patients will be asked to update adult and childhood immunizations at each in-person primary care visit.
16. The CFHC Nurse Coordinator or designee will monitor the number of reports to the health department for reportable infections that are identified by CFHC and report back to the Infection Control Committee.
17. The CFHC Nursing Coordinator or designee will monitor the Health Advisory Network, CDC notifications. McLean County Health Department & forward to Medical Director and CFHC Director and report to the Infection Control Committee
18. All CHFC staff will be assigned up to date information as relevant for emerging infectious disease.

Infection/Exposure Control Plan
Chestnut Family Health Center (CFHC) – Northgate and Maryville
February 2024

Infection Control

Goal: To identify and reduce the risks of acquiring and transmitting infections among the individuals served, staff and visitors.

1. All CFHC staff will demonstrate Safety and Infection Control Competencies annually with the initial demonstration occurring prior to providing patient care. This competency includes hand hygiene, routine cleaning and disinfecting, appropriate use of PPE, and regulated medical waste disposal.
2. All CFHC staff will complete training on hand hygiene as part of their annual Safety/Infection Control Training. Training scores will be monitored in the regional infection control meeting. The training will be updated if a pattern of low scores is detected. In addition, additional live training may take place when a pattern is noted.
3. A member of the Infection Control Committee or designee will conduct quarterly inspections of CFHC facilities to assure hand sanitizer, soap, and other cleaning supplies being utilized are clearly marked with expiration date of the solution and not identified as expired upon inspection.
4. A member of the Infection Control Committee will complete monthly ATP testing on designated items in the health center. Results will be reported in the infection control meeting.
5. When disposing of regulated medical waste, including needles, staff will follow written guidelines in the Safety Manual. Regulated medical waste packed for transport will not be stored in the facility for more than 90 calendar days.
6. The Annual Airborne Risk Assessment will be conducted annually, and the results will be reported to the Infection Control Committee. The Infection Control Committee will make recommendations for appropriate procedural changes or other interventions.
7. The Annual Infection Control Risk Assessment – site specific – will be conducted annually by the Safety Manager or designee and reviewed by the Infection Control Committee.
8. Any conversion of a staff TB test from negative to positive will be reported to the Infection Control Committee. The Infection Control Committee will make recommendations for appropriate procedural changes or other interventions.
9. Exposures or potential exposures to blood or blood products documented on an Incident Report form will be monitored by the Infection Control Committee. The Infection Control Committee will make recommendations for appropriate procedural changes or other interventions.
10. All CFHC staff will be offered an annual influenza immunization during the designated influenza season (September – April). The percentage of CFHC staff/interns that obtain an influenza immunization (either at Chestnut or elsewhere) will be monitored and reported to the Infection Control Committee.
11. CFHC nursing leadership will monitor the number of patients that obtained an influenza immunization between September 1 and April 30th of each year (immunization could have been provided by Chestnut or by another entity but is documented in the patient's medical record). CFHC nursing leadership is responsible for providing data to the Infection Control Committee.
12. CFHC nursing leadership will monitor the number of patients that obtained a COVID -19 immunization (provided by another entity but is documented in the patient's medical record). CFHC nursing leadership is responsible for providing data to the Infection Control Committee.
13. A review of the Illinois COVID-19 Surveillance Report and Illinois Influenza Surveillance Report will be conducted by the Nurse Coordinator or designee and reported to the Infection Control Committee.
14. The CFHC Nurse Coordinator or designee will monitor the number of patients diagnosed by Chestnut Family Health Center with influenza/Covid and report to the Infection Control Committee.
15. CFHC patients will be asked to update childhood immunizations at each in-person primary care visit.

*Due to the proximity of the Northgate and Maryville office this plan reflects both locations.

Infection/Exposure Control Plan
Chestnut Family Health Center (CFHC) Dental – 720
March 2024

Infection Control

Goal: To identify and reduce the risks of acquiring and transmitting infections among the individuals served, staff and visitors.

1. All CFHC dental staff will demonstrate Safety and Infection Control Competencies annually with the initial demonstration occurring prior to providing patient care. This competency includes hand hygiene, routine cleaning and disinfecting, appropriate use of PPE, and regulated medical waste disposal.
2. All CFHC dental staff will complete training on hand hygiene as part of their annual Safety/Infection Control Training with the initial completion occurring prior to providing patient care. Training scores will be monitored in the regional infection control meeting. The training will be updated if a pattern of low scores is detected. In addition, additional live training may take place when a pattern is noted.
3. A member of the Infection Control Committee or designee will conduct monthly inspections of CFHC facilities to assure hand sanitizer, soap, distilled water, and other cleaning supplies being utilized are clearly marked with expiration date of the solution and not identified as expired upon inspection.
4. A member of the Infection Control Committee will complete monthly ATP testing on designated items in the health center. Results will be reported in the infection control meeting.
5. When disposing of regulated medical waste, including needles,
6. staff will follow written guidelines in the Safety Manual. Regulated medical waste packed for transport will not be stored in the facility for more than 90 calendar days.
7. The Annual Airborne Risk Assessment will be conducted annually, and the results will be reported to the Infection Control Committee. The Infection Control Committee will make recommendations for appropriate procedural changes or other interventions.
8. The Annual Infection Control Risk Assessment – site specific – will be conducted annually by the Safety Manager or designee and reviewed by the Infection Control Committee.
9. Any conversion of a staff TB test from negative to positive will be reported to the Infection Control Committee. The Infection Control Committee will make recommendations for appropriate procedural changes or other interventions.
10. Exposures or potential exposures to blood or blood products documented on an Incident Report form will be monitored by the Infection Control Committee. The Infection Control Committee will make recommendations for appropriate procedural changes or other interventions.
11. Dental patients that arrive for an appointment with cold sores or open wounds on face, or sores in mouth that are determined to be viral will be rescheduled as per program procedures.
12. All CFHC dental staff will be offered an annual influenza immunization during the designated influenza season (September – April). The percentage of staff/interns that obtain an influenza immunization (either at Chestnut or elsewhere) will be monitored and reported to the Infection Control Committee.
13. Dental staff will follow the directions of Chestnut Family Health Center related to Covid protocols.
14. All CHFC dental staff will be assigned up to date information as relevant for emerging infectious disease.

Infection/Exposure Control Plan
Chestnut Family Health Center (CFHC) – Belleville
February 2024

Infection Control

Goal: To identify and reduce the risks of acquiring and transmitting infections among the individuals served, staff and visitors.

1. All CFHC staff will demonstrate Safety and Infection Control Competencies annually with the initial demonstration occurring prior to providing patient care. This competency includes hand hygiene, routine cleaning and disinfecting, appropriate use of PPE, and regulated medical waste disposal.
2. All CFHC staff will complete training on hand hygiene as part of their annual Safety/Infection Control Training. Training scores will be monitored in the regional infection control meeting. The training will be updated if a pattern of low scores is detected. In addition, additional live training may take place when a pattern is noted.
3. A member of the Infection Control Committee or designee will conduct quarterly inspections of CFHC facilities to assure hand sanitizer, soap, and other cleaning supplies being utilized are clearly marked with expiration date of the solution and not identified as expired upon inspection.
4. A member of the Infection Control Committee will complete monthly ATP testing on designated items in the health center. Results will be reported in the infection control meeting.
5. When disposing of regulated medical waste, including needles, staff will follow written guidelines in the Safety Manual. Regulated medical waste packed for transport will not be stored in the facility for more than 90 calendar days.
6. The Annual Airborne Risk Assessment will be conducted annually, and the results will be reported to the Infection Control Committee. The Infection Control Committee will make recommendations for appropriate procedural changes or other interventions.
7. The Annual Infection Control Risk Assessment – site specific – will be conducted annually by the Safety Manager or designee and reviewed by the Infection Control Committee.
8. Any conversion of a staff TB test from negative to positive will be reported to the Infection Control Committee. The Infection Control Committee will make recommendations for appropriate procedural changes or other interventions.
9. Exposures or potential exposures to blood or blood products documented on an Incident Report form will be monitored by the Infection Control Committee. The Infection Control Committee will make recommendations for appropriate procedural changes or other interventions.
10. All CFHC staff will be offered an annual influenza immunization during the designated influenza season (September – April). The percentage of CFHC staff/interns that obtain an influenza immunization (either at Chestnut or elsewhere) will be monitored and reported to the Infection Control Committee.
11. CFHC nursing leadership will monitor the number of patients that obtained an influenza immunization between September 1 and April 30th of each year (immunization could have been provided by Chestnut or by another entity but is documented in the patient's medical record). CFHC nursing leadership is responsible to provide data to Infection Control Committee.
12. CFHC nursing leadership will monitor the number of patients that obtained a COVID -19 immunization (provided by another entity but is documented in the patient's medical record). CFHC nursing leadership is responsible to provide data to Infection Control Committee.
13. A review of the Illinois COVID-19 Surveillance Report and Illinois Influenza Surveillance Report will be conducted by the Nurse Coordinator or designee and reported to the Infection Control Committee.
14. The CFHC Nurse Coordinator or designee will monitor the number of patients diagnosed by Chestnut Family Health Center with influenza/Covid and report to the Infection Control Committee.
15. CFHC patients will be asked to update childhood immunizations at each in-person primary care visit.

16. The CFHC Nurse Coordinator or designee will monitor the number of reports to the health department for reportable infections that are identified by CFHC and report back to the Infection Control Committee.
17. The CFHC Nursing Coordinator or designee will monitor the Health Advisory Network, CDC notifications. St. Clair County Health Department & forward to Medical Director and CFHC Director and report to the Infection Control Committee
18. All CHFC staff will be assigned up to date information as relevant for emerging infectious disease.

**Infection/Exposure Control Plan
Central Region Behavioral Health
Revised March 2024**

Infection Control

Goal: To identify and reduce the risks of acquiring and transmitting infections among the individuals served, staff and visitors.

