

INFECTION PREVENTION GUIDELINES

1. PURPOSE: To prevent the transmission of healthcare-acquired infections (HAIs) to patients and personnel during patient care in the Medical Center, Community Living Center (CLC), Community-Based Outpatient Clinic (CBOC), and Primary Care Telehealth Outpatient Clinics (PCTOC's).

2. POLICY: Because ALL patients have the potential to carry and transmit infectious disease, **standard precautions (previously known as Universal Precautions)** will be practiced by ALL healthcare workers (HCWs) during the care of ALL patients. Transmission-Based precautions will be used when additional precautions are required to prevent transmission of infectious agents. The Centers for Disease Control and Prevention (CDC) guidelines contain two tiers of precautions: **standard precautions** are used for **all** of the patients, **all** of the time, and **transmission-based precautions** are for patients with recognized specific syndromes. Attachments A, B, and C define general **transmission-based precautions**.

3. STANDARD PRECAUTIONS:

a. Purpose:

1) Standard precautions are based on the principle that all blood, body fluids, non-intact skin, mucous membranes, secretions, and excretions except sweat may contain transmissible infectious agents. Standard precautions include a group of infection prevention practices that apply to all patients, regardless of suspected or confirmed infection status, in any setting in which healthcare is delivered. These include: hand hygiene; use of gloves, gown, mask, eye protection, or face shield, depending on the anticipated exposure; and safe injection practices. Also, equipment or items in the patient environment likely to have been contaminated with infectious body fluids must be handled in a manner to prevent transmission of infectious agents (i.e., wear gloves for direct contact, contain heavily soiled equipment, properly clean and disinfect or sterilize reusable equipment before use on another patient).

2) The application of standard precautions during patient care is determined by the nature of the health care worker-patient interaction and the extent of anticipated blood, body fluid, or pathogen exposure.

3) Standard precautions are also intended to protect patients by ensuring that healthcare workers do not carry infectious agents to patients on their hands or via equipment used during patient care.

4) **Standard precautions should be practiced for ALL patients at ALL times.** Standard precautions include hand hygiene and respiratory hygiene/cough etiquette.

b. Hand Hygiene: **Hand hygiene is the single most important measure for reducing the risk of transmitting microorganisms from one person to another.** Adherence to these guidelines is monitored. The observed percent of compliance is reported quarterly to the Infection Prevention and Control Committee.

c. Respiratory Hygiene and Cough Etiquette: Respiratory hygiene and cough etiquette applies to all patients, visitors and Healthcare worker (HCWs). Cover mouth/nose when coughing or sneezing. Cough or sneeze into sleeve of clothing if possible. When using tissues, dispose of used tissues immediately into no-touch receptacle and do hand hygiene immediately after soiling of hands with respiratory secretions, before touching another person, piece of equipment, or any other surface or object. Surgical masks are offered to patients with respiratory symptoms. If patients cannot wear a mask or cover coughs or sneezes, HCWs wear a surgical mask when within three (3) feet of patient. Triage patients with respiratory symptoms as soon as possible, to avoid common waiting areas with close proximity of patients. Signs are posted throughout the Medical Center, CLC, CBOC and PCTOCs with information about hand hygiene and respiratory etiquette. Hand hygiene and respiratory etiquette stations are located right after entry to the Medical Center, CLC, CBOC, and PCTOCs. Visitors with symptomatic illness are encouraged not to visit inpatients.

d. Patient Placement:

1) Prioritize for single-patient room if patient is at increased risk of transmission, is likely to contaminate the environment, does not maintain appropriate hygiene, or is at increased risk of acquiring infection or developing adverse outcome following infection.

2) Patients may have roommates when the following two criteria are met:

a) Both practice good personal hygiene. **GOOD PERSONAL HYGIENE IS DEFINED AS PATIENTS WHO WASH THEIR HANDS AFTER USING THE BATHROOM, COVER THEIR MOUTH AND NOSE WITH TISSUE WHEN COUGHING OR SNEEZING AND DO NOT SOIL ARTICLES IN THE ROOM WITH BLOOD, PUS, FECES, URINE OR ORAL SECRETIONS.** When the patient's personal hygiene cannot be accurately assessed or is questionable, a private room may be indicated until further data is collected.

b) Neither has an infection which requires a private room.

4. CDC GUIDELINES FOR HAND HYGIENE

a. Guidelines:

1) Use an alcohol hand-rub or antimicrobial soap to routinely decontaminate your hands before and after you touch a patient.

- 2) Put gloves on before you touch non-intact skin, blood, mucous membranes, or other potentially infectious materials, including contaminated items or equipment. Remove gloves immediately after use and decontaminate hands.
- 3) Use an alcohol-based hand-rub or antimicrobial soap before donning sterile gloves when inserting a central venous catheter, an indwelling urinary catheter, a peripheral vascular catheter, or performing other similar invasive procedures.
- 4) Remove gloves after caring for a patient or touching potentially infectious materials, and use an alcohol-based hand-rub or antimicrobial soap to decontaminate your hands after removing gloves.
- 5) HCWs that may have direct contact with patients at high risk for infection must not wear artificial fingernails.
- 6) Wash your hands with antimicrobial soap and water if they are visibly soiled or contaminated with body fluids.
- 7) Wash your hands with antimicrobial soap and water after using a restroom.
- 8) Wash your hands with antimicrobial soap and water before eating.
- 9) Wearing rings, especially multiple rings with stones, makes decontaminating hands more difficult. Limit wearing of rings.
- 10) All staff will follow proper procedure for hand hygiene upon entering and exiting a patient/resident room.

b. Hand Hygiene Procedure:

- 1) **Hand washing with plain soap or with antimicrobial soap**
 - Wet hands thoroughly with warm running water.
 - Apply soap and distribute over hands and wrists.
 - **Vigorously rub** hands together for at **least 15 seconds**, covering all surfaces of hands and fingers.
 - Rinse.
 - Pat dry with paper towel.
 - Turn off water with paper towel.
- 2) **Hand decontamination with alcohol foam/gel**
 - Apply appropriate amount (dime-sized) of product to palm of one hand.
 - Rub hands together, covering all surfaces: hands, fingers, wrists.
 - Rub until hands are dry (15 to 25 seconds).
 - **Do not** wash hands immediately before or afterwards with soap

and water as this may lead to dermatitis.

c. Hand Hygiene Adherence Monitoring.

1) DIRECTIONS

a) All staff with proper instruction may participate in observations. (A variety of employees from various departments known as secret shoppers are scheduled for the monthly observation monitoring process). Completed observation reports are sent to the Patient Safety Manager for review, retention, and reporting purposes.

b) Observer should watch another employee enter or exit a patient care area.

c) Record one observation per column = one ENTRY or one EXIT, or both.

d) Use the definitions and abbreviations provided on this page to complete each block.

e) Data will be compiled and reported back to staff by the MRSA Prevention Coordinator.

2) DEFINITIONS

a) PATIENT CARE AREAS = Rooms or any area where patient care is delivered.

b) CONTACT PRECAUTIONS/ISOLATION AREA = Defined by facility.

c) OBSERVED Staff Job Title = Title of person being observed.

d) OBSERVER Staff Job Title = Person doing the observation.

3) ABBREVIATIONS

N/A – not applicable

MD – attending,
resident/fellow

PT – physical therapist

MS – medical student

RT – respiratory therapy

CH – Chaplain

RN – registered nurse

OT – occupational therapist

SW – social worker

SN – student nurse

XR – radiologic technologists

EMS - housekeeper

NA – nursing assistant

LT – laboratory technician

ST – speech therapist

LPN – licensed practical
nurse

O – other, identified in
comments

4) Hand Hygiene and Contact Precaution/Isolation Area Compliance Observation Tool. Try for an equal number of contact precaution/isolation area and non-isolation patient care area observations, and an equal number of entries and exits.

(see form below)

Month _____ Unit _____

Number of observation	1	2	3	4	5	6	7	8	9	10
DATE										
Observed Staff Job Title (No names please!)										
Type of Patient Care Area/Room I = Isolation, N = non-isolation										
GOING IN to patient care area										
Hand Hygiene W=wash, S=sanitize, N =none										
GOING OUT of patient care area										
Contact Precaution/ Isolation Area Only										
Gloves off Y = Yes, N = No										
Gown off Y = Yes, N = No										
Hand Hygiene W=wash, S=sanitize, N =none										
COMMENTS:										
OBSERVER Staff Job Title/Initial										

5) Directions for use of Observation Tool for Compliance to Hand Hygiene & Contact Precautions/Isolation.

a) Anyone who completes the Education Module that accompanies this package may serve as an observer. Effort should be made to recruit observers from a variety of disciplines.

b) Each column on the graph should include only one observation. One observation may include BOTH going in and coming out of the same patient care area/episode, but it is not necessary to wait around to observe both. Record only what you observe.

c) Each month, try to get an equal number of

- i. GOING IN observations and GOING OUT observations.
 - ii. Contact precaution/isolation areas and Non-isolation areas.
- d) Hand hygiene can be either
- i. HAND WASHING = with soap and water for a full 15-seconds.
 - ii. SANITIZER = use of alcohol hand sanitizer and rubbing until dry.
- e) In Contact precautions/isolation areas, proper gowning and gloving should be done as follows:
- i. GOING IN to area
 - a. Hand Hygiene.
 - b. Don gown.
 - c. Don gloves.
 - ii. GOING OUT of area
 - a. Remove gloves.
 - b. Remove gown.
 - c. Hand hygiene.
- f) Special Circumstances for groups rounding to see patients:
- i. Hand hygiene, gowning and gloving is strongly encouraged for ALL persons entering patient rooms, as per 4 and 5 above.
 - ii. However, groups of rounding providers may use special circumstance criteria.
 - a. One or two providers should be delegated as the persons who will actually touch and examine the patient.
 - b. ALL OTHERS in the group MUST stay either behind a designated "line" or observe the "3-foot rule", touching NOTHING at all in the room.
 - 1. Lines, i.e., red line on floor, and/or "3-foot rule" may be designated locally.

2. ANYONE crossing the locally determined line must have completed hand hygiene, and be appropriately gowned and gloved, or will be considered NOT in compliance.

3. Personnel in the group who do not cross the line should touch NOTHING IN THE PATIENTS ROOM THAT THE PATIENT MAY HAVE TOUCHED, i.e., light switch, bed frame, chairs, linen, door handles, privacy curtains, etc., and so are not required to do hand hygiene and/or gown and glove.

g) All observations should be anonymous. The only identification on the Tool should be the unit name and the initials of the observer.

h) Goal is a MINIMUM of 30 observations per unit per month.

i) Return completed observations to the Infection Preventionist (IP) monthly.

5. PROCEDURES: Appropriate personal protective equipment should be used based on anticipated **INTERACTION** of the HCW with the patient. No labels identifying a specific infectious hazard will be used for any patient or body substance, as all will be handled in the same careful manner. The following personal protective equipment should be used on **ALL PATIENTS AT ALL TIMES** in routine patient care interactions.

a. Personal Protective Equipment (PPE) used:

1) Gloves: Clean non-sterile GLOVES are worn for anticipated contact with any patient's moist body substances (blood, body fluids, secretions, excretions, mucus membranes and non-intact skin) and contaminated items. Change gloves between task and procedures on the same patient after contact with material that may contain a high concentration of microorganisms. Remove gloves promptly after use, before touching non-contaminated items/environmental surfaces and before going to another patient. Skin microbial counts can actually increase while wearing gloves due to the "greenhouse effect"; therefore, hands must always be decontaminated after gloves are removed. Gloves are not necessary for contact with unsoiled articles or intact skin.

2) Gowns: Clean, non-sterile GOWNS are worn to protect skin and to prevent soiling of clothing during procedures and patient-care activities when contact of clothing or exposed skin with blood, body fluids, secretions, and excretions is anticipated. Remove a soiled gown as promptly as possible and wash hands to avoid transfer of microorganisms to other patients or environments. **DO NOT** re-use disposable gowns.

3) Mask, Eye Protection (Goggles/Face Shield): Wear during procedures and patient care activities likely to generate splashes or sprays of blood, body fluids, secretions, especially suctioning, endotracheal intubation.

b. Care of Articles from Patient's Room:

1) Laboratory Specimens: Laboratory specimens from all patients are handled with equal care. All specimens will be placed in clear plastic bags with a biohazard label. The outside of specimen containers should be clean; visibly soiled containers may be rejected by laboratory. No isolation labeling will be used. After specimens are taken to the laboratory, transporting personnel should decontaminate their hands.

2) Dishes: No special precautions needed.

3) Soiled Patient Care Equipment: Handle in a manner that prevents transfer of microorganisms to others and to the environment; wear gloves if visibly contaminated; perform hand hygiene. Reusable equipment is to be cleaned by nursing staff per manufactures recommended guidelines. Soiled sharp instruments are identified and either disposed of at the bedside or transported in containers that allow for safe handling. Rolling stock (wheelchairs, IV poles, etc.) are to be cleaned when removed from the room and prior to using with another patient. IV pumps are covered with a plastic bag (pump) post cleaning and marked as clean.

4) Syringes, Needles, and Disposable Sharps: Used syringes, needles and other sharp objects are placed in rigid plastic needle disposal containers with a biohazard label at the point of use. Needle/sharp disposal containers should be closed and discarded when 3/4 full to avoid puncture wounds when handling containers. Do not recap, bend, break, or hand-manipulate used needles; if recapping is required, use a one-handed scoop technique only. Use safety needle devices whenever possible.

5) Linen: The purpose of bagging soiled linen is to prevent leakage. All used linen is considered contaminated and handled with equal care. Heavily soiled linen (i.e., likely to soak through the laundry bag) should be placed in a **clear** plastic bag prior to placing it in the laundry bag. Plastic bags **MUST** be inside a cloth laundry bag. **NEVER** put a plastic bag down the linen chute unless it is inside a cloth laundry bag. **NEVER** toss loose linen down the linen chute. Soiled linen should be handled and transported in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and avoids transfer of microorganisms to other patients and environments.

6) Trash: Trash and disposable articles soiled with body substances are bagged to prevent leakage. HCWs gathering trash wear gloves. Articles such as dressings that are heavily soiled with body fluids (i.e., likely to drip) should be placed in a plastic bag at the point of use and taken to the contaminated trash in the soiled utility room. Infectious waste is defined and handled according to MCM 137-4, "Regulated Waste."

7) Environmental Control: Discharge cleaning of the patient room is performed in a routine and consistent fashion and includes close attention to frequently touched items.

- 8) Patient Resuscitation: Use mouthpiece, resuscitation bag, or other ventilation device to prevent contact with mouth and oral secretions.
- 9) Respiratory Hygiene/Cough Etiquette: Instruct symptomatic persons to cover mouth/nose when sneezing/coughing; use tissues and dispose in no-touch receptacle. Do hand hygiene after soiling of hands with respiratory secretions. Wear a surgical mask if tolerated or maintain separation, three feet if possible.
- 10) Thermometers: Electronic thermometers with disposable cots are used for all patients. A new cot is used for each patient and it is disposed in the regular hospital trash after a single use.
- 11) Facility procedures and protocols will be followed for cleansing of stethoscopes and other non-critical Reusable Medical Equipment (RME).
- 12) Razors: Disposable safety razors will be available for those patients who do not have their own razors. Disposable electric razors are available for those patients on anticoagulant therapy who do not have their own razors. Patients and their families are encouraged to bring their own shaving supplies when admitted to the hospital or CLC.
- 13) Body Substance Disposal: Body substance disposal from all patients should be done in the same manner, taking care to avoid splashes into the face and onto the clothing of personnel. Urine and feces are flushed down the toilet, hopper or Verna care system. Blood products and fluids from suction canisters are poured carefully down an appropriate drain then flushed into the sewer system. In the Operating Room, a solidifier is added to suction canister waste and the canister is then placed in Biohazard Waste container. Wear appropriate PPE if splash is anticipated. Spills of body substances should be cleaned up immediately wearing gloves. Surfaces should be cleaned with a germicide detergent. Large blood spills should be disinfected with approved germicide solution. Spill kits are available.
- 14) Private Room: A private room is necessary for:
 - a) A patient with an infectious disease transmitted by the airborne route (i.e., tuberculosis or disseminated Herpes Zoster). The patient will be placed in a negative airflow private room known as an Airborne Infection Isolation Room (AIIR).
 - b) A patient with altered mental status whose hygiene is poor, (i.e., a patient who does not wash his hands after touching infective material (feces, purulent drainage or secretions), and contaminates the environment or shares contaminated articles.
 - c) A patient colonized/infected with microorganisms of special clinical epidemiological significance (i.e., Methicillin Resistant Staph Aureus (MRSA), Clostridium difficile (C. diff), Vancomycin-Resistant Enterococcus (VRE)). This patient may be cohorted with another patient having the same organism, but no other infection.

15) Visitors:

- a) Visitors must observe the same precautions as HCWs.
- b) Visitors must be instructed in the use of the medical center-approved mask when visiting with patients with airborne disease.
- c) Visitors who may wish to assist with care must be instructed in good hand hygiene technique and appropriate use of gloves and gowns when encountering body substances.

16) Books and Magazines: Books, magazines visibly soiled with body substances must be disposed in the regular hospital trash. Notify Library Service, ext. 2254, if a book having a card, pocket and spine label must be discarded so the patient is not billed for the book and it may be replaced.

17) Postmortem Handling of Bodies:

- a) Postmortem handling of bodies must be done in the same manner as if the patient were still alive.
- b) Mask and eye protection are necessary if aerosolization of tissue is expected during the procedure. Powered Air-Purifying Respirator (PAPR) respirators are used if chest or head are dissected.
- c) Gloves and gowns must be worn to prevent skin and clothing contamination of personnel.

6. PATIENT TEACHING: All patients should be taught that potentially infectious agents are present in their body fluids and that they may be susceptible to infections from others. Hand hygiene, respiratory etiquette, isolation precautions, and good personal hygiene should be emphasized for their protection and the protection of others.

7. REFERENCES:

- a. Siegal, JD, Healthcare Infection Control Practices Advisory Committee. "Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, 2007".
- b. Siegal, JD, Healthcare Infection Control Practices Advisory Committee. "Management of Multidrug-Resistant Organisms in Healthcare Settings, 2006".
- c. Jensen, PA. "Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings, 2005", MMWR 2005; 54 (No. RR-17, 1-141)
- d. CDC, "Guidelines for Preventing Health-Care-Associated Pneumonia,"

2003, (www.cdc.gov/ncidod/dhqp/guidelines.html)

e. Garner, J. and Simmons, B., CDC “Guideline for Hand Hygiene in Health-Care Settings”, *MMWR*, Oct 25, 2002/Vol 51/No. RR-16 (www.cdc.gov/ncidod/dhqp/guidelines.html)

f. VHA Directive 2005-002, Required Hand Hygiene Practices, January 13, 2005.

8. ATTACHMENTS:

- a. Attachment A – Transmission-Based Precautions (Empiric Isolation)
- b. Attachment B – Transmission-Based Precautions (Protective Environment)
- c. Attachment C – Respiratory Hygiene/Cough Etiquette

9. COORDINATION: 001,11, 003, 112, 113, 138, QSV.

10. RESCISSION: Medical Center Memorandum 00Q-11, Infection Prevention Guidelines, dated September 2015.

Michael Kilmer
Director

DISTRIBUTION: A

EMPIRIC ISOLATION TRANSMISSION-BASED PRECAUTIONS

1. **POLICY:** In many instances, the risk of transmission of infectious disease may be highest before a definitive diagnosis can be made, before precautions based on that diagnosis can be implemented, or before laboratory results are finalized. The routine use of Standard Precautions for all patients greatly reduces this risk. While it is not possible to identify all patients that require isolation precautions, certain clinical syndromes and conditions carry a sufficiently high risk to warrant the empiric addition of isolation precautions while a more definitive diagnosis is being pursued.

a. TRANSMISSION:

1. Certain clinical syndromes and conditions carry a sufficiently high risk of transmission of infectious disease before a definitive diagnosis can be made.

2. **RESPONSIBILITY:** All persons involved with the care of or contact with all patients.

3. **PROCEDURE:** Clinical syndromes or conditions warranting empiric transmission-based precautions in addition to standard precautions pending confirmation of diagnosis.

Clinical Syndrome	Potential Pathogen	Empiric Precautions
Diarrhea		
Acute diarrhea with likely infectious cause in an incontinent or diapered patient.	Enteric pathogens.	Contact Precautions.
Watery non-bloody diarrhea, may have had recent antibiotic therapy.	Clostridium Difficile	Contact Precautions, wash hands with soap and water only, clean with bleach product.
Meningitis		
	Neisseria Meningitidis (Gram negative diplococci on gram stain, petechial/ecchymotic generalized rash w/fever, CNS symptoms)	Droplet Precautions for first 24 hrs of appropriate antibiotics. Mask and face protection for intubation.
	M. tuberculosis	Airborne Precautions if accompanied by pulmonary infiltrate. Airborne Precautions

Clinical Syndrome	Potential Pathogen	Empiric Precautions
		plus contact precautions if potentially infectious. draining body fluid present
Rashes or Exanthems, Generalized, Unknown Cause		
Petechial/ecchymotic with fever (general). -If positive history of travel to an area with an ongoing outbreak of VHF in the 10 days before onset of fever.	Neisseria meningitidis Ebola, Lassa, Marburg viruses	Droplet Precautions for first 24 hours of appropriate antibiotics. Droplet Precautions plus contact Precautions, with face/eye protection, emphasizing safety sharps and barrier precautions when blood exposure likely. Use N96 or higher respiratory protection when aerosol generating procedure performed.
Vesicular	Varicella-zoster, herpes simplex, variola (smallpox), vaccinia virus.	Airborne plus Contact Precautions Contact only for zoster, herpes simplex, vaccinia virus.
Maculopapular with cough, coryza, fever.	Rubeola (measles)	Airborne Precautions
Respiratory Infections		
Cough, fever, upper lobe infiltrate in an HIV negative or low risk patient for HIV.	M. tuberculosis, respiratory viruses, Strep pneumoniae, MSSA or MRSA	Airborne Precautions + Contact Precautions
Cough, fever, infiltrate in any lobe in HIV + patient or high risk patient for HIV.	M. tuberculosis, respiratory viruses, Strep pneumoniae, MSSA or MRSA	Airborne Precautions + Contact Precautions Use face and eye protection if generating respiratory aerosols
Cough, fever, infiltrate in any lobe in patient w/	M. tuberculosis, SARS CoV, Avian Influenza	Airborne + Contact Precautions +eye

Clinical Syndrome	Potential Pathogen	Empiric Precautions
recent travel (last 10-21 days) to country with active outbreaks of SARS, Avian Influenza. Flu-like sx + Prolonged cough in adults, paroxysms.	Pertussis	protection Droplet Precautions.
Skin or Wound Infections		
Abscess or draining wound that cannot be covered.	MSSA or MRSA, Group A streptococcus.	Contact Precautions. Add Droplet Precautions for the first 24 hours of appropriate antibiotic therapy if invasive Group A strep is suspected.

4. REFERENCES: Centers for Disease Control and Prevention (CDC), "Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, June 2007, <http://www.cdc.gov/ncidod/dhqp/pdf/isolation2007.pdf>.

5. RESCISSION: No Recissions

PROTECTIVE ENVIRONMENT

POLICY: The immune compromised patient will be placed in a “protective environment”. Special precautions for the care and transport of the patient are utilized to prevent the patient from exposure to pathogenic microorganisms that may compromise their health due to impaired immune response.

RESPONSIBILITY: All healthcare personnel caring for immuno-compromised patients (patients with a total WBC less than 1000 or neutrophils less than 500 or if ordered by physician).

1. PROTECTIVE ENVIRONMENT PROCEDURES:

a. Patient Placement

1. Private room (if available).
2. Do not use Airborne Infection Isolation Rooms (AIIR) unless patient has another indication for Airborne Precautions

b. Hand Hygiene and PPE

1. Perform hand hygiene as per Hand Hygiene MCM.
2. Standard Precautions as appropriate for the task performed.
3. Use PPE (gowns, gloves, masks) as indicated per physician order.

c. Patient Transport

1. Minimize the length of time that patients are outside their rooms for diagnostic procedures and other activities.
2. Patient may wear a mask when leaving the patient room.

d. Environmental Control

1. Keep patient's door closed.
2. Room windows are to remain closed at all times.
3. Prohibit dried and fresh flowers and potted plants.
4. Restrict all persons who have colds, flu, or other infectious diseases.
5. Restrict visits from persons who have been recently (last 72 hours) vaccinated with an attenuated live vaccine (i.e., DPT and MMR vaccinations).

e. Patient Care Equipment

1. Disinfect any equipment that has been used with other patients before taking into the patient's room.
2. When possible dedicate noncritical patient-care equipment and items such as stethoscope for use with single patient.

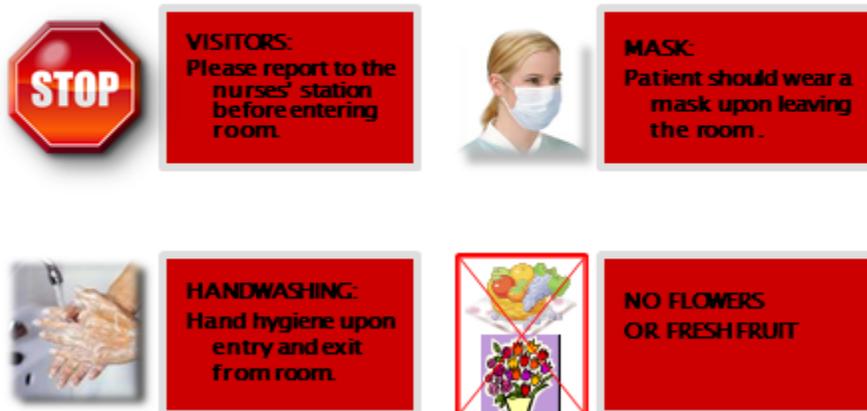
f. Food Trays

1. No fresh fruit or vegetables.
- g. **Linens**
 1. Per Standard precautions.
- h. **Waste**
 1. Per Standard precautions.
- i. **Patient, Family, Visitor Education**

Provide information regarding protective environment procedures and appropriate hand hygiene.

PROTECTIVE ENVIRONMENT

(in addition to Standard Precautions)



2. **REFERENCES:** Centers for Disease Control and Prevention (CDC), "Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, **June 2007**, <http://www.cdc.gov/ncidod/dhqp/pdf/isolation2007.pdf>.
3. **RESCISSION:** Medical Center Memorandum 003-79, Protective Environment, dated May 2012.

RESPIRATORY HYGIENE/COUGH ETIQUETTE

1. POLICY: To control the transmission of undiagnosed transmissible respiratory infections. This applies to any person entering the healthcare facility with signs of illness including cough, congestion, rhinorrhea, or increased production of respiratory secretions.

A. TRANSMISSION: Respiratory droplets are generated when an infected person coughs, sneezes, or talks.

2. RESPONSIBILITY: All persons involved with the care of or contact with all patients.

3. PROCEDURES:

A. Patient Placement

1. When space and chair availability permit; encourage coughing persons to sit at least three feet away from others in common waiting areas. Hospital personnel may direct patients and visitor seating.

B. Hand Hygiene and PPE

1. Cover the nose/mouth with a tissue when coughing or sneezing. If a tissue is not available, cough or sneeze into your sleeve.
2. Use tissue to contain respiratory secretions and promptly dispose after use.
3. Perform hand hygiene after having contact with respiratory secretions and contaminated objects/materials. Alcohol-based hand sanitizer is available for public use.
4. Wear procedure/surgical mask as tolerated with Respiratory Symptoms. Procedure/surgical masks are available for use by persons with respiratory symptoms.

C. Patient, Family, Visitor Education

1. Provide information regarding respiratory hygiene/cough etiquette and appropriate hand hygiene.
2. Teach patients to cover their nose/mouth with tissue when coughing or sneezing and proper disposal of tissue (i.e., respiratory etiquette) at all times.
3. Public signs are posted in languages appropriated to populations served with instructions regarding above control measures.

4. REFERENCES: Centers for Disease Control and Prevention (CDC), "Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, **June 2007**, <http://www.cdc.gov/ncidod/dhqp/pdf/isolation2007.pdf>.

5. RESCISSION: Medical Center Memorandum 003-74, Respiratory Hygiene/Cough Etiquette, dated October 2011.

HAND HYGIENE

1. PURPOSE: Hand Hygiene is the single most important procedure for preventing the transmission of infections and has been shown to prevent the spread of infectious agents in clinical settings for over 150 years. This Medical Center Memorandum provides guidance for establishing basic requirements for hand hygiene practice in the VA Western Colorado Health Care System (WCHCS).

2. POLICY: Contaminated hands of health care workers are an important source of healthcare-associated infections (HAIs). Hand hygiene is recognized as the single most effective action for preventing the spread of infections in the health care setting.

a. Antimicrobial Soap – A soap containing an ingredient active against skin flora; i.e. chlorhexidine gluconate (CHG), chloroxylenol (PCMX).

b. Alcohol-based sanitizer – A gel or foam product that is designed to disinfect hands in the absence of gross soiling, containing a minimum of 70% ethyl alcohol.

c. Chlorhexidine gluconate (CHG)-compatible hand lotion – a hand lotion formulated to not diminish the residual effectiveness of CHG-based antimicrobial soaps

3. DEFINITIONS: Contaminated hands of health care workers are an important source of healthcare-associated infections (HAIs). Hand hygiene is recognized as the single most effective action for preventing the spread of infections in the health care setting.

a. Antimicrobial Soap – A soap containing an ingredient active against skin flora; i.e. chlorhexidine gluconate (CHG), chloroxylenol (PCMX).

b. Alcohol-based sanitizer – A gel or foam product that is designed to disinfect hands in the absence of gross soiling, containing a minimum of 70% ethyl alcohol.

c. Chlorhexidine gluconate (CHG)-compatible hand lotion – a hand lotion formulated to not diminish the residual effectiveness of CHG-based antimicrobial soaps.