1. All medical and residential staff will demonstrate Safety and Infection Control Competencies annually with the initial demonstration occurring prior to providing patient care. This competency includes hand hygiene, routine cleaning and disinfecting and regulated medical waste disposal.
2. All staff will complete training on hand hygiene as part of their annual Safety/Infection Control Training. Training scores will be monitored in the residential safety meeting. The training will be updated if a pattern of low scores is detected. In addition, additional live training may take place when a pattern is noted.
3. A member of the Infection Control Committee or designee will conduct monthly inspections of facilities to assure hand sanitizer, soap, and other cleaning supplies being utilized are clearly marked with expiration date of the solution and not identified as expired upon inspection.
4. A member of the Infection Control Committee will complete monthly ATP testing on designated items in behavioral health settings. Results will be reported in the residential safety meeting.
5. When disposing of regulated medical waste, including needles, staff will follow written guidelines in the Safety Manual. Regulated medical waste packed for transport will not be stored in the facility for more than 90 calendar days.
6. The Annual Airborne Risk Assessment will be conducted annually, and the results will be reported in the residential safety meeting. The committee will make recommendations for appropriate procedural changes or other interventions.
7. The Annual Infection Control Risk Assessment – site specific – will be conducted annually by the Safety Manager or designee and reviewed in the residential safety meeting.
8. Any conversion of a staff TB test from negative to positive will be reported in the residential safety meeting. The committee will make recommendations for appropriate procedural changes or other interventions.
9. Exposures or potential exposures to blood or blood products documented on an Incident Report form will be monitored in the residential safety meeting. The committee will make recommendations for appropriate procedural changes or other interventions.
10. All staff will be offered an annual influenza immunization during the designated influenza season (September – April). The percentage of staff/interns that obtain an immunization (either at Chestnut or elsewhere) will be monitored and reported to the committee. Infections that are acquired during treatment on residential units will be tracked and reported in the residential safety meeting. Appropriate action will be taken to limit the spread including, but not limited to, increased cleaning, wearing PPE, and limiting the number of admissions.
11. All staff will be assigned up to date information as relevant for emerging infectious disease.
12. All residential staff will receive Food Handler training at hire.
13. All recalls (medication, food, equipment) will be tracked by the Safety Manager, or designee, and appropriate actions will be taken based on recall recommendations.

**Infection/Exposure Control Plan
Southern Region Behavioral Health
Revised February 2024**

Infection Control

Goal: To identify and reduce the risks of acquiring and transmitting infections among the individuals served, staff and visitors.

1. All medical staff will demonstrate Safety and Infection Control Competencies annually with the initial demonstration occurring prior to providing patient care. This competency includes hand hygiene, routine cleaning and disinfecting and regulated medical waste disposal.
2. All staff will complete training on hand hygiene as part of their annual Safety/Infection Control Training. Training scores will be monitored in the regional infection control meeting. The training will be updated if a pattern of low scores is detected. In addition, additional live training may take place when a pattern is noted.
3. A member of the Infection Control Committee or designee will conduct quarterly inspections of facilities to assure hand sanitizer, soap, and other cleaning supplies being utilized are clearly marked with expiration date of the solution and not identified as expired upon inspection.
4. A member of the Infection Control Committee will complete monthly ATP testing on designated items in behavioral health settings. Results will be reported in the infection control meeting.
5. When disposing of regulated medical waste, including needles, staff will follow written guidelines in the Safety Manual. Regulated medical waste packed for transport will not be stored in the facility for more than 90 calendar days.
6. The Annual Airborne Risk Assessment will be conducted annually, and the results will be reported to the Infection Control Committee. The Infection Control Committee will make recommendations for appropriate procedural changes or other interventions.
7. The Annual Infection Control Risk Assessment – site specific – will be conducted annually by the Safety Manager or designee and reviewed by the Infection Control Committee.
8. Any conversion of a staff TB test from negative to positive will be reported to the Infection Control Committee. The Infection Control Committee will make recommendations for appropriate procedural changes or other interventions.
9. Exposures or potential exposures to blood or blood products documented on an Incident Report form will be monitored by the Infection Control Committee. The Infection Control Committee will make recommendations for appropriate procedural changes or other interventions.
10. All staff will be offered an annual influenza immunization during the designated influenza season (September – April). The percentage of staff/interns that obtain an influenza immunization (either at Chestnut or elsewhere) will be monitored and reported to the Infection Control Committee.
11. Clients in supportive housing and residential units are offered influenza immunization through Chestnut Family Health Center.
12. Infections that are acquired during treatment on residential units will be tracked and reported to the Infection Control Committee. Appropriate action will be taken to limit the spread including, but not limited to, increased cleaning, wearing PPE, and limiting the number of admissions.
13. All staff will be assigned up to date information as relevant for emerging infectious diseases.

Environment of Care Plan

January 2024

Goal: To maintain safe facilities so that all individuals served, all staff, and all visitors may comfortably utilize Chestnut facilities, free from concern about their safety.

1. A building walk-through will be completed at least semiannually by a member of each of the following departments: Quality Management, Facilities, Infection Control nurse or designee. This walk-through will focus on infection control, the environment of care, and concerns relating to suicide prevention. The Safety Coordinator is responsible for scheduling and completing required documentation of the walk-through.
2. Facilities staff will complete a monthly walk-through of all sites. This walk-through will focus on Life safety and environment of care items such as fire extinguishers, smoke and carbon monoxide detectors, emergency lighting and elevator recall button. Documentation will be kept by the facilities department.
3. Emergency lighting will be tested for 1 ½ hours at least annually. Documentation of testing will be kept by the facilities department.
4. Automatic fire sprinkler systems main drains at system low point or at all system risers will be tested at least annually. Documentation of testing will be kept by the facilities department.
5. For automatic sprinkler systems: Every quarter, inspect all fire department water supply connections. Documentation of testing will be kept by the facilities department.
6. For automatic sprinkler systems: Annually test fire pumps under flow. Fire pump supervisory signals for “pump running” and “pump power loss”. Documentation of testing will be kept by the facilities department.
7. Test supervisory signal devices on the inventory in accordance with the following time frames: - Quarterly for pressure supervisory indicating devices (including both high- and low-air pressure switches), water level supervisory indicating devices, water temperature supervisory indicating devices, room temperature supervisory indicating devices, and other suppression system supervisory initiating devices - Semiannually for valve supervisory switches. Documentation will be kept by the facilities department.
8. Every 6 months, test vane-type and pressure-type water flow devices and valve tamper switches. Documentation will be kept by the facilities department.
9. For automatic sprinkler systems: test electric motor–driven fire pumps monthly and diesel engine–driven fire pumps every week under no-flow conditions. Documentation will be kept by the facilities department.
10. Every 5 years, conduct hydrostatic and water flow tests for standpipe systems. Documentation will be kept by the facilities department.
11. Conducts hydrostatic tests on standpipe occupant hoses 5 years after installation and every 3 years thereafter. Documentation will be kept by the facilities department.
12. Annually, test duct detectors, heat detectors, manual fire alarm boxes, and smoke detectors. Documentation will be kept by the facilities department.
13. Annually, test visual and audible fire alarms, including speakers and door-releasing devices. Documentation will be kept by the facilities department.
14. Annually test fire alarm equipment for notifying off-site fire responders. Documentation will be kept by the facilities department.
15. Operate fire and smoke dampers one year after installation and then at least every six years to verify that they fully close. Documentation will be kept by the facilities department.
16. Annually test automatic smoke-detection shutdown devices for air-handling equipment. Documentation will be kept by the facilities department.
17. Fire extinguisher maintenance, including recharging is completed annually. Documentation of inspections will be kept by the facilities department.
18. Generators Self-test for 30 consecutive minutes monthly, and are load tested annually. Documentation of testing will be kept by the facilities department and a copy will be sent to the Safety Coordinator.

19. All utility system failures will be investigated by Facilities Management or designated staff person. Facilities Managers will make appropriate recommendations and take action to remedy the situation. Documentation should be completed via an incident report and supervisor follow-up.
20. The Facilities Manager will ensure compliance with the utility system inspection schedule.
21. A pre-construction risk assessment will be completed by the facility manager before performing construction. This assessment will be stored by the Safety Coordinator.
22. All incident reports will be reviewed by the Program Supervisor and Safety Coordinator.
23. Incident reports will be monitored for trends. Recommendations for procedure, policy or other appropriate changes to the environment of care will be made when necessary.
24. In residential facilities, 24-hour staff will conduct surveillance of residential buildings after business hours checking for doors being unlocked. Any incidents of exterior doors or medication storage areas found unlocked will result in the filing of an incident report other internal doors found unlocked will be logged on a monthly inspection sheet and turned into the Safety Coordinator at the end of the month.

Emergency Management Plan Tracking Document 2024

Goal: To maintain safe facilities so that all individuals served, all staff, and all visitors may comfortably utilize Chestnut facilities, free from concern about their safety.

1. Fire Drills will be completed at least annually in all facilities classified as a business occupancy.
2. Fire Drills will be completed at least bi-monthly in all facilities classified as residential, this also includes housing locations. These drills will be conducted at various times of day and under various conditions. At least two drills annually will be completed during the “dead of the night”.
3. Tornado Drills will be completed at least annually in all locations.
4. The Safety Coordinator is responsible for monitoring the status of drill completion.
5. Annually a Hazard Vulnerability Assessment will be completed.
6. CMS Emergency Drills will be completed at least annually in facilities classified as a business occupancy and Semi-Annually in residential facilities.
7. CMS Emergency Drills will be completed in coordination with community partners and be based off of the Hazard Vulnerability Assessment.
8. The Safety Coordinator along with the Safety Manager are responsible for coordinating CMS Emergency Drills and are responsible for completing required documentation of the drills
9. Recommendations for procedural changes based off of drill reports will be brought to the Chestnut Management Team.
10. Changes that are made to processes will be monitored to verify that the desired outcomes happen. If the desired outcome does not happen more procedural changes will be made in order to achieve the desired outcome.
11. At least annually Business Unit Emergency plans will be reviewed and updated.
12. The Safety Coordinator is responsible for monitoring the status of Business Unit Emergency plan updates.

Missing Person Checklist

Date	Action Required	Time	Print Name
	Patient identified as missing		
	Program Supervisor notified		
	Who was the last staff to see the person		
	Time and place of last sighting		
	Clothing worn when last seen		
	Ask others if they have seen the missing person. Who was asked:		
	Activate incident command.		
	All staff on duty advised of missing person.		
	Description of patient is circulated to all staff.		
	Immediate area searched including all rooms and bathrooms.		
	Search of building and grounds is completed.		
	Security recordings are reviewed by a person that knows the missing person.		
	Notify Police.		
	Notify patient's emergency contact.		
	Follow directions of police.		
	When patient is found contact all staff.		
	Document incident in patient record.		
	Complete an incident report.		
	Review patient record and process incident to reduce the risk of a repeat incident.		