4. RESPONSIBILITIES:

a. The WCHCS Director is responsible for:

(1) Ensuring system-wide support and compliance with VA Directive 1131, Management of Infectious Disease and Infection Prevention and Control Programs and this policy.

(2) Assuring sufficient financial support for an effective hand hygiene program.

b. The Environmental Management Service (EMS) is responsible for:

(1) (1) Following the guidelines for this service in the Infection Control Manual Departmental Guidelines.

(2) Following the guidelines for this service (formerly known as Facilities Management Service) in the Infection Control Manual Departmental Guidelines sanitizers that have been approved by the Infection Control Committee.

(3) Assuring that alcohol hand sanitizers are available at the entrance of EVERY patient room (at a minimum just inside the door or just outside the door).

(4) Supplying pocket-sized containers of alcohol hand sanitizer to all employees who wish to use them.

c. The Infection Prevention and Control Committee (IPCC) is responsible for approving hand hygiene products selected with input from staff for use in the system.

d. Infection Prevention and Control is responsible for:

(1) Ensuring that all employees receive training about infection prevention according to World Health Organization (WHO) guidelines.

(2) Developing and implementing hand hygiene monitors and reporting results to the IPCC and staff on a quarterly basis

(3) Ensuring that all Standards and Elements of Performance relating to hand hygiene and infection control of The Joint Commission Standards Manual are adequately monitored.

e. Service Chiefs are responsible for:

(1) Enforcing adherence to hand hygiene policies and following up appropriately with non-compliance.

(2) Discussing with employees results of their work unit's hand hygiene adherence monitoring on a regular basis.

f. Employee Occupational Health is responsible for:

(1) Monitoring and compiling dermatological complaints or problems experienced by employees associated with hand hygiene products and reporting to the IPCC annually.

(a) Hand hygiene products for employees requiring special accommodations will be approved for use by Employee Occupational Health Services in conjunction with Infection Prevention and Control; and used in compliance with the hand hygiene practices outlined in this policy.

1. Hand hygiene products for the affected employee will be purchased by EMS (WCHCS).

g. Employees are responsible for complying with all aspects of this policy

5. PROCEDURES:

a. All health care workers in direct patient contact areas, i.e., inpatient rooms, outpatient clinics, etc., as well as those who may have direct or indirect patient contact in other settings, such as radiology technicians, phlebotomists, linen service workers, etc., must adhere to the following standards:

(1) An alcohol-based hand rub or antimicrobial soap and water will be used to routinely decontaminate hands upon room entry and room exit, regardless of duration of time or activity while in the room; and if the room is multi-patient, prior to caring for another patient.

(a) If hands are not visibly soiled, an alcohol-based hand rub may be used for routinely decontaminating hands; manufacturers' instructions need to be followed when using these products. Hand washing with water and antimicrobial soap is also acceptable.

(b) When hands are visibly dirty or contaminated with proteinaceous material or are visibly soiled with blood or other body fluids, such as after contact with excretions, mucous membranes, non-intact skin, or wound dressings, hands must be washed with antimicrobial soap and water.

NOTE: Avoid using hot water, as repeated exposure to hot water can increase the risk of dermatitis. Proper hand hygiene techniques are illustrated in the WHO brochure: HAND HYGIENE: Why, How, and When? (see References).

(2) An alcohol-based hand rub or antimicrobial soap and water will be used:

(a) Before and after inserting or handling any invasive device for patient care.

(b) Before donning gloves and after removing gloves.

(c) If moving from a contaminated body site to another body site during care of the same patient.

(d) Before handling medication or food.

(e) After contact with inanimate surfaces and objects (including medical equipment) in the immediate vicinity of the patient.

(3) Gloves will be worn when contact with blood, body fluids, secretions, excretions, or other potentially infectious materials, mucous membranes, skin rashes and non-intact skin is anticipated. Gloves must be removed after caring for a patient and disposed of in the patient room. Hand hygiene will be performed after immediately after removing gloves. Gloves will not be worn in the hallways, elevators, stair wells, or other non-direct patient care areas.

(4) If gloves become visibly soiled, or if patient care is performed on a contaminated site, gloves will be removed and hand hygiene will be performed, fresh gloves will be donned before moving to another body site on the same patient, a device, or the environment. Gloves are to be disposed of after each use, and are not to be worn outside of patient rooms.

NOTE: The correct technique for donning and removing non-sterile examination gloves is illustrated in Attachment B; World Health Organization, Geneva, 2009.

(5) For surgical procedures, an antimicrobial soap or an appropriate surgical hand rub with persistent activity will be used before donning sterile gloves. Persistent activity is the prolonged or extended antimicrobial activity that prevents the growth or survival of microorganisms after application of a given antiseptic.

(6) When using a surgical hand rub:

- (a) Follow the manufacturer's instructions,
- (b) Apply to dry hands,
- (c) Use a sufficient amount to keep hands and forearms wet throughout the preparation procedure, and
- (d) Allow the surgical hand rub to dry completely before donning sterile gloves.

(7) Hands will be washed with soap and water for at least 20 seconds whenever they are visibly soiled or contaminated with blood or body fluids, and after exposure to potential spore-forming pathogens, such as *Clostridium difficile*, Norovirus.

(a) Hands will be dried using a method that will not re-contaminate them, such as using individual paper towels.

(b) Fingernails (ALL supervisory and non-supervisory persons who regularly or occasionally provide direct patient care are subject to these restrictions.):

1. Natural nails will be clean, neat, and trimmed to ¼ inch or less
2. Nail polish is acceptable so long as it is intact and not chipped or worn

3. Artificial nails (including acrylic overlays, gels, silk wraps, shellac, tips or nail extenders or nail jewelry) are prohibited for direct patient-care staff.

(c) All facility staff will wash hands with soap and water for at least 20 seconds before eating and after using the toilet.

(d) Appropriate hand hygiene supplies are provided, to include the following:

1. An alcohol-based hand rub is readily available at the point of patient care, e.g., at the entrance to each patient room, as well as other locations such as clinics, emergency rooms, Community Living Center (CLC), Post-Anesthesia Care Units (PACUs), etc.

NOTE: Alcohol-based hand rubs may present an abuse risk in certain patient care areas, such as inpatient psychiatric or mental health residential rehabilitation treatment programs. Discretion will be used with alcohol-based products in these areas.

2. Antimicrobial soap is available in all patient care areas (i.e., at all sinks with a soap dispenser).

3. Pocket-sized containers of alcohol-based hand rub are available to all facility staff through EMS (WCHCS).

4. Appropriate hand lotions or creams to minimize irritant contact dermatitis are provided.

NOTE: Store-bought hand lotion can reduce the effectiveness of the Chlorhexidine Gluconate (CHG) soap and may not be compatible with the gloves provided. Use only the lotion provided by EMS in Denver and TSS at all other locations in southern Colorado.

5. Gloves (in multiple sizes) will be available for easy access at the point of care within ALL patient rooms. Gloves will be available at the entry point of any room used for a patient in Contact Precautions.

(e) Soap must be dispensed from disposable bladders or other containers that prevent old and new soap from mixing. Soap is not added to partially-empty dispensers, "topping off" soap dispensers can lead to contamination.

(f) Installation of wall-mounted hand sanitizer dispensers and storage of alcohol-based hand sanitizer will be consistent with fire safety requirements.

(g) VHA food service workers will practice appropriate hand hygiene as they perform their duties. Use of soap and water is required rather than alcohol-based hand rubs in food preparation settings. Food service workers will comply with hand hygiene requirements in this policy and with practices outlined in Handbook 1109.04.

(h) EMS workers will practice appropriate hand hygiene as they perform their duties. Gloves will be changed between rooms, and when soiled. Hand hygiene will be performed after glove removal. Gowns, gloves and masks will not be worn in the hallways.

1. Environment Management Service staff refer to guidance on hand hygiene and related practices in the Environmental Management Services Sanitation Procedure Guide provided by the Environmental Programs Service within the VHA Office of the Deputy Under Secretary for Operations and Management
http://vaww.ceosh.med.va.gov/10N/10NA7-EPS/Pages/EPS_Guidebooks.shtml

NOTE: This is an internal web site and is not available to the public.

6. REFERENCES:

VHA Directive 1131 Management of Infectious Diseases and Infection Prevention and Control Programs, 11/07/2017

Centers for Disease Control and Prevention (CDC) web site with Guideline for Hand Hygiene in Health-Care Settings and related materials,
<http://www.cdc.gov/handhygiene/>

CDC Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007,
<http://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html>

FDA Retail Food Protection: Employee Health and Personal Hygiene Handbook,
<http://www.fda.gov/Food/GuidanceRegulation/RetailFoodProtection/IndustryandRegulatoryAssistanceandTrainingResources/ucm113827.htm>; please see section on "Employee Health and Highly Susceptible Populations."

The Joint Commission E-dition, Hand Hygiene Information,
http://www.jointcommission.org/topics/hai_hand_hygiene.aspx

VHA Handbook 1109.04, Food Service Management Program,
http://vaww.va.gov/VHApublishations/ViewPublication.asp?pub_ID=2941
World Health Organization (WHO) brochure: HAND HYGIENE: Why, How, and When?
http://who.int/gpsc/5may/Hand_Hygiene_Why_How_and_When_Brochure.pdf

World Health Organization Guidelines on Hand Hygiene in Health Care, 2009.

World Health Organization Hand Hygiene Tools and Resources,

WHO: Interim Infection Prevention and Control Guidance for Care of Patients with Suspected or Confirmed Filovirus Hemorrhagic Fever in Health-Care Settings, with Focus on Ebola, August 2014, Technique for Donning and Removing Non-Sterile Examination Gloves.

7. ATTACHMENTS:

A – Technique for donning and removing non-sterile examination gloves.

8. COORDINATION: 11, 003, 001, 111, 113, 112, Patient Safety, 00Q, 00A, 116,

9. RESCISSION: Medical Center Memorandum 00Q-10, Hand Hygiene, dated September 2017.

Michael T. Kilmer
Director

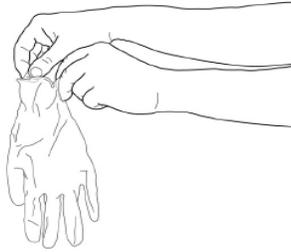
DISTRIBUTION: E (00, 11, 003, 111, 112, 113, 116, 00Q, PSM, 142D)

Attachment A:

I. HOW TO DON GLOVES:



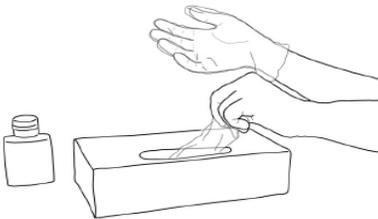
1. Take out a glove from its original box



2. Touch only a restricted surface of the glove corresponding to the wrist (at the top edge of the cuff)



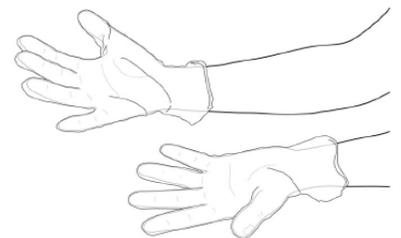
3. Don the first glove



4. Take the second glove with the bare hand and touch only a restricted surface of glove corresponding to the wrist

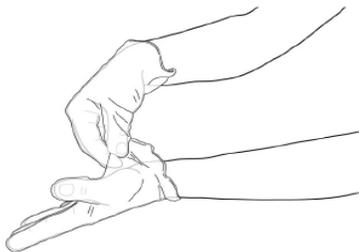


5. To avoid touching the skin of the forearm with the gloved hand, turn the external surface of the glove to be donned on the folded fingers of the gloved hand, thus permitting to glove the second hand

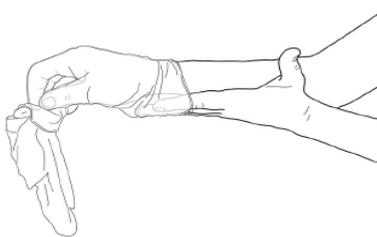


6. Once gloved, hands should not touch anything else that is not defined by indications and conditions for glove use

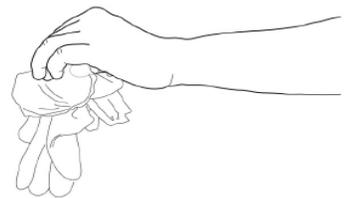
II. HOW TO REMOVE GLOVES:



1. Pinch one glove at the wrist level to remove it, without touching the skin of the forearm, and peel away from the hand, thus allowing the glove to turn inside out



2. Hold the removed glove in the gloved hand and slide the fingers of the ungloved hand inside between the glove and the wrist. Remove the second glove by rolling it down the hand and fold into the first glove



3. Discard the removed gloves

4. Then, perform hand hygiene by rubbing with an alcohol-based handrub or by washing with soap and water

LATEX ALLERGY

1. PURPOSE: To reduce the risk of latex allergy and ensure safe outcomes for patients and health care workers with latex allergy at the Grand Junction Veterans Health Care System (GJVHCS).

2. RATIONALE:

a. The incidence of latex allergy has grown dramatically among patients and health care workers over the past few years. It is estimated that approximately 10% of health care workers have some form of latex sensitivity or allergy.

b. The term latex refers to natural rubber latex, the product manufactured from a milky fluid from the rubber tree. Latex exposure occurs through contact with the skin or mucous membrane, inhalation, ingestion, parenteral injection, or wound inoculation. Risk factors include exposure to latex, multiple surgical procedures or mucosal instrumentation involving latex, and a personal or family history of allergies. Clinical features distinguish the three reactions to latex.

1) Irritant contact dermatitis caused by irritants.

2) Allergic contact dermatitis caused by chemical sensitizers.

3) Immediate hypersensitivity (urticaria) caused by a response to protein allergens in latex.

c. The use of latex gloves is a prominent cause of latex allergen exposure by cutaneous contact, inhalation, wound inoculation, and ingestion. Higher allergen levels are found in powdered gloves than in powder free gloves, and glove powder is a major factor in allergen exposure. Corn starch in the powder actively extracts and binds proteins from latex. The powder and latex proteins accumulate on the glove wearers' hands and transfers onto objects, and aerosols may remain suspended in the air for up to five (5) hours.

d. Workers rely increasingly on latex gloves to prevent the transmission of human immunodeficiency virus (HIV), hepatitis B virus, and other infectious agents.

e. Recommendations from the National Institute of Occupational Safety and Health (NIOSH) are for reduction of exposures, using appropriate work practices, training and education of health care workers, monitoring symptoms, and substitution of non-latex products when appropriate.

3. POLICY:

a. All health care workers are to be aware of latex allergy, its related issues, and how to protect themselves and patients from undue latex exposure.

b. Non-latex gloves are supplied to all health care workers as a standard practice. Special requests for latex gloves are approved based on need and are powder-free. Powdered latex gloves are discouraged from use.

c. All patients and health care workers are screened initially for allergies. A latex-safe environment is provided to patients and health care employees that report latex allergy. A latex safe environment is an area with minimal latex allergen, insufficient to elicit a latex allergic reaction.

d. Health care workers are asked to report symptoms suggestive of latex allergy to Employee Health for early detection and treatment.

4. RESPONSIBILITIES:

a. **Health Care Workers:** Use powder free non-latex gloves for activities that are not likely to involve contact with infectious materials.

b. **Supply Chain Management:** Provides powder free non-latex gloves to health care workers that have been evaluated for durability and barrier protection. **Supply Chain Management** maintains a product list and inventory of non-latex alternatives for latex medical devices and supplies.

c. **Infection Control Nurse:** Provides education regarding latex allergy in annual Infection Control training for health care workers.

d. **Employee Health Physician/Nurse:** Provides early detection by screening with the Latex Allergy Questionnaire (Attachment A) and assist with treatment of health care workers with the allergy.

e. **Safety Officer:** Assists Infection Control Nurse and Employee Health Nurse in assessing the facility to ensure a latex safe environment for patients and health care workers with latex allergy.

5. PROCEDURES:

a. Patients are routinely screened regarding allergies. Allergy status is documented in the medical record and updated at each visit to the facility. Patients that report latex allergy are provided a latex safe environment. When a latex allergic patient is scheduled for surgery, the operating room staff is notified of the allergy and the allergy is documented on the operating room schedule board.

b. Health care workers are initially screened regarding allergies at time of hire. Health care workers are educated to recognize the signs and symptoms of possible latex allergy and encouraged to report the development of these symptoms to Employee Health.

c. Adverse events including allergic reactions related to medical devices are reported to the Food and Drug Administration Med Watch Program (1-800-FDA-0178).

d. Powder free, non-latex gloves (sterile and non-sterile) are available to all health care workers and are routinely used unless special permission has been given to use latex gloves. Logistics monitors the use of latex gloves and medical supplies.

e. Information on latex allergy is included in the annual Infection Control training provided to all Medical Center employees. During New Employee Orientation, latex allergy information is part of the Standard Precautions topic.

f. To ensure a latex safe environment, the Safety Officer and Environment of Care team are to periodically assess the facility during walk around reviews for OSHA compliance.

6. REFERENCES:

a. Abby Plambeck, RN, BSN, "Type I Versus Type IV Allergic Reactions: How do they Differ?", Fall 2005, Vol. 10, No. 3, American Latex Allergy Association.

7. ATTACHMENT:

a. Attachment A - Latex Allergy Questionnaire.

8. COORDINATION: 001, 11, 003, 111, 112, 90E, 05, and 007.

9. RESCISSION: Medical Center Memorandum No. 003-41, Latex Allergy, dated August 2014.

Michael T. Kilmer
Director

DISTRIBUTION:E

August
2017

Latex Allergy Questionnaire

Job Title: _____ Duty Location: _____

Yes No

- ___ ___ 1. Do you have regular contact with latex gloves or other rubber products?
- ___ ___ 2. Do your hands break out when wearing latex gloves?
- ___ ___ 3. Have you ever had any adverse reaction associated with exposure to latex products, i.e., gloves, balloons, condoms, shoe wear or any other products containing rubber or latex?
- ___ ___ 4. Have you had frequent dental procedures or other medical conditions that resulted in multiple operations or chronic medical instrumentation, such as urinary catheterization?
- ___ ___ 5. If you use any latex containing gloves (whether low powder, low protein, or powder-free), do you have any symptoms of rhinitis, swelling around the eyes, itching or hives?
- ___ ___ 6. Have you ever experienced hay fever, eczema, anaphylaxis, urticaria or symptoms of asthma?
- ___ ___ 7. If a history of asthma, do you use an inhaler or have asthma attacks more often at work?
- ___ ___ 8. Do you have a history of adverse reaction after eating any of the following foods?
- a. Avocados, bananas, potatoes, tomatoes, chestnuts, kiwis?
 - b. Any other fruits or vegetables? _____
- ___ ___ 9. Have you ever experienced any allergic reaction to anything not included in any of the questions above?
- _____
- ___ ___ 10. Do you have any history of symptoms of an allergic reaction? If yes, specify the causes if known; otherwise, specify "unknown".
- _____

If all above questions are negative, annotate assessment as "Negative".

Comments:

Employee Signature Date

Health Care Provider Signature Date

DISPOSAL OF HAZARDOUS WASTE

1. **PURPOSE:** To define the procedures for disposal of hazardous waste.
2. **POLICY:** All materials will be consumed in use, recycled, reclaimed, or disposed of through reutilization unless cost is prohibitive. Only then will any material be disposed of as a waste. Costs of disposal must be considered (waste minimization). Hazardous waste will not be mixed with any other materials, whether within its own classification or otherwise. Services will maintain a current inventory of hazardous waste that will be reconciled with hazardous materials inventories. These will be by name, quantity, state (gas, liquid, or solid), and concentration. Disposal will be per applicable federal, state, and local regulations.
3. **PROCEDURES:** Any chemical that exhibits hazardous characteristics as defined by federal and/or state rules and regulations is unusable or unwanted in any way and poses a potential hazard to individuals, the environment or public health is a hazardous chemical waste. Examples may include, but will not be limited to, the following:
 - Waste and opened surplus chemicals.
 - Expired or off-specification chemicals.
 - Carcinogens and cytotoxic (antineoplastic) agents.
 - Prescription drugs and controlled substances.
 - Empty chemical drums and other chemical containers with a capacity of 10 gallons and greater.
 - Thermometers and other items containing mercury.
 - Non-returnable gas cylinders and lecture bottles or pressurized chemicals.
 - Residue of spill clean-up materials-contaminated rags and absorbents.
 - Non-radioactive lead shielding and lead scrap.
 - Used oil --- motor, vacuum pump, lubricating.
 - Pesticides.
 - Used solvents.
 - Batteries.
 - Paint, paint thinners, brush cleaners, linseed oil, thinner contaminated rags.
 - Heavy metal containing waste or products (arsenic, barium, cadmium, chromium, lead, mercury, selenium and silver).
 - a. **Chemical:**
 - 1) Chemicals that are consumed in use and/or rendered non-hazardous will be disposed of through normal waste disposal means.
 - 2) Chemicals that are not rendered non-hazardous or become hazardous will be disposed of as outlined in Attachment A.
 - b. **Compressed Gases:**
 - 1) Waste gases will be disposed of pursuant to Attachment B.

- 2) Each Service using compressed gases will have written policies on use, handling, and disposal.

c. **Biological/Regulated Medical Waste:**

- 1) Will be handled, stored, transported and disposed of via an approved vendor, e.g., Stericycle or by any other approved methods by VHA, the state of Colorado and/or in the state of Utah.

d. **Physical:**

- 1) Asbestos containing material (ACM), lead paint, chlorofluorocarbons (CFCs), mercury, fluorescent light tubes (FLT) will be containerized and disposed of in accordance applicable state or federal regulations and in accordance of Attachment C.

4. **RESPONSIBILITIES:**

- a. **The Director** will support training, and required compliance with policy and all applicable laws and regulations.

- b. **Service Chiefs** are responsible for:

- 1) Ensuring compliance with this policy.
- 2) Ensuring that a service level policy applicable to use, handling, and disposal is written and in place in accordance with Attachment B for those services using compressed gas.

- c. **Supervisors** are responsible for:

- 1) Notifying the Safety Office when hazardous materials need to be picked-up, disposed of, identifying the material and giving all pertinent information.
- 2) Ensuring hazardous materials requiring disposal remain in the service until notified of a pick up, or are given to Environmental Management Service (EMS) or the Safety Office for disposal.
- 3) Ensuring hazardous material inventory is reconciled with those materials consumed, disposed of, or rendered non-hazardous in use.

- d. **Safety & Occupational Health Office/GEMS** is responsible for:

- 1) Initiating disposal process with Pharmacy, EMS, Radiology and Dental Service when sufficient quantities of materials have accumulated.
- 2) Notifying Services when a pickup of hazardous materials requiring disposal will occur.

3) Assist with staff training and program/plan oversight.

- e. **Supply Chain Management Service (SCMS)** is responsible for providing support necessary for the contract award of an approved, authorized disposal contractor and ensuring process of green purchasing are followed in accordance with E.O. 13693 and VHA Directive's.
- f. **Contractors** are responsible for picking up waste in service and transporting to a packing area, packaging appropriately, transporting to disposal site, and disposing of waste. All operations will be per applicable local, State, and Federal regulations.

All manifests and documentation will be completed as required and delivered to the Safety Office.

g. **Environmental Management Services (EMS)** is responsible for:

- 1) Transporting puncture resistant regulated medical waste, sharps and chemo containers for disposal to Building 14 in biohazard labeled red plastic bags for disposal by contracted medical waste disposal company.
- 2) Transporting Isolation/Operating Room waste in leak-proof, red biohazard labeled bags in containers to Building 14 for disposal by authorized contractor.
- 3) Maintaining required documentation of transportation disposal.
- 4) Ensures contractor packages waste appropriately, and provides transportation and disposal within Federal, State and local regulations.

h. **Operating Room/Nurse Manager** is responsible for ensuring isolation/operating room waste is placed in leak-proof biohazard labeled bags and placed in appropriately labeled containers.

i. **Laboratory Section** is responsible for:

- 1) Placing waste biohazard agents in leak-proof, biohazard labeled bags. Bags are then placed into rigid, leak-proof containers for collection by EMS and transport to the facility's satellite waste accumulation area.
- 2) Disposing of human blood samples as described above.

5. **REFERENCES:** 40 CFR, Parts 260, 263, 270-272; Joint Commission-Environment of Care Standards; EPA; Executive Order 13693; VHA Directives; Colorado Department of Public

Health and Environment; Utah Public Health; Medical Center Memorandum Hazardous Material Management Plan No. 007-8; Medical Center Memorandum Asbestos Management Plan No. 138-15.

6. ATTACHMENTS:

- Attachment A: HAZARDOUS WASTE DISPOSAL
- Attachment B: MANAGEMENT AND DISPOSAL OF COMPRESSED GAS CYLINDERS
- Attachment C: MANAGEMENT AND DISPOSAL OF FLUORESCENT LAMPS & BALLAST

7. COORDINATION: 001, 11, 137, 138 and NAGE.

8. RESCISSION: Medical Center Memorandum No. 007-10, Disposal of Hazardous Waste, dated May, 2014.

Michael T. Kilmer
Director

DISTRIBUTION: D, NAGE

HAZARDOUS WASTE DISPOSAL

1. When hazardous waste accumulates and disposal is necessary, the generating Service shall contact the GJVHCS Safety Office, who shall facilitate waste collection and appropriate disposal.
2. This notice will identify the material (as identified in the Hazardous Materials Inventory), number of containers, the amount in each container, and state (liquid, solid, or gas).
3. Periodically, the Safety & Occupational Health Office (SOHO), and Supervisor EMS will determine the amount of hazardous waste requiring disposal. When sufficient quantities have accumulated, the SOHO will initiate the disposal process. The inventory of hazardous waste requiring disposal will be maintained by the Safety Office.
4. Hazardous waste requiring disposal will remain within a satellite accumulation area within the Service area until collection by the Safety Office.
5. Buckets, cans, or any other receptacles that contain materials classified as hazardous and are no longer of use will be disposed of as hazardous waste and shall be turned in for disposal when notified of a disposal pick up, unless considered RCRA empty.
6. Volatile chemicals shall not be disposed of by evaporation in a chemical fume hood or to the atmosphere.

SERVICE SPECIFIC:

Laboratory Service safety policies are part of the program by reference.

Pharmacy Service will control “P” and “U” listed pharmaceutical hazardous waste. It will be collected and disposed of using a “reverse distributor” program in accordance with state and federal regulations, or by the Safety Officer at a designated licensed Waste Disposal facility. Pharmacy services and the Safety Office shall maintain all waste disposal manifests associated with pharmacy waste.

Safety Office is responsible for Dental waste amalgam collection and disposal in accordance with service policy and state and federal regulations.

MANAGEMENT AND DISPOSAL OF COMPRESSED GAS CYLINDERS

1. Empty, reusable tanks and cylinders will be transported to the dock area, south of the hallway between Building 1 and Building 20, placed in the secured storage cage and secured from movement. SCMS shall coordinate return of compressed gas cylinders with the gas supplier/vendor. Cylinders are considered empty when the cylinder pressure gauge on the regulator registers approximately twenty-five (25) psig (pounds per square inch, gauge) or less.
2. Empty cylinders will be stored separately from full cylinders.
3. Non-reusable cylinders that are empty will be recycled as scrap metal, where allowed by local code and vendor approval. "Empty" cylinders shall be depressurized to atmospheric pressure prior to recycling. Cylinders which are equipped / configured with pressure vent valves shall have those valves activated to depressurize prior to recycling. If the cylinder is not empty, cannot be depressurized safely, or is a "listed" hazardous waste, the guidance for disposal contained in Attachment A shall be followed. When doubt exists related to the method(s) of disposal, the vendor / supplier / manufacturer shall be contacted for specific disposal instructions.
4. Anesthetic waste gases shall be vented directly to the outside through a dedicated exhaust system and stack located away from any intakes. This system will be checked for leaks every six (6) months.

MANAGEMENT AND DISPOSAL OF FLUORESCENT LAMPS & BALLAST

This MCM provides procedural requirements for the management and disposal of fluorescent and High Intensity Discharge (HID) lamps and lighting ballasts. Inoperable fluorescent and HID lamps are classified as "Universal Waste," and shall be collected from their location of use by Facility Engineering Electricians at the time of lamp and/or ballast maintenance and/or replacement. Disposal of such lamps and ballast shall be accomplished via recycling at the Mesa County Hazardous Waste Disposal Facility. Fluorescent lamps, and ballast associated with them, shall not be disposed as municipal solid waste.

1. Lamps and ballasts which are removed from service shall be accumulated in a designated, "Universal Waste" accumulation container, which will be stationed on the north loading dock of Building 1. The container, with waste lamps/ballast inside, can remain in place for a maximum period of one (1) year from the date on which lamps were first placed in the container.
2. Precautions shall be taken during handling, movement, and containerizing of lamps to prevent breakage.
3. If possible, use the box from which the replacement (new) lamps were taken as a transport medium for the lamps to be moved to the Universal Waste container.
4. The Universal Waste accumulation container shall remain closed except when adding or removing lamps/ballast.
5. Broken lamps must be bagged and boxed separately. The inner bag should be sealed with tape or equivalent fastener. Broken lamps will be disposed of as Hazardous Waste.
6. The box will be labeled with the words "Universal Waste - Lamps" and dated with the date that the first lamp was placed into the box.
7. The Safety Office shall have responsibility for monitoring the load status of the Universal Waste container and the scheduling of lamp recycling/disposal with the Mesa County Hazardous Waste Disposal Facility.