Annual Influenza Vaccination Data				
	On-Site CR	On-Site SR	Off- Site*	Total
2012	91	101	47	239 / 742 32%
2013	91	102	43	236 / 625 38%
2014	99	131	32	262 / 685 38%
2015	116	151	Included in onsite numbers	267 / 710 37%
2016	113	125	47	285 / 660 43%
2017	117	154	Included in onsite numbers	271 / 655 41%
2018	121	147	Included in onsite numbers	468/660 41%
2019	61	157	Included in onsite numbers	218 / 623 35%
2020	50	129	96	275 / 686 40%
2021	115	Combined	122	237 / 674 35%
2022	195	Combined	98	293 / 744 39%
2023	261	Combined	Combined	261 / 850 31%
Strategies/Initiative By Year 2012 – Internal vaccination “clinic” days, Branching Out article for education 2013 – Internal survey for factors that influence decision to get vaccinated, Branching Out article with link to CDC website (Flu Vaccine Facts), increased and varied time offerings for internal flu clinics in both regions 2014 – Continued on-site vaccination clinics & internal survey for factors influencing vaccination decisions. Provided education via email regarding an IL resident’s flu story. 2015 - Continued on-site vaccination clinics & internal survey for factors influencing vaccination decisions. 2016 - Continued on-site vaccination clinics & internal survey for factors influencing vaccination decisions. Incentives offered, gift card drawing. 2017 - Continued on-site vaccination clinics & internal survey for factors influencing vaccination decisions. Incentives offered, gift card drawing. 2018 – Continued on-site vaccination clinics & internal survey for factors influencing vaccination decisions. Incentives offered, gift card drawing. 2019 – Continued on-site vaccination clinics and the availability for staff to get shots at Genoa any time the pharmacy was open. 2020- Availability for staff to get shots at Genoa any time the pharmacy was open. Internal survey for factors influencing vaccination decisions. Incentives offered, gift card drawing. 2021 – Continued on-site vaccination clinics and the availability for SR staff to get shots at Genoa any time the pharmacy was open. CR staff can get during any COVID clinic. Gift card drawing for each region. 2022 – Continued with the same efforts that were performed in 2021. 2023 – Continued with the same efforts that were performed in previous years.				

Building Evacuation Client Tracking Form

[illegible]

Fire Watch Documentation

Date:

Date:

[illegible]

Construction/Demolition Assessment

Site: _____ Assessment Date: _____

Completed by: _____

Description of construction project: _____

Air Quality

Issue needing mitigation	Who will be effected	How will effects be mitigated

Infection Control

Infection needing mitigation	Who will be effected	How will effects be mitigated

Utility Systems

Utility needing mitigation	Who will be effected	How will effects be mitigated

Noise

Origin of noise needing mitigation	Who will be effected	How will effects be mitigated

Vibration

Vibration intensity?	Who will be effected	How will effects be mitigated

Follow up to ensure mitigating actions are affective, list date of inspection and results:

Other possible disruptions during construction:

MEDICAL EMERGENCY TRACKING FORM

This form is to be used for documentation during an emergency. The information on this form should be documented in the patient's electronic medical record immediately after the incident occurs. This form will be shredded after documentation is entered in the patient's electronic medical record.

Patient/Visitor Name: _____ **Date:** _____ **Time:** _____

Incident was witnessed: ☐ No ☐ Yes, witnessed by: _____

911 Called: ☐ No ☐ Yes; time called: _____

Narrative:

Medications Given

Time	Medication	Given By

Vitals

Time	BP	Pulse	Respirations	O2 Sat

CPR

Time Started: _____

AED

Time Applied: _____

Oxygen

Time Applied _____ at _____ Liters

Ambulance Arrival Time: _____ Patient's condition upon leaving: ☐ Good ☐ Fair
☐ Poor

Bomb Threat Checklist

The following is a checklist to be utilized by an operator or person receiving a call which threatens the safety or security of Chestnut Health Systems.

Complete as thoroughly as possible immediately following the call.

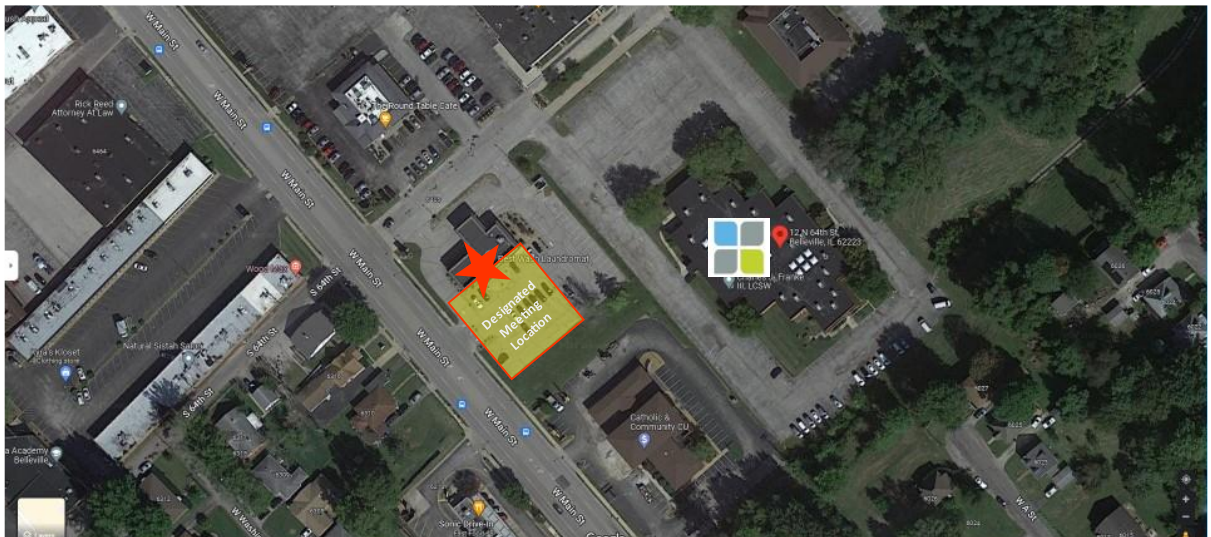
1. Callers name and address (if known): _____
2. Time of the call: _____
3. Gender (circle one): Male Female
4. Estimated age: _____
5. Bomb Facts:
 - a. When will it go off? _____
 - b. Building? _____
 - c. Exact Location? _____
6. Origination (check one):
 - ☐ Local
 - ☐ Long Distance
 - ☐ Unknown
8. Speech (check all that apply):
 - ☐ Fast
 - ☐ Slow
 - ☐ Distorted
 - ☐ Cursing
 - ☐ Slurred
 - ☐ Lisp
 - ☐ Disguised
 - ☐ Poor
 - ☐ Pleasant
10. Accent (check one):
 - ☐ Local
 - ☐ Not Local
 - ☐ Foreign
12. Background Noise (check all that apply):
 - ☐ Office Machine
 - ☐ Factory Machines
 - ☐ Bedlam
 - ☐ Animals
 - ☐ Quiet
 - ☐ Street Traffic
 - ☐ Airplanes
 - ☐ Trains
 - ☐ Voices
 - ☐ Music
 - ☐ PA System
 - ☐ Radios
 - ☐ Party
 - ☐ Static
 - ☐ Cellular Phone
7. Voice Characteristics
Tone (check all that apply):
 - ☐ Loud
 - ☐ Soft
 - ☐ High Pitch
 - ☐ Low Pitch
 - ☐ Stutter
9. Language (check all that apply):
 - ☐ Excellent
 - ☐ Good
 - ☐ Fair
 - ☐ Raspy
 - ☐ Nasal
11. Manner (check all that apply):
 - ☐ Poor Grammar
 - ☐ Well Spoken
 - ☐ Taped
 - ☐ Message Read
 - ☐ Emotional
 - ☐ Irrational
 - ☐ Deliberate
 - ☐ Laughing