EMPLOYEE ON-THE-JOB INJURY, OCCUPATIONAL ILLNESS, OR DISEASE

1. **PURPOSE:** The purpose of this memorandum is to establish Medical Center policies and procedures to reduce accidents among employees, provide for a system of filing accident reports and Office of Workers' Compensation Programs (OWCP) forms, and assign program responsibilities to all operational levels in the Medical Center.

2. **POLICY:** It is the policy of this Medical Center to:

a. Provide a safe, hazard-free work environment for all employees and continuously take all necessary actions to eliminate or drastically reduce the accident and injury rates at this Medical Center.

b. Provide emergency diagnosis and initial treatment of injury or illness during working hours. (Note: Occupational illness will not receive care through Employee Health until the claim has been accepted by the U.S. Department of Labor as work-related).

c. Authorize employees who suffer an on-the-job injury to visit a private physician of their choice for treatment. (Note: Employees injured at work may elect to receive care through Employee Health.)

d. Provide training to managers, supervisors, and employees on accident prevention and OWCP benefits.

e. Comply with all reporting requirements and provide assistance to employees in developing OWCP claims.

f. Provide, where possible, alternative duty assignments for employees who are able to work but unable to carry out their normal duties.

3. **PROCEDURES:**

a. **Introduction:** The Federal Employees Compensation Act (FECA) provides for the rights of employees to medical care and hospitalization for injury, illness, and disease proximately caused by the conditions of employment; compensation for loss of wages or disability resulting from work-related injury, illness, or disease; vocational rehabilitation in cases of permanent disability; and survivor benefits and burial expenses for work-related death. The FECA is the sole remedy for employees in the case of work-related injury, illness, disease, or death. An employee or his/her survivors are **not** entitled to sue the U.S. Government in such cases or to recover damages under any other statute.

b. **Definitions:**

1) A traumatic injury is defined as a wound or other condition of the body caused by external force, including stress or strain. The injury must be identifiable by time and

place of occurrence and member of the body affected. It must be caused by a specific event or incident, or series of events or incidents within a single day or work shift. Traumatic injury also includes damage to or destruction of prosthetic devices or appliances, including eyeglasses and hearing aids if they were damaged incidental to personal injury requiring medical care.

2) An occupational disease is defined as a condition produced in the work environment over a period longer than one workday or shift. It may result from systemic infection, repeated stress or strain, exposure to toxins, poisons, or fumes, or other continuing conditions of the work environment.

3) The term "physician" includes surgeons, osteopathic practitioners, podiatrists, dentists, clinical psychologists, optometrists, and chiropractors. However, chiropractors may be reimbursed only for treatment consisting of manual manipulation of the spine to correct a subluxation demonstrated by x-ray.

c. **Reporting Injuries:** An employee who suffers a traumatic injury while at work or while performing official duties away from the work site, must immediately report the injury to his or her supervisor. In the case of an emergency such as chest pain, respiratory distress, eye injury, bleeding, sudden change in level of consciousness, employee should report immediately to the Emergency Department (ED). Complete form CA-1 within two work days and print a copy of the CA-1 with the electronic signatures. The employee and the supervisor must sign the CA-1 using blue ink and get the original form to Human Resources Workers Compensation Coordinator as soon as possible but no later than 5 days after the injury. Employees should report even minor injuries. This is for their protection should the minor injury develop into a more serious condition. The supervisor will:

- 1) Create Incident Report
- 2) Complete/Validate/Sign Incident Report
- 3) Initiate the CA-1 through the Automated Safety Incident Surveillance Tracking System (ASISTS) Program.
- 4) Inform the employee that the accident report has been initiated and that he/she needs to complete the employee section.
- 5) Review the front of the Form CA-1 for completeness and accuracy, and assist the employee in correcting any deficiencies.
- 6) Sign and return to the employee the receipt attached to Form CA-1 and furnish a copy of the form to the employee, if requested.
- 7) Inform the employee of the right to elect continuation of pay, annual leave, or sick leave if time loss will occur, and inform the employee of their obligation to return to work as soon as possible.

8) Refer or accompany the employee to Human Resource Workers Compensation Coordinator for non-emergency treatment.

9) Complete the Form CA-1 on the employee's behalf if the employee cannot complete it within five working days.

Human Resources Workers Compensation Coordinator will forward the Form CA-1 to OWCP or file it in the Employee Medical Folder (SF-66-D), depending on the circumstances of the case. Note: HR cannot transmit the CA-1 or CA-2 without the pen and ink signature.

d. **Occupational Illness:** An employee who incurs an occupational illness should notify their supervisor who will initiate a CA-2 in ASISTS. Claims for occupational illness must also be accompanied by a narrative response to a list of questions which will be provided to the claimant by Human Resources Workers Compensation Coordinator. The supervisor will review the CA-2 and the narrative and assist the employee with corrections, receipt for the form, and complete the reverse side of the form as outlined above for Form CA-1. The supervisor will also complete a response to the narrative provided by the employee. The supervisor should then forward the form and the narrative responses to Human Resources Workers Compensation Coordinator.

Human Resources Workers Compensation Coordinator will coordinate with the employee and the supervisor in the development of the claim. In general, medical care for occupational illness can only be authorized by OWCP. Continuation of pay is not authorized for occupational illness.

e. **Medical Care:** When an employee requires medical treatment for a work-related injury, he or she is entitled to the initial selection of a physician. The employee may be seen by the Employee Health physician or (on off tours) by the Medical Officer on Duty for emergency treatment, if necessary. Following emergency treatment, the employee may elect further care with VA Employee Health or may seek further treatment with his or her private physician if further treatment is necessary. The employee may elect the VA as a physician of choice. When an employee needs to see a private physician, he or she should be referred to the Human Resources Workers Compensation Coordinator. The Human Resources Workers Compensation Coordinator will have the employee contact the physician and, when an appointment has been made, issue a Form CA-16, authorizing treatment, when appropriate.

Under OWCP regulations, the physician chosen should normally be located within 25 miles of the place of injury, the work site, or the employee's home. Once an employee has made a choice of physicians, he or she may not change physicians without prior authorization from OWCP. Once selected, the attending physician may engage the services of other facilities which provide x-ray and laboratory services, or specialists whom the physician feels are necessary to consult. Certain forms of medical treatment, however, must be approved by OWCP in advance in order to guarantee payment. These include such things as surgery of any kind, private hospital rooms, physical therapy, orthopedic appliances, wheelchairs, and other items. Employees who have questions about authorization to obtain any service should contact the Human Resources Workers Compensation Coordinator.

f. **Continuation of Pay (COP):** An employee's regular pay may be continued for up to 45 calendar days of lost time due to disability and/or medical treatment following a traumatic injury. COP is subject to income tax, retirement, and other deductions. When the employee stops work on the day of injury, COP begins at the start of the next official workday. The day of injury is counted as excused absence. If an employee is injured at work but continues working and subsequently time is lost because of the injury, the first day off duty is counted against COP. Weekends and holidays are counted against the 45-day limitation. In addition, when a partial day of work is lost to obtain medical treatment, this counts as a full day of COP. COP must be taken within 45 days of the date of injury. An employee may use annual or sick leave to cover all or part of an absence due to injury. If an employee elects to use leave, each full day or partial day for which leave is taken will be counted against the 45 days of entitlement. Therefore, while an employee may use COP intermittently along with sick leave or annual leave, entitlement is not extended beyond 45 days of combined absences. If an employee has elected to use annual or sick leave and later wants to change to COP, the change may be made, subject to the 45-day limitation. All periods of COP must be supported by medical evidence.

g. **Controverting Continuation of Pay.** Sometimes the agency may object to paying continuation of pay for one of the reasons provided by regulation. This action is called controversion. The supervisor may controvert a claim by completing the indicated portion of Form CA-1 and submitting detailed information in support of conversion to OWCP. Even though a claim is controverted, the employee's regular pay must be continued unless certain specific conditions apply. The Human Resources Workers Compensation Coordinator will advise the supervisor on whether or not these conditions are applicable. COP should not be stopped until the Human Resources Workers Compensation Coordinator receives medical information from the attending physician stating the employee is no longer disabled for work.

1. The Human Resources Workers Compensation Coordinator receives notice from OWCP that continuation of pay should be terminated.
2. The 45-calendar day entitlement expires.

h. **Compensation Benefits:** If the employee remains disabled beyond the 45-day COP period, he or she may apply for disability compensation. An employee without dependents is entitled to compensation at the rate of $66 \frac{2}{3}$ percent of annual salary. With dependents, he or she is entitled to 75 percent of salary. These benefits are not taxable. Further details on compensation benefits are available from the Human Resources Workers Compensation Coordinator.

i. **Alternative Duty Assignments (Light Duty).** If the attending physician indicates that the employee can perform duties within certain restrictions, the Service must make every effort to provide an alternative duty assignment for the employee. If there are questions regarding the employee's ability to perform light duty, supervisors should seek advice from Ergonomics/Employee Health. The Employee Health physician will review the medical evidence and may contact the attending physician to clarify the employee's duty status.

Supervisors should not contact an employee's physician except through the Employee Health

Physician. Each Service Chief is responsible for establishing, in advance, alternative duty assignments within their Service. A brief position description will be developed for each alternative duty assignment in the service and a copy of this position description will be forwarded to the Human Resources Workers Compensation Coordinator. (The format for alternative duty position descriptions is in Attachment C to this policy memorandum.) The Human Resources Workers Compensation Coordinator will maintain a file of alternative duty assignments within the Medical Center, and will assist Services with alternative duty placements when none are available within the Service. In general, however, Services should make every effort to locate alternative duty assignments within the service for injured employees.

j. **Return to Duty:** An employee returning to duty from a continuation of pay or compensation status must present satisfactory evidence of his or her ability to perform regular duties and be cleared by the supervisor before reporting for work. The supervisor will review the medical evidence to determine if the employee can resume their regular duties or will need an alternative duty assignment. Human Resources Workers Compensation Coordinator will need a copy of these documents.

k. **Accident Investigation:** This will be the responsibility of the immediate supervisor. Each accident or injury should be thoroughly investigated to determine its cause and to develop measures for preventing future incidents of a similar nature. When appropriate, the Service Chief may appoint additional personnel within the service to investigate accidents and make recommendations. The Safety and Occupational Health Specialist will be available to assist and advise service chiefs and supervisors in performing investigations. In conducting investigations, Supervisors must comply with applicable provisions of the Department of Veterans Affairs-National Association of Government Employees Master Agreement. Investigations of all lost time accidents will be reviewed by the Safety and Occupational Health Specialist and by the Accident Review Team.

1) **Penalties:** Any person who makes a false statement to obtain Federal Employees' Compensation or who accepts compensation payments to which he or she is not entitled, is subject to a fine of no more than \$2,000 or imprisonment for no more than one year, or both. Any person charged with the responsibility for making reports, in connection with an injury who willfully fails, neglects, or refuses to do so; knowingly files a false report; induces, compels, or directs an injured employee to forego filing a claim; or willfully retains any notice, report, or paper required in connection with an injury, is subject to a fine of no more than \$500 or imprisonment for no more than one year, or both.

4. **RESPONSIBILITIES:**

a. **Medical Center Director** is responsible for compliance with compensation laws at this Medical Center and for the overall direction of the Medical Center fire and safety programs.

b. **Chief, Human Resources Service** is delegated full authority and responsibility for the overall administration of the (OWCP) employee on-the-job injury program at this Medical Center. In this capacity he or she will:

- 1) Ensure that employees are given up-to-date information on benefits and procedures for work-related injuries, illnesses, diseases, or death, and advise them of their rights and responsibilities.
- 2) Authorize continuation of pay in traumatic injury cases and notify the service concerned, the Safety Officer, and the Fiscal Officer of such authorization.
- 3) Controvert continuation of pay (COP) under appropriate conditions.
- 4) Ensure that treatment for on-the-job injuries is authorized, that the procedures of OWCP are followed, and that approval of OWCP is secured in advance when required.
- 5) Provide training to supervisors in OWCP policies and procedures.

c. **Hospital Safety Officer** will provide annual environment of care, fire, and safety training to Service supervisors, conduct an organized fire and safety inspection program, compile on-the-job injury statistical data and reports, and maintain liaison with the Occupational Safety and Health Administration (OSHA).

d. **Consolidated Patient Accounts Center (CPAC) Coordinator** will collect all chargeable bills for medical treatment provided to employees by the VA.

e. **Employee Health Physician** will provide non-emergency medical care to hospital employees for injury or illness caused by their employment, complete medical records required in processing compensation, ensure that complete information is entered in the concerned employee's health record, and will be primary liaison between this hospital and the employee's private physician when necessary or provide follow-up care for injuries if designated to do so by employee and indicated by condition.

f. **Medical Officer of the Day (MOD)** will provide for emergency care, during evening and night shifts, weekends, and holidays, will provide authorized medical care for on-the-job injury. Following initial treatment, the MOD should refer the employee to their private physician for follow-up on the next working day or arrange for VA follow-up if that is the choice of the employee. **The supervisor, based upon the physician's recommendation, is the only person authorized to release an employee from duty.**

g. **Service Chiefs will:**

- 1) Provide overall training & administrative direction of the Occupational Safety and Health Program within their Service.
- 2) Identify alternative duty work assignments which are suitable for employees injured on the job and prepare appropriate position descriptions.
- 3) Ensure that policies and procedures governing occupational injury or illness

and alternative duty work assignments are communicated to all employees within their service.

h. Supervisors will:

- 1) Ensure to the maximum extent possible, that the work site is safe and free of hazards, which may contribute, to accidents and/or injury to their subordinates.
- 2) Advise employees of their responsibility to report injuries, illnesses, and diseases and of their right to claim benefits under the compensation laws.
- 3) Assist employees in preparing claims and in submitting required additional reports. This includes completing the supervisory portion of OWCP forms as required. Employees shall not complete the supervisor's portion of the CA-1; this is the supervisor's responsibility.
- 4) Advise employees of their appeal rights and their right to representation in pursuing their claims.
- 5) Investigate all accidents and injuries, which take place in their area of responsibility and take steps to avoid recurrence of similar incidents. In those instances where supervisors disagree with any aspect of a claim or wish to controvert continuation of pay, a full written explanation will be prepared and provided to the Human Resources Workers Compensation Coordinator with the CA-1.
- 6) Support training provided by the Service in the Safety & Environment of Care Program.

i. Employees will:

- 1) Ensure to the extent possible that their work area is free of hazards which might create unsafe working conditions, report safety hazards to proper supervisory authorities, and perform their duties in a careful and safe manner. This includes the proper use of tools and equipment and the exercise of correct body mechanics for lifting, bending, stooping, etc. in accordance with provided training.
- 2) Promptly report any job-related injury, illness, or disease, to their supervisor and complete Form CA-1 for occupational injury or form CA-2 for occupational disease.
- 3) Obtain from the attending physician a fully documented medical certification for all periods of lost time due to work related injury, and provide such evidence to their immediate supervisor.
- 4) Provide Human Resources Workers Compensation Coordinator with required forms from provider including CA-17 and CA-20. Employee will provide updated CA-17 after every doctor visit.

5) Notify the attending physician that restricted duty assignments are available at the Medical Center.

6) Comply with treatment plan to recover and return to full duty.

5. **REFERENCES:** OWCP Regulation 810; Title 5, U.S.C., Chapter 81; JCAHO.

6. **ATTACHMENTS:**

Attachment A, Common Office of Workers Compensation Forms
Attachment B, Instructions to Employees Injured on the Job
Attachment C, Sample Light Duty Assignment

7. **COORDINATION:** 001, 007, 04, 05, 05-EH, 11, 111, NAGE.

8. **RESCISSION:** Medical Center Memorandum No. 05-26, Employee On-The-Job Injury, Occupational Illness, or Disease dated May 2015.

Michael T. Kilmer
Director

DISTRIBUTION: A

COMMON OFFICE OF WORKERS COMPENSATION FORMS

<u>Form NO.</u>	<u>Title</u>
CA-1	Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation
CA-2	Federal Employee's Notice of Occupational Disease and Claim for Compensation
CA-2a	Notice of Employee's Recurrence of Disability and Claim for Pay/Compensation
CA-5	Claim for Compensation by a widow, widower, and/or children
CA-6	Official Superior's Report of Employee's Death
CA-7	Claim for Compensation on Account of Traumatic Injury or Occupational Disease
CA-7a	Time Analysis Form
CA-7b	Leave Buy-back Worksheet/Certification and Election
CA-16	Authorization for Examination and/or Treatment
CA-17	Duty Status Report
CA-20	Attending Physician's Report
CA-20a	Attending Physician's Supplemental Report
CA-35	Federal Injury Compensation Checklist
HCFA-1500	American Medical Association Standard Health Insurance Claim Form (This medical provider's claim form may also be designated OWCP-1500, RRB-1500, or CHAMPUS 501, all of which are acceptable to OWCP).

INSTRUCTIONS TO EMPLOYEES INJURED ON THE JOB

1. These instructions are provided to inform you of your rights and responsibilities under the Federal Employees' Compensation Act. Please read them carefully. Failure to follow proper procedures could affect your benefits. **IMPORTANT: IF THE EMPLOYEE HEALTH PHYSICIAN OR MEDICAL OFFICER OF THE DAY RECOMMENDS PUTTING YOU OFF DUTY, YOU MUST OBTAIN YOUR SUPERVISORS AUTHORIZATION BEFORE LEAVING THE MEDICAL CENTER.**

2. **You are eligible for emergency treatment by our ER, MOD, and for non-emergent treatment** by our Employee Health Physician, following which you have a right to request treatment by a physician of your choice provided that the physician is located within a 25 miles radius of the Medical Center, or your residence. Chiropractic care is authorized only for treatment consisting of manipulation of the spine to correct a subluxation demonstrated by x-ray to exist. If you incur expense for any other kind of chiropractic care, OWCP will **not** be responsible for payment.

3. Once you have made a choice of physicians (except for immediate first aid in ER or Employee Health following an accident) this physician becomes the **only** physician authorized for follow-up care unless prior approval for a change of physicians is granted by OWCP. This primary physician may make referrals to specialists or for ancillary treatment such as physical therapy. These referrals will be honored by OWCP without prior approval. **ANY SURGERY, EXCEPT EMERGENCY SURGERY, MUST HAVE PRIOR APPROVAL OF OWCP.**

4. If you elect to be treated by a private physician, you must see the Personnel Specialist in the Human Resources Workers Compensation Coordinator Office. He/She will give you a CA-16, Authorization for Examination and/or Treatment, to take to your physician. If you are unable to come to Human Resources due to the severity of the injury, call extension 5065 to arrange to have the CA-16 mailed to your physician. You are responsible for prompt submission of medical reports. After your initial visit to your doctor, a CA-20, Attending Physician's Report, should be given to your physician each time you report for treatment. Your doctor should mail the completed form to Human Resources Workers Compensation Coordinators Office. Please request these additional forms from Human Resources, as you need them.

1) If your treating physician recommends that you be sent off duty following a job-related injury, your pay will be continued for the period of total disability up to a maximum, of 45 calendar days. Continuation of pay must be supported by medical documentation that shows you are incapacitated for any duties because of your work-related injury. Continuation of pay will be terminated if medical evidence is not received within 10 work days from the start of COP or the beginning of disability. You will be charged sick leave, annual leave, leave without pay, or absence without leave, as appropriate, for any absence not supported by medical documentation. If you are able to perform some duties (within certain medical restrictions), an alternative duty assignment will be made available to you. You are required to report for work when your attending physician determines that you are able to perform any type of duty.

5. If, after you return to duty following the original injury, your physician again determines that you are medically unable to perform any duty because of the same injury, you must contact the Human Resources Workers Compensation Coordinator immediately. Please keep careful records of the days and times you were unable to work because of this injury.

Attachment C
 Medical Center Memorandum No. 05-26
 May 2018

LIGHT DUTY ASSIGNMENTS

SERVICE _____ SECTION _____ LOCATION _____

WORK SCHEDULE: DAYS/WEEK _____ HOURS/DAY _____

DUTIES _____

Specify the usual work requirements of the position. Check whether employee would perform these tasks or is exposed continuously or intermittently, and give number of hours.

ACTIVITY	CONTINUOUS	INTERMITTENT	TIME
a. Lifting/Carrying: State Max Wt.	#lbs.	#lbs.	PER DAY HRS.
b. Sitting			PER DAY HRS.
c. Standing			PER DAY HRS.
d. Walking			PER DAY HRS.
e. Climbing			PER DAY HRS.
f. Kneeling			PER DAY HRS.
g. Bending/Stooping			PER DAY HRS.
h. Twisting			PER DAY HRS.
i. Pulling/Pushing			PER DAY HRS.
j. Simple Grasping			PER DAY HRS.
k. Fine Manipulation (Includes keyboard)			PER DAY HRS.
l. Reaching above shoulder			PER DAY HRS.
m. Driving a vehicle (Specify)			PER DAY HRS.
n. Operating Machinery (Specify)			PER DAY HRS.
o. Temp. Extremes			PER DAY HRS.
p. High Humidity			PER DAY HRS.
q. Chemicals, Solvents, etc. (identify)			PER DAY HRS.
r. Fumes/Dust (Identify)			HRS. PER DAY
s. Noise (Give dba)			PER DAY HRS.
t. Other (Describe)			PER DAY HRS.

SUPERVISOR: _____ NAME _____ SIGNATURE _____

SERVICE CHIEF: _____ NAME _____ SIGNATURE _____

BAR CODE MEDICATION ADMINISTRATION (BCMA) CONTINGENCY PLAN

1. **PURPOSE:** To establish policies and procedures to ensure medication information is available to Medical Staff for inpatients in the event that Bar Code Medication Administration (BCMA) becomes inaccessible.

2. **POLICY:** Should BCMA and the Computerized Patient Record System (CPRS) become unavailable to staff, medications will be administered through the use of a paper Medication Administration Record (MAR). The MAR will be printed from a designated computer workstation connected to a back-up power supply with a dedicated printer attached. The decision to initiate the use of the contingency plan will be made by the Associate Chief Nurse (ACN)/Nurse Manager or designee during normal business hours and by the Nurse Officer of the Day (NOD) during off-tour and weekend hours.

3. **RESPONSIBILITIES:**

a. The **Medical Center Director** has overall responsibility for reviewing and approving the recommendations and actions for the BCMA contingency plan.

b. The **Chief, Information Technology Service (ITS)** is responsible for assigning staff to ensure:

1) MAR contingency software is loaded and maintained on a computer workstation that has been designated as the MAR contingency workstation.

2) Updating and modifying the program when deficiencies are identified by staff.

3) Configuration of a MAR patient file for each inpatient and ensuring the MARs are consistently and fully downloaded to the identified workstation on the ward in real time.

4) Ensuring a slave (hardwired) printer is configured and tested for use when the network printers are unavailable; the slave printer's software drivers have been configured so the printed MAR is useable for staff.

5) Providing notification to staff of planned system downtime.

c. **ACN/Nurse Manager/NOD** is responsible for:

1) Initiating the contingency plan and notifying the Administrative Officer of the Day (AOD).

2) Ensure patient care units continue with safe uninterrupted patient care.

d. **BCMA Coordinator** is responsible for:

- 1) Ensuring all nursing staff are trained and able to access medication information (MAR) via the designated back-up computer.
- 2) Assists to ensure all back-up system testing occurs as needed and any identified problems are reported to the appropriate individuals.
- 3) If a problem is identified, will ensure 24-hour testing is available and corrections are made.
- 4) During BCMA/CPRS failure, will serve as a resource in troubleshooting and initiating the contingency plan.

e. **Supervisor, Pharmacy Section** is responsible for:

- 1) Printing pick list for comparison to MARs when tests are conducted to ensure all medications are showing in the back-up system.
- 2) Identifying staff to consult/assist inpatient nursing staff, as needed, during system downtime.
- 3) Identifying staff to enter any handwritten orders into the computer when services resume. They will provide notification to nursing when BCMA operations can be resumed following a computer failure. It should not be resumed until all written orders have been entered into BCMA.

f. **Nursing Staff** are responsible for implementing and following the BCMA contingency plan.

- 1) The charge nurse or designee will log into the BCMA backup software (BCBU icon), choose PW (for your selected ward), current (orders), 3 days (days of MARS), 1, barcode backup software BCBU (printer).
- 2) Nursing will also be responsible for logging into the BCBU program daily to ensure backup medication data has pulled from the server and this will be recorded in a file on the unit.

g. **Providers** will follow established BCMA Contingency Plan procedures.

h. **Engineering Services** will ensure back up PC's are connected to emergency power.

4. **PROCEDURES:** The BCMA barcode backup software (BCBU) provides real time updates to the MAR. The BCBU workstation must remain on at all times as it is continually receiving information from VistA.

a. When BCMA is down during normal business hours the ACNS or Nurse Manager on the ward will notify ITS at extension 4357.

b. During off-tours: the nurse in charge will notify the NOD at extension 3291. The NOD will then notify the AOD who will contact a member of the ITS staff at 260-3391.

c. During normal business hours: OI&T will investigate and provide the ACN/Nurse Manager with an estimated downtime (i.e., >30 minutes) within 15 minutes. Staff will be directed by their ACN/Nurse Manager if MAR's are to be printed via the BCBU system.

d. During off-tours: The charge nurse or designee on the ward will begin to print MARs from the back-up system located in the nurses' station on the unit and begin passing medications via MARs. Due to limited availability of OI&T staff during off-tours, assume the downtime will be greater than 60 minutes.

e. Once the contingency plan is initiated, physicians and other clinical staff will be notified of the system being down via email if available or if not, via telephone.

f. If a patient is administered medication during a BCMA downtime, the MAR will be stored on the medication cart until time of discharge or for a period of 24 hours after resuming use of the BCMA system, whichever comes first.

g. Any orders received during down time, will be written on a paper order sheet (VA Form 10-1158). Nurses will enter orders into CPRS. Carbon copies of new orders are hand-carried to the Pharmacy for review and filling. Physicians must sign these within 24 hours.

h. Paper MARs will be part of the official hard copy medical record. Nurses must put a note in CPRS (Titled: BCMA DOWN) about the use of paper MAR and the period for which it was used.

i. It is not necessary to enter information into BCMA after operations have resumed. The ward medical support assistant or unit nurse will make sure that the paper MAR's are sent to medical records for filing in the patient's record.

j. If BCMA becomes usable in the middle of a major medication pass, the MAR should be used until the Pharmacy has given the approval for resumption of the use of BCMA.

k. During normal business hours, once BCMA is available, the Pharmacy will complete any unfinished orders and the Pharmacy Supervisor will then contact the ACN/Nurse Manager to resume use of the BCMA system. During off-tours, resumption of the use of BCMA will be done by OI&T, who then will alert the NOD to notify staff that BCMA is now usable.

5. REFERENCES:

- a. VHA National Center for Patient Safety.
- b. Fargo VAMC Management of Information Circular IM-16, Subj: BCMA Contingency Plan.

6. **ATTACHMENTS:**

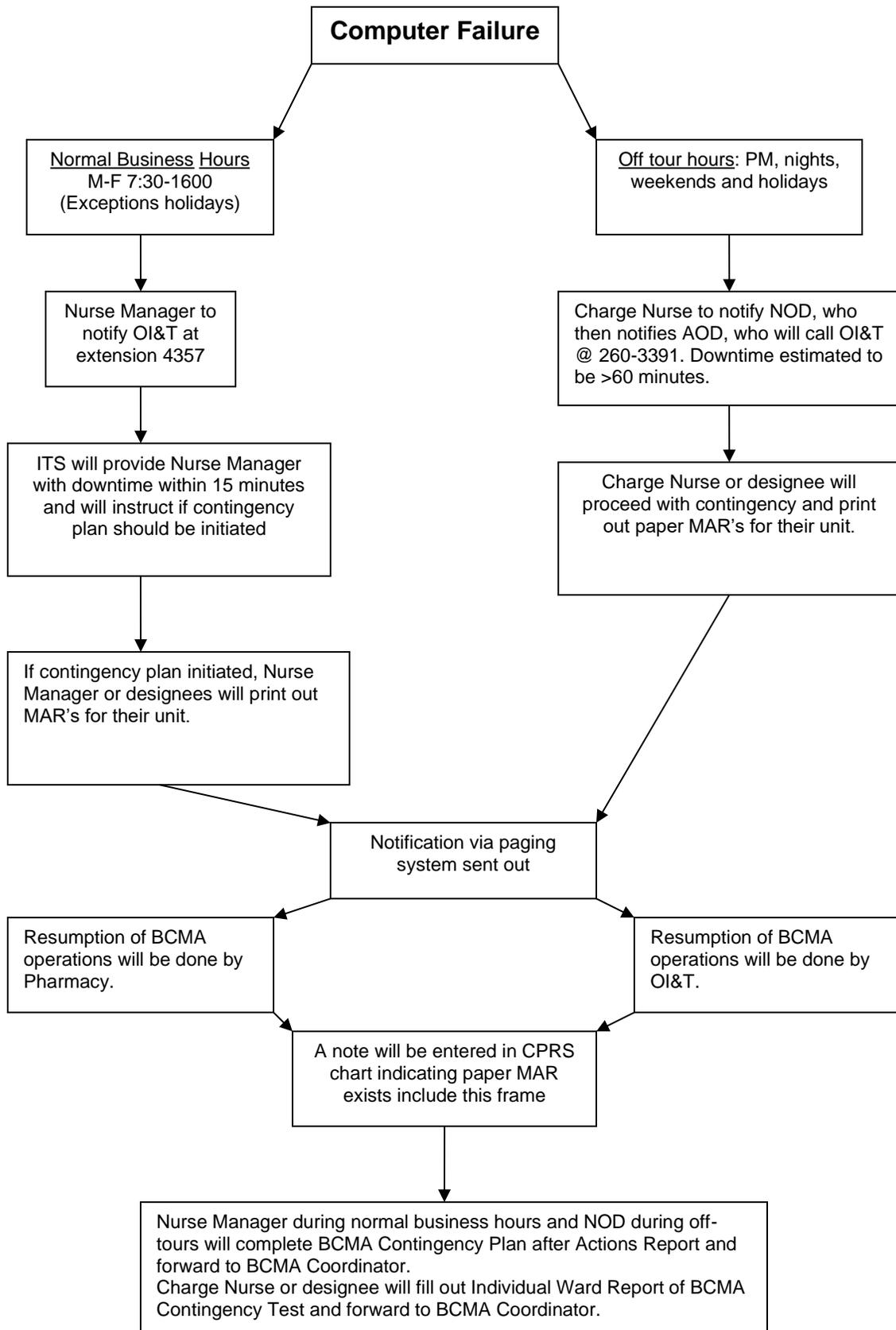
- a. Attachment A - BCMA Contingency Plan Flow Chart.
- b. Attachment B - BCMA Contingency Plan After Action Report.

7. **COORDINATION:** 001, 11, 003, 111, 112, 116, 119, and ITS.

8. **RESCISSION:** Medical Center Memorandum No. 003-31, Bar Code Medication Administration Contingency Plan, dated April 2015.

Michael T. Kilmer.
Director

DISTRIBUTION: E (00/001, 11, 003, 111, 112, 116, 119, ITS, 142D)



BCMA Contingency Plan After Action Report

INSTRUCTIONS: The ACN/Nurse Manager or designee will complete this report any time the BCMA Contingency Plan is initiated. The completed report will be submitted to the Associate Director for Patient Care Services (AD/PCS) for review and action.

Date & Time BCMA Contingency Plan was initiated:

Unit/Ward plan was initiated:

Date & Time Electronic Medical Record became available for clinical activity:

Did the Unit/Ward experience any difficulties with the MAR program?

No (If No, submit the report to the committee for review)

Yes (If Yes, complete the remaining portion and submit to the AD/PCS)

Mark all areas where difficulties were experienced using the BCMA Contingency Plan:

- The MAR Icon was not present on the desk top
- The MAR file was out of date (More than two hours old)
- The print size (font) on the MAR printout was too small to read
- The printer did not work
- Staff did not know how to print out the MAR
- Patient list was incomplete on the MAR
- Followed the printed directions but the MAR did not print out
- The print out was unreadable (blurred, fuzzy)
- No printer was available to print out the MAR
- Other (Specify)

How long was the unit/ward unable to pass medication the patients?

30 min 1 Hr 2 Hrs 3 Hrs 4 Hrs More than 4 Hrs

How long after the electronic record was unavailable did the unit wait to print the MAR?

30 min 1 Hr 2 Hrs 3 Hrs 4 Hrs More than 4 Hrs

Did the unit/ward submit a task log or notify IRM of the identified problem?

Yes No Unable to submit a work order Task Number

Did the unit/ward call the OI&T help desk for assistance with the BCMA Contingency Plan?

No Yes Yes (Left Message) Yes (No Answer, No Message)

Did the unit/ward call any other resources to assist with the BCMA Contingency Plan problems?

Specify:

On the back side, describe other difficulties experienced in using the MAR Program.

Emergency Operations Plan (EOP)

Table of Contents

I. Basic Plan (Memorandum 007-1)

1. Overview	3
2. Purpose	3
3. Policy	4
4. Program Responsibilities	5
A. Director	5
B. Associate Director	6
C. Chief of Staff	6
D. Emergency Preparedness Coordinator	6
E. Service Chiefs	7
F. Medical Center Employees	7
G. Emergency Management Committee	7
5. Hazard Vulnerability Analysis	8
6. Emergency Do's and Don'ts	8
7. Concept of Operations	9
8. Incident Command System	10
9. Reporting Procedures	11
10. EOP Development and Maintenance	12
11. References	12
12. Attachments	
A. Acronyms	
B. Issue Brief	
C. Operating Status and Capability Assessment Report (OSCAR)	
D. Situation Report (SITREP)	

II. Functional Annexes (Separate from the Basic Plan)

A. ICS-Hospital Command Center (HCC) Procedures	
B. Communications	
B-1 Important Emergency Phone Numbers	
B-2 Use of Two Way Radios	
B-3 Cascade Call Back System	
C. Medical Treatment Areas	
D. Damage Assessment	
D-1 Standard Operating Procedure	
D-2 Damage Assessment Flow Chart	
D-3 Rapid Evaluation Safety Assessment Form	
D-4 Detailed Evaluation Safety Assessment Form	
D-5 Fixed Equipment Checklist	
D-6 Unsearched/Locked Rooms Report	

- E. Evacuation**
 - E-1 HICS 260, Evacuation Transportation Tag
- F. Personnel Pool**
- G. Public Information**
 - G-1 Crisis Communication Plan
- H. Security, Traffic, Crowd Control**
- I. Shelter in Place**
 - I-1 Registration Form
 - I-2 Pet Safe Harboring
- J. Continuity of Operations Plan (COOP)**
- K. Demobilization Plan**
- L. Decontamination of Patients**
- M. Emergency Contracting Plan**
- N. All Hazards Emergency Cache**
- O. Emergency Color Codes**
- P. Survival Plan**
- Q. Transportation of Critical Staff to the Facility During an Emergency**

III. Incident Specific Appendices (Separate from the Basic Plan)

- 1. Fire**
- 2. Hazardous Materials**
 - 2.1 Quick Reference
- 3. Weapons of Mass Destruction (WMD)**
 - 3-1 Bioterrorism Agent Summary
 - 3-2 Notification Protocol
 - 3-3 Bioterrorism Infection Practices for Management
 - 3-4 Agent Specific Recommendations
- 4. Utility Failure**
- 5. Bomb Threat**
 - 5.1 Bomb threat Checklist
- 6. Behavioral Emergency**
- 7. Active Shooter**
- 8. Hostage/Barricade Situation**
- 9. Mass Casualty / External Emergency**
- 10. Mass Fatality Incident**
- 11. Thunderstorm/Lightning**
- 12. Winter Storm**
- 13. Pandemic Influenza Plan**
 - 13-1 Influx of Patients Triage / Drive-Up / Parking Lot
 - 13-2 Building Six Pandemic Flu Triage Area

EMERGENCY OPERATIONS PLAN (EOP)

1. OVERVIEW:

a. The Grand Junction Veteran's Health Care System (GJVHCS) Emergency Operations Plan (EOP) has been developed to provide a comprehensive guide to responding to emergency situations that may face the facility. The EOP was created to delineate the authorities, responsibilities and procedures to be followed by staff, volunteers and community organizations to effectively respond to a disaster either within the hospital or within the community. This plan was developed under the auspices of the Emergency Management Committee with the coordination of the Emergency Preparedness Coordinator.

b. The EOP is based upon the National Incident Management System (NIMS): NIMS provides a consistent, flexible and adjustable national framework within which government and private entities at all levels can work together to manage domestic incidents, regardless of their cause, size, location, or complexity. In accordance with NIMS, GJVHCS uses the Hospital Incident Command System (HICS) and Standard Operating Procedures (SOPs) to manage emergency events. This EOP is divided into four sections:

1) Basic Plan: The Basic Plan (this document) provides general information on the Purpose, Scope, Policy, General Responsibilities and Procedures, how/why a Hazard Vulnerability Analysis (HVA) is performed and how it is used to develop the EOP, concept of operations and how the EOP is activated.

2) Functional Annexes: Contains guidance for the Incident Command structure and how it is implemented, general procedures to follow for "All Hazards" incidents.

3) Incident/Hazard Specific Annexes: These contain short, concise guidance (pre-plans) on the initial response to the HVA priority hazards, threats and events.

4) Service-level Plans: These are Service level or Site specific emergency operations plans which meet general and specific responsibilities outlined in this EOP.

2. **PURPOSE:** To establish a basic emergency operations plan for the wide range of contingencies both natural and man-made. These events may disrupt normal health care system operations and require specific and pre-planned responses to both internal and external emergencies. Because each situation is unique, the plan sets up responses and organization necessary to begin to deal with the emergency. It also assumes that the individual who is in charge of the response will use good judgment and adapt the response plan to the unique needs of the situation. This policy applies to all facilities, resources and personnel at the GJVHCS. The purpose of this plan is:

a. To attend promptly and efficiently to all individuals requiring medical attention in an emergency situation;

b. To provide maximum safety and protect patients, visitors, and staff from injury;

- c. To respond appropriately and quickly with the surrounding community's disaster plan;
- d. To protect federal property, facilities, and equipment;
- e. To satisfy all applicable regulatory requirements;
- f. To provide a logical and flexible chain of command to allow maximum use of resources;
- g. To have a clear document that eliminates unneeded definitions, obscure terms, or unique vernacular that would not be clear to all users;
- h. To maintain and restore normal services as quickly as possible following an emergency incident or disaster;
- i. To provide supportive action to the Federal response under Emergency Support Function #8 (Health and Medical).

3. **POLICY:**

a. It is the policy of the GJVHCS to continue essential patient care functions while providing special services necessary in an emergency or wide spread disaster. The plan is activated by either an internal or external emergency that cannot be handled by normal operations and/or resources of the hospital (facility). This would include the Federal Response Plan (FRP), the Mesa County Emergency Operations Plan (MCEOP), or by periodic drills required by The Joint Commission (TJC). The Medical Center has adopted Comprehensive Emergency Management Program (CEMP) for emergency programs and activities to address all hazards through the following:

- 1) **Mitigation** – reduce risk through anticipatory actions.
- 2) **Preparedness** – undertaken before an emergency and/or disaster occurs, with focus on the development of emergency operations plans and systems.
- 3) **Response** – focus on minimizing personal injury and property damage through emergency function (such as warning, evacuation, search and rescue, provision of shelter and medical service).
- 4) **Recovery** – begins immediately following an emergency and/or disaster with efforts to restore minimum services and continues with longer-term efforts to return to normal or near normal conditions.

b. The Medical Center will manage all emergency incidents, exercises and preplanned recurring/special) events in accordance with Incident Command System (ICS) organizational structures, doctrine and procedures, as defined in National Incident Management System (NIMS). ICS provides structure to facilitate activities in five major areas: command, operations, planning,

logistics and finance administration. The structure of the ICS is outlined in the Emergency Operations Plan (EOP).

4. **RESPONSIBILITIES:** Emergency preparedness is a line responsibility at every level of management at GJVHCS. Each supervisor and manager is responsible to ensure that employees are familiar with their care team or service responsibilities. The following depicts specific responsibilities:

a. Medical Center Director: is responsible for the development and implementation of the CEMP program that addresses all facilities under the control of the Medical Center for internal and external hazards, threats and events. The Director will:

- 1) Establishing an Emergency Management Committee (MCM 007-12)
- 2) Appoint an Emergency Preparedness Coordinator (EPC).
- 3) Manage and activate the All Hazards Emergency Cache in accordance with Veterans Healthcare Administration Directive 1047(1) in the event of a significant incident when required.
- 4) Approve the role of the Medical Center in the community during emergencies.
- 5) Review and approve Memorandum of Understanding (MOUs) sharing agreements for medical resources, supplies, medical care and alternate treatment sites.
- 6) In the case of an emergency, activate emergency operations plan and Incident Command System (ICS) as appropriate; and notify the Network Director.
- 7) When the Director implements the EOP, he/she will notify the Network Director.
- 8) Ensure appropriate systems are in place to provide accurate and timely information regarding personnel and other resource availability.
- 9) The Director will remain in charge of emergency operations at the (Facility) and will establish an Incident Command System (ICS) structure that is consistent with the community and those used in the Network. The overall goal is to provide continuity of patient care operations. The objectives that support this include:
 - a) Providing maximum safety for patients, visitors, and staff.
 - b) Protecting the environment, property, facilities, equipment, and vital records.
 - c) Maintaining the integrity of the chain of command.
 - d) Having a clearly defined Incident Command Structure.

e) Maintaining and restoring services as quickly as possible following an emergency incident or disaster.

b. Associate Director will serve as the Chairperson of the Emergency Management Committee (EMC).

c. Chief of Staff is responsible for the development, endorsement, training and implementation of clinical guideline protocols for the CEMP and the EOP. The Chief of Staff will:

1) Endorse all clinical treatment protocols distributed to GJVHCS health care providers addressing the delivery of patient care during an emergency.

2) Maintain coordination of emergency medical activities with the Facility Director, and Veterans Integrated Service Network leadership.

d. Emergency Preparedness Coordinator (EPC):

1) Ensures the GJVHCS Comprehensive Emergency Management Program (CEMP) meets Veterans Administration (VA), Veterans Health Administration (VHA), and other federal directives, standards and guidance;

2) Ensures TJC and Commission on Accreditation of Rehabilitation Facilities (CARF) requirements for emergency management are accomplished;

3) Provides ongoing education for key facility staff on the EOP;

4) Assumes the ICS position as designated by the Incident Commander (e.g., Liaison Officer) for all incidents that occur on GJVHCS property; and

5) Serves as the Co-Chairman of the Emergency Management Committee (EMC).

e. Service Chiefs:

1) Develop a service specific emergency plan, assigning responsibilities to specific positions to maintain control of critical service functions. These plans are submitted to the EMC through the Safety Office. Each department will maintain an updated copy of this policy.

2) Ensures their personnel have been trained on their roles and responsibilities during emergencies. Each Service Chief or designee will participate in hospital wide training and exercises. In addition, the Service Chiefs are responsible for providing staff support as required during emergency preparedness and response activities.

3) Providing copies of the service specific and the Medical Center CEMP program for immediate reference to employees in their service.

4) Participating in the CEMP, including planning, training and implementation during drills, exercise and actual threats/events, as well as post-event analysis.

5) Reviewing their service emergency plan annually and updating the Emergency Notification Cascade when personnel and numbers change. Any changes in the Emergency Notification Cascade will be provided to the EPC/Safety.

f. All employees of this Medical Center are responsible for:

1) Employees are responsible to understand the role their service center may be required to play in an emergency.

2) They should be familiar with basic fire, hazardous materials (HAZMAT) and emergency response procedures. Where possible they should act to protect the life and safety of patients, visitors, volunteers and employees.

3) Participate in training and exercises. These exercises are intended to practice emergency response activities and improve readiness.

g. Emergency Management Committee: The committee is a vital link in the emergency preparedness planning process. The committee will provide support, direction and guidance to the Emergency Management Coordinator and will make recommendations revisions in the Emergency Management Program. Each primary or designated representative should attend the Emergency Management Committee meetings. The committee or appropriate departments will participate in planning of all facility exercises. They will provide technical assistance in the planning process as well as oversight to the final plan. Subcommittees will be established to work on special projects.

1) Membership:

a) Medical Center Director: Ex-Officio

b) Associate Medical Center Director: Chairperson

(1) Emergency Preparedness Coordinator

(2) Chief of Staff

(3) Associate Director, Patient Care Services

(4) Chief, Engineering Service

(5) Chief, Human Resources

(6) Chief, Police Service

(7) Chief, Safety

(8) Coordinator, Green Environmental Management System (GEMS)

(9) Patient Safety Manager

2) Responsibilities of the EMC:

a) Establish goals and objectives for CEMP.

- b) Develop, review and update the facility Emergency Operations Plan.
- c) Review Service Plans that supplement this plan.
- d) Develop a training and exercise plan.
- e) Plan, coordinate, conduct and evaluate emergency preparedness exercises. The HVA should be used to develop appropriate scenarios.
- f) Provide advice, support, guidance and technical assistance to the Emergency Management Coordinator in the development of the CEMP.
- g) Provide ongoing education to facility personnel on Emergency Operations Programs.
- h) Meet on the fourth Thursday of each month in the Directors Board Room. Meetings may be more frequent, at the discretion of the Chair.
- i) Accomplish an annual review of the CEMP for submission to GJVHCS leadership.

5. **HAZARDS VULNERABILITY ANALYSIS (HVA):** The purpose of the HVA is to identify potential impacts to mission-critical systems that support our ability to deliver services. GJVHCS conducts an annual review of its risks, hazards and potential emergencies for the main hospital, the VA clinics located in Montrose, Glenwood Springs and Craig Colorado and Moab Utah. The annual review and update of the HVA is accomplished in coordination with Mesa County, CO Emergency Management, St. Mary's Medical Center, Community Hospital, Family Health West and the Emergency Management Committee. The priority hazards have "Pre-Plans" developed to address mitigation, preparedness, initial response and recovery/restoration activities. These are located in the Incident Specific Annexes.

6. **GENERAL EMERGENCY DO'S AND DON'T'S:**

- a. Each employee should take immediate action to protect life and property.
- b. If there is obvious building damage, move employees and patients to a safe area. Ensure patients have suitable shoes in case of debris and broken glass.
- c. Do not use elevators. Engineering Service will release trapped persons using elevator safety features. All able-bodied personnel will use stairways to the extent possible.
- d. If required the Engineering Service will be assigned the responsibility to control essential elevators not affected by the emergency. Only the Fire Department and selected Engineering Service personnel will determine if any elevators can be used during fire emergencies.
- e. Utilize appropriate emergency plans.

7. **CONCEPT OF OPERATIONS:**

a. Situation. An emergency situation is any event that threatens to affect continuity of patient care and/or safety of patients, visitors and employees. It begins upon recognition or notification that a threat exists; continues while all activities are underway to assess, control and correct on-going adverse or negative effects; and ends when determined by the Director.

1) An external disaster is an event, which requires expansion of facilities to receive and care for a large number of casualties resulting from a mass casualty incident or disaster. Usually the event causes little or no damage to the facility or staff.

2) An internal disaster is an event which causes, or threatens to cause, physical damage and injury to the facility, personnel or patients within one or more of the divisions of the facility. Examples are: fire, explosion, hazardous material releases, or bomb threat.

3) If a warning or notification is received that a situation threatens to disrupt continuity of patient care and/or poses a risk to patients, visitors and staff, the Director will take the necessary action(s) to assess, organize, mobilize and deploy the resources required to protect patients, visitors, employees, and property based upon the threat.

b. Notification.

1) Any employee who observes an incident or condition which, could result in an emergency should report it immediately to the facility Police by dialing extension 2178.

2) If a fire situation is encountered, the employee should pull the nearest fire alarm box and dial extension 6-911. The employee should identify himself/herself and state the location of the fire. The Boiler Plant Operator at extension 2013 will notify the Medical Center Director at extension 2270 or after-hours, the Administrative Officer of the Day (AOD) at extension 2121.

3) In the case of an extreme emergency within the facility, the senior management official (Service Chief/Director, Section Chief, Clinical Nurse Officer or Nursing Unit Charge Nurse) may make the decision for immediate evacuation and control of the area, if time does not allow for communication with the Director, due to risk to staff or patients. After the initial response, the Director shall be notified of the situation.

4) The Emergency Preparedness Coordinator, Safety Manager or Administrator on Duty will notify facility leadership with recommendations to activate the Incident Command System, Emergency Operations Plan and the Hospital Command Center.

c. Activation of the Emergency Operations Plan/Hospital Command Center (HCC):

1) Authority to activate the Emergency Operations Plan and initiate notifications normally rests with the Chain of Command.

2) <u>Chain of Command</u>	<u>Extension</u>
(1) Director	2270
(2) Associate Director	1334
(3) Chief of Staff	5064

(4) Associate Director for Patient Care Services	2120
(5) Chief, Engineering Service	2052
(6) Chief, Human Resources	5072
(7) Chief, Logistics	5011
(8) Chief, Fiscal Service	2325

3) During off-hours (4:30 P.M. - 7:00 A.M.), holidays and weekends, the Medical Officer on Duty or the AOD will activate the Emergency Operation Plan and notify the Director or Acting Director.

4) The AOD will also notify the Boiler Plant operator (extensions 2013) and provide them with all information regarding injuries, damage, Executive Leadership Team (ELT) members contacted and actions directed by the ELT member.

5) If an ELT member can't be contacted, the AOD is in command and MUST decide whether or not to declare an emergency and what action to take.

6) The HCC is where information is passed about the emergency, the required response and decisions are made by the Incident Commander. During normal business hours the HCC is Building 1, 6th floor conference room. During non-business hours the HCC will be in the Emergency Department (ED), until moved by the Director or Incident Commander. The alternate HCC is in Building 6. The Emergency Preparedness Coordinator and/or Safety Manager will be the primary individuals responsible for setting up the HCC. See Functional Annex A, for HCC setup checklist.

8. INCIDENT COMMAND SYSTEM:

a. The Incident Command System (ICS) will be used to plan, organize, staff, direct and control emergency situations. The specific ICS organizational structure put in place will depend upon the requirements of the emergency. The organization's staff builds from the top down with responsibility and performance placed initially with the Initial Incident Commander. As the need exists, four separate Sections (Operations, Plans, Logistics, and Finance/Administration) can be developed, each with several units that can be established, as required. If one individual can simultaneously manage all major functional areas, no further organization is required. If one or more of the areas require independent management, an individual is named to be responsible for that area.

b. In an incident without warning, such as a fire on a ward, the Initial Incident Commander may be a nurse on duty who first recognizes the danger. In an incident that provides warning, the Director will designate the Incident Commander. If one individual can simultaneously manage all major functional areas, no further organization is required. If one or more of the areas require independent management, an individual is named to be responsible for that area.

c. Depending on the magnitude, complexity and/or duration of the emergency, the responsibility for Incident Command will transition to the most qualified individual, who will initiate the incident action planning process.

d. Some or all of the following activities may be necessary to effectively prepare for, respond to, and/or recover from an emergency:

- 1) Verification that a threatening situation exists.
- 2) Analysis of incident factors to determine the level and extent of EOP implementation.
- 3) Alert/notify key staff and external authorities, as appropriate.
- 4) Issuance of an internal warning message and instructions.
- 5) Pre-impact preparations.
- 6) Establishment of an Incident Command System organizational structure.
- 7) On-going situation and resource assessments.
- 8) Incident operations necessary to protect life and property.
- 9) Request for, or provision of, mutual assistance.
- 10) Demobilization.
- 11) Incident critique.
- 12) After-Action review and corrective actions.
- 13) See Functional Annex A for information on ICS and activation of the HCC.

9. **REPORTING PROCEDURES:** It is imperative that notification is made as soon as possible (within 1 hour) to the Network Office of any incident which impacts normal operations even if it appears that no additional VA assistance is required.

a. Contact the Network Office as soon as feasible to inform them of the situation to include the submission of the Issue Brief. Contact with the Network Office will be initiated by telephone and followed by e-mail messages or other means of communication as required. E-mail messages will be sent to the Network Director and the Veterans Integrated Service Network (VISN) 19 Steering Committee for Emergency Management (STEM) distribution group found in Outlook Global Address Directory. Primary point of contact (POC) is the VISN 19 Emergency Manager: (303) 489 4612.

b. For events which affect normal operations and/or capabilities complete the Operating Status and Capability Assessment Report – OSCAR and e-mail, fax, or telephone to the Network Office as soon as possible.

c. The VHA Watch Officer position is staffed 24/7. Contact: WatchOfficer-VHA@va.gov (202) 461-0268 or (202) 461-0269.

d. Maintain routine contact with Network Office during the course of the emergency to include submitting Situation Reports (SITREP) as required / designate Operational Periods if extending past 24 hours. SITREPs are normally provided on a daily basis, but more frequent reporting may be necessary depending upon the event or at the request of higher headquarters.

e. For events which extend past one operational period forward a copy of the Incident Action Plan to the VISN 19 Emergency Manager and Director.

10. **EOP DEVELOPMENT AND MAINTENANCE:** The Emergency Management Coordinator has overall responsibility for the EOP. However, the Emergency Management

Committee (EMC) is responsible for providing input, edits and review to ensure the Plan supports the Comprehensive Emergency Management Program. This plan will be reviewed annually. Reviews will be documented in the EMC meeting minutes.

11. REFERENCES:

- a. VA Directive 0320, VA Comprehensive Emergency Management Program.
- b. VISN 19 Emergency Operations Plan.
- c. Emergency Management Program (EMP) Guidebook (Current edition).
- d. National Incident Management System (NIMS).

12. ATTACHMENTS:

- a. Acronyms
- b. Issue Brief
- c. Operating Status and Capability Assessment Report (OSCAR)
- d. Situation Report (SITREP)

13. ANNEXES/APPENDICES: (These are maintained as separate documents on the GJVHCS Policy shared drive under GRJ MCMs in the GRJ User Icons folder):

- a. Functional Annexes
- b. Incident Specific Appendices

14. COORDINATION: 001, 003, 04, 05, 11, 111, 112, 114, 119, 132, 135, 137, 138, 132, OI&T, HBPC Coordinator, and NAGE

15. RESCISSION: Medical Center Memorandum No. 007-1, Emergency Operations Plan, dated January 2015.

Michael T. Kilmer
Director

DISTRIBUTION: D

LIST OF ACRONYMS

Acronym	Description
AAR	After Action Report
AEM	Area Emergency Manager
AOD	Administrative Officer of the Day
CBOC	Community Based Outpatient Clinic
CDC	Centers for Disease Control and Prevention
CEMP	Comprehensive Emergency Management Program
COOP	Continuity of Operations
DECON	Decontamination
DEMPS	Disaster Emergency Medical Personnel System
ED	Emergency Department
EM	Emergency Manager
EMAC	Emergency Management Assistance Compact
EMAP	Emergency Management Accreditation Program
EMC	Emergency Management Committee
EMPG	Emergency Management Program Guidebook
EMTALA	Emergency Medical Treatment and Active Labor Act
ENDEX	End of Exercise
EOP	Emergency Operations Plan
EP	Elements of Performance
EPA	Environmental Protection Agency
EPC	Emergency Program Coordinator (Emergency Preparedness Coordinator)
ESF	Emergency Support Function
EXPLAN	Exercise Plan
FCC	Federal Coordinating Center
FCD	Federal Continuity Directive
FEMA	Federal Emergency Management Agency
GETS	Government Emergency Telephone System
HAZMAT	Hazardous Materials
HCC	Hospital Command Center
HHS	Department of Health and Human Services
HICS	Hospital Incident Command System
HIPAA	Health Insurance Portability and Accountability Act
HR	Human Resources
HSEEP	Homeland Security Exercise & Evaluation Program
HSPD	Homeland Security Presidential Directive
HVA	Hazard Vulnerability Analysis
HVAC	Heating, Ventilation and Air Conditioning
IAP	Incident Action Plan
IAW	In Accordance With
IC	Incident Commander

ICS	Incident Command System
ILSM	Interim Life Safety Measures
IMT	Incident Management Team
IOC	Integrated Operations Center
IP	Improvement Program
ISO	Information Security Officer
IT	Information Technology
JIC	Joint Information Center
JIC/JOC	Joint Information Center/Operations Center
JOC	Joint Operations Center
LEPC	Local Emergency Planning Committee
MCI	Mass Casualty Incident
MOA	Memorandum of Agreement
MOU/A	Memorandum of Understanding/Agreements
MRC	Medical Reserve Corps
MSEL	Master Sequence of Events List
NFPA	National Fire Protection Association
NIMS	National Incident Management System
NRF	National Response Framework
OEM	Office of Emergency Management (VHA)
OI&T	Office of Information and Technology
OSCAR	Operating Status Checklist and Reports
PAO	Public Affairs Officer
POC	Point Of Contact
PPE	Personal Protective Equipment
REM	Regional Emergency Manager
SITREP	Situation Report
SOP	Standard Operating Procedure
TJC	The Joint Commission
VAMC	VA Medical Center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

GJVHCS Grand Junction Issue Brief

**E-mail – visn19stem@va.gov and/or VISN 19 Director
VISN Emergency Management Coordinator: Office: (303) 504-2698
BlackBerry: (720) 810-1536**

Issue Title:

Date of Report:

Brief Statement of Issue and Status:

Actions, Progress, and Estimated Resolution Date:

Contact for Further Information:

Operating Status and Capability Assessment Report (OSCAR)
E-mail – visn19stem@va.gov and/or VISN 19 Director
VISN Emergency Management Coordinator: Office: (303) 504-2698
BlackBerry: (720) 810-1536

Questions	Yes	No	Comments
1. Can you continue to treat incoming patients?	<input type="checkbox"/>	<input type="checkbox"/>	If No, why not?
2. Any patient evacuated to outside the hospital?	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, where? _____ _____ Total Evacuated _____ No. of unstable/critical
3. Any fatalities?	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, _____ Patients _____ Staff
4. Any patients/staff injured?	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, _____ Patients _____ Staff
5. Any structural damage? Identify.	<input type="checkbox"/>	<input type="checkbox"/>	Partial Collapse? Total Collapse?
6. Any major non-structural problems?	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, what are the problems?
7. Power from any source?	<input type="checkbox"/>	<input type="checkbox"/>	
8. Can you communicate with the outside world?	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, how?
9. Access to all essential areas of the hospital?	<input type="checkbox"/>	<input type="checkbox"/>	If No, is anyone trapped?
10. Sufficient number of elevators working?	<input type="checkbox"/>	<input type="checkbox"/>	
11. Water lines intact to essential areas?	<input type="checkbox"/>	<input type="checkbox"/>	
12. Natural gas lines intact to essentials areas?	<input type="checkbox"/>	<input type="checkbox"/>	
13. Medical gas lines intact to essential areas?	<input type="checkbox"/>	<input type="checkbox"/>	
14. Adequate staff at the hospital?	<input type="checkbox"/>	<input type="checkbox"/>	
15. Adequate staff at the hospital?	<input type="checkbox"/>	<input type="checkbox"/>	
16. Outside assistance needed?	<input type="checkbox"/>	<input type="checkbox"/>	
17. Need structural engineer sent to hospital?	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, what?
18. Number of Critical Care Beds? _____			
19. Number of Medical/Surgical Beds? _____			
20. Number of Psychiatry beds _____			
21. Number of specialty beds available (state number and type)? _____			

Questions	Yes	No	Comments
22. Number of OR suites open and ready for surgery? _____			
23. Number of Patients Admitted Since Last Report? _____ Total No. Pts Date/Time of Last Report _____ _____ Medical/Surgical _____ Critical Care _____ Psychiatric _____ Other (Type)			
24. Number of Patients Seen in ER Since Last Report? _____ Total No. Pts Date/Time of Last Report _____ _____ No. of Pts Admitted _____ No. of Pts Transferred _____ No. of Pts Treated and Released			
25. Do you have at least a 96-hour operations capacity in each of the following areas?			
Yes	No	Comments	
<input type="checkbox"/>	<input type="checkbox"/>	Communications?	
<input type="checkbox"/>	<input type="checkbox"/>	Electrical Power?	
<input type="checkbox"/>	<input type="checkbox"/>	Natural Gas?	
<input type="checkbox"/>	<input type="checkbox"/>	Diesel Fuel (Generator)?	
<input type="checkbox"/>	<input type="checkbox"/>	Sewage/Refuse Disposal?	
Supplies? (Specify)			
<input type="checkbox"/>	<input type="checkbox"/>	Oxygen?	
<input type="checkbox"/>	<input type="checkbox"/>	Pharmaceuticals?	
<input type="checkbox"/>	<input type="checkbox"/>	Other Medical Supplies?	
<input type="checkbox"/>	<input type="checkbox"/>	Non-Medical Supplies?	
<input type="checkbox"/>	<input type="checkbox"/>	Equipment?	
<input type="checkbox"/>	<input type="checkbox"/>	Food?	
<input type="checkbox"/>	<input type="checkbox"/>	Other? (Specify)	

Situation Report (SITREP)

(Numbered Sequentially) Report No. _____

(Event) Date of Report _____

I. Background and Current Situation: (Give brief background of the event and situation update from the last SITREP.)

Example: "On November 12, 2001, a structural fire resulted in damage to the nursing home facility (Building 4301) causing the evacuation and relocation of 52 patients. Patients were evacuated without incident and are temporarily being provided care and housed in the main hospital building. Most of the damage was resulted from smoke and water. Investigation completed yesterday has determined that the cause of the fire was careless use and disposal of smoking materials by a painting contractor working in the nursing home facility.