Designated meeting spots

Northgate



Belleville



Madison



Mainstay



Oakmont



Collinsville



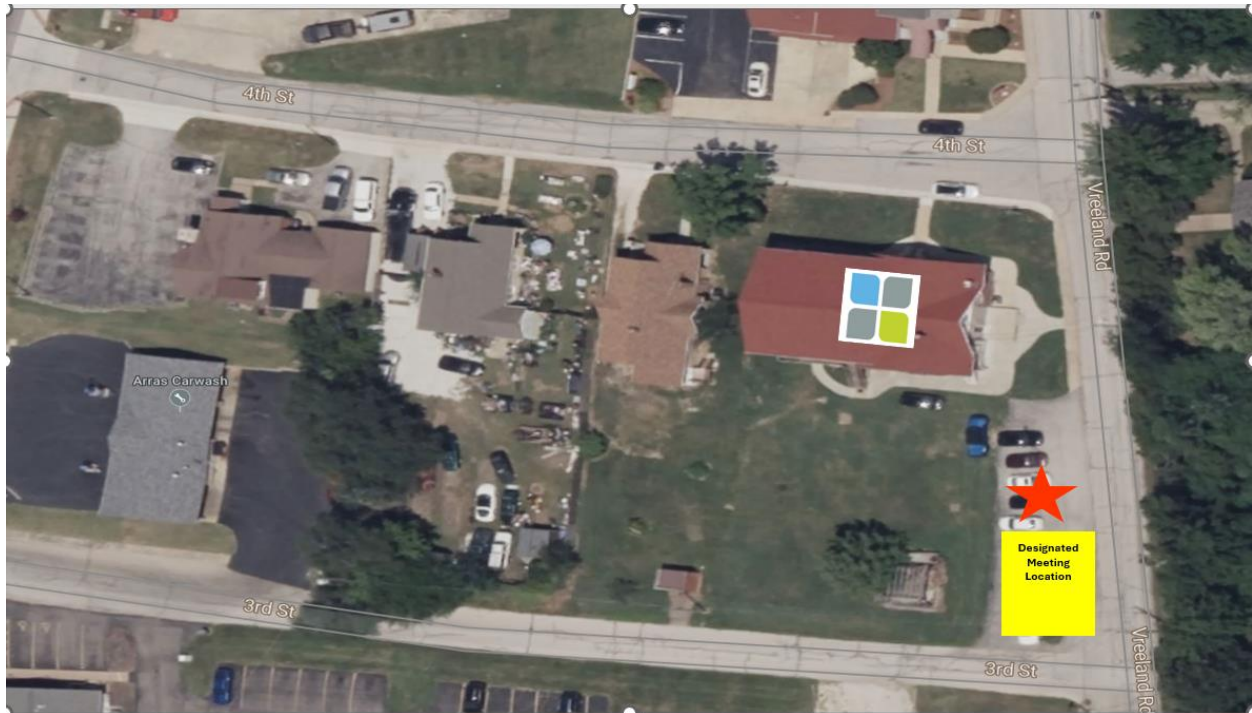
Fairview



Maryville



Hillsboro



Crossroads



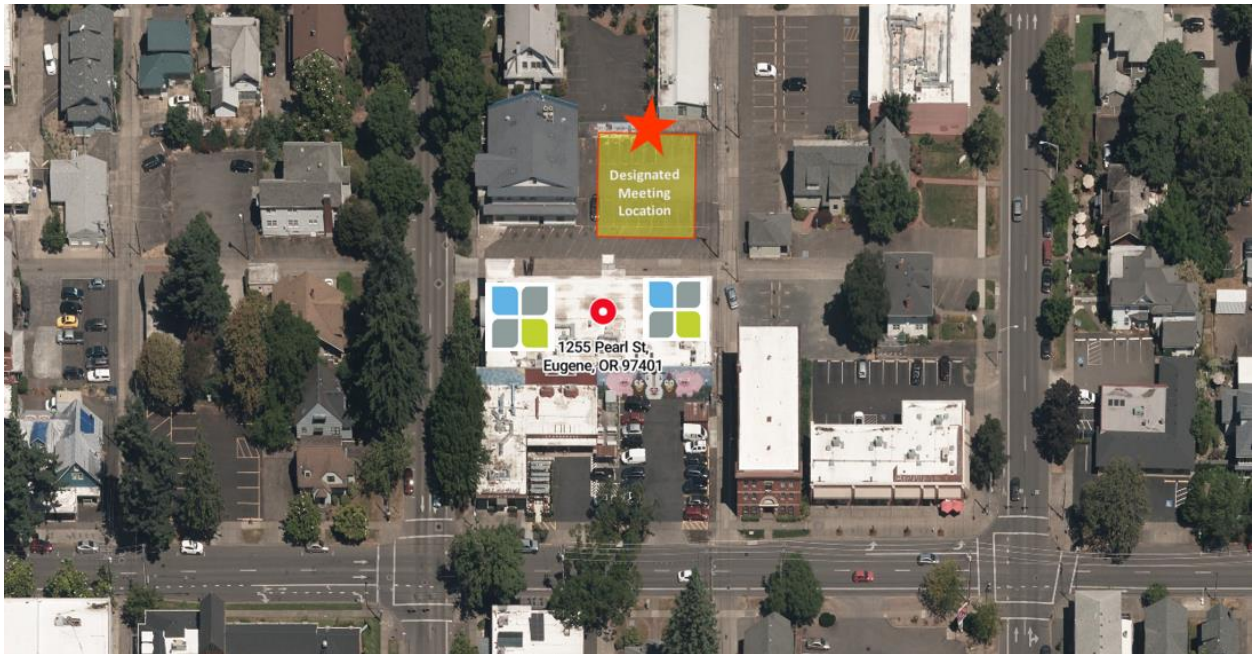
1003 Martin Luther King Drive



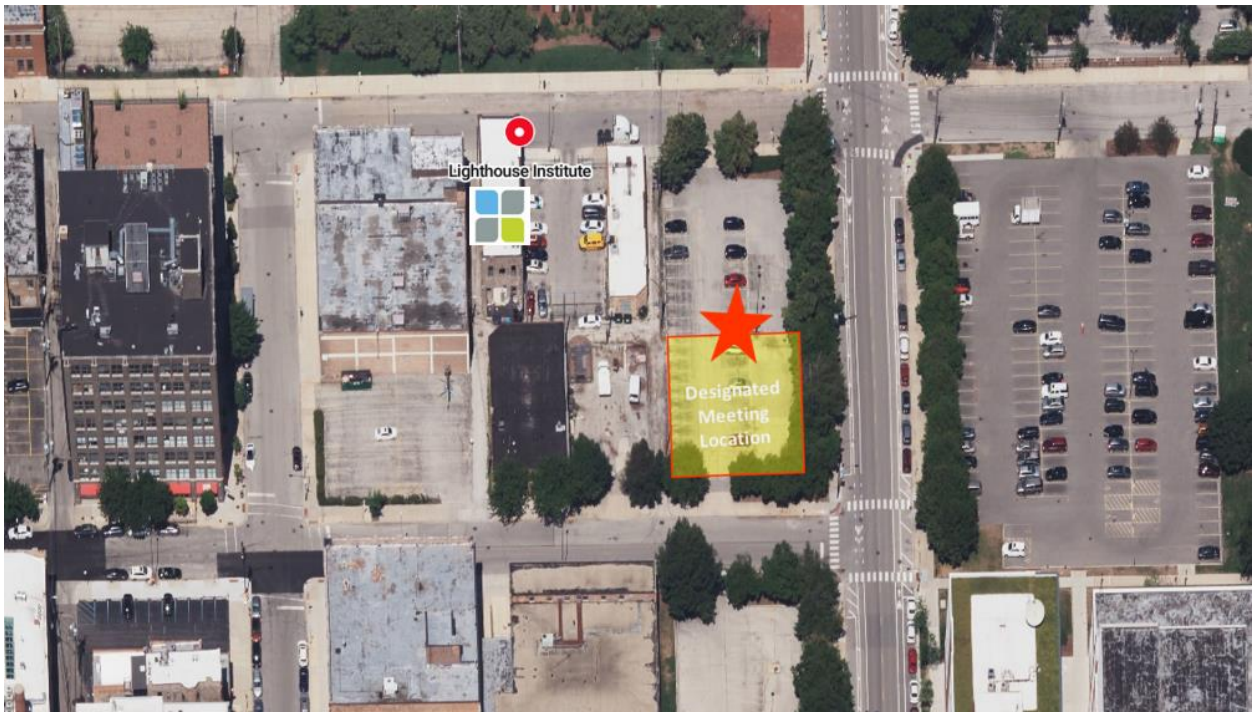
702 and 720 West Chestnut



Oregon



Chicago



Eye Wash Stations Weekly Checklist

Eye wash stations should be tested weekly by allowing them to run for 10 seconds.

Location:

	Date of test	Signature
Week 1		
Week 2		
Week 3		
Week 4		
Week 5		

Location:

	Date of test	Signature
Week 1		
Week 2		
Week 3		
Week 4		
Week 5		

Location:

	Date of test	Signature
Week 1		
Week 2		
Week 3		
Week 4		
Week 5		

Location:

	Date of test	Signature
Week 1		
Week 2		

Week 3		
Week 4		
Week 5		

Location:

	Date of test	Signature
Week 1		
Week 2		
Week 3		
Week 4		
Week 5		

Location:

	Date of test	Signature
Week 1		
Week 2		
Week 3		
Week 4		
Week 5		

Nurse Call Button Test

Location:

The nurse call button was tested on the following date:

- ☐ All call buttons worked correctly
- ☐ Some call buttons worked correctly (list areas that did not work)
- ☐ Call buttons did not work correctly

- ☐ All pagers worked correctly
- ☐ Some pagers worked correctly (list areas that did not work)
- ☐ Pagers did not work correctly

- ☐ Batteries Replaced

In the event that call buttons did not work correctly IT was contacted on the following date:

Staff checking the button

Date

Complete a follow up test once buttons are fixed.

Phone Paging/911 Test

Location:

The paging/911 system was tested on the following date:

- ☐ The system worked correctly
- ☐ The system did not work correctly

In the event that the paging/911 system did not work correctly IT was contacted on the following date:

Staff checking the paging/911 system

Date

Complete a follow up test once phones are fixed.

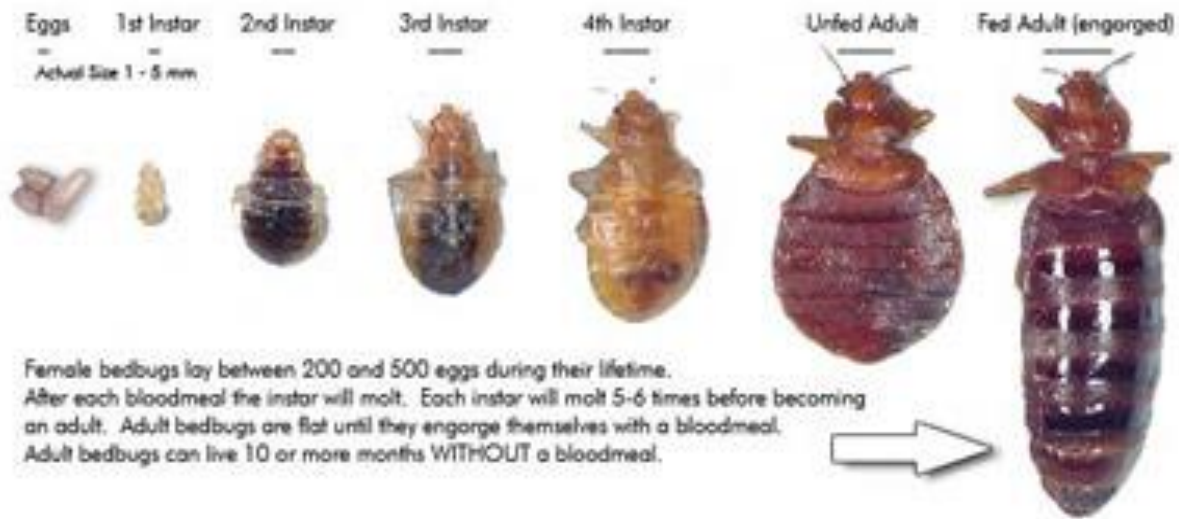
Bed Bug Information Sheet

What are bed bugs?

Bed bugs (*Cimex lectularius*) are small, flat, parasitic insects that feed solely on the blood of people and animals while they sleep. Bed bugs are reddish-brown in color, wingless, range from 1mm to 7mm (roughly the size of Lincoln's head on a penny).

Bedbug Life Cycle

4 Weeks - 5 Months Depending On Conditions



Where are bed bugs found?

Bed bugs are found across the globe and their presence is not determined by the cleanliness of the living conditions where they are found.

Bed bug infestations usually occur around or near the areas where people sleep. They hide during the day in places such as seams of mattresses, box springs, bed frames, headboards, dresser tables, inside cracks or crevices, behind wallpaper, or any other clutter or objects around a bed. Bed bugs have been shown to be able to travel over 100 feet in a night but tend to live within 8 feet of where people sleep.

Do bed bugs spread disease?

Bed bugs are not known to spread disease. Bed bugs can be an annoyance because their presence may cause itching and loss of sleep. Sometimes the itching can lead to excessive scratching that can sometimes increase the chance of a secondary skin infection.

What are the signs and symptoms of a bed bug infestation?

One of the easiest ways to identify a bed bug infestation is by the tell-tale bite marks on the face, neck, arms, hands, or any other body parts while sleeping. However, these bite marks may take as long as 14 days to develop in some people so it is important to look for other clues when determining if bed bugs have infested an area. These signs include:

- the bed bugs' exoskeletons after molting,
- bed bugs in the fold of mattresses and sheets,
- rusty-colored blood spots due to their blood-filled fecal material that they excrete on the mattress or nearby furniture, and
- a sweet musty odor.

How did I get bed bugs?

Bed bugs are experts at hiding. Their slim flat bodies allow them to fit into the smallest of spaces and stay there for long periods of time. Bed bugs are usually transported from place to place as people travel. The bed bugs travel in the seams and folds of luggage, backpacks, or purses, clothes, bedding, furniture, and anywhere else where they can hide. Most people do not realize they are transporting stow-away bed bugs as they travel from location to location, infecting areas as they travel.