Situation reports will include:

- a. Summary of beds availability
- b. Number of NDMS patients admitted to date
- c. Number of NDMS patients currently hospitalized and clinical status
- d. Significant clinical issues
- e. Significant issues involving veteran care and services
- f. Significant supply, equipment, pharmaceutical issues
- g. Significant staffing/personnel issues
- h. Significant public affairs activities
- i. Other issues deemed appropriate.

II. Operations Status/Update: (Provide overall status by color code: Green, Yellow, Red or Black; followed by narrative providing specifics relating to the response to the event; and if applicable, information relating to efforts to attain full operational status with an estimated date.)

Operational Status is as follows:

- Green (Fully Operational)
- Yellow (Operational but with emergency systems [e.g., power] functioning)
- Red (Partial Operational)
- Black (Non-Operational)

Example: Facility Status: "Red"

1. *Nursing home admissions curtailed pending clean up and repair of building 4301. Estimated completion date is November 19, 2001. In the interim new admissions are being referred to our contract facility.*
2. *VA Police have cited contractor employee for smoking in a restricted area. Regional General Counsel's Office reviewing whether further actions are warranted against the individual and/or contractor.*
3. *Estimated damages are \$155,000.*

III. Point(s) of Contact: (List name, phone, cell phone, fax and pager numbers of individual(s) who should be contacted if additional information is desired.)

Signature of Medical Center Director or Designee)

Date

EMERGENCY MEDICAL MANAGEMENT (INCLUDES CODE BLUE)

1. **PURPOSE:** To establish policy, responsibility and procedures necessary to provide a rapid, efficient and organized method of response to emergency medical condition.

2. **POLICY:**

a. The Facility is to have a policy for a rapid, efficient, and organized method of responding to emergency medical conditions for any location on the Grand Junction facility grounds and at the Montrose VA Clinic, the Glenwood Springs VA Clinic, the Moab VA Clinic, and the Maj. William E. Adams VA Clinic, Craig.

b. It is policy that the Facility Director must ensure that trained staff is available at all times, and that a process is in place to identify who must receive training and how the training is to be provided.

c. It is this facility's policy to have a critical care committee made up of multi-disciplinary team members to evaluate, analyze, and identify opportunities to improve both outcomes and processes of resuscitation/emergency medical conditions.

3. **PROCEDURES:**

a. Code Blue occurs when a staff member identifies that a patient's condition indicates emergency management within the main building.

1) The staff member who finds an unresponsive person or a person in crisis will call for help and/or activate Code Blue and initiate Basic Life Support (BLS). A Code Blue alert is activated by depressing the nearest Code Blue button and/or dialing 2111 from any facility phone. The staff member activating the Code Blue will identify the location of the Code Blue to the Administrative Officer on Duty (AOD) or delegate who answers the phone. The AOD or delegate upon receiving a call to 2111, will announce overhead via the Overhead paging system, "Code Blue, location (Room number, Area)." This is repeated three times

2) When the Code Blue alert is activated, the following team will respond to include but not limited to: Hospitalist, Medical Officer of the Day (MOD), (when Emergency Department acuity allows), Intensive Care Unit (ICU) Nurse or delegate, Hospitalist Advanced Practitioner, Nurse, or the Nurse of Day (NOD), Out of Operating Room Airway Management (OORAM) trained Respiratory therapist. The Grand Junction Veterans Police will respond to assist in crowd control and elevator override. Universal precautions and protective equipment will be utilized.

3) A staff member will bring the nearest crash cart to the scene and then assist with BLS.

4) The First Physician or the nurse will perform BLS or Advanced Cardiac Life Support (ACLS) activities and will assume the leadership role until the Code Blue Team arrives. If a nurse is leading the code, the lead will pass once the physician arrives. The MOD or Hospitalist is the team leader, and is responsible for leading the resuscitation and writing the Code Blue note in Computerized Patient Record System (CPRS).

5) Only certified ACLS providers may perform ACLS components of resuscitation.

6) Code team members will have designated roles during a Code Blue:

a) **NOD or delegate** will be assigned to starting IV and giving medications,

b) **ICU nurse or delegate** will manage the defibrillator,

c) **MOD/hospitalist** will act as team leader,

d) **Respiratory therapist** is responsible for airway management including endotracheal intubation. A properly credentialed physician may also perform endotracheal intubation and anesthesia will be available on call for difficult intubations.

e) **Additional staff** will participate in BLS or Cardiopulmonary Resuscitation (CPR) and time keeper/recording duties as directed by team leader.

f) **Grand Junction Veterans Police** will be responsible for crowd control, override the elevator, and participate with BLS activities as directed.

7) A time keeper/recorder will complete the Code Blue Worksheet, kept on the side of the Crash Cart, then return to AOD so that copies can be made and forwarded to the Chairperson of the Critical Care Committee, and sent up to packet for review at morning report by Chief of Staff and Associate Director Patient Care Services (ADPCS). (Code Blue worksheet is attachment F).

8) After resuscitation, the Charge Nurse or nurse delegate for the unit is responsible for processing the used crash cart using the procedure below: (instructions will be laminated on each crash cart).

a) Remove all used items and disinfect the surfaces of the equipment and crash cart.

b) Obtain clean stocked crash cart from 5 Medical/Surgical Clean Utility Room 5401 (primary) or Dental (secondary).

- c) A New Crash Cart will be picked up by Nursing Staff and taken to the area where crash cart was originally taken from.
- d) Used Crash Cart bagged, clean tag, taken to Logistics.
- e) Logistics will restock the crash cart, tag it when it is ready, and take it to the Pharmacy.
- f) The Pharmacy will restock the cart and red tag it when it is fully stocked and return it storage area on 5th floor locked store room. (Contents of crash cart are listed on Attachment B).

9) Each unit will be responsible for visually checking the Crash Cart daily except when the unit is not occupied. Each unit will verify that the Defibrillator is working within manufacturer's guidelines, that the cart is locked, stocked, and the oxygen tank is full. Verification will be documented on the Crash Cart Check List with date, time, and initials. Each cart will have an identifier, which also needs to be identified on the crash cart check list for assistance in identifying the cart was used if items are reported missing during a code (Crash Cart check list and directions for daily inspection- Attachment C).

10) Automated External Deliberator (AED)s will be checked and visible in Building one as well as surrounding buildings. (See Attachment A for AED locations).

11) The overhead paging system will be used as a primary notification for code blue with the code team pagers being the secondary notification system. The paging system will be checked on a regularly scheduled basis and any failures are reported to the Chief of Staff, ADPCS, and patient safety immediately. (see Standard Operating Procedures (SOP) regarding code blue pager testing schedule, attachment G).

a) The Codes **in the Operating Room (OR)** will be managed by ACLS certified physician or Anesthetist. (See Attachment E).

b) Emergency response/Code Blue at the VA outlying clinics: Staff members will contact Emergency Medical Services (EMS) at 911. Employees will initiate BLS and remain with patient until community emergency responders arrive. Staff will enter a note in CPRS about this emergency response and add Chairperson of Critical Care Committee (CCC) as a co-signer. CBOC nurse managers or delegate will report emergency responses where patients had to be transported via EMS to local hospital to CCC chairperson monthly on 1st of month. This information will be reported at Clinical Executive Board (CEB) and analyzed during CCC.

c) Emergency Response/Code Blue **outside the main building**: upon discovery of a person outside the main building who appears to be having a medical emergency; (definition of emergency is below).

(1) Staff, family member or police are to contact Emergency Medical Service (EMS) by calling 911 immediately.

(2) Notify Grand Junction Veterans police or tell dispatch (911) to notify Veterans Administration (VA) police.

(3) Notify AOD by telephone. AOD to call 911 if person finding the emergency has not been able to do so due to lack of cell phone or other problems.

(a) AOD calls ED and/or Emergency Medical Technician (EMT) (if on duty in the emergency department) #4 EMT/nurse will respond to the emergency with BLS supply bag.

(b) If believed that patient would require community level of care i.e. St Mary's Emergency Room, then stay with patient providing BLS until EMS arrives. EMS assessment may determine that patient can be brought to Grand Junction Veterans Emergency Department (ED), and will contact ED staff as per their protocol.

(c) If upon a quick assessment of the patient it is believed that patient has no emergency need for transport; cancel the ambulance and assist patient to ED or other clinic as needed. It is better to error on side of caution and allow EMS to further evaluate upon their arrival. If after EMS assessment believes patient can be managed at VA hospital they may contact ED staff as per their protocol.

12) Definition of Emergencies

Patient with any of the below complaints;

a) Unconscious or unable to answer questions.

b) Chest Pain.

c) Possible Stroke:

(1) Sudden numbness or weakness of face, arm or leg.

(2) Sudden confusion, trouble speaking/understanding; visual problems.

(3) Sudden trouble walking, dizziness, loss of balance or coordination.

(4) Sudden severe headache.

- d) Difficulty breathing.
- e) ANY trauma to head, neck, abdomen or hips. I.E. visible head injury, burns, inability to walk.
- f) ANY fall where patient is unable to get up without mechanical assistance, i.e. stretcher.
- g) ANY extrication from an automobile where the patient is unable to move because of injury or any symptom as listed above.
- h) Active labor.

Documentation: ED or NOD will place a nurse visit note for all patients contacted by medical staff when EMS is called.

13) Training Requirements:

- a) Only AHA (American Heart Association), ASHI (American Safety and Health Institute), and MTN (Military Training Network) will be accepted for certification for facility staff.
- b) REdi (Resuscitation education initiative) is a national program to standardize, document, track, and monitor the provision of ACLS, BLS, Advance Trauma Life-support (ATLS) and other resuscitation training programs throughout Veterans Health Administration (VHA).
- c) All clinically active staff will maintain current BLS certification during their assigned working hours. (See Attachment D).
- d) Certain physicians, nurses and health care workers in critical areas maintain current ACLS certification (See Attachment D).
- e) Health profession trainees are responsible for maintaining the BLS or ACLS certification required by their National Accrediting body or local certification standards. All records will be maintained by the Educational Institution and employees will not be able to work unless they maintain current on these certifications.

4. RESPONSIBILITIES:

- a. The Critical Care Committee is responsible for establishing policies and procedures for reviewing all Code Blues to determine the overall performance and make recommendations for corrective actions if applicable to the CEB quarterly. The committee is also responsible for reviewing crash cart equipment, medications, and supplies and reviewing/updating Medical Center Memorandums (MCM) annually. (MCM 111-33)

- b. Education Department is responsible for maintaining BLS/ACLS certification records and reporting compliance to the Critical Care Committee quarterly.
- c. Cardio–pulmonary is responsible for staffing the facility with OORAM trained staff.
- d. Logistics is responsible for restocking the crash cart and transfer to Pharmacy Service for completion.
- e. Pharmacy is responsible for stocking the crash cart as required.
- f. Service Chiefs are responsible for monitoring crash cart review completions and staff training compliance.

5. DEFINITIONS:

a. Certification: Refers to the successful completion (passing grade) in an approved BLS or ACLS course. Only AHA (American Heart Association) or MTN (Military Training Network) certification cards for BLS and ACLS are accepted for staff renewing their certifications. In-house certification is required for existing, full-time permanent staff renewing their certifications. However, certification obtained through an affiliate or other institution can be allowed if deemed of sufficient quality by the Director or his designee". **NOTE:** Certification should be considered in a similar manner as licensure is considered for a clinical professional. Staff should not let certification expire.

b. Clinically Active Staff: Any health care provider who is actively participating in direct patient care in any clinical setting including community/home care settings.

c. Non-Clinically Active Staff: Physicians, licensed nurses, physician assistants, licensed independent providers, medical technicians engaged only in non-human research or similar activities are not considered clinically active staff.

d. Non-VA Employee: Any person not directly paid by VA (e.g. Student trainees, Without Compensation (WOC) personnel, Contractors, Volunteers).

6. REFERENCES:

a. VHA Directive 1177 Cardiopulmonary Resuscitation, basic life support, and advanced cardiac life support training for staff.

b. TJC Accreditation Manual for Hospitals.

c. American Heart Association (AHA) Cardiopulmonary Resuscitation and Emergency Cardiac Care (CPR and ECC) Guidelines.

http://www.heart.org/HEARTORG/CPRAndECC/Science/Guidelines/Guidelines_UCM_303151_SubHomePage.jsp.

7. **ATTACHMENTS:**

Attachment A: Crash Cart/Defibrillator Locations

Attachment B: Crash Cart Item Check List

Attachment C: Daily Crash Cart Check List

Attachment D: ACLS/BLS Required List of Positions

Attachment E: Cardiac/Pulmonary Arrest in the Operating Room

Attachment F: Code Blue worksheet

Attachment G: Standard Operating Procedures regarding code blue pager testing schedule.

8. **COORDINATION:** 001, 11, 003, 00Q, 111, 112, 114, 116, 117, 119, 132, 138, 160.

9. **RESCISSION:** Medical Center Memorandum 111-9, Emergency Medical Management (Including Code Blue), dated June 2018.

Michael T. Kilmer
Director

DISTRIBUTION: E

CRASH CART/DEFIBRILLATOR LOCATIONS

1st Floor

ER	Zoll Defibrillator Crash Cart
Amb Surg	Zoll Defibrillator Crash Cart
CLC	Zoll Defibrillator Crash Cart

2nd Floor

Cardiopulmonary	Zoll Defibrillator Crash Cart
Radiology	Zoll Defibrillator Crash Cart
Dental	Zoll Defibrillator Crash Cart

3rd Floor

OR	Zoll Defibrillator Crash Cart
ICU	Zoll Defibrillator Crash Cart
PACU	Zoll Defibrillator Crash Cart

5th Floor

5MS	Zoll Defibrillator Crash Cart
Building 1	AED
Canteen	AED

6 th Floor	AED
-----------------------	-----

3 rd floor clinic	AED
Chapel	AED
Building 35	AED
Building 36	AED
Building 37	2 AED
Building 5	AED
Building 6	AED
Building 13	AED
Police Car	AED

CRASH CART CHECK LIST

TOP OF CART

Suction machine with Yank Auer suction and connector tube, Defibrillator with electrodes, patient cable, two sets of defibrillator paper, and two sets of defibrillator pads, Sharps Container, and 3 in 1 oxygen mask.

SIDE OF CART

CODE BLUE Worksheet, Daily Checklist (on clipboard), Oxygen tank with regulator, nasal cannula, and Ambu Bag

CARDIAC BOARD ON BACK OF CART

FIRST DRAWER

Name of Item/Drug	Quantity
• Adenosine 6 mg/2ml Inj	5
• Amiodarone 150mg/3ml syringe	4
• Atropine 1mg/10ml syringe	4
• Calcium Chloride 1gm/10ml syringe	2
• Dextrose 50%/50ml syringe	1
• Diphenhydramine 50 mg/ml Inj	2
• Epinephrine 1:10,000 Syringe	8
• Flumazenil 0.5mg/5ml MDV	2
• Lidocaine 100mg/ml 5ml syringe	2
• Magnesium Sulfate 50% 1 gm/2ml amp	2
• Naloxone 0.4mg/ml Inj	5
• Sodium Bicarb 8.4% 50 ml syringe	3
• Bacteriostat NS 30ml MDV	2
• Carpuject holder	1

SECOND DRAWER

• Infusion set primary	2
• Stat Lock IV Start Kits	2
• 20 cc syringe	2
• 10 cc syringe	4
• 5 cc syringe	6
• 3 cc syringe	4
• 22 G x 1 ½ Needle	4
• 20 G x 1 ½ Needle	4
• 18 G x 1 ½ Needle	4

CRASH CART CHECK LIST (continued)
SECOND DRAWER continued...

• 16 G IV Catheter autoguard	2
• 18 G IV Catheter autoguard	6
• 20 G IV Catheter autoguard	2
• 18 G x 3” Spinal Needle	3
• Needle filter	2
• Vacutainer 21G Blood Collection	2
• Bite Stick	1
• Tape Surgical 1”	2
• Applicator Providone Iodine	4
• Pads Isopropyl Alcohol	10
• Tourniquet	2
• Tongue Depressor	4
• Adapter Buffalo Cap	2
• Vial Access Multi Dose	5
• Syringe pro-vent	2

THIRD DRAWER

• Scissors	1
• Surgilube/lubufax	1
• Box of non-sterile gloves nitrile sz lrg, and med	1 of each size
• Tongue depressors	4
• Surgical tape	2
• Bio-gel sterile gloves sizes 6-8.5	2 pair of each size

FOURTH DRAWER

• Sphygmomanometer aneroid/Stethoscope	1
• Airway Robertazzi 32 F	1
• Airway nasopharyngeal 6.0	1
• Stylet Intubation 14fr	2
• Glidescope Stylet	1
• Laryngeal Mask Airway (LMA)	1
• 10 cc Syringe	1
• Airway Berman Adult disposable LRG 100mm	1
• Detector CO2 easy cap	1
• Blade Macintosh sz 3	1
• Blade Macintosh sz 4	1
• Blade Miller sz 2	1
• Blade Miller sz 3	1

CRASH CART CHECK LIST (continued)
FOURTH DRAWER continued...

- Endotracheal tubes sizes 5.0, 6.0, 7.0, 7.5, 8.0, and 9 (2 each)
- Tracheal suction set 14fr 2
- Tip Yankauer 2
- Suction argyle Yankauer 2
- C Batteries 2
- Laryngoscope Handle 1
- Hollester airway securing device 1

FIFTH DRAWER

- Introducer, endo, bougie 15fr 1
- Resuscitation Bag 1
- 15' Extension Cord 1
- Normal Saline 1000ml Bag 1
- Normal Saline 250ml Bag 1
- Dextrose 5% in Water 250ml 1
- Normal Saline Flush 10ml Syr 10

Daily Crash Cart Checklist (revised 2/2017)

UNIT:		SUN	MON	TUE	WED	THUR	FRI	SAT
	DATE:							
	TIME:							
Crash Cart Number/ Identifier								
Multi-function electrodes in sealed packages x2 Cables not cracked or broken								
Cart is locked + Lock Number								
Oxygen tank is full								
Suction machine is functional								
AMBU bag, Nasal cannula, 3 in 1 mask hanging on cart								
Pharmacy/SPD date stickers on cart not expired***								
Test Pacer operation every Tues/Fri								
Discharge Defib every Tues/Fri								
Rotate Defib battery every Friday								
INITIALS:								
UNIT:		SUN	MON	TUE	WED	THUR	FRI	SAT
	DATE:							
	TIME:							
Crash Cart number/ Identifier								
Multi-function electrodes in sealed packages x2 Cables not cracked or broken								
Cart is locked + Lock Number								
Oxygen tank is full								
Suction machine is functional								
AMBU bag, Nasal cannula, 3 in 1 mask								
Pharmacy/SPD date stickers not expired***								
Test Pacer operation every Tues/Fri								
Discharge Defib every Tues/Fri								
Rotate Defib battery every Friday								
INITIALS:								

***Notify NOD if date stickers are expired

- KEEP ON FILE FOR 6 months

Daily Visual Inspection Equipment

Ensure that the unit is clean (with no fluid spills) and free of visible damage. Inspect all cables, cords, and connectors for good condition (no cuts, fraying or bent pins). Top of the cart should have: Zoll defibrillator attached to pads, portable suction, CODE BLUE recording sheet, bag with Bag-Valve –Mask/simple mask/nasal cannula, and only supplies listed below.

Supplies and Accessories

Verify the presence of only these supplies on top of the cart (2 packs Zoll One Step pads, 1 pack ECG monitoring electrodes, extra pack of square EKG strip paper, 1 Yankauer suction, 1 suction tubing.) Check the expiration date on ZOLL One Step pad packages.

Batteries/External Power Supply

Check that a fully charged battery pack is installed in the unit. Check that a fully charged portable suction accompanies the Zoll defibrillator, and that both are plugged into an AC power outlet.

Code Readiness Status

Look at the \checkmark/x Code Readiness indicator on the R Series defibrillator. It should show a green checkmark. If the Code Readiness indicator displays a red “X” the unit is not ready for therapeutic use. Check expiration date on pads. Perform defibrillator testing, if no change Contact Biomed.

9650-0904-01 Rev. M ZOLL R Series Operator’s Guide

Defibrillator Testing with Hands-Free Therapy Electrodes

1. Turn the Mode Selector to **DEFIBRILLATE**.
2. Press the **ENERGY SELECT** buttons to set the energy to **30 joules**.
3. Press the **CHARGE** button on the front panel.
4. When the charge-ready tone sounds, press the **ENERGY SELECT** buttons to set the energy to **20 joules**. The defibrillator will disarm itself.

5. Press the **ENERGY SELECT** buttons to reset the energy to **30 joules**

Note: For testing, the unit discharges the defibrillator only if the energy is set to 30 joules.

1. Press the **CHARGE** button on the front panel.
7. When the Ready tone sounds, press the **SHOCK** button on the front panel until the shock is delivered.

The unit will display the message *30J TEST OK* and prints a stripchart indicating *30J TEST OK* and the delivered energy.

If the message *30J TEST FAILED* appears, contact Biomed

ACLS Certification is required for:

1. Health care personnel that order, administer, monitor, or supervise moderate sedation, monitored anesthesia care, or general anesthesia.
2. Any health care provider, including Medical Officer of the Day, who would be required to serve as a Code Leader.
3. Nurse of the Day (NOD)
4. PA or NP working in the E.R. or Hospitalist
5. Hospitalist
6. For dental suites, ACLS is required for dental providers administering or monitoring moderate sedation or general anesthesia.
7. Privileged licensed independent practitioner (LIP's), registered nurses and respiratory therapist who work in the following high-risk areas:
 - a. Intensive Care Units
 - b. Coronary care or Step-down units
 - c. Telemetry monitoring stations (unless remotely located in non-clinical areas)
 - d. Post-operative recovery areas, same day surgery areas, where registered nurses monitor patients who have received sedation or anesthesia.
 - e. Procedure rooms such as Cardiac Catherization Labs, Electrophysiology Labs, Interventional Radiology Labs, and Gastroenterology Endoscopy Labs.

Basic Life Support Certification is required for:

1. All clinically active staff employed by the V.A. who are not identified for the ACLS training. This includes anyone having patient contact such as:
 - a. Direct clinical care staff
 - b. LIP's
 - c. PA's, NP's
 - d. Respiratory Therapy
 - e. Clinical therapists (mental health, psychology, and social work)
 - f. Pharmacists/clinical pharmacy techs
 - g. PT & OT and assistants
 - h. Radiology/CT/MRI techs
 - i. Dental hygienist/dental assistant
 - j. V.A. Police
 - k. O.R. scrub techs
 - l. Lab techs/phlebotomist
 - m. Dieticians

Exemptions and Notes

1. Board certified Emergency Medical Physicians are strongly encouraged, but not required to have current BLS and/or ACLS certification.
2. Advanced Trauma Life Support (ATLS) is an acceptable alternative to ACLS. Staff certified in ATLS will not be required to have ACLS and/or BLS.
2. Any other employees not mentioned above may be otherwise determined by the facility Critical Care Committee and/or the COS.
3. Personnel who fall under the ACLS requirement do not need to have BLS

Training

The Medical Center will ensure all clinically active staff will receive instruction and maintain current BLS/ACLS certification during their assigned working hours. This will be completed by either RQI (as assigned) or Heartcode. Any incoming staff needing certification will complete this in TMS via Heartcode.

1. The Medical Center is part of the Resuscitation Quality Improvement program (RQI). As such, all clinically active personnel who are required to have BLS/ACLS, will be enrolled into the RQI program at the direction of the BLS/ACLS Program Director.
2. Those enrolled in RQI will complete quarterly assessments via TMS, as well as a comprehensive test once a year. If the quarterly assessment is not completed by the end of the next quarter, the supervisor will be notified.
3. Maintaining RQI requirements will ensure the clinical staff member's BLS/ACLS remains active.
4. No cards will be printed. Clinically active staff will be instructed how to print their e-card for BLS/ACLS.
5. New employees needing BLS/ACLS must complete required certification prior to assuming clinical duties. This will be completed via Heart code and TMS, and assigned as needed by the BLS/ACLS Program Director. The Grand Junction VAMC no longer sponsors live BLS/ACLS classes.
6. The Education Department will maintain a list of clinically active staff. For those who are not part of the RQI program, notification will be sent via TMS 30 days prior to expiration. Facility expectation is for renewal of certification by the 15th of the month in which it will expire. The Education Department will notify the supervisor of staff who have not renewed.
7. The supervisor may request a written waiver of up to 60 days if it is in the best interest of Veteran care and access to care. The waiver must be submitted through their chain of command within five business days prior to the expiration. An additional 30 days may be granted for extenuating circumstances (i.e., illness, injury). It is the responsibility of the Service Chief to determine if the individual may participate in patient care. This waiver may be use for either the Heart code program or the RQI program.

Attachment D

If there is a need for a permanent waiver with BLS and/or ACLS, the staff member must submit a request through their manager to the education department where the waiver will be presented to the COS/CNO or their designee for review and action. Staff member must be willing to provide reason for permanent waiver so COS/CNO or their designee can make an appropriate decision that is in the best interest of Veteran patient care. Didactic training will still be required with waiver.

8. If certification expires, the supervisor will take action including leave without pay until the training has been completed.

Cardiac/Pulmonary Arrest in the Operating Room

1. **Procedure:** All OR personnel, including Surgeons, Anesthesia, Physician Assistants, RNs and Scrub Techs are required to perform roles in Cardio-Pulmonary Resuscitation (CPR).

a. Regular Tour

- i. Immediately upon discovery of cardio-pulmonary arrest, the Circulating Nurse will send an alert to the front desk by activating the "Call Assist" option of the Jeron intercom system. All available OR staff will respond for support.
- ii. The ACLS certified Anesthesiologist/Anesthetist will direct the resuscitation efforts.
- iii. In the event the victim is the ACLS certified Anesthesiologist/Anesthetist, the senior member of the Surgical Team will assume the direction of the resuscitation, and the Code Blue System will be activated immediately to acquire additional help.
- iv. The Physician will initiate CPR. In the absence of a physician, the Registered Nurse or Physician Assistant will initiate CPR.
- v. The OR front desk clerk will page the Hospitalist and the OR Charge Nurse and the Associate Chief Nurse.
- vi. The Code Blue system can be activated at any time more assistance is needed.
- vii. The Code Blue system will not be activated to obtain additional nursing help in the OR Suite. If additional nursing help is required in the Operating Room, the "Call Assist" option of the Jeron intercom system only is to be used.
- viii. Scrub Tech will assist in maintaining the sterility of the field if possible and/or assist with chest compressions.
- ix. Instrument, sponge and needle counts will be done following the Code or an x-ray taken to check for retained items when wound is closed and patient is stabilized.
- x. All Code Blue documentation will be completed and routed for review, per routine.

Attachment E

- b. **Weekend or Off-Tour:** Code Blue system is to be activated by pushing the Blue 'Code Blue' button and dialing 2111 stating the location of the Code.
- c. **In the Event the Arrest Victim is Not the Patient:**
 - i. Anyone of the OR Staff in attendance, not absolutely required to care for the surgical patient, will respond to resuscitation needs of the victim.
 - ii. Regular Tour: procedure for notification for help and resuscitation measures will be as described in A above.
 - iii. Off Tour: procedure for notification for help and resuscitation measures will be conducted as described in B above.
 - iv. The ICU/PACU will be contacted to ascertain availability of space.
 - v. The victim will be transported to the appropriate ICU/PACU space as available for continuation of resuscitative efforts. All OR Staff not needed to continue the resuscitation efforts will return to the Operating Room to continue to provide care for the patient in Surgery.

STANDARD OPERATING PROCEDURE FOR CODE/RRT PAGER TESTING

1. The pagers will be checked on a monthly basis, but subject to change based on data collected after evaluation by the Critical Care Committee. The time of day pagers are tested will be alternated day/night shift.

2. The results of the pager testing program will be evaluated by the Critical Care Committee quarterly with the expectation that changes to frequency will be made using data established through testing.

3. **AOD responsibilities:**

a. The AOD will test paging system – there will be no specific time when this needs to be done and it can be randomly determined by the AOD.

b. The AOD will test the paging system by paging the 300 pager and enter 2121 as a call back. The people that receive the page will call back and respond with their name, role, and location in hospital (i.e. Jason – ICU nurse, ICU).

c. AOD will check them off the list as received the page. (see check list attachment).

d. AOD will then, page the 800 pager via the phone system only and enter 2121 as a call back number. Again, responders should call back with name and role.

e. AOD will check them off as “received the page” on checklist.

f. Documentation of time pagers were tested and results of test pages (who responded) will be logged in AOD log sheet.

4. **Code Blue Team/Rapid response team members (ICU nurse, NOD, MOD, Hospitalist, Mid-levels, and Respiratory Therapy):**

a. Respond to the “Test page” within 5 minutes by calling the AOD at 2121.

b. Respond by briefly stating your name, title/role, and location in hospital (i.e. Ray – RT, 3rd floor hallway)

5. Providers that are not on duty should shut off pagers to avoid this daily test page.

6. Notification of failure on a day to day basis will be reported by the AOD to the Associate Director and Patient Safety Manager.

CLINICAL TRAINEES: ROLES AND PROCEDURES FOR STUDENT TRAINEES

1. **PURPOSE:** To define roles and responsibilities of Grand Junction Veterans Health Care System (GJVHCS) personnel and affiliating program personnel for student clinical rotations and to establish procedures for GJVHCS related to education of clinical trainees to ensure safe patient care, offer positive learning experiences for students of academic affiliates.
2. **POLICY:** Clinical GJVHCS Professionals retain full responsibility for the care of patients and maintains administrative and professional supervision of students in conjunction with the faculty of the affiliating institution. Students attending a preceptor experience are supervised at all times by the designated preceptor and/or clinical instructor. The Education and Development department will support education of trainees including promoting appropriate Veterans Affairs (VA) student access, orientation and in processing, safety of Veterans and Trainees, and positive learning experiences for students.
3. **RESPONSIBILITIES:**
 - a. The Education and Development Department (as delegated to the Clinical Scholar Coordinator):
 - 1) Coordinates Clinical Trainee placement with appropriate preceptors according to area of specialty and approval of Manager.
 - 2) Maintains trainee records in trainee spreadsheet for annual reports.
 - 3) Participates in Clinical Trainees MCM revision, student selection process, interviews, and coordinates the clinical portion of internship programs including those that involve a stipend such as the Veterans Affairs Learning Opportunities Residency (VALOR) program.
 - 4) Investigates and verifies the information requested in the Affiliations Trainee Qualifications and Credentials Verification Letter (TQCVL), Educational Program Letter of Agreement (EPLA) and forwards it to Designated Learning Officer (DLO).
 - 5) Approves proposals at the graduate level. Upon completion of special projects, students need approval to share findings with the staff, school, professional organizations, and/or administration through in-services, oral/poster presentations, or written reports.
 - 6) Coordinates clinical experiences and student projects with approved clinical preceptors and appointed faculty of the affiliate institution.
 - 7) Maintains data regarding students.
 - 8) Ensures that affiliate faculty:

- a) Are oriented to and knowledgeable about GJVHCS policies and procedures related to patient care, occupational and environmental safety, bar code medication administration (BCMA), infection control and nursing service standard operating procedure for nursing trainees.
- b) Maintain a faculty-student ratio of 1:10 or less.
- c) Comply with fingerprints, VetPro, and complete background checks and all other requirements of on-boarding process to work at GJVHCS one month prior to start of clinical rotation.
- d) Coordinates with appropriate resources and instructors: Training for computer codes, electronic medical records/computerized patient records system (CPRS), Bar Code Medication Administration (BCMA) and other technical training as needed.
- e) Ensures that students and faculty comply with information security and patient privacy policies of GJVHCS when delivering patient care or utilizing information for class work or assignments (HIPAA, Cyber Security, emails, IT).
- f) Collaborates with affiliate faculty, Managers, and Directors in student placements at GJVHCS. Student placements are contingent upon:
 - (1) Patient acuity, census, and service resources to support clinical objectives.
 - (2) Mission critical goals and strategic priorities of GJVHCS.
 - (3) Availability of experienced preceptors with a degree equal or higher than the degree for which the trainee is enrolled.
 - (4) Availability of approved preceptors.
- g) Communicates student placements, training schedules and conference room availability to Affiliate faculty, and GJVHCS staff.
- h) Shares written post-clinical evaluations or school reports with appropriate staff.
- i) Upon completion of each clinical rotation, ensure faculty and students complete GJVHCS evaluations of their clinical experience: Clinical Trainee Evaluation & the National Online Learners Perception Survey accessed at <http://www.va.gov/oaa/surveys/>
- j) Provide opportunities for preceptors to give feedback regarding student performance and shares with respective faculty members in order to improve processes.

k) Support, resource, and professional development advocate for Preceptors and Clinical Scholars; continued growth, expansion, and recruitment of the Clinical Scholar Program; collaborates with Clinical Scholars throughout facility to facilitate learning experiences; continued evaluation of Clinical Scholar program for quality improvement.

l) Makes the final decision for student placements when requests for student placements from multiple schools exceed the available resources to support students, after consulting the Designated Learning Officer (DLO) and patient care managers.

m) Collaborates and explores with affiliate other alternative settings where Veteran care is delivered.

n) Communicates with Academic Affiliates and conducts an annual review to improve the quality of learning experiences at GJVHCS and to recommend curriculum improvements.

o) Attends regular meetings to continue to develop and expand student education: Clinical Practice Committee, VA Educators Integrated Network (VEIN) Committee, Clinical Scholar, and VALOR.

p) Follows recommendations from the Office of Academic Affiliations regarding employees enrolled in school, and clinical rotations at the GJVHCS:

(1) While a full-time employee of GJVHCS, the employee cannot simultaneously be receiving a VA stipend as a trainee.

(2) The training rotation must be temporally and physically separated from the employee's regular duties (i.e., the training hours must be different from the work hours). The employee's "tour of duty" must not include any training hours nor can authorized absence be given for participation in training. Training activities must be on the person's "own time" and not VA time.

(3) The work supervisor and training supervisors must be different.

(4) There must be two separate appointments. Aside from the regular work appointment, there must be a Without Compensation (WOC) temporary trainee appointment. When functioning as a trainee, the employee must take utmost care not to blend the two roles and GJVHCS must never call on the trainee to perform employee duties during training hours. If writing notes in the medical record as a trainee, it is important that the written notes state this and not include signature indicating VA employment status or role. This can be done by editing the signature line before finalizing the note.

(5) For employees in Compensated Work Therapy (CWT) programs, having a dual-role as a trainee raises a multitude of both ethical and legal challenges. Office of Academic Affiliations (OAA) recommends consultation with human resources, ethics,

and legal experts before beginning a program involving dual roles for employees in CWT programs.

q) Affiliate Faculty Members:

(1) Affiliate instructors or Program Director(s) are responsible for submitting an official request for students to complete clinical hours at GJVHCS via the Trainee Qualifications and Credentials Verification Letter (TQCVL) and Educational Program Letter of Agreement (EPLA) to Education and Development.

(2) All Affiliate faculty members planning to be the primary clinical instructor will contact Human Resources to complete all Information Technology (IT) requirements one month prior to start of clinical rotation: VetPro, Request for Personal Identity Verification (PIV) Card, fingerprinting, background check, Talent Management System (TMS) training, computer training and other requirements.

(3) The instructor is responsible for completing GJVHCS orientation and facility tour with Education and Development.

(4) Maintain accountability for student clinical performance, adherence to policies, documentation, and safe patient care.

(5) Holds self and students accountable to follow facility protocols and procedures concerning computer access codes, patient privacy and information security.

(6) Ensure that students maintain professional behavior, wear GJVHCS Identification (ID) badges, and adhere to GJVHCS dress code regulations while on hospital grounds (available in the GJVHCS Student Handbook).

(7) Provide a copy of the Clinical Rotation Schedule including dates and times students will be on the unit(s) including prep times. Post and communicate student's Clinical Rotation Schedule and faculty contact information in designated area prior to start of first clinical work day.

(8) Provide Clinical Scholar Coordinator with curriculum, objectives and skills list for students.

(9) Remains available for direct supervision, observation and mentoring of students, especially during high risk procedures (i.e., medication administration and invasive procedures) unless otherwise delegated to nurse preceptor/clinical scholar.

(10) Ensures proper supervision of students (including VALOR Students) during medication administration:

(a) Clinical faculty for Registered Nurse (RN), Licensed Practical Nurse (LPN), or Associate of Applied Science (AAS) students are to ensure that medication administration is observed by the instructor or the nurse assigned to work with the student as appropriate. All students are to be observed throughout the entire process of medication administration and not to be left unattended for any period of time during medication administration or when co-signatures are required.

(b) LPN students may administer intravenous fluids through venous access devices, pre-mixed IV fluids including electrolytes, vitamins, and antibiotics. They are not permitted to administer IV push medications, other IV medications and/or blood administration.

(11) In case of accidents or mistakes involving students, the instructor must report immediately to the manager, the nurse in charge of the patient, and the Clinical Scholar Coordinator. Documentation needs to take place in the appropriate forms.

(12) Students requiring emergent health care should be transported to the Emergency Department (ED). Expedited arrangements for transition of care should be made with the Academic Affiliate. Immediate notification of the Clinical Scholar Coordinator/Education Department and the Employee Health Nurse is required.

(13) Coordinates starting time of assigned tour to match the unit's tour of duty.

(14) Upon leaving the clinical areas, ensure that students report to the clinical staff in charge of the assigned patients and that documentation is completed consistent with the overall interdisciplinary plan of care.

(15) Communicate and resolve concerns with the Manager, and/or Clinical Instructor/Clinical Scholar Coordinator.

(16) Upon completion of the clinical rotation, ensures self and students complete out-processing and return GJVHCS badges (temp or PIV) and revoke access to GJVHCS. GJVHCS Clinical Trainees and faculty should complete GJVHCS Evaluations. Access can be reinitiated upon approval from the Education Department. Issuance of a badge is required for physical access of GJVHCS.

r) Student:

1) Completes all paperwork, mandatory trainings, orientation and IT requirements for on-boarding process at GJVHCS. All paperwork/forms and fingerprinting must be completed one month before the start of clinical rotation. Any delay in completing in-processing will delay or effect rotation availability. Fingerprinting is done by GJVHCS for all faculty and students. Proper ID must be presented during fingerprinting procedures (see requirements).

2) Safeguard Student Badge: signs out a badge from Education Department during orientation; agrees to safeguard as property of GJVHCS, wears at all times while on duty during clinical rotation at GJVHCS; surrenders at termination of clinical rotation, and is aware that failure to return GJVHCS badge may result in legal action.

3) Is present for clinical learning and is not to be depended upon for staffing. They may attend report and participate in direct patient care only under the supervision of a clinical instructor or preceptor.

4) Reports to the assigned staff when leaving the unit for breaks and conferences, and give synopsis of care at the end of each clinical day. Untoward signs and symptoms are reported when detected. The student is responsible for informing the assigned preceptor which procedures are beyond his/her capabilities and which procedures he/she must contact an instructor for supervised performance.

5) Approved students may administer medication via the Bar Code Medication Administration (BCMA) under the direct supervision of the instructor or preceptor.

6) Students may document in the patient's medical record, i.e., progress notes, flow sheets if computer access is granted. Entries must be reviewed and signed by the preceptor prior to submission/finalization.

7) The student contacts the instructor for any invasive procedures that are for first-time supervision. The assigned preceptor performs the procedure if the instructor is unavailable and the procedure cannot wait. The preceptor verifies approval of skill to be completed by the student with instructor or skill checklist.

8) When problems arise, the student contacts the instructor or Clinical Scholar Coordinator. If unavailable, the student will seek assistance with his/her preceptor.

9) Upon Completion of the clinical rotation, ensures immediate out-processing and returns GJVHCS badges (temp or PIV) and revoke access to GJVHCS. GJVHCS Clinical Trainees and faculty are required to complete GJVHCS Evaluations. Failure to do so may influence future access to GJVHCS. Access can be reinitiated upon approval from the Education Department. Issuance of a badge is required for physical access of GJVHCS.

s) Managers and Unit Staff:

1) All GJVHCS staff will be vigilant in ensuring any student at GJVHCS acting as a clinical trainee (i.e., Nursing and VALOR students, non-nursing students, completing assigned clinical hours, present in patient care areas, aligned with staff caring for patients) is wearing a student badge or non-PIV card. Any student present in a clinical setting who does not have a GJVHCS badge will be immediately sent to the Education and Development Department to complete in-processing.

2) Ensure they receive hand-off from students and faculty regarding objectives and skills checklists for assigned rotation.

3) Offer guidance and preceptorship as needed regarding location of unit resources; procurement of supplies, medications, equipment; and referrals for consultation with the interdisciplinary team for patient care.

4) Model professional practice and customer service.

5) Accept report from students and/or affiliate faculty at the end of the student's tour.

6) Provide input to faculty regarding student's clinical performance.

7) Report to Supervisor and Clinical Scholar Coordinator any issues regarding students that adversely influence safe patient care. (Complete incident reports and follow-up care according to protocol).

8) If the condition of the patient previously assigned to a student changes in a way that precludes student care, the staff in collaboration with the instructor will support Veteran reassignment.

4. **PROCEDURES:**

a. All schools seeking clinical placements for their students must ensure an Affiliation Agreement is in place with GJVHCS. All academic affiliations (Affiliation Agreements) between the school and GJVHCS must be in place prior to the start of any clinical rotation.

b. Schools requesting affiliations with GJVHCS will contact the Education and Development Department Clinical Scholar Coordinator to assess adequacy of resources in meeting mutual goals and clinical objectives. The Education Department will support the development of appropriate Academic Affiliation Agreement.

c. Affiliated schools and programs follow all guidelines established by the Department of Veterans Affairs.

1) The Trainee Qualifications and Credentials Verification Letter (TQCVL) must be completed for every student, including Capstone/Senior Specialty, each semester.

2) Completion of an Education Program Letter of Agreement (EPLA), which specifies the terms of the training program between the school and nursing service. This agreement covers specific information regarding the requesting service/section, specific training program, type of trainees, program objectives, specific learning opportunities available for trainees in alignment with the VA's mission, vision and values, and point of contact for both institutions. An

updated EPLA must be completed initially and updated as needed upon request from the Clinical Scholar Coordinator.

3) Affiliate faculty and students are appointed to a non-compensated or WOC status during clinical rotations, with the exception of students enrolled in stipend programs such as Allied Health Professions and VALOR.

4) Approval of student placement and orientation to the institution for students and teachers is coordinated by the Clinical Scholar Coordinator.

d. Program Directors are required to maintain a copy of updated Cardiopulmonary Resuscitation (CPR) status and verification of immunizations and health clearance for all students and faculty, and verification of associated license of clinical faculty assigned to supervise students on site. Clinical faculty must attend, along with students, Student/Faculty Orientation. VetPro (Federal Credentialing) clearance is required for all instructors and initiated by the GJVHCS Clinical Scholar Coordinator.

e. The Clinical Scholar Coordinator arranges affiliate faculty orientation to the facility, student/teachers expectations, issuing of badges, finger prints, computer training, and completion of the VA web based training for trainees.

f. Students are not independent practitioners, and as such need supervision of patient care activities by the clinical faculty or the assigned clinical preceptor. Therefore, all students must be aligned with an academic affiliate. Medication administration and performance of invasive procedures requires co-signatures and direct observation throughout the entire process by clinical instructor or the assigned preceptor..

g. Students and non-VA clinical faculty (unless long term agreement) must complete out-processing and return temporary and/or ID VA badges. Upon completion of clinical rotations, all students and non-VA clinical faculty (unless long term agreement) lose their privileges to participate in patient care at GJVHCS, without approval from the Education Department. Note: lapse of returning clinical faculty and students must re-initiate and complete/update in-processing steps as directed.

5. **SUPPLEMENTAL INFORMATION:**

a. Definitions:

Education Program Letter of Agreement (EPLA): Each program requires an education program letter of agreement. This agreement covers specific information regarding the requesting service/section, specific training program, type of trainees, program objectives, specific learning opportunities available for trainees in alignment with the GJVHCS's mission, vision and values, and point of contact for both institutions.

Without compensation (WOC) status: Written agreement indicating that affiliate faculty and students do not receive VA benefits or compensation for services rendered.

Accredited Schools of Nursing: A school whose program has been accredited by one or more of the following: the Commission of Collegiate Nursing Education (CCNE), or the National League of Nursing (NLN) of the American Association of Colleges and Nursing.

Clinical Scholar Coordinator: Individual responsible for approving nursing affiliates and for coordination of student placement.

Clinical Scholar: Advanced Preceptor.

Preceptor: Clinical expert and trainer for students/staff of GJVHCS. All employees are expected to share clinical expertise with the next generation of healthcare workers.

Instructor: Academic Affiliate or GJVHCS employee assuming official responsibility for the oversight of student clinical rotation/education.

Out-Processing: Task associated with completing a clinical rotation removing clinical access of student or instructor to the GJVHCS.

VA Clinical Trainee: Students of an Academic Affiliate involved in the care of a Veteran. Note: GJVHCS student/clinical trainee access requires an affiliate to confirm student status and program enrollment.

Faculty/Student Badges: Upon completion of GJVHCS In-Processing, students and faculty will be issued a temporary badge from Education and Development that must be worn at all times during clinical rotation. This badge signifies that the student has completed in-processing, is oriented to GJVHCS policies/procedures, is current on all TMS training for trainees, and is legally and rightfully able to participate as a clinical trainee at GJVHCS. These badges expire annually and vigilance to ensure badge is worn by clinical trainees and not expired is an expectation of all staff, faculty and students.

6. **RESCISSION:** MCM 003-87, Clinical Trainees: Roles and Procedures for Student Trainees, dated March 2015.

7. **COORDINATION:** Human Resources Management (05), Education and Development, and Nursing Administration (003).

Michael Kilmer
Director

DISTRIBUTION: E

NICOTINE/SMOKING/TOBACCO CESSATION PROGRAM

1. **PURPOSE:** To define the procedure for providing a Nicotine/Smoking/Tobacco Cessation Program to patients, employees and volunteers.
2. **POLICY:** It is the policy of the Grand Junction Veterans Health Care System (GJVHCS) that evidence-based smoking and tobacco use cessation care, to include counseling and medications, will be made available to all Veterans who are attempting to quit smoking or other tobacco use. All patients desiring assistance with tobacco cessation will be provided with evidence-based interventions or other resources appropriate to the individual Veteran's situation.
3. **PROCEDURES:** Patient referral to tobacco cessation resources may be self-initiated or provider-driven. The program consists of several components including the referral process, individual education materials, support group sessions, group training classes, and nicotine replacement.
4. **RESPONSIBILITIES**
 - a. The **Medical Center Director** is responsible for:
 1. Identification of a Smoking and Tobacco Use Cessation Lead Clinician, to be the principle point of contact for all clinical communications and reports regarding smoking cessation and tobacco control related issues to the Office of Public Health Policy and Prevention (PHPP).
 2. Reviewing, on an annual basis, the contact information to ensure that the information is correct.
 - b. The **Smoking and Tobacco Use Cessation Lead Clinician** is responsible for:
 1. Serving as an advocate for excellence in smoking and tobacco use cessation clinical care and related public health issues.
 2. Serving as the facility point of contact for communications to and from the Office of PHPP.
 - c. The **Primary Care Providers (PCP)** and **Mental Health Providers** will:
 1. Screen patients according to clinical practice guidelines.
 2. Strongly advise and encourage all inpatients and outpatients identified as currently smoking to quit.

3. Ensure patients receive education regarding the availability of smoking cessation services and treatments. Tobacco use pharmacotherapies, e.g., nicotine replacement therapy and gum, are to be offered and provided for interested Veterans with no medical contraindications. Veterans identified as currently smoking are to be identified using the diagnosis code Tobacco Use Disorder (305.1) in their Active Medical Problem List and PCPs are to thoroughly document their efforts in determining the patient's position and/or readiness to quit in the medical record.
 4. Primary care providers will work collaboratively with mental health clinicians to provide tobacco cessation pharmacological interventions.
 - d. The **Director, Addictive Disorders Services** is responsible for the overall management of the Smoking Cessation Program.
 - e. **Addiction Counselors** are responsible for:
 1. Response to consultation service requested by the Primary Care Provider (PCP) and Mental Health Provider for individual and group smoking cessation services using CPRS referral mechanisms.
 2. Implementing intervention strategies which are evidence-based and adapted to the Veteran's individual needs.
 3. Facilitation of access to additional multidisciplinary services that encourage healthy lifestyle modifications, such as dietary consultation or recreation therapy.
 - f. **Library Technician** will maintain Library health education resources that include tobacco cessation topics by direct request to the Library charge desk personnel during business hours.
 - g. **Service Chiefs and Supervisors** will support employees who are requesting assistance with smoking cessation, as resources permit.
5. **REFERENCES:**
- a. Department of Veterans Affairs: VHA Directive 1056, National Smoking and Tobacco Use Cessation Program, February 10, 2014.
 - b. Clinical Practice Guideline: Treating Tobacco Use and Dependence, 2008
 - c. Varenicline Criteria for Prescribing, VA Center for Medication Safety, Tobacco Use Cessation Technical Advisory Group, Public Health Strategic Healthcare Group, VA Pharmacy Benefits Management Services, VISN Pharmacist Executives, and Medical Advisory Panel, Updated February 2010.

6. **COORDINATION:** 001, 003, 00Q, 111, 112, 116, 119
7. **RESCISSION:** Medical Center Memorandum No. 11-14 Nicotine/Smoking/Tobacco Cessation Program, dated January 2014.

Lori A. Lohar, MS, RD
Acting Medical Center Director

DISTRIBUTION: E

ABUSE AND NEGLECT

1. PURPOSE: To outline policy and procedures for the identification, evaluation, treatment, referral, and reporting of possible victims of neglect, including involuntary seclusion, exploitation, and abuse and exploitation, resulting from physical assault, rape or other sexual molestations, domestic abuse, or abuse of elders, dependent adults or children.

2. POLICY:

a. Possible victims of abuse and neglect will be identified utilizing established criteria so that treatment can be provided to address the underlying cause of trauma as well as its manifestations in presenting complaints and symptoms. Relevant state statutes will be followed for the identification, evaluation, treatment, referral, and reporting of possible victims of abuse and neglect unless otherwise specified by Grand Junction Veterans Health Care System (GJVHCS) policy or indicated by federal law.

b. In the reporting of possible abuse and neglect, it is the policy of GJVHCS to cooperate with all law enforcement agencies, including state, county and local government departments which are charged by law with the protection of the public health and safety. This policy is based on standing written requests of Colorado state and local law enforcement agencies made pursuant to Section 5701(f)(2) of Title 38 United States Code.

c. Legal opinion by VA General Counsel states that when any VA healthcare professional receives information about abuse or neglect in the course of their VA employment:

1) State law cannot independently impose any obligation on that employee to follow state reporting requirements.

2) The state may not bring civil or criminal action against the employee or the employee's state license for failure to report.

3) The employee making a good-faith effort to report and acting within the scope of their VA employment will have immunity from civil liability.

d. The identity of those persons who report abuse is confidential and is disclosed only between the involved social service agencies, local law enforcement agencies, long-term care ombudsman coordinators, licensing agencies, and the district attorney (in criminal prosecution, upon waiver of confidentiality by the reporter, or by court order).

e. Unless the Veteran victim of abuse gives consent, the information released must be limited to name, address, and the facts of abuse. The release cannot include information about the Veteran's medical condition unless their consent is given.

f. All Emergency Department patients will be screened for possible abuse or neglect during the triage process.

g. The risk of neglect, exploitation or abuse can come from anyone, including staff, students, volunteers, other residents/patients, visitors, and family members.

3. DEFINITIONS:

a. **Reporting Incidents** are instances where a GJVHCS staff involved in provision of health care services has reason to suspect abuse, neglect, or exploitation resulting from physical assault, rape or other sexual molestation, domestic abuse, or abuse of elders, dependent adults or children.

b. **Elder:** A person 60 years of age or older.

c. **Dependent Adult:** A person between the ages of 18 and 64 who has physical or mental limitations which restrict their ability to carry out normal activities or are unable to protect their rights including, but not limited to; persons who have physical or developmental disabilities, or whose physical or mental abilities have diminished because of age. This includes any person between the ages of 18 and 64 who is admitted as an inpatient to a 24-hour health facility, including an acute hospital.

d. **Child:** A person under the age of 18 years.

e. **Child Abuse:** Physical injury inflicted by other than accidental means on a child by another person. This may include sexual abuse of a child, any act of willful cruelty, unjustified punishment or unlawful corporal punishment, injury to a child, neglect of a child, or abuse in out-of-home care.

f. **Physical Abuse/Assault:** Intentionally or recklessly causing or attempting to cause bodily injury, or placing another person in reasonable apprehension of imminent serious bodily injury to them self or another.

g. **Rape:** An act of sexual intercourse accomplished with a person not the spouse of the perpetrator against a person's will by means of force, violence, duress, menace, or fear of immediate and unlawful bodily injury on the person or another; or where a person is incapable, due to a mental disorder or developmental or physical disability, of giving legal consent.

h. **Domestic Violence.** Domestic violence (DV) means any violence or abuse that occurs within the "domestic sphere" or "at home," and may include child abuse, elder abuse, and other types of interpersonal violence.

i. **Intimate Partner Violence.** Intimate partner violence (IPV) means physical violence, sexual violence, stalking, or psychological aggression (including coercive tactics) by a current or former intimate partner (i.e., spouse, boyfriend/girlfriend, dating partner, or ongoing sexual partner). Partners may or may not be cohabitating and may be same or opposite sex.

j. **Neglect:** Acts or omissions harming or threatening to harm the health or welfare of the child, elder, or dependent adult.

k. **Mental Suffering:** Fear, agitation, confusion, severe depression, or other forms of serious emotional distress brought about by threats, harassment, or other forms of intimidating behavior.

l. **Abandonment:** The desertion or willful forsaking of a child, elder, or dependent adult by anyone having care or custody of that person under circumstances in which a reasonable person would continue to provide care and custody.

m. **Fiduciary Abuse:** Occurs in a situation where any person who has the care and custody of an elderly or dependent adult or who stands in a position of trust steals, secretes, or appropriates that adult's money or property for any use or purpose not in the due or lawful execution of their trust. It includes extortion, fraud, theft, and the misuse of funds or property.

n. **Exploitation:** An unjust or improper use of another person for one's own benefit.

o. **Elder Abuse.** Elder abuse means any abuse or neglect of persons age 60 or older by a caregiver or another person in a relationship involving an expectation of trust.

Covered Professionals are VHA employees or contractors who are Physicians, Dentists, medical residents or interns, hospital personnel and Administrators, Nurses, Health Care Practitioners, Chiropractors, Osteopaths, Pharmacists, Optometrists, Podiatrists, Emergency Medical Technicians, Ambulance Driver, Medical Examiners, alcohol or drug treatment personnel, and persons performing a healing role or practicing the healing arts. The term also includes Psychologists, Psychiatrists and mental health professionals, Social Workers, licensed or unlicensed marriage, family, and individual counselors; and child care workers and administrators. Note: All VHA trainees have a duty to report suspected cases of abuse and neglect directly to their VHA supervisor. If the situation requires additional reporting to a state agency, the supervisor will assist and support the trainee through the process.

4. RESPONSIBILITIES:

a. **Administrators and employees of both acute and long-term health care facilities** who work directly with patients as part of their official duties are "care custodians" and as such identify and treat patients who are victims of assault, abuse, and neglect. They are also required by law to report the abuse of children, elders, and dependent adults, as well as, incidents of physical assault, rape or other sexual molestations, and domestic violence. They are considered to be "mandatory reporters."

b. **Each Service Chief** is responsible for ensuring that all clinical staff receive instruction about, and comply with, policy on identification, evaluation, treatment, referral, and reporting of possible victims of abuse, exploitation and neglect.

c. **The Associate Director for Patient Care Services** (or designee), as Confidentiality Officer, is responsible for assisting in the implementation of mandatory reporting procedures; and ensuring a process for documentation.

d. **The Chief, Police Service**, is responsible for ensuring procedures are in place for the handling and safeguarding of evidence, and interfacing with local police and other law enforcement agencies in cases of physical assault, sexual assault, and domestic violence, as appropriate.

e. **Social Workers** are responsible for developing linkages with community resources specializing in the evaluation and care for victims of abuse.