Who is at risk for getting bed bugs?

Everyone is at risk for getting bed bugs when visiting an infected area. However, anyone who shares living and sleeping quarters where other people have previously slept has a higher risk of being bitten and or spreading a bed bug infestation.

How are bed bugs treated and prevented?

When visiting others it is a good idea to not take in extra bags or items that you would lay on a bed, couch, or floor. Sit on a hard chair (such as a kitchen or folding chair) that is not touching a wall. Limit items that others bring in to your apartment when visiting. Launder items that have come into contact with a suspected bed bug on the highest setting allowed and dry on high heat. Bed bug infestations are commonly treated by insecticide spraying. If you suspect that you have an infestation, contact your landlord or staff immediately. It is helpful if you can put one of the bugs in a sealed plastic bag so that it can be visually inspected to determine if it is in fact a bed bug.

Room Preparation Checklist for Bed Bugs	
*To reduce the risk of picking up bed bugs while working in the infested area wear a tyvek suit. Before entering office discard the suit by changing immediately and seal the suit in a plastic bag before discarding. Carefully shake out your clothes. Consider bringing a change of clothes and shoes for work, change clothes at work and keep the clothes in a sealed bag for laundering. When washing clothing use the highest setting possible and dry on high heat.	
Task	Check if complete
The room should be vacuumed thoroughly, this includes vacuuming the mattress, box springs, chairs, and couches. The bag should be removed from the vacuum, placed in a sealed trash bag, and discarded in an outside dumpster. Vacuum should then be placed in a sealed bag.	☐
Remove all blankets, sheets, covers, pillows, bath towels, mats, and curtains from room and place them into sealed bags for transport to the laundry.	☐
Empty drawers and closets and place belongings into plastic bags. Place all clothing and coats into bags for transport to the laundry. Shoes, pillows, and children's plush toys should be bagged for the laundry.	☐
Plastic toys, books, electronics, and anything that cannot be washed should be bagged separately for inspection.	☐
The room should be empty of all cloth and plush items, except plush furniture. If possible, the pillows of push furniture should be removed and laundered.	☐
Move furniture at least 18 inches away from the walls.	☐
Remove outlet covers and switch plates on all walls.	☐
Picture frames should be removed from the walls and cleaned or treated.	☐
People and pets must leave the area during treatment and wait the stated amount of time before reentering, usually 4 hours.	☐
If there is a fish tank in the household, it should be covered with a towel or plastic because fish are very sensitive to many pesticides.	☐
All clothing, linens and other items must be cleaned (free of bed bugs) and kept isolated until the client is moved to a new room or location, or until the bed bug problem is eliminated.	☐
Make sure the pest control professional can get to all furniture, closets, beds, and baseboards to inspect and treat.	☐

Tenant Bed Bug Agreement

Date:

To:

From:

Cc:

Due to recent bed bug event at _____, below are recommendations to provide safety and wellness for all consumers and staff at _____.

1. Bring a change of clothes to the office prior to visiting family.
2. After returning from visiting from family, immediately come to the office bathroom to shower.
3. Place clothes in towel and promptly place in dryer to reduce further exposure of bed bugs.

Please let housing staff know if you have any further questions or concerns.

Sincerely,

My signature indicates that I have read and understood the above tenant agreement

Signature

Date

BLOOD EXPOSURE / EXPOSURE TO UNKNOWN POWDERED SUBSTANCE PACKET

Revised 02/02/2022

Table of Contents

BLOOD EXPOSURE PACKET	186
WHAT IS AN EXPOSURE	187
OSHA BLOODBORNE PATHOGEN STANDARD	194
HEPATITIS B VACCINATION	190
BLOOD EXPOSURE RISK DETERMINATION CLASSIFICATION	191
INFORMATION FOR EMPLOYEE AFTER EXPOSURE	193
IMMEDIATE PROCEDURE FOR EMPLOYEE	198
EXPOSURE TO UNKNOWN POWDERED SUBSTANCE PACKET	199
IMMEDIATE PROCEDURE FOR AGENCY CONTRACTED STAFF	205
SOURCE PATIENT	206

Manual:	Blood Exposure Packet
Manual Section:	Introduction
Name:	What Is An Exposure
Effective Date:	01/01/2022
Policy Cross Reference(s):	SI 30 Blood Exposure Risk Determination Classification

WHAT IS AN EXPOSURE

Per the Center for Disease Control, "An exposure that might place Health Care Providers at risk for Hepatitis B Virus (HBV), Hepatitis C Virus (HCV), or HIV infection is defined as percutaneous injury (e.g., a needlestick or cut with a sharp object), contact of mucous membranes, or contact of skin (especially when the exposed skin is chapped, abraded, or afflicted with dermatitis or when the contact is prolonged or involves an extensive area) with blood, tissues, or other potentially infectious body fluids. These fluids include a) semen, vaginal secretions, breast milk or any other body fluid visibly contaminated with blood, because these substances have been implicated in the transmission of HIV infection; b) cerebrospinal fluid, synovial fluid, pleural fluid, peritoneal fluid, pericardial fluid, and amniotic fluid, because the risk of transmission of HIV from these fluids has not yet been determined; ..."

"Feces, nasal secretions, saliva, sputum, sweat, tears, urine, and vomitus are not considered potentially infectious unless they contain blood. The risk for transmission of HBV, HCV, and HIV infection from these fluids and materials is extremely low." Above quote from MMWR, Recommendations and Reports, "Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposure to HBV, HCV, and HIV and Recommendations for Post-Exposure Prophylaxis, June 29, 2001, Vol. 50, No. RR-11.

Manual: Blood Exposure Packet

Manual Section: Introduction

Name: OSHA Bloodborne Pathogen Standard

Effective Date: 01/01/2022

Policy Cross Reference(s): SI 30 Blood Exposure Risk Determination Classification

OSHA BLOODBORNE PATHOGEN STANDARD

Occupational Safety & Health Administration

Bloodborne pathogens - 1910.1030

This standard can be found at the following web address:

http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051

Requirement Standard	Reference Section
Information Provided to the Healthcare Professional.	1910.1030(f)(4)(i)
The employer shall ensure that the healthcare professional responsible for the employee's Hepatitis B vaccination is provided a copy of this regulation.	1910.1030(f)(4)(ii)
The employer shall ensure that the healthcare professional evaluating an employee after an exposure incident is provided the following information: • A copy of this regulation; • A description of the exposed employee's duties as they relate to the exposure incident; • Documentation of the route(s) of exposure and circumstances under which exposure occurred; • Results of the source individual's blood testing, if available; and • All medical records relevant to the appropriate treatment of the employee including vaccination status, which are the employer's responsibility to maintain.	1910.1030(f)(4)(ii)
Healthcare Professional's Written Opinion. The employer shall obtain and provide the employee with a copy of the evaluating healthcare professional's written opinion within 15 days of the completion of the evaluation.	1910.1030(f)(5)
The healthcare professional's written opinion for Hepatitis B vaccination shall be limited to whether Hepatitis B vaccination is indicated for an	1910.1030(f)(5)(ii)

employee, and if the employee has received such vaccination. The healthcare professional's written opinion for post-exposure evaluation and follow-up shall be limited to the following information: • That the employee has been informed of the results of the evaluation; and • 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. All other findings or diagnoses shall remain confidential and shall not be included in the written report.	
Medical Recordkeeping. Medical records required by this standard shall be maintained in accordance with paragraph (h)(1) of this section.	1910.1030(g)

Manual:	Blood Exposure Packet
Manual Section:	Introduction
Name:	Hepatitis B Vaccination
Effective Date:	01/01/2022
Policy Cross Reference(s):	SI 35 Hepatitis B Vaccination

HEPATITIS B VACCINATION

All jobs are classified by risk factors for occupational exposure to Bloodborne Pathogens. All employees in job category I and II must either obtain the vaccine or sign a declination form that will be placed with the employee's personnel file within 10 days from the start of employment. The vaccine will be offered at no cost to the employee. The employee may request the vaccine at any later date and incur no charge for the vaccine. Employees without risk of occupational exposure can request the Hepatitis B vaccine from Chestnut with supervisor and nursing permission. All documentation regarding status of the vaccine will be maintained by Chestnut Health Systems Human Resources. When the vaccine is administered, the documentation of the administration will be maintained in the nursing office.

Manual: Blood Exposure Packet

Manual Section: Introduction

Name: Blood Exposure Risk Determination Classification

Effective Date: 01/01/2022

Policy Cross Reference(s): SI 30 Blood Exposure Risk Determination Classification

BLOOD EXPOSURE RISK DETERMINATION CLASSIFICATION

A list of job classifications for Chestnut Health System's employees is listed below.

Employee Risk Factor Classifications

Category I: All Employees Risk Occupational Exposure

Category I includes employees who routinely risk exposure to blood or other potentially infectious materials as a part of their daily job activities, should they fail to use personal protective equipment and procedures as instructed.

Job Title	Tasks with potential to exposure
Consulting Physician	Physical examinations, injections, drawing and handling of blood samples, care of minor wounds, dressing changes, vaginal exams, disposal of regulated waste, assisting with a sick or injured client in an emergency
Nurse Practitioner	Physical examinations, injections, drawing and handling of blood samples, care of minor wounds, dressing changes, vaginal exams, disposal of regulated waste, assisting with a sick or injured client in an emergency
Registered Nurse	Physical examinations, injections, drawing and handling of blood samples, care of minor wounds, dressing changes, vaginal exams, disposal of regulated waste, assisting with a sick or injured client in an emergency
Licensed Practical Nurse	Injections, drawing and handling of blood samples, care of minor wounds, dressing changes, vaginal exams, disposal of regulated waste, assisting with a sick or injured client in an emergency
Nursing Clerk	Handling of blood samples, disposal of regulated waste, disposal of urine

Category II Some Employees Risk Occupational Exposure

Category II includes employees in which some employees occasionally risk exposure to blood or other potentially infectious materials should they fail to use personal protective equipment and procedures as instructed.