5. **PROCEDURES FOR IDENTIFICATION, EVALUATION, TREATMENT, AND REFERRAL:** In accordance with federal law, names of patients believed to be victims of, or accused of domestic abuse will be automatically "opted out" of the patient directory. In particular, if a next of kin, emergency contact, or person with a power of attorney or privacy waiver has been accused of abusing a patient attempts to contact or visit the patient they will be given the following statement, "I have no information on that person that I can give you."

a. All Emergency Department patients will be screened by a Registered Nurse (RN) in the Emergency Room department during the triage process with referral to Social Work for any positive results.

b. Possible victims of abuse and neglect will be identified utilizing established criteria (see Attachment A). Staff is reminded that none of the indicators provide conclusive evidence, but rather must be understood in the context of all of the information available.

c. Assessment and treatment of victims of alleged or suspected abuse or neglect will be conducted, as appropriate, with the consent of the patient or legal conservator in accordance with hospital policy.

d. Privacy will be ensured in interviewing and examining the patient. Recognition and validation of the patient's situation will be conveyed.

e. Emergent medical needs will be assessed and addressed. Victims will be referred to the appropriate department of jurisdiction (i.e., Grand Junction Police Department, Mesa County Sheriff Department) through the VA Police for examination and collection of evidence once the patient's treating physician declares them medically stable.

f. The collection, retention, and safeguarding of specimens, photographs, and other evidentiary material released by the patient will be accomplished by police procedure.

g. When abuse is suspected or identified, a referral will be made to the Social Worker to assist in the assessment, treatment, referral, reporting, and documentation of abuse. Referrals will be made to the appropriate GJVHCS professionals, including Psychiatrists, Psychologists, Social Workers, Nurses, and to community resources serving victims of the specific trauma.

h. The medical record/report of Contact will include documentation of examinations; detailed descriptions of any injuries, including type, number, size, location, resolution, possible causes, and explanations provided; treatment given (including whether any specific evidence has been retained such as specimens or photographs); referrals made to other care providers and to community agencies; and reporting to required authorities.

i. Photographs of injuries will be taken after signed informed consent is obtained and when indicated. All photographs will be taken by arrangement with the VA Police Service.

6. PROCEDURES FOR REPORTING:

a. Responsibilities:

1) **Any Health Care Practitioner** who, in their professional capacity or within the scope of their employment, must ensure that an immediate oral report is made within 24 hours with written documentation of progress notes/Report of Contact provided to the appropriate authorities during regular business hours or to local law enforcement, if not during business hours. Initiation of oral report should be made if mistreatment is observed or if the person is at imminent risk. Although not actually treating children, all **Health Care Practitioners** employed in either paid or without compensation positions by GJVHCS, **MUST REPORT ACTUAL OR SUSPECTED CHILD ABUSE IMMEDIATELY OR AS SOON AS PRACTICALLY POSSIBLE BY TELEPHONE AND WITHIN 24 HOURS IN WRITING.** GJVHCS Social Work Service is to be flagged as an additional signer on all documentation if victim is a patient.

2) **GJVHCS personnel** are not relieved of their mandated reporting obligation if a physician fails to report an injury caused by domestic violence. Any staff member may make a mandated report on behalf of GJVHCS. Mental health professionals who simply learn of these injuries in the course of providing mental health services are exempt from the reporting requirement.

3) **The VA Police Service** will be responsible for notifying the law enforcement agency of jurisdiction, seeing that progress notes/report of Contact and a written report is filed, and explaining that any decision to prosecute or press charges will be made by a law enforcement representative, not the victim.

4) The **Social Worker** is responsible for coordinating the reporting of the abuse during the administrative work week and will assist the Health Care Practitioner by providing the appropriate phone numbers, and ensuring the appropriate reporting procedures are followed. The Social Worker is responsible for determining the

need for follow-up and making appropriate referrals to follow-up personnel within GJVHCS or community agencies. The Social Worker is also responsible for providing each victim with a list of appropriate resources, including the names and addresses of shelters and appropriate hotline numbers, and documenting all contacts in the medical record or Report of Contact.

5) All **Health Care Practitioners** who have knowledge of or reasonably suspect that other types of abuse described below have been inflicted upon an elder or dependent adult or that their emotional well-being is endangered in any other way, **MAY REPORT** such known or suspected instance of abuse to a long-term care ombudsman coordinator (when the abuse is alleged to have occurred in a long-term care facility) or to the county adult protective services agency (when the abuse is alleged to have occurred anywhere else).

a) When the **Health Care Practitioner** has observed an incident that reasonably appears to be physical abuse, exploited or neglect.

b) When the **Health Care Practitioner** has observed a physical injury where the nature of the injury, its location on the body, or the repetition of the injury clearly indicates that physical abuse has occurred.

c) When the **Health Care Practitioner** is told by a child that they have experienced behavior constituting abuse or neglect.

d) When the **Health Care Practitioner** is told by a Veteran, spouse, or other source that a child has been abused, exploited, neglected, or maltreated.

e) When the **Health Care Practitioner** is told by an elderly or dependent adult or by someone close to them that they have experienced behavior constituting physical abuse.

f) The **Health Care Practitioner** who discovers the injury is responsible for informing other appropriate members of the health care team, and for documenting any physical or other evidence in the patient's medical chart or on a Report of Contact as outlined below.

6) If the suspected abuse is perpetrated by a GJVHCS staff member, the GJVHCS Police will be notified along with the appropriate Service Chief. The **Chief of Staff or Risk Manager** will arrange for reporting the matter as required by VA regulations.

7) The **Administrative Officer of the Day (AOD)** is responsible for coordinating the reporting of the abuse during off-tours by providing the appropriate phone numbers and copying all documentation to be submitted to the social worker for purposes of follow-up.

a) Procedures:

1) Assessment and Documentation:

a) Upon discovering an injury caused by domestic violence or other assaultive or abusive conduct, the **treating physician** will contact the VA Police Service, and request that the law enforcement agency of jurisdiction be contacted immediately.

b) In addition to the telephonic report, the **physician or designated representative** will make a written progress note in the patient's chart or report of contact. Unless the Veteran involved gives consent, the information released must be limited to name, address, and the facts of the domestic violence incident. The release cannot include information about the Veteran's medical condition except for the injury being reported unless their consent is given. The results of a physical examination which indicate abuse should be documented completely in the patient's medical record or Report of Contact, including corroborating statements and pertinent psychosocial information.

c) After patient's written consent is obtained, photographs of the injuries should be taken, and one copy filed in the patient's Medical Record, and another copy given to VA Police Service.

d) Any evidence of physical abuse should be labeled and given to VA Police Service for safekeeping.

e) The **VA Police Service** will collect information and telephone the law enforcement agency of jurisdiction to report the injury and request that the agency come to GJVHCS to interview the victim and conduct an investigation if appropriate.

f) The **Health Care Practitioner**, with other appropriate members of the health care team, will evaluate situations of actual or suspected child abuse, exploitation, neglect, or maltreatment.

g) The child's parent or guardian will be informed that the staff is mandated to report any suspicion of child abuse, exploitation, neglect, or maltreatment to the proper authorities.

h) Consent: The **clinician** will attempt to obtain Veteran's consent to discuss all aspects of the case with community agencies so that full investigation and follow-up can be conducted.

ALTHOUGH CONSENT OF THE PATIENT TO RELEASE INFORMATION SHOULD BE SOUGHT, REFUSAL BY THE PATIENT WILL NOT BAR REPORTING.

i) Telephone Reports: Mandated reports of abuse must be made immediately, or as soon as possible, by telephone by the **professional health care practitioner** who has observed or learned of the alleged abuse to the appropriate authorities. If the Veteran has not given consent for release of information, the information reported about the Veteran will be limited to the Veteran's name and address, and the facts of abuse. It cannot include information about a Veteran's medical condition.

1) When the alleged abuse has occurred in a long-term facility, (i.e., board and care, residential care, intermediate care, or skilled nursing facility) the report should be made by calling the Long-Term Care Ombudsman or the Grand Junction Police Department within 24 hours.

2) When the alleged abuse has occurred elsewhere, the report should be made by calling the Department of Social Services Adult Protective Services or the Grand Junction Police Department.

3) When the conduct involves criminal activity, it must be reported immediately to the VA Police Service, who will then report to the appropriate law enforcement agency.

4) Although consent of the patient to release information should be sought, refusal by the patient will not bar reporting.

j) Written reports: A written report of the alleged abuse, with limitations as in h) above, should be made by the **Health Care Practitioner** to the appropriate authorities. Long-Term Care Ombudsman (if the suspected abuse occurred in a long-term care facility), to Department of Social Services (for all other cases), with a copy filed in the Veteran's administrative file and a copy sent to the attention of a **Social Worker** for purposes of follow-up.

k) During regular working hours, the **Social Worker** should be contacted to provide the practitioner with assistance in making the telephone report, completing the necessary paperwork and ensuring that the appropriate agency is notified. During off-tours, the **Health Care Practitioner** should telephone in the report, contact the **AOD**, who will ensure that the information is sent to a Social Worker on the next regular administrative work day.

l) When the adult Veteran is returning to the same environment where the alleged abuse, exploitation, or neglect occurred, they will be referred for a home evaluation through either a GJVHCS **Social Worker** or a home health agency.

m) When appropriate, the adult Veteran will be assisted with relocation to a more suitable placement.

7. **REFERENCES:**

- a. M-1, Part I, Chapters 4, 5, and 11; MP-1, Part I, Chapter 2, DM&S Supplement,
- b. M-2, Part I, Change 66, DM&S Circular 10-89-29.
- c. MCM HIMS-1, "Release of Information from Claimant's Records".
- d. Comprehensive Accreditation Manual for Hospitals.
- e. VHA Directive 1605.1.
- f. CRS 18-65-108 <http://codes.findlaw.com/co/title-18-criminal-code/co-rev-st-sect-18-6-5-108.html>.

8. **ATTACHMENT:**

Attachment A-Indicators of Abuse.

Attachment B-VHA Directive 1199, Appendix A.

9. **COORDINATION:** 001, 11, 003, 111, 112, 116, 122, 132, and 00Q.

10. **RESCISSION:** Medical Center Memorandum No. 003-48, Abuse and Neglect, dated August 2015.

Michael T. Kilmer
Director

DISTRIBUTION: E

INDICATORS OF ABUSE

1. DOMESTIC ABUSE

a. Medical Indicators (Female):

- 1) Injuries to head and neck are most common: periorbital hematoma, fractured mandible, orbit fractures, nasal fractures, perforated tympanic membranes, lacerations around the eyes and lips, contusions and soft tissue injuries, and injuries above the hairline.
- 2) Injuries to breasts and broken ribs (usually from kicking).
- 3) Arm injuries (fractures from warding off blows to the head or from severe pulling or twisting of the arm).
- 4) Strangulation, bilateral carotid artery compression, and resulting bruises.
- 5) Back or spine injuries from being thrown, pushed, or kicked.
- 6) Soft tissue injuries to the torso or extremities that may be hidden by clothing.
- 7) Injuries to the abdomen during pregnancy and miscarriage as a result of trauma.
- 8) Injuries sustained from weapons of any type.
- 9) Burns as a result of cigarettes, appliances (irons), friction (rug burns), scalding liquids, chemicals, or arson.
- 10) Multiple injuries, particularly in combination with evidence of old injury.
- 11) Chronic pain, psychogenic pain, or pain due to diffuse trauma without visible evidence.
- 12) Physical symptoms related to stress, chronic post-traumatic stress disorder, other anxiety disorders, or depression (i.e., sleep and appetite disturbances; fatigue, decreased concentration, sexual dysfunction, chronic headaches, abdominal and gastrointestinal complaints, palpitations, dizziness, paresthesia, dyspnea, atypical chest pain).
- 13) Gynecologic problems; i.e., frequent vaginal and urinary tract infections, dyspareunia, pelvic pain.
- 14) Frequent use of prescribed minor tranquilizers or pain medications.

15) Frequent visits with vague complaints or symptoms without evidence of physiologic abnormality.

16) Exacerbation or poorly controlled chronic illnesses such as asthma, seizure disorder, diabetes, arthritis, hypertension, and heart disease.

17) Frequent visits with increasingly severe trauma.

b. Mental Health/Psychiatric Indicators (female):

1) Feelings of isolation and inability to cope.

2) Suicide attempt or gestures.

3) Depression.

4) Panic attacks and other anxiety disorders.

5) Alcohol or drug abuse.

6) Post-traumatic stress disorder reactions.

c. Behavioral Indicators (female):

1) Seeming discrepancies between injury and explanation.

2) Delay in seeking medical care.

3) Partner accompanies patient, insists on staying close, and answers all questions directed to patient.

4) Reluctance of a patient to speak or disagree in front of partner.

5) Intense irrational jealousy or possessiveness expressed by partner or reported by patient.

6) Denial or minimization of violence by partner or patient.

7) Exaggerated sense of personal responsibility for the relationship, including self-blame for partner's violence.

8) History of drug/alcohol abuse by either the patient or partner.

9) History of child abuse/neglect in the family.

10) History of rape by partner.

d. Profile of an Abused Man:

1) Manifests injuries primarily on legs, back, head, or shoulders.

2) Presents with injuries requiring emergency attention.

3) Maintains strong, rigid expectations of each parent's specific role.

4) Has body size or shape not relevant to the type or degree of injury.

5) Indicates, on questioning, that verbal aggression led to physical aggression.

2. **PHYSICAL ASSAULT**

a. Physical Findings:

1) Trauma, especially to head, neck, abdomen from beating (i.e., soft tissue injuries, major organ injuries in specific area of blunt trauma).

2) Stab wounds, usually to the chest or abdomen, resulting in major blood loss, sucking chest wounds, organ penetration.

3) Missile injuries (i.e., projectile from pistol, rifle, shotgun, or explosion enters and exits the body or lodges in the body).

4) Injuries ranging from minor puncture wounds to life-threatening wounds of the chest, abdomen, or head.

5) Lacerated tissue in bullet's path, possible injury to remote organs.

6) Initial wound, subsequent tissue injury (not necessarily in direct path of the bullet); secondary infection.

b. Crime Victim Reactions:

1) Fear, anger, grief, resentment, dependency, powerlessness, desire for revenge, and perhaps shame and guilt.

2) Victims may experience troublesome mood swings, mental confusion, hypersensitivity to the reactions of others, and to noise.

a) Physical symptoms include, but are not limited to, headaches, backaches, and other body pains, nausea and other gastrointestinal problems; intense shaking.

b) Pre-existing medical, physical or psychological problems can be exacerbated.

3. **RAPE AND OTHER SEXUAL MOLESTATION**

a. Rape:

1) Special considerations for health care providers:

a) Only a small minority of rape victims seek assistance soon after they are raped and acknowledge that they have been raped.

b) Other victims seek medical care with complaints based on symptoms, but do not disclose that an assault has occurred.

c) Others do not present until months after the incident, but then contact the medical community repeatedly over time.

d) Immediate impacts on physical health and wellbeing:

1) Physical effects of trauma may include soreness, bruising, and rectal bleeding.

2) Gastrointestinal irritability, fatigue, tension headaches, intense startle reactions, and disturbed sleeping and eating patterns, also are noted.

3) Gynecological trauma, pregnancy, HIV and other infections, and sexually transmitted diseases are potential consequences, and pose further fear.

4) Alcohol and other drugs may be used for escape, sleep aid, or self-medication.

e) Long-term Effects:

1) Chronic anxiety and feelings of vulnerability, loss of control, and self-blame.

2) Catastrophic fantasies, feelings of alienation and isolation, sexual dysfunction, and physical distress.

3) Post-traumatic stress disorder indicators such as numbing of affects, chronic states of arousal, nightmares, and flashbacks.

4) Mistrust of others, phobias, depression, hostility, and somatic symptoms.

f) Other Considerations:

1) Partner rape is frequent among women who are being physically assaulted by their partners.

2) Women who have been sexually abused as children are at increased risk of rape.

b. Adult Survivors of Child Sexual Molestation Indicators:

1) Symptoms of post-traumatic stress disorder without an apparent history of current or past rape, date violence, partner abuse, or other trauma.

2) Evidence of ongoing severe depression, especially if accompanied by self-harm and suicide attempts.

- 3) Evidence of sexual dysfunction or unusual anxiety involving sexual activities or exposure of the body (possibly including medical and especially gynecological examinations).
- 4) Early onset of alcohol or drug abuse.
- 5) Childhood history of running away.
- 6) History of repeated physical or sexual victimization.
- 7) Somatic disorders, particularly abdominal pain, headaches, and eating disorders.

4. **CHILD ABUSE OR NEGLECT:**

a. Factors which may be Predictors of Abuse and/or Neglect in Children: Premature birth; hospitalization of neonate which prevents or discourages parental contact; congenital abnormalities or deficiencies; colic which makes an infant difficult to console; presence of any condition or situation which interferes with parent-child bonding; birth of a child to adolescent parents.

b. Characteristics of Families at High Risk for Child Abuse/Neglect: Other violence in the home; substance abuse by parents or caretakers; lack of maturity on the part of parents or caretakers to care for the child; parental expectations inconsistent with the child's developmental abilities; socially isolated families; family stresses such as inadequate housing, job loss, increased financial burdens, serious illness, death in the family, separation or divorce.

c. Suspect History of Injury: Unexplained history of injury; discrepant histories; histories blaming third parties, alleging self-injury, and histories that inadequately explain injury; delay in seeking care more than 24 hours; absence of parental concern; and unrelated adult seeking medical care for child.

d. Suspicious Physical Injuries:

1) Bruises and welts: Face, lips, mouth, ears, eyes, neck or head; trunk, back, buttocks, thighs or extremities; regular pattern formation, often resembling the shape of the article used to inflict the injury (i.e., hand, teeth, belt buckle, electrical cord).

2) Burns: Cigar or cigarette, especially on the soles, palms, back or buttocks; immersion burns (stocking or glove-like on extremities; doughnut-shaped on buttocks or genitals); patterned burns resembling an electrical appliance (i.e., iron, burner, or grill).

3) Fractures: Skull, ribs, nose, facial structure, or long bones; multiple or spiral fractures; fractures in various stages of healing; metaphyseal "break" fractures; unusual locations of periosteal reaction.

4) Lacerations or Abrasions: Rope burns on wrists, ankles, neck or torso; palate, mouth, gums, lips, eyes, or ears; external genitalia, body surfaces.

5) Abdominal Injuries: Bruises of the abdominal wall; intramural hematoma of duodenum or proximal jejunum, intestinal perforation, ruptured liver or spleen, ruptured blood vessels, kidney or bladder injury, pancreatic injury.

6) Central Nervous System Injuries: Subdural hematoma (reflective of blunt trauma or shaking), retinal hemorrhage, subarachnoid hemorrhage (reflective or shaking).

e. Child Behavioral Indicators of Physical Abuse: Negativism or less compliance with expectations; anger, isolation, or destructiveness; abusive behavior toward parents; difficulty in developing relationships; general unhappiness; either excessive or complete absence of anxiety about separation from parents; inappropriate caretaking behavior toward others; constant searching for attention, favors, food; developmental delay.

f. Historical Indicators of Neglect: Lack of appropriate well-child care, including immunizations; lack of appropriate medical care of chronic illness; absence of necessary health aids such as eyeglasses or hearing aids; absence of appropriate dental care.

g. Physical Indicators of Neglect: Malnourished, poor hygiene, developmental delay, untreated medical conditions, rampant dental caries.

h. Behavioral Indicators of Neglect: Depression, anxiety, enuresis, sleep disturbances, excessive masturbation, impaired interpersonal relations (i.e., lack of cuddliness, relations avoidance, reference for inanimate objects), discipline problems, aggressive behavior, poor school performance, "role reversal" in which child assumes caretaker role, excessive household responsibilities, excluding child care.

i. Physical Indicators of Sexual Assault: Physical trauma to body, complaints of pain, sleep disturbances, genital injury, loss of appetite, vaginal or penile discharge indicative of sexually transmittable disease, pregnancy, difficulty urinating.

j. Behavioral Indicators of Sexual Assault: Withdrawn and daydreaming excessively; poor peer relationships; poor self-esteem; frightened or phobic, especially of adults, distortion of body image; general feelings of shame or guilt, sudden deterioration in academic performance, pseudomature personality development, suicide attempt; regressive behavior, enuresis and/or encopresis, excessive masturbation, highly sexualized play, sexual promiscuity, abused sibling.

5. INDICATORS OF POSSIBLE ABUSE OR NEGLECT OF ELDERS OR DEPENDENT ADULTS:

The following indicators do not signify abuse or neglect per se. They are clues; however, and may be helpful in assessing the client's situation. The physical assessment of abuse should be done by a physician or trained health practitioner.

a. Physical Indicators:

- 1) Injuries that have not been cared for properly.
- 2) Any injury incompatible with history provide.
- 3) Pain on touching.
- 4) Cuts, lacerations, puncture wounds.
- 5) Bruises, welts, discoloration:
 - a) Bilateral on upper arms.
 - b) Clustered on trunk.
 - c) Imprints of objects (i.e., slapping an older person may leave handprint).
 - d) Presence of both old and new bruises at the same time.
- 6) Dehydration/malnutrition without illness-related cause; weight loss.
- 7) Pallor.
- 8) Sunken eyes, cheeks.
- 9) Evidence of inadequate care (i.e., gross decubiti without medical care).
- 10) Eye problems, retinal detachment.
- 11) Poor skin hygiene.
- 12) Absence of hair and/or hemorrhaging below scalp.
- 13) Soiled clothing or bed.
- 14) Burns; may be caused by cigarettes, caustics, acids or friction from ropes.
- 15) Signs of confinement (tied to furniture/bathroom fixtures, locked in room).
- 16) Lack of bandages on injuries or stitches when needed; evidence of unset broken bones.

Injuries are sometimes hidden on areas of the body normally covered by clothing. Repeated injuries should be noted, and careful attention paid to their location and treatment. Frequent use of the emergency department, and/or hospital or health care "shopping" may indicate physical abuse. The lack of appliances such as walker, canes, bedside commodes, and the lack of necessities such as heat, food, and water, may indicate abuse or neglect.

b. Behavioral Indicators: These behaviors in themselves do not indicate abuse or neglect. However, they may be clues and should prompt the worker to ask more questions and look beyond the obvious.

- 1) Fear.
- 2) Withdrawal.
- 3) Depression.
- 4) Helplessness.
- 5) Resignation.

- 6) Hesitation to talk.
- 7) Anger.
- 8) Denial.
- 9) Implausible stories.
- 10) Non-responsiveness.
- 11) Agitation, anxiety.
- 12) Confusion/disorientation.
- 13) Ambivalence/contradictory statements not due to mental dysfunction.

c. Indicators from the Family/Caregiver:

- 1) The older client may not be given the opportunity to speak for them self, or to see others if the suspected abuser is not present.
- 2) Obvious absence of assistance, attitudes of indifference, or anger toward the dependent person.
- 3) Family member or caregiver "blames" the client (i.e., for incontinence).
- 4) Aggressive behavior (threats, insults, harassment).
- 5) Previous history of abuse to others.
- 6) Problems with alcohol or drugs.
- 7) Inappropriate flirtatious behavior.
- 8) Social isolation of the older adult or family.
- 9) Conflicting accounts of incidents by the family, victim, or others.
- 10) Unwillingness/reluctance to work with service providers planning for care.
- 11) Withholding affection.

d. Possible Indicators of Financial Abuse: While the following indicators may suggest financial abuse, the reader should fully evaluate a situation before coming to the conclusion that abuse has occurred. Great care must be taken before making any accusations. The list is not intended to be exhaustive.

- 1) Unusual activity in bank accounts.
- 2) Power of attorney given when the person is unable to comprehend finances.
- 3) Unusual interest in the amount of money being expended for the care of the older person by family members, caregivers or others.

- 4) Refusal to spend money on the care of the older person by responsible parties. Numerous unpaid bills, overdue rent, etc.
- 5) Recent acquaintances expressing exaggerated affection for wealthy elder.
- 6) Recent change of title of house in favor of a "friend" when the older person is incapable of understanding the nature of the transaction.
- 7) Recent will when the person is clearly incapable of making a Will.
- 8) Caregiver asks only financial questions of worker, does not show concern.
- 9) Placement in care facilities that are not commensurate with size of estate.
- 10) Lack of amenities (i.e., TV, personal grooming items, appropriate clothing) which the older person can afford.
- 11) Personal belongings missing (i.e., artwork, silverware, jewelry).
- 12) Promises of life-long care in exchange for willing or deeding property/bank accounts to the caretaker.
- 13) Signatures on checks/documents differing from elder's signature.

November 28, 2017 VHA DIRECTIVE 1199

APPENDIX A

APPLICATION TO VHA PRACTITIONERS: LAWS RELATED TO REPORTING SUSPECTED ABUSE AND NEGLECT

1. FEDERAL LAW APPLICABLE TO VA: CHILD ABUSE a. Federal law, the Victims of Child Abuse Act of 1990, as amended, provides that if a person in a covered profession (including certain cadres of Federal health care professionals), while engaged in that professional capacity or activity on Federal land or in a federally operated (or contracted) facility, learns of facts that give reason to suspect that a child has suffered an incident of child abuse, that person shall make a report of the suspected abuse as soon as possible to the agency designated by the United States Attorney General to receive such reports. See Title 42 United States Code (U.S.C.) 31031. The U.S. Assistant Attorney General also addressed whether a covered professional's mere knowledge that a patient had viewed child pornography would trigger that professional's duty to report the suspected child abuse. It was concluded that a covered professional's knowledge of a patient under his or her care viewing child pornography also triggers the reporting requirement under section 13031, because they may be aware of facts that give reason to suspect that the child-- subject of the pornographic images viewed by the patient-- has suffered an incident of child abuse under 42 U.S.C. 13031(a). In addition, some state laws mandate the reporting of downloading, streaming or accessing child pornography through electronic or digital media.

a. The putative purpose of this timely reporting requirement is to facilitate the investigation and prosecution of these types of crimes by appropriate law enforcement officials. The U.S. Assistant Attorney General advises that "section 13031 is best read to impose a reporting obligation on all persons who, while engaged in the covered professions and activities on Federal lands or in Federal facilities, learn of facts that give reason to suspect that child abuse has occurred, regardless of where the abuse might have occurred or where the suspected victim is cared for or resides." See U.S. Department of Justice, Office of Legal Counsel, Assistant Attorney General's Memorandum for Will A. Gunn General Counsel, United States Department of Veterans Affairs, dated May 29, 2012 [*Re: Duty to Report Suspected Child Abuse Under 42 U.S.C. § 13031*]. That is, a covered professional is required to report suspected child abuse discovered while engaged in the covered activities (i.e., professions or occupations specified in section 13031(b)) on federal lands or in federal facilities. This is not to be interpreted as limiting the reporting requirement to cases of suspected child abuse occurring or taking place on Federal lands or in Federal facilities. "Covered professionals" subject to this requirement include "hospital personnel," "persons performing a healing role," and "social workers." 42 U.S.C. 13031(b)(1), (3).

b. The Department of Justice has issued regulations providing that the reports required under the Act be made to "the local law enforcement agency or the local child care protective services agency that has the jurisdiction to investigate reports of child abuse or to protect child abuse victims in the land area or facility in question." Title 28 Code of Federal Regulations (CFR) 81.2. In other words, Federal law requires the reporting of suspected acts of child abuse to entities designated by state law to receive such reports.

B November 28, 2017 VHA DIRECTIVE 1199 APPENDIX A**A-2**

c. Again, the Federal child abuse reporting law is intended to facilitate the investigation and timely prosecution of such crimes, as the federal prosecution of child abuse crimes is subject to a specified statute of limitations. 18 U.S.C. 3283. A covered professional's failure to make a timely report can result in the imposition of significant criminal penalties. See 18 U.S.C. § 2258. Any questions regarding the scope of the Federal reporting requirement (for suspected child abuse) should be directed to your Office of Chief Counsel in the District (Chief Counsel) who, if necessary, can seek any needed clarification from the local Assistant United States Attorney. (Note that it is the Department of Justice, not VA, which has ultimate responsibility for interpretation and enforcement of this Federal reporting law). **NOTE:** Visit <https://www.va.gov/OGC/DistrictOffices.asp> to locate contact information for your Office of Chief Counsel District.

2. STATE ABUSE AND NEGLECT REPORTING LAWS a. State reporting laws generally pertain to abuse suffered by specified (vulnerable) populations and do not require global reporting of assaults, etc. For the same policy reasons, states have similar reporting laws for certain cadres of professionals who, while acting within their official or professional capacity, learn of or reasonably suspect that a child or an adult is, or has been, the subject of abuse or neglect. In general they are required to report that information as soon as possible to the appropriate local or state law enforcement agency in accordance with state law. These reports are typically directed to state and local law enforcement agencies/department tasked with responsibility for the advocacy, protection, and/or health of such individuals. Those entities then investigate the reports and, if confirmed, refer the reports onward for appropriate prosecution.

a. A state cannot ordinarily compel a VA facility or its employees acting within the scope of their VA employment to comply with state law. Further, the Privacy Act at 5 U.S.C. 552a, the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule at 45 CFR Parts 160 and 164, and 38 U.S.C. 5701 and 7332 govern the disclosure of VA patient information; reporting may not occur unless the requirements of these statutes, as applicable, are followed. Work with your Office of Chief Counsel in the District to determine if a particular case of suspected abuse or neglect of a child or adult is one that is subject to mandatory state reporting requirements and if so whether VA has legal authority to disclose the pertinent information to the state. **NOTE:** Visit <https://www.va.gov/OGC/DistrictOffices.asp> to locate contact information for your Office of Chief Counsel District. Chief Counsels can also advise on how the state reporting laws define covered professionals and other key terms, such as child, adult, abuse, and neglect. As to the latter, adults covered by state reporting laws are characteristically those who are aged, incapacitated, dependent, disabled, ill (particularly from mental health conditions), recipients of certain health care or custodial services, victims of domestic abuse, and the like. In other words, these laws are aimed implicitly at protecting adults who are most vulnerable to abuse and neglect by others and are likely unable to report such incidents to the proper authorities themselves.