Job Title	Tasks with potential to exposure
Residential Detox Counselor (I, II)	Assisting with a sick or injured client in an emergency, cleaning contaminated areas and, searching client belongings
Residential Counselor (I, II)	Assisting with a sick or injured client in an emergency, cleaning contaminated areas, and searching client belongings
Recreation Coordinator	Assisting with a sick or injured client in an emergency
Recreation Assistant	Assisting with a sick or injured client in an emergency
Residential Counselor (Shift Supervisor)	Assisting with a sick or injured client in an emergency, cleaning contaminated areas, and searching client belongings
Residential Youth Coordinators	Assisting with a sick or injured client in an emergency, cleaning contaminated areas, and searching client belongings
Maintenance Worker	Disposing of potentially infectious waste, Cleaning contaminated areas or surfaces
Drug Screen Technicians	Disposal of urine
Case Manager (I, II)	Assisting with a sick or injured client in an emergency and searching client belongings
Housing Case Manager	Assisting with a sick or injured client in an emergency and cleaning contaminated areas.
Housing Technician	Assisting with a sick or injured client in an emergency and cleaning contaminated areas.
Residential Technician	Assisting with a sick or injured client in an emergency, cleaning contaminated areas, and searching client belongings
Housing Coordinators	Assisting with a sick or injured client in an emergency, cleaning contaminated areas, and searching client belongings
Clinician (I, II)	Assisting with sick or injured client in an emergency and searching client belongings
Outreach Workers	Assisting with a sick or injured client in an emergency. Disposing of potentially infectious waste.
Van Drivers	Assisting with a sick or injured client in an emergency. Disposing of potentially infectious waste.
Behavioral Health Technician	Disposing of potentially infectious waste. Cleaning contaminated areas or surfaces.
Utility Workers	Disposing of potentially infectious waste. Cleaning contaminated areas or surfaces
Driver in Maintenance department	Performing duties of Utility Worker
Childcare Worker	Assisting with a sick or injured child in an emergency. Disposing of potentially infectious waste.
Intake Services Coordinator	Assisting with a sick or injured client in an emergency. Disposing of potentially infectious waste.
Intervention Specialist I & II	Assisting with a sick or injured client in an emergency. Disposing of potentially infectious waste.
Recovery Coach	Assisting with a sick or injured client in an emergency. Disposing of potentially infectious waste.

Manual: Blood Exposure Packet

Manual Section: Introduction

Name: Information for employee after exposure

Effective Date: 01/01/2022

Policy Cross Reference(s): SI 80 Accidental Employee Needle Stick or Blood Exposure

INFORMATION FOR EMPLOYEE AFTER EXPOSURE

We know you have been through a stressful situation. Please take the opportunity to process this with your supervisor. Also, Chestnut's EAP program is available to you. For more information, please contact our Human Resources Department.

Information Regarding the Occupational Safety & Health Administration Bloodborne pathogens 1910.1030 standard can be found at the following web address:

http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051

Morbidity and Mortality Weekly Bulletin Guidance on Evaluating Blood Exposures
This is an excerpt from the MMWR article. The complete article can be accessed via the internet.



June 29, 2001 / Vol. 50 / No. RR-11

Updated Public Health Service Guidelines for the Management of Health-Care Worker Exposures to HIV and Recommendations for Postexposure Prophylaxis

*This interagency working group comprised representatives of CDC, the Food and Drug Administration (FDA), the Health Resources and Services Administration, and the National Institutes of Health. Information included in these recommendations may not represent FDA approval or approved labeling for the particular product or indications in question. Specifically, the terms "safe" and "effective" may not be synonymous with the FDA-defined legal standards for product approval.

INTRODUCTION

Avoiding occupational blood exposures is the primary way to prevent transmission of hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV) in health-care settings (1). However, hepatitis B immunization and postexposure management are integral components of a complete program to prevent infection following bloodborne pathogen exposure and are important elements of workplace safety (2).

The U.S. Public Health Service (PHS) has published previous guidelines for the management of HIV exposures that included considerations for postexposure prophylaxis (PEP) (3–5). Since publication of the 1998 HIV exposure guidelines (5), several new antiretroviral agents have been approved by the Food and Drug Administration (FDA), and more information is available about the use and safety of HIV PEP (6–11). In addition, questions exist regarding considerations about PEP regimens when the source person's

virus is known or suspected to be resistant to one or more of the antiretroviral agents that might be used for PEP. Concern also has arisen about the use of PEP when it is not warranted. Data indicate that some health-care personnel (HCP) take a full course of HIV PEP after exposures that do not confer an HIV transmission risk (10,11).

In September 1999, a meeting of a PHS interagency working group* and expert consultants was convened by CDC. The PHS working group decided to issue updated recommendations for the management of occupational exposure to HIV. In addition, the report was to include recommendations for the management of occupational HBV and HCV exposures so that a single document could comprehensively address the management of occupational exposures to bloodborne pathogens. This report updates and consolidates the previous PHS guidelines and recommendations for occupational HBV, HCV, and HIV exposure management for HCP. Specific practice recommendations for the management of occupational bloodborne pathogen exposures are outlined to assist health-care institutions with the implementation of these PHS guidelines (Appendices A and B). As relevant information becomes available, updates of these recommendations will be published. Recommendations for nonoccupational (e.g., sexual, pediatric, and perinatal) HBV, HCV, and HIV exposures are not addressed in these guidelines and can be found elsewhere (12–15).

Definition of Health-Care Personnel and Exposure

In this report, health-care personnel (HCP) are defined as persons (e.g., employees, students, contractors, attending clinicians, public-safety workers , or volunteers) whose activities involve contact with patients or with blood or other body fluids from patients in a health-care, laboratory, or public-safety setting. The potential exists for blood and body fluid exposure to other workers, and the same principles of exposure management could be applied to other settings.

An exposure that might place HCP at risk for HBV, HCV, or HIV infection is defined as a percutaneous injury (e.g., a needlestick or cut with a sharp object) or contact of mucous membrane or nonintact skin (e.g., exposed skin that is chapped, abraded, or afflicted with dermatitis) with blood, tissue, or other body fluids that are potentially infectious (16,17). In addition to blood and body fluids containing visible blood, semen and vaginal secretions also are considered potentially infectious. Although semen and vaginal secretions have been implicated in the sexual transmission of HBV, HCV, and HIV, they have not

been implicated in occupational transmission from patients to HCP. The following fluids also are considered potentially infectious: cerebrospinal fluid, synovial fluid, pleural fluid, peritoneal fluid, pericardial fluid, and amniotic fluid. The risk for transmission of HBV, HCV, and HIV infection from these fluids is unknown; the potential risk to HCP from occupational exposures has not been assessed by epidemiologic studies in health-care settings. Feces, nasal secretions, saliva, sputum, sweat, tears, urine, and vomitus are not considered potentially infectious unless they contain blood. The risk for transmission of HBV, HCV, and HIV infection from these fluids and materials is extremely low. Any direct contact (i.e., contact without barrier protection) to concentrated virus in a research laboratory or production facility is considered an exposure that requires clinical evaluation. For human bites, the clinical evaluation must include the possibility that both the person bitten and the person who inflicted the bite were exposed to bloodborne pathogens. Transmission of HBV or HIV infection only rarely has been reported by this route (18–20) (CDC, unpublished data, 1998).

BACKGROUND

This section provides the rationale for the postexposure management and prophylaxis recommendations presented in this report. Additional details concerning the risk for occupational bloodborne pathogen

transmission to HCP and management of occupational bloodborne pathogen exposures are available elsewhere (5,12,13,21-24).

Occupational Transmission of HBV

Risk for Occupational Transmission of HBV

HBV infection is a well recognized occupational risk for HCP (25). The risk of HBV infection is primarily related to the degree of contact with blood in the work place and also to the hepatitis B e antigen (HBeAg) status of the source person. In studies of HCP who sustained injuries from needles contaminated with blood containing HBV, the risk of developing clinical hepatitis if the blood was both hepatitis B surface antigen (HBsAg)- and HBeAg-positive was 22%–31%; the risk of developing serologic evidence of HBV infection was 37%–62%. By comparison, the risk of developing clinical hepatitis from a needle contaminated with HBsAg-positive, HBeAg-negative blood was 1%–6%, and the risk of developing serologic evidence of HBV infection, 23%–37% (26). Although percutaneous injuries are among the most efficient modes of HBV transmission, these exposures probably account for only a minority of HBV infections among HCP. In several investigations of nosocomial hepatitis B outbreaks, most infected HCP

could not recall an overt percutaneous injury (27,28), although in some studies, up to one third of infected HCP recalled caring for a patient who was HBsAg-positive (29,30). In addition, HBV has been demonstrated to survive in dried blood at room temperature on environmental surfaces for at least 1 week (31). Thus, HBV infections that occur in HCP with no history of nonoccupational exposure or occupational percutaneous injury might have resulted from direct or indirect blood or body fluid exposures that inoculated HBV into cutaneous scratches, abrasions, burns, other lesions, or on mucosal surfaces (32–34). The potential for HBV transmission through contact with environmental surfaces has been demonstrated in investigations of HBV outbreaks among patients and employee of hemodialysis units (35–37).

Blood contains the highest HBV titers of all body fluids and is the most important vehicle of transmission in the health-care setting. HBsAg is also found in several other body fluids, including breast milk, bile, cerebrospinal fluid, feces, nasopharyngeal washings, saliva, semen, sweat, and synovial fluid (38). However, the concentration of HBsAg in body fluids can be 100–1000—fold higher than the concentration of infectious HBV particles. Therefore, most body fluids are not efficient vehicles of transmission because they contain low quantities of infectious HBV, despite the presence of HBsAg. In serologic studies conducted in the United States during the 1970s, HCP had a prevalence of HBV infection approximately 10 times higher than the general population (39–42). Because of the high risk of HBV infection among HCP, routine preexposure vaccination of HCP against hepatitis B and the use of standard precautions to prevent exposure to blood and other potentially infectious body fluids have been recommended since the early 1980s (43). Regulations issued by the Occupational Safety and Health Administration (OSHA) (2) have increased compliance with these recommendations. Since the implementation of these recommendations, a sharp decline has occurred in the incidence of HBV infection among HCP.

PEP for HBV

Efficacy of PEP for HBV.

The effectiveness of hepatitis B immune globulin (HBIG) and/or hepatitis B vaccine in various postexposure settings has been evaluated by prospective studies. For perinatal exposure to an HBsAg-, HBeAg-positive mother, a regimen combining HBIG and initiation of the hepatitis B vaccine series at birth is 85%–95% effective in preventing HBV infection (44,45). Regimens involving either multiple doses of HBIG alone or the hepatitis B vaccine series alone are 70%–75% effective in preventing HBV infection (46). In the occupational setting, multiple doses of HBIG initiated within 1 week following percutaneous exposure to

HBsAg-positive blood provides an estimated 75% protection from HBV infection (47–49). Although the postexposure efficacy of the combination of HBIG and the hepatitis B vaccine series has not been evaluated in the occupational setting, the increased efficacy of this regimen observed in the perinatal setting, compared with HBIG alone, is presumed to apply to the occupational setting as well. In addition, because persons requiring PEP in the occupational setting are generally at continued risk for HBV exposure, they should receive the hepatitis B vaccine series.

Safety of PEP for HBV

Hepatitis B vaccines have been found to be safe when administered to infants, children, or adults (12,50). Through the year 2000, approximately 100 million persons have received hepatitis B vaccine in the United States. The most common side effects from hepatitis B vaccination are pain at the injection site and mild to moderate fever (50–55). Studies indicate that these side effects are reported no more frequently among persons vaccinated than among those receiving placebo (51,52). Approximately 45 reports have been received by the Vaccine Adverse Event Reporting System (VAERS) of alopecia (hair loss) in children and adults after administration of plasma-derived and recombinant hepatitis B vaccine; four persons sustained hair loss following vaccination on more than one occasion (56). Hair loss was temporary for approximately two thirds of persons who experienced hair loss. An epidemiologic study conducted in the Vaccine Safety Datalink found no statistical association between alopecia and receipt of hepatitis B vaccine in children (CDC, unpublished data, 1998). A low rate of anaphylaxis has been observed in vaccine recipients based on reports to VAERS; the estimated incidence is 1 in 600,000 vaccine doses distributed. Although none of the persons who developed anaphylaxis died, anaphylactic reactions can be life-threatening; therefore, further vaccination with hepatitis B vaccine is contraindicated in persons with a history of anaphylaxis after a previous dose of vaccine. Hepatitis B immunization programs conducted on a large scale in Taiwan, Alaska, and New Zealand have observed no association between vaccination and the occurrence of serious adverse events. Furthermore, in the United States, surveillance of adverse events following hepatitis B vaccination has demonstrated no association between hepatitis B vaccine and the occurrence of serious adverse events, including Guillain-Barré syndrome, transverse myelitis, multiple sclerosis, optic neuritis, and seizures (57–59) (CDC, unpublished data, 1991). However, several case reports and case series have claimed an association between hepatitis B vaccination and such syndromes and diseases as multiple sclerosis, optic neuritis, rheumatoid arthritis, and other autoimmune diseases (57,60–66). Most of these reported adverse events have occurred in adults, and no report has compared the frequency of the purported vaccine-associated syndrome/disease with the frequency in an unvaccinated population. In addition, recent case-control studies have demonstrated no association between hepatitis B vaccination and development or short-term risk of relapse of multiple sclerosis (67,68), and reviews by international panels of experts have concluded that available data do not demonstrate a causal association between hepatitis B vaccination and demyelinating diseases, including multiple sclerosis (69).

HBIG is prepared from human plasma known to contain a high titer of antibody to HBsAg (anti-HBs). The plasma from which HBIG is prepared is screened for HBsAg and antibodies to HIV and HCV. The process used to prepare HBIG inactivates and eliminates HIV from the final product. Since 1996, the final product has been free of HCV RNA as determined by the polymerase chain reaction (PCR), and, since 1999, all products available in the United States have been manufactured by methods that inactivate HCV and other viruses. No evidence exists that HBV, HCV, or HIV have ever been transmitted by HBIG commercially available in the United States (70,71). Serious adverse effects from HBIG when administered as recommended have been rare. Local pain and tenderness at the injection site, urticaria and angioedema might occur; anaphylactic reactions, although rare, have been reported following the injection of human immune globulin (IG) preparations (72). Persons with a history of anaphylactic reaction to IG should not receive HBIG.

PEP for HBV During Pregnancy

No apparent risk exists for adverse effects to developing fetuses when hepatitis B vaccine is administered to pregnant women (CDC, unpublished data, 1990). The vaccine contains noninfectious HBsAg particles and should pose no risk to the fetus. HBV infection during pregnancy might result in severe disease for the mother and chronic infection for the newborn. Therefore, neither pregnancy nor lactation should be considered a contraindication to vaccination of women. HBIG is not contraindicated for pregnant or lactating women.

Manual:	Blood Exposure Packet
Manual Section:	Procedure
Name:	Immediate Procedure for Employee
Effective Date:	01/01/2022
Policy Cross Reference(s):	SI 80 Accidental Employee Needle Stick or Blood Exposure

IMMEDIATE PROCEDURE FOR EMPLOYEE

Should an employee be exposed to blood either via a used needle/sharp or via a spill/splatter of another individual's blood onto an open wound or mucous membrane (eye, mouth, etc.), the following procedure should be followed:

- The site should be immediately and thoroughly washed
- Apply a gauze dressing to stop the bleeding
- The exposure is to be immediately reported to supervisor on duty or designee
- Within 1 hour after the incident, the employee must see a health care professional at a hospital for a post-exposure evaluation. Items to be taken to the hospital with employee include:
 - Employee Medical Information form, found in the appendix
 - Source Patient's Blood Status form, found in the appendix
 - Instructional Sheet for Health Care Professional, found in the appendix
- An Incident Report is to be completed prior to the end of the employee's shift during which the exposure occurred (this can be completed by a supervisor or nurse if employee is unavailable).

The name of the source patient must be kept confidential. With the employee's consent, a blood sample will be collected and tested for HIV, Hepatitis B and Hepatitis C. If the employee consents to the blood collection but not for HIV antibody testing, the sample will be preserved for 90 days and the employee can consent to the test within that time period. The results of this baseline test will remain with health care professional (and will not be provided to Chestnut). The health care professional should provide post-test counseling and post-exposure prophylaxis if indicated. All diagnosis and test results remain confidential between the occupational health provider and employee.

EXPOSURE TO UNKNOWN POWDERED SUBSTANCE PACKET

For Incidents Not Involving Overdose

Revised 5/1/22

- The exposure is to be immediately reported to supervisor on duty or designee
- If staff exposure, immediately after the incident, the employee must see a health care professional for a post-exposure evaluation (see below). If Agency contracted staff, the staff should follow the procedures of the employer.
- A Chestnut Incident Report is to be completed prior to the end of the staff's shift during which the exposure occurred.

Chestnut has guidelines and preferred providers for employees who require a post-exposure evaluation.

Occupational Health Provider Documents – at the end of packet

- Instructional sheet regarding billing and post-exposure evaluation

Immediately after the incident, the employee must see a health care professional for a post-exposure evaluation. The employee should take the Exposure Packet with them and provide this to the health care professional. The health care professional should provide post-exposure treatment if indicated. All diagnosis and test results remain confidential between the occupational health provider and employee.

Accidental Employee Exposure to Unknown Powdered Substance

Fentanyl

Preventing Occupational Exposure to Healthcare Personnel in Hospital and Clinic Settings

Illicit fentanyl and its analogues (for the purpose of this document, referred to as illicit fentanyl) pose a potential hazard to healthcare personnel who could come into contact with these drugs in the course of their work in hospital and clinic settings. This potential risk, which is related to external sources of fentanyl (i.e., originating in the community), is distinct from the hazards posed by diversion of pharmaceutical fentanyl (which is used in many healthcare settings as part of routine patient care).

Possible exposure routes to illicit fentanyl vary based on the source and form of the drug. Healthcare personnel might be exposed when the patient or their personal items are contaminated with illicit fentanyl, which may be present in powder, tablet, or liquid forms. While the clinical findings for a person presenting with fentanyl (or other opioid overdose) may be wide-ranging, respiratory depression or arrest, disorientation or stupor, and pinpoint pupils (miosis) generally suggest severe opioid toxicity.

Potential exposure routes of greatest concern include inhalation of powders or aerosols, mucous membrane contact, ingestion, or exposure secondary to a break in the skin (for example a needlestick). Any of these exposure routes can potentially result in a variety of symptoms that can include the rapid onset of life-threatening respiratory depression. Skin contact is also a potential exposure route, but is not likely to lead to overdose unless exposures are to liquid or to a powder over an extended period of time. Brief skin contact with illicit fentanyl is not expected to lead to toxic effects if any visible contamination is promptly removed.

The Centers for Disease Control and Prevention (CDC) has no occupational exposure data on illicit fentanyl for workers potentially exposed in the course of their job duties. There are no established federal or consensus occupational exposure limits for illicit fentanyl. These recommendations are based on the reported toxicity and the chemical and physical properties of illicit fentanyl; CDC's National Institute for Occupational Safety and Health (NIOSH) guidance for other similar chemicals (or in the same family); recommendations from previous NIOSH health hazard evaluation reports about law enforcement personnel exposures to other drugs and chemicals; and the basic principles of industrial hygiene. As new research becomes available, these recommendations will be updated.

Work Practices¹

The following work practices should be established and followed when illicit fentanyl is known or potentially present on patients presenting for healthcare with or without symptoms of opioid exposure. These work practices are recommended along with decontamination procedures and use of personal protective equipment (PPE) noted below.

1. When first encountering a patient, the healthcare personnel should assess the risk for hazards, and determine whether the presence of illicit fentanyl is suspected. Gathering relevant information from the patient or other persons accompanying the patient is important when possible.
2. Healthcare personnel should follow established work practices as well as these recommendations:
 - Staff should recognize when they are entering and leaving potentially contaminated areas.
 - Do not eat, drink, smoke, or use the bathroom while working in an area with known or suspected illicit fentanyl.
 - **Do not touch the eyes, mouth, or nose after touching any surface potentially contaminated with illicit fentanyl.**
 - **Wash hands (or other unprotected skin) with soap and water immediately after a potential exposure and after leaving an area where illicit fentanyl is known or suspected to be present to avoid potential exposure and cross contamination. Do not use alcohol-based hand rubs to clean contaminated skin in situations where**

exposure to illicit fentanyl is suspected. Use of such hand rubs could increase absorption through the skin.

- Avoid performing tasks (such as shaking potentially contaminated clothing or bedding) that might aerosolize illicit fentanyl that is present on the patient or in the environment because it might increase risk of exposure to healthcare personnel. Activities that aerosolize illicit fentanyl require the use of higher levels of PPE as recommended below and should be conducted by appropriately trained personnel in accordance with facility policies and procedures.
- Removal or changing of a patient's clothes or bedding might be necessary during the care of a patient that is suspected or confirmed to have used or been exposed to illicit fentanyl. These materials should be handled in a manner which minimizes contact with the materials, dispersion of any illicit fentanyl which may be present, and production of any aerosols from the materials. If powder or dust is identified on clothing, a wet wipe should be used while wearing the PPE as recommended below to remove it. The materials should be carefully placed in labeled durable 6 mil polyethylene bags and segregated from other laundry until they are laundered.
- Notify other healthcare personnel involved with the care of the patient of the potential for illicit fentanyl contamination until the patient, room, work surfaces, and laundry are decontaminated.
- Launder clothes worn by healthcare personnel caring for a patient that is suspected or confirmed to have used or been exposed to illicit fentanyl at the healthcare facility if in-house laundry facilities are available. Clothing should be carefully placed in labeled durable 6 mil polyethylene bags and segregated from other laundry until they are laundered. If a healthcare facility does not have in-house laundry facilities, the potentially contaminated linens or uniforms should be segregated and identified when sent for laundering.
- If collection of unknown substances suspected to be illicit fentanyl is needed in the healthcare setting, develop a specific plan to perform those types of collections in accordance with the policies and procedures of the facility and applicable law enforcement. Personnel specifically trained to perform such collections should do so while using the PPE recommended below. Never handle illicit fentanyl without using the appropriate PPE.