B November 28, 2017 VHA DIRECTIVE 1199 APPENDIX A**A-3**

b. In addition to Federal information law concerns and requirements, VHA recognizes that a VA provider's compliance with state reporting laws may be a condition of the provider's state licensure or certification requirements. This can place that VA provider in a difficult position with their state licensing board. In light of these facts, VHA has decided that, as a matter of policy, VHA providers, with the single exception for military sexual trauma (see paragraph 3 of this Appendix), are required to comply with state abuse and neglect reporting laws and procedures provided that all such disclosures are done consistent with Federal law and in the manner described in paragraphs 5 and 6 of this directive. If required by applicable state law, such reports must also include reports of domestic violence/intimate partner violence (DV/IPV) and sexual assaults by non-VA healthcare providers. (Note that other mechanisms, including a regulatory duty to report for employees, are already in place to address reports of abuse and neglect occurring within the VA system separate from the Federal child abuse reporting mandate discussed above.)

c. Reports of abuse and neglect to states in accordance with Federal and state law may only be done in a manner consistent with Federal information disclosure laws. For purposes of this policy, this means that reports are to be filed pursuant to a standing written request letter from a law enforcement agency (ies); in the event no such letter exists, then the report may only be made with the consent of the individual whose information is to be disclosed to the state. See VHA Directive 1605.01, Privacy and Release of Information, dated August 31, 2016, or subsequent policy, and 38 U.S.C. 5701(f). In order for a standing written request to be valid, the letter must be prepared by the qualified representative of the state agency that is qualified as a law enforcement authority charged with the protection of the public health or safety. In order to qualify as a law enforcement authority, the state agency must have the power to enforce some aspect of the state reporting scheme, such as by penalizing the institution for failure to report or by penalizing the individual, who is the subject of the report. VHA facilities should work with the health care facility's Privacy Officer and/or their area Chief Counsels to develop tools to assist them in streamlining and standardizing this reporting activity. Note too that a standing written request letter allows VA to give the name and address of the Veteran who may be the abuser, general information on the individual being abused, and the type of abuse, but a letter pursuant to 5 U.S.C. 552a(b)(7) is required if the state requests the medical records of the Veteran.

3. MILITARY SEXUAL TRAUMA a. For purposes of this policy, VHA has decided not to invoke its permissive authority to either allow or require a covered VHA professional to disclose to states information (pursuant to their abuse reporting laws) that a Veteran, while in service, experienced sexual trauma (to include sexual assault) as that term is described and defined in 38 U.S.C. 1720D(a)(1). VA commonly refers to the type of psychological trauma caused by this experience as military sexual trauma (MST). Simply put, reports of MST, including sexual assault, are excluded from the scope of this policy. This exclusion should be narrow in effect, however, because most Veterans who present for counseling or treatment of MST-related conditions, or who report such an experience to their VA provider, would typically not fall under the categories of adults covered by state reporting laws, e.g., vulnerable adults unable to make such reports to the proper authorities themselves. Moreover, state laws are not likely to include incidents of abuse falling under the investigative and prosecutorial jurisdiction of Department of Defense (DoD).

B November 28, 2017 VHA DIRECTIVE 1199 APPENDIX A**A-4**

a. As for active duty service members (ADSMs), DoD permits those who experience sexual assaults in service to request restricted reporting of that information to their DoD health care providers, thus guaranteeing their chains of command have no access to information about the sexual assaults. To align with DoD's approach in affording ADSMs with the option of requesting restricted reporting of sexual assaults, VHA providers will provide ADSMs receiving MST-related counseling through VA Vet Centers with oral and written information on how to make a report of sexual assault through DoD's safe helpline, which allows for the service member to request and file a restricted report. **NOTE:** *If an ADSM is receiving VA MST-related care or services pursuant to a sharing agreement (38 U.S.C. 8111), then the terms of the sharing agreement dictate the terms of disclosure of patient information.*

b. Information obtained by VHA professionals performing pre-discharge or Integrated Disability Evaluations of an ADSM at a VA facility that confirms or suggests the ADSM experienced MST, including sexual assault, while in service are likewise excluded from the abuse and neglect reporting requirements established by this policy. Instead, these individuals are to receive oral and written information on how to make a restricted report of sexual assault through DoD's safe helpline.

4. APPLICATION TO VHA PRACTITIONERS a. With the exception for adult survivors of MST, the scope of VA's reporting requirement relevant to state law reporting requirements, as established by this policy, extends to cases identified in the performance of VHA authorized health care activities occurring on VA property, in federally operated facilities, and off-site, as that term is defined below. The terms of each state's law(s) will define, among other things, the categories of children and adults, and the type of abuse covered by those laws. In all cases, disclosure of any information must be done in a manner consistent with Federal information disclosure laws, i.e., the Privacy Act at 5 U.S.C. § 552a, the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule at 45 CFR Parts 160 and 164, and 38 U.S.C. 5701 and 7332. If required by state law, they must include reports of Domestic Violence (DV)/ Intimate Partner Violence (IPV).

a. The Federal and state reporting requirements for VHA professionals, as discussed above, extend to VHA examiners who perform forensic health examinations, including Compensation and Pension examinations, or disability-related examinations performed in completing forms pursuant to 38 CFR 17.38(a)(1)(xv).

b. As noted earlier in this appendix, information of MST-related experiences experienced by Veterans will not be reported to the states. Active duty service members receiving MST-related counseling through VA Vet Centers will likewise not be reported to the states; instead, those individuals shall receive oral and written information on how to make a restricted report of sexual assault through DoD's safe helpline.

DEPARTMENT OF VETERANS AFFAIRS NATIONAL RULES OF BEHAVIOR

I understand, accept, and agree to the following terms and conditions that apply to my access to, and use of, information, including U.S. Department of Veterans Affairs (VA) information or information systems.

1. GENERAL RULES OF BEHAVIOR

a. I understand that an essential aspect of my job is to take personal responsibility for the secure use of VA systems and the VA data that they contain or that may be accessed through them, as well as the security and protection of VA information in any form (e.g., digital, paper, verbal).

b. I understand that when I use any government information system, I have NO expectation of privacy in any records that I create or in my activities while accessing or using such information system.

c. I understand that authorized VA personnel may review my conduct or actions concerning VA information and information systems, and take appropriate action. Authorized VA personnel include my supervisory chain of command as well as VA system administrators and Information Security Officers (ISOs). Appropriate action may include monitoring, recording, copying, inspecting, restricting access, blocking, tracking, and disclosing information to authorized Office of Inspector General (OIG), VA, and law enforcement personnel.

d. I understand that the following actions are prohibited: unauthorized access, unauthorized uploading, unauthorized downloading, unauthorized changing, unauthorized circumventing, or unauthorized deleting of information on VA systems, modifying VA systems, unauthorized denying or granting access to VA systems, using VA resources for unauthorized use on VA systems, or otherwise misusing VA systems or resources. I also understand that attempting to engage in any of these unauthorized actions is also prohibited.

e. I understand that such unauthorized attempts or acts may result in disciplinary or other adverse action, as well as criminal or civil penalties. Depending on the severity of the violation, disciplinary or adverse action consequences may include: suspension of access privileges, reprimand, and suspension from work, demotion, or removal. Theft, conversion, or unauthorized disposal or destruction of Federal property or information may also result in criminal sanctions.

f. I understand that I have a responsibility to report suspected or identified information security incidents (security and privacy) to my VA supervisor, ISO and Privacy Officer (PO), immediately upon suspicion.

g. I understand that I have a duty to report information about actual or possible criminal violations involving VA programs, operations, facilities, contracts or information systems to my VA supervisor; Information System Owner, local Chief Information Officer (CIO), or designee; and ISO, any management official or directly to the OIG, including reporting to the OIG Hotline.

I also understand that I have a duty to immediately report to the OIG any possible criminal matters involving felonies, including crimes involving information systems.

h. I understand that the VA National Rules of Behavior (ROB) do not and should not be relied upon to create any other right or benefit, substantive or procedural, enforceable by law, by a party in litigation with the U.S. Government.

i. I understand that the VA National ROB do not supersede any policies of VA facilities and other agency components that provide higher levels of protection to VA's information or information systems. The VA National ROB provides the minimal rules with which individual users must comply.

j. I understand that if I refuse to sign this VA National ROB as required by VA policy, I will be denied access to VA information systems or VA information. Any refusal to sign the VA National ROB may have an adverse impact on my employment with the Department.

2. SPECIFIC RULES OF BEHAVIOR

a. Basic

(1) I will follow established VA information security and privacy policies and procedures.

(2) I will comply with any directions from my supervisors, VA system administrators, POs, and ISOs concerning my access to, and use of, VA information and information systems or matters covered by these ROB.

(3) I understand that I may need to sign a non-VA entity's ROB to obtain access to their system in order to conduct VA business. While using their system, I must comply with their ROB. However, I must also comply with VA's National ROB whenever I am accessing VA information systems or VA information.

(4) I may be required to acknowledge or sign additional specific or unique ROB in order to access or use specific VA systems. I understand that those specific ROB may include, but are not limited to, restrictions or prohibitions on limited personal use, special requirements for access or use of the data in that system, special requirements for the devices used to access that specific system, or special restrictions on interconnections between that system and other IT resources or systems

(5) I understand VA's system of records may contain Confidential Medical Information that relates to the diagnosis or treatment of drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus (HIV), or sickle cell anemia. I will not disclose information relating to the diagnosis or treatment of drug abuse, alcoholism or alcohol abuse, HIV, or sickle cell anemia without appropriate legal authority as outlined in applicable federal laws and regulations, including 38 U.S.C. § 7332. I understand my responsibilities as outlined in 38 U.S.C. § 7332, and I understand unauthorized disclosure of this information may have a serious adverse effect on agency operations, agency assets, or individuals.

b. Data Protection

(1) I will safeguard electronic VA sensitive information at work and remotely. I understand that all VA owned mobile devices and portable storage devices must be encrypted using Federal Information Processing Standards (FIPS) 140-2, *Security Requirements for Cryptographic Modules*, validated encryption (or its successor) unless encryption is not technically possible, as determined and approved by my local ISO, CIO and the Deputy Assistant Secretary for Information Security (DAS for OIS). This includes laptops, flash drives, and other removable storage devices and storage media (e.g., Compact Discs (CD), Digital Video Discs (DVD)).

(2) I understand that per VA Directive 6609, Mailing of Sensitive Personal Information (SPI), the following types of SPI are excluded from the encryption requirement when mailed according to the requirements outlined in the directive:

(a) Information containing the SPI of a single individual to:

1. That person (e.g., the Veteran's, beneficiary's, dependent's, or employee's own information) or to his or her personal representative (e.g., guardian, attorney-in-fact, attorney, or Veteran Service Organization contact person). Such information may be mailed to an entity, not otherwise the subject of an exception, with the express written consent of the individual. Such information may be mailed via U.S. Postal Service regular mail unless tracked delivery service is requested and paid for by the recipient;

2. A business partner such as a health plan or insurance company, after reviewing potential risk;

3. A court, adjudicative body, parties in litigation, or to persons or entities in the course of a judicial or administrative proceeding; and

4. Congress, law enforcement agencies, and other governmental entities.

(b) Information containing SPI of one or more individuals when sent to a person or entity that does not have the capability of decrypting the data, provided that the mailing is approved in advance and in writing by my supervisor or ISO.

(3) I understand that I must have approval from my supervisor to use, process, transport, transmit, download, or store electronic VA sensitive information remotely (outside of VA owned or managed facilities (e.g., medical centers, community based outpatient clinics (CBOC), or regional offices)).

(4) If approved to use, process, store, or transmit electronic VA sensitive information remotely, I must ensure any device I utilize is encrypted using FIPS 140-2 (or its successor) validated encryption. VA owned and approved storage devices/media must use VA's approved configuration and security control requirements. The Information System Owner, local CIO, or designee, and ISO and PO must review and authorize the mechanisms for using,

processing, transporting, transmitting, downloading, or storing VA sensitive data outside of VA owned or managed facilities.

(5) I will ensure that all printouts of VA sensitive information that I work with, as part of my official duties, are physically secured when not in use (e.g., locked cabinet, locked door).

(6) I acknowledge that particular care should be taken to protect SPI aggregated in lists, databases, or logbooks, and will include only the minimum necessary SPI to perform a legitimate business function.

(7) I recognize that access to certain databases, whether regional-level or national-level data, such as data warehouses or registries containing patient or benefit information, and data from other Federal agencies, such as the Centers for Medicare and Medicaid or the Social Security Administration, has the potential to cause great risk to VA, its customers and employees due to the number and/or sensitivity of the records being accessed. I will act accordingly to ensure the confidentiality and security of these data commensurate with this increased potential risk.

(8) If I have been approved by my supervisor to take printouts of VA sensitive information home or to another remote location outside of a VA facility, or if I have been provided the ability to print VA sensitive information from a remote location to a location outside of a VA facility, I must ensure that the printouts are destroyed to meet VA disposal requirements when they are no longer needed and in accordance with all relevant record retention requirements. Two secure options that can be used are to utilize a cross-cut shredder that meets VA and National Institute of Standards and Technology (NIST) requirements or return the printouts to a VA facility for appropriate destruction.

(9) When in an uncontrolled environment (e.g., public access work area, airport, or hotel), I will protect against disclosure of VA sensitive information which could occur by eavesdropping, overhearing, or overlooking (shoulder surfing) from unauthorized persons. I will also follow a clear desk policy that requires me to remove VA sensitive information from view when not in use (e.g., on desks, printers, fax machines, etc.). I will also secure mobile devices and portable storage devices (e.g., laptops, Universal Serial Bus (USB) flash drives, smartphones, tablets, personal digital assistants (PDA)).

(10) I will use VA-approved encryption to encrypt any email, including attachments to the email, which contains VA sensitive information before sending the email. I will not send any email that contains VA sensitive information in an unencrypted form. I will not encrypt email that does not include VA sensitive information or any email excluded from the encryption requirement under paragraph b(2).

(11) I will not auto-forward email messages to addresses outside the VA network.

(12) I will take reasonable steps to ensure fax transmissions are sent to the appropriate destination, including double checking the fax number, confirming delivery of the fax, using a fax cover sheet with the required notification message included and only transmitting individually identifiable information via fax when no other reasonable means exist and when

someone is at the machine to receive the transmission or the receiving machine is in a secure location.

(13) I will protect VA sensitive information from unauthorized disclosure, use, modification, or destruction, and will use encryption products approved and provided by VA to protect sensitive data. I will only provide access to sensitive information to those who have a need-to-know for their professional duties, including only posting sensitive information to web-based collaboration tools restricted to those who have a need-to-know and when proper safeguards are in place for sensitive information. For questions regarding need-to-know and safeguards, I will obtain guidance from my VA supervisor, ISO, and/or Information System Owner, local CIO, or designee before providing any access.

(14) When using wireless connections for VA business I will only use VA authorized wireless connections and will not transmit VA sensitive information via wireless technologies unless the connection uses FIPS 140-2 (or its successor) validated encryption.

(15) I will properly dispose of VA sensitive information, either in hardcopy, softcopy, or electronic format, in accordance with VA policy and procedures.

(16) I will never swap or surrender VA hard drives or other storage devices to anyone other than an authorized Office of Information and Technology (OI&T) employee.

c. Logical Access Controls

(1) I will follow established procedures for requesting access to any VA computer system and for notification to the VA supervisor, ISO, and/or Information System Owner, local CIO, or designee when the access is no longer needed.

(2) I will only use passwords that meet the VA minimum requirements defined in control IA-5: Authenticator Management in VA Handbook 6500, Appendix F, including using compliant passwords for authorized web-based collaboration tools that may not enforce such requirements.

(3) I will not share my password or verify codes. I will protect my verify codes and passwords from unauthorized use and disclosure. I will not divulge a personal username, password, access code, verify code, or other access requirement to anyone.

(4) I will not store my passwords or verify codes in any file on any IT system, unless that file has been encrypted using FIPS 140-2 (or its successor) validated encryption and I am the only person who can decrypt the file. I will not hardcode credentials into scripts or programs.

(5) I will use elevated privileges (e.g., Administrator accounts), if provided for the performance of my official duties, only when such privileges are needed to carry out specifically assigned tasks which require elevated access. When performing general user responsibilities, I will use my individual user account.

d. Remote Access/Teleworking

(1) I understand that remote access is allowed from other Federal Government computers and systems to VA information systems, subject to the terms of VA and the host Federal agency's policies.

(2) I agree that I will directly connect to the VA network whenever possible. If a direct connection to the VA network is not possible, then I will use VA-approved remote access software and services. I will use VA-provided IT equipment for remote access when possible.

(3) I agree that I will not have both a VA network connection and any non-VA network connection (including a modem or phone line or wireless network card, etc.) physically connected to any computer at the same time unless the dual connection is explicitly authorized by my VA supervisor, ISO, and/or Information System Owner, local CIO, or designee.

(4) I am responsible for the security of VA property and information, regardless of my work location. VA security policies are the same and will be enforced at the same rigorous level when I telework as when I am in the office. I will keep government furnished equipment (GFE) and VA information safe, secure, and separated from my personal property and information.

(5) I will ensure that VA sensitive information, in any format, and devices, systems and/or software that contain such information are adequately secured in remote locations (e.g., at home and during travel). I agree that if I work from a remote location, pursuant to an approved telework agreement with VA sensitive information, authorized OI&T personnel may periodically inspect the remote location for compliance with security requirements.

(6) I will protect information about remote access mechanisms from unauthorized use and disclosure.

(7) I will notify my VA supervisor, ISO, and/or Information System Owner, local CIO, or designee prior to any international travel with a mobile device (laptop, PDA) so that appropriate actions can be taken prior to my departure and upon my return, including potentially issuing a specifically configured device for international travel and/or inspecting the device or reimaging the hard drive upon return.

(8) I will exercise a higher level of awareness in protecting mobile devices when traveling internationally as laws and individual rights vary by country and threats against Federal employee devices may be heightened.

(9) I understand that VA prohibits access to VA's internal network from countries that pose a significant security risk. I will therefore not access VA's internal network from any foreign country designated as such unless approved by my VA supervisor, ISO, local CIO, and Information System Owner. This prohibition does not affect access to VA external web applications.

e. Non-VA Owned Systems

(1) I agree that I will not allow VA sensitive information to reside on non-VA systems or devices unless specifically designated and authorized in advance by my VA supervisor, ISO, and Information System Owner, local CIO, or designee. I agree that I will not access, transmit, or store remotely any VA sensitive information that is not encrypted using VA-approved encryption.

(2) I will only use VA-approved solutions for connecting non-VA-owned systems to VA's network. I will follow VA Handbook 6500 requirements for connecting any non-VA equipment to VA's network.

(3) I will not use personally-owned information systems (capable of storing data) on-site at a VA facility to directly connect to VA's network. I will not use personally-owned information systems on-site to perform assigned official duties unless approved by the Information System Owner, local CIO, or designee. I will obtain my Information System Owner, local CIO, or designee's approval prior to using remote access capabilities to connect personally-owned equipment to VA's network while within the VA facility.

f. System Security Controls

(1) I will not attempt to override, circumvent, or disable operational, technical, or management security controls unless expressly directed to do so by authorized VA staff. I will not attempt to alter the security configuration of government equipment unless authorized.

(2) I will only use virus protection software, anti-spyware, and firewall/intrusion detection software authorized by VA on VA equipment.

(3) I will not disable or degrade software programs used by VA that install security software updates to VA computer equipment, to computer equipment used to connect to VA information systems, or to create, store or use VA information.

(4) I agree to have issued GFE scanned and serviced by VA authorized personnel. This may require me to return it promptly to a VA facility upon demand.

(5) I will permit only those authorized by OI&T to perform maintenance on IT components, including installation or removal of hardware or software.

g. System Access

(1) I will use only VA-approved devices, systems, software, services, and data which I am authorized to use, including complying with any software licensing or copyright restrictions.

(2) I will only use VA-approved collaboration technologies for conducting VA business.

(3) I will not download software from the Internet, or other public available sources, offered as free trials, shareware, or other unlicensed software to a VA-owned system.

(4) I will not host, set up, administer, or operate any type of Internet server or wireless access point on any VA network unless explicitly authorized by my Information System Owner,

local CIO, or designee and approved by my ISO. I will ensure that all such activity is in compliance with Federal and VA policies.

(5) I will not attempt to probe computer systems to exploit system controls or to obtain unauthorized access to VA sensitive data.

(6) I will only use my access to VA computer systems and/or records for officially authorized and assigned duties. The use must not violate any VA policy regarding jurisdiction, restrictions, limitations or areas of responsibility.

(7) I will use my access under VA Directive 6001, *Limited Personal Use of Government Office Equipment Including Information Technology*, understanding that this Directive does not pertain to accessing VA applications or records. I will not engage in any activity that is prohibited by the Directive.

(8) I will prevent unauthorized access by another user by ensuring that I log off or lock any VA computer or console before walking away or initiate a comparable application feature that will keep others from accessing the information and resources available in my computing session.

h. Miscellaneous

(1) I will complete mandatory periodic security and privacy awareness training within designated time frames, and complete any additional role-based security training required, based on my roles and responsibilities.

(2) I will take precautions as directed by communications from my ISO and local OI&T staff to protect my computer from emerging threats.

(3) I understand that while logged into authorized Web-based collaboration tools I am a representative of VA and I will abide by the ROB and all other policies and procedures related to these tools.

(4) I will protect government property from theft, loss, destruction, or misuse. I will follow VA policies and procedures for handling Federal Government IT equipment and will sign for items provided to me for my exclusive use and return them when no longer required for VA activities.

(5) If as an Other Federal Government Agency employee, I cause any level of data breach, I understand it may result in disciplinary or other adverse action, as well as criminal or civil penalties; and I recognize that I will be required to complete VA's security and privacy awareness training as part of incident remediation measures.

DRESS CODE

MCP 575-05-41

Western Colorado Health Care System
Grand Junction, CO 81501

Rescinded Document:
MCM 05-41 Dress Code

Signatory Authority:
Executive Director

Effective Date:
June 1, 2020

Responsible Owner:
Human Resources Officer

Recertification Date:
June 30, 2025

1. POLICY

This medical center policy (MCP) establishes guidelines concerning the dress and appearance of employees in order to present a professional image to Veterans, visitors, customers and staff. This policy covers all medical center employees (full and part-time), volunteers, work without compensation (WOC) employees, and contract personnel, while on official status in the medical center.

2. JUSTIFICATION

The personal appearance of all personnel contributes to the overall image of VA Western Colorado Health Care System (WCHCS). It is policy of WCHCS that personnel wear appropriate clothing suitable to the professional healthcare environment and maintain standards of personal hygiene and grooming that promote safety and enhance infection prevention and control.

3. GUIDANCE

a. Every employee should present a positive and professional appearance to the Veterans and other members of the public served.

b. Personal cleanliness, appearance, professionalism and safety are important employee and organization responsibilities. For this reason, anything that could be considered offensive, distracting, or not in the best interest of the Veterans Health Administration (VHA) will not be permitted. Each employee reflects the organization's image.

c. Employees required to wear a uniform should refer to Service specific guidance.

d. Exceptions to the dress code may be granted for medical reasons pursuant to an application for reasonable accommodation as outlined in VA Handbook 5975.1 and/or religious reasons pursuant to Guidelines on Religious Exercise and Religious Expression in the Federal Workplace issued by the White House on August 14, 1997. As outlined in VA Handbook 5975.1, "When a disability or need for reasonable accommodation is not obvious or otherwise not already known to the VA, the Local

Reasonable Accommodation Committee (RCA) may request that the employee submit appropriate medical documentation about the disability and his or her functional limitations through VA Form 0857a." Requests for exceptions should be made through the Supervisor to the Human Resources.

e. The Director may approve activities or events that allow special items of clothing; i.e., holidays, dress down, theme attire, etc.

f. No dress code can anticipate all the potential styles and choices that employees may make.

4. PROCEDURES

a. Hygiene and Grooming:

(1) Employees are expected to be clean and odor-free, included but not limited to excessive perfumes and tobacco smoke.

(2) Hair, beards, sideburns and mustaches will be clean, neat and well groomed.

b. Accessories and Jewelry:

(1) Jewelry, ties, scarves and belts will reflect a professional appearance and not be distracting, contain offensive material, or present a safety hazard.

(2) Facial jewelry, other than earrings are prohibited.

(3) Hats, caps, hoods, head covers, sweat bands, sunglasses and political campaign buttons are considered inappropriate.

c. Makeup, Perfume and Cologne:

(1) Makeup will be worn in moderation, being mindful that excessive makeup may be distracting and offensive to our customers.

(2) The use of perfume, cologne and other scents should be minimal due to a potential reaction by other staff members and customers.

d. Tattoos:

(1) Tattoos deemed to be inappropriate or offensive by the Reasonable Person Standard will be required to be covered at all times during an employee's shift.

(2) Inappropriate or offensive tattoos may depict but are not limited to gang related images, racially inappropriate, sexually suggestive, refers to intolerance or discrimination against any race, color, creed, religion, gender, origin, sexual orientation, or groups that advocate such intolerance or behavior.

e. Name Badges

(1) Name badges are provided by the medical center and must be worn at all times while on station and duty. Badges must be in an upright and readable position with the employee's name and picture visible on the upper torso.

f. Clothing

(1) Clothing should not distract from the mission but should promote it by providing a professional atmosphere.

(2) All clothing is to be clean, wrinkle-free, in good repair, and appropriate to the employee's position. Discretion should be used to length and fit of clothing.

(3) All shoes are to be kept clean, neat and in good repair.

g. Monday through Thursday is established as Business Professional Attire

(1) Monday through Thursday Men's Clothing Options:

Collared, short or long sleeved business or casual shirts, dress slacks or khakis. Jackets and ties are optional (no denim and/or carpenter pants of any color).

(2) Monday through Thursday Women's Clothing Options:

Short or long sleeved business or casual shirts or dresses, tailored sleeveless dresses, shirts, or shells (generally worn with business appropriate jacket or cardigan), dress skirts, dress slacks or khakis. Jackets and hosiery are optional (no denim and/or carpenter pants of any color).

(3) Monday through Friday Footwear:

Dress or casual shoes (including open toe style heels and flats) and dress boots are acceptable. Flip-flops are not acceptable.

h. Casual Friday, Saturday, and Sunday:

(1) If employees are acting in a representative capacity (i.e., meetings with customers and/or facility staff); then they are required to wear business professional attire.

(2) Casual Friday clothing option; blue, black, white, or khaki jeans. Jeans must be in good condition, free of wrinkles, rips, tears or fading, and are clean and with no holes. Shirt and shoe requirements remain unchanged.

i. Inappropriate Clothing and Apparel:

(1) Clothing should not distract from the mission but should promote it by providing a professional atmosphere.

(2) Extreme fashion trends, which could be offensive to Veterans, visitors, customers and other employees, are not acceptable.

(3) Articles of clothing that are inappropriate include but are not limited to the following:

- a) Athletic wear (sweat pants, spandex, wind and jogging suits).
- b) T-shirts, track jackets, jerseys and sweatshirts.
- c) Strapless/Halter/Spaghetti Strap Tops/Dresses.
- d) Uncovered tank tops and muscle shirts.
- e) Shorts, Capri pants and Mini Skirts.
- f) Cargo Pants/unless approved by your Service.
- g) Pajama tops and bottoms.
- h) Plunging/low necklines (front or back).
- i) See through/sheer or revealing garments.
- j) Beach sandals, flip flops, and house shoes/slippers.

6. OTHER PARAGRAPHS

None.

7. DEFINITIONS

a. **Business Casual.** A dress code that allows employees to tone down their professional attire while maintaining a neat and modest appearance.

b. **Business Professional Attire.** A dress code that requires employees to be more formal in their attire and appearance.

c. **Dress Code.** A dress code is a set of standards that organizations develop to help provide their employees with guidance about what is appropriate to wear to work.

8. REFERENCES

a. Guidelines and Religious Exercise and Religious Expression in the Federal Workplace issued by the White House on August 14, 1997.

b. U.S. Equal Employment Opportunity Commission: Religious Garb and Grooming in the Workplace: Rights and Responsibilities.

c. VA Handbook 5975.1 Processing Requests for Reasonable Accommodation from Employees and Applicants with Disabilities

d. Central Office Human Resources Service Letter Number 12-01 dated February 12, 2008, "Workplace Attire".

2. RESCISSION

Medical Center Memorandum (MCM) 05-41 Dress Code, January 2017 is rescinded.

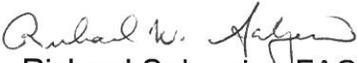
3. REVIEW

This MCP must be reviewed, at minimum at recertification and including when there are any changes to national policy. This review is documented on the WCHCS SharePoint site: <https://dvagov.sharepoint.com/sites/VHAGRJ/SitePages/Home.aspx>. **NOTE: This is an internal VA site that it not available to the public.**

4. RECERTIFICATION

This MCP is scheduled for recertification on or before the last working day of May 31, 2025. This MCP will continue to serve as local policy until it is recertified or rescinded. In the event of contradiction with national policy, the national policy supersedes and controls.

5. SIGNATORY AUTHORITY


Richard Salgueiro, FACHE
Executive Director
Date Approved:

NOTE: *The signature remains valid until rescinded by an appropriate administrative action.*

DISTRIBUTION: Check applicable Distribution Group

- Distribution A – One copy to each Supervisor
- Distribution B – One copy to each clinical Supervisor
- Distribution C – One copy to each administrative Supervisor
- Distribution D – One copy to each employee

MCPs are available at:
<https://dvagov.sharepoint.com/sites/VHAGRJ/SitePages/Home.aspx>.