Training

Personnel in healthcare facilities who perform jobs where illicit fentanyl is reasonably anticipated to be present should receive special training in how to conduct a risk assessment and demonstrate an understanding of the following elements. Whether as part of a [formal or informal triage process](#), healthcare personnel should incorporate the following training elements into the initial part of the patient assessment process to help guide subsequent actions related to minimizing potential exposure to illicit fentanyl:

- Potential exposure routes for illicit fentanyl.
- How to recognize the signs and symptoms of opioid exposure (applicable to patients and other healthcare personnel).
- How to recognize potential illicit fentanyl contamination in patients.
- When to use PPE; what PPE is necessary; how to properly put on, use, take off, dispose of, and maintain PPE; and the limitations of PPE.
- When and how to decontaminate a patient.

Personal Protective Equipment (PPE)

Healthcare personnel may be at increased risk of exposure to illicit fentanyl if small amounts of fentanyl products are visible on the patient, clothing, or possessions. In this case, healthcare personnel would use the following PPE:

- At least an N100, R100, or P100 disposable filtering facepiece respirator² or a respirator that provides a higher level of protection
- Face and eye protection that may include goggles or a faceshield when wearing a filtering facepiece respirator³
- Powder-free nitrile gloves⁴
- Wrist/arm protection, such as sleeve covers, that would cover skin which may not be covered by usual clothing or uniform such as gowns or coveralls

It is important to recognize that the healthcare personnel's potential for exposure may change during the patient encounter or stay in a healthcare facility, and PPE for these purposes should be adjusted accordingly. For situations in which no fentanyl products are visible on the patient, clothing, or possessions, the PPE noted above would not be recommended. Additionally, the PPE noted above would no longer be recommended if decontamination was performed as recommended below.

In all cases, employers should identify hazards to which their personnel might be exposed and provide appropriate PPE to protect them. All PPE should be used in accordance with the Occupational Safety and Health Administration (OSHA) PPE standard ([29 CFR 1910.132](#)). When required, respirator use should be in the context of a comprehensive respiratory protection program in accordance with the OSHA Respiratory Protection Standard ([29 CFR 1910.134](#)) and other requirements. Healthcare personnel who need to wear respirators should be medically cleared, trained, and fit-tested for respirator use. Detailed information on respiratory protection programs, including fit-testing procedures, can be accessed in [OSHA's Respiratory Protection eTool](#).

Decontamination

Patients who may be contaminated⁵ and healthcare personnel who come into contact with illicit fentanyl should immediately remove clothing and use soap and water to thoroughly wash and rinse potentially contaminated skin. They should avoid breaking the skin during the decontamination process and they should cover all open wounds. **Do not use alcohol-based hand rubs** or bleach solutions to clean contaminated skin. All contaminated clothing should be removed, segregated from other laundry, and laundered at the healthcare facility when possible, being careful not to disturb any areas of contamination. Employers should establish policies and staffing to ensure that healthcare personnel shower and change clothing immediately after a potential exposure.

Decontamination of reusable PPE and equipment should be done according to the manufacturer's recommendations. Contaminated single use PPE should be placed in labeled durable 6 mil polyethylene bags and disposed of appropriately.

Laundering (laundry may include bed sheets and blankets, towels, personal clothing, patient apparel, uniforms, scrubs, and gowns) should be done in a manner that minimizes disturbance of any areas of contamination and segregates contaminated laundry, allowing it to be handled safely. Laundering in a healthcare facility should be done in accordance with the Laundry and Bedding section in the [CDC Guidelines for Environmental Infection Control in Health-Care Facilities](#).

Routine cleaning of work surfaces and rooms in healthcare facilities should be done in accordance with the Principles of Cleaning and Disinfecting Environmental Surfaces section of the [CDC Guidelines for Environmental Infection Control in Health-Care Facilities](#). Surfaces suspected or known to be contaminated with illicit fentanyl that are able to be cleaned (such as hard, non-porous surfaces) should first be washed with soap and water as outlined in the Cleaning Housekeeping Surfaces section before using a disinfectant (such as bleach). Any activity which could result in making an unknown contaminant airborne (such as dry sweeping or vacuuming with a standard vacuum) should not be performed. A high-efficiency particulate air (HEPA) filter vacuum should be used when sweeping or vacuuming is required.

References

[1] Standard precautions are used for all patient care (<https://www.cdc.gov/infectioncontrol/basics/standard-precautions.html>). Standard precautions are intended to protect healthcare personnel from infection and prevent the spread of infection from patient to patient.

[2] N: not resistant to oil, P: oil proof, R: resistant to oil.

[3] Faceshields are recommended when additional protection is needed to protect against possible body fluid splashes when wearing filtering facemasks.

[4] Powder-free nitrile gloves should be worn with a minimum thickness of 5 +/- 2 mil (i.e. 0.127 +/- 0.051 millimeters; 1 mil=0.0254 millimeters), unless manufacturer provides performance breakthrough data for thinner gloves.

[5] If patient is incapacitated, this should be done for the patient by the healthcare personnel.

Instructional Sheet for Health Care Professional

Employee: Please provide this to the health care professional during the post-exposure evaluation.

To Health Care Professional:

This employee of Chestnut Health Systems has been accidentally exposed to an unknown powdered substance. We have requested that the employee receive a post-exposure evaluation. The cost of this evaluation can be billed to:

Chestnut Health Systems

Human Resources

1003 Martin Luther King Drive

Bloomington, IL 61701

(309) 827-6026

We request that a written opinion of the post-exposure evaluation be provided for our OSHA mandated recordkeeping within 15 days of this evaluation. As per OSHA mandates, the written opinion should include confirmation that our employee was informed of all available test results and any medical condition resulting from the exposure. The employee's diagnosis and test results should be kept confidential and not part of the written opinion.

Please send written opinion to:

Chestnut Health Systems

1003 Martin Luther King Drive

Bloomington, IL 61701

Attn: HR Director, confidential material enclosed

Manual:	Blood Exposure Packet
Manual Section:	Procedure
Name:	Immediate Procedure for Agency Contracted Staff
Effective Date:	01/01/2022
Policy Cross Reference(s):	SI 80 Accidental Employee Needle Stick or Blood Exposure

IMMEDIATE PROCEDURE FOR AGENCY CONTRACTED STAFF

Should an agency contracted staff be exposed to blood either via a used needle/sharp or via a spill/splatter of another individual's blood onto an open wound or mucous membrane (eye, mouth, etc.), the following procedure should be followed:

- The site should be immediately and thoroughly washed
- Apply a gauze dressing to stop the bleeding
- The exposure is to be immediately reported to supervisor on duty or designee
- Contact the contracting agency and follow their blood exposure procedures
- An Incident Report is to be completed prior to the end of the staff's shift during which the exposure occurred (this can be completed by a supervisor or nurse if staff is unavailable).

Manual: Blood Exposure Packet

Manual Section: Procedure

Name: Source Patient

Effective Date: 01/01/2022

Policy Cross Reference(s):

SOURCE PATIENT

A Chestnut Health Systems Medical Director should immediately complete the Source Patient Blood status form following a blood exposure incident as defined in the Safety Manual. Once completed, exposed employee should take this form with them to the post exposure evaluation and give to the health care provider. If a Medical Director is not available, please inform the health care professional that this information is not currently available.

Employee Medical Information Form

Employee: This form is to be completed by the employee that was exposed and taken to the post-exposure evaluation and provided to the health care professional.

Employee's Name: _____

Primary Care Physician: _____

1. Date of last tetanus toxoid vaccination (tetanus shot): _____
2. Have you ever had a Hepatitis B vaccination series? ☐ YES ☐ No

IF YES:

3. Have you completed the three step Hepatitis B vaccination series?
☐ YES date completed: _____
☐ NO
4. If you have started the series for a Hepatitis B vaccination but not finished when was the date of last vaccination in series: _____

If you completed the series more than ten years ago have you had a titer to assure immunity from Hepatitis B? ☐ YES date of titer: _____ ☐ NO

Source Patients Blood Status Form

Employee: This form is to be completed only by a Chestnut Health Systems Medical Director immediately following a blood exposure incident as defined in the Safety Manual. Once completed, take this form with you to the post exposure evaluation and give to the health care provider. If a Medical Director is not available, please inform the health care professional that this information is not currently available.

To be completed by Medical Director only:

I, _____, a Chestnut Health Systems' Medical Director submit this to be provided to the healthcare professional my knowledge of the source patient for the blood exposure incident occurring on _____ involving (employee's name) _____.

- ☐ I am unaware of the source patient's HIV or Hepatitis B status.
- ☐ The source patient has been asked to complete Hepatitis B and HIV testing. Results will be provided to the Medical Director who will then report the results to treating provider, assuring that the source patient's name and other PHI is not given to either. The Medical Director will then communicate the results to the exposed patient and report back that they had the conversation to the Learning and Safety Manager and/or Director of Quality and Compliance and Chief Operating Officer and General Counsel.
- ☐ The source patient refuses to comply with testing. I am aware the source patient's HIV status is:

- ☐ I am aware the source patient's Hepatitis B status is: _____

Signature: _____

Date: _____

Instructional Sheet for Health Care Professional

Employee: Please provide this to the health care professional during the post-exposure evaluation.

To Health Care Professional:

This employee of Chestnut Health Systems has been accidentally exposed to blood. We have requested that the employee receive a post-exposure evaluation. The cost of this evaluation can be billed to:

Chestnut Health Systems

Human Resources

1003 Martin Luther King Drive

Bloomington, IL 61701

(309) 827-6026

We request that a written opinion of the post-exposure evaluation be provided for our OSHA mandated recordkeeping within 15 days of this evaluation. As per OSHA mandates, the written opinion should include confirmation that our employee was informed of all available test results and any medical condition resulting from the exposure. Please also indicate if the Hepatitis B vaccination is indicated and/or received. The employee's diagnosis and test results should be kept confidential and not part of the written opinion.

Please send written opinion to:

Chestnut Health Systems

1003 Martin Luther King Drive

Bloomington, IL 61701

Attn: HR Director, confidential material enclosed

Safety Manual Revisions:

6/29/94	12/26/00	1/8/07	2/2/17	5/24/23
8/23/95	8/6/02	1/21/08	8/1/18	6/25/24
12/20/96	11/4/03	1/29/09	5/22/19	
12/17/97	1/2/05	1/21/10	11/18/21	
5/21/99	1/31/06	2/10/11	2/17/22